



All-State Medicaid and CHIP Call

April 28, 2026



Agenda

- Medicaid and CHIP Policy Implementation Roadmap
- Implementation of Section 71109, Alien Medicaid Eligibility, of the “Working Families Tax Cut” Legislation (Public Law 119-21)
- State Directed Payments: Ensuring Compliance with Upcoming Regulatory Requirements
- State Medicaid & CHIP Behavioral Health Toolkit
- Q&A

Medicaid and CHIP Policy Implementation Roadmap

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Medicaid and CHIP Policy Implementation Roadmap

Understanding State Systems Impact of Recently Released Policy or Technical Guidance

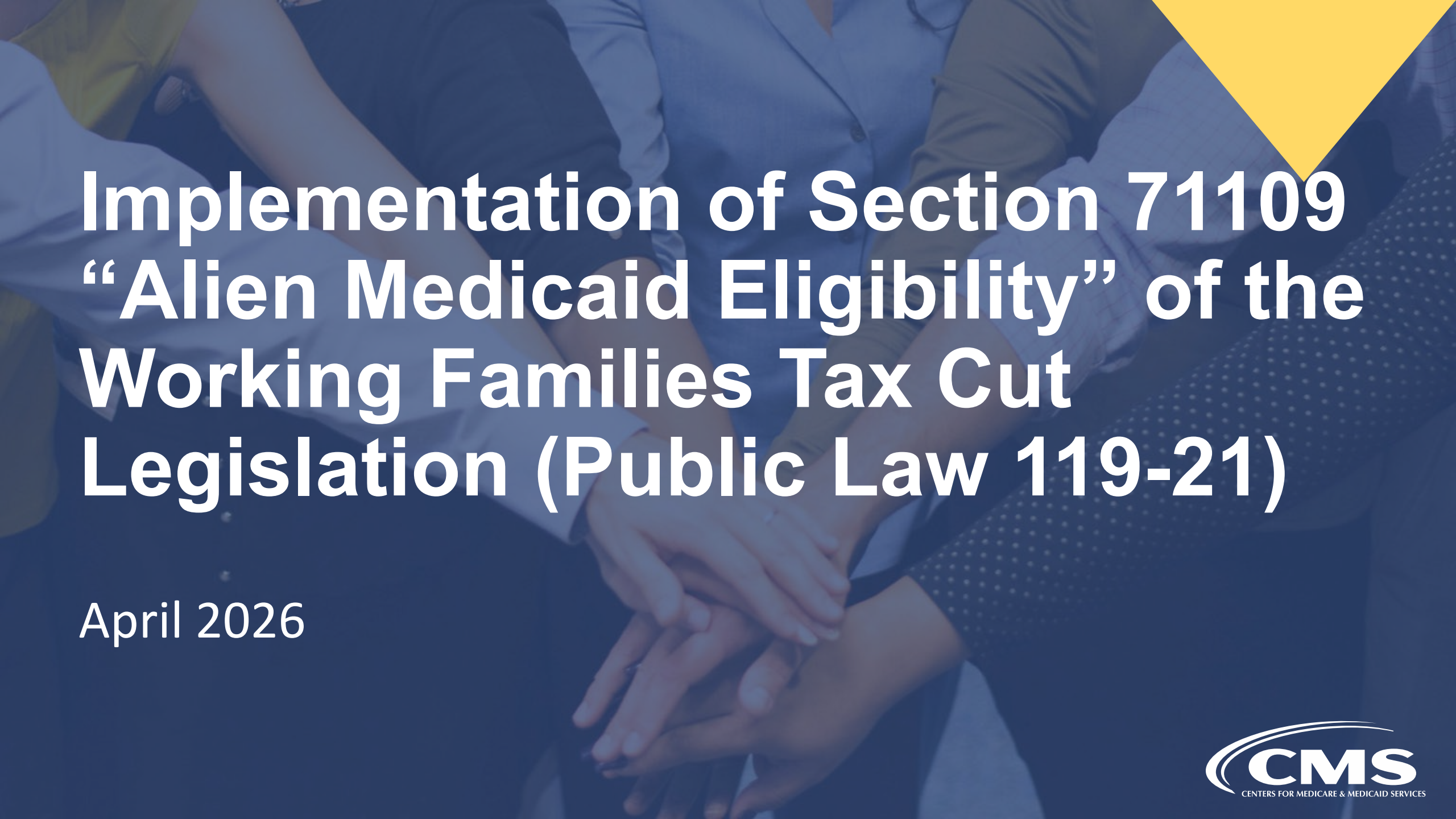
Statute, regulations, and guidance governing requirements of the Medicaid, CHIP, and/or BHP program(s) are constantly evolving. In response, State Medicaid Agencies (SMAs) need to review and make necessary adjustments to their policy, operations, and Medicaid Enterprise Systems (MES) to ensure compliance with new or updated Medicaid policy. As states review and assess new releases from CMS, identifying and understanding the impact these changes will have on state systems is critical to their ability to conduct proactive project planning and ensure program compliance.

