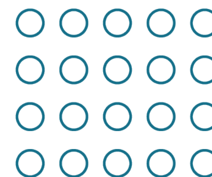

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Distilling New EPSDT Guidance

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The following is a compilation of Policy Corners that were published in Innovations Institute's TA Telegram from October–December 2024.

In September 2024, the Centers for Medicare & Medicaid Services (CMS) issued a State Health Official letter (SHO) titled, "**Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements**" (SHO #24-005). This SHO outlines expectations about the administration of EPSDT and spotlights strategies and approaches for leveraging Medicaid reimbursement for services and supports for children. Innovations Institute has reviewed the SHO and has compiled this resource to highlight approaches, strategies, and guidance from the document.

Introduction to EPSDT

EPSDT is a federally required benefit that provides complete health care services for children and youth under 21 who are enrolled in Medicaid. CMS considers EPSDT a cornerstone of the Medicaid program: "The goal of EPSDT is to ensure that individual eligible children get the health care they need, when they need it, in the most appropriate setting." This benefit entitles eligible children to access health care, diagnostic services, treatment, and other measures that are medically necessary to correct or ameliorate illness and conditions.

CMS highlights important information about EPSDT in the **SHO**:

- States must provide eligible children access to a full range of medically necessary services regardless of whether the services are covered under their state plan.
- The definition of "correct or ameliorate" should be broadly interpreted; services can maintain or improve a child's condition, including preventing worsening or developing additional health problems.
- EPSDT's requirements create a higher standard of coverage for children than adults.
- States may not limit available services to those that are convenient for the state to cover simply because they are aligned with what is typically available for adults.
- States retain the ultimate responsibility for assuring compliance with EPSDT, regardless of whether the state utilizes managed care to deliver services.

Transportation

States and communities strive to ensure that behavioral health services are accessible to children and their families, and transportation is a critical part of that equation. The recent **SHO**, *Best Practices in Adhering to EPSDT Requirements,* explicitly calls out transportation more than 30 times. CMS explains that states are responsible for informing Medicaid enrollees about their benefits, including how transportation is available to access services, and are required to offer and

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provide, if requested, assistance with transportation. In Table 3 (p.13-15), CMS provides policies, strategies, and best practices related to transportation and EPSDT.

CMS directs states to "consider the needs and best interests of the child when providing additional assistance with transportation" (p.13), going on to say this expectation means **states must cover the cost of transportation for anyone who needs to accompany the child**, including roundtrip for both admission and discharge. CMS notes that states may pay for transportation of **caregivers or family members to enable them to actively participate in treatment** (e.g., family therapy, medical decision-making), including when a child is receiving care in a residential facility, even when that care is provided out-of-state [emphasis added].

The SHO further outlines how states may cover non-emergency medical transportation services and leverage federal matching funds, including as an administrative activity, optional medical service, or both. States may also incorporate transportation costs into the rate for a service and use broker models to support access. The September 2023 *State Medicaid Director Letter:* ***Assurance of Transportation: A Medicaid Transportation Coverage Guide*** *(SMD #23-006)* provides extensive information about the assurance of transportation, flexibilities under the state plan and other Medicaid Authorities, access requirements, considerations for special populations, payment, and more.

Care Coordination

The SHO explains that *care coordination* and *case management* are terms used to describe various activities that connect individuals to services. Medicaid defines *case management* as a service under section 1905(a). CMS notes that *care coordination*, despite not being defined as a service in statute, may be covered in certain circumstances, with managed care plans being required to provide medically necessary care coordination. CMS observes that "the level of care coordination and case management must be appropriate for the complexity of the beneficiary's situation and one approach may not be sufficient to meet varied needs," (p.15).

The SHO outlines the six Medicaid authorities that can be leveraged to provide case management and care coordination. Some, but not all, of these authorities exist under EPSDT: 1) primary care case management; 2) managed care plans; 3) community health workers; 4) case management/targeted case management; 5) health homes; and 6) administrative case management.

The SHO spotlights community-based care management entities (CME) providing moderate or intensive care coordination as a best practice for children with complex behavioral health needs. CMS notes that, while managed care plans and others can provide some limited case management, care coordination includes development of a care plan guided and driven by the youth and their family and a level of care and support that is more comprehensive, extensive, and frequent than would otherwise be available. This description is consistent with the definition of intensive care coordination using High Fidelity Wraparound, which many states and communities are implementing to support children, youth, and their families with complex needs across life domains.

Best Practices in Children's Behavioral Health

EPSDT provides states with opportunities to strengthen access to and the quality and effectiveness of services for children and youth with complex behavioral health needs. Below we explore some of the areas that CMS has identified as best practices to support children and youth and their families in the implementation of EPSDT:

- **Elevate the role of continuous quality improvement, data analysis, and reporting activities.**
  States can use data to analyze provider network adequacy (including pediatric and specialty provider types) and decisions regarding prior authorization, appeals, and/or state fair hearing requests provided to EPSDT-eligible children. Reviewing data on individual services requests resulting in single-case agreements can help states identify service gaps. When possible, data should be stratified by managed care plan (if applicable), service type, geographic area, demographic factors, and involvement with child welfare or juvenile justice systems.
- **Ensure that EPSDT-eligible children are not inappropriately impacted by utilization management strategies.**
  Although states and managed care plans may implement requirements for prior authorization and other utilization management controls, they must be done in a manner consistent with EPSDT. That means limits on the amount, duration, or scope of services are "soft limits" that may be exceeded based on individual medical necessity. Additionally, CMS reiterates states should avoid requiring an EPSDT-eligible child to have a specific behavioral health diagnosis to receive services, particularly for children under five, and states cannot impose prior authorization requirements on screening services.
- **Utilize payment methodologies to expand the EPSDT workforce.**
  Payment methodologies incentivizing EPSDT provider participation can include implementing differential rates for specific populations and providing add-on rates for use of specified tools or models. CMS notes that rates for services may need to increase to ensure sufficient workforce capacity and cautions that benchmarking rates to Medicare may not be sufficient because many medically necessary services for EPSDT-eligible children are not covered by Medicare. As outlined in **SMD #24-001**, states can claim "an increased Skilled Professional Medical Personnel (SPMP) federal matching rate to support employing qualified individuals with advanced skills to meet the needs of children with complex health needs" (p.51).
- **Support youth currently and formerly in foster care with EPSDT services.**
  In addition to requirements while youth are in foster care, states are required to maintain Medicaid coverage for former foster youth until age 26. These youth retain EPSDT eligibility until age 21. States are encouraged to require managed care plans to establish liaisons and trauma-informed care managers to support youth currently and formerly in foster care.

Resources

EPSDT & CMS Guidance:

- Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements (SHO #24-005)
- Early and Periodic Screening, Diagnostic, and Treatment (CMS Website)
- EPSDT–A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents
- Assurance of Transportation: A Medicaid Transportation Coverage Guide (SMD #23-006)
- Administrative Claiming for Nurse Advice Lines & for Skilled Professional Medical Personnel for Certain Behavioral Health Professionals (SMD #24-001)

Care Coordination:

- Wraparound
- FOCUS
- National Wraparound Implementation Center