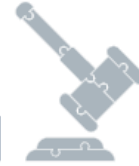




AUTISM SPEAKS®



AUTISM LEGAL  
RESOURCE CENTER

# ABA Through Medicaid EPSDT Tool Kit

A tool kit to help families request funding for Applied Behavior Analysis services through their state Medicaid plan



June 2017

Dear Families:

Thank you for requesting this information packet, which was assembled to help families who are working to secure Medicaid payment for Applied Behavior Analysis (ABA) services. It is our hope that these materials make the process smoother for your family. You may want to share these materials with your ABA provider.

The American population receives its health care coverage from a variety of sources. Some people have private health insurance arranged and paid for (perhaps partially) by their employers. Others purchase health insurance on their own in the individual market. As of January 2014, some Americans purchase insurance through “marketplaces” under the Affordable Care Act. Still others are insured through public insurance programs such as Medicaid or Medicare.

In order to qualify for Medicaid, a child has to either meet certain financial requirements or certain disability requirements. Disability serves as a basis for Medicaid eligibility only in some states, depending on whether that state has adopted a program called TEFRA or Katie Beckett. (See Tab H.) Once a child is eligible for Medicaid, that child is entitled to receive coverage for any covered service in that state’s Medicaid plan or coverable service under federal law.

Under a program called Early Periodic Screening Diagnostic and Treatment (EPSDT), any Medicaid-eligible child under age 21 is entitled to all health care services that are found to be medically necessary to treat conditions discovered in the child. States are required to provide all such services that are coverable under the Federal Medicaid program regardless of whether the service is covered in a state's Medicaid plan.

Although the EPSDT program has been around for decades, only recently did the federal government clarify or emphasize to state Medicaid agencies that all medically necessary services for autism spectrum disorder must be included. (See Tab B.)

The state determines medical necessity on a case-by-case basis; thus, you must include in your request for services documentation showing that ABA is medically necessary for your child in order to get coverage under Medicaid. Within this packet is a sample letter to a state Medicaid agency requesting ABA services under EPSDT, along with suggestions for the documents you should include for your child. (See Tab C.) Some states, or managed care organizations (MCOs)



within states, also require that you file a particular form, such as the “Request for Non-Covered Services” required (at least by some MCOs) in North Carolina. (See Tab D.)

A copy of the EPSDT law is found at Tab A.

At Autism Speaks, we are committed to helping all families access meaningful health insurance coverage for their children with autism. Please do not hesitate to let us know how we can help you.

With kind regards,

Lorri Shealy Unumb, Esq.  
Vice President, State Government Affairs

Daniel Unumb  
President, Autism Legal Resource Center



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## **EPSDT Toolkit**

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## EPSDT Toolkit

### TAB A

Title 42 United States Code

§ 1396a – State Plans for Medical Assistance

§ 1396d(a) – Definitions: Medical Assistance

§ 1396d(r) – Definitions: Early and Periodic  
Screening, Diagnostic and Treatment Services

## §1396a. State plans for medical assistance

### (a) Contents

A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them; . . .

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness; . . .

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals; . . .

(10) provide—

(A) for making **medical assistance** available, **including at least the care and services listed in paragraphs (1) through (5), (17), (21), and (28) of section 1396d(a) of this title**, to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37),<sup>1</sup> 606(h),<sup>1</sup> or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 682(e)(6)<sup>1</sup> of this title),

(II)(aa) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193) and would continue to be paid but for the enactment of that section), (bb) who are qualified severely impaired individuals (as defined in section 1396d(q) of this title), or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under subchapter XVI if subparagraphs (A) and (B) of section 1382(c)(7) of this title were applied without regard to the phrase “the first day of the month following”,

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title,

(IV) who are described in subparagraph (A) or (B) of subsection (I)(1) of this section and whose family income does not exceed the minimum income level

the State is required to establish under subsection (l)(2)(A) of this section for such a family; <sup>2</sup>

(V) who are qualified family members as defined in section 1396d(m)(1) of this title,

(VI) who are described in subparagraph (C) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) of this section for such a family,

(VII) who are described in subparagraph (D) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) of this section for such a family; <sup>2</sup> or

(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of subchapter XVIII, or enrolled for benefits under part B of subchapter XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved, subject to subsection (k); <sup>3</sup>

(ii) at the option of the State, to <sup>4</sup> any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to <sup>4</sup> any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment; <sup>2</sup>

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1396b(f)(4)(C) of this title,

(VI) who would be eligible under the State plan under this subchapter if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1396n of this title they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1396n of this title,

(VII) who would be eligible under the State plan under this subchapter if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1396d(o) of this title; <sup>2</sup>

(VIII) who is a child described in section 1396d(a)(i) of this title—

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of subchapter IV of this chapter) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of subchapter IV of this chapter were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of subchapter IV of this chapter; <sup>2</sup>

(IX) who are described in subsection (l)(1) of this section and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII); <sup>2</sup>

(X) who are described in subsection (m)(1) of this section; <sup>2</sup>

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under subchapter XVI of this chapter), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under section 1382e or 1383c of this title; <sup>2</sup>

(XII) who are described in subsection (z)(1) of this section (relating to certain TB-infected individuals); <sup>2</sup>



(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income (subject, notwithstanding section 1396o of this title, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine); <sup>2</sup>

(XIV) who are optional targeted low-income children described in section 1396d(u)(2)(B) of this title; <sup>2</sup>

(XV) who, but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income, who is at least 16, but less than 65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish; <sup>2</sup>

(XVI) who are employed individuals with a medically improved disability described in section 1396d(v)(1) of this title and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, but only if the State provides medical assistance to individuals described in subclause (XV); <sup>2</sup>

(XVII) who are independent foster care adolescents (as defined in section 1396d(w)(1) of this title), or who are within any reasonable categories of such adolescents specified by the State; <sup>2</sup>

(XVIII) who are described in subsection (aa) of this section (relating to certain breast or cervical cancer patients); <sup>2</sup>

(XIX) who are disabled children described in subsection (cc)(1); <sup>2</sup>

(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh); <sup>2</sup>

(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards); <sup>2</sup> or

(XXII) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1396n(i) of this title, or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A) or (E), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance—

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title or the care and services listed in any 7 of the paragraphs numbered (1) through (24) of such section;

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services;

...

## §1396d. Definitions

For purposes of this subchapter—

### (a) Medical assistance

The term “medical assistance” means payment of part or all of the cost of the following care and services or the care and services themselves, or both (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1) of this section, if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—

- (i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,
- (ii) relatives specified in section 606(b)(1) <sup>1</sup> of this title with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,
- (iii) 65 years of age or older,
- (iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,
- (v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,
- (vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI of this chapter,
- (vii) blind or disabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under subchapter XVI of this chapter,
- (viii) pregnant women,
- (ix) individuals provided extended benefits under section 1396r-6 of this title,
- (x) individuals described in section 1396a(u)(1) of this title,
- (xi) individuals described in section 1396a(z)(1) of this title,
- (xii) employed individuals with a medically improved disability (as defined in subsection (v) of this section),
- (xiii) individuals described in section 1396a(aa) of this title,
- (xiv) individuals described in section 1396a(a)(10)(A)(i)(VIII) or 1396a(a)(10)(A)(i)(IX) of this title,
- (xv) individuals described in section 1396a(a)(10)(A)(ii)(XX) of this title,
- (xvi) individuals described in section 1396a(ii) of this title, or

(xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1396n(i) of this title, or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection,

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for mental diseases);

(2)(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1) of this section) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1) of this section) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (l)(2) of this section) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4)(A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21; (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies; and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb));

(5)(A) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1395x(r)(2) of this title) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1395x(r)(1) of this title);

(6) 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;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services, including 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;

(14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1396a(a)(31) of this title, to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h) of this section;

(17) services furnished by a nurse-midwife (as defined in section 1395x(gg) of this title) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

(18) hospice care (as defined in subsection (o) of this section);

(19) case management services (as defined in section 1396n(g)(2) of this title) and TB-related services described in section 1396a(z)(2)(F) of this title;

(20) respiratory care services (as defined in section 1396a(e)(9)(C) of this title);

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider;

(22) home and community care (to the extent allowed and as defined in section 1396t of this title) for functionally disabled elderly individuals;

(23) community supported living arrangements services (to the extent allowed and as defined in section 1396u of this title);

(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, 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 who is not a member of the individual's family, and (C) furnished in a home or other location;

(25) primary care case management services (as defined in subsection (t) of this section);

(26) services furnished under a PACE program under section 1396u-4 of this title to PACE program eligible individuals enrolled under the program under such section;

(27) subject to subsection (x) of this section, primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease;

(28) freestanding birth center services (as defined in subsection (l)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; and

(29) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary,

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

## [42 USCS § 1396d](#)

Current through PL 115-37, approved 6/2/17

### **United States Code Service - Titles 1 through 54 > TITLE 42. THE PUBLIC HEALTH AND WELFARE > CHAPTER 7. SOCIAL SECURITY ACT > TITLE XIX. GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS**

**(r)** Early and periodic screening, diagnostic, and treatment services. The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

**(1)** Screening services--

**(A)** which are provided--

- (i)** at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1928(c)(2)(B)(i) [[42 USCS § 1396s\(c\)\(2\)\(B\)\(i\)](#)] for pediatric vaccines, and
- (ii)** at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

**(B)** which shall at a minimum include--

- (i)** a comprehensive health and developmental history (including assessment of both physical and mental health development),
- (ii)** a comprehensive unclothed physical exam,
- (iii)** appropriate immunizations (according to the schedule referred to in section 1928(c)(2)(B)(i) [[42 USCS § 1396s\(c\)\(2\)\(B\)\(i\)](#)] for pediatric vaccines) according to age and health history,
- (iv)** laboratory tests (including lead blood level assessment appropriate for age and risk factors), and
- (v)** health education (including anticipatory guidance).

**(2)** Vision services--

**(A)** which are provided--

- (i)** at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
- (ii)** at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

**(B)** which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

**(3)** Dental services--

**(A)** which are provided--

- (i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and
    - (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
  - (B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.
- (4) Hearing services--
- (A) which are provided--
    - (i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
    - (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
  - (B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.
- (5) Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) [subsec. (a) of this section] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this [title \[42 USCS §§ 1396](#) et seq.] shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this [title \[42 USCS §§ 1396](#) et seq.] in early and periodic screening, diagnostic, and treatment services.





## EPSDT Toolkit

### TAB B

Center for Medicaid Services Informational Bulletin,  
*Clarification of Medicaid Coverage of Services to Children  
with Autism, July 7, 2014*

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## CMCS Informational Bulletin

**DATE:** July 7, 2014

**FROM:** Cindy Mann, Director  
Center for Medicaid and CHIP Services

**SUBJECT:** **Clarification of Medicaid Coverage of Services to Children with Autism**

In response to increased interest and activity with respect to services available to children with autism spectrum disorder (ASD), CMS is providing information on approaches available under the federal Medicaid program for providing services to eligible individuals with ASD.

### **Background**

Autism spectrum disorder is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that used to be diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called autism spectrum disorder. Currently, the Center for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD.<sup>1</sup>

Treatments for children with ASD can improve physical and mental development. Generally these treatments can be categorized in four categories: 1) behavioral and communication approaches; 2) dietary approaches; 3) medications; and 4) complementary and alternative medicine.<sup>2</sup> While much of the current national discussion focuses on one particular treatment modality called Applied Behavioral Analysis (ABA), there are other recognized and emerging treatment modalities for children with ASD, including those described in the ASD Services, Final Report on Environmental Scan (see link below)<sup>3</sup>. This bulletin provides information related to services available to individuals with ASD through the federal Medicaid program.

The federal Medicaid program may reimburse for services to address ASD through a variety of authorities. Services can be reimbursed through section 1905(a) of the Social Security Act (the Act), section 1915(i) state plan Home and Community-Based Services, section 1915(c) Home

<sup>1</sup> <http://www.cdc.gov/ncbddd/autism/facts.html>

<sup>2</sup> <http://www.cdc.gov/ncbddd/autism/treatment.html>

<sup>3</sup> <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/Autism-Spectrum-Disorders.pdf>

and Community-Based Services (HCBS) waiver programs and section 1115 research and demonstration programs.

### **State Plan Authorities**

Under the Medicaid state plan, services to address ASD may be covered under several different section 1905(a) benefit categories. Those categories include: section 1905(a)(6) - services of other licensed practitioners; section 1905(a)(13)(c) - preventive services; and section 1905(a)(10) - therapy services. States electing these services may need to update the Medicaid state plan in order to ensure federal financial participation (FFP) is available for expenditures for these services. In addition, for children, as discussed below, states must cover services that could otherwise be covered at state option under these categories consistent with the provisions at 1905(a)(4)(B) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Below is information on these coverage categories for services to address ASD. Under these section 1905(a) benefit categories all other state Medicaid plan requirements such as state-wideness and comparability must also be met.