To assist states with their implementation and planning efforts, CMS developed the timelines linked below to reflect key provisions with policy or technology requirements for selected final rules and statutes that may require changes to state MES. These timelines are not inclusive of all regulatory provisions, nor are they inclusive of all regulations or statutes that may impact the Medicaid and CHIP programs, but instead focus on ones that might have potential systems impacts. Because each state Medicaid agency is unique, and these actions may impact each state and territory differently, this timeline is only meant as an illustrative reference guide and outlines key provisions in the selected statutes and final rules. States should review the final rules and/or statutes for a comprehensive list of provisions, and the content in each final rule is the official record. States should also review the applicability charts published as reference guides for each final rule for a full summary of all applicability dates for the final rules.

Overview of Current and Upcoming Compliance Dates

[High-level timeline view](#)

[Detailed timeline view](#)



Implementation of Section 71109 “Alien Medicaid Eligibility” of the Working Families Tax Cut Legislation (Public Law 119-21)

April 2026

Overview of Section 71109 (1/2)

Beginning October 1, 2026, section 1903(v)(5) of the Social Security Act¹ (the Act) restricts, with limited exceptions, FFP for non-emergency medical assistance under title XIX (Medicaid) and for child and pregnancy-related health assistance under title XXI (CHIP) to the following groups, provided the individual meets all other eligibility criteria:²

- U.S. citizens and U.S. nationals
- LPRs (“green card holders”)
- Cuban/Haitian entrants
- Compacts of Free Association (COFA) migrants

Key Definitions:

FFP-eligible noncitizens = LPRs, Cuban/Haitian entrants, and COFA migrants, as described in sections 1903(v)(5)(B)(ii) - (iv) of the Act.³

Full Medicaid and CHIP benefits = full Medicaid benefits, partial or limited Medicaid benefits (e.g., only family planning services, Medicare Savings Programs (MSPs)), and CHIP coverage; it excludes Medicaid payment for the limited coverage of an emergency medical condition (“emergency Medicaid”) provided under section 1903(v)(2) of the Act.

States = The 50 states, the District of Columbia, and all U.S. territories, unless otherwise specified.

1. Added by section 71109 of the WFTC legislation and made applicable to CHIP through section 2107(e)(1)(R) of the Act.
2. Individuals must be a state resident and meet all other applicable criteria in the state.
3. See SHO page 4, footnotes 10, 11, and 12 for additional information these categories of noncitizens.

Overview of Section 71109 (2/2)

Section 1903(v)(5) of the Act describes three exceptions to the FFP limitations:

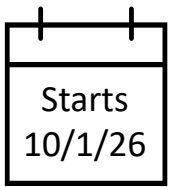
1. Emergency Medicaid, per section 1903(v)(2) of the Act
2. Coverage under the CHIPRA 214 option, per section 1903(v)(4) of the Act¹
3. Health Services Initiatives (HSIs), which are programs designed to improve the health of low-income children, authorized under section 2105(a)(1)(D)(ii) of the Act²

FFP is available under section 1903(v)(5) of the Act for Medicaid or CHIP expenditures provided under these three exceptions.

