State Medicaid & CHIP Toolkit for Children's Behavioral Health Services and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Requirements

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Introduction

Improving access to high quality behavioral health treatment is among the Centers for Medicare & Medicaid Services' (CMS) highest priorities. In 2021, approximately 30 percent of children with public health coverage reported a mental, emotional, developmental, or behavioral problem.[1] As the largest single source of funding for behavioral health treatment and support services in the United States,[2] Medicaid and the Children's Health Insurance Program (CHIP) provide critical coverage for behavioral health conditions for the 38 million children enrolled in these programs.

The prevalence of behavioral health conditions among children and adolescents in the United States is a known and concerning issue. Data from 2022 to 2023 indicate that, among children ages 3 to 17, 11 percent had diagnosed anxiety, 8 percent had diagnosed behavior disorders, and 4 percent had diagnosed depression.[3] Over the last decade, the prevalence of mental health conditions increased among adolescents ages 12 to 17, with 15 percent having a diagnosis of anxiety, depression, or behavior/conduct problems in 2016 compared to 20 percent in 2023.[4] Additionally, during the 2021 to 2023 timeframe, approximately 20 percent of adolescents reported seriously considering attempting suicide in the last year.[5] While the percentage of adolescents who reported using illicit drugs has remained steady or declined over recent years, overdose deaths among teens has increased dramatically between 2010 and 2021.[6]

Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements at section 1905(a)(4)(B) and (r) of the Social Security Act (the Act), certain children and youth who are enrolled in Medicaid and under the age of 21 are entitled to coverage of health care, diagnostic services, treatment, and other measures described at section 1905(a) of the Act that are medically necessary to correct or ameliorate defects and physical and mental illness and conditions.[7,8] While "behavioral health" is not an identified, stand-alone service within the Act,

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[1] https://www.medicaid.gov/medicaid/quality-of-care/downloads/child-and-adolescent-behavioral-health-infographic.pdf.
[2] Behavioral health is used to describe mental health, substance use, and social and emotional well-being needs.
[3] https://www.cdc.gov/children-mental-health/data-research/index.html.
[4] https://mchb.hrsa.gov/sites/default/files/mchb/data-research/nsch-data-brief-adolescent-mental-behavioral-health-2023.pdf.
[5] https://www.cdc.gov/children-mental-health/data-research/index.html.
[6] https://nida.nih.gov/news-events/news-releases/2023/12/reported-drug-use-among-adolescents-continued-to-hold-below-pre-pandemic-levels-in-2023.
[7] Children eligible for EPSDT generally include beneficiaries under the age of 21 enrolled: in Medicaid through a categorically needy group; in Medicaid through a medically needy group in a state that has elected to include EPSDT in the medically needy benefit package; in a title XXI-funded Medicaid-expansion CHIP program; or in a separate CHIP program that has elected to cover EPSDT. This includes beneficiaries with an institutional level of care who are eligible for Medicaid by virtue of their enrollment in a home and community-based services (HCBS) waiver under section 1915(c) of the Act. EPSDT is not available to beneficiaries without satisfactory immigration status who are eligible only for treatment of an emergency medical condition and other groups of individuals under age 21 who are eligible only for limited services as part of their Medicaid eligibility, such as, for example, family planning services.
[8] While babies, children, adolescents, and youth may have distinct health care needs, throughout this document, CMS uses "child" and "children" to describe all EPSDT-eligible beneficiaries under the age of 21 for Medicaid or under age 19 for a separate CHIP. In those instances where a policy, strategy, or best practice is specific to a subset of EPSDT-eligible individuals under the age of 21, we specifically identify and define those individuals. Additionally, for minor beneficiaries, the involvement of parents, legal guardians, and other caregivers is often necessary to ensure

states are, nevertheless, obligated to cover an array of medically necessary mental health and substance use disorder (SUD) services along the care continuum. EPSDT provisions specifically require states to include an assessment of both physical and mental health development in EPSDT-required screenings, as well as diagnostic and treatment services to correct or ameliorate illnesses and conditions identified by that screening.[9]

CMS developed this behavioral health toolkit to support state Medicaid and CHIP agencies in ensuring that children and youth experiencing behavioral health conditions get the care they need. The main body of the toolkit is divided into four main sections that include actionable state strategies and sub-strategies: 1) developing and supporting a behavioral health care delivery system that can meet a range of children's needs; 2) promoting early intervention for children's behavioral health conditions; 3) improving children's access to behavioral health care through service coordination and integration; and 4) increasing the workforce capacity for children's behavioral health services. When possible, we included state examples within each strategy and sub-strategy to demonstrate various implementation options.

The toolkit also includes three appendices to provide supplemental information to states as they consider how to expand their behavioral health coverage for children. Specifically, Appendix A includes tables that include descriptive information on behavioral health services and models of care that are discussed in the toolkit. For each service or model of care, the table includes a description, the behavioral health service array under which the service/model of care could fall, the settings where the service could be delivered, possible Medicaid authorities/levers, resources, and/or state examples. Appendix B identifies various impact categories, such as coverage policy and operational efficiency, that could apply to each of the strategies and sub-strategies described in the toolkit. States can use these impact categories to determine which strategies and/or sub-strategies to implement based on the actions they would need to take and/or the desired outcome. Finally, Appendix C includes resources related to the delivery of behavioral health services for children and youth.

access to benefits. When we refer to a child's family, that term is meant broadly to include all persons who would be considered a child's family under applicable law.

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

Overview of EPSDT and Behavioral Health

EPSDT requirements at section 1905(r) of the Act entitle Medicaid-enrolled children who are EPSDT-eligible and under the age of 21 to screening, diagnostic, and treatment services described at 1905(a) of the Act when they are medically necessary. While there is no nationally available standard for assessing children's mental health needs and describing the related continuum of care using a common language, the extent of possible Medicaid coverage allows states to cover a broad array of behavioral health services necessary to achieve good outcomes for children.[10]

States can use a combination of strategies to meet children's behavioral health needs, including creating a children's behavioral health benefit package with a range of section 1905(a) services to adhere to EPSDT requirements, as well as other state plan services (e.g., sections 1915(i) state plan home and community-based services (HCBS), 1915(j) self-directed personal assistance services, 1915(k) Community First Choice HCBS state plan services, and/or 1945 Health Homes[11]) and waiver services (e.g., 1915(c) HCBS waiver services). Services authorized through 1915 and 1945 authorities can be used to augment section 1905(a) services covered under EPSDT.

Without treatment, children with behavioral health conditions face a range of problems in adulthood, including increased risk of criminal justice involvement and instability in employment and relationships, and adverse effects on health.[12] EPSDT can play a vital role in ensuring that children and their families are connected to behavioral health care that supports stability, minimizes the need for higher levels of care, and prevents involvement with child welfare and juvenile justice systems. CMS provides many options to help states design benefits that are aimed at promoting healthy development throughout childhood and that can help reduce risk and prevent the onset of serious behavioral health conditions.

[10] In 2018, CMS issued *Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance*, which includes a detailed table of Medicaid authorities that may apply to specific mental health services. See: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

[11] Under section 1945 of the Act, states have the option to cover health home services for Medicaid-eligible individuals with two or more chronic conditions, with at least one chronic condition and who are at risk for a second, or with at least one serious and persistent mental health condition. Section 1945A of the Act gives states the option to cover health home services for Medicaid-eligible children under age 21 with medically complex conditions who choose to enroll in a section 1945A health home by selecting a designated provider, a team of health care professionals operating with a designated provider, or a health team as the child's health home services provider. https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center; https://www.medicaid.gov/federal-policy-guidance/downloads/smd22004.pdf.

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

Section 1: Developing and Supporting a Behavioral Health Care Delivery System that can Meet a Range of Children's Needs

To meet their EPSDT obligations, states have broad discretion to use a variety of section 1905(a) Medicaid benefit categories, as well as other Medicaid authorities, for covering behavioral health services and supports. Children's behavioral health needs can change throughout their development and can be most effectively met by establishing a delivery system that can account for these differences.

This section describes the following strategies related to developing and supporting a behavioral health care delivery system to meet children's needs:

- Strategy 1.1: Cover a continuum of behavioral health care for children that accounts for a range of needs, as well as the different stages of childhood development.
- Strategy 1.2: Implement a CHIP Health Services Initiative (HSI) focused on improving the behavioral health of low-income children.
- Strategy 1.3: Monitor the use of inpatient behavioral health care among children and ensure they receive appropriate post-hospitalization follow up care.
- Strategy 1.4: Develop a behavioral health delivery system that accounts for children with specialized needs.
- Strategy 1.5: Ensure implementation of utilization controls and fair hearings for behavioral health services are consistent with EPSDT requirements.

Strategy 1.1: Cover a continuum of behavioral health care for children that accounts for a range of needs, as well as the different stages of childhood development.

Delivering mental health and SUD treatment services to children poses challenges unlike those in other areas of care and states should account for these challenges when developing a behavioral health continuum of care.[13] Behavioral health treatments that are effective for adults may not be effective for children and, similarly, the type of treatments and their effectiveness may vary across the stages of childhood—infancy (0 to 2 years old), early childhood (3 to 5 years old), middle childhood (6 to 11), and adolescence (12 to 18 years old). When children are younger, behavioral health treatment may be directed at parents or caregivers (e.g., parent training in behavior management where a therapist helps the parents/caregivers learn or improve skills to manage the child's behavior).[14] Older children, however, may have the capacity to work directly with a provider by talking, playing, or participating in other activities that help express feelings, though parental support is still important in these situations.

Covering behavioral health services that account for these stages of childhood development and clinical needs, range in intensity, and vary in service delivery location can help states to ensure that children get the right care in the right setting at the right time, without having to rely on high-cost inpatient services except when clinically indicated. In addition to covering a range of services that can be authorized under section 1905(a) to meet EPSDT obligations, states can also consider using other Medicaid authorities to supplement, not supplant, coverage for EPSDT-eligible children. These authorities include other state plan authorities, such as sections 1915(i) state plan HCBS, 1915(j) self-directed personal assistance services, 1915(k) Community First Choice HCBS state plan services, and 1945 Health Homes, as well as section 1915(c) HCBS waivers and section 1115 demonstrations.[15, 16]

[13] EPSDT requirements apply to EPSDT-eligible children enrolled in Medicaid, as well as EPSDT-eligible children enrolled in a state's separate CHIP that has elected to cover EPSDT. However, all separate CHIPs—regardless of whether EPSDT coverage of has been elected—must cover all of the developmental and behavioral health related screenings and preventive services recommended in the Bright Futures periodicity schedule, as well as those with a grade of an A or B by the U.S. Preventive Services Task Force. For more information, please see: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho20001.pdf.

[14] https://www.cdc.gov/children-mental-health/treatment/index.html.

[15] For separate CHIPs, section 5022 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P. L. 115-271), referred to as the SUPPORT Act, specifically requires that child health and pregnancy related assistance "include coverage of mental health services (including behavioral health) necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders, including substance use disorders." CMS issued related guidance for all states with separate CHIPs on how to ensure a state's overall benefit array and levels of care are sufficient to treat a broad range of behavioral health conditions. See: https://www.medicaid.gov/federal-policy-guidance/downloads/sho20001.pdf.

[16] For more information about the intersection of EPSDT requirements with requirements for other Medicaid authorities, such as managed care and HCBS authorities, see: https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

Within children's mental health, there is not yet a nationally available standard or common language for describing the continuum of care. A service array of behavioral health care that is consistent with EPSDT requirements includes, but is not limited to:

1. Screening and assessment;
2. Services to address early signs or symptoms of behavioral health conditions, with or without a diagnosis;
3. Community-based services at varying levels of intensity necessary to correct or ameliorate a wide range of behavioral health acute and/or chronic conditions, including routine community-based services as well as services to meet more intensive needs;
4. Services to address urgent and crisis needs; and
5. Inpatient care only when medically necessary.

Within each segment of the care continuum, states can cover a variety of services to meet their EPSDT obligations and meet the needs of children with behavioral health conditions. Behavioral health services can be provided in a range of settings through various mandatory and optional 1905(a) state plan benefits (e.g., physician services, outpatient hospital services, inpatient hospital services, rehabilitative and preventive services).[17] States can tailor these benefits to meet the specific needs identified by the state and designed to ensure responsible use of taxpayer dollars, so long as statutory and regulatory requirements are met.

Table 1 below describes each of the five segments of the care continuum. For examples of Medicaid services that fall within each of these segments, see *Appendix A: Medicaid Behavioral Health Service Descriptions*. The examples in *Appendix A* include service descriptions, related 1905(a) benefits categories and/or other Medicaid coverage authorities, potential service settings, examples of states with Medicaid coverage of the service, and any relevant resources.

Table 1: Behavioral Health Care Continuum Segment Descriptions

1. Screening and assessment	
	EPSDT 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 whether a change in a previously diagnosed illness or condition requires additional services. The decision of whether a screening service outside of the periodicity schedule is necessary may be made by the child's physician or dentist, or a health, developmental, or educational professional who is in 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. Any qualified provider operating within the scope of their practice, as defined by state law, can provide a screening service. The screening need not be conducted by a

[17] https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits.

Medicaid provider 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 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 directly from the state or the health care provider.

A comprehensive assessment provides the basis for an individualized care plan (initial and subsequent), which may include a range of services and supports for a beneficiary and their family. Assessments may be completed by an individual provider or a multi-disciplinary team and should include face-to-face evaluation of the child, their parents/caregivers, and may include other individuals who are part of the family's support system.

2. Services to address early signs or symptoms of behavioral health conditions

Early detection of behavioral health conditions is crucial to the overall health of children and may reduce or eliminate the effects of a condition if detected and treated early.[18] This makes routine screenings, early identification, and engagement in treatment as early as possible critical for children and youth. Services to address early signs or symptoms of behavioral health conditions can be covered in a variety of settings, such as schools and primary care offices.

3. Community-based services at varying levels of intensity for a wide range of behavioral health acute and/or chronic conditions

Community-based services can be provided at varying intensities to support children and their families at their level of need. These services can occur in various community settings, such as community mental health centers, hospitals, federally qualified health centers (FQHCs), co-located in primary care offices, certified community behavioral health clinics (CCBHCs), office-based settings, homes, and schools.

Children should have access to the behavioral health services they need in their communities while living at home whenever possible. When treatment options do not exist or are limited, a child's unmet behavioral health needs may intensify, requiring more costly and disruptive interventions such as inpatient or residential care, and sometimes driving parents to relinquish custody of their children to the child welfare system to access care.[19] This is not the preferred outcome due to a state's lack of a well-developed range of community-based services.

[18] https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf.
[19] https://aspe.hhs.gov/sites/default/files/documents/35ca9fc3ef5f522e2ed18ec2a277f99c/custody-relinquishment-prevalence-characteristics.pdf.

4. Services to address urgent and crisis needs

Providing community-based crisis response services supports children and their families at home, often preventing unnecessary emergency department utilization and out-of-home treatment.[20] Community-based crisis care for children includes:[21, 22]

- "Someone to call" (single access to care, crisis call lines that include text and chat options, 988)
- "Someone to respond" (mobile response teams)
- "A safe place to be" within a system to support children and their families (stabilization services or crisis stabilization units)

5. Inpatient care only when medically necessary

Inpatient behavioral health services are provided to children with symptoms that are too severe to be managed in the community (e.g., suicidality, severe depression or anxiety, acute behavioral dysregulation, severe harm to self or others, or psychosis). Inpatient care has two tiers: 1) acute care to provide immediate stabilization, usually of short duration (e.g., three to seven days), and 2) subacute/intermediate care to provide short-term, highly structured specialized care in an inpatient setting for children with more complex needs.

Inpatient psychiatric hospitalization can be delivered in psychiatric hospitals, psychiatric units in general acute care hospitals, and psychiatric residential treatment facilities (PRTF).[23] This level of care should only be used when clinically indicated to ensure children receive behavioral health services in the most integrated and least restrictive setting whenever possible.

States cannot rely on institutional care if a child's needs can be met at home or in the community,[24, 25] in alignment with the Americans with Disabilities and Rehabilitation Acts.

[20] *A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth*—developed for the National Association of State Mental Health Program Directors by the Innovations Institute at the University of Connecticut—describes the components of crisis stabilization services for children, youth, young adults, and their families. See: https://innovations-socialwork.media.uconn.edu/wp-content/uploads/sites/3657/2023/03/Safe-Place-to-Be_Childrens-Crisis-and-Supports_NASMHPD-4.pdf.
[21] https://innovations-socialwork.media.uconn.edu/wp-content/uploads/sites/3657/2023/03/Safe-Place-to-Be_Childrens-Crisis-and-Supports_NASMHPD-4.pdf.
[22] https://988crisissystemshelp.samhsa.gov/sites/default/files/2025-04/national-guidelines-crisis-care-pep24-01-037.pdf.
[23] https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-11-28-12.pdf.
[24] https://www.medicaid.gov/federal-policy-guidance/downloads/smd011001a.pdf.
[25] 42 C.F.R. § 441.152.

Strategy 1.2: Implement a CHIP Health Services Initiative (HSI) focused on improving the behavioral health of low-income children.

States have the option under CHIP to develop state-designed Health Services Initiatives (HSI) that must directly improve the health, including behavioral health, of low-income children less than 19 years of age who are eligible for CHIP and/or Medicaid, but may serve children regardless of income.[26, 27] While an HSI must directly improve health, statute and regulations provide states with flexibility in designing the purpose of the HSI. Typically, this has involved the provision of preventive services and interventions.

Several states have used HSIs for behavioral health initiatives. For example, states have used HSIs to provide opioid overdose reversal kits, train public school employees to administer opioid overdose reversal drugs, and support consultation and collaboration between pediatric primary care and mental health specialists.

HSI expenditures (including administration of the HSI itself) are subject to a cap that also applies to administrative expenses. Under section 2105(c)(2)(A) of the Act, claims for HSIs and administrative expenses cannot exceed 10 percent of the total amount of title XXI funds claimed by the state each quarter. In addition, states must assure in the CHIP state plan that they will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds. States should be able to demonstrate that they have a process for coordinating work with other federal agencies and other federal funds.

For additional technical assistance on implementing an HSI, please reach out to your CHIP Project Officer.

[26] HSIs are permitted under section 2105(a)(1)(D)(ii) of the Act and are defined in regulations at 42 C.F.R. § 457.10.
[27] https://www.medicaid.gov/federal-policy-guidance/downloads/faq11217.pdf.

Strategy 1.3: Monitor the use of inpatient behavioral health care among children and ensure they receive appropriate post-hospitalization follow up care.

Inpatient behavioral health treatment should be reserved for children and youth who cannot be safely and effectively treated in community-based settings. States should monitor the use of inpatient treatment among children and youth[28] to ensure it is only used when medically necessary. To help ensure that children can access inpatient services when needed, states can track utilization and capacity of inpatient beds for behavioral health conditions by implementing a state-run bed tracking system[29, 30] that provides information on the number of beds available within a certain geographic area. This information can also help states identify the need to increase or decrease bed capacity in the state.

In addition to tracking utilization of inpatient behavioral health services, states should work to ensure that children who received those services have appropriate follow up care. Timely ambulatory follow-up care for children treated for behavioral health conditions in inpatient settings has been shown to reduce suicidal ideation, inpatient readmissions, and emergency department revisits, and to improve medication adherence.[31] Timely follow-up care is associated with decreased behavioral health costs due to reductions in preventable hospital visits for primary mental health services that could be provided in an outpatient setting.[32]

The recommended post-discharge treatment following hospitalization for behavioral health conditions, including SUDs, includes a visit with a mental health provider within 30 days of discharge, and ideally, within 7 days of discharge.[33] However, Child Core Set Data for 2024 indicate that, nationwide, only 45% of children ages 6 to 17 had follow-up care within 7 days after a hospitalization for a mental illness.[34, 35] To promote follow-up care for children after a behavioral health hospitalization, states can monitor quality measures,[36] initiate care

[28] EPSDT-eligible beneficiaries have access to medically necessary psychiatric inpatient hospitalization in a general hospital, a freestanding psychiatric hospital, or a psychiatric residential treatment facility under the section 1905(a) "inpatient psychiatric services for individuals under age 21" benefit. See section 1905(a)(16)(A) of the Act and 42 C.F.R. §§ 440.160, 441.151.
[29] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/smi-rcr-oy3-crisis-stabilization.pdf.
[30] https://aspe.hhs.gov/reports/inpatient-bed-tracking-state-responses-need-inpatient-care-0#results.
[31] https://www.medicaid.gov/medicaid/quality-of-care/downloads/bhfua-high-light-reprt.pdf.
[32] https://www.medicaid.gov/medicaid/quality-of-care/downloads/improvement-initiatives/behavioral-health-ag-factsheet.pdf.
[33] https://www.samhsa.gov/sites/default/files/suicide-risk-practices-in-care-transitions-11192019.pdf.
[34] https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-core-set-reporting.pdf.
[35] Although not specific to follow-up care post-hospitalization, the Child Core Set also includes a measure tracking the percentage of adolescents who receive care following an emergency department visit for substance use. In 2024, the data indicate that, nationally, approximately 22% of adolescents ages 13 to 17 received follow-up care within 7 days of an emergency department visit for substance use. See: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-core-set-reporting.pdf and https://www.medicaid.gov/medicaid/quality-of-care/core-set-data-dashboard/welcome.
[36] For more information on Medicaid behavioral health data related to post-hospitalization follow-up, see *Section 2: Access to Services – Data Spotlight on Behavioral Health Services* in CMS's *Medicaid and CHIP Access: Coverage and Behavioral Health Data Spotlight*, available at: https://www.medicaid.gov/medicaid/access-care/downloads/coverage-and-behavioral-health-data-spotlight.pdf.

coordination before discharge,[37] and ensure coverage of non-emergency medical transportation (NEMT) for families so they can participate in treatment meetings and interventions that would benefit the child.[38, 39]

State Examples

Iowa has a behavioral health bed registry that tracks the number of available inpatient psychiatric beds by gender for children, adults, and geriatric patients.[40] Psychiatric units are required to update the registry at least two times per day and the state monitors participation daily. If the state identifies any units that are not adhering to the guidelines, they send a reminder email about updating the information. To further promote timeliness, the state legislation that created their bed tracking system indicates that a hospital's Medicaid reimbursement could be impacted if bed availability is not entered timely.

In addition, Iowa's robust, interactive Medicaid Dashboards[41, 42] provide a wealth of information on various services and performance measures that allow the state to monitor and improve the quality of care, including behavioral health care, that is delivered in their Medicaid program. For example, using their "Quality Scores" dashboard, the state can easily track whether the results of each Child Core Set performance measure (e.g., children who receive follow-up care within 7 days after a mental health hospitalization) are higher or lower than the national average for three federal fiscal years. The "Behavioral Health Treatment and Services" dashboard allows the state to monitor utilization information that can be filtered by type of behavioral health (i.e., mental health or SUD), specific behavioral health service (e.g., mental health residential treatment), state fiscal year, managed care plan, sex, age group, race, and county. Their "Provider Network Access" dashboard includes information on various provider types such as inpatient behavioral health and outpatient behavioral health providers and reports, for example, average distance to the providers, members with access, and provider counts.