### **Other Licensed Practitioner Services**

Other Licensed Practitioner services (OLP) services, defined at 42 CFR 440.60, are “medical or remedial care or services, other than physicians’ services, provided by licensed practitioners within the scope of practice as defined under State law.” If a state licenses practitioners who furnish services to address ASD, the state may elect to cover those providers under this section of their state plan even if the providers are not covered under other sections of the plan (e.g., physical therapist, occupational therapist, etc.). A state would need to submit a state plan amendment (SPA) to add the new licensed provider to their Medicaid plan. The SPA must describe the provider’s qualifications and include a reimbursement methodology for paying the provider.

In addition, services that are furnished by non-licensed practitioners under the supervision of a licensed practitioner could be covered under the OLP benefit if the criteria below are met:

- Services are furnished directly by non-licensed practitioners who work under the supervision of the licensed practitioners;
- The licensed provider is able to furnish the service being provided;
- The state’s Scope of Practice Act for the licensed practitioners specifically allows the licensed practitioners to supervise the non-licensed practitioners who furnish the service;
- The state’s Scope of Practice Act also requires the licensed practitioners to assume professional responsibility for the patient and the service furnished by the unlicensed practitioner under their supervision; and
- The licensed practitioners bill for the service;

### **Preventive Services**

Preventive Services, defined at 42 CFR 440.130(c) are “services recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to—

- (1) Prevent disease, disability, and other health conditions or their progression;
- (2) Prolong life; and
- (3) Promote physical and mental health and efficiency”

A regulatory change that took effect January 1, 2014, permits coverage of preventive services furnished by non-licensed practitioners who meet the qualifications set by the state, to furnish services under this state plan benefit as long as the services are recommended by a physician or other licensed practitioner. Under the preventive services benefit, in the state plan, the state must 1) list the services to be provided to ensure that services meet the definition of preventive services as stated in section 4385 of the State Medicaid Manual (including the requirement for the service to involve direct patient care); 2) identify the type(s) of non-licensed practitioners who may furnish the services; and 3) include a summary of the state's provider qualifications that make these practitioners qualified to furnish the services, including any required education, training, experience, credentialing, supervision, oversight and/ or registration.

### Therapy Services

Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders, may be covered under the Medicaid therapies benefit at 42 CFR 440.110. Physical and occupational therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law and provided to a beneficiary by or under the direction of a qualified therapist. Services for individuals with speech, hearing and language disorders mean diagnostic, screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

States would need to include an assurance in the state plan that the state furnishes the therapy in accordance with 42 CFR 440.110. States would also need to describe the supervisory arrangements if a practitioner is furnishing the therapy under the direction of a qualified therapist. Finally, for audiology services, the state plan must reflect the supervision requirements as set forth at 42 CFR 440.110(c)(3).

### Section 1915(i) of the Social Security Act

States can offer a variety of services under a section 1915(i) state plan Home and Community-Based Services (HCBS) benefit. The benefit may be targeted to one or more specific populations including individuals with ASD and can provide services and supports above and beyond those included in section 1905(a). Participants must meet state-defined criteria based on need and typically receive a combination of acute-care medical services (like dental services, skilled nursing services) and other long-term services such as respite care, supported employment, habilitative supports, and environmental modifications.

### Other Medicaid Authorities

There are several other Medicaid authorities that may be used to provide services to address ASD. Below is a discussion of each of those authorities:

### Section 1915 (c) of the Social Security Act

The section 1915(c) Home and Community-Based Services waiver program allows states to provide a combination of medical services and long-term services and supports. Services include

but are not limited to adult day health services, habilitation (both day and residential), and respite care. States can also propose “other” types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. Participants must meet an institutional level of care but are served in the community. Section 1915(c) waiver programs also require that services be furnished in home and community-based settings. For individuals under the age of 21 who are eligible for EPSDT services, an HCBS waiver could provide services and supports for ASD that are above and beyond services listed in section 1905(a), such as respite care. Additionally, for individuals who are receiving state plan benefits as part of EPSDT that are not available to adults under the state plan, waiver services may be used to help these individuals transition into adulthood and not lose valuable necessary services and supports.

#### Section 1115 Research and Demonstration Waiver

Section 1115 of the Act provides the Secretary of the Department of Health and Human Services broad authority to authorize experimental, pilot, or demonstration programs that promote the objectives of the Medicaid program. Flexibility under section 1115 is sufficiently broad to allow States to test substantially new ideas, including benefit design or delivery system reform, of policy merit. The Secretary can approve an 1115 demonstration for up to five years, and states may submit extension requests to continue the program for additional periods of time. Demonstrations must be "budget neutral" over the life of the program, meaning they cannot be expected to cost the Federal government more than it would cost without the demonstration.

#### EPSDT Benefit Requirements

Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to arrange for and cover for individuals eligible for the EPSDT benefit any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. Good clinical practice requires ruling out any additional medical issues and not assuming that a behavioral manifestation is always attributable to the ASD. EPSDT also requires medically necessary diagnostic and treatment services. When a screening examination indicates the need for further evaluation of a child’s health, the child should be appropriately referred for diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to assure that children get the health care they need, when they need it – the right care to the right child at the right time in the right setting.

The role of states is to make sure all covered services are available as well as to assure that families of enrolled children, including children with ASD, are aware of and have access to a broad range of services to meet the individual child’s needs; that is, all services that can be covered under section 1905(a), including licensed practitioners’ services; speech, occupational,

and physical therapies; physician services; private duty nursing; personal care services; home health, medical equipment and supplies; rehabilitative services; and vision, hearing, and dental services.

If a service, supply or equipment that has been determined to be medically necessary for a child is not listed as covered (for adults) in a state's Medicaid State Plan, the state will nonetheless need to arrange for and cover it for the child as long as the service or supply is included within the categories of mandatory and optional services listed in section 1905(a) of the Social Security Act. This longstanding coverage design is intended to ensure a comprehensive, high-quality health care benefit for eligible individuals under age 21, including for those with ASD, based on individual determinations of medical necessity.

### **Implications for Existing Section 1915(c), Section 1915 (i) and Section 1115 Programs**

In states with existing 1915(c) waivers that provide services to address ASD, this 1905(a) policy clarification may impact on an individual's eligibility for the waiver. Waiver services are separated into two categories: waiver services and extended state plan services. Extended state plan services related to section 1905(a) services are not available to individuals under the age of 21 (individuals eligible for EPSDT) because of the expectation that EPSDT will meet the individual's needs. There are therefore a limited number of services that can be provided to this age group under 1915 (c) waivers, primarily respite, and/or environmental/vehicle modifications.

For states that currently provide waiver services to individuals under age 21 to address ASD, the ability to provide services under the 1905(a) state plan may have the effect of making these individuals ineligible for the waiver unless another waiver service is provided. This implication is especially important for individuals with ASD who may not otherwise be eligible for Medicaid absent the (c) waiver. States need to ensure that these individuals are receiving a waiver service, not coverable under section 1905(a), to ensure that they do not lose access to all Medicaid services by losing waiver eligibility. Individuals age 21 and older may continue to receive services to address ASD through the waiver if a state does not elect to provide these services to adults under its Medicaid state plan.

The same issues arise for children under the 1915(i) authority, which allows for services above and beyond section 1905(a) to be provided under the state plan. CMS is available to provide technical assistance to states that currently have approved waivers or state plans that may be impacted by this clarification. Similarly, states with existing 1115 demonstrations authorizing reimbursement for services provided to children with autism should contact CMS to ensure that EPSDT requirements are met.

We hope this information is helpful. If you have questions please send them to [AutismServicesQuestions@cms.hhs.gov](mailto:AutismServicesQuestions@cms.hhs.gov).



## EPSDT Toolkit

### TAB C

Sample Template Letter to Request EPSDT Authorization

Date

Dear [State Medicaid Agency]:

My name is Mary Smith, and I am the parent of an X-year-old child with autism, John Smith. John's doctor has recommended Applied Behavior Analysis and determined it to be medically necessary for John. I write to request authorization for Applied Behavior Analysis services under the Early Periodic Screening Diagnostic and Treatment (EPSDT) provision of our State Medicaid Plan. In support of my request, I attach the following:

- 1 – A copy of John's Medicaid card
- 2 – A copy of John's diagnosis with autism by a licensed medical professional
- 3 – A copy of the recommendation for Applied Behavior Analysis services with the notation of medical necessity

Please let me know if you require additional information. I can be reached at 333-333-3333 or [first.name@emailaddress.com](mailto:first.name@emailaddress.com).

Thank you in advance for your prompt attention to this request.

With kind regards,

First Name Last Name

Full Address





**EPSDT Toolkit**

**TAB D**

North Carolina Request for Non-Covered Services



## About EPSDT

The **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** entitles Medicaid beneficiaries under the age of 21 to medically necessary screening, diagnostic and treatment services within the scope of Social Security Act that are needed to “correct or ameliorate defects and physical and mental illnesses and conditions,” regardless of whether the requested service is covered in the NC State Plan for Medical Assistance. This means that children under 21 years of age can receive services in excess of benefit limits, or even if the service is no longer covered or not covered under the State Plan. To request a service that is not covered by the State Plan but covered under 1905(a) of the Social Security Act, please email Non-Covered State Medicaid Plan Services Request Form for Recipients Under the Age of 21 to [UM@TrilliumNC.org](mailto:UM@TrilliumNC.org).

According to CMS, “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. Basic EPSDT criteria are that the service must be covered under 1905(a) of the Social Security Act, and that it must be safe, effective, generally recognized as an accepted method of medical practice or treatment, and cannot be experimental or investigational (which means that most clinical trials cannot be covered).

All requests for MH/IDD/SA services for Medicaid-eligible children under the age of 21 are reviewed using EPSDT criteria. Requests for NC Innovations Waiver services are reviewed under EPSDT if the request is both a waiver and an EPSDT service. Most NC Innovations Waiver services are not covered under the Social Security Act (i.e. respite, home modifications and all habilitative services).

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Definitions of the Federal Medicaid services can be found in the [Code of Federal Regulations 42 CFR 440.1-440.170](#).

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**Trillium requires Prior Approval for EPSDT services. Please use the form starting on page 2.**



Please submit the completed form using secure email to the Trillium Health Resources UM Department, at [UM@TrilliumNC.org](mailto:UM@TrilliumNC.org). You may use additional sheets to supply any other information you think would be helpful. Include evidence-based literature, if available.

1. Recipient Information: This must be completed by a physician, licensed clinician, or other provider.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (mm/dd/yyyy)      Medicaid ID Number: \_\_\_\_\_

Address:

Empty rectangular box for recipient address.

2. Medical Necessity: All requested information, including CPT and HCPCS codes, if applicable, as well as provider information, must be completed. Please submit medical records that support medical necessity.

Requestor Name: \_\_\_\_\_ Requestor Name: \_\_\_\_\_

NPI: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Requested procedure,  
product or service: \_\_\_\_\_ CPT/HCPCS code: \_\_\_\_\_ / \_\_\_\_\_

3. In what capacity have you treated the recipient? (Include how long you have cared for the recipient and the nature of the care.)

Large empty rectangular box for provider information and care details.

4. What is the recipient's health history?

5. What is/are the recent diagnosis(es) related to this request? (Include the onset and course of the disease and the recipient's current status.)

6. What treatment has been given for the diagnosis(es) above? (Include previous and current treatment regimens, duration, treatment goals, and the recipient's response to treatment(s).)

7. Please provide a description of how the requested procedure, product or service will correct or ameliorate the recipient's defect, physical or mental illness, or condition (the problem.) This description *must* include a detailed discussion about how the service, product, or procedure will improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Is this request for an experimental or investigational treatment?  Yes  No

If yes, provide name and protocol number \_\_\_\_\_

8. Is the requested product, service or procedure effective?  Yes  No

If no, please explain

9. Are there alternatives to the product, procedure, or service requested that would be more cost effective but similarly medically effective?  Yes  No

If yes, specify what alternatives are appropriate for the recipient and provide evidence base with this request, if available

10. What is the expected duration of treatment?

\_\_\_\_\_  
Requestor's Signature & Credentials

\_\_\_\_\_  
Date



**EPSDT Toolkit**

**TAB E**

List of State Medicaid Agencies and Links to State  
Descriptions and Plans

## Medicaid: State by State Descriptions & Plans

Medicaid is a federal-state partnership, with state laws, state regulations, federally approved state waivers, and approved "state plans" all creating significant variations from state to state. Listed below are selected links to information about existing Medicaid plans and reform proposals within individual states. It is hoped they will be of general use:

1) to residents seeking basic information about their individual state.

2) to policymakers and researchers interested in comparing activities in one state to those in another.