1. Applicable to CHIP through a cross-reference to section 1903(v)(4) of the Act at section 2107(e)(1)(Q) of the Act.

2. Section 2107(e)(1)(R) of the Act.

Implementation Date for Section 71109 of the WFTC Legislation



- States must ensure they appropriately claim FFP in accordance section 71109 of the WFTC legislation¹ for all individuals **enrolled in or determined eligible** for Medicaid or CHIP on and after October 1, 2026.
- States will need to implement any systems and operational changes necessary to accurately determine Medicaid and CHIP eligibility, provide the appropriate scope of coverage, and ensure proper FFP claiming by October 1, 2026.

1. Under sections 1903(v)(5) and 2107(e)(1)(R) of the Act, including under an exception specified at sections 1903(v)(2), 1903(v)(4), or 2105(a)(1)(D)(ii) of the Act.

Interaction between Section 71109 of the WFTC Legislation and PRWORA (1/2)

- The WFTC legislation did not amend the following sections of PRWORA:
 - the definition of qualified alien and the limitation that eligibility for federal public benefits, including full Medicaid and CHIP benefits, is restricted to qualified aliens; or
 - the applicability of the five-year waiting period or the exceptions.¹
- States must continue to apply the five-year waiting period and exceptions to certain qualified noncitizens (8 U.S.C. § 1613) who are also FFP-eligible noncitizens in Medicaid or CHIP:
 - LPRs are generally subject to the five-year waiting period unless they meet an exception (e.g., five-year bar does not apply to LPRs who are veterans or active-duty armed forces service members or certain family members of such an individual)
 - Cuban/Haitian entrants and COFA migrants are exempt from the five-year waiting period.

1. 8 U.S.C. §§ 1641(b), 1611(a), and 1613.

Interaction between Section 71109 of the WFTC Legislation and PRWORA (2/2)

- CMS will not require states to provide state-only funded health coverage to individuals for whom FFP is not available for full Medicaid and CHIP benefits beginning October 1, 2026 (e.g., asylees, refugees, parolees, and victims of trafficking who are also not FFP-eligible noncitizens and not covered under the CHIPRA 214 option).¹
- States that provide state-only funded coverage to noncitizens for whom, beginning October 1, 2026, FFP will not be available for full Medicaid or CHIP benefits under 1903(v)(5) and 2107(e)(1)(R) of the Act, must implement financial controls to limit FFP claims to emergency Medicaid expenditures, if all eligibility requirements are met.

1. See, e.g., *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17-18 (1981); *Harris v. McRae*, 448 U.S. 297, 30809 (1980); see also *Detgen ex rel. Detgen v. Janek*, 945 F. Supp. 2d 746, 759 (N.D. Tex. 2013), *aff'd*, 752 F.3d 627 (5th Cir. 2014).

Implementation Requirements

- States will need to implement changes by October 1, 2026, to comply with the FFP limitations in section 1903(v)(5) of the Act for individuals who apply for coverage on and after October 1, 2026, and for beneficiaries who are enrolled in Medicaid or CHIP on October 1, 2026.
 - States will need to apply these new requirements when verifying citizenship or satisfactory immigration status to new applicants and current beneficiaries.¹
- Because section 1903(v)(5) of the Act affects certain individuals' eligibility for federally funded coverage, CMS interprets this as a statutory change that may affect an individual's eligibility for Medicaid or CHIP coverage, and states must act promptly on this statutory change.

1. As required under sections 1137 and 2105(c)(9) of the Act, and implementing regulations at 42 C.F.R. §§ 435.406, 435.956, and 457.380(b).

Implementation Requirements: Redetermination of Eligibility of Current Medicaid and CHIP Beneficiaries by October 1, 2026



Identify all potentially affected beneficiaries

Potentially affected beneficiaries include all those receiving full Medicaid or CHIP benefits whose immigration status or category is not LPR, Cuban/Haitian entrant, or COFA migrant, or are not lawfully residing children or pregnant women in states that have elected the CHIPRA 214 option.