Massachusetts has a state behavioral health bed registry that provides information on the availability of beds for youth and family services, mental health services, and SUD services.[43] The state requires hospitals to update the registry on bed availability three times a day and includes a performance metric in their Medicaid managed care performance contracts on timely updates to the registry. Massachusetts has implemented the Behavioral Health Treatment and Referral Platform (BH TRP), which supports streamlining referral processes, sharing essential information on provider capacity, standardizing admissions information, and offering a transparent view of patients in emergency departments or hospitals awaiting inpatient psychiatric placement.

[37] https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf.
[38] https://www.medicaid.gov/federal-policy-guidance/downloads/smd23006.pdf.
[39] For more quality improvement technical assistance on improving behavioral health follow-up care, see: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/behavioral-health-learning-collaborative and https://www.medicaid.gov/medicaid/quality-of-care/downloads/bhfua-measures-qi.pdf.
[40] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//190716/IPBedTrack.pdf.
[41] https://hhs.iowa.gov/media/549/download?inline.
[42] https://hhs.iowa.gov/about/data-reports/medicaid-reports.
[43] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//190716/IPBedTrack.pdf.

Strategy 1.4: Develop a behavioral health delivery system that accounts for children with specialized needs.

Children with specialized needs face unique health care issues, including complex behavioral health conditions, that may impact their development. For children with substance use disorders, co-occurring behavioral health conditions and intellectual and developmental disabilities, children in or formerly in foster care, and youth experiencing early or first-episode psychosis, early detection and treatment is particularly important for achieving optimal health.

1.4.a: Ensure coverage of a range of services and supports to identify, treat, and support the recovery of youth with substance use disorders (SUD).

Most people with an SUD develop their addiction during adolescence and their substance use is more likely to develop and continue into adulthood the earlier they start using.[44] The incidence of co-occurring mental health disorders among youth with SUDs is high, with SUDs increasing the risk for mental health disorders and vice versa, and research has shown that early identification and treatment of these conditions improves outcomes.[45] For example, early interventions conducted by comprehensive school-based mental health and substance treatment systems have been associated with enhanced academic performance, decreased need for special education, fewer disciplinary encounters, increased engagement with school, and elevated rates of graduation. At the same time, deaths due to drug overdose among youth ages 12 to 17 more than doubled from 2018 (253 deaths) to 2022 (723 deaths),[46] further emphasizing the need for ensuring a wide availability of screening and treatments for youth with SUDs.

Screening is essential for identifying and addressing SUDs, and any co-occurring mental health conditions, as early as possible.[47] In order to achieve a level of functioning capable of supporting and sustaining recovery, youth identified as having a SUD should undergo an assessment to inform the development of an initial treatment or service plan, which can range in intensity and duration and should be individualized to the youth's developmental stage. The plan should include necessary treatment, level of care, continuing care, and recovery support recommendations and discharge criteria.[48]

1.4.b: Cover a robust array of services for children with Intellectual and Developmental Disabilities (IDD) and behavioral health conditions and highlight opportunities for providers to learn more about identifying and treating these co-occurring conditions.

In 2021, approximately 6% of children ages 3 to 17 had a developmental delay and 2% had an intellectual disability.[49] While estimates vary, research suggests that approximately 40% of

[44] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf.
[45] https://www.medicaid.gov/federal-policy-guidance/downloads/cib20190701.pdf.
[46] https://www.kff.org/mental-health/recent-trends-in-mental-health-and-substance-use-concerns-among-adolescents/.
[47] https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-01-26-2015.pdf.
[48] Ibid.
[49] https://www.cdc.gov/nchs/data/databriefs/db473-tables.pdf.

children with IDD also have a diagnosable mental health condition, a rate that is at least double that of children without IDD.[50, 51] However, that estimate may be low as individuals with IDD are at risk of having undiagnosed mental health conditions, due to inadequate screening, a shortage of mental health providers who are trained to work with children with IDD, or providers attributing symptoms of a mental health condition to the IDD rather than a separate, distinct condition, for example.

Children with co-occurring behavioral health conditions and IDD often have a combination of functional limitations, chronic health condition(s), ongoing use of medical technology, and/or high resource need and use. To help treat and manage these conditions, states should cover a robust set of section 1905(a) services provided by primary care and pediatric subspecialists, as well as numerous therapists. While not required under EPSDT, states can help these children remain in integrated home and community-based settings by also covering services authorized under other Medicaid authorities, such as HCBS waivers under section 1915(c) of the Act and state plan HCBS under section 1915(i) of the Act.[52]

Although more research is needed on effectively treating behavioral health conditions among children with IDD, recent studies suggest that children with mild-to-moderate IDD can benefit from behavioral therapies with adaptations, such as shortening sessions or using visual aids.[53, 54] Parenting programs such as Triple P (Positive Parenting Program) have also been shown to improve outcomes for children, including children with IDD, by giving parents strategies to manage their children's behavior and prevent problems from developing.[55] The Stepping Stones Triple P program in particular is geared toward parents of pre-adolescent children with IDD who have disruptive behavior.[56]

Regardless of the service array that states cover for children with IDD, it is important to keep in mind that children who have a disability, including an IDD, may not be categorically excluded from receiving coverage for and provision of behavioral health services.[57] Given the historical misconception that individuals with IDD do not have co-occurring behavioral health conditions,

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[50] Totsika, Vasiliki et al. (2022). Mental health problems in children with intellectual disability. *The Lancet Child & Adolescent Health, 6*(6). Available at: https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(22)00067-0/abstract.

[51] Buckley N, Glasson EJ, Chen W, et al. (2022). Prevalence estimates of mental health problems in children and adolescents with intellectual disability: A systematic review and meta-analysis. *Australian & New Zealand Journal of Psychiatry, 54*(10). Available at: https://journals.sagepub.com/doi/10.1177/0004867420924101.

[52] When developing benefits and programs for children with IDD, states should be mindful of various federal requirements. In addition to Medicaid requirements, states are obligated to meet the requirements of the Americans with Disabilities Act and the Supreme Court's decision in *Olmstead* v. L.C., 527 U.S. 581 (1999). Compliance with Medicaid requirements, or receipt of the Secretary's approval of specific Medicaid programs, does not necessarily indicate compliance with civil rights statutes, including Title II of the Americans with Disabilities Act.

[53] Constantino JN, Strom S, Bunis M, Nadler C, et al. (2020). Toward Actionable Practice Parameters for "Dual Diagnosis": Principles of Assessment and Management for Co-Occurring Psychiatric and Intellectual/Developmental Disability. *Current Psychiatry Reports*, (2). Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC6995447/; https://onlinelibrary.wiley.com/doi/10.1111/jir.13046.

[54] https://childmind.org/article/intellectual-developmental-disorder-and-mental-health/.

[55] https://www.triplep.net/.

[56] https://www.triplep.net/glo-en/the-triple-p-system-at-work/the-system-explained/specialist-programs/.

[57] See: Title II of the Americans with Disabilities Act, 42 U.S.C. 12132; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794(a); sections 1902(a)(10)(B) and 1905(r)(5) of the Act; and 42 C.F.R. § 440.240.

states may need to review their Medicaid Management Information System (MMIS) to ensure there are no limitations on billing codes for services in these situations.

To ensure behavioral health conditions are identified in children with IDD, states should increase providers' confidence in identifying these co-occurring conditions by developing new, or highlighting existing, related resources. States can also encourage providers to participate in trainings or other learning opportunities on this topic. For example, some universities offer free participation in a Project ECHO (Extension for Community Healthcare Outcomes) learning collaborative on improving behavioral health care for individuals with IDD.[58, 59]

State Examples

Alaska's Mental Health and Developmental Disabilities (MHDD) Project ECHO[60] is operated by the University of Alaska Anchorage Center for Human Development and explores increasing access to evidence-based mental health and developmental disability services in communities where people live. Participants (e.g., mental health care providers, disability service providers, people with lived experience, etc.) learn how to increase collaboration within multidisciplinary teams, support communities of practice, and explore best practices that improve the quality of life for people with IDD and co-occurring mental health issues.

Washington state's Wraparound with Intensive Services (WISe)[61] uses a team-based approach to provide intensive mental health services and care coordination to children, including children with IDD, who are under the age of 21 and have behavioral health symptoms that interfere with their functioning in their community. The goal of WISe is to help children live and thrive in their communities and to avoid costly and disruptive out-of-home placements. Each child has a Child and Family Team (CFT) consisting of the child, natural supports, and other partners (e.g., clinicians, teachers, etc.) that helps develop an individualized plan of care based on the child's and family's strengths and needs. WISe provides wraparound care coordination for the child's intensive therapeutic services, which can include family therapy, teaching families to manage symptoms, and a variety of other interventions. On average, children receive WISe for approximately 9 months before being discharged to a different level of care.

1.4.c: Ensure children in or formerly in foster care receive trauma-focused screening and include requirements in managed care plan (MCP) contracts that focus on the special needs of this population.

A high percentage of children involved in foster care have been exposed to trauma, which can create wide-ranging and lasting adverse effects on developmental functioning, and physical, social, and emotional well-being.[62] Due to this complex trauma, which arises from adverse childhood experiences, children who are in foster care experience significantly higher rates of

[58] For more information on Project ECHO, see the related strategy under *Section 4: Increasing the Workforce Capacity for Children's Behavioral Health Services*.
[59] https://showmeecho.org/clinics/developmental-disabilities/; https://iecho.org/public/program/PRGM1696635377192WWEUOHVQ74; https://connect.oregonechonetwork.org/cohortDetails/19aa6eab-cf5a-4eb6-b742-d0a586fcef13; https://wainclude.org/echo/echo-idd-psychiatric-care/.
[60] https://iecho.org/public/program/PRGM1696635377192WWEUOHVQ74.
[61] https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-behavioral-health-support/wraparound-intensive-services-wise; https://www.hca.wa.gov/assets/program/wise-info-idd-including-asd-20210930.pdf.
[62] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf.

behavioral health conditions than those who are not in foster care.[63] In addition, the use of psychotropic medication is higher among children in foster care.[64]

Medicaid is an important source of reimbursement for services and supports for children who have experienced complex trauma and have behavioral health needs requiring treatment.[65] For these children, the integrated use of trauma-focused screening, functional assessments, and evidence-based practices in child-serving settings will likely result in improved social, emotional, and health outcomes.

Additionally, states can utilize MCPs that only serve children in foster care, allowing the Medicaid agency to draft a contract that includes the requirements of both the Medicaid and child welfare agencies and enables the MCP to specialize and focus on the special needs, including the behavioral health needs, of this population. States can require these MCPs to use case managers who are familiar with the foster care landscape, comply with network adequacy requirements specific to the needs of this population, and report on performance measures that can help the state determine whether these children are receiving services timely.

Alternatively, states can enroll children in foster care into the same MCPs as other children and include contract requirements to help ensure children in foster care receive the care they need. For example, states can require the MCP to identify beneficiaries in foster care; train MCP staff in complex trauma identification, the physical and behavioral health needs of children in foster care, family-centered engagement, and relevant child welfare processes; require MCP care coordinators to collaborate with child welfare case managers; develop dashboards on trends and outcomes; and provide oversight and monitoring of psychotropic medication.

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[63] Keefe RJ, Cummings A, et al. (2021). A Comparison Study of Mental Health Diagnoses of Foster and Non-Foster Children on Medicaid. *Pediatrics*, 147. Available at: https://publications.aap.org/pediatrics/article/147/3_MeetingAbstract/83/4972/A-Comparison-Study-of-Mental-Health-Diagnoses-of?autologincheck=redirected.

[64] https://aspe.hhs.gov/sites/default/files/documents/51f80cd88e92eae6c4fc77efada9506b/T-MSIS-Child-Welfare-Overview-Brief.pdf.

[65] https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-07-11.pdf.

State Examples

Rhode Island implemented the Child and Adolescent Needs and Strengths (CANS) assessment[66] for all children entering congregate care or specialized foster care. Assessment data from the CANS are collected and imported into the Rhode Island Department of Children, Youth & Families data system to support information sharing and care coordination between the Department and the Neighborhood Health Plan of Rhode Island, the state's managed care organization for youth in substitute care. Rhode Island also implemented CANS Comprehensive – Trauma Version,[67] which includes domains that assess traumatic exposures and related symptoms for all children, in addition to assessing strengths. By utilizing the CANS assessment, Rhode Island ensures that children's behavioral health needs are comprehensively identified and that the children and their families are involved in decision-making and care planning.

The **Washington** state Health Care Authority contracts with a single integrated specialty managed care plan Apple Health Core Connection (AHCC) for all children in foster care.[68] AHCC are responsible to conduct age-appropriate screenings including medical and behavioral health, supported by the Department of Children, Youth, and Family's Child Health and Education Tracking Program (CHET). AHCC ensures Continuity of Care for youth with chronic or acute conditions, including behavioral health disorders. The specialty MCP utilizes the CANS assessment tool to identify children's behavioral health needs and ensures children in foster care receive a wide range of services, including complex care management. The MCP collaborates closely with children, their families, and the children's care teams and offers all network providers with education and training about delivering trauma-informed care.

1.4.d: Improve outcomes for youth experiencing early or first-episode psychosis by covering coordinated specialty care (CSC).

Adolescence or early adulthood (i.e., teenage years through mid-20's) is when a majority of people with severe mental illness experience their first psychotic symptoms.[69, 70] Although the specific definition varies across clinical and research settings, first-episode psychosis is generally regarded as the early period (up to five years) after the onset of psychotic symptoms due to a serious mental illness (SMI) and unrelated to substance use, brain injury, or other non-SMI medical issues (e.g., dementia).[71] Studies indicate that people experiencing first-episode psychosis often go untreated for a year or longer, and untreated symptoms increase the risk of developing an SUD, engaging in self-injury, or becoming homeless or unemployed.[72]

Timely access to evidence-based interventions—like coordinated specialty care—can significantly improve outcomes and support recovery for individuals experiencing psychosis.[73]

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[66] https://dcyf.ri.gov/behavioral-health/assessments.php.
[67] https://www.nctsn.org/measures/nctsn-cans-comprehensive-trauma-version-cans-trauma.
[68] https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-medical-dental-or-vision-care/foster-care#apple-health-core-connections-ahcc.
[69] https://www.medicaid.gov/medicaid/downloads/accomplishments-report.pdf; https://library.samhsa.gov/sites/default/files/pep23-01-00-003.pdf.
[70] EPSDT applies to eligible individuals under the age of 21.
[71] https://library.samhsa.gov/sites/default/files/pep23-01-00-003.pdf.
[72] https://www.nimh.nih.gov/research/research-funded-by-nimh/research-initiatives/recovery-after-an-initial-schizophrenia-episode-raise.
[73] https://www.nimh.nih.gov/sites/default/files/documents/health/topics/schizophrenia/raise/evidence-based-treatments-for-first-episode-psychosis.pdf.

Coordinated specialty care,[74] a comprehensive treatment approach designed to be implemented soon after first episode psychosis, encompasses five core activities: 1. cognitive or behavioral psychotherapy, 2. medication management, 3. family education and support, 4. service coordination and/or case management, and 5. supported employment and education.[75]

States can cover most CSC services under section 1905(a) state plan authorities, such as the rehabilitation services benefit and the new Certified Community Behavioral Health Clinic (CCBHC) benefit.[76] States can also utilize 1915(c) HCBS waiver programs, 1915(i) state plan HCBS, and section 1115 demonstrations to cover services not included under section 1905(a).[77] Other funding options for CSC services include a set-aside of the SAMHSA Mental Health Block Grants funds and state and local funds.[78]

State Example

Idaho's Early Serious Mental Illness (ESMI) program[79] uses a multidisciplinary approach to treat adolescents and young adults who are experiencing FEP. ESMI provides early intervention services to help youth avoid a higher level of care such as partial hospitalization and to support youth who are stepping down from a higher level of care. A team of specialists work with youth to create a personal treatment plan that includes services such as peer support, crisis intervention, and therapy.

[74] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf.
[75] https://library.samhsa.gov/sites/default/files/pep23-01-00-003.pdf#:~:text=As%20of%202022%2C%20there%20were%20an%20estimated,to%20FEP%20clients%20in%20the%20United%20States.&text=In%202021%2C%2024%2C206%20clients%20were%20admitted%20to,CSC%20services%20for%2075%2C794%20individuals%20with%20FEP.
[76] Section 1905(a)(13) and (a)(31) of the Act.
[77] For more information about options for Medicaid coverage of CSC services, see: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf.
[78] For more information on funding strategies for CSC services, as well as financing strategies from five states, see:https://library.samhsa.gov/sites/default/files/pep23-01-00-003.pdf.
[79] https://magellanofidaho.com/documents/2446693/3042016/ibhp_prov_handbook_appC.pdf/2046bdcf-dab9-fa0b-f5ff-4fb5371edbe5?t=1718993330450; https://magellanofidaho.com/documents/2446693/2727142/IBHP+Member+Handbook+-+English.pdf/646ea371-3d0c-86e3-6e45-1cd04f4b0e8c?t=1717425333894.

Strategy 1.5: Ensure implementation of utilization controls and fair hearings for behavioral health services are consistent with EPSDT requirements.

States' medical necessity criteria and prior authorization requirements must reflect consideration of the EPSDT requirement to cover section 1905(a) services, including behavioral health services, that are necessary to correct or ameliorate identified medical needs for EPSDT-eligible children.[80] While states may impose—and may permit MCPs to impose—these utilization controls to safeguard against unnecessary use of care and services, they must do so in a manner that is consistent with EPSDT requirements.[81] States should also ensure that hearing officers who conduct Medicaid fair hearings[82] that involve EPSDT are knowledgeable about EPSDT requirements.

Medical necessity criteria cannot have the effect of imposing a limit on the amount, duration, or scope of services that can never be exceeded for EPSDT-eligible children, nor can they be arbitrary or result in inappropriate limits on access to a service.[83] Prior authorizations, under CMS's interpretation of section 1905(r)(5), must be conducted on a case-by-case basis, evaluating each child's needs individually, and it must not delay the delivery of needed treatment services.[84] Finally, state Medicaid agencies must exercise appropriate oversight of their Medicaid fair hearing systems to ensure fair hearing decisions correctly apply all relevant federal and state law, regulations, and policies, including the EPSDT "correct or ameliorate" standard.[85]

To ensure appropriate application of utilization controls, states can monitor utilization trends, track outcomes, and meet regularly with providers and/or MCPs to review the impact of the utilization policy and make data-informed adjustments as needed. States with MCPs can also utilize the required external quality reviews (EQR) to assess the extent to which prior authorization requests for children's behavioral health services, as well as claims denials for those services, are clinically appropriate. Medicaid MCPs must undergo an annual EQR by a

[80] States must ensure compliance with the mental health parity requirements in the Mental Health Parity and Addiction Equity Act (MHPAEA) (Pub. L. 110-343) by ensuring that any financial requirements or treatment limitations imposed on mental health and substance use disorder services in separate CHIPs, in Medicaid Alternative Benefit Plans, and for enrollees in Medicaid managed care organizations (MCO) are no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical services in the same benefit classification. For more information about the mental health and SUD parity requirements for managed care in Medicaid and CHIP, see CMCS's CIB, available at: https://www.medicaid.gov/federal-policyguidance/downloads/cib06122024.pdf. Parity also applies to Alternative Benefit Plans, section 1937 of the Act and 42 C.F.R. § 440.395.
[81] 42 C.F.R. §§ 440.230(d), 438.210.
[82] Medicaid "fair hearings" are also sometimes colloquially called appeals. In this document, we will use the term "fair hearing" to refer to the request that individuals can make when they disagree with an action taken by the state. 42 C.F.R. part 431, subpart E.
[83] Section 1905(r)(5) of the Act; per 42 C.F.R. § 438.210(a)(5)(i), each contract between a state and an MCP must specify what constitutes medically necessary services in a manner that is no more restrictive than that used in the state Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in state statutes and regulations, the state plan, and other state policy and procedure.
[84] Note that new requirements regarding timing of prior authorization decisions and reporting state data about prior authorizations will apply to Medicaid FFS and managed care delivery systems beginning in 2026. 42 C.F.R. §§ 440.230(e)(1) and (3), 438.210(d) and 438.210(f).
[85] 42 C.F.R. §§ 431.10(c)(3)(i)-(ii) and 431.205(a).

qualified External Quality Review Organization (EQRO), which analyzes and evaluates aggregated information on the quality, timeliness, and access to the health services that an MCP or its contractors provide to beneficiaries.[86]

State Example

New York's Medicaid agency enforces a state law[87] that prohibits MCPs from requiring prior authorizations or conducting concurrent reviews during the first 14 days of psychiatric inpatient admissions for children under 18 years of age. The Medicaid agency communicated this policy by issuing guidance[88] to health plans and hospitals, ensuring that care can begin immediately upon admission, while still requiring facilities to notify managed care plans promptly and to ensure that all services are medically necessary.

[86] 42 C.F.R. §§ 438.350, 438.358.
[87] NY Ins. Law§§ 3216(i)(35)(G), 3221 (l)(5)(G), and 4303(9)(8).
[88] https://omh.ny.gov/omhweb/bho/guidance-memo-on-14-day-no-um-for-under-18-inpatient.pdf.

Section 2: Promoting Early Intervention for Children's Behavioral Health Conditions

Approximately half of adults with mental illness experience an onset of symptoms by age 14, and 75% by age 24.[89] Early screening and assessment for behavioral health needs can prevent escalation of needs and promote well-being across an individual's lifespan. Furthermore, four in 10[90] children in the United States are covered by Medicaid and CHIP,[91] providing an opportunity for states to develop a set of benefits that is responsive to children's needs, with the goals of prevention and early intervention wherever possible and timely and effective treatment when needed.

Prevention and early intervention help to ensure children receive care earlier, when concerns are first identified by parents, caregivers, schools, and primary care providers. This means implementing screening, assessment, and service interventions that meet children and families where they are—in schools, at home, and in their communities.

This section describes the following strategies related to promoting early intervention for children's behavioral health conditions:

- Strategy 2.1: Use EPSDT informing materials and other guidance to facilitate early intervention for children's behavioral health conditions.
- Strategy 2.2: Implement a comprehensive, standardized behavioral health assessment tool to assist providers in identifying appropriate diagnostic and treatment services for children.
- Strategy 2.3: Encourage primary care providers to conduct developmental and behavioral health screenings by developing specific reimbursement rates for these screenings.
- Strategy 2.4: Allow behavioral health services to be provided without a formal behavioral health diagnosis and ensure providers are aware of this policy.
- Strategy 2.5: Establish a quality improvement plan to identify early intervention opportunities for children's behavioral health conditions and to monitor the provision of interventions following screenings and assessments.
- Strategy 2.6: Support early intervention for behavioral health conditions by covering infant and early childhood mental health (IECMH) services.