NOTE: The links listed below were published either by state agencies or by state-based research and advocacy organizations. Please consider and evaluate:

1. the source as listed and described, including any potentially partisan presentation
  2. the date of the information.
  3. nothing contained on this page is intended as legal or medical advice.
- [Centers for Medicare and Medicaid Services \(CMS\)](#) - details from the federal agency -7/09
  - [Federal Poverty Guidelines for 2009](#) - published by HHS January 23, 2009
  - [National Association of State Medicaid Directors \(NASMD\)](#)
  - [State Medicaid Information](#) - 50 state statistics by Kaiser Commission on Medicaid and the Uninsured
  - [Medicaid: State Facts Online](#) - by Kaiser Family Foundation
  - [Medicaid - General State Information](#) by Families USA (includes consumer contacts; updated frequently)
  - [Additional Federal Allocations \(FMAP\) to States for Medicaid Costs](#) under the American Recovery and Reinvestment Act of 2009 (PL 111-5) **Updated** 3/09
  - Basic [Federal Matching Fund Rate \(FMAP\)](#) for all 50 states - how much is paid for each dollar expended in FY2008 and FY2009\*  
\* NOTE: FY 2009 figures were published in the Federal Register November 2007
  - [Medicaid by National Conference of State Legislatures](#) - health policy research for the 50 states
  - [State Medicaid Sites on the Web: State agency home pages](#) (via Murphy's Unofficial Medicaid Page)
  
  - [ALABAMA: Official state agency](#)
  - [ALASKA: Medicaid](#) (Division of Public Assistance; Dept. of Health & Social Services) - 3/08
  - [ARIZONA: Medicaid \(AHCCCS\)](#)
  - [ARKANSAS: Medicaid](#)
  - [CALIFORNIA: Medi-Cal \(Medicaid State agency\)](#) (Dept. of Health Services) | [Pharmaceuticals](#)
  - [COLORADO: Office of Medical Assistance](#) **Updated** 7/09
  - [CONNECTICUT: Medicaid](#) (Dept. of Social Services)
  - [DELAWARE Medicaid](#) (Dept. of Health & Social Services)
  - [DISTRICT OF COLUMBIA Medicaid](#) (Dept. of Health) | [Pharmaceuticals-PDL](#)
  - [FLORIDA: Medicaid](#) (Agency for Health Care Administration) | [Pharmaceuticals](#) **Updated** 5/21/10
  - [GEORGIA: Medicaid / description 2008](#) (Dept. of Community Health)
  - [HAWAII Medicaid](#) (Med-QUEST Div; Dept. of Human Services)
  - [IDAHO: Division of Medicaid | ID Medicaid](#) (Dept. of Health & Welfare) | [Pharmaceuticals](#) **Updated** 3/2011
  - [ILLINOIS: Medicaid](#) (Dept. of Health & Family Services [HFS])
  - [INDIANA Medicaid program](#) (Family and Social Services Agency [FSSA]) | [Pharmaceuticals](#) **Updated** 4/21/2010
  - [IOWA Medicaid / description for consumers, 2008](#) (Dept. of Human Services)
  - [KANSAS Medicaid](#) (KS Health Policy Authority) - 11/06
  - [KENTUCKY: Medicaid Services Dept.](#) (Cabinet for Health and Family Services)
  - [LOUISIANA: Medicaid](#) (Medicaid- Bureau of Health Services Financing, Dept. of Health & Hospitals)
  - [MAINE: MaineCare Office of MaineCare Services](#)- 8/07
  - [MARYLAND: Medicaid Program](#) - (MD Department of Health & Mental Hygiene)
  - [MASSACHUSETTS: Medicaid/MassHealth](#) (Division of Medical Assistance)
  - [MICHIGAN Medicaid agency](#) **Updated** 3/09
  - [MINNESOTA Medicaid](#) (MN. Dept of Human Services)
  - [MISSISSIPPI: Division of Medicaid](#) (official state agency)
  - [MISSOURI: Medicaid](#)
  - [MONTANA: Medicaid](#) - 3/08
  - [NEBRASKA: Medicaid Program](#)
  - [NEVADA Medicaid](#) (Division of Health Care Financing & Policy)
  - [NEW HAMPSHIRE: Medicaid Services | Pharmaceuticals](#)

- [NEW JERSEY: Medicaid](#) - Medical Assistance and Health Services
- [NEW MEXICO: Medicaid Division info.](#) | [Pharmaceuticals](#)
- [NEW YORK: Medicaid](#) (Dept. of Health) | [Pharmaceuticals](#) | [Consumer Rx Prices](#)
- [NORTH CAROLINA: Medicaid - Division of Medical Assistance](#)
- [NORTH DAKOTA - Medicaid Agency](#)  
> North Dakota: [Medicaid](#) - other information
- [OHIO: Medicaid agency](#)
- [OKLAHOMA Medicaid](#) (OK Health Care Authority)
- [OREGON: Oregon Health Plan](#) (Medicaid) ~~Updated~~<sup>3/10</sup>
- [PENNSYLVANIA: Office of Medical Assistance Programs \(OMAP - Medicaid\)](#) | [Pharmaceuticals](#)
- [RHODE ISLAND: Medicaid](#) (Department of Human Services)
- [SOUTH CAROLINA: Medicaid](#)
- [SOUTH DAKOTA Medicaid office](#); + [Program Expenditures](#)
- [TENNESSEE: TennCare Agency](#) - serving Medicaid eligibles and more | [Pharmaceuticals](#)
- [TEXAS: Medicaid](#) (Health and Human Services Commission) | [Pharmaceuticals](#)
- [UTAH: Medicaid](#) (Dept. of Health) | [Pharmaceuticals](#)
- [VERMONT Medicaid Program](#)
- [VIRGINIA: Medicaid](#) (Dept. of Medical Assistance Services)
- [WASHINGTON: Medical Assistance](#) (Health & Recovery Services Admin.) | [Pharmaceuticals](#)
- [WEST VIRGINIA: Medicaid](#) (Bureau for Medical Services) | [Pharmaceuticals](#)
- [WISCONSIN: ForwardHealth \(Medicaid\)](#) (Dept. of Health and Family Services) | [Pharmaceuticals](#)
- [WYOMING: Medicaid \(EqualityCare\)](#) Office of Healthcare Financing (OHCF), Dept. of Health ~~Updated~~<sup>7/11</sup>





## EPSDT Toolkit

### TAB F

Center for Medicaid Services and State Medicaid Agency  
Contacts

CMS AND STATE EPSDT CONTACTS

Updated January 2016

Region/State	Contact	Address	Telephone Number	Email
<b>Region I</b>	Aimee Campbell-O'Connor	John F. Kennedy Federal Building Room 2325 Boston, MA 02203	617-565-1642	<a href="mailto:Aimee.campbell-oconnor@cms.hhs.gov">Aimee.campbell-oconnor@cms.hhs.gov</a>
CT	Patricia O'Hagan	Department of Social Services 25 Sigourney Street Hartford, CT 06106	860-424-5636 860-424-4958 (fax)	<a href="mailto:Patricia.O'Hagan@ct.gov">Patricia.O'Hagan@ct.gov</a>
MA	Priscilla Ryan Portis, Director	MassHealth, Specialty Provider Network EOHHS/ Providers & Plans 100 Hancock Street, 6th Floor Quincy, MA 02171	617-847-6545	<a href="mailto:Priscilla.portis@state.ma.us">Priscilla.portis@state.ma.us</a>
ME	Beth Pearce	Beth A. Pearce, EPSDT Coordinator DHHS Office of MaineCare Services 11 State House Station Augusta, ME 04333  Ginger Roberts-Scott Children and Waiver Services Program Manager DHHS, MaineCare Services 11 SHS, 242 State Street Augusta, ME 04333	207-624-4006 Fax#: 207-287-8682  207-624-4048	<a href="mailto:Beth.Pearce@maine.gov">Beth.Pearce@maine.gov</a>  <a href="mailto:Ginger.Roberts-scott@maine.gov">Ginger.Roberts-scott@maine.gov</a>
NH	Constance Manus (financial reporting)  Jane Hybsch (policy)	NH DHHS Office of the Commissioner 129 Pleasant Street Concord, NH 03301-6521  NH DHHS, Thayer 105 Pleasant Street Concord, NH 03301	603-271-9294  603-271-4367	<a href="mailto:constance.manus@dhhs.state.nh.us">constance.manus@dhhs.state.nh.us</a>  <a href="mailto:jane.hybsch@dhhs.state.nh.us">jane.hybsch@dhhs.state.nh.us</a>

CMS AND STATE EPSDT CONTACTS

Region/State	Contact	Address	Telephone Number	Email
RI	Deborah J. Florio, Administrator	Center for Child and Family Health Office of Health & Human Services 600 New London Ave Cranston, RI 02920	401-462-0140  401-462-6353 (fax)	<a href="mailto:Deb.Florio@ohhs.ri.gov">Deb.Florio@ohhs.ri.gov</a>
VT	Susan Coburn, MPH RD  Wendy Davis, MD	Vermont Department of Health Division of Community Public Health P.O. Box 70 Burlington, VT 05404	802-652-4184  802-863-7229 (fax)	<a href="mailto:Susan.Coburn@state.vt.us">Susan.Coburn@state.vt.us</a>  <a href="mailto:Wendy.davis@state.vt.us">Wendy.davis@state.vt.us</a>
<b>Region II</b>	Nicole McKnight Vennetta Harrison	26 Federal Plaza Room-37-100 New York, NY 10278	212-616-2429 212-616-2214	<a href="mailto:nicole.mcknight@cms.hhs.gov">nicole.mcknight@cms.hhs.gov</a> <a href="mailto:vennetta.harrison@cms.hhs.gov">vennetta.harrison@cms.hhs.gov</a>
NJ	Valerie Harr Deputy Director	State of New Jersey Department of Human Services Div. of Medical Asst. & Health Services Quackerbridge Plaza Building 7 P O Box 712 Trenton, N.J. 08625	609-588-2601 or 800-356-1561	<a href="mailto:Valerie.j.harr@dhs.state.nj.us">Valerie.j.harr@dhs.state.nj.us</a>
NY	Ron Bass Director	New York State Dept. of Health Bureau of Policy Development and Coverage Office of Health Insurance Programs One Commerce Plaza, Room 727 Albany, NY 12260	518-473-2160	<a href="mailto:Rjb08@health.state.ny.us">Rjb08@health.state.ny.us</a>
PR	Ricardo Colon Padilla Medicaid & CHIP Director	Puerto Rico Department of Health Medicaid Program P. O. Box 70184 San Juan, Puerto Rico 00936-8184	787-765-2929 x 6700	<a href="mailto:Ricardo.colon@salud.pr.gov">Ricardo.colon@salud.pr.gov</a>
VI	Renée Joseph Rhymer, MSW Medicaid Director	Bureau of Health Insurance and Medical Assistance Department of Human Services 1303 Hospital Ground, Building A	340-774-0930 x4353/4398	<a href="mailto:Renee.JosephRhymer@dhs.vi.gov">Renee.JosephRhymer@dhs.vi.gov</a>

Region/State	Contact	Address	Telephone Number	Email
		St. Thomas, USVI 00802		
<b>Region III</b>	Margaret Kosherzenko	The Public Ledger Building 150 S. Independence Mall West, Suite 216 Philadelphia, PA 19106-3499	215-861-4288 215-861-4280 (fax)	<a href="mailto:Margaret.Kosherzenko@cms.hhs.gov">Margaret.Kosherzenko@cms.hhs.gov</a>
DE	Stephen Groff	Social Services Senior Administrator Dept. of Health and Social Services Division of Social Services P.O. Box 906 New Castle, Delaware 19720-0906	(302) 255-9663 302-577-4899 (fax)	<a href="mailto:Stephen.groff@state.de.us">Stephen.groff@state.de.us</a>
DC	Colleen Sonosky, JD	Department of Children's Health Services Department of Health Care Finance Government of the District of Columbia 441 4 <sup>th</sup> Street, NW Washington DC 20001	202-442-5913 202-442-4790 (fax)	<a href="mailto:Colleen.sonosky@dc.gov">Colleen.sonosky@dc.gov</a>
MD	Michelle Lehner Deputy Director	Dept. of Health and Mental Hygiene Acute Care, Office of Health Services State Office Building Complex 201 West Preston Street Baltimore, MD 21201	410 767-1489 410-333-5185 (fax)	<a href="mailto:lehnerm@dhmh.state.md.us">lehnerm@dhmh.state.md.us</a>
PA	Barry C. Decker	HSPSS Bureau of Policy, Budget and Planning Office of Medical Assistance Programs Pennsylvania Department of Public Welfare 17105	717 772-6113	<a href="mailto:bdecker@state.pa.us">bdecker@state.pa.us</a>
VA	Ashley Harrell  Daniel A. Plain Sr. Health Care Services Manager	Dept. Of Medical Assistance Services 600 East Broad Street, Suite 1300 Richmond, VA 23219	804 786-0342  804-786-3206 804-225-3961 fax	<a href="mailto:ashley.harrell@dmas.virginia.gov">ashley.harrell@dmas.virginia.gov</a>  <a href="mailto:Daniel.Plain@dmas.virginia.gov">Daniel.Plain@dmas.virginia.gov</a>

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**EPSDT Toolkit**

**TAB G**

Letter from Center for Medicaid Services Regarding  
EPSDT in Managed Care

*CMCS Informational Bulletin*

**DATE:** January 5, 2017

**FROM:** Vikki Wachino, Director  
Center for Medicaid & CHIP Services (CMCS)

**SUBJECT: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for children and youth in managed care**

For more than 40 years, Medicaid's EPSDT benefit has ensured that children and youth under age 21 receive a comprehensive array of preventive, diagnostic, and treatment services, as specified in section 1905(r) of the Social Security Act (the Act). This pediatric benefit is a comprehensive, high quality health benefit and helps meet children's health and developmental needs. EPSDT covers age-appropriate medical, dental, vision and hearing screening services at specified times, and when health problems arise or are suspected. In addition to screening, EPSDT covers diagnostic and treatment services described in section 1905(a) of the Act to correct or ameliorate identified conditions.