Redetermine eligibility based on available information

States must attempt to reverify if beneficiary continues to have a satisfactory immigration status through electronic data sources (i.e., DHS's SAVE program)¹ before attempting to contact the beneficiary.



Request additional information, if needed

If the state is unable to verify satisfactory immigration status electronically, the state must request information from the beneficiary.² If beneficiary responds with a new declaration of satisfactory immigration status and the state is unable to verify such status, provide a 90-day reasonable opportunity period (ROP).³



Determine eligibility for full Medicaid or CHIP benefits

If the state verifies that the beneficiary continues to have a satisfactory immigration status, beneficiary retains coverage.

If information or documentation provided demonstrates the individual no longer has FFP-eligible noncitizen status, or if they do not respond within the time specified, the state must consider all bases of eligibility⁴ and terminate if not eligible on another basis.



Provide Notice

See slide 12.

See slide 12.

1. Department of Homeland Security's (DHS's) Systematic Alien Verification for Entitlements (SAVE) program.
2. And give the individual a reasonable period of time to provide information prior to the state taking adverse action, in accordance with 42 C.F.R. §§ 435.952(b) and (c) (2023) and 457.380(f).
3. As required at 42 C.F.R. §§ 435.956(b) and 457.380(b)(1)(ii).
4. For example, under a state's election under the CHIPRA 214 option and emergency Medicaid.

Implementation Requirements for Current Medicaid and CHIP Beneficiaries – Providing Notice

- If the individual is determined eligible, the state should notify the beneficiary that they continue to be eligible for the coverage in which they are enrolled.
- If the individual no longer has satisfactory immigration status for full Medicaid or CHIP benefits, or does not respond within the timeframe specified, states must provide advance notice of adverse action, including the right to a Medicaid fair hearing or CHIP review before terminating coverage or reducing benefits.
 - For **Medicaid**¹ - States must provide at least ten days advance notice of the proposed termination and an opportunity for a fair hearing
 - For **CHIP**² - States must provide a timely and adequate written notice of the proposed termination and an opportunity for review.

1. 42 C.F.R. §§ 435.917, 435.918, and 42 C.F.R Part 431 Subpart E.

2. 42 C.F.R. §§ 457.340(e), 457.1130(a), and 457.1180 (2023).

Operational and Claiming Considerations

- **Updates to Applications, Renewal Forms and Other Materials**
- **Verification, including Hub Service**
- **FMAP**
- **Financial Systems and Proper Claiming**
- **SPA Submissions**

Updates to Applications

- CMS anticipates that the application modifications needed to effectuate these statutory changes may vary among states.
 - States that prompt applicants to identify their immigration status or document type from a list may need to modify the list to account for the changes to the law.
 - States may need to revise state-specific instructions or help text included in the application.
- In states that have elected the CHIPRA 214 option, application changes may be more limited as the application must continue to collect the necessary information to determine eligibility.

States are **not** required to submit a SPA to CMS to make these changes to their single streamlined or alternative applications.

Updates to Renewal Forms and Other Materials for Medicaid and CHIP

Renewal forms

- States that prompt beneficiaries to identify their immigration status and/or documents on the renewal form from a list may need to modify the list, as well as any instructions, to account for the changes made by this provision.

Other materials

- States may also need to update other Medicaid or CHIP materials to reflect the changes described in the SHO letter. For example:
 - Policy and procedure manuals
 - Eligibility worker training materials
 - Call center scripts
 - Website language

Verification of Immigration Status or Category

- States must electronically verify an individual’s immigration status or category through DHS/USCIS’s SAVE program for all individuals who have declared to have a satisfactory immigration status.¹
- CMS and DHS/USCIS make available three pathways for states to access SAVE.² States may also use a combination of the pathways:
 1. **The Hub** VLP service;
 2. A **direct connection** between the state’s eligibility system and SAVE; or
 3. SAVE’s web-based **GUI**.
- SAVE provides “point in time” verification and does not update past SAVE verification responses when there is a change in immigration status or category.
 - States would submit a new SAVE verification request when redetermining eligibility for potentially affected beneficiaries to obtain the most up-to-date data available.