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[89] Kessler RC, Berglund P, et al. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *JAMA Archives of General Psychiatry, 62*(6). Available at: https://pubmed.ncbi.nlm.nih.gov/15939837/.

[90] https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[91] States must provide the full array of EPSDT services to all children enrolled in Medicaid program, including Medicaid expansion CHIP program (M-CHIP programs). However, separate CHIP programs are not required to provide EPSDT services.

Strategy 2.1: Use EPSDT informing materials and other guidance to facilitate early intervention for children's behavioral health conditions.

The first step in facilitating early intervention for children's behavioral health conditions is to ensure that EPSDT-eligible children and their providers are aware of EPSDT coverage requirements for behavioral health screenings and related medically necessary treatments. States can use the specific strategies below to ensure awareness of EPSDT coverage, with the goal of improving early intervention for behavioral health conditions.

2.1.a: Include specific information on behavioral health screenings and services in EPSDT informing materials for beneficiaries.

To help improve early intervention for behavioral health conditions, states' EPSDT informing materials, such as beneficiary handbooks, should notify EPSDT-eligible children of the behavioral health screenings and treatment available to them, as well as how to access these services.[92] For example, a state could describe in EPSDT informing materials that EPSDT-required well-child visits should include developmental and behavioral health screenings. States could also include this information in any other regular communications with families. To improve comprehension regarding coverage of behavioral health screenings and services under EPSDT, states should consider using plain language at an easy-to-understand grade-level.

State Examples

California's EPSDT benefits are also known as "Medi-Cal for Kids & Teens," and the state's associated outreach brochures[93] contain information on covered behavioral health services for children and teens. The brochures outline what to expect at a checkup with a provider, including checks for developmental milestones, anxiety, depression in new mothers, and other health concerns. California's *Your Medi-Cal Rights* fact sheet[94] informs children and families about next steps if care (including a behavioral health screening or treatment) is denied, delayed, reduced, or stopped. The state also developed a companion brochure[95] that is specific to behavioral health and further expands upon the comprehensive services, including those under EPSDT, that are available for Medi-Cal members.

Oklahoma provides families with a Child Health Checkup Guide[96] so they know what to expect from a well-child visit, including why well-child visits are important and when children need them. The guide provides a "Special Note About Teenagers and Health Checkups" that describes typical adolescent development and red flags related to social and emotional health that would indicate a family should seek help from their child's primary care provider.

[92] States are required to use a combination of written and oral methods to inform EPSDT-eligible beneficiaries and their families about the services available to EPSDT-eligible children. States that utilize a managed care delivery system may satisfy EPSDT informing obligations by including this responsibility in their contracts with MCPs. Section 1902(a)(43) of the Act and 42 C.F.R. § 441.56(a)(4).
[93] https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Resources.aspx.
[94] https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Documents/MediCal-Rights-Letter-ENG.pdf.
[95] https://www.dhcs.ca.gov/services/MH/Pages/BH-Brochures.aspx.
[96] https://oklahoma.gov/content/dam/ok/en/okhca/docs/individuals/guides-and-manuals/Child%20Health%20Guide%202022.pdf.

2.1.b: Include guidance on developmental and behavioral health screenings in provider manuals and managed care contracts.

Provider manuals can be an effective way to communicate important information about Medicaid policies to providers. States could include specific guidance in provider manuals on developmental and behavioral health screenings, periodicity schedules, recommended screening tools, billing codes, and reimbursement rates. Additionally, states could consider developing educational brochures on behavioral health screenings and services that providers could share with beneficiaries.

To encourage EPSDT-eligible children enrolled in a Medicaid MCP to receive their regular well-child check-ups, states can describe in the managed care contract the requirement that MCPs take specific steps to facilitate these visits, which must include developmental and behavioral health screenings.[97]

State Examples

The **District of Columbia**'s Medicaid managed care contract[98] indicates that MCPs must require providers to screen all children under the age of 21 according to the District's EPSDT periodicity schedule,[99] which includes a schedule of behavioral health and developmental screenings, relevant billing codes, and associated screening and assessment tools.

Pennsylvania's Medical Assistance Bulletin[100] on well-child visits describes for providers the required activities for the visit by age, along with the corresponding billing codes. The periodicity schedule depicted in the Bulletin clearly identifies the well-child visits during which developmental and behavioral health screenings should be provided and identifies the related reimbursement codes for providers.

[97] Section 1905(a)(r) of the Act.
[98] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/MCP%20Contract%20PUBLIC.pdf.
[99] https://www.dchealthcheck.net/resources/healthcheck/periodicity.html.
[100] https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/MAB2024102901.pdf.

Strategy 2.2: Implement a comprehensive, standardized behavioral health assessment tool to assist providers in identifying appropriate diagnostic and treatment services for children.

Providers use comprehensive assessments to develop individualized care plans that describe the services and supports, including behavioral health care, that are needed by a beneficiary to achieve optimal functioning. Implementing a standardized behavioral health assessment tool has a number of potential benefits that can result in children getting access to appropriate diagnostic and treatment services. For example, a standardized assessment tool could establish a consistent process for assessment process among providers and across settings and could ensure transparency and accountability to children and their families. Establishing specific codes and requiring the use of the tool in MCP contracts can help facilitate providers' implementation.

State Medicaid and CHIP agencies should work with other child-serving state agencies and stakeholders to select a standardized assessment tool. Additionally, state Medicaid and CHIP agencies should collaborate with state and local behavioral health agencies to support provider training, capacity building, and licensure or certification requirements that could be necessary to implement a new assessment tool. Separate CHIPs are required to identify a strategy to facilitate the use of validated clinical assessment tools for determining the most appropriate services for children experiencing behavioral health issues.[101]

Examples of comprehensive assessment tools include Child and Adolescent Needs and Strengths (CANS),[102] Child and Adolescent Level of Care/Service Intensity Untilization System (CALOCUS-CASII),[103] and American Society of Addiction Medicine (ASAM) Criteria.[104]

State Examples

Arizona's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), adopted and implemented the CALOCUS as a standardized assessment tool[105] that provides determination of the appropriate intensity of services needed by a child or adolescent and their family. The state requires all children receiving behavioral health services to have a CALOCUS conducted upon initiation of behavioral health services and updated every 6 months across settings, and developed a provider FAQ on the tool.[106]

Michigan requires providers to incorporate the Michigan Child and Adolescent Needs and Strengths (MichiCANS) into their assessment process.[107] Michigan's Community Mental Health Service Providers (CMHSP), Prepaid Inpatient Health Plans (PIHP), and Certified Community Behavioral Health Clinics (CCBHC) all use this standardized tool in their access, intake, and service planning processes for children, youth, and their families/caregivers.

[101] For more information, see https://www.medicaid.gov/federal-policy-guidance/downloads/sho20001.pdf.
[102] https://praedfoundation.org/tcom/tcom-tools/the-child-and-adolescent-needs-and-strengths-cans/.
[103] https://www.calocus-casii.org/.
[104] https://www.asam.org/asam-criteria.
[105] https://azahcccs.gov/Resources/Downloads/SystemOversiteStructure/CALOCUS_FAQ.pdf.
[106] Ibid.
[107] https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf.

Strategy 2.3: Encourage primary care providers to conduct developmental and behavioral health screenings by developing specific reimbursement rates for these screenings.

States can develop specific rates that separately pay primary care providers for developmental and behavioral health screenings, including during well-child visits and interperiodic visits.[108, 109] This strategy can not only encourage primary care providers to conduct these important screenings, they could also help facilitate the integration of physical and behavioral health care, which can help reduce costs and improve care.[110, 111]

States may need to work with CMS to determine if a state plan amendment (SPA) is needed to establish or modify payment for the screenings as distinct, billable services in primary care settings.[112, 113]

State Example

Washington state developed an EPSDT Well-Child Program Billing Guide[114] for providers that lists screenings, including developmental and behavioral health screenings, that are covered for EPSDT-eligible children. The Guide describes the specific CPT billing codes, as well as "add-on" codes, that providers should use when billing for the various components of well-child visits.

[108] In addition to screenings on the timetable set by the state's periodicity schedule, children are entitled to interperiodic screenings at any time based on an indication of medical need. For example, a child whose school nurse recommends a vision screening because the teacher suspects a vision problem is entitled to that screening even if he is not yet due for another regularly scheduled screening according to the periodicity schedule. Section 1902(a)(43)(B) and 1905(r)(1)(A)(ii) of the Act.
[109] https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.
[110] https://www.macpac.gov/wp-content/uploads/2016/03/Integration-of-Behavioral-and-Physical-Health-Services-in-Medicaid.pdf.
[111] For more information and strategies related to the integration of physical and behavioral health, see *Strategy 3.3: Facilitate the integration of primary and behavioral health care to improve children's access to care.*
[112] https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments.
[113] https://www.medicaid.gov/federal-policy-guidance/downloads/cib051823.pdf.
[114] https://www.hca.wa.gov/assets/billers-and-providers/EPSDT-bg-20231001.pdf.

Strategy 2.4: Allow behavioral health services to be provided without a formal behavioral health diagnosis and ensure providers are aware of this policy.

Diagnosing children, especially young children, with a behavioral health condition is challenging for a number of reasons and may require multiple assessments, including sessions to observe the child and discuss the behavior with parents and caregivers, over time. While difficult behaviors could be caused by an underlying condition, they could also be developmentally appropriate for a child's age. Children may also be unable to express how they are feeling, resulting in a reliance on parents' and caregivers' observations of the child's behavior. Furthermore, children are constantly changing emotionally, socially, and cognitively so potential behavioral health symptoms should be observed over time to ensure they are noteworthy and not merely a point in time.

During the course of being assessed for a behavioral health condition, it may be beneficial for children to receive services to address symptoms that have not been formally diagnosed. States can promote early intervention for these potential symptoms by identifying services that, if medically necessary, could be provided to EPSDT-eligible children without a diagnosed behavioral health condition.[115] For example, Parent-Child Interaction Therapy (PCIT)—a type of behavioral therapy to help parents and caregivers strengthen their relationship with their children and learn skills to manage their child's behavior—could be useful for a child who does not have a behavioral health diagnosis but is exhibiting difficult behaviors. States that use a managed care delivery system for children's behavioral health services should include this policy as it relates to service claims, as well as prior authorization requests, in their contracts with MCPs.

Regardless of delivery system, states that implement this strategy should monitor its use to maintain a balance between improving access to necessary care and preserving program integrity. To achieve this balance, states could identify billing codes for specific behavioral health services, such as certain types of outpatient therapy or crisis services, that would not require a diagnosis when provided to EPSDT-eligible children. States could also educate providers on what constitutes sufficient medical documentation when submitting behavioral health service claims and prior authorization requests when a child has not received a formal diagnosis. Whatever the specifics, states should ensure awareness of the policy by describing it in EPSDT informing materials, provider manuals, and/or MCP contracts.

[115] For more information, see: https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf.

State Examples

Alaska issued guidance[116] for providers on using the International Classification of Diseases, Tenth Edition (ICD-10) "Z" codes as a primary code for certain behavioral health services. The ICD-10 "Z" codes signify a health or emotional well-being concern that warrants treatment but lacks a specific diagnosis.[117, 118] Alaska's Native Health Tribal Association has a list of common "Z" codes[119] that can be included on claims as part of the state's Behavioral Health Aide program.

California's FFS providers and MCPs are responsible for ensuring coverage of non-specialty mental health services, including individual, group, and family therapy, for children who have a potential mental health condition without a formal diagnosis.[120] In addition, using Section 1915(b) waiver authority, California's county mental health plans provide a range of specialty mental health services (e.g., intensive care coordination, intensive home-based services, therapeutic foster care, therapeutic behavioral services, etc.) for children without a behavioral health diagnosis if a child is high risk for developing such a condition.[121, 122] High risk factors include, for example, traumatic exposure, child welfare or justice system involvement, or housing insecurity. Providers are made aware of this policy via the Medi-Cal for Kids and Teens EPSDT mandatory provider training.

Colorado's Department of Health Care Policy and Financing (HCPF), which administers the state's Medicaid program, is required by state statute[123] to allow providers to bill for a limited set of behavioral health services for EPSDT-eligible children without a clinical diagnosis. These services, which must be provided as part of the state's managed care system, include family, group, and individual therapies; services related to prevention, promotion, education, or outreach; evaluation, intake, case management, and treatment planning; and other services identified based on stakeholder feedback. As of October 2025, the state identified 18 specific behavioral health service codes that fall under this policy.[124]

[116] https://content.govdelivery.com/attachments/AKDHSS/2021/10/13/file_attachments/1964906/SFY%2022%20Guidance%20Document%204%201115%20BH%20Z%20codes.pdf.

[117] "Z" codes are used for factors influencing health status and contact with health services (Z00-Z99). These codes may be used as either a principle or secondary code, depending on the circumstances of the encounter. Certain "Z" codes may only be used as a principal diagnosis. Using "Z" codes as a primary diagnosis does not require CMS approval. For more information, see: https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf and https://www.cms.gov/medicare/coding-billing/icd-10-codes.

[118] States can also allow providers to use ICD-10 "R" to document symptoms before a definitive diagnosis has been established. "R" codes are less well-defined conditions and symptoms and that, without additional information, are equally likely to be related to two or more diseases or systems of the body. More generally, these codes could be designated "not otherwise specified," "unknown etiology," or "transient." Codes R40-R46 specifically are for symptoms and signs involving cognition, perception, emotional state and behavior. Using "R" codes as a primary diagnosis does not require CMS approval.
https://evsexplore.semantics.cancer.gov/evsexplore/concept/icd10cm/R00-R99.

[119] https://www.akchap.org/behavioral-health-aide/about/.

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

[121] https://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx

[122] https://www.dhcs.ca.gov/services/MH/Pages/Specialty_Mental_Health_Services.aspx.

[123] https://leg.colorado.gov/bills/sb23-174; https://s3.us-west-2.amazonaws.com/beta.leg.colorado.gov/d2254b5a56a29bf0e95ae854067a95f2.

[124] https://hcpf.colorado.gov/sites/hcpf/files/October%202025%20SBHS%20Billing%20Manual.pdf.

Strategy 2.5: Establish a quality improvement plan to identify early intervention opportunities for children's behavioral health conditions and to monitor the provision of interventions following screenings and assessments.

States can develop measurable goals to identify opportunities for early behavioral health interventions and to monitor whether children receive intervention services following behavioral health screenings and assessments. For example, states can use the Medicaid and CHIP Core Sets of Health Care Quality measures, commonly referred to as the Child Core Set,[125] and Medicaid administrative data to identify quality measures of interest, establish performance baselines, and determine performance targets.[126] These analyses could be done at a statewide level or can be stratified by MCP, provider, and/or practice.

Prior to implementing quality improvement activities, states should evaluate whether providers are correctly documenting interventions and that they are being accurately captured. Additionally, states should ensure they have the resources (e.g., staff, data analysis software, etc.) necessary to analyze data, track performance, and distribute any notable results.

State Example

Louisiana maintains a Medicaid Managed Care Quality Dashboard[127] that displays select outcome performance measures[128] from the CMS Adult and Children Core Set and the Healthcare Effectiveness Data and Information Set (HEDIS), among other sources, that are reported annually by the MCPs. The performance measures are grouped by domain of care, including behavioral health care for adults and children and care for children and adolescents, and the data for each performance measure are reported for the most recent year, by plan and statewide. Additionally, for some measures, trend information is available dating back to 2015. The state incentivizes a core set of quality and health outcomes by withholding one percent of an MCP's monthly capitated payments. The MCP can earn back the full withhold amount for a performance year by either meeting the measurement target or improving performance by at least two percentage points from the prior measurement year.

[125] https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-core-set.pdf; https://www.medicaid.gov/medicaid/quality-of-care/core-set-data-dashboard/welcome.
[126] For information on developing a managed care quality strategy for Medicaid and CHIP services covered under a managed care delivery system, see: https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf and https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/performance-measures-state-capacity-for-reporting.pdf.
[127] https://qualitydashboard.ldh.la.gov/.
[128] https://ldh.la.gov/assets/docs/MQI/MQIStrategy.pdf.

Strategy 2.6: Support early intervention for behavioral health conditions by covering infant and early childhood mental health (IECMH) services.

The earliest years of life are a critical window to promote a strong foundation for mental health and prevent and address emerging concerns.[129] Infant and early childhood mental health (IECMH) includes a range of supports and services to help children from birth to age 5 to express a range of emotions and to enjoy playing, communicating, and interacting with trusted caregivers.[130] When children develop these important skills early on in life, they experience a higher likelihood of school success and reduced risk of mental health and behavior problems in later childhood and beyond.

States can cover IECMH services, and add these services to MCP contracts, to improve outcomes for children, build capacity for caregivers, and facilitate early identification and treatment of behavioral health concerns before they develop into serious behavioral health conditions.[131] Medicaid-coverable IECMH services and supports include social-emotional screenings for infants and young children, parental/caregiver screenings, IECMH consultation, parents supports, assessment and diagnosis, treatment interventions, and case management.[132, 133]

State Examples

To promote child and family well-being and prevent long-term behavioral health issues, **Georgia** established a well-defined system of care for IECMH.[134] This system includes access to early care and learning in safe, nurturing environments, social resources and parenting support, pediatric care for physical and mental health, and early intervention and treatment for children with indicated need. The state's *IECMH Billing Guide for Preventive Services*[135] provides a list of covered services, along with the appropriate billing codes.

Maryland's Medicaid program covers HealthySteps,[136] an evidence-based model that integrates a child development expert (called a HealthySteps Specialist) into primary care to promote the development of children under the age of 3 and to support their families.[137] The state provides enhanced reimbursement to HealthySteps accredited sites, as well as those with pending accreditations, to offset implementation costs. Providers at a HealthySteps site can use code H0025 to bill for behavioral prevention education services, alongside typical well-child visit codes. The state requires that its MCPs contract with at least one HealthyStep site and offered an incentive payment for contracting with at least two sites during the initial implementation period.

[129] https://acf.gov/sites/default/files/documents/ecd/IECMH-Compendium.-11.26-FINAL.pdf.
[130] Horen NM, Sayles J, McDermott K, et al. (2024). Infant and Early Childhood Mental Health (IECMH) and Early Childhood Intervention. *International Journal of Environmental Research and Public Health, 21*(7). Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC11277513/.
[131] https://www.nccp.org/wp-content/uploads/2024/02/NCCP-Medicaid-Brief_2.27.24.pdf.
[132] https://acf.gov/sites/default/files/documents/ecd/IECMH-Compendium.-11.26-FINAL.pdf.
[133] For more information about IECMH services, see the IECMH table in *Appendix A: Medicaid Behavioral Health Service Descriptions*.
[134] https://www.decal.ga.gov/documents/attachments/DecalIssuebrief.pdf.
[135] https://medicaid.georgia.gov/programs/all-programs/infant-and-early-childhood-behavioral-health-services.
[136] https://health.maryland.gov/mmcp/medicaid-mch-initiatives/Pages/HealthySteps.aspx.
[137] https://www.nccp.org/wp-content/uploads/2024/02/NCCP-Medicaid-Brief_2.27.24.pdf.

Section 3: Improving Children's Access to Behavioral Health Care through Service Coordination and Integration

Children with behavioral health needs may receive services and supports from a range of providers, such as physical and behavioral health care clinicians, social service caseworkers, and school-based clinicians. Covering care coordination and promoting the integration of physical and behavioral health can help minimize the potential for fragmentation or duplication of services and supports.

Effective care coordination and case management can help children with behavioral health needs and their families connect to services and supports, navigate systems, and provide information and referrals.[138] This can be particularly important for children as they near the age of transitioning out of EPSDT eligibility. It is critical that they have assistance with coordinating appointments, transferring medical records, and connecting with new health care providers to ensure continuity of, and access to, necessary health care.

Many states are testing approaches to promote physical and behavioral health integration by implementing a range of clinical and policy strategies to bring together physical and behavioral health care service providers, payment systems, and administrative and oversight functions that address all aspects of a patient's well-being. Some models of integration involve behavioral health clinicians providing services in a primary care practice in person, through consultation with a primary care provider, or via telehealth.[139] These efforts have the potential to increase access to high-quality care, improve beneficiary outcomes, and lower total health care costs.

This section describes the following strategies related to improving children's access to behavioral health care through service coordination and integration:

- Strategy 3.1: Utilize care coordination and case management to ensure children receive medically necessary behavioral health services.
- Strategy 3.2: Ensure transition planning for youth with complex behavioral health conditions when moving from pediatric to adult care.
- Strategy 3.3: Facilitate the integration of primary and behavioral health care to improve children's access to care.
- Strategy 3.4: Design and implement a single pathway for children and their families to access behavioral health care.
- Strategy 3.5: Cover children's behavioral health services when delivered via telehealth to improve access to care.

[138] https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-care-coordination-strategy-guide.pdf.

Strategy 3.1: Utilize care coordination and case management to ensure children receive medically necessary behavioral health services.

States can use various care coordination and case management[140] approaches to ensure continuity of care for children and their families, especially during times of care transitions.[141, 142] Care coordination and case management are used to describe a range of activities that link individuals to services and can vary in intensity depending on a child and family's needs.

- Care coordination is the organization of a patient's care across multiple providers and may focus on a specific service or condition, such as referring and connecting individuals to other programs that support mental health recovery. While Medicaid regulations do not define "care coordination," nor is it a specific section 1905(a) service, it can be covered if it meets the definitions and requirements of existing Medicaid authorities. Medicaid MCPs are required to provide medically necessary care coordination to enrollees.[143, 144]

- Case management is a section 1905(a) service and is furnished to assist individuals who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, and other services.[145]

For children, especially young children, care coordination and case management are typically provided to the child through the parent or other caregiver. For families, care coordination and case management can ease the process of receiving services by helping to manage the care of the child, reducing duplication of effort, and limiting gaps between service providers. For older youth, families may not be as closely involved but the youth and/or family may still require extra assistance coordinating care in a complex delivery system. While care coordination and case management can be highly effective at improving health outcomes and reducing costs, it is important to ensure that children and their families are not overwhelmed to the extent that they decide to opt out of using these support services.