States have flexibility in determining how to ensure the provision of these services. Specifically, beneficiaries under age 21 are entitled to EPSDT services, whether they are enrolled in a managed care plan or receive services in a fee-for-service (FFS) delivery system. In states that use managed care to deliver some or all of the services included in the EPSDT benefit, it is important to include enough specificity in managed care plan contracts to avoid confusion about what the benefit includes and what entity is responsible for delivering it to ensure that eligible individuals under age 21 have access to the full EPSDT benefit.

States and plans can accomplish this in three ways.

First, states can be clear in their managed care contracts about the scope of services the state expects the plan to provide to children. Contracts between the state and the managed care plan must identify, define, and specify the amount, duration, and scope of each service that the managed care plan is required to furnish to enrollees (42 C.F.R. §438.210(a)(1)).<sup>1</sup> If a managed care plan is expected to provide the full range of preventive, screening, diagnostic and treatment services which must be available to beneficiaries under age 21, in other words the full EPSDT benefit, it must be clearly stated and described in the contract between the state and the managed care plan. Alternatively, states may carve out some EPSDT services, or services beyond contracted limits, and retain responsibility for them in fee-for-service coverage, or contract with another managed care plan to provide those services. For example, states may include well-child screenings and medical services within the managed care contract, but exclude behavioral health, dental care, or other services when they are provided through other contracts or through FFS. If a

<sup>1</sup> Pursuant to 42 C.F.R. §457.1230(d), the provisions in §438.210, excluding paragraphs (a)(5) and (b)(2)(iii), apply to CHIP managed care contracts.



managed care plan is not required under its contract to provide all EPSDT services, the contract must clearly describe which services are included.

Any EPSDT benefits not provided by the managed care plan remain the responsibility of the state Medicaid agency, so that in combination with benefits delivered through managed care and directly by the agency, eligible individuals under age 21 will have access to the full EPSDT benefit. If a managed care contract excludes benefits over specified limits, the state retains responsibility for providing necessary services above those limits.

Second, contracts should reflect a state's decision with respect to whether a plan or the state carries responsibility for informing beneficiaries of EPSDT benefits. States must inform all eligible individuals under age 21 about EPSDT benefits, provide or arrange for the provision of screening services in all cases where they are requested, and arrange for corrective treatment (42 C.F.R. §441.56). If the managed care plan's contract includes coverage of services within the EPSDT benefit, the plan's enrollee handbook must include information about EPSDT, both information on services provided by the plan as well as other EPSDT services delivered outside the plan and how to access them if applicable.

Finally, states must also report EPSDT data, by age and by basis of eligibility, on child health screening services, referrals for corrective treatment, and dental services to the Secretary each fiscal year, pursuant to section 1902(a)(43) of the Act. Fulfilling this obligation requires participation from contracted managed care plans, and contracts should ensure that states have access to the plan data necessary to meet this requirement.

In addition, states have options as to how to incorporate the EPSDT benefit into their state plan. Many states add language to each service section of the plan specifying that limitations in the plan do not apply to EPSDT eligible beneficiaries under age 21. Other states detail services available only to children in a separate EPSDT section of the state plan. To assure consistency and that the state plan reflects the statutory requirements, we encourage states to consider including the following language in their state Medicaid plan:

*All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT-eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.*

For more information about EPSDT, please see [EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents](#)

For more information about this bulletin, please contact Susan Ruiz at [susan.ruiz@cms.hhs.gov](mailto:susan.ruiz@cms.hhs.gov) or call 415-744-3567.



## EPSDT Toolkit

### TAB H

Guide to Medicaid Eligibility-Katie Becket/TEFRA List



# EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents



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**Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**

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## I. INTRODUCTION

The Medicaid program's benefit for children and adolescents is known as Early and Periodic Screening, Diagnostic and Treatment services, or EPSDT. EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act). The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.

***EPSDT's goal is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.***

States share responsibility for implementing the benefit, along with the Centers for Medicare & Medicaid Services (CMS). States have an affirmative obligation to make sure that Medicaid-eligible children and their families are aware of EPSDT and have access to required screenings and necessary treatment services.<sup>1</sup> States also have broad flexibility to determine how to best ensure such services are provided. In general, they either administer the benefit outright (through fee for service arrangements) or provide oversight to private entities with whom they have contracted to administer the benefit (e.g., managed care entities). States must arrange (directly or through delegations or contracts) for children to receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions. Through the EPSDT benefit, children's health problems should be addressed before they become advanced and treatment is more difficult and costly.

<sup>1</sup> CMS, State Medicaid Manual §§ 5010, 5121, 5310 (requiring states to “[a]ssure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly, . . . that informing methods are effective, . . . [and] that services covered under Medicaid are available.”)

EPSDT entitles enrolled infants, children and adolescents to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Act if that treatment or service is necessary to “correct or ameliorate” defects and physical and mental illnesses or conditions.<sup>2</sup> 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 and substance use disorders; treatment for vision, hearing and dental diseases and disorders, and much more. This broad coverage requirement results in a comprehensive, high-quality health benefit for children under age 21 enrolled in Medicaid.

***Children’s health problems should be addressed before they become advanced and treatment is more difficult and costly.***

States report annually to CMS certain data about their delivery of services under the EPSDT benefit.<sup>3</sup> The reporting is made on the [CMS Form 416](#). CMS and states use this data to monitor EPSDT performance.

This guide is intended to help states, health care providers and others to understand the scope of services that are covered under EPSDT so that they may realize EPSDT’s goals and provide the best possible child and adolescent health benefit through their Medicaid programs. While it does not establish new EPSDT policy, this guide serves the important purpose of compiling into a single document various EPSDT policy guidances that CMS has issued over the years.

**This guide outlines:**

- ✓ EPSDT’s screening requirements, including when interperiodic screening should be provided;
- ✓ Scope of services covered under EPSDT;
- ✓ EPSDT’s requirements governing dental, vision, and hearing services;
- ✓ Permissible limitations on service coverage under EPSDT;

<sup>2</sup> Section 1905(r)(5) of the Social Security Act.

<sup>3</sup> Sections 1902(a)(43)(D) and 2108(e) of the Social Security Act; CMS, State Medicaid Manual § 2700.4.

- ✓ States' responsibilities to assure access to EPSDT services and providers;
- ✓ Assistance to states as they work with managed care plans to provide the best child health benefit possible; and
- ✓ Notice and appeal procedures required when services are denied, reduced or terminated.



## II. PERIODIC AND INTERPERIODIC SCREENINGS

EPSDT covers regular screening services (check-ups) for infants, children and adolescents. These screenings are designed to identify health and developmental issues as early as possible. States have the responsibility to ensure that all eligible children (and their families) are informed of both the availability of screening services, and that a formal request for an EPSDT screening service is not required. States must provide or arrange for screening services both at established times and on an as-needed basis. Covered screening services are medical, mental health, vision, hearing and dental. Medical screenings has five components:

- ✓ Comprehensive health and developmental history that assesses for both physical and mental health, as well as for substance use disorders;<sup>4</sup>
- ✓ Comprehensive, unclothed physical examination;
- ✓ Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices;
- ✓ Laboratory testing (including blood lead screening appropriate for age and risk factors);<sup>5</sup> and
- ✓ Health education and anticipatory guidance for both the child and caregiver.<sup>6</sup>

Under the Act, states must establish a periodicity schedule for each type of screening service: medical, vision, hearing, and dental. The periodicity schedules set the frequency by which certain services should be provided and will be covered.<sup>7</sup> The schedules are not prescribed by federal law, but should be based on current standards of pediatric medical and dental practice, and states are required to consult with recognized medical and dental organizations involved in child health care to assist in developing their periodicity schedules. One commonly used source is [Bright Futures](#) (developed by the American Academy of Pediatrics), which, for example, suggests that developmental screenings be conducted when children are ages 9 months, 18 months, and 30 months. The American Academy of Pediatric Dentistry (AAPD) has published a [recommended periodicity schedule](#) for dental services for children and adolescents. States should review their EPSDT periodicity schedules regularly to keep them up to date.

<sup>4</sup> CMS issued an [Informational Bulletin](#) on March 27, 2013, discussing Prevention and Early Identification of Mental Health and Substance Use Conditions in Children and informing states about resources available to help them meet the needs of children under EPSDT.

<sup>5</sup> CMS issued [guidance on June 22, 2012](#) to align blood lead screening for Medicaid children with recommendations of the Centers for Disease Control and Prevention (CDC). After providing data that demonstrates that universal screening 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 screening of all Medicaid-eligible children ages 1 and 2.

<sup>6</sup> Section 1905(r)(1)(B) of the Social Security Act.

<sup>7</sup> 42 C.F.R. § 441.58; CMS, State Medicaid Manual §§ 5110, 5140.

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

EPSDT also requires coverage of medically necessary “interperiodic” screening outside of the state’s periodicity schedule. Coverage for such screenings is required based on an indication of a medical need to diagnose an illness or condition that was not present at the regularly scheduled screening or to determine if there has been a change in a previously diagnosed illness or condition that requires additional services. The determination of whether a screening service outside of the periodicity schedule is necessary may be made by the child’s physician or dentist, or by 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. A state may not limit the number of medically necessary screenings a child receives and may not require prior authorization for either periodic or “interperiodic” screenings.

**Example of Screenings Beyond Those Required by the Periodicity Schedule**

A child receives a regularly scheduled periodic vision screening at age 5 at which no problem is detected. According to the state’s periodicity schedule, his next vision screening is due at age 7. At age 6, the school nurse recommends to the child’s parent that the child see an optometrist because a teacher suspects a vision problem. Even though the next scheduled vision screening is not due until the age of 7, the child would be entitled to receive a timely “interperiodic” screening to determine if there is a vision problem for which treatment is needed. The screening should not be delayed if there is a concern the child may have a vision problem.

Source: NPRM, 58 Fed. Reg. 51288, 51290, 51291 (Oct. 1, 1993)

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.<sup>8</sup> The affirmative obligation to connect children with necessary treatment makes EPSDT different from Medicaid for adults.<sup>9</sup> It is a crucial component of a quality child health benefit.

<sup>8</sup> Section 1902(a)(43)(C) of the Social Security Act.

<sup>9</sup> CMS, State Medicaid Manual § 5124.B.

***The affirmative obligation to connect children with necessary treatment makes EPSDT different from Medicaid for adults.***

Any qualified provider operating within the scope of his or her practice, as defined by state law, can provide a screening service. The screening *need not be* conducted by a Medicaid provider in order to trigger EPSDT coverage for follow up diagnostic services and medically necessary treatment by a qualified Medicaid provider. A screening service provided before a child enrolls in Medicaid is sufficient to trigger EPSDT coverage, after enrollment, for follow-up diagnostic services and necessary treatment. The family or beneficiary need not formally request an EPSDT screening in order to receive the benefits of EPSDT. Rather, any visit or contact with a qualified medical professional is sufficient to satisfy EPSDT's screening requirement, and states should consider a beneficiary who is receiving services to be participating in EPSDT, whether the beneficiary requested screening services directly from the state or the health care provider.<sup>10</sup>

***Any qualified provider operating within the scope of his or her practice, as defined by state law, can provide a screening service.***

States establish their own fee schedules for screening services and should be using Health Insurance Portability and Accountability Act (HIPAA) compliant billing codes. States may develop a bundled payment rate to pay for the physical health screening components under one billing code. States may also recognize each component of the EPSDT screening separately. For example, one state pays for the visit itself with one code and pays separately for each individual screening service delivered during the visit. This payment methodology not only encourages providers to perform every component of an EPSDT well-child visit, it also provides the state, through claims, information as to whether the physician actually met the elements of the EPSDT guidelines set out in the periodicity

<sup>10</sup> CMS, State Medicaid Manual § 5310; HCFA, Title XIX State Agency Letter No. 91-33 (April 3, 1991).

schedules. States may encourage providers to perform all five components of the EPSDT screening but may not exclude providers who perform only partial screenings from being reimbursed for the parts they do provide.