1. In accordance with section 1137(d)(3) of the Act and 42 C.F.R. §§ 435.956(a)(2) and 457.380(b).

2. SAVE returns a different set of codes depending on which of the pathways the state uses. See page 15 in the SHO for the specific differences in the codes.

The Hub VLP Service

- The Hub interprets the immigration codes received from SAVE to help states determine Medicaid and CHIP eligibility.
- The **Hub v37.1, Version 2** will continue to transmit to states current indicators as well as a new indicator reflecting FFP-eligible noncitizen status for each noncitizen verified by the Hub:
 - citizenship (for individuals with naturalized or derived citizenship)
 - lawful presence (used for Marketplace and the CHIPRA 214 option)
 - qualified noncitizen
 - eligible noncitizen (**new indicator added for FFP-eligible noncitizen*)¹
 - if the five-year waiting period is applicable (only for qualified noncitizens)
 - if the five-year waiting period is met (only for qualified noncitizens, when applicable)
 - the underlying immigration codes received from SAVE

1. See Appendix B in SHO for a summary of the Hub changes to verify FFP-eligible noncitizen status. The Hub will use a simplified term of “eligible noncitizen” for the new indicator, which has the same meaning as “FFP-eligible noncitizen.”

Direct Connection and GUI

- States that connects with SAVE through a direct web services connection or through the GUI would read and interpret the immigration codes and other responses to verify and determine FFP-eligible noncitizen status.
- States may need to update their eligibility logic to utilize the SAVE codes to correctly determine if an individual is an FFP-eligible noncitizen.
 - For example, a state receives data from SAVE confirming an individual's LPR status and grant date, then applies the state's eligibility logic to determine whether the five-year waiting period applies and, if so, whether it has been met.

FMAP

FMAP for Full Medicaid and CHIP Benefits (including under CHIPRA 214 Option)

- Section 71109 of the WFTC legislation did not change the Act's FMAP provisions, but it did affect for whom FFP can be claimed for full Medicaid and CHIP coverage beginning October 1, 2026.¹
- Beginning October 1, 2026, the applicable FMAP and reporting for expenditures for full Medicaid and CHIP benefits and for FFP-eligible noncitizens would generally remain the same as prior to October 1, 2026.

FMAP for Emergency Medicaid

- In general, emergency Medicaid is claimed at the applicable FMAP.
- Section 1905(kk) of the Act² limits the FMAP for emergency Medicaid services to no greater than the state's regular FMAP. This impacts expenditures for claims for the adult group and other applicable eligibility groups, such as the Optional Breast and Cervical Cancer Treatment group.
- Beginning October 1, 2026, the FMAP for expenditures related to services provided to individuals receiving emergency Medicaid will be matched at the state's regular FMAP under section 1905(b) of the Act.

CMS plans to modify functionality in the Medicaid and CHIP Financial System (MACFin) to reflect the appropriate FMAP under section 1905(kk) of the Act for supplemental payments and provide technical instructions to states regarding appropriate reporting.

1. For CHIPRA 214 FMAP policies, see SHO letter #10-006 (issued July 1, 2010) available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/SHO10006.pdf>.

2. As added by section 71110 of the WFTC legislation.

Financial Systems and Proper Claiming

- States should continue to ensure proper claiming and expenditure reporting on the quarterly budget and expenditure reports in the Medicaid and CHIP Budget and Expenditure System (MBES/CBES).
- States may need to update their MMIS and/or other accounting systems to ensure accurate claiming of related expenditures.
- States must be able to identify and isolate administrative costs directly related the administration of the Medicaid program (and if applicable, to CHIP) from state-only health program costs incurred, to ensure accurate reporting of FFP claims and to implement allocation methodologies in accordance with the authority to claim administrative costs.
- CMS intends to continue conducting oversight to ensure state FFP claims for full Medicaid and CHIP benefits and emergency Medicaid comply with federal requirements.