For older children who will soon be transitioning out of coverage that is subject to EPSDT requirements, care coordination and case management can facilitate the development of a

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[140] Care coordination and case management can be covered under multiple Medicaid benefits and authorities and some, but not all, of these benefits and authorities fall under EPSDT requirements. For more information on care coordination and case management, as well as the Medicaid benefits and authorities that can be used to cover these services, see *Appendix A: Medicaid Behavioral Health Service Descriptions*.
[141] https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.
[142] https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf.
[143] 42 C.F.R. § 438.208.
[144] Medicaid MCOs, PIHPs, and PAHPs are required by regulation to coordinate health care services for each of their enrollees and to designate a person or entity, such as a primary care practice or other ongoing source of care appropriate to the child's needs, to provide an ongoing source of care and coordinate services accessed by the enrollee. Coordinating health care services for their enrollees is also a critical MCP function inherent to a managed care delivery system at the plan level. Care must be coordinated across settings of care and delivery systems when a child receives Medicaid services through an MCP, and an MCP must also coordinate care furnished to its enrollees through the state's FFS program, other MCPs, and community support providers. 42 C.F.R. § 438.208(b).
[145] 42 C.F.R. § 440.169(a).

comprehensive care plan that outlines the transition process, including referrals to appropriate providers and services. Planning should begin well in advance of a beneficiary's transition and can be facilitated by transition coordinators or care managers who can help coordinate appointments, transfer medical records, and connect families with new health care providers.

Like other services covered under EPSDT, case management covered under EPSDT must address a child's specific needs.[146] One child may need care coordination between two providers (e.g., between a primary care provider and an orthopedic specialist for a child with a broken bone), whereas another child with co-occurring medical, developmental, and/or behavioral health conditions may need more complex case management to support the child's access to services and supports provided by a wide range of providers, state agencies, and the education system.[147] Given the role of the education system in the lives of children, states are encouraged to include collaboration with Local Educational Agencies as an accepted practice within Medicaid case management and care coordination to reduce service fragmentation and enhance comprehensive coordination of Medicaid services across settings.[148, 149]

[146] Section 1905(r)(5) of the Act.
[147] More detailed information about the delivery of Medicaid services in schools can be found in the 2022 CMCS Informational Bulletin *Information on School-Based Services in Medicaid: Funding, Documentation and Expanding Services* and subsequent 2023 guidance *Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming*. See: https://www.medicaid.gov/federal-policy-guidance/downloads/sbscib081820222.pdf and https://www.medicaid.gov/sites/default/files/2023-07/sbs-guide-medicaid-services-administrative-claiming-ud.pdf.
[148] See: https://www.medicaid.gov/faq/index.html?search_api_fulltext=ID:166416.
[149] Local Educational Agencies are public boards of education or other public authorities legally constituted within a state for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a state. 34 C.F.R. § 300.28.

State Example

Ohio uses a Section 1915(b) managed care waiver for children and youth with complex behavioral health and multisystem needs to cover care coordination that is organized into three tiers based on a child's intensity of need.[150] Children are placed into one of the coordination tiers based on a standardized assessment.

- Tier 1. Limited care coordination is for children with less intense behavioral health needs. Coordination is provided directly by the Medicaid MCP, with a maximum of one care coordinator to 62 children.
- Tier 2. Moderate care coordination is for children with moderately intensive behavioral health needs. Coordination is provided through a community-based care management entity[151] under contract with the Medicaid MCP, with a maximum of one care coordinator to 25 children.
- Tier 3. Intensive care coordination[152] is for children with highly intensive behavioral health needs. Coordination is provided by a community-based care management entity under contract with the Medicaid MCP, with a maximum of one care coordinator to 10 children.

[150] https://codes.ohio.gov/ohio-administrative-code/rule-5160-59-03.2.
[151] Ohio's care management entities also manage and monitor the use of primary and secondary flex funds for services, equipment, or supplies not otherwise provided through the Medicaid state plan benefit. The use of funds is identified based on individualized need and is documented in the care plan developed in collaboration with the child and family. The care plan is participant-directed.
[152] https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/5a41372d-db3f-451e-a29f-4275572cc1d2/OHR+CME+Manual.pdf?MOD=AJPERES&CVID=o6W7gh0.

Strategy 3.2: Ensure transition planning for youth with complex behavioral health conditions when moving from pediatric to adult care.

Transitioning out of coverage that is subject to EPSDT requirements can be particularly difficult for older children (youth) with complex medical, developmental (e.g., IDD), and behavioral health conditions and youth in foster care.[153] These youth often have long-term needs that require consistency in medical and behavioral health care and disruptions to that care could negatively impact their health. Any youth no longer entitled to EPSDT who maintains Medicaid eligibility would transition to the Medicaid benefit package(s) available to adults in their respective state; the services included in their adult benefits might be subject to amount, duration, or scope limitations that did not apply under EPSDT. Because states are not required to cover optional section 1905(a) benefits for adults, some services may no longer be available and, depending on the state, some youth may no longer be eligible for Medicaid and would need to transition into other coverage.

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

[153] To address challenges in the transition to adult coverage and care, state Medicaid agencies are required to maintain coverage for former foster youth until age 26, including for those foster youth who were enrolled in another state when they turn age 18. These youth retain EPSDT eligibility until age 21. See: https://www.medicaid.gov/federal-policy-guidance/downloads/sho22003.pdf and https://www.acf.hhs.gov/sites/default/files/documents/cb/im2304.pdf.

Strategy 3.3: Facilitate the integration of primary and behavioral health care to improve children's access to care.

Integrated care generally aims to treat the whole person's health care needs in a coordinated way and is critical to transforming care for all individuals, including children, with behavioral health conditions. States can take steps toward integrating primary care and behavioral health care by supporting collaborative models of care and expanding the types of providers who can deliver behavioral health services.

3.3.a: Support collaborative models of care among pediatric primary care and behavioral health providers.

States can use team-based, interdisciplinary models of care to integrate behavioral health care with primary care to facilitate treatment of children who have more significant or chronic behavioral health needs. Interprofessional consultations[154]—when one health care provider requests the opinion or advice of another health care provider with particular expertise to assist in the treatment of a patient—is typically part of these models and is a core component of state and federal initiatives to increase access to behavioral health care for children. The Collaborative Care Model (CoCM) and the Pediatric Mental Health Care Access (PMHCA) grant[155] program are examples of collaborative approaches to care that states can use to help facilitate children's access to behavioral health care.

The CoCM has been demonstrated to effectively treat children with depression and other behavioral health conditions in medical settings such as primary care clinics, precluding the need for families to seek care elsewhere for their child and alleviating primary care provider burnout.[156] CoCM requires ongoing co-management of patients and includes behavioral health screening, diagnosis, and treatment, care coordination with systematic psychiatric reviews and consultation, and regular monitoring.[157, 158] In addition to the child and their family, the CoCM team typically consists of:

- a primary care provider who identifies pediatric patients who need treatment and participates in team communications on the treatment plan;
- a behavioral health care manager who coordinates care and provides brief evidenced-based behavioral interventions; and
- a psychiatric consultant: Provides input on diagnostic assessment and overall treatment planning.

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[154] www.medicaid.gov/federal-policy-guidance/downloads/sho23001.pdf.
[155] For information on accessing enhanced federal Medicaid matching rates for state information technology expenditures to improve access to behavioral health and care coordination, see: https://www.medicaid.gov/federal-policy-guidance/downloads/cib06142024.pdf.
[156] https://aims.uw.edu/wordpress/wp-content/uploads/2023/06/Pediatric-CoCM-Implementation-Guide_Final-Reduced-Size.pdf.
[157] https://www.ncahec.net/practice-support/collaborative-care-2/.
[158] https://mmhpi.org/wp-content/uploads/2023/05/Improving-Behavioral-Health-Care-for-Youth_CoCM-Expansion.pdf.

States can implement CoCM under section 1905(a) state plan, demonstration, or waiver authorities.

State Examples

Massachusetts requires Medicaid providers to adopt widely used CoCM-specific reimbursement codes to align with other public coverage and commercial coverage,[159] thereby reducing administrative burden. Additionally, the MassHealth Primary Care Sub-Capitation Program[160] supports early intervention for children's behavioral health by incentivizing primary care providers to integrate behavioral health screening, coordination, and treatment into routine care. Through innovative payment models and clinical requirements, the program enhances access to timely services and invests in workforce expansion to strengthen the pediatric behavioral health system statewide.

New Hampshire's Medicaid managed care contracts require MCPs, to the extent feasible, to ensure physical and behavioral health providers co-locate or integrate care as defined by the CoCM or by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Six Levels of Collaboration/Integration.[161],[162] The MCPs must regularly submit to the state Medicaid agency a Behavioral Health Strategy Plan on their progress toward coordinating care.

North Carolina requires Medicaid providers to adopt widely used CoCM-specific reimbursement codes to align with other public coverage and commercial coverage,[163] thereby reducing providers' administrative burden. The state also created a CoCM Consortium[164] to build statewide capacity and increase adoption of CoCM across payers (including Medicaid). The Consortium, which includes representation from primary care, psychiatry, payers, and community organizations, is responsible for providing technical assistance to clinicians and developing CoCM role descriptions, codes, and reimbursement rates that align with Medicare.

The PMHCA grant program, which is administered by the Health Resources and Services Administration (HRSA),[165] supports existing and emerging child psychiatric consultation programs by funding states' and regional pediatric mental health care teams' provision of teleconsultations, training, technical assistance, and care coordination for pediatric primary care providers to diagnose, treat, and refer children and youth for mental health conditions and substance use disorders.[166] Encouraging primary care providers to utilize consultations with pediatric behavioral health specialists through a PMCHA program can improve access and

[159] https://www.mass.gov/doc/bulletin-2023-04-psychiatric-collaborative-care-model-issued-january-4-2023/download?_ga=2.242306114.1723039634.1757974604-2093889663.1757974604&_gl=1*8ypl5o*_ga*MjA5Mzg4OTY2My4xNzU3OTc0NjA0*_ga_MCLPEGW7WM*czE3NTc5NzQ2MTIkbzEkZzAkdDE3NTc5NzQ2MTIkajYwJGwwJGgw.
[160] https://www.mass.gov/masshealth-primary-care-sub-capitation-program.
[161] https://media.sos.nh.gov/govcouncil/2023/1220/033%20GC%20Agenda%20122023.pdf.
[162] https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56.
[163] https://medicaid.ncdhhs.gov/blog/2022/12/15/nc-medicaid-enhancements-integrated-physical-and-behavioral-health.
[164] https://medicaid.ncdhhs.gov/collaborative-care-model-north-carolina-policy-paper/download?attachment.
[165] See: https://mchb.hrsa.gov/programs-impact/programs/pediatric-mental-health-care-access.
[166] https://www.nncpap.org/.

outcomes for EPSDT-eligible children who require behavioral health care. As of February 2025, 46 states and the District of Columbia have PMHCA programs.[167]

States may need to submit a Medicaid SPA to cover the aspect of a PMHCA that is provided for the direct benefit of an individual beneficiary, but regardless of whether a coverage SPA is needed, a SPA to enact payment is required.[168]

State Examples

The **Pennsylvania** child psychiatry access program, Telephonic Psychiatric Consultation Service (TiPS) Program,[169] provides immediate behavioral health consultation to clinicians who are treating Medicaid-eligible children under the age of 21 who have behavioral health conditions. TiPS is designed to increase the availability of child psychiatry consultation teams, regionally and by phone, to primary care providers and other prescribers of psychotropic medications.

The **Washington** State Health Care Authority collects an assessment based on covered lives from Washington health insurers combined with state general funds and federal Medicaid funds to cover the costs for running the Partnership Access Line (PAL)[170] that is operated by Seattle Children's Hospital. PAL assists primary care providers with questions on the provision about children's mental health care such as diagnostic clarification, medication adjustment, and treatment planning. The PAL program partners with the Mental Health Referral Service also operated by Seattle Children's Hospital to connect families with available outpatient mental health services in their community. A master's-level social worker available via PAL to help providers locate mental health resources for their patients. In 2020, the state legislature permanently extended PAL by funding it through an annual assessment on the state's health insurers.

3.3.b: Encourage the integration of primary care and behavioral health care by expanding the types of clinicians who can deliver certain behavioral health services and eliminating prohibitions on same-day billing.

Integration of primary care and behavioral health care should facilitate same-day access and "warm hand-offs" by primary care providers to behavioral health care providers to help ensure individuals follow through with their first behavioral health appointments. States can allow a wide range of providers, including non-behavioral health clinicians (e.g., primary care physicians, pediatricians, and school-based providers) to provide and bill for behavioral health services such as screenings, brief interventions, and medication management.[171] States may need to update Medicaid state plans and revise fee schedules to incorporate additional provider types.

Additionally, same-day billing prohibitions may impede behavioral health consultations and integration with primary care. To facilitate payment for behavioral health services that occur in

[167] See: https://www.nncpap.org/.
[168] For more information about SPA requirements for interprofessional consultation in general, see: https://www.medicaid.gov/federal-policy-guidance/downloads/sho23001.pdf.
[169] https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/tips.
[170] https://www.hca.wa.gov/assets/program/provider-access-lines-faq.pdf.
[171] Ibid.

conjunction with a PCP visit, states can eliminate prohibitions on same-day billing, limit copays in CHIP to one per day, and when relevant, require managed care plans to do the same.[172]

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

Strategy 3.4: Design and implement a single pathway for children and their families to access behavioral health care.

EPSDT-eligible children's families may struggle to identify and access behavioral health care when the need arises, potentially resulting in the inappropriate use of hospital emergency departments even if a child does not have acute needs. Designing and implementing a single pathway for accessing behavioral health care can facilitate timely access and reduce this unnecessary utilization of emergency departments.

A single point of entry can take many forms, from a state system-wide, payer-agnostic approach to a Medicaid-specific system to meet the needs of beneficiaries with particular needs or in a particular plan. States have latitude to determine the scope of functions that could be accommodated by a single point of entry. For example, a call center that provides immediate crisis de-escalation services and related information, referrals, and linkage to care (e.g., the 988 Suicide & Crisis Lifeline) could serve any individual in the state, regardless of the individual's health insurance. Alternatively, a state could create a "no wrong door" pathway to a fully developed behavioral health system for Medicaid beneficiaries.

3.4.a: Coordinate with local 988 Suicide & Crisis Lifelines to facilitate children's access to behavioral health care.

The 988 Suicide & Crisis Lifeline[173, 174] provides access to crisis counselors for individuals who are struggling with mental health, suicide, and/or substance use-related conditions. The counselors are staffed at over 200 local crisis centers nationwide and are available 24 hours a day, 7 days a week. States can use the 988 Lifeline as a "no wrong door" pathway for individuals, including children and their families, to access behavioral health care by making connections to local crisis services, as well as the broader array of Medicaid-covered services and supports.[175, 176]

States interested in this approach may need to work with their legislatures and 988 Lifeline lead agencies to secure funding for the resources and infrastructure needed to connect individuals in crisis with appropriate supports.[177] Additionally, states would need to establish authority to pay and claim for 988 Lifeline supports using either direct service claiming or state program administrative claiming.[178] To use administrative claiming for crisis call center services, states must justify in a reasonable manner how many callers are Medicaid beneficiaries to properly allocate Medicaid costs.

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[173] https://988lifeline.org/.
[174] https://www.samhsa.gov/mental-health/988/faqs.
[175] For state 988 crisis service system examples, see: https://aspe.hhs.gov/sites/default/files/documents/0c5931fc7861a682bf1e2c1c6056c44a/innovative-988-crisis-service-systems.pdf.
[176] For information on accessing enhanced federal Medicaid matching rates for state information technology expenditures to improve access to behavioral health and care coordination, see: https://www.medicaid.gov/federal-policy-guidance/downloads/cib06142024.pdf.
[177] https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf.
[178] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Enhanced federal match may be available for state Medicaid information technology expenditures related to improving access to and coordination of treatment and support services for Medicaid beneficiaries with behavioral health conditions, such as 988 call centers.[179]

State Example

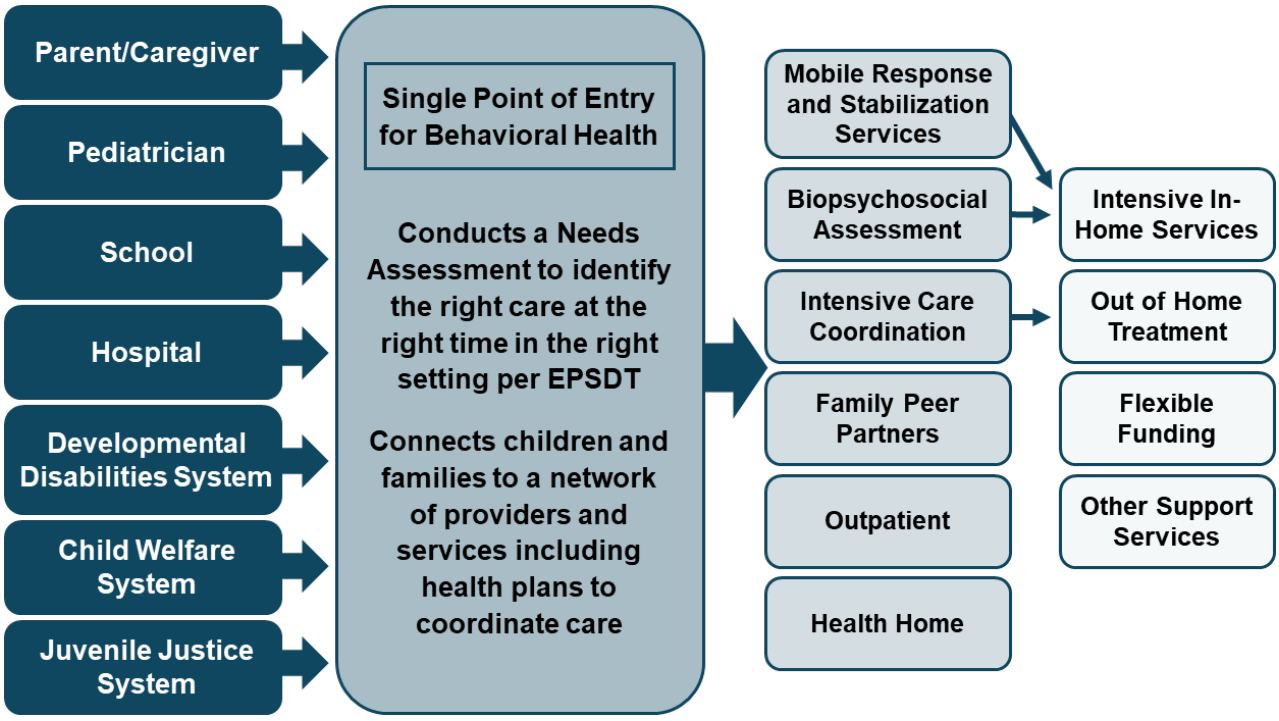
Arizona's crisis response system integrates the national 988 Suicide & Crisis Lifeline with a network of locally operated services.[180] When someone in Arizona calls, texts, or chats 988, they are typically routed to the state's single crisis line provider. The state Medicaid agency coordinates this system and funds crisis services statewide through Regional Behavioral Health Authorities (RBHA).[181] Local crisis lines bill for services through Medicaid under AHCCCS using standardized Healthcare Common Procedure Coding System (HCPCS) codes. The primary code for telephonic crisis intervention is H0030, which covers behavioral health hotline services.[182] RBHAs coordinate these claims for state-operated crisis services. This structure ensures prompt reimbursement without prior authorization, supporting rapid access to care for individuals in distress. 988-related calls, texts, and chats are funded through federal grant programs.

3.4.b: Design and implement a "no wrong door" pathway to a fully developed behavioral health system.

A "no wrong door" pathway (also referred to as a single point of entry) for behavioral health services streamlines referrals for care through a single entity, which then connects individuals to services available in a state. Under this kind of model, referral sources, such as inpatient and outpatient providers, community organizations, and schools, can also connect a family directly to a provider without going through the single point of entry, ensuring a "no wrong door" approach.[183] Figure 2 provides a high-level example of how behavioral health care can be accessed through a single point of entry.

[179] https://www.medicaid.gov/federal-policy-guidance/downloads/cib06142024.pdf.
[180] https://www.azahcccs.gov/BehavioralHealth/Downloads/FrequentQuestionsAboutCrisisServices.pdf.
[181] Ibid.
[182] https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/AHCCCSCoveredBHServicesManual.pdf.
[183] For more information on developing a behavioral health system with a single point of entry, see the following: https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf; https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource2.pdf; https://gucchd.georgetown.edu/products/PRIMER2ndEd_FullVersion.pdf; and https://gucchd.georgetown.edu/products/Toolkit_SOC.pdf.

Figure 2: Model of a Single Point of Entry for Behavioral Health Services



Establishing a "no wrong door" pathway has a number of benefits, such as simplifying families' navigation of behavioral health care systems, streamlining children's access to care to allow for early intervention and prevention, and ensuring children's assessments identify the most appropriate services at the right intensity, but establishing such a system is a significant undertaking.[184] Key steps for designing, implementing, and financing a single point of entry include, for example:

1) defining the population to be served,
2) clarifying responsibilities and functions, and
3) establishing the geographic scope.

If a state decides to serve only Medicaid-eligible children through the single point of entry, the information and referral processes should be included as part of its design, as it is unlikely that community members and referral sources will know the insurance status of all children and families. To ensure this approach is successful and results in children being connected to the appropriate services, states must identify a "no wrong door" entity that understands the landscape of services available in the state. This entity could be a state agency, an MCP, a specialized MCP,[185] administrative services organization, a community-based organization, or another entity, depending on the system in a particular state. To ensure awareness among

[184] Isaacs A, Bonsey A, Couch D. (2023). Centralized Intake Models and Recommendations for Their Use in Non-Acute Mental Health Services: A Scoping Review. *International Journal of Environmental Research and Public Health, 20*(9). Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10177908/.

[185] In this toolkit, we use the term "specialized MCP" to mean MCPs that serve specific populations (e.g., children in or formerly in foster care, children with disabilities or other complex health needs, etc.). However, "specialized MCP" is not a designation referenced in federal statute or regulations.

providers and beneficiaries, states can describe the "no wrong door" access approach to behavioral health services in EPSDT informing materials.

State Example

New York state law[186] mandates that local government units use the county-level Children's Single Point of Access (C-SPOA)[187] to connect children who have a serious emotional disturbance, as well as their families, with timely access to intensive mental health services and supports. C-SPOAs screen children, collaborate across all child systems, ensure appropriate access to care, and ensure accountability within the system. Families can be referred to a C-SPOA by a community provider or they can self-refer, at which point the C-SPOA serves as a link to intensive mental health services, when needed.[188] C-SPOAs serve children with and without Medicaid and, if the C-SPOA determines a non-enrolled child is eligible for Medicaid, it will support the family with enrollment. The state funds the C-SPOA[189] and does not involve Medicaid reimbursement. Additionally, children and their families can access less intensive behavioral health services outside of the C-SPOA process. A variety of providers, such as social workers, psychologists, psychiatrists, outpatient clinics, school-based clinics, and primary care settings, offer children another pathway for behavioral health services covered under the state's Medicaid program.