Professional guidelines (e.g., Bright Futures) recommend that physicians include an oral health screening as part of the well-child visit at specified ages. In addition, states are permitted to include dental or oral health screening as a separately covered EPSDT service. These screening services, 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 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. Two new procedure codes were added to the Code on Dental Procedures and Nomenclature (CDT) in 2012 to facilitate payment for oral health screenings and assessments: CDT 0190 and CDT 0191.

***In 2012, two new procedure codes were added to facilitate payment for oral health screenings and assessments: CDT 0190 and 0191.***

Vision and hearing screening services must also be provided. States should consult with ophthalmologists and optometrists to determine what procedures should be used during a vision screening and to establish the criteria for referral for a diagnostic examination. For hearing screenings, appropriate procedures for screening and methods of administering them can be obtained from audiologists or from state health or education departments.<sup>11</sup>

<sup>11</sup> CMS, State Medicaid Manual § 5123.2.F.

### III. DIAGNOSTIC SERVICES

EPSDT covers medically necessary diagnostic services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis without delay.

A child's diagnosis may be performed by a physician, dentist or other practitioner qualified to evaluate and diagnose health problems at locations, including practitioners' offices, maternal and child health (MCH) facilities, community health centers, rehabilitation centers, and hospital outpatient departments. Diagnosis can generally be made on an outpatient basis. However, inpatient services are covered when necessary to complete a diagnosis.

***When a screening examination indicates the need for further evaluation of a child's health, the child should be referred for diagnosis without delay.***

## IV. THE SCOPE OF EPSDT TREATMENT SERVICES

### A. Scope of Services

The Act provides for coverage of all medically necessary services that are included within the categories of mandatory and optional services listed in section 1905(a), regardless of whether such services are covered under the State Plan. These include physician and hospital services, private duty nursing, personal care services, home health and medical equipment and supplies, rehabilitative services, and vision, hearing, and dental services. Covered EPSDT services also include “any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.”<sup>12</sup> The role of states is to make sure the full range of EPSDT services is available as well as to assure that families of enrolled children are aware of and have access to those services so as to meet the individual child’s needs. The broad scope of services enables states to design a child health benefit to meet the individual needs of the children served by its Medicaid program—a benefit design that has the potential to result in better care and healthier children at a lower overall cost. As discussed in the next section: while children enrolled in Medicaid are entitled to a broad scope of treatment services, no such service is covered under Medicaid unless medically necessary for that particular child.

***The Act provides for coverage of all medically necessary services that are included within the categories of mandatory and optional services listed in section 1905(a), regardless of whether such services are covered under the State Plan.***

<sup>12</sup> Section 1905(a)(29) of the Social Security Act.

If a service, supply or equipment that has been determined to be medically necessary for a child is not listed as covered (for adults) in a State Medicaid Plan, the state will nonetheless need to provide it to the child as long as the service or supply could be covered under the State Plan, that is, as long as it is included within the categories of mandatory and optional services listed in section 1905(a). In such circumstances, the state would need to develop a payment methodology for the service, supply or equipment, including the possibility that payment may need to be made using a single-service agreement with an in-state provider or an out-of-state provider who will accept Medicaid payment.

A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered in EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable." Thus, services such as physical and occupational therapy are covered when they have an ameliorative, maintenance purpose. This is particularly important for children with disabilities, because such services can prevent conditions from worsening, reduce pain, and avert the development of more costly illnesses and conditions. Other, less common examples include items of durable medical equipment, such as decubitus cushions, bed rails and augmentative communication devices. Such services are a crucial component of a good, comprehensive child-focused health benefit.

## **B. Covering a Range of Treatment Services to Meet a Child's Needs**

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As noted above, EPSDT covers physical and mental health and substance use disorder services, regardless of whether these services are provided under the State Plan and regardless of any restrictions that states may impose on coverage for adult services, as long as those services *could* be covered under the State Plan. This section provides some examples of EPSDT's broad scope of services, focusing on mental health and substance use services, personal care services, oral health and dental services, and vision and hearing services.

### ***a. Mental Health and Substance Use Services***

Treatment for mental health and substance use issues and conditions is available under a number of Medicaid service categories, including hospital and clinic services, physician services, and services provided by a licensed professional such as a psychologist. States should also make use of rehabilitative services. While rehabilitative services can meet a range of children's treatment needs, they

can be particularly critical for children with mental health and substance use issues. Rehabilitative services are defined to 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.*<sup>13</sup>

Like other services covered under EPSDT, rehabilitative services need not actually cure a disability or completely restore an individual to a previous functional level. Rather, such services are covered when they ameliorate a physical or mental disability, as discussed above. Moreover, determinations of whether a service is rehabilitative must take into consideration that a child may not have attained the ability to perform certain functions. That is, a child's rehabilitative services plan of care should reflect goals appropriate for the child's developmental stage.

***Rehabilitative services are particularly critical for children with mental health and substance use issues.***

Depending on the interventions that the individual child needs, services that can be covered as rehabilitative services include:

- ✓ Community-based crisis services, such as mobile crisis teams, and intensive outpatient services;
- ✓ Individualized mental health and substance use treatment services, including in non-traditional settings such as a school, a workplace or at home;
- ✓ Medication management;
- ✓ Counseling and therapy, including to eliminate psychological barriers that would impede development of community living skills; and
- ✓ Rehabilitative equipment, for instance daily living aids.

With respect to the provision of rehabilitative services, including those noted above, CMS requires more specificity of providers and services due to the wide spectrum of rehabilitative services coverable under the broad definition. CMS

<sup>13</sup> Section 1905(a)(13) of the Social Security Act; 42 C.F.R. § 440.130(d).



would expect a state to include in their State Plan the services, and providers with their qualifications, as well as a reimbursement methodology for each service it provides. CMS is available to provide technical assistance to states that are covering a service for children that has not otherwise been identified in their State Plan.

A number of [home and community-based services](#), including those that can be provided through EPSDT, have proven to significantly enhance positive outcomes for children and youth. These include intensive care coordination (“wraparound”), intensive in-home services, and mobile crisis response and stabilization.

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.

### **b. Personal Care Services**

EPSDT requires coverage of medically necessary personal care services, which:

*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 . . . in other location.<sup>14</sup>*

Personal care services provide a range of assistance with performing activities of daily living, such as dressing, eating, bathing, transferring, and toileting; and instrumental activities of daily living, such as preparing meals and managing medications.<sup>15</sup> While it is optional for states to provide personal care services for adults in locations other than the home, this is not the case for a child. Under EPSDT, personal care services are to be provided, for example, in a school or group home if necessary to “correct or ameliorate” a condition.

The determination of whether a child needs personal care services must be based upon the child’s individual needs and provided in accordance with a plan of treatment or service plan. Under regular State Plan Medicaid, no Medicaid payments are available for personal care services provided by the child’s legally

<sup>14</sup> Section 1905(a)(24) of the Social Security Act; 42 C.F.R. § 440.167.

<sup>15</sup> CMS, State Medicaid Manual § 4480.

responsible relatives.<sup>16</sup> In addition, the determination of whether a child needs personal care services must be based upon the child's individual needs and a consideration of family resources that are actually—not hypothetically—available.

### **c. Oral Health and Dental Services**

Dental services required in the EPSDT benefit include:<sup>17</sup>

- ✓ Dental care needed for relief of pain, infection, restoration of teeth, and maintenance of dental health (provided at as early an age as necessary); and
- ✓ 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.<sup>18</sup>

In addition, medically necessary oral health and dental services,<sup>19</sup> including those identified during an oral screening or a dental exam, are covered for children. States must provide orthodontic services to EPSDT-eligible children to the extent necessary to prevent disease and promote oral health, and restore oral structures to health and function.<sup>20</sup> Orthodontic services for cosmetic purposes are not covered.

Once a child reaches the age specified by the state in its pediatric dental periodicity schedule, typically age one, a direct dental referral is required.<sup>21</sup> The referral must be for an encounter with a dentist or with another dental professional, such as a dental hygienist, working under the supervision of a dentist.<sup>22</sup> Dental supervision includes the entire range, for example, direct, indirect, general, public health and collaborative practice arrangements.

<sup>16</sup> 42 C.F.R. § 440.167.

<sup>17</sup> Information on CMS efforts working with states to improve access to oral health services for children enrolled in Medicaid and CHIP can be found in CMS, *Improving Access to and Utilization of Oral Health Services for Children in Medicaid and CHIP Programs: CMS Oral Health Strategy* (April 11, 2011). Approaches states can use to improve the delivery of dental and oral health services to children in Medicaid and CHIP can be found in *Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children and Adolescents* and in *Improving Oral Health Care Delivery in Medicaid and CHIP: A Toolkit for States*. All of these documents are available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html>.

<sup>18</sup> CMS, State Medicaid Manual § 5124.B.2.b.

<sup>19</sup> CMS, State Medicaid Manual § 2700.4 (Form 416 Instructions, Note for Line 12 Data). Dental services are those performed by or under the supervision of a dentist. Oral health services are those performed by other licensed providers not working under the supervision of a dentist, for example, a physician or nurse, or by a dental professional operating without a supervisory relationship to a dentist (e.g., an independent practice dental hygienist).

<sup>20</sup> CMS, State Medicaid Manual § 5124.B.2.b

<sup>21</sup> 42 C.F.R. § 441.56(b)(vi).

<sup>22</sup> CMS, State Medicaid Manual § 5123.2.G.

***Current clinical guidelines recommend that a child have a first dental visit when the first tooth erupts or by age one.***

Dental care must be provided at intervals indicated in the pediatric dental periodicity schedule adopted by the state after consultation with a recognized dental organization involved in child health care.<sup>23</sup> Current [clinical guidelines](#) recommend that a child have a first dental visit when the first tooth erupts or by age one, whichever occurs first. 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.<sup>24</sup> For example, a child determined by a qualified provider to be at moderate or high risk for developing early childhood caries could be covered to receive dental exams and preventive treatments more frequently than the twice-yearly periodicity schedule recommended by the AAPD.

As determined by dental practice acts in individual states, there is a wide range of dental professionals who can work under the supervision of a dentist, for example, dental hygienists, dental therapists, dental health aide therapists, dental hygienists in advanced practice, advanced practice dental therapists, dental assistants, and community dental health coordinators. Some state practice acts permit specified dental professionals to work without dentist supervision in certain circumstances. Such provisions can help ensure access to dental care as well as promote an integrated health care delivery system. As with medical care, any qualified provider operating within the scope of his or her practice, as defined by state law, can provide a dental or oral health service to a Medicaid enrollee. To qualify for federal matching funds, State Plans must list all provider types that will be permitted to bill for dental or oral health services. However, rendering providers (providers who actually serve the patient) need not be separately enumerated in the State Plan.

Better integration of primary medical care with dental care can help identify children at risk for tooth decay at the youngest age possible, offer evidence-based preventive care, such as fluoride varnish and oral health education, and refer children to a dental professional for a complete check-up and any needed treatment. Three oral health risk assessment CDT billing codes can support this

<sup>23</sup> Section 1905(r)(3) of the Social Security Act; CMS, State Medicaid Manual § 5110.

<sup>24</sup> CMS, State Medicaid Manual § 5110.

approach, potentially preventing the need for costly treatment, such as that provided in an operating room.

State Medicaid and CHIP programs can use risk assessment codes to help children access services based on their individual levels of risk, instead of assuming that all children need the same level of intervention. AAPD guidelines encourage providers to customize care plans based on an assessment of each child's individual risk for developing dental disease. 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.

In addition to dental providers, states may reimburse primary care medical providers for conducting oral health risk assessments, providing oral health education to parents and children, applying preventive measures such as fluoride varnish, and making referrals to dental professionals. The 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.

#### **d. Vision and Hearing Services**

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

EPSDT requires 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, to determine the existence of a suspected illness or condition. At a minimum, vision services must include diagnosis 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, diagnosis and treatment for defects in hearing, including hearing aids.<sup>25</sup>

In addition, if hearing and vision problems are detected through screening, medically necessary services that are coverable under section 1905(a) must be covered. This includes not only physician and clinic services, but services from licensed professionals such as ophthalmologists, and equipment such as augmentative communication devices and cochlear implants.

<sup>25</sup> Sections 1905(r)(2) and (4) of the Social Security Act.

### **e. Other Services**

Examples of other services covered for children under Medicaid when medically necessary (and for which a federal match is available) include, but are not limited to, case management services (including targeted case management);<sup>26</sup> 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 nutritional supplements.

Physicians and other providers use medical terminology, not Medicaid terms or legal terms, when recommending or prescribing medical services and treatments. If a requested service or treatment is not listed by name in Medicaid's list of services, it should nonetheless be provided if the service or item is determined to be medically necessary and coverable under the list of services at section 1905(a). In general, states are encouraged to include in their State Plans a range of provider types and settings likely to be sufficient to meet the needs of enrollees. Nonetheless, there may be cases in which the type of provider that is needed is not already participating in Medicaid. In such an instance, the state could meet the EPSDT requirement by, for example, entering into a single-service agreement with the needed provider.