SPA Submission

- CMS expects all states, territories, and the District of Columbia to submit a Medicaid SPA and, for separate CHIPs, a CHIP SPA to update their state plan to be consistent with section 1903(v)(5) of the Act.
 - **States must submit Medicaid SPAs to CMS no later than December 31, 2026**, for an effective date of October 1, 2026.
 - **States must submit CHIP SPAs (for separate CHIPs) to CMS:**
 - For states that have not elected the CHIPRA 214 option for all covered populations, this will restrict eligibility and SPAs need to be submitted **no later than November 30, 2026**.¹
 - For states that have elected the CHIPRA 214 option for all covered populations, by the **end of their state fiscal year**.²

CMS is revising the Medicaid and CHIP SPA templates and will provide additional information in forthcoming guidance.

1. Since these SPAs would be considered a restriction of eligibility, the submission timeframe and public notice requirements at 42 C.F.R. § 457.65(b) are applicable.

2. The SPA must be submitted by the end of the state fiscal year in which October 1, 2026 falls.



State Directed Payments: Ensuring Compliance with Upcoming Regulatory Requirements

CMCS Managed Care Group (MCG)

All-State Call

April 2026



State directed payments Agenda

- Background on State directed payments (SDPs)
- Ensuring Compliance with Upcoming SDP Regulatory Requirements
 - Preprint Submission Timing Requirements
 - Contract Documentation Requirements
 - Other Key SDP Regulatory Requirements
- Q & A

Background

- All of the regulatory requirements outlined in this presentation are existing SDP regulatory requirements found in 42 CFR § 438.6.
- This presentation will not cover regulations that are under development, or the Working Families Tax Cut legislation (Public Law 119-21).
- This is not intended as a comprehensive summary of all SDP regulatory requirements or applicability dates.
- States may reach out to Statedirectedpayment@cms.hhs.gov at any time to receive technical assistance on these or any other SDP requirements.

Preprint Submission Timing Requirements

Current Status: For SDPs that require written prior approval by CMS, States must submit preprints for new or renewal SDPs before the end of the applicable Medicaid managed care rating period. [42 CFR § 438.6(c)(2)(i)]

Key Regulatory Change: “A State must complete and submit all required documentation for each State directed payment for which written prior approval is required under (c)(2)(i) and for each amendment to an approved State directed payment, respectively, before the start date of the State directed payment or the start date of the amendment.” [42 CFR § 438.6(c)(2)(viii)]

Applicability Date: First rating period beginning on or after July 9, 2026.

Impact: SDP preprints, and any preprint amendment, must be submitted in advance of the start date of the SDP payment arrangement.

Preprint Submission Timing Requirements: Illustrative Example

State Example: State X has an annual rating period tied to the Calendar Year (CY). State X wishes to implement a uniform dollar increase SDP for inpatient and outpatient hospital services for the CY 2027 rating period, effective with the start of the rating period, January 1, 2027.

Applicability Date: 42 CFR § 438.6(c)(2)(viii) is applicable for rating periods beginning on or after July 9, 2026. The first rating period for State X that is impacted is the CY 2027 rating period.

Ensuring Compliance: To implement the SDP by the January 1, 2027 start date, the State **must** submit the preprint to CMS **no later than December 31, 2026**.

- If the State misses that submission date, they may submit the preprint at a later date but the start date of the SDP must be prospective.
- For example, if the State submits the preprint on February 15, 2027, the SDP submission start date documented in the preprint must be February 16, 2027 or later.

Note: The timing requirements also apply to **SDP amendments**; if the State wishes to amend an SDP they must do so prospectively.