[186] https://newyork.public.law/laws/n.y._mental_hygiene_law_section_41.05.
[187] https://omh.ny.gov/omhweb/childservice/.
[188] Ibid.
[189] https://nyconnects.ny.gov/services/spoa-non-medicaid-care-coordination-omh-pr-106607464005.

Strategy 3.5: Cover children's behavioral health services when delivered via telehealth to improve access to care.

Telehealth has a demonstrated ability to maintain or enhance access to behavioral health treatment without negatively impacting patient outcomes or satisfactions, leading most states to take steps to maintain or further expand coverage for behavioral health delivered via telehealth.[190] However, when implementing new, or expanding upon existing, telehealth coverage and payment policies for mental health and SUD services delivered to children and youth, states should consider factors specific to this population. The sub-strategies below describe how states can expand their coverage of behavioral health services when delivered using telehealth, as well as the unique factors to consider when expanding this coverage to children.

3.5.a: Expand the coverage of children's behavioral health services that can be delivered using telehealth and the settings from which services may be delivered using telehealth.

For most Medicaid benefits, federal laws and regulations do not specifically address telehealth delivery methods or criteria and, as a result, states have a great deal of flexibility in designing the parameters of service delivery using telehealth.[191] This includes the specific services that can be delivered using telehealth, the providers that can deliver those services, and the settings from which the services may be delivered. However, states must continue to meet any federal requirements related to coverage of the benefits and other applicable federal law, including the requirements of Title XIX of the Act and federal regulations (as interpreted in published CMS guidance), and the parameters of a state's CMS-approved Medicaid state plan and/or demonstration projects and waivers.

Studies show that telehealth visits with children and youth are feasible for a wide range of conditions, including behavioral health conditions, and that patients and caregivers are generally satisfied with remote services.[192] States can expand access to behavioral health care by authorizing the delivery of services, including mental health treatment, SUD treatment, counseling, and medication-assisted treatment (MAT), through telehealth. Additionally, some components of the EPSDT-required well-child visits such as developmental and behavioral screenings can be covered when delivered using telehealth.

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[190] https://www.kff.org/mental-health/telehealth-delivery-of-behavioral-health-care-in-medicaid-findings-from-a-survey-of-state-medicaid-programs/#:%7E:text=In%20particular%2C%20states%20report%20that,telehealth%20utilization%20among%20Medicaid%20enrollees.

[191] For more information about the flexibilities for covering Medicaid services delivered using telehealth, as well as general telehealth information (e.g., the four main telehealth modalities—real-time audio-video, audio-only, asynchronous communication, and remote patient monitoring), see: https://www.medicaid.gov/sites/default/files/2024-02/telehealth-toolkt.pdf.

[192] Curfman A, Hackell JM, et al. (2022). SECTION ON TELEHEALTH CARE, COMMITTEE ON PRACTICE AND AMBULATORY MEDICINE, COMMITTEE ON PEDIATRIC WORKFORCE; Telehealth: Opportunities to Improve Access, Quality, and Cost in Pediatric Care. *Pediatrics, 149*(3). Available at: https://publications.aap.org/pediatrics/article/149/3/e2021056035/184902/Telehealth-Opportunities-to-Improve-Access-Quality?searchresult=1?autologincheck=redirected.

Medicaid OUD services, including medications for OUD, can also be covered when delivered using telehealth.[193] The use of telehealth to deliver these services has been associated with a reduced overdose risk, increased length of stay for individuals in treatment, and increased access and convenience for patients, particularly for historically underserved populations such as those in rural areas.[194, 195] Access to buprenorphine could also be increased by permitting mid-level practitioners to deliver OUD services via telehealth, as nurse practitioners and physician assistants have been central to the increase in buprenorphine prescription growth among Medicaid beneficiaries and individuals living in rural areas.[196]

States should review policies and procedures to ensure that behavioral health care can be provided in a range of settings for youth like schools and homes.[197, 198] States may partner with school districts to embed telehealth services into school-based health centers or counseling programs and provide access to behavioral health professionals in schools that lack on-site staff. States can facilitate integration by providing guidance to schools on reimbursement policies and procedures.[199]

State Examples

Kentucky allows all provider types to deliver all Medicaid services that they are otherwise qualified to provide via telehealth, including via audio-only technologies.[200]

Wisconsin allows providers to deliver behavioral health screenings and treatment and targeted case management for populations, including children with complex medical needs, via telehealth when doing so is just as effective as delivering the services in-person.[201] Additionally, in 2023, the state released a new "Border Status" policy[202] to leverage providers, including behavioral health providers, not located in the state. Under this new policy, certain out-of-state providers, who are subject to the same provider requirements as in-state providers, may be eligible to enroll in Wisconsin Medicaid as border-status providers. These providers include those who are in a state that physically borders Wisconsin, as well as providers not located in a state that physically borders Wisconsin who meet the definition of a border-status provider as described in the state's administrative code and who provide services only via telehealth to Wisconsin beneficiaries.

[193] States considering strategies to improve access to OUD treatment using telehealth must ensure their Medicaid coverage and payment policies are consistent with current, relevant regulations and guidance from SAMHSA and the Drug Enforcement Administration.
[194] https://www.cms.gov/newsroom/press-releases/increased-use-telehealth-opioid-use-disorder-services-duringcovid-19-pandemic-associated-reduced.
[195] https://www.pew.org/en/research-and-analysis/issue-briefs/2021/12/state-policy-changes-could-increase-access-to-opioid-treatment-via-telehealth.
[196] Ibid.
[197] https://www.medicaid.gov/sites/default/files/2024-02/telehealth-toolkt.pdf.
[198] For more information on best practices for covering telehealth for behavioral health services delivered school-based settings, see: https://telehealth.hhs.gov/providers/best-practice-guides/school-based-telehealth.
[199] https://nashp.org/wp-content/uploads/2021/05/telehealth-report.pdf.
[200] https://apps.legislature.ky.gov/law/kar/titles/907/003/170/.
[201] https://www.dhs.wisconsin.gov/telehealth/member-faqs.htm.
[202] https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Certification/EnrollmentCriteria.aspx?topic=12.

3.5.b: Ensure policies related to delivering children's behavioral health services via telehealth account for consent requirements and provider licensure and credentialing.

When implementing new, or expanding upon existing, telehealth coverage and payment policies for mental health and SUD services delivered to children and youth, states should consider factors that are specific to this population. The development of any new telehealth coverage policies should account for consent laws, regulations, procedures, and policies for pediatric populations. Age of consent is the age at which children can provide their own consent without the parent or legal guardian and can vary by type of service. Depending on the requirements, there may be a need for reconsent, new consent, or parent/guardian involvement at some point during treatment.

Additionally, states should review their provider licensure and credentialing requirements for pediatric behavioral health providers to evaluate whether they present barriers to telehealth delivery in their states. This is particularly important for providers who may be out-of-state but providing services to individuals within the state. Before expanding the providers who can deliver behavioral health services to children via telehealth, states should consider which providers' scope of services enables them to bill Medicaid for services delivered using telehealth.[203] State Medicaid agencies may need to collaborate with state licensing boards to discuss whether scope of practice laws can be expanded to ensure maximum utilization of telehealth flexibilities for some providers. States should also consider enabling additional providers or provider types (e.g., paraprofessionals) to deliver behavioral health services to children using telehealth.

State Example

Connecticut requires that services delivered via telehealth to a child under 18 years old must include the presence of a parent or legal guardian to the same extent as for in-person services.[204] In addition, informed consent for services delivered via telehealth must be obtained by the parent or legal guardian prior to providing the services and annually thereafter.

[203] https://www.ama-assn.org/practice-management/scope-practice/what-scope-practice#:%7E:text=Scope%20of%20practice%20refers%20to,by%20the%20appropriate%20licensing%20entity.
[204] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb23_38.pdf&URI=Bulletins/pb23_38.pdf.

Section 4: Increasing the Workforce Capacity for Children's Behavioral Health Services

State Medicaid agencies may want to make changes to attract and retain qualified behavioral health providers by reducing administrative burden on providers, covering providers with a broad array of qualifications, and offering sufficient reimbursement rates and training for providers. States can play a role in providing direct support through Medicaid to grow the children's behavioral health workforce (e.g., rate adjustments, centralized credentialing, easing administrative burdens). States can work more broadly in partnership with other state agencies that are addressing the recruitment and training of a behavioral health workforce as a statewide issue, as this will ultimately impact the delivery and timeliness of quality services for Medicaid beneficiaries. These approaches can support both current and future members of the workforce, helping to address immediate shortages while building long-term capacity.

Generally, in Medicaid FFS programs, states must ensure that a Medicaid beneficiary may obtain covered services from any institution, agency, pharmacy, person, or organization that is qualified and willing to furnish the services to that particular beneficiary.[205] States that use a Medicaid managed care delivery system must ensure that their MCPs maintain provider networks that are sufficient to provide accessible and timely care to enrollees, including EPSDT-eligible children.[206]

This section describes the following strategies related to increasing the workforce capacity for children's behavioral health services:

- Strategy 4.1: Continually monitor the roster of behavioral health providers available to serve children.
- Strategy 4.2: Reduce the administrative burden and regulatory barriers for providers that could impede their participation in delivering behavioral health care for EPSDT-eligible children.
- Strategy 4.3: Cover Project ECHO (Extension for Community Healthcare Outcomes), the tele-mentoring program designed to create provider communities of learning, to strengthen and sustain the behavioral health workforce.
- Strategy 4.4: Establish reimbursment rates that are sufficient to attract behavioral health providers who deliver services, including via telehealth, to children.
- Strategy 4.5: Cover behavioral health providers with an array of qualifications, including qualified non-licensed professionals, to broaden the behavioral health workforce across the continuum of care.
- Strategy 4.6: Partner with state agencies to provide financial support for prospective behavioral health practitioners and reimburse for services delivered by behavioral health interns.

[205] Section 1902(a)(23)(A) of the Act and 42 C.F.R. § 431.51(b). See also 42 C.F.R. § 441.61(b).
[206] Section 1932(b)(5) of the Act, Section 1902(a)(4) of the Act, 42 C.F.R. §§ 438.68(a)-(b), 438.206(a).

Strategy 4.1: Continually monitor the roster of behavioral health providers available to serve children.

Before taking steps to address any potential workforce shortages, states should assess the availability of pediatric behavioral health providers as compared to the prevalence of children's behavioral health conditions and the extent to which these children are able to receive care timely. States can use this information to identify gaps in the availability of these providers, by provider type and geographically, and develop a strategy for continual monitoring to assure adequate access to care.

If data are not readily available to assess the availability of children's behavioral health providers, states can consider collecting survey information from EPSDT-eligible children and their families regarding their experiences accessing behavioral health services.[207] Similarly, states can collect survey information from behavioral health providers on their experiences, including any challenges, related to providing these services to EPSDT-eligible children. Additionally, behavioral health providers' enrollment and credentialing information could be useful for identifying geographic disparities.

Once relevant data have been identified and/or collected, states can consider developing, and regularly updating, a data report or dashboard[208] on the availability of children's behavioral health providers. This kind of monitoring tool could include information on the prevalence of children's behavioral health conditions, their behavioral health service utilization, the availability of behavioral health providers, and relevant behavioral health quality measures.[209] To maximize usefulness, states could enable the behavioral health reports or dashboards to be disaggregated by condition, type of provider, utilization of services, and the children's demographic information such as age range and geographic location (e.g., county, zip-code, etc.).

States that use a managed care delivery system to cover behavioral health could monitor the ratio of children with behavioral health conditions who are enrolled with an MCP to behavioral health providers that participate in the MCP's provider network. These ratios could also be calculated at more granular levels, such as by specific behavioral health conditions as compared to relevant behavioral health specialists. The state could use these ratios as an oversight mechanism to develop or revise quantitative network adequacy standards or appointment wait time standards that MCPs must comply with to target any suspected or confirmed gaps in network adequacy.

[207] https://aspe.hhs.gov/sites/default/files/documents/792ca3f8d6ae9a8735a40558f53d16a4/behavioral-health-network-adequacy.pdf.
[208] For more information on Medicaid data analytics, including building a dashboard, see: https://www.medicaid.gov/resources-for-states/innovation-accelerator-program/functional-areas/data-analytics.
[209] https://www.medicaid.gov/medicaid/benefits/downloads/rtc-intrm-rprt-cngrss.pdf.

State Examples

Kansas's Medicaid MCP contracts include specific network adequacy standards[210] for children's behavioral health services, including home-based family therapy; alcohol and drug rehabilitation; positive behavior support; screening, brief intervention, and referral to treatment (SBIRT); and consultive clinical and therapeutic services and intensive individual support for children. Access to these services must be within 30 miles or 60 minutes in urban areas, 45 miles or 75 minutes in densely settled rural areas, and 60 miles or 90 minutes in rural and frontier areas. Each MCP submits a map of their provider coverage for pediatric, home-based, community-based, and ancillary services each quarter to the state for review.[211]

Louisiana's Medicaid MCPs must ensure 90% of their members under the age of 21 have access to behavioral health specialists—specifically, Advanced Practice Registered Nurses (Behavioral Health Specialty; Nurse Practitioners or Clinical Nurse Specialists), Medical or Licensed Psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Licensed Master Social Workers, Provisionally Licensed Professional Counselors, and Provisionally Licensed Marriage and Family Therapists—within 30 miles from members' residences in rural parishes and 15 miles from members' residences in urban parishes.[212] Network adequacy standards are applied across the identified behavioral health specialist providers collectively.

To improve access to care for children in the Medicaid program, **New Jersey** requires its Medicaid MCPs to maintain certain network adequacy standards for pediatric primary and specialty care, including developmental and behavioral pediatricians.[213] MCPs that do not meet these requirements can be fined.

[210] https://aspe.hhs.gov/sites/default/files/documents/792ca3f8d6ae9a8735a40558f53d16a4/behavioral-health-network-adequacy.pdf.
[211] https://www.kancare.ks.gov/data-policy/quality-measurement#:~:text=Network%20Adequacy%20Reporting,where%20providers%20are%20located.
[212] https://ldh.la.gov/assets/docs/BayouHealth/CompanionGuides/MCO_ProviderNetworkCompanionGuide_5.17.21.pdf.
[213] https://www.billtrack50.com/BillDetail/1244705.

Strategy 4.2: Reduce the administrative burden and regulatory barriers for providers that could impede their participation in delivering behavioral health care for EPSDT-eligible children.

Providers' administrative tasks, such as documenting patient encounters and submitting prior authorization requests, can require a significant amount of time, resources, and expertise. Research suggests that primary care providers spend nearly 2 hours on tasks related to electronic health records for every hour they spend with patients.[214] State Medicaid agencies can increase the behavioral health workforce using various approaches to reduce providers' administrative burdens. This includes, among other things, selectively reducing or eliminating prior authorization requirements, streamlining provider credentialing, and allowing for license reciprocity.

4.2.a: Review prior authorization requirements for behavioral health services to identify adjustments that could reduce providers' administrative burden while maintaining the quality of care.

State Medicaid agencies have the flexibility to establish prior authorization requirements for services provided to EPSDT-eligible children provided they reflect consideration of the EPSDT requirement to cover section 1905(a) services, including behavioral health services, that are necessary to correct or ameliorate identified medical needs. Behavioral health services are among those Medicaid services that most commonly require prior authorizations.[215] Although such limitations are meant to ensure that care is necessary, cost-effective, and clinically appropriate, they can have the unintended consequence of increasing providers' administrative burdens and limiting access to care.

To ensure accountability and effectiveness, states and MCPs can monitor the impact of prior authorizations on Medicaid service utilization trends and outcomes. States should also meet regularly with providers and/or MCPs to review the impact of prior authorization policies . These activities can help states identify services with high rates of prior authorizations approvals, which could justify either altering or removing the prior authorization requirement altogether, for example.

[214] Arndt BG, Beasley JW, et al. (2017). Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations. *Annals of Family Medicine, 15*(5). Available at: https://pubmed.ncbi.nlm.nih.gov/28893811/.
[215] https://www.macpac.gov/wp-content/uploads/2024/08/Prior-Authorization-in-Medicaid.pdf.

State Example

Under **West Virginia**'s "gold card" law,[216] health insurers, including Medicaid MCPs, may exempt certain providers from submitting prior authorization requests for six months or longer if the provider averages 30 procedures per year and has a 90% approval rate for prior authorizations over a six-month period.[217]

4.2.b: Allow interstate licensure portability models for behavioral health providers and streamline their credentialing to expand the pool of available providers.

Generally, each state licenses or certifies providers to practice in the state, a process that can be burdensome for providers, in particular if they practice in more than one state. States that use a managed care delivery system must establish a uniform credentialing and recredentialing policy for certain providers, including behavioral health providers, and must require their MCPs to follow these policies.[218] By participating in interstate licensure portability models and streamlining the process for credentialing providers, states can facilitate behavioral health providers' participation in the Medicaid workforce and enhance geographic availability of services.

Interstate licensure portability models, such licensure compacts and reciprocity, establish a centralized roster of providers who can deliver services across participating states and can help address workforce shortages by making it easier for qualified professionals to work across state lines.[219] The Interstate Compact for Counselor Licensure,[220] for example, allows licensed professional behavioral health counselors, who are licensed in their own state, to deliver services in person or using telehealth across state lines without having to obtain additional licensing in other Compact states.[221]

State Medicaid agencies interested in pursuing licensure compacts and/or reciprocity should assess providers' licensing and credentialing requirements. Depending on legislative requirements, the state Medicaid agency may need to collaborate with the state legislature to amend related laws or regulations. Additionally, the state should assess its Medicaid state plan to determine whether any updates are necessary to facilitate out-of-state providers' use of telehealth to deliver services.[222]

Similar to licensing, provider credentialing can be time intensive and costly for states, MCPs, and providers, and the associated burden may disincentivize providers from participating in

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[216] https://code.wvlegislature.gov/33-25-8P/.
[217] https://www.macpac.gov/wp-content/uploads/2024/08/Prior-Authorization-in-Medicaid.pdf.
[218] 42 C.F.R. § 438.214(b).
[219] https://aspe.hhs.gov/sites/default/files/documents/405ad876b1de337a81b4db0257666586/barriers-opportunities-improving-interstate-licensure.pdf.
[220] https://counselingcompact.org/wp-content/uploads/2022/03/Final_Counseling_Compact_3.1.22.pdf.
[221] https://prod761aul1.wpenginepowered.com/wp-content/uploads/2021/02/CC_Infographic.pdf.
[222] For more information on Medicaid and CHIP telehealth requirements, see: https://www.medicaid.gov/medicaid/benefits/downloads/telehealth-toolkt.pdf.

Medicaid.[223] Federal regulations require states to establish a uniform managed care credentialing and recredentialing policy related to various providers, including mental health and SUD providers, and the MCPs must demonstrate that all networked providers are credentialed according to this policy.[224]

To ease the administrative burden of the credentialing process, while still ensuring a robust and thorough process, states should consider centralizing or implementing universal credentialing. For example, states can develop online portals to streamline credentialing for providers, including behavioral health providers, offer provisional credentialing for newly practicing providers, or centralize provider credentialing at the Medicaid agency, which then provides the credentialing information to MCPs. States can also require MCPs to track metrics on length of time for credentialing, provider satisfaction, and network adequacy and evaluate these date to identify possible efficiencies in the credentialing process.

State Examples

In **Louisiana**, health care providers, including behavioral health providers, can apply to be credentialed with health plans and networks using the Universal Credentialing DataSource.[225] This national process eliminates the need for multiple credentialing applications and has no costs for providers. Additionally, Louisiana allows providers who applied to be credentialed in Louisiana Medicaid for the first time to be provisionally credentialed for up to 60 days.[226] Provisional credentialing can be an important tool to incentivize providers who are newly practicing in the state to participate as Medicaid providers.

Ohio implemented a centralized credentialing initiative[227] to replace the previous process, which required each of the state's MCPs to conduct credentialing for every provider. With this new process, the state Medicaid agency credentials providers, a process that includes confirming a provider's education, licensing, and certification and ensuring the provider has no criminal or licensing violations, for example. The state shares the credentialing information for each provider with all of the MCPs and sends daily updates on any credentialing changes. The benefits of this centralized process include minimizing administrative burdens on providers and the MCPs and improving data integrity.

[223] https://www.macpac.gov/wp-content/uploads/2025/06/MACPAC-FY-2026-Budget-Justification-FINAL.pdf.
[224] 42 C.F.R. § 438.206, 438.214(b).
[225] https://www.ldi.la.gov/industry/taxes-and-assessments/hipaa-quality-management/caqh.
[226] https://ldh.la.gov/assets/medicaid/MCPP/2.20.23/1449_LHCC_LA.CRED.01_Practitioner_Credentialing_and_ReCredentialing.pdf.
[227] https://dam.assets.ohio.gov/image/upload/managedcare.medicaid.ohio.gov/PNM/Centralized-Credentialing-FAQ.pdf.

Strategy 4.3: Cover Project ECHO (Extension for Community Healthcare Outcomes), the tele-mentoring program designed to create provider communities of learning, to strengthen and sustain the behavioral health workforce.

Project ECHO uses telehealth to build knowledge and support for primary care providers who see patients with complex conditions, including behavioral health issues, with the goal of increasing access to specialty care and improving the quality of healthcare.[228, 229] Through this model, specialists at an academic "hub" are virtually connected to providers in local communities—the "spokes" of the model—to provide remote training and specialist consultations.[230] Project ECHO is frequently used in rural and frontier areas to enhance providers' capacity to treat specific conditions (e.g., opioid use disorder).[231]

For technical assistance on the Medicaid authorities that can support Project ECHO, contact your Division of Program Operations State Lead.

[228] https://www.cdc.gov/rural-health/php/policy-briefs/child-mental-health-policy-brief.html.
[229] https://www.medicaid.gov/medicaid/benefits/downloads/rtc-reducing-barriers-may-2020.pdf.
[230] Ibid.
[231] https://www.commonwealthfund.org/blog/2023/how-changes-medicaid-can-help-primary-care-providers-treat-patients-behavioral-health.

State Examples

Missouri's Show-Me ECHO[232] is operated by the Missouri Telehealth Network at the University of Missouri School of Medicine and uses partnerships with Medicaid MCPs, as well as state appropriations, to reach every county in the state.[233, 234] Show-Me ECHO supports tele-mentoring between primary care providers and interdisciplinary experts in a number of categories, including child psychiatry; vaping, tobacco, and nicotine treatment among children and adolescents; and suicide prevention in health care for children and adolescents.[235, 236]

New Mexico requires its Medicaid MCPs[237] to contract with the University of New Mexico Health Sciences Center, which operates Project ECHO in the state.[238] The MCPs receive monthly Medicaid capitated payments, creating dependable funding and providing the MCPs with flexibility to tailor their ECHO initiatives. Among other programs, New Mexico's Adverse Childhood Experiences ECHO Program (ACEs ECHO)[239] addresses the high prevalence of adverse childhood experiences, such as substance use, in the state. The program helps providers learn how to identify children at risk, provide immediate intervention, and refer children to long-term interventions.