***When providers use medical terminology instead of Medicaid or legal terms to recommend medically necessary services, the recommended services should be covered if coverable under section 1905(a).***

## **C. Enabling Services**

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### **a. Transportation Services**

In order to promote access to needed preventive, diagnostic and treatment services, states must offer appointment scheduling assistance and are required to assure necessary transportation, to and from medical appointments, for children

<sup>26</sup> Section 1905(a)(19) of the Social Security Act; 42 C.F.R. §§ 440.169, 441.18.

enrolled in Medicaid.<sup>27</sup> This includes covering the costs of an ambulance, taxi, bus, or other carrier. It can also include reimbursing for mileage. As with other services covered through EPSDT, states may cover the least expensive means of transportation if it is actually available, accessible, and appropriate. For example, public transportation can be covered instead of a taxi if the public transportation is physically accessible for a particular beneficiary and takes a reasonable amount of time. In addition, “related travel expenses” are covered if medically necessary, including meals and lodging for a child and necessary attendant.<sup>28</sup>

Some states have addressed the transportation requirement by offering non-emergency transportation through brokers who coordinate transportation services, or through administrative managers who act as gatekeepers for 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, or otherwise to contract out administration of the service, the state must administer the service itself. No matter the type of arrangement, it is important to remember that the state has ultimate responsibility for ensuring the provision of transportation services.

### ***b. Language Access and Culturally Appropriate Services***

Many Medicaid-enrolled children live in families where English is not spoken at home. State Medicaid agencies and their contractors should inform eligible individuals about the EPSDT benefit with a combination of written and oral methods “using clear and nontechnical language” and “effectively informing those individuals who . . . cannot read or understand the English language.”<sup>29</sup> State Medicaid agencies and Medicaid managed care plans, as recipients of federal funds, also have responsibilities to assure that covered services are delivered to children without a language barrier. They are required take “reasonable steps” to assure that individuals who are limited English proficient have meaningful access to Medicaid services.<sup>30</sup> This may include providing interpreter services, including at medical appointments, depending on factors such as the number of limited English proficient individuals served by the program.<sup>31</sup>

<sup>27</sup> Section 1905(a)(29) of the Social Security Act; 42 C.F.R. §§ 440.170, 441.62.

<sup>28</sup> 42 C.F.R. § 440.170(a).

<sup>29</sup> 42 C.F.R. § 441.56(a); CMS, State Medicaid Manual §§ 5121.A, 5121.C.

<sup>30</sup> 42 U.S.C. § 2000d (Title VI of the Civil Rights Act); Affordable Care Act § 1557;

CMS [Dear State Medicaid Director \(Aug. 31, 2000\)](#).

<sup>31</sup> Department of Health & Human Services, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311 (August 8, 2003).

Though interpreter services are not classified as mandatory 1905(a) services, all providers who receive federal funds from HHS for the provision of Medicaid services are obligated, under Title VI of the Civil Rights Act, to make language services available to those with limited English proficiency.

***Though interpreters are not Medicaid qualified providers, their services may be reimbursed when billed by a qualified provider rendering a Medicaid covered service.***

States are not required to (but may) reimburse providers for the cost of language services. States may consider the cost of language services to be included in the regular rate of reimbursement for the 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 claim for the cost of interpretation services, either as medical-assistance related expenditures or as administration.<sup>32</sup>

*Claiming Federal Matching Funds for Interpreter Services.* Interpreters are not Medicaid qualified providers. However, their services may be reimbursed when billed by a qualified provider rendering a Medicaid covered service. Interpreters may not be paid separately. As of February 2009, oral interpreter services can be claimed using billing code T-1013 along with the CPT code used for the medical encounter. States can also raise reimbursement rates to recognize additional service costs, including interpreter costs, but must do so for services rendered by all providers in the class. With the enactment of the Children's Health Insurance Program Reauthorization Act in 2009, states were given the option to claim a higher federal matching rate (75% under Medicaid) for translation and interpretation services that are claimed as administration and are related to the enrollment, retention and use of services under Medicaid and CHIP by children of families for whom English is not their primary language.<sup>33</sup> Otherwise, longstanding CMS policy permits reimbursement at the standard 50% federal

<sup>32</sup> CMS, [Dear State Medicaid Director \(July 1, 2010\)](#); CMS, [CMCS Informational Bulletin: Recent Developments in Medicaid \(April 26, 2011\)](#).

<sup>33</sup> Section 1903(a)(2)(E) of the Social Security Act.

matching rate for translation and interpretation activities that are claimed as an administrative expense, so long as they are not included and paid for as part of the reimbursement rate for direct services.<sup>34</sup>

***State Medicaid programs, managed care entities, and Medicaid-participating health care providers should all be culturally competent.***

The HHS Office for Civil Rights and the Department of Justice have provided guidance for recipients of federal funds on expectations of how to provide language services.<sup>35</sup>

State Medicaid programs, managed care entities, and Medicaid-participating health care providers should all be culturally competent. This means they need to recognize and understand the cultural beliefs and health practices of the families and children they serve, and use that knowledge to implement policies and inform practices that support quality interventions and good health outcomes for children. Given changing demographics, this process is ongoing. The [DHHS Office of Minority Health](#) offers numerous resources, including:

- ✓ Center for Linguistic and Cultural Competence in Health Care;
- ✓ Think Cultural Health;
- ✓ A Physician's Practical Guide to Culturally Competent Care;
- ✓ The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards); and
- ✓ The National CLAS Standards' implementation guide, A Blueprint for Advancing and Sustaining CLAS Policy and Practice.

## **D. Settings and Locations for Services**

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### **a. Services Provided Out of State**

States may need to rely upon out-of-state services if necessary covered services are not available locally, or if a Medicaid beneficiary is out of state at the time a need for medical services arises. States are required to pay for services provided

<sup>34</sup> CMS, Dear State Medicaid Director (August 31, 2000).

<sup>35</sup> *Id.*; U.S. Department of Justice, Executive Order 13166.



in another state to the same extent services furnished in-state would be paid for if:

- ✓ The out-of-state services are required because of an emergency;
- ✓ The child's health would be endangered if she or he were required to travel to their home state;
- ✓ The state determines that the needed services are more readily available in the other state; or
- ✓ It is a general practice of the locality to use the services of an out-of-state provider, for example, in areas that border another state.<sup>36</sup>

Including out-of-state providers gives states the opportunity to expand the range and accessibility of Medicaid services that are available to their enrollees.<sup>37</sup>

### ***b. Services Provided in Schools***

Services provided in schools can play an important role in the health care of adolescents and children. Whether implemented for children with special needs under the Individuals with Disabilities Education Act (IDEA) or through school-based or linked health clinics, school-centered programs may be able to provide medical and dental care efficiently and effectively while avoiding extended absences from school.

In order for Medicaid to reimburse for health services provided in the schools, the services must be included among those listed in section 1905(a) of the Act and included in the State Plan, or be available under the EPSDT benefit. There is no benefit category in the Medicaid statute titled "school health services" or "early intervention services." Therefore a state must describe its school health services in terms of the specific section 1905(a) services which will be provided. In addition, there must be a provider agreement in place between the state Medicaid agency and the provider billing for the service; and the school must agree to comply with Medicaid-specific requirements regarding service documentation and claims submission.<sup>38</sup> States are encouraged to promote relationships between school-based providers and managed care plans.

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

<sup>36</sup> Section 1902(a)(16) of the Social Security Act; 42 C.F.R. § 431.52.

<sup>37</sup> HCFA, Dear State Medicaid Director (July 25, 2000).

<sup>38</sup> 42 C.F.R. § 431.107.

Schools are particularly appropriate places to provide medical, vision, and hearing screenings; vaccinations; some dental care; and behavioral health services. The Individuals with Disabilities Education Act (IDEA) requires that every child with a disability have available a free appropriate public education that includes special education and related services. Part B of IDEA requires the development and implementation of an individualized education program (IEP) that addresses the unique needs of each child with a disability ages 3 through 21.<sup>39</sup> A child's IEP identifies the special education and related services needed by that child. Medicaid covered services included in the IEP may be provided in, and reimbursed to, schools. Part C of IDEA covers early intervention services, which are developmental services designed to meet a child's developmental needs in physical, cognitive, communication, adaptive, and social and emotional development, for children from birth to age 3. These services are provided pursuant to an Individualized Family Service Plan (IFSP).

Examples of IDEA services that can be covered by Medicaid for a Medicaid eligible child include physical therapy, occupational therapy, personal care, and services for children with speech, hearing and language disorders.<sup>40</sup>

### ***c. 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 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.

***Community-based care is a best practice for supporting children with disabilities and chronic conditions.***

CMS has long encouraged states to provide services in home and community settings, particularly for children, not only because of *Olmstead*, but because community-based care is considered a best practice for supporting children with

<sup>39</sup> While EPSDT covers children only through age 20 (up to the 21st birthday), the IDEA covers children through age 21 (up to the 22nd birthday).

<sup>40</sup> Additional information about Medicaid-covered services provided in schools can be found in the CMS, [Medicaid School Based Administrative Claiming Guide \(2003\)](#).

disabilities and chronic conditions. In addition, it is generally more cost-effective.<sup>41</sup>

EPSDT provides states with many options for covering physical and mental health services in the community. The EPSDT benefit requires coverage of medically necessary personal care, private duty nursing, physical, occupational and speech-language therapy. And, as discussed below, optional services provided through home and community based services waivers can further advance the state's efforts to provide services in the community.

<sup>41</sup> HCFA, Dear State Medicaid Director, Olmstead Update Nos. 2 and 3 (July 25, 2000), No. 5 (January 10, 2001); CMS, Dear State Medicaid Director (May 20, 2010); CMS, [Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions \(May 7, 2013\)](#).

## V. PERMISSIBLE LIMITATIONS ON COVERAGE OF EPSDT SERVICES

### A. Individual Medical Necessity

Services that fit within the scope of coverage under EPSDT must be provided to a child only if necessary to correct or ameliorate the individual child's physical or mental condition, i.e., only if "medically necessary." The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child. The state (or the managed care entity as delegated by the state) should consider the child's long-term needs, not just what is required to address the immediate situation. The state should also consider all aspects of a child's needs, including nutritional, social development, and mental health and substance use disorders. 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 requirement. As discussed above, services such as physical and occupational therapy are covered when they have an ameliorative, maintenance purpose.

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

Because medical necessity decisions are individualized, flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements.<sup>42</sup> States may adopt a definition of medical necessity that places tentative limits on services pending an individualized determination by the state, or that limits a treating provider's discretion, as a utilization control, but additional services must be provided if determined to be medically necessary for

<sup>42</sup> HCFA, *Regional Transmittal Notice* (Region IV) (Sept. 18, 1990); Memorandum from Rozann Abato, Acting Director, HCFA, to Associate Regional Administrator, Atlanta (Sept. 5, 1990); Memorandum from Christine Nye, HCFA Medicaid Director, to Regional Administrator Region VIII (FME-42) (1991).

an individual child.<sup>43</sup> For example, while a state may place in its State Plan a limit of a certain number of physical therapy visits per year for individuals age 21 and older, such a “hard” limit could not be applied to children. A state could impose a “soft” limit of a certain number of physical therapy visits annually for children, but if it were to be determined in an individual child’s case, upon review, that additional physical therapy services were medically necessary to correct or ameliorate a diagnosed condition, those services would have to be covered.

While the treating health care provider has a responsibility for determining or recommending that a particular covered service is needed to correct or ameliorate the child’s condition,<sup>44</sup> both the state and a child’s treating provider play a role 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 decision, for the individual child, based on the evidence. That decision may be appealed by the child (or the child’s family) under the state’s Medicaid fair hearing procedures, as described in Section VIII below.

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## **B. Prior Authorization**

States may impose utilization controls to safeguard against unnecessary use of care and services. For example, a state may establish tentative limits on the amount of a treatment service a child can receive and require prior authorization for coverage of medically necessary services above those limits.<sup>45</sup> Prior authorization must be conducted on a case-by-case basis, evaluating each child’s needs individually. Importantly, prior authorization procedures may not delay delivery of needed treatment services and must be consistent with the “preventive thrust” of EPSDT.<sup>46</sup> As such, prior authorization may not be required for any EPSDT screening services. In addition, medical management techniques used for mental health and substance use disorders should comply with the Mental Health Parity and Addiction Equity Act.

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## **C. 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 would be effective to address the child’s condition.<sup>47</sup> Neither the Federal Medicaid statute nor the regulations define what constitutes an experimental

<sup>43</sup> 42 C.F.R. §§ 440.230(c), (d); HCFA Dear State Medicaid Director (May 26, 1993).

<sup>44</sup> Sections 1905(a) and (r) of the Social Security Act.

<sup>45</sup> *Id.*

<sup>46</sup> H.R. Rep. No. 101-247 at 399, *reprinted in* U.S.C.C.A.N. 1906, 2125.