Contract Documentation Requirements

Current Status: States must document all SDPs as a contractual obligation within the applicable managed care contract(s). [definition of State directed payment, 42 CFR § 438.2(a)]

Key Regulatory Change: For each SDP, States must document all minimum components required under 42 CFR § 438.6(c)(5) for the type of SDP within the applicable Medicaid managed care contract(s), and any changes to the SDP (e.g., SDP preprint amendments) require that the contract be updated accordingly.

Applicability Date: First rating period beginning on or after July 9, 2026.

Contract Documentation Requirements (continued)

Impact: States must include **detailed information about each SDP in the applicable managed care contract(s)**, and contract amendments are needed for any SDP changes. For all SDPs, states will need to document at least:

- The SDP start date and, if applicable, the end date within the applicable rating period;
- A description of the provider class eligible for the SDP and all eligibility requirements;
- Any encounter reporting and separate reporting requirements necessary for auditing the SDP in addition to the reporting requirements;
- A description of the SDP, which the regulations specifies for each type of SDP; and
- Additional documentation requirements are outlined in 42 CFR § 438.6(c)(5)(iii)(A) through (E) for each type of SDP: uniform increases, minimum fee schedules, maximum fee schedules, pay for performance, and population-based or condition-based payments.

Contract Documentation Requirements

Illustrative Example

State Example: State X has an annual rating period tied to the State Fiscal Year (SFY) of July through June. State X wishes to implement a minimum fee schedule for primary care services for the SFY 2028 rating period (i.e., July 1, 2027 through June 30, 2028).

Applicability Date: 42 CFR § 438.6(c)(5) is applicable for rating periods beginning on or after July 9, 2026. The first rating period for State X impacted will be the SFY 2028 rating period.

Contract Documentation Requirements

Illustrative Example (continued)

Ensuring Compliance: In addition to the minimum documentation described on the previous slide (e.g., start and end dates, provider class, and encounter reporting requirements), State X must include the following minimum documentation in the contract describing the minimum fee schedule SDP in SFY 2028:

- The required fee schedule;
- The procedure and diagnosis codes to which the fee schedule applies;
- The applicable dates of service within the rating period for which the fee schedule applies;
- For SDPs that specify **State plan approved rates**, the contract must also reference the State plan page, when it was approved, and a link to the currently approved State plan page when possible; and
- For SDPs that specify a **Medicare-referenced fee schedule**, the contract must also include information about the Medicare fee schedule(s) that is necessary to implement the SDP, including identifying the specific Medicare fee schedule, the time period for which the Medicare fee schedule is in effect, and any material adjustments due to geography or provider type that need to be applied.

Other Key SDP Regulatory Requirements: Effective with the first rating period on or after July 9, 2026

Regulatory Requirements	Provision Summary	Applicability Date
42 CFR § 438.6(c)(2)(vi)(C)(3)-(4)	Payments under population and condition-based SDPs must fully replace the negotiated payment rate between provider and plan.	First rating period beginning on or after July 9, 2026

Other Key SDP Regulatory Requirements: Effective with the first rating period on or after July 9, 2027

Regulatory Requirements	Provision Summary	Applicability Date
42 CFR § 438.6(c)(2)(ii)(D) and (F), 438.6(c)(2)(iv) and (v), and 438.6(c)(7)	Strengthen evaluation requirements for SDPs by requiring states with SDP spending above 1.5% of total capitation payments to submit evaluation results to CMS and post these evaluation results publicly.	First rating period beginning on or after July 9, 2027
42 CFR § 438.6(c)(6)	Require SDPs to be included in actuarially sound capitation rates (i.e., prohibit use of separate payment terms).	First rating period beginning on or after July 9, 2027
42 CFR § 438.6(c)(2)(vii)	Require states to condition fee schedule based SDPs on actual utilization during the rating period and prohibit post-payment reconciliation processes that initially condition payment on historical utilization outside the rating period.	First rating period beginning on or after July 9, 2027

Other Key SDP Regulatory Requirements: Effective with the first rating period on or after July 10, 2028

Regulatory Citation	Provision Summary	Applicability Date
42 CFR § 438.6(c)(5)(v) and 438.7(c)(6)	Establish submission timeframes for documentation of SDPs in rate certifications and managed care plan contracts to require submission no later than 120 days after the start date of the SDP.	First rating period beginning on or after July 10, 2028



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

April 28, 2026



Background on the Children's Behavioral Health Toolkit

- The Centers for Medicare & Medicaid Services is committed to improving access to high quality behavioral health treatment.
- As the largest single source of funding for behavioral health treatment and support services in the United States, 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.
- CMS developed the 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.