Ohio's System of Care Project ECHO for Youth Involved with Multiple Systems (SoC ECHO)[240] is a partnership among the Ohio Department of Medicaid, the Ohio Department of Mental Health and Addiction Services, and the Ohio Department of Developmental Disabilities, among other entities. SoC ECHO is a virtual learning community for providers focused on caring for youth with complex conditions and their families in their communities.

[232] https://showmeecho.org/about/.
[233] https://medicine.missouri.edu/offices-programs/missouri-telehealth-network.
[234] https://www.chcs.org/resource/using-project-echo-to-deliver-specialty-care-in-rural-areas/.
[235] https://showmeecho.org/clinics/.
[236] https://showmeecho.org/child-adolescent-behavioral-mental-health/.
[237] https://www.hsd.state.nm.us/wp-content/uploads/Turquoise-Care-MCO-Model-Contract-CLEAN_Final.pdf.
[238] https://www.chcs.org/resource/using-project-echo-to-deliver-specialty-care-in-rural-areas/.
[239] https://iecho.org/public/program/PRGM1690820760387MT36LF3X5L.
[240] https://iecho.org/public/program/PRGM1713974538045ODNZAWZZNR.

Strategy 4.4: Establish reimbursement rates that are sufficient to attract behavioral health providers who deliver services, including via telehealth, to children.

As states monitor the number and distribution of enrolled providers, they may identify gaps in the number and type of available providers. Sufficient provider rates help to ensure choice for EPSDT-eligible children, especially for children with specialized needs and children who reside in rural areas, and can help strengthen and expand the behavioral health provider network. When developing payment methodologies and rates, states should be sure to account for various factors such as provider supervision requirements that impact payment sufficiency.

States and MCPs should consider routinely recalibrating rates for services delivered by children's behavioral health providers to stay on pace with market-based rates and reflect the costs of service delivery, including administrative tasks, provider supervision, and service documentation. States and MCPs may also consider different provider rates based on the age of the child or the complexity of care (e.g., children with co-occurring SUD), or for pediatric behavioral health subspecialists or other difficult-to-recruit providers.[241]

State Examples

Arkansas requires health plans, including the state's Medicaid program, to cover and reimburse for services provided using telehealth on the same basis as services provided in person.[242] However, if a service provided using telehealth is not comparable to the same service provided in person, the health plan is not required to reimburse for that service.

In 2024, **North Carolina** increased its reimbursement rates for providers of mental health, SUD, and IDD-related services to, among other things, support more behavioral health providers working in the public health system and ensure upstream services are provided to promote early intervention.[243] The services for which rates increased included diagnostic assessments, facility-based crisis services for children, peer support, and various outpatient behavioral health services, among others.

[241] https://www.medicaid.gov/medicaid/home-community-based-services/downloads/rate-setting-methodology.pdf.
[242] Arkansas State Code 23-79-1601 and 1602, available at: https://law.justia.com/codes/arkansas/2019/title-23/subtitle-3/chapter-79/subchapter-16/section-23-79-1601-d-1/ and https://law.justia.com/codes/arkansas/title-23/subtitle-3/chapter-79/subchapter-16/section-23-79-1602/. According to the state's regulations, health plan generally means an individual, blanket, or group plan, policy, or contract for health care services issued or delivered by an insurer, as well as a health benefit program that receives state or federal appropriations from the state, which includes the state's Medicaid program.
[243] https://medicaid.ncdhhs.gov/blog/2023/11/15/nc-medicaid-behavioral-health-services-rate-increases.

Strategy 4.5: Cover behavioral health providers with an array of qualifications, including qualified non-licensed professionals, to broaden the behavioral health workforce across the continuum of care.

States can cover paraprofessional practitioners to expand the Medicaid workforce available to serve children and to allow licensed providers, such as social workers, psychologists, and psychiatrists, to focus on the more complex or clinically intensive services that they alone can provide. The behavioral health continuum of care consists of a range of services with various levels of complexity, and states can cover a range of providers with qualifications that correspond to the complexity of those services. While more complicated behavioral health care generally requires providers to have a higher degree of education and licensure standards, some services that are relatively less complicated (but still important in the care continuum) could be delivered by non-licensed professionals who meet state-established qualifications.

Generally, states have flexibility to establish reasonable Medicaid provider qualifications related to the fitness of the provider to perform covered medical services, and states can require that MCPs use network providers that meet these standards.[244] Federal statute and regulations require that many Medicaid benefits be provided or recommended by physicians or other licensed practitioners. Where that is not the case, states can create provider types with paraprofessional qualifications and provide related training and support.

Peer support practitioners are one such example of a non-licensed behavioral health provider that states can cover to broaden the behavioral health workforce.[245] Peer support services are an evidence-based behavioral health model of care that involves a qualified peer support provider assisting children (and parents/legal guardians when for the direct benefit of the child) with recovery from a mental illness and/or an SUD. These services can be covered under a number of different Medicaid authorities, including section 1905(a) services such as rehabilitative services.[246] Other examples of non-licensed behavioral health providers include certified SUD professionals who perform screenings and provide counseling services and case management, and behavioral health technicians who perform screenings and provide counseling.[247]

To ensure fiscal responsibility for services provided by non-licensed practitioners, states must identify the Medicaid authority for coverage and payment, and describe the service, the provider of the service, and the provider qualifications in full detail. Provider qualifications must include state-defined training, certification, and ongoing continuing education that ensure basic competencies to perform the service, and states must determine the required amount, duration, and scope of supervision by a competent health professional. States must also assure that

[244] 42 C.F.R. §§ 431.51(c)(2), 438.214(a) and (b).
[245] https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf and https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf.
[246] Section 1905(a)(13) of the Act. https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf.
[247] For more examples of non-licensed providers for SUD services in particular, see: https://nashp.org/50-state-scan-how-medicaid-agencies-leverage-their-non-licensed-substance-use-disorder-workforce/.

there are mechanisms in place, such as utilization management methods, to prevent over-billing for services.

To add coverage of non-licensed providers, states may need to add the provider type and/or benefit, as well as the related reimbursement rates, to their Medicaid state plan or other relevant Medicaid authorities, such as a 1915(c) HCBS waiver program.[248]

State Example

Kentucky has distinct certification processes for adult, family, and youth peer support specialists serving SUD populations.[249] Once these specialists complete 30 hours of training and pass a written and oral test, they are able to provide services with regular supervision. The state's Department for Behavioral Health, Developmental and Intellectual Disabilities is responsible for developing the trainings, the core competencies for which differ for each type of specialist.[250] For example, the training for youth peer support specialists includes a core competency that focuses specifically on youth support.

[248] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf.
[249] https://dbhdid.ky.gov/sud/ebpi-recovery.
[250] https://apps.legislature.ky.gov/law/kar/titles/908/002/240/.

Strategy 4.6: Partner with state agencies to provide financial support for prospective behavioral health practitioners and reimburse for services delivered by behavioral health interns.

State Medicaid agencies should partner with other state agencies—including public health and behavioral health agencies—community-based organizations, and accredited institutions to identify gaps in qualified provider pools and opportunities to address those gaps. These partnerships can help identify state- or federally-funded scholarships, grants, and loan forgiveness programs to support potential behavioral health providers as they pursue a medical education.[251] These types of financial support opportunities could be contingent upon participation as a behavioral health provider for a state's Medicaid and/or CHIP programs.

Similarly, states should be aware of federal grant opportunities for accredited institutions and programs that help to enhance the quality of behavioral health providers' education and clinical training and increase the number of practicing professionals and paraprofessionals. For example, the Behavioral Health Workforce Education and Training Programs,[252] funded by HRSA, provides grants to accredited institutions to support the education and training of behavioral health professionals. The program focuses on increasing the supply of behavioral health professionals and improving the distribution of a well-trained workforce, and has a particular focus on understanding the needs of children, adolescents, and young adults at risk for mental health, trauma, and behavioral health disorders.[253]

Covering and paying for services provided by behavioral health interns can help expand the workforce in states' Medicaid programs.[254, 255] States interested in allowing behavioral health interns to provide certain Medicaid services should verify that the licensing and credentialing requirements in the states' laws and regulations would not impede this approach.

[251] Medicaid funding is not available for activities like scholarships, grants, and loan forgiveness programs.
[252] https://bhw.hrsa.gov/programs/bhwet-program-professionals.
[253] https://grants.gov/search-results-detail/355772.
[254] https://familymedicine.uw.edu/wp-content/uploads/2025/04/RHRC_PRAPR2025_MED_Oster.pdf.
[255] https://www.apa.org/ed/graduate/about/reimbursement/state-progress.

State Examples

California's Department of Health Care Access and Information administers various health workforce programs,[256] including the Behavioral Health Scholarship Program (BHSP), to increase the number of trained health professionals. Through the BHSP, the state provides scholarships to behavioral health students who are working toward a certificate or degree program. Students who receive a scholarship must provide full-time direct behavioral health care for at least 12 months in a designated location, including medically underserved areas, primary care shortage areas, and rural healthcare centers, for example.

To advance their system of behavioral health care, **Florida**'s state legislature created a new Behavioral Health Teaching Hospital (BHTH) designation, established a grant program to fund the BHTHs, and established the Florida Center for Behavioral Health Workforce.[257] The state's Medicaid agency, the Florida Agency for Health Care Administration (AHCA),[258] is responsible for designating certain hospitals as BHTHs and awarding the grant funds to the BHTHs. The new Center, established within the University of South Florida's Louis de la Parte Florida Mental Health Institute, works to support the state's behavioral health system and to develop and disseminate best practices.[259]

Within certain parameters, **Nevada**'s Medicaid program allows licensed behavioral health interns to provide some behavioral health services.[260] Licensed clinical social worker interns, licensed clinical professional counselor interns, and psychological interns, for example, can practice when supervised in accordance with state regulations and when they are practicing within the scope of their licensures.

The **Texas** Department of State Health Services shares information on student loan repayment programs for various types of providers, including behavioral health providers, when they agree to work in federally designated underserved areas.[261] The program requirements vary by provider type, minimum length of service and loan repayment amount. Funding sources include both federal and state agencies. The state specifically identifies programs for behavioral health, mental health, and substance use providers, including, for example, the state's "Loan Repayment Program for Mental Health Professionals." Under this program, certain mental health providers, such as psychiatrists and licensed chemical dependency counselors, are eligible to receive loan repayments when they agree to provide 5 consecutive years of service in a Mental Health Professional Shortage Area and provide direct mental health services to Medicaid and/or Texas CHIP enrollees.[262]

[256] https://hcai.ca.gov/workforce/financial-assistance/scholarships/bhsp/.
[257] https://www.flsenate.gov/Session/Bill/2024/330.
[258] https://ahca.myflorida.com/.
[259] https://www.flsenate.gov/Committees/BillSummaries/2024/html/330.
[260] Nevada covers and reimburses for services provided by psychological Interns under the section 1905(a)(13)(d) rehabilitation services benefit in its Medicaid state plan. See: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NV/NV-16-008.pdf and https://dhcfp.nv.gov/uploadedfiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSP/Sec3/Section3-1AttachmentA.pdf.
[261] https://www.dshs.texas.gov/center-health-statistics/texas-primary-care-office-tpco/student-loan-repayment-programs-texas-primary-care-office-tpco.
[262] https://www.hhloans.com/mental-health-professionals-loan-repayment-program/.

Conclusion

This Behavioral Health Toolkit represents an important step in supporting states to improve the provision and quality of behavioral health services for children and youth, as required under EPSDT. The toolkit focuses on outlining actions that state Medicaid agencies can take to work toward building a behavioral health system that provides the right level of care for children and youth, identifies and treats concerns early, and ensures "no wrong door" for entry into behavioral health care. Addressing needs when they arise can have a significant impact on children's behavioral health that carries into adulthood.

In addition, the toolkit lays out specific strategies and examples that states can take to strengthen their existing systems, including strategies to ensure access to an array of behavioral health services, improve integration of behavioral health services with physical health services, and use policy levers (such as quality strategies and oversight of managed care plans) to improve the provision of behavioral health services to meet EPSDT requirements. It also notes a variety of strategies for building and maintaining a robust, well-qualified workforce, ensuring an adequate network, and improving access to services. Through a continued partnership between federal and state agencies, we can continue to improve access to quality and timely Medicaid-covered behavioral health services for children, youth, and their families.

Appendix A: Descriptions of Children's Behavioral Health Services and Models of Care

The tables in this appendix include information on the behavioral health services and models of care that are described in this toolkit. For each service or model of care, the related behavioral health service array/s, potential service setting/s, and Medicaid authorities or lever are included in the table. Related state examples and resources are also included when available.

The services and models of care are listed in this appendix in alphabetical order, as follows:

- Assertive Community Treatment (ACT)
- Care Coordination and Case Management
- Certified Community Behavioral Health Clinic (CCBHC) Services
- Coordinated Specialty Care for First Episode Psychosis Services
- Crisis Services
- Day Treatment
- Infant and Early Childhood Mental Health Services
- Psychiatric Hospital Services for Individuals under age 21
- Medication Assisted Treatment (Medications of Opioid Use Disorder and Medications for Alcohol Use Disorder)
- Medication Management
- Partial Hospitalization and Intensive Outpatient Services
- Peer Support Services (Youth and Family)
- Psychosocial Rehabilitation Services
- Residential Treatment Services
- Respite Services
- Screening, Assessment, and Early Intervention
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Skills Training
- Therapy and Counseling Services (Individual, Family, and Group), including Substance Use and Tobacco Use Cessation Services
- Withdrawal Management Services

Assertive Community Treatment (ACT)	
Description	Assertive Community Treatment (ACT) offers treatment, rehabilitation, and support services using a person-centered, recovery-based approach to individuals who have been diagnosed with severe and persistent mental illness. ACT is built around a multi-disciplinary team that provides treatment, rehabilitation, and support services in a highly integrated approach to care.[263]
Behavioral health service array	Community-based services
Service settings	Community mental health centers, hospitals, federally qualified health centers, primary care offices, CCBHCs, office-based settings, and schools
Medicaid Authorities/Levers	Coverable under a number of section 1905(a) benefits, such as a section 1905(a)(13) rehabilitative services, among others
Resource	State Medicaid Director (SMD) Letter # 06-07-99: ACT programs: https://www.medicaid.gov/federal-policy-guidance/downloads/SMD060799b.pdf

[263] https://www.samhsa.gov/data/sites/default/files/URSTables2021/2021-URS-Data-Definitions-508.pdf.

Care Coordination and Case Management	
Description	Care coordination and case management are used to describe a range of activities that link individuals to services and can vary in intensity depending on a child and family's needs.[264] Medicaid defines case management as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, and other services.[265] Care coordination is the organization of a patient's care across multiple providers and may focus on a specific service or condition, such as referring and connecting individuals to other programs that support mental health recovery. Care coordination is not defined in section 1905(a) as a service but can be covered in certain circumstances.[266] There are multiple Medicaid authorities under which states can deliver care coordination and case management. Some, but not all, of these authorities are included in the scope of services covered under EPSDT. Below are the various vehicles for care coordination and case management. • Primary Care Case Management (PCCM): According to the Act, "primary care case management services," an optional section 1905(a) benefit, means case management-related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a PCCM contract.[267] If a state is delivering care in a PCCM delivery system, individual services are paid FFS and each beneficiary is assigned a primary care provider who acts as case manager in the sense that the provider makes sure well-child services are received as recommended, referrals are provided and followed up, and ongoing health issues are monitored for each child assigned to the practice. The provider receives a small monthly amount to perform these activities. • Managed Care Plans (MCP): Medicaid Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP) are required by regulation to coordinate health care services for each of their enrollees and to designate a person or entity, such as a primary care practice or other ongoing source of care appropriate to the child's needs, to provide an ongoing source of care and coordinate services accessed by the enrollee.[268] Coordinating health care services for their enrollees is also a critical MCP function inherent to a managed care delivery system at the plan level. Care must be coordinated across settings

[264] See: https://www.medicaid.gov/sites/default/files/2019-12/epsdt-care-coordination-strategy-guide.pdf.
[265] 42 C.F.R. § 440.169(a).
[266] 42 C.F.R. § 438.208.
[267] Sections 1905(a)(25) and (t)(1) of the Act, 42 C.F.R. § 440.168.
[268] 42 C.F.R. § 438.208(b).

Care Coordination and Case Management	
	of care and delivery systems when a child receives Medicaid services through an MCP. An MCP must also coordinate care furnished to its enrollees through the state's FFS program, other MCPs, and community support providers.[269] • Case Management/Targeted Case Management: Case management services are established in 1905(a) of the Act and defined in regulation as "services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services."[270] Therefore, case management services must be available to EPSDT-eligible children who meet medical necessity criteria for this service. States have additional flexibility under section 1915(g) to target these case management services to a subgroup of Medicaid beneficiaries, such as Medicaid beneficiaries in foster care. In these instances, case management is referred to as "Targeted Case Management" (TCM). Using TCM authority, states do not need to comply with federal requirements for statewideness and comparability of services, enabling them to target case management to an area within the state and/or to defined subgroups of Medicaid beneficiaries (the targeted population).[271] Because the TCM flexibility is defined in section 1915 (and not 1905(a)), it does not fall under EPSDT requirements. As a result, while every EPSDT-eligible child must have access to section 1905(a) case management services when medically necessary, states are not required to ensure availability of TCM for EPSDT-eligible children. Case management includes the following four components:[272] 1. Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social, or other services. 2. Development (and periodic revision) of a specific care plan based on the information collected through the assessment. 3. Referrals and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services. 4. Monitoring and follow up activities.

[269] Ibid.
[270] Section 1905(a)(19) of the Act and 42 C.F.R. § 440.169(a). See also section 1915(g)(2)(A) of the Act.
[271] Section 1915(g)(1) of the Act and 42 C.F.R. § 440.169(b).
[272] 42 C.F.R. § 440.169(d).

Care Coordination and Case Management	
	• Health Homes: Health Homes and Health Homes for Children with Medically Complex Conditions, while not covered as part of the EPSDT requirements, are optional Medicaid state plan benefits that support care coordination for eligible people, including children, with chronic conditions, and for children with medically complex conditions.[273], [274], [275] Health Home services include comprehensive care management; care coordination; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; and referral to community and social support services. • Administrative Case Management: Case management as an administrative activity (rather than as a covered Medicaid service) involves the facilitation of access to and coordination of services covered under the state's Medicaid program.[276] These activities can include, for example, facilitating access to specialty care and coordinating appointments with multiple providers. A state may not claim costs for administrative activities if the activities are an integral part or extension of a direct medical service.[277]
Behavioral health service array	Services to address early signs or symptoms of behavioral health conditions, community-based services
Service settings	Primary care offices, schools, in-home, community mental health centers, hospitals, federally qualified health centers, CCBHCs, clinics, and office-based settings
Medicaid Authorities/Levers	Sections 1905(a) and 1915(g) of the Act

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

Care Coordination and Case Management	
State Examples	• **Ohio** uses a section 1915(b) managed care waiver to cover care coordination that is organized into three tiers based on a child's intensity of need.[278] Children are placed into one of the coordination tiers based on a standardized assessment. ○ Tier 1. Limited care coordination is for children with less intense behavioral health needs. Coordination is provided directly by the Medicaid MCP, with a maximum of one care coordinator to 62 children. ○ Tier 2. Moderate care coordination is for children with moderately intensive behavioral health needs. Coordination is provided through a community-based care management entity[279] under contract with the Medicaid MCP, with a maximum of one care coordinator to 25 children. ○ Tier 3. Intensive care coordination[280] is for children with highly intensive behavioral health needs. Coordination is provided by a community-based care management entity under contract with the Medicaid MCP, with a maximum of one care coordinator to 10 children. • **Colorado** has four Regional Accountable Entities (RAE) and two managed care programs that support providers in coordinating and delivering behavioral health services.[281] • In **Connecticut**, HUSKY Health offers administrative case management services[282] through an interprofessional team over the phone, in person, or through videoconference. This group supports scheduling for EPSDT well-child visits.

[278] https://codes.ohio.gov/ohio-administrative-code/rule-5160-59-03.2.
[279] Ohio's care management entities also manage and monitor the use of primary and secondary flex funds for services, equipment, or supplies not otherwise provided through the Medicaid state plan benefit. The use of funds is identified based on individualized need and is documented in the care plan developed in collaboration with the child and family. The care plan is participant-directed.
[280] https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/5a41372d-db3f-451e-a29f-4275572cc1d2/OHR+CME+Manual.pdf?MOD=AJPERES&CVID=o6W7gh0.
[281] https://hcpf.colorado.gov/accphaseIII.
[282] https://www.huskyhealthct.org/members/intensive_care_mngmnt.html.

Care Coordination and Case Management	
Resources	• SHO# 24-005: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements (includes information about case management, targeted case management, and strategies for implementing these services in Medicaid programs): https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf • CMS/SAMHSA Joint CIB: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf • CMS/SAMHSA Joint CIB: Intensive Care Coordination for Children and Youth with Complex Mental and Substance Use Disorders, State and Community Profiles: https://library.samhsa.gov/sites/default/files/intensive-care-youth-coordination-pep19-04-01-001.pdf

Certified Community Behavioral Health Clinic (CCBHC) Services	
Description	CCBHCs are designed to ensure access to coordinated comprehensive behavioral health care. CCBHCs must meet standards for the range of services they provide and are required to get people into care quickly. The CCBHC model requires: • Crisis services to be available 24 hours a day, 7 days a week. • Comprehensive behavioral health services to be available so people who need care don't have to piece together the behavioral health support they need across multiple providers. • Care coordination to be provided to help people navigate behavioral health care, physical health care, social services, and the other systems they are involved in. Under the new CCBHC state plan option, states must cover the following nine services either directly or through formal relationships with other providers, including: 1) crisis services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization; 2) screening, assessment, and diagnosis, including risk assessment; 3) patient-centered treatment planning or similar processes, including risk assessment and crisis planning; 4) outpatient mental health and substance use services;

Certified Community Behavioral Health Clinic (CCBHC) Services	
	5) outpatient clinic primary care screening and monitoring of key health indicators and health risk; 6) intensive case management services; 7) psychiatric rehabilitation services; 8) peer support and counselor services and family supports; and 9) intensive, community-based mental health care for members of the armed forces and veterans who are eligible for medical assistance.[283]
Behavioral health service array	Community-based services
Service settings	Community, CCBHCs
Medicaid Authorities/Levers	Coverable under the section 1905(a)(31) CCBHC state plan benefit, as well as under other 1905(a) benefits, such as section 1905(a)(13) rehabilitative services, among others Additionally, states have had the option since 2014 to implement a CCBHC Demonstration program, which was authorized under Section 223 of the Protecting Access to Medicare Act (PAMA) (Pub. L. 113-93).
State Example	**Oklahoma** is concurrently running both Demonstration and state plan amendment CCBHCs.[284] The CCBHC model requires family-driven care and trauma-informed practice.
Resources	• SAMHSA website on CCBHC Demonstrations: https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics • CMS website on CCBHC Demonstrations: https://www.medicaid.gov/medicaid/financial-management/certified-community-behavioral-health-clinic-ccbhc-demonstration • CMS anticipates publishing guidance on the new CCBHC state plan benefit (1905(a)(31)) in 2026.