<sup>47</sup> CMS, State Medicaid Manual §§ 4385.C.1, 5122.F.

treatment. The state's determination of whether a service is experimental must be reasonable and should be based on the latest scientific information available.<sup>48</sup>

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.<sup>49</sup>

## D. 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. Also, a state need not make services available in every possible setting as long as the services are reasonably available through the settings where the service is actually offered. States may cover services in the most cost effective mode as long as the less expensive service is equally effective and actually available.<sup>50</sup> The child's quality of life must also be considered.<sup>51</sup> In addition, the ADA and the *Olmstead* decision require states to provide services in the most integrated setting appropriate to a child's needs, as long as doing so does not fundamentally alter the state's program. See above, Section IV.D. Thus, if an institutional setting is less costly than providing services in a home or community, the ADA's integration mandate may nevertheless require that the services be provided in the community.<sup>52</sup>

***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.***

<sup>48</sup> Memorandum from S. Richardson to State Medicaid Directors (April 17, 1995).

<sup>49</sup> Memorandum from S. Richardson to State Medicaid Directors (April 17, 1995).

<sup>50</sup> CMS, Dear State Medicaid Director, Olmstead Update No. 4 (January 10, 2001); Letter from Rozann Abato, Acting Director, Medicaid Bureau, to State Medicaid Directors (May 26, 1993).

<sup>51</sup> *Id.*

<sup>52</sup> 28 C.F.R. § 35.130(d); CMS, Dear State Medicaid Director, Olmstead Update No. 4 (January 10, 2001); DOJ, [Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the ADA and \*Olmstead v. L.C.\* \(June 22, 2011\)](#).

## VI. SERVICES AVAILABLE UNDER OTHER FEDERAL AUTHORITIES

### A. Home and Community Based Services Waivers

A state Medicaid program may offer services through home and community based services (HCBS) waiver programs. Such programs allow states to provide HCBS to individuals who would otherwise need long-term care in a nursing facility, intermediate care facility, or hospital. Waiver programs provide for coverage of services that are not otherwise available through the Medicaid program (including EPSDT) because they do not fit into one of the categories listed in section 1905(a). This includes habilitative services, respite services, 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.<sup>53</sup>

Children under age 21 who are enrolled in an HCBS waiver program are also entitled to all EPSDT screening, diagnostic, and treatment services. Because HCBS waivers can provide services not otherwise covered under Medicaid, waivers and EPSDT can be used together to provide a comprehensive benefit for children with disabilities who would otherwise need the level of care provided in an institutional setting. This enables those children to remain in their homes and communities while receiving medically necessary services and supports. The HCBS waiver services essentially “wrap-around” the EPSDT benefit. If a child enrolled in Medicaid is on a waiting list for HCBS waiver services, EPSDT requirements apply and necessary services that fit into the categories listed in 1905(a) must be covered.<sup>54</sup>

***Children who are enrolled in an HCBS waiver program are also entitled to all EPSDT services.***

States may also choose to offer [services](#) to children under section 1915(j) (self-directed personal assistance services), section 1915(k) (home and community-based attendant services and support) and section 1945 (coordinated care in

<sup>53</sup> Section 1915(c) of the Social Security Act.

<sup>54</sup> CMS, Dear State Medicaid Director, Olmstead Update No. 4, Att. 4-B (Jan. 10, 2001).

health homes for individuals with chronic conditions). Like services provided pursuant to a 1915(c) waiver, these services are not subject to EPSDT coverage provisions, but are instead available to supplement EPSDT services.

## B. Alternative Benefit Plans

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States must assure access to services available under the EPSDT benefit for all EPSDT-eligible children under age 21 enrolled in [Alternative Benefit Plans](#) (formerly known as benchmark plans and benchmark-equivalent plans).<sup>55</sup>

## C. Role of Maternal and Child Health Services

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Federal rules require state Medicaid agencies and Title V Maternal and Child Health (MCH) agencies and grantees to collaborate to assure better access to and receipt of the full range of screening, diagnostic, and treatment services covered under EPSDT.<sup>56</sup> [Title V](#) is administered by the Health Resources and Services Administration. Many state Medicaid agencies have entered into written agreements with their sister MCH programs and collaborate on improving access to EPSDT services in order to improve child health status. Among other things, cooperating MCH agencies can provide outreach, screening, diagnostic or treatment services, health education and counseling, case management and other assistance in achieving a comprehensive and effective child health benefit. MCH programs can also help Medicaid programs to enlist providers who can help deliver a broad array of services. In addition, they can inform potential and actual Medicaid recipients about EPSDT and refer them to necessary services.<sup>57</sup> CMS encourages such collaborations as MCH programs are crucial partners in the creation and delivery of a high quality, well-integrated child health benefit.

***Many state Medicaid agencies have written agreements with their states' MCH programs and collaborate to improve access to EPSDT services.***

<sup>55</sup> 42 C.F.R. § 440.345.

<sup>56</sup> 42 U.S.C. §§ 705(a)(5)(F), 709(a)(2); 42 C.F.R. § 441.61(c).

<sup>57</sup> CMS, State Medicaid Manual § 5230.



## VII. ACCESS TO SERVICES

### A. Access to Providers

Access to covered services is of course a critical component of delivering an appropriate health benefit to children. Accordingly, a number of Medicaid and EPSDT provisions are intended to assure that children have access to an adequate number and range of pediatric providers. For example, states are required to “make available a variety of individual and group providers qualified and willing to provide” services to children.<sup>58</sup> States must also “take advantage of all resources available” to provide a “broad base” of providers who treat children.”<sup>59</sup> Some states may find it necessary to recruit new providers to meet children’s needs.<sup>60</sup> In the event a child needs a treatment that is not coverable under the categories listed in section 1905(a), states are to provide referral assistance that includes giving the family or beneficiary the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.<sup>61</sup>

***States are required to make available a variety of providers who are qualified and willing to treat EPSDT children.***

A child is entitled to receive Medicaid services from any provider qualified to provide the service and willing to furnish it, unless CMS has decided that this “freedom of choice” requirement will not apply.<sup>62</sup> Most states have received permission from CMS to provide some services to some children through managed care arrangements that restrict the free choice of provider.

An appropriate level of reimbursement can be critical to ensuring adequate access to providers.<sup>63</sup> While the statute provides states with broad authority to set provider payment rates, it requires that payments to providers must be consistent with efficiency, economy, and quality care and be sufficient to enlist enough

<sup>58</sup> 42 C.F.R. § 441.61.

<sup>59</sup> CMS, State Medicaid Manual § 5220.

<sup>60</sup> *Id.*

<sup>61</sup> 42 C.F.R. § 441.61(a).

<sup>62</sup> Sections 1902(a)(23) and 1932(a) of the Social Security Act; 42 C.F.R. § 431.51(b).

<sup>63</sup> HCFA, Dear State Medicaid Director (Jan 18, 2001).

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 geographic area.<sup>64</sup>

Federal regulations provide that a Medicaid provider must agree to accept, as payment in full, the Medicaid payment for a covered service or item.<sup>65</sup> 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.

Section 1905(a) lists coverable Medicaid services and some provider types. There are at least two means by which a state may cover a service by a provider type that is not specified in section 1905(a). 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." Thus, a state may cover services performed by a class of providers (such as licensed dietitians) when the service they provide is not specified in section 1905(a) as long as the service is determined medically necessary for a child. 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 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.

## **B. Managed Care**

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EPSDT benefits must be available to all children covered by Medicaid. As such, children enrolled in managed care plans, prepaid inpatient health plans, prepaid ambulatory health plans, primary care case management systems (collectively referred to as managed care entities) are entitled to the same EPSDT benefits they would have in a fee for service Medicaid delivery system. Properly implemented, managed care can enhance and promote EPSDT's goals of ensuring that care is provided in a coordinated way and with an emphasis on prevention.

States are responsible for assuring that the full EPSDT benefit is available to all Medicaid children in the state, even if the state contracts with a managed care entity to deliver some or all of the services available under EPSDT. The state's

<sup>64</sup> Section 1902(a)(30)(A) of the Social Security Act; Medicaid Program: Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342 (May 11, 2011) (proposed regulations).

<sup>65</sup> 42 C.F.R. § 447.15.

contracts with managed care entities should be drafted with sufficient precision so that the entity's responsibilities with respect to children are clearly delineated. A contract can provide that the managed care entities will be responsible for providing services under the EPSDT benefit to the same degree that the services are covered by the state. Or, if certain responsibilities are carved out of the managed care contract, those carve-outs must be explicit, and the state will retain the responsibility for ensuring that those carved-out services are provided to enrolled children. For example, the state may 'carve out' dental services from the managed care contract; nonetheless, the state must assure that children receive those services (through either fee for service or a specialized dental plan).

***Managed care entities may not use a definition of medical necessity for children that is more restrictive than the state's definition.***

Managed care entities may not use a definition of medical necessity for children that is more restrictive than the state's definition. One way to ensure this is for the state to include its definition of medical necessity in the entity's contract. States should review managed care entities' medical necessity definitions and criteria to ascertain whether they meet this requirement. As a further step to provide for consistency across the delivery system and proper implementation of the children's benefit package, it is the state's responsibility to educate its contracted managed care entities about EPSDT requirements, as well as to verify that managed care providers are informed about EPSDT requirements through trainings and provider manuals. Further, states are responsible for ensuring that managed care entities fulfill their contractual responsibilities to inform all families of the services available under EPSDT and how to access them.<sup>66</sup> Information made available to enrollees, usually included in a member handbook, should clearly explain which EPSDT services the managed care entity will provide and how any EPSDT services not within the scope of the contract can be accessed by enrollees. Managed care entities must make available to all enrolled children the entire scope of services included in the EPSDT benefit that is within their contract with the state.<sup>67</sup>

<sup>66</sup> Sections 1902(a)(5) and (a)(43) of the Social Security Act.

<sup>67</sup> 42 C.F.R. § 438.210(a)(4).

Managed care entities must demonstrate to the state that they have adequate provider capacity in the plan to serve enrolled children, 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.<sup>68</sup>

Monitoring managed care entities' compliance with EPSDT requirements is essential; a strong oversight framework ensures that states are meeting their responsibilities to children as well as Federal monitoring requirements.<sup>69</sup> There are several methods of exercising effective oversight in managed care systems.

First, states contracting with managed care organizations (MCOs) or prepaid inpatient health plans (PIHPs) are statutorily required to draft, implement, and maintain a managed care quality strategy.<sup>70</sup> The quality strategy is intended to provide a blueprint for states in assessing and improving the quality of care provided to managed care enrollees.<sup>71</sup> By means of this strategy, states can monitor and evaluate managed care entities' compliance with quality initiatives, track their performance on specified performance measures, and require them to design, implement and report the results of performance improvement projects.

Second, states are also required to ensure that external quality review of MCOs and PHIPs are performed by unbiased, external entities.<sup>72</sup> In this way, states can determine whether managed care entities are reporting accurate performance outcomes data and whether they are in compliance with state contract provisions.

Third, states can engage in an ongoing 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 reports and perform data analysis of managed care entities' encounter data to detect underutilization of services by children.

In addition, all states are required to complete and file the Form 416 each year.<sup>73</sup> This reports the number of children receiving health screening services, dental and oral health services, and referrals for corrective treatment, as well as the state's rates of meeting EPSDT participation goals.

<sup>68</sup> 42 C.F.R. § 438.206.

<sup>69</sup> 42 C.F.R. § 438.240.

<sup>70</sup> Section 1932(c)(1) of the Social Security Act; 42 C.F.R. §§ 438.202, 438.204.

<sup>71</sup> 42 C.F.R. § 438.202.

<sup>72</sup> Section 1932(c)(2) of the Social Security Act; 42 C.F.R. § 438.350.

<sup>73</sup> Section 1902(a)(43)(D) of the Social Security Act.

## C. Timeliness

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Services under the EPSDT benefit, like all Medicaid services, must be provided with “reasonable promptness.”<sup>74</sup> The state must set standards to ensure that EPSDT services are provided consistent with reasonable standards of medical and dental practice. The state must also ensure that services are initiated within a reasonable period of time. What is reasonable depends on the nature of the service and the needs of the individual child. Because states have the obligation to “arrang[e] for . . . corrective treatment” either directly or through referral to appropriate providers, a lack of providers does not automatically 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.

***Services under the EPSDT benefit, like all Medicaid services, must be provided with reasonable promptness.***

<sup>74</sup> Section 1902(a)(8) of the Social Security Act.