[283] Section 1905(a)(31) and (jj) of the Act.
[284] http://www.odmhsas.org/picis/Documents/CCBHC%20Manuals/CCBHCManual_Updates%202022%20FINAL.pdf.

Coordinated Specialty Care for First Episode Psychosis Services	
Description	Coordinated Specialty Care (CSC) is an evidence-based, recovery-oriented team approach to treating early psychosis that promotes easy access to care and shared decision making among specialists, the person experience psychosis, and family members.[285] It includes services like psychotherapy, family support, supported employment and education, medication management, primary care coordination, and case management.[286, 287]
Behavioral health service array	Services to address early signs or symptoms of behavioral health conditions, community-based services
Service settings	Primary care offices, schools, in-home, community mental health centers, hospitals, federally qualified health centers, CCBHCs, clinics, and office-based settings
Medicaid Authorities/Levers	Coverable under section 1905(a)(13), 1915(i) state plan HCBS, 1945 Health Home, 1915(c) HCBS waiver
State Example	**Idaho**'s Early Serious Mental Illness (ESMI) program[288] uses a multidisciplinary approach to treat adolescents and young adults who are experiencing first-episode psychosis. ESMI provides early intervention services to help youth avoid a higher level of care such as partial hospitalization and to support youth who are stepping down from a higher level of care. A team of specialists work with youth to create a personal treatment plan that includes services such as peer support, crisis intervention, and therapy.
Resources	• SAMHSA: Coordinated Specialty Care for First Episode Psychosis: Costs and Financing Strategies: https://library.samhsa.gov/sites/default/files/pep23-01-00-003.pdf • CMS/SAMHSA/National Institute of Mental Health Joint CIB: Coverage of Early Intervention Services for First Episode Psychosis: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf

[285] https://library.samhsa.gov/sites/default/files/pep23-01-00-003.pdf.
[286] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf.
[287] https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf.
[288] https://magellanofidaho.com/documents/2446693/3042016/ibhp_prov_handbook_appC.pdf/2046bdcf-dab9-fa0b-f5ff-4fb5371edbe5?t=1718993330450.

Crisis Services	
Description	Crisis response services are instrumental in defusing and de-escalating mental health situations and preventing unnecessary out-of-home placements, particularly hospitalizations. Crisis services include "someone to contact," including 988 and other hotlines; "someone to respond," including mobile crisis teams; and "a safe place for help," which includes services such as crisis stabilization units (CSU) and crisis respite services.[289] Mobile crisis response may include Mobile Response and Stabilization Services (MRSS), a youth- and family-specific crisis intervention model, where stabilization is in the child's own home.[290] Mobile crisis services are available 24/7 and can be provided in the home or any setting where a crisis may be occurring.[291] Residential crisis stabilization provides intensive short term, out of home resources for the child and family, helping to avert the need for psychiatric inpatient treatment.[292]
Behavioral health service array	Community-based services, services to address urgent and crisis needs, inpatient care
Service settings	Home or community setting, hospital, or other residential crisis stabilization treatment settings
Medicaid Authorities/Levers	Coverable under a number of section 1905(a) benefits, such as a section 1905(a)(13) rehabilitative services, among others, 1915(i) HCBS state plan, 1915(c) HCBS waiver, 1115 demonstration
State Examples	• **Arizona**'s crisis response system integrates the national 988 Suicide & Crisis Lifeline with a network of locally operated services. When someone in Arizona calls, texts, or chats 988, they are typically routed to the state's single crisis line provider. The state Medicaid agency coordinates this system and funds crisis services statewide through Regional Behavioral Health Authorities (RBHA).[293] Local crisis lines bill for services through Medicaid under AHCCCS using standardized Healthcare Common Procedure Coding System (HCPCS) codes. The primary code for telephonic crisis intervention is H0030, which covers behavioral health hotline services.[294] RBHAs coordinate these claims for state-operated crisis services. This structure ensures prompt reimbursement

[289] https://www.samhsa.gov/mental-health/national-behavioral-health-crisis-care.
[290] https://www.medicaid.gov/federal-policy-guidance/downloads/sho25004.pdf.
[291] https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf.
[292] Ibid.
[293] https://www.azahcccs.gov/BehavioralHealth/Downloads/FrequentQuestionsAboutCrisisServices.pdf.
[294] https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/AHCCCSCoveredBHServicesManual.pdf.

Crisis Services	
	without prior authorization, supporting rapid access to care for individuals in distress. 988-related calls, texts, and chats are funded through federal grant programs. • **Georgia** uses Medicaid administrative funds to support the Georgia Crisis and Access Line (GCAL),[295] which is the home of the 988 Suicide and Crisis Lifeline in the state.[296]
Resources	• CMS/SAMHSA Joint SHO# 25-0004: Best Practices for Implementing the Continuum of Crisis Services Under Medicaid and CHIP: https://www.medicaid.gov/federal-policy-guidance/downloads/sho25004.pdf • CMS/SAMHSA Joint CIB: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions (includes information on crisis services): https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf • SHO# 21-008: Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf • CMS website: State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-option-provide-qualifying-community-based-mobile-crisis-intervention-services

[295] https://www.nashp.org/wp-content/uploads/2022/01/Mental-Health-Crisis-Systems-Conference-2021-Master-Slide-Deck.pdf.
[296] https://dbhdd.georgia.gov/be-dbhdd/crisis-system-georgia.

Day Treatment	
Description	Day treatment services for behavioral health conditions generally include person-centered, comprehensive coordinated, structured treatment services and activities. A day treatment program consists of a scheduled series of structured, face-to-face therapeutic sessions organized at various levels of intensive and frequency in order to assist the persons served in achieving their goals. Day treatment programs are offered four or more days per week and may minimize the need for a more intensive level of treatment. It may also function as a step-down from inpatient care or partial hospitalization.[297]
Behavioral health service array	Community-based services
Service settings	Primary care offices, schools, in-home, community mental health centers, hospitals, federally qualified health centers, CCBHCs, clinics, and office-based settings
Medicaid Authorities/Levers	Coverable under section 1905(a), 1915(i) HCBS state plan, 1915(c) HCBS waiver

[297] https://www.cms.gov/files/document/som107apfcmhc.pdf.

Infant and Early Childhood Mental Health Services	
Description	Infant and Early Childhood Mental Health (IECMH) services include a range of programs that help to ensure the well-being of families earlier in a child's life and are aligned with the EPSDT benefit, including dyadic services that allow a child and their parent/caregiver to receive treatment together and group parenting programs.[298] IECMH services are typically delivered by specialists who work with PCPs for the benefit of the child and family.
Behavioral health service array	Community-based services
Service settings	Primary care offices, schools, in-home, community mental health centers, hospitals, federally qualified health centers, CCBHCs, clinics, and office-based settings
Medicaid Authorities/Levers	Coverable under section 1905(a)
State Examples	• To promote child and family well-being and prevent long-term behavioral health issues, **Georgia** established a well-defined system of care for IECMH.[299] This system includes access to early care and learning in safe, nurturing environments, social resources and parenting support, pediatric care for physical and mental health, and early intervention and treatment for children with indicated need. The state's *IECMH Billing Guide for Preventive Services*[300] provides a list of covered services, along with the appropriate billing codes. • **Maryland**'s Medicaid program covers HealthySteps,[301] an evidence-based model that integrates a child development expert (called a HealthySteps Specialist) into primary care to promote the development of children under the age of 3 and to support their families.[302] The state provides enhanced reimbursement to HealthySteps accredited sites, as well as those with pending accreditations, to offset implementation costs. Providers at a HealthySteps site can use code H0025 to bill for behavioral prevention education services, alongside typical well-child visit codes. The state requires that its MCPs contract with at least one HealthyStep site and offers an incentive payment for contracting with at least two sites.

[298] https://www.iecmhc.org/documents/overview-iecmhc-approach-within-early-childhood-system.pdf.
[299] https://www.decal.ga.gov/documents/attachments/DecalIssuebrief.pdf.
[300] https://medicaid.georgia.gov/programs/all-programs/infant-and-early-childhood-behavioral-health-services.
[301] https://health.maryland.gov/mmcp/medicaid-mch-initiatives/Pages/HealthySteps.aspx.
[302] https://www.nccp.org/wp-content/uploads/2024/02/NCCP-Medicaid-Brief_2.27.24.pdf.

Infant and Early Childhood Mental Health Services	
Resources	• SHO# 23-001: Coverage and Payment of Interprofessional Consultation in Medicaid and the Children's Health Insurance Program (CHIP) (includes information about IECMH services): https://www.medicaid.gov/federal-policy-guidance/downloads/sho23001.pdf • Zero to Three: Exploring State Strategies for Financing Infant and Early Childhood Mental Health Assessment, Diagnosis, and Treatment: https://www.zerotothree.org/wp-content/uploads/2022/04/Exploring-State-Strategies-for-Financing-Infant-and-Early-Childhood-Mental-Health-Assessment-Diagnosis-and-Treatment.pdf

Psychiatric Hospital Services for Individuals under age 21	
Description	Inpatient psychiatric hospital services for individuals under age 21 are services furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable conditions of participation, or an accredited psychiatric facility that meets certain requirements.[303] Psychiatric Residential Treatment Facilities (PRTF) are a separate type of nonhospital inpatient setting that provide intensive support to children with behavioral health needs. These facilities are reimbursed through a per diem rate that typically covers room, board, and treatment services, offering a comprehensive care environment for individuals who require a higher level of support than outpatient or community-based services.[304] Services are provided by an interdisciplinary team that consists of psychiatrists, psychologists, social workers, and licensed therapists experienced in treating individuals with behavioral health needs. Children receiving treatment in PRTFs retain their EPSDT entitlement to additional, non-behavioral health services that are medically necessary.[305] Not all states have PRTFs. Children may receive treatment at an out-of-state facility if the state agency finds that in-state care is not available.[306] Although coverage is provided in line with the federal requirement, care may be negotiated through a single-case agreement for the appropriate services and length of stay. States should work in close partnership with states' children's behavioral health agencies to ensure best practices for children are integrated into the PRTF program design, and that transition planning back to home and community is part of care planning from day of admission.
Behavioral health service array	Inpatient care
Service settings	PRTF, hospital
Medicaid Authorities/Levers	Coverable under section the section 1905(a)(16) benefit for inpatient psychiatric hospital services for individuals under age 21
State Examples	• **Iowa**'s behavioral health bed registry[307] tracks the number of available inpatient psychiatric beds by gender for children, adults, and geriatric patients. Psychiatric units are required to update the registry at least two times per

[303] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.
[304] The Omnibus Budget Reconciliation Act of 1990 established criteria for PRTFs.
[305] https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib062018.pdf.
[306] 42 C.F.R. § 431.52.
[307] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//190716/IPBedTrack.pdf.

Psychiatric Hospital Services for Individuals under age 21	
	day and the state monitors participation daily. If the state identifies any units that are not adhering to the guidelines, they send a reminder email about updating the information. To further promote timeliness, the state legislation that created their bed tracking system indicates that a hospital's Medicaid reimbursement could be impacted if bed availability is not entered timely. • **Massachusetts** has a state behavioral health bed registry[308] that provides information on the availability of beds for youth and family services, mental health services, and SUD services. The state requires hospitals to update the registry on bed availability three times a day and includes a performance metric in their Medicaid managed care performance contracts on timely updates to the registry. Massachusetts has implemented the Behavioral Health Treatment and Referral Platform (BH TRP), which supports streamlining referral processes, sharing essential information on provider capacity, standardizing admissions information, and offering a transparent view of patients in emergency departments or hospitals awaiting inpatient psychiatric placement.
Resources	• SMD# 18-0011: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance (includes information on psychiatry hospital services for individuals under age 21): https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf • SHO# 20-005: Mandatory Medicaid State Plan Coverage of Medication-Assisted Treatment (includes information about inpatient services for SUD treatment): https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf • SMD# 24-004: Extension of Medicaid Coverage of Substance Use Disorder Treatment and Managed Care Medical Loss Ratio Provisions in the Consolidated Appropriations Act, 2024: https://www.medicaid.gov/federal-policy-guidance/downloads/smd24004.pdf • CMS website on PRTFs: https://www.cms.gov/medicare/health-safety-standards/certification-compliance/psychiatric-residential-treatment-facility-providers • CMS/SAMHSA Joint CIB: Coverage of Behavioral Health Services for Children, Youth, and Young • Adults with Significant Mental Health Conditions (includes information on PRTFs): https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf

[308] Ibid.

Medication Assisted Treatment (Medications of Opioid Use Disorder and Medications for Alcohol Use Disorder)	
Description	There are types of medication assisted treatment for different conditions. Medications for opioid use disorder are specifically for treating opioid use through approved medications, most often in combination with counseling. There are also approved medications for alcohol use disorder available.[309]
Behavioral health service array	Community-based services, inpatient care
Service settings	Specialized settings
Medicaid Authorities/Levers	Coverable under section 1905(a)
Resources	• SAMHSA website: Substance Use Disorder Treatment Options (includes information about MAT): https://www.samhsa.gov/substance-use/treatment/options • SAMHSA website: Statutes, Regulations, and Guidelines (includes information about MAT): https://www.samhsa.gov/substance-use/treatment/statutes-regulations-guidelines • SHO# 20-005: Mandatory Medicaid State Plan Coverage of Medication-Assisted Treatment: https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf • SHO# 20-002: Access to Mental Health and Substance Use Disorder Services for Children and Pregnant Women in the Children's Health Insurance Program: https://www.medicaid.gov/federal-policy-guidance/downloads/sho20001.pdf • SMD# 24-004: Extension of Medicaid Coverage of Substance Use Disorder Treatment and Managed Care Medical Loss Ratio Provisions in the Consolidated Appropriations Act, 2024: https://www.medicaid.gov/federal-policy-guidance/downloads/smd24004.pdf • CMS\SAMHAS Joint CIB: Coverage of Behavioral Health Services for Youth with Substance Use Disorders (includes information on MAT): https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf

[309] https://www.samhsa.gov/find-support/learn-about-treatment/types-of-treatment.

Medication Management	
Description	For some behavioral health conditions, medications can help improve symptoms. Medications have to be prescribed by a doctor, nurse practitioner, or physician's assistant.[310] The critical elements for evidence-based medication management for behavioral health conditions include utilization of a systemic plan for medication, objective measures of outcomes, thorough documentation, and use of shared decision making.[311]
Behavioral health service array	Community-based services, inpatient care
Service settings	Community mental health centers, hospitals, federally qualified health centers, primary care offices, CCBHCs, office-based settings, clinics, and schools
Medicaid Authorities/Levers	Coverable under section 1905(a)

[310] https://www.samhsa.gov/find-support/learn-about-treatment/types-of-treatment.
[311] https://www.samhsa.gov/data/sites/default/files/URSTables2021/2021-URS-Data-Definitions-508.pdf.

Partial Hospitalization and Intensive Outpatient Services	
Description	A partial hospitalization program (PHP) is a structured in-person program for children experiencing an acute behavioral health episode, that may also sometimes be delivered via telehealth. Children in these programs need intensive support that does not rise to a level requiring inpatient admission. In these programs, children attend multiple therapy sessions during the day, allowing them to remain in their own homes. These sessions may include individual, group, and family therapy, as well as education programs and medication management. Services are delivered following an established treatment by a team of providers led by a licensed physician. Partial hospitalization programs can be used following a discharge from an inpatient program or as a "step up" from other outpatient services to prevent inpatient admissions. An intensive outpatient program (IOP) provides similar services at a lower intensity than PHP and may be used as a "step down" from PHP to provide intensive clinical support. IOP may also be provided as a standalone service for children who need intensive clinical intervention while remaining in their own home and community.
Behavioral health service array	Community-based services
Service settings	Hospital, clinic
Medicaid Authorities/Levers	Coverable under a number of section 1905(a) benefits, such as a section 1905(a)(13) rehabilitative services, among others
State Examples	**Kentucky** statute[312] requires that coverage of IOP services be provided as an alternative to or transition from a higher level of care for a mental health, SUD, or co-occurring condition. The services should be a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than other outpatient therapy. Services must be provided face-to-face for a minimum of six hours per week for adolescents and should include individual, group, and family therapy, crisis intervention, or psychoeducation. individual therapy, group therapy, or family therapy. Services should be available to an individual based on their individualized treatment plan.
Resource	SAMHSA TIP 47: Substance Abuse: Clinical Issues in Intensive Outpatient Treatment: https://www.samhsa.gov/resource/ebp/tip-47-substance-abuse-clinical-issues-intensive-outpatient-treatment

[312] https://apps.legislature.ky.gov/law/kar/titles/907/015/010/.

Peer Support Services (Youth and Family)	
Description	Youth and family peer support services are provided by individuals with similar experiences as the child beneficiaries and their family, either as "near-peer" youth who received behavioral health services or as a family member to a child with behavioral health needs. Youth and family peer support specialists can provide support that may reduce the need for more costly and intensive treatment or may be part of a clinical team for a child with intensive needs, with the goal of maintaining that child at home and in the community. Aspects of peer behavioral health services may include helping navigate complex service systems, providing psychoeducation on coping strategies, self-advocacy, and promoting empowerment of youth and their families. Peer support increases engagement in treatment, helps youth and their families navigate complex systems to access resources, and improves health outcomes.[313, 314] Youth peer support services differ from family peer support services, and states should consider their design and role expectations carefully. For example, youth peer support providers use their lived experiences and formal training to help young adults transitioning from child to adult systems. Youth peer support partners must understand both child and adult systems and the resources available in each to help guide and support their peers. This knowledge allows them to effectively support youths in the child-serving system and as they move from receiving care in that system to accessing services in the adult system.[315]
Behavioral health service array	Community-based services
Service settings	Various settings, including home, community, clinics, offices, and schools, among others
Medicaid Authorities/Levers	Coverable under a number of section 1905(a) benefits, such as a section 1905(a)(13) rehabilitative services, among others. Sections 1915(b) and 1915(c) HCBS waiver authorities may also be used by states for coverage of peer support services.[316]

[313] https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/family-parent-caregiver-support-behavioral-health-2017.pdf.
[314] Hopkins, L., Kuklych, J., Pedwell, G. et al. (2021). Supporting the Support Network: The Value of Family Peer Work in Youth Mental Health Care. *Community Ment Health Journal, 57*. Available at: https://link.springer.com/article/10.1007/s10597-020-00687-4.
[315] https://nwi.pdx.edu/pdf/Providing-Youth-and-Young-Adult-Peer-Support-through-Medicaid.pdf.
[316] https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf.

Peer Support Services (Youth and Family)	
State Examples	• **Georgia** includes parent peers and youth peers who can provide services either in groups or individually as standalone services; payment for their services in other treatment settings is also available.[317] • **Maine** provides peer services through innovative Health Home models using code T2022, which is billed per member/per month.[318]
Resources	• Frequently Asked Questions on Medicaid and CHIP Coverage of Peer Support Services: https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf • SAMHSA: Medicaid Funding for Family and Youth Peer Support Programs in the United States: https://youthmovenational.org/wp-content/uploads/2021/01/Medicaid-Funded-Youth-and-Family-Peer-Support-Guide-2020.pdf • SMD# 08-15-07: Peer Support Services: https://www.medicaid.gov/federal-policy-guidance/downloads/SMD081507A.pdf

[317] https://dbhdd.georgia.gov/recovery-transformation/cps.
[318] https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/health-homes.

Psychosocial Rehabilitation Services	
Description	Psychosocial rehabilitation helps people develop the social, emotional and intellectual skills they need in order to live happily with the smallest amount of professional assistance they can manage. Psychosocial rehabilitation uses two strategies for intervention: learning coping skills so that they are more successful handling a stressful environment and developing resources that reduce future stressors. Treatments and resources vary from case to case but can include medication management, psychological support, family counseling, vocational and independent living training, housing, job coaching, educational aide and social support.[319]
Behavioral health service array	Community-based services
Service settings	Primary care offices, schools, in-home, community mental health centers, hospitals, federally qualified health centers, CCBHCs, clinics, and office-based settings
Medicaid Authorities/Levers	Coverable under section 1905(a)(13) state plan, 1915(i) HCBS state plan, 1915(c) HCBS waiver, 1115 demonstrations
Resource	MACPAC, Behavioral health services covered under state plan authority (includes information on psychosocial rehabilitation services): https://www.macpac.gov/subtopic/behavioral-health-services-covered-under-state-plan-authority/

[319] https://www.nami.org/about-mental-illness/treatments/psychosocial-treatments/#:~:text=Psychosocial%20rehabilitation%20helps%20people%20develop,professional%20assistance%20they%20can%20manage.

Residential Treatment Services	
Description	Residential treatment involves providing health services or treatment in a 24-hour-a-day, 7-day-a-week structured living environment for individuals who need support for their mental health or substance use recovery before living on their own, but where inpatient treatment is not needed. Care is provided for limited periods of time and has the goal of preparing people to move into the community at lower levels of care.[320] Residential services are clinically managed and medically monitored services that typically provided in freestanding, appropriately licensed facilities or residential treatment facilities without acute medical care capacity.[321]
Behavioral health service array	Community-based services
Service settings	Residential treatment facilities without acute medical care capacity
Medicaid Authorities/Levers	Coverable under section 1115 demonstration
Resources	SMD# 15-003: New Service Delivery Opportunities for Individuals with a Substance use Disorder: https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf

[320] https://aspe.hhs.gov/reports/state-residential-treatment-behavioral-health-conditions.
[321] https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf.

Respite Services	
Description	Respite services provide short-term care and supervision of children in a child's home or an approved community setting. This service allows primary caregivers to have a reprieve from caretaking and supports children remaining in their homes and communities, by decreasing family stressors. While the child is in the temporary care of a provider, the caregiver may choose to rest, address personal matters, or care for other members (e.g. siblings, aging parent) of the household. Respite is typically provided in increments of hours or days, depending on a child's plan of care. Community-based organizations, relatives, neighbors, friends, or licensed childcare or medical facilities may be eligible respite service providers.
Behavioral health service array	Community-based services
Service settings	Home or community settings
Medicaid Authorities/Levers	While respite cannot be covered as a 1905(a) state plan service, states have the option to cover respite under a section 1915(i) HCBS state plan authority or 1915(c) HCBS waiver program authority
Resources	• ARCH: National Respite Guidelines, Guiding Principles for Respite Models and Services: https://archrespite.org/wp-content/uploads/2022/04/NationalRespite_Guidelines_Final_October_2011_1MB.pdf • NASHP: State Medicaid Approaches to Respite Care for Children and Youth with Chronic and Complex Needs: https://nashp.org/state-medicaid-approaches-to-respite-care-for-children-and-youth-with-chronic-and-complex-needs/

Screening, Assessment, and Early Intervention	
Description	Section 1905(r)(1) of the Act requires that screenings for EPSDT-eligible children include but not be limited to: • Physical and mental health screenings • Screening for substance use • Appropriate immunizations • Laboratory tests • Health education Other services provided in screening, assessment, and early intervention may include biopsychosocial assessments, behavioral interventions, and brief interventions.
Behavioral health service arrays	Screening and assessment, community-based services
Service settings	Primary care offices, schools, in-home, community mental health centers, hospitals, federally qualified health centers, CCBHCs, and office-based settings
Medicaid Authorities/Levers	Coverable under section 1905(a)
State Examples	• **Michigan** requires providers to incorporate the Michigan Child and Adolescent Needs and Strengths (MichiCANS) into their assessment process.[322] Michigan's Community Mental Health Service Providers (CMHSP), Prepaid Inpatient Health Plans (PIHP), and Certified Community Behavioral Health Clinics (CCBHC) all use this standardized tool in their access, intake, and service planning processes for children, youth, and their families/caregivers. • **Arizona** requires all children receiving behavioral health services to have a CALOCUS[323] conducted upon initiation of behavioral health services and updated every 6 months across settings and developed a provider FAQ on the tool.

[322] https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf.
[323] Arizona has adopted and implemented the CALOCUS as a way to identify the appropriate intensity of services needed for youth and their family and is not considered a standard comprehensive behavioral health assessment tool for diagnostic services for children. See more at: https://azahcccs.gov/Resources/Downloads/SystemOversiteStructure/CALOCUS_FAQ.pdf.

Screening, Assessment, and Early Intervention	
	• **California**'s EPSDT benefits are also known as "Medi-Cal for Kids & Teens," and the associated resource materials[324] contain information on covered behavioral health services available for children and teens, including mental health and substance use disorder services, with appropriate contact information. Brochures outline what to expect at a checkup with a provider, including checks for developmental milestones, anxiety, depression in new mothers, and other health concerns. California's Your Medi-Cal Rights fact sheet[325] informs children and families about next steps if care (including a behavioral health screening or treatment) is denied, delayed, reduced, or stopped. The state's Department of Health Care Services (DHCS) requires all providers to complete regular training on the program.[326] In November 2025, DHCS also released a companion brochure[327] that is specific to behavioral health and further expands upon the comprehensive services available for Medi-Cal members, including those under EPSDT. Specifically, the brochure provides more granular details on covered Medi-Cal behavioral health services, including non-specialty mental health and substance use disorder services provided through the Medi-Cal fee-for-service (FFS) or managed care delivery systems (through contracted Medi-Cal managed care plans (MCPs) as well as specialty mental health services and substance use disorder services provided through the county behavioral health delivery system (through county mental health plans and substance use disorder providers). It also includes information specific to American Indian/Alaskan Native members as well as additional, appropriate contact information for getting connected to care and other specialized resources. • **Oklahoma** provides families with a Child Health Checkup Guide[328] so they know what to expect from a well-child visit, including why well-child visits are important and when children need them. The guide provides a "Special Note About Teenagers and Health Checkups" that describes typical adolescent development and red flags related to social and emotional health that would indicate a family should seek help from their child's primary care provider.

[324] https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Resources.aspx.
[325] https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Documents/MediCal-Rights-Letter-ENG.pdf.
[326] https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Provider-Information.aspx.
[327] https://www.dhcs.ca.gov/services/MH/Pages/BH-Brochures.aspx.
[328] https://oklahoma.gov/content/dam/ok/en/okhca/docs/individuals/guides-and-manuals/Child%20Health%20Guide%202022.pdf.

Screening, Assessment, and Early Intervention	
Resource	The American Academy of Pediatrics' Bright Futures Guidelines and Pocket Guide: https://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-guidelines-and-pocket-guide/

Screening, Brief Intervention, and Referral to Treatment (SBIRT)	
Description	SBIRT was originally developed as a public health model for use within primary care and other health care settings. SBIRT uses screening to assess the severity of substance use, employs brief intervention focusing on increasing insight and awareness regarding substance use and motivation toward behavioral change, and refers to the appropriate level of treatment in a variety of settings, including primary care, community health settings, and schools.
Behavioral health service array	Screening and assessment, services to address early signs or symptoms of behavioral health conditions, community-based services
Service settings	Primary care offices, schools, in-home, community mental health centers, hospitals, federally qualified health centers, CCBHCs, clinics, and office-based settings
Medicaid Authorities/Levers	Coverable under section 1905(a)
State Example	Oklahoma provides reimbursement for administering SBIRT services, including maternal depression screening (billing code: 96161) during a well-child visit and SUD screening and brief intervention services (billing code: 99408). Providers that meet requirements for performing screenings on individuals ages 5 and above may receive a quarterly incentive payment.[329]
Resource	SAMHSA website on Screening, Brief Intervention, and Referral to Treatment: https://www.samhsa.gov/substance-use/treatment/sbirt

[329] https://oklahoma.gov/content/dam/ok/en/odmhsas/documents/prevention/sbirt/SBIRT--Reimbursement.pdf.

Skills Training	
Description	Skills training focuses on developing and/or restoring individuals' skills to their best possible functional level and minimizing any challenges with physical, emotional, and/or mental wellness so that they can live independently. States may offer a wide range of recovery-oriented services, including skills training for independent living, employability, and relationships.[330]
Behavioral health service arrays	Community-based services
Service settings	Community mental health centers, hospitals, federally qualified health centers, primary care offices, CCBHCs, office-based settings, clinics, and schools
Medicaid Authorities/Levers	Coverable under the section 1905(a)(13) rehabilitative services benefit, 1915(i) state plan HCBS, 1915(c) HCBS waiver

[330] https://library.samhsa.gov/sites/default/files/sma13-4773_mod3.pdf.

Therapy and Counseling Services (Individual, Family, and Group), including Substance Use and Tobacco Use Cessation Services	
Description	There are many types of therapy and counseling. They are part of most treatment plans and usually happen with a licensed behavioral health professional, either in an individual, family or group setting. Counseling and therapy are usually focused on developing healthy skills to cope, like handling the loss of a loved one, drug or alcohol use, or a problem in your relationship.[331] States have broad flexibility to authorize a range of practitioner types and settings to maximize the support available to children with behavioral health needs, and their families.
Behavioral health service array	Services to address early signs or symptoms of behavioral health conditions, community-based services, inpatient care
Service settings	Primary care offices, schools, in-home, community mental health centers, hospitals, federally qualified health centers, CCBHCs, clinics, and office-based settings
Medicaid Authorities/Levers	Coverable under section 1905(a)
State Example	**California**'s FFS providers and MCPs are responsible for ensuring coverage of non-specialty mental health services, including individual, group, and family therapy, for children who have a potential mental health condition without a formal diagnosis.[332] In addition, using Section 1915(b) waiver authority, California's county mental health plans provide a range of specialty mental health services (e.g., intensive care coordination, intensive home-based services, therapeutic foster care, therapeutic behavioral services, etc.) for children without a behavioral health diagnosis if a child is high risk for developing such a condition.[333],[334] High risk factors include, for example, traumatic exposure, child welfare or justice system involvement, or housing insecurity. Providers are made aware of this policy via the Medi-Cal for Kids and Teens EPSDT mandatory provider training, which includes information on providing all medically necessary mental health services for children and youth under age 21 regardless of their level of distress or impairment, or the presence of a diagnosis.

[331] https://www.samhsa.gov/find-support/learn-about-treatment/types-of-treatment.
[332] https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf.
[333] Ibid.
[334] https://www.dhcs.ca.gov/services/MH/Pages/Specialty_Mental_Health_Services.aspx.

Therapy and Counseling Services (Individual, Family, and Group), including Substance Use and Tobacco Use Cessation Services	
Resources	• CIB: Strategies to Improve Delivery of Tobacco Cessation Services: https://www.medicaid.gov/federal-policy-guidance/downloads/cib03072024.pdf • SHO# 20-002: Access to Mental Health and Substance Use Disorder Services for Children and Pregnant Women in the Children's Health Insurance Program: https://www.medicaid.gov/federal-policy-guidance/downloads/sho20001.pdf • National Academy for State Health Policy (NASHP) 50-State Scan: How Medicaid Agencies Leverage their Non-Licensed Substance Use Disorder Workforce: https://nashp.org/50-state-scan-how-medicaid-agencies-leverage-their-non-licensed-substance-use-disorder-workforce/

Withdrawal Management Services	
Description	Withdrawal management services are crucial for safely managing withdrawal symptoms and stabilizing children with SUD. Withdrawal management is the person-centered and evidence-based medical and psychological care of individuals who are experiencing withdrawal symptoms as a result of ceasing or reducing use of a substance.[335] People experience withdrawal symptoms (e.g., nausea, insomnia, restlessness, etc.) when they are physically dependent on substances and abruptly stop or significantly reduce the amount they are taking.
Behavioral health service array	Community-based services, inpatient care
Service settings	Various settings, including hospitals and specialized facilities
Medicaid Authorities/Levers	Coverable under a number of section 1905(a) benefits, such as a section 1905(a)(13) rehabilitative services, among others

[335] https://library.samhsa.gov/sites/default/files/oud-treatment-state-prisons-pep25-02-003.pdf.

Appendix B: Matrix of Impact Categories for Behavioral Health Strategies and Sub-Strategies

This appendix identifies various impact categories that could apply to each of the strategies and sub-strategies described in this toolkit. The impact categories, described below, can help states identify which strategies and/or sub-strategies to implement based on the actions they would need to take and/or the desired outcome.

- **Coverage Policy**: The strategy or sub-strategy has implications for the state's behavioral health coverage policies.
- **Streamline Care**: Implementing the strategy or sub-strategy could help streamline the provision of behavioral health care.
- **Quality of Care**: Implementing the strategy or sub-strategy could improve the quality of behavioral health care.
- **Financial Policy**: The strategy or sub-strategy has implications for the state's behavioral health financial policies.
- **Operational Efficiency**: Implementing the strategy or sub-strategy could result in operational efficiencies for the state's behavioral health care system.
- **Data Analysis**: The state would need to analyze data as a component of implementing the strategy or sub-strategy.
- **Information or Knowledge Sharing**: The strategy or sub-strategy would involve the sharing of information or knowledge by the state to beneficiaries or providers and/or among the provider community.
- **Internal and/or External Collaboration**: To implement the strategy or sub-strategy, the state Medicaid agency would need to coordinate with other state agencies and/or external stakeholders.

Table B-1. Matrix of the Behavioral Health Strategies and Sub-Strategies and Various Impact Categories

Strategy/Sub-Strategy	Coverage Policy	Streamline Care	Quality of Care	Financial Policy	Operational Efficiency	Data and Analytics	Information or Knowledge Sharing	Internal and/or External Collaboration
Section 1: Developing and Supporting a Behavioral Health Care Delivery System that can Meet a Range of Children's Needs								
1.1: Cover a continuum of behavioral health care for children that accounts for a range of needs, as well as the different stages of childhood development.	X							

Strategy/Sub-Strategy	Coverage Policy	Streamline Care	Quality of Care	Financial Policy	Operational Efficiency	Data and Analytics	Information or Knowledge Sharing	Internal and/or External Collaboration
1.2: Implement a Health Services Initiative (HSI) focused on improving the behavioral health of low-income children.	X		X					
1.3: Monitor the use of inpatient behavioral health care among children and ensure they receive appropriate post-hospitalization follow up care.			X		X			
1.4: Develop a behavioral health delivery system that accounts for children with specialized needs.								
1.4.a: Ensure coverage of a range of services and supports to identify, treat, and support the recovery of youth with substance use disorders (SUD).	X		X					
1.4.b: Cover a robust array of services for children with Intellectual and Developmental Disabilities (IDD) and behavioral health conditions and highlight opportunities for providers to learn more about identifying and treating these co-occurring conditions.	X		X			X		
1.4.c: Ensure children in or formerly in foster care receive trauma-focused screening and include requirements in managed care plan (MCP) contracts that focus on the special needs of this population.	X		X					
1.4.d: Improve outcomes for youth experiencing early or first-episode psychosis by covering	X		X					

Strategy/Sub-Strategy	Coverage Policy	Streamline Care	Quality of Care	Financial Policy	Operational Efficiency	Data and Analytics	Information or Knowledge Sharing	Internal and/or External Collaboration
coordinated specialty care (CSC).								
1.5: Ensure implementation of utilization controls and fair hearings for behavioral health services are consistent with EPSDT requirements.	X				X			
Section 2: Promoting Early Intervention for Children's Behavioral Health Conditions								
2.1: Use EPSDT informing materials and other guidance to facilitate early intervention for children's behavioral health conditions.								
2.1.a: Include specific information on behavioral health screenings and services in EPSDT informing materials for beneficiaries.							X	
2.1.b: Include guidance on developmental and behavioral health screenings in provider manuals and managed care contracts.			X				X	
2.2: Implement a comprehensive, standardized behavioral health assessment tool to assist providers in identifying appropriate diagnostic and treatment services for children.			X		X			
2.3: Encourage primary care providers to conduct developmental and behavioral health screenings by developing specific reimbursement rates for these screenings.			X	X				
2.4: Allow behavioral health services to be provided without a formal behavioral health diagnosis and ensure providers are aware of this policy.	X						X	

Strategy/Sub-Strategy	Coverage Policy	Streamline Care	Quality of Care	Financial Policy	Operational Efficiency	Data and Analytics	Information or Knowledge Sharing	Internal and/or External Collaboration
2.5: Establish a quality improvement plan to identify early intervention opportunities for children's behavioral health conditions and to monitor the provision of interventions following screenings and assessments.	X		X			X		
2.6: Support early intervention for behavioral health conditions by covering infant and early childhood mental health (IECMH) services.	X		X					
Section 3: Improving Children's Access to Behavioral Health Care through Service Coordination and Integration								
3.1: Utilize care coordination and case management to ensure children receive medically necessary behavioral health services.	X		X					
3.2: Ensure transition planning for youth with complex behavioral health conditions when moving from pediatric to adult care.	X		X					
3.3: Facilitate the integration of primary and behavioral health care to improve children's access to care.								
3.3.a: Support collaborative models of care among pediatric primary care and behavioral health providers.		X			X		X	
3.3.b: Encourage the integration of primary care and behavioral health care by expanding the types of clinicians who can deliver certain behavioral health services and eliminating prohibitions on same-day billing.		X		X	X			
Strategy 3.4: Design and implement a single pathway for children and their families to access behavioral health care.								
3.4.a: Coordinate with local 988 Suicide & Crisis Lifelines to		X			X			

Strategy/Sub-Strategy	Coverage Policy	Streamline Care	Quality of Care	Financial Policy	Operational Efficiency	Data and Analytics	Information or Knowledge Sharing	Internal and/or External Collaboration
facilitate children's access to behavioral health care.								
3.4.b: Design and implement a "no wrong door" pathway to a fully developed behavioral health system.		X			X			
Strategy 3.5: Cover children's behavioral health services when delivered via telehealth to improve access to care.								
3.5.a: Expand the coverage of children's behavioral health services that can be delivered using telehealth and the settings from which services may be delivered using telehealth.	X							
3.5.b: Ensure policies related to delivering children's behavioral health services via telehealth account for consent requirements and provider licensure and credentialing.	X				X			X
Section 4: Increasing the Workforce Capacity for Children's Behavioral Health Services								
4.1: Continually monitor the roster of behavioral health providers available to serve children.						X		
4.2: Reduce the administrative burden and regulatory barriers for providers that could impede their participation in delivering behavioral health care for EPSDT-eligible children								
4.2.a: Review prior authorization requirements for behavioral health services to identify adjustments that could reduce providers' administrative burden while maintaining the quality of care.					X	X		
4.2.b: Allow interstate licensure portability models for behavioral health providers and streamline					X			X

Strategy/Sub-Strategy	Coverage Policy	Streamline Care	Quality of Care	Financial Policy	Operational Efficiency	Data and Analytics	Information or Knowledge Sharing	Internal and/or External Collaboration
their credentialing to expand the pool of available providers.								
4.3: Cover Project ECHO (Extension for Community Healthcare Outcomes), the tele-mentoring program designed to create provider communities of learning, to strengthen and sustain the behavioral health workforce.	X		X		X		X	X
4.4: Establish reimbursement rates that are sufficient to attract behavioral health providers to deliver services, including via telehealth, to children.				X				
4.5: Cover behavioral health providers with an array of qualifications, including qualified non-licensed professionals, to broaden the behavioral health workforce across the continuum of care.					X			
4.6: Partner with state agencies to provide financial support for prospective behavioral health practitioners and reimburse for services delivered by behavioral health interns.				X				X

Appendix C: Resources

CMS and other federal agencies in HHS have issued behavioral health-related guidance for state and stakeholders on program resources that could be leveraged in the delivery of behavioral health services for children and youth. For resources specific to covering a particular behavioral health service (e.g., peer support services, coordinated specialty care, etc.), please see the resources listed in the related service table in *Appendix A: Descriptions of Children's Behavioral Health Services and Models of Care*.

While not an exhaustive list, the following resources could be useful as states make decisions about these services.

Focus Area	Resource
General Resources on coverage and design opportunities for behavioral health care	
EPSDT (with behavioral health information)	• General EPSDT information, including strategy guides to support states in effectuating required Medicaid coverage: https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment • SHO# 24-005: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements (includes policies, strategies, and best practices on improving care for children with behavioral health needs): https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf
Mental health and SUD	• CIB: Coverage and design opportunities for mental health and SUD treatment: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-12-03-12.pdf • CIB: Leveraging Medicaid, CHIP and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth: https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf • CMS website: Behavioral Health Services, Children and Youth: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/children-and-youth • SAMHSA website: Mental Illness and Substance Use in Young Adults: https://www.samhsa.gov/mental-health/children-and-families/young-adults
Mental health and SUD in schools	• SMD# 14-006: Medicaid Payment for Services Provided without Charge ("Free Care"): https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf • CMS School-Based Services Guide:https://www.medicaid.gov/sites/default/files/2023-07/sbs-guide-medicaid-services-administrative-claiming-ud.pdf • CMS/SAMHSA Joint CIB: Guidance to States and School Systems on Addressing Mental health and Substance Use Issues in Schools: https://www.medicaid.gov/federal-policy-guidance/downloads/cib20190701.pdf • SAMHSA website that includes guidance on mental health and SUD in schools: https://www.samhsa.gov/mental-health/children-and-families/school-health

SUD	• CMS/SAMHSA Joint CIB: Coverage of Behavioral Health Services for Youth with Substance Use: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-01-26-2015.pdf • Service delivery opportunities for individuals with SUD: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-10-29-14.pdf • SMD# 15-003: New Service Delivery Opportunities for Individuals with a Substance use Disorder: https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf
Resources that focus on specific behavioral health conditions and/or populations	
Autism Spectrum Disorder	CIB: EPSDT coverage of services for children and adolescents with an autism spectrum disorder: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-07-14.pdf
Complex mental health and/or SUDs	• CMS/SAMHSA Joint CIB: Intensive Care Coordination for Children and Youth with Complex Mental and Substance Use Disorders, State and Community Profiles: https://library.samhsa.gov/sites/default/files/intensive-care-youth-coordination-pep19-04-01-001.pdf • CMS/SAMHSA Joint CIB: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions (includes information on crisis services): https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf
Maternal population	CIB: Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children: https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf
Mental health (significant)	CIB: CMS/SAMHSA joint guidance on services for children and adolescents with significant mental health conditions: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf
Neonatal SUD	• CIB: Neonatal Abstinence Syndrome and prenatal substance use: https://www.medicaid.gov/federal-policy-guidance/downloads/cib090420.pdf • CIB# 07-26-19: Residential pediatric recovery centers for infants with neonatal abstinence syndrome: https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1007.pdf • ASPE: Treatment and prevention of fetal alcohol spectrum disorders: https://aspe.hhs.gov/fasd-research-briefs
Opioid use disorder	HHS Office for Civil Rights (OCR) resources on civil rights and opioid use disorder: https://www.hhs.gov/civil-rights/for-individuals/special-topics/opioids/index.html
Prevention and Identification	CIB: Prevention and identification of mental health conditions and SUD: https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/CIB-03-27-2013.pdf
Psychiatric Medications	• A Review of State Medicaid Approaches on Child Antipsychotic Monitoring Programs: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/state-medicaid-dur-summaries.pdf

	• CIB: Collaborative Efforts and Technical Assistance Resources to Strengthen the Management of Psychotropic Medications for Vulnerable Populations: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-08-24-12.pdf
Psychiatric Medications and Children in Foster Care	SMD# 11-23-11: Use of Psychotropic Medications Among Children in Foster Care: https://www.medicaid.gov/federal-policy-guidance/downloads/smd-11-23-11.pdf
Resources on CHIP and behavioral health care	
Mental health and SUDs	SHO# 20-002: Access to Mental Health and Substance Use Disorder Services for Children and Pregnant Women in the Children's Health Insurance Program: https://www.medicaid.gov/federal-policy-guidance/downloads/sho20001.pdf
Health Services Initiatives	FAQ: Health Services Initiatives: https://www.medicaid.gov/federal-policy-guidance/downloads/faq11217.pdf
Other resources related to Medicaid and behavioral health care	
Monitoring behavioral health quality	Technical Assistance Resource: Allowance of Telehealth in the 2025 Child, Adult, and Health Home Core Sets Measure Specifications: https://www.medicaid.gov/medicaid/quality-of-care/downloads/telehealth-ta-resource.pdf
Paying for behavioral health	SMD# 24-001: Administrative Claiming for Nurse Advice Lines and for Skilled Professional Medical Personnel for Certain Behavioral Health Professionals: https://www.medicaid.gov/federal-policy-guidance/downloads/smd24001.pdf
Telehealth	• State Medicaid and CHIP Telehealth Toolkit (February 2024): https://www.medicaid.gov/medicaid/benefits/downloads/telehealth-toolkt.pdf • CIB: Medicaid Substance Use Disorder Treatment via Telehealth : https://www.medicaid.gov/federal-policy-guidance/downloads/cib040220.pdf • Report to Congress: Reducing Barriers to Using Telehealth and Remote Patient Monitoring for Pediatric Populations under Medicaid: https://www.medicaid.gov/medicaid/benefits/telehealth/support-act-section-1009-services-and-treatment-for-substance-use-disorders-delivered-telehealth-including-school-based-health-centers