## VIII. NOTICE AND HEARING REQUIREMENTS

Children under age 21, like all other people enrolled in Medicaid, have the right to notice and an opportunity for a hearing. If a state or managed care entity takes an “action” – to deny, terminate, suspend, or reduce a requested treatment or service, it must give the beneficiary written notice of the action and of their right to a hearing (a pre-termination hearing, in instances where services are reduced or terminated), including instructions on how to request a hearing.<sup>75</sup> When services are being terminated or reduced, the notice must be sent at least ten days before the effective date of the action.<sup>76</sup> Under exceptional circumstances, the notice must be mailed no later than the day of the action, such as when the beneficiary’s physician prescribes a change in treatment or the beneficiary has been admitted to an institution and is no longer eligible.<sup>77</sup> The notice must contain a statement of the intended action, the specific reasons and legal support for the action, and an explanation of the individual’s hearing rights, rights to representation and to continued benefits.<sup>78</sup>

***If a state or managed care entity takes an action to deny, terminate, suspend, or reduce a requested treatment or service, it must give the beneficiary written notice of the action and of their right to a hearing.***

The beneficiary is entitled to a hearing before the state Medicaid agency, or, if a state’s hearing process provides for it, an evidentiary hearing at the local level (for example at a county department of social services) with a right of appeal to the state agency.<sup>79</sup> The hearing must be conducted at a reasonable time, date, and place by an impartial hearing official. A beneficiary must be allowed to present his or her case to an impartial decision maker and present evidence and

<sup>75</sup> Section 1902(a)(3) of the Social Security Act; *Goldberg v. Kelly*, 397 U.S. 254 (1970).

<sup>76</sup> 42 C.F.R. § 431.211.

<sup>77</sup> 42 C.F.R. § 431.213.

<sup>78</sup> 42 C.F.R. §§ 431.206, 431.210.

<sup>79</sup> 42 C.F.R. § 431.205(b).

witnesses.<sup>80</sup> The beneficiary is also entitled to have representation, including legal counsel, a relative, or a friend.<sup>81</sup> Before the hearing, beneficiaries must have the right to examine the case file and all documents that will be used at the hearing.<sup>82</sup>

When a service is terminated or reduced, if the beneficiary requests a hearing within ten days of receiving notice of the termination or reduction, the beneficiary has the right to continued coverage of services pending a hearing decision.<sup>83</sup> This is sometimes called “aid paid pending.” Once the agency issues a final decision, the beneficiary generally has the right to appeal that decision to state court.

Managed care enrollees must have access to in-plan grievance and appeal processes, in addition to the state fair hearing system.<sup>84</sup> Managed care plans must provide enrollees written notices that explain the action, the reason for the action, and the procedures for using the in-plan grievance and state fair hearing processes, including rights to continued benefits. Managed care plans must resolve complaints in a timely manner, including within three working days when the enrollee or provider indicates that delay could seriously jeopardize the enrollee’s life, health or ability to attain, maintain, or retain maximum function.<sup>85</sup> The state can require enrollees to exhaust the plan’s internal grievance process before obtaining a state fair hearing.

The state agency must issue and publicize its hearing decisions.<sup>86</sup> In addition, the public must have access to all fair hearing decisions, subject to regulatory requirements providing for safeguarding of confidential personal and health information.<sup>87</sup>

<sup>80</sup> 42 C.F.R. §§ 431.240, 431.242.

<sup>81</sup> 42 C.F.R. § 431.206(b)(3).

<sup>82</sup> 42 C.F.R. § 431.242.

<sup>83</sup> 42 C.F.R. § 431.230.

<sup>84</sup> 42 C.F.R. § 438.402.

<sup>85</sup> 42 C.F.R. § 438.408.

<sup>86</sup> 42 C.F.R. § 431.206(a).

<sup>87</sup> 42 C.F.R. § 431.244(g).

## **IX. CONCLUSION**

The goal of EPSDT is to assure that all Medicaid-enrolled children under age 21 receive the health care they need. EPSDT covers not only medically necessary treatment to correct or ameliorate identified conditions, but also preventive, and maintenance services. In addition, EPSDT covers age-appropriate medical, dental, vision and hearing screening services at specified times, and when health problems arise or are suspected.

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, attention is needed on issues affecting access to services, including supply of providers, the presence of managed care, linguistic and disability access, and transportation. CMS is available to help states address these issues to ensure that EPSDT coverage meets the needs of children under age 21 who depend on Medicaid for their health care.



## X. 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, or have medical conditions (e.g., asthma) requiring ongoing use of prescription drugs. Medicaid helps these children and adolescents receive 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 any medical treatment needed to promote healthy growth and development.

### **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 check-ups recommended at each age. These are often 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 it. 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 check-ups when a condition or problem is suspected.

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

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

- A comprehensive health and developmental history, including both physical and mental health development assessments;
- Physical exam;
- Age-appropriate immunizations;
- Vision and hearing tests;
- Dental exam;
- Laboratory tests, including blood lead level assessments at certain ages; and
- Health education, including anticipatory guidance.

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

When a well-child check-up or other visit to a health care professional shows that a child or adolescent might have a health problem, follow up diagnostic testing and evaluations must be provided under EPSDT. Diagnosis of mental health, substance use, vision, hearing and dental problems is included. Also included are any necessary referrals so that the child or adolescent receives all needed treatment.

### **TREATMENT: Correct, reduce or control health problems found**

EPSDT covers health care, treatment and other measures necessary to correct or ameliorate the child or adolescent’s physical or mental conditions found by a screening or a diagnostic procedure. In general, States must ensure the provision of, and pay for, any treatment that is considered “medically necessary” for the child or adolescent. 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 orthodontia is also covered.

## XI. RESOURCES

### **CMS Resources**

- [CMS, State Medicaid Manual §§ 2700.4 and 5010-5360](#)
- [CMS, Early and Periodic Screening Diagnostic and Treatment Resources](#)

### **Adolescent Health**

- [CMS, Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits \(Feb. 2014\)](#)

### **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 Issues \(April 18, 2013\)](#)
- [Improving Oral Health Care Delivery in Medicaid and CHIP: A Toolkit for States \(February 2014\)](#)

### **Mental Health**

- [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 \(May 7, 2013\)](#)

### **Screening Services**

- [CMS, Guide for States Interested in Transitioning to Targeted Blood Lead Screening for Medicaid-eligible Children \(May 2012\)](#)

### **Accessibility**

- [CMS, CMCS Informational Bulletin \(April 26, 2011\) \(federal funding for interpretation and translation services\)](#)
- [CMS, Dear State Medicaid Director \(Aug. 31, 2000\) \(Limited English Proficiency\)](#)
- [CMS, Dear State Medicaid Director, Olmstead Update No. 4, Att. 4-B EPSDT \(Jan. 10, 2001\)](#)
- [CMS, Medicaid School-Based Administrative Claiming Guide \(May 2003\)](#)

## **Other Federal Resources**

- [CDC, Vaccine Recommendations of the ACIP](#)
- [HRSA, EPSDT & Title V Collaboration to Improve Child Health](#)
- [Health Resources and Services Administration EPSDT website](#)
- [HHS Office of Minority Health's \*Think Cultural Health: Advancing Health Equity at Every Point of Contact\*](#)
- [HHS Office of Minority Health's \*A Physician's Practical Guide to Culturally Competent Care\*](#)
- [HHS Office of Minority Health's \*Culturally Competent Nursing Care: A Cornerstone of Caring\*](#)
- [HHS Office of Minority Health's \*Cultural Competency Curriculum for Disaster Preparedness and Crisis Response\*](#)
- [HHS Office of Minority Health's \*Cultural Competency Program for Oral Health Professionals\*](#)
- [HHS Office of Minority Health's \*National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care \(the National CLAS Standards\)\*](#)
- [HHS Office of Minority Health's \*A Blueprint for Advancing and Sustaining CLAS Policy and Practice \(The Blueprint\)\*](#)

## **Other Resources**

- [American Academy of Pediatrics, \*Bright Futures\* \(2014\)](#)
- [American Academy of Pediatrics, \*Bright Futures Recommendations for Pediatric Preventive Care\* \(2014\)](#)
- [American Academy of Pediatric Dentistry, \*Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents\* \(2013\)](#)
- [Association of Maternal and Child Health Programs, \*Standards for Systems of Care for Children and Youth with Special Health Care Needs\* \(March 2014\)](#)
- [George Washington University, Health Information & The Law, \*Understanding the Interaction Between EPSDT and Federal Health Information Privacy and Confidentiality Laws\* \(2013\)](#)
- [National Academy of State Health Policy, \*Managing the "T" in EPSDT Services\* \(2010\)](#)
- [National Academy of State Health Policy, \*Resources to Improve Medicaid for Children and Adolescents\*](#)
- [National Health Law Program, \*Toward a Healthy Future: Medicaid EPSDT Services for Poor Children and Youth\*](#)
- [National Health Law Program, \*Annotated Federal Documents\*](#)



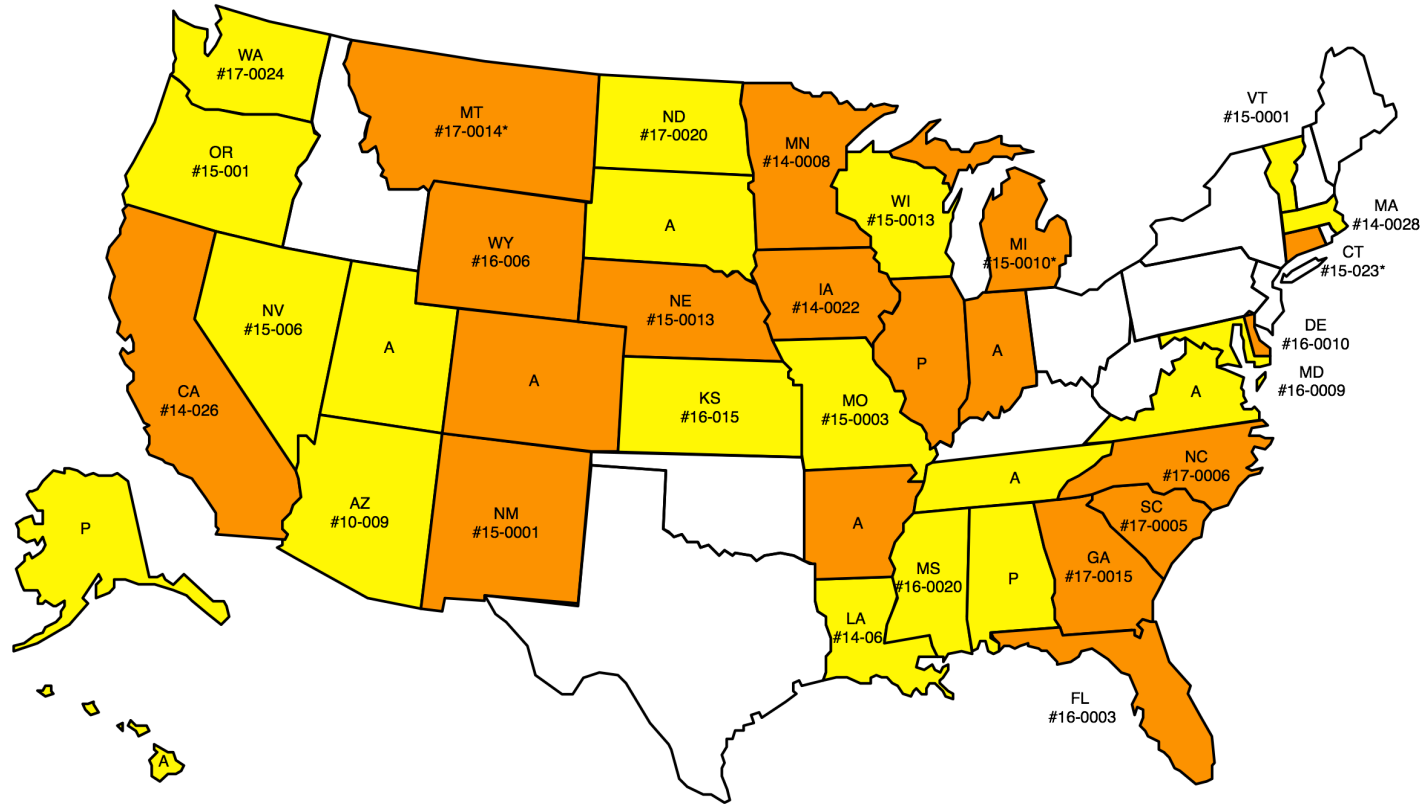
EPSDT Toolkit

TAB I

EPSDT/Medicaid Coverage of ABA in the States

# Medicaid (EPSDT) coverage for ABA

last updated Feb. 22, 2018  
subject to change



CMS has approved State Plan Amendments (SPAs) in **14 states** that allow for ABA to be provided by *non-licensed* Board Certified Behavior Analysts (BCBAs).\*



SPAs were not filed but state regulations have been adopted (A) or are pending (P) which otherwise recognize *non-licensed* BCBAs as approved Medicaid providers of ABA.



CMS has approved SPAs in **13 states** that include *licensed* behavior analysts among providers approved to deliver ABA services.



SPAs were not filed but state regulations have been adopted (A) or are pending (P) which otherwise recognize *licensed* behavior analysts as approved Medicaid providers of ABA.



Implementation of coverage for ABA under EPSDT is not actively progressing or the status is unclear.

\* CT, MI and MT enacted behavior analyst licensure after CMS approved SPAs allowing for non-licensed BCBAs to provide service under EPSDT.