Background on the Children's Behavioral Health Toolkit (cont.)

- The main body of the toolkit is divided into four main sections that include actionable state strategies and sub-strategies and, when possible, state examples to demonstrate various implementation options:
 - Section 1: Developing and Supporting Behavioral Health Care Delivery Systems that Can Meet a Range of Children's Needs
 - Section 2: Promoting Early Intervention for Children's Behavioral Health Conditions
 - Section 3: Improving Children's Access to Behavioral Health Care through Service Coordination and Integration
 - Section 4: Increasing the Workforce Capacity for Children's Behavioral Health Services
- The toolkit also includes three appendices to provide supplemental information to states as they consider how to expand their behavioral health coverage for children.

Overview of EPSDT and Behavioral Health

- 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 illnesses and conditions.
- 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.
- 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.

Section 1: Developing and Supporting Behavioral Health Care Delivery Systems that Can Meet a Range of Children's Needs(1/3)

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.

Section 1: Developing and Supporting Behavioral Health Care Delivery Systems that Can Meet a Range of Children's Needs (2/3)

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.
- Covering behavioral health services that account for 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.

Section 1: Developing and Supporting Behavioral Health Care Delivery Systems that Can Meet a Range of Children's Needs (3/3)

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. (cont.)

- 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 for a wide range of behavioral health acute and/or chronic conditions
 4. Services to address urgent and crisis needs
 5. Inpatient care only when medically necessary

Section 1: Developing and Supporting Behavioral Health Care Delivery Systems that Can Meet a Range of Children's Needs (Cont.)

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 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.
- Several states have used HSIs for behavioral health initiatives, including, for example, providing opioid overdose reversal kits and training public school employees to administer opioid overdose reversal drugs.
- 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.

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

This section of the toolkit describes 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.

Section 2: Promoting Early Intervention for Children's Behavioral Health Conditions (Cont.)

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 a beneficiary needs to achieve optimal functioning.
- Implementing a standardized behavioral health assessment tool can help children get access to appropriate diagnostic and treatment services, establish a consistent process for assessment among providers, and ensure transparency and accountability to children and their families.
- State Medicaid and CHIP agencies should work with other child-serving state agencies and stakeholders to select a standardized assessment tool and should collaborate with state and local behavioral health agencies to support provider training, capacity building, and licensure or certification requirements to implement the new assessment tool.

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

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.

Section 3: Improving Children’s Access to Behavioral Health Care through Service Coordination and Integration (Cont.)

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

Designing and implementing a single pathway for accessing behavioral health care can facilitate timely access and reduce 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.

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

- The 988 Suicide & Crisis Lifeline provides access to crisis counselors for individuals who are struggling with mental health, suicide, and/or substance use-related conditions.
- 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.

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

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 reimbursement 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.

Section 4: Increasing the Workforce Capacity for Children's Behavioral Health Services (Cont.)

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 can require a significant amount of time and resources. States can increase the behavioral health workforce by reducing these burdens.

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.
- By participating in interstate licensure portability models and streamlining the credentialing process, states can facilitate behavioral health providers' participation in the Medicaid workforce and enhance availability of services.
- States interested in pursuing these options should assess providers' licensing and credentialing requirements. The state Medicaid agency may need to collaborate with the state legislature to amend related laws or regulations.

Appendices: Behavioral Health Care Tools for States

- *Appendix A: Descriptions of Children’s Behavioral Health Services and Models of Care.* Includes 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 levers are identified.
- *Appendix B: Matrix of Impact Categories for Behavioral Health Strategies and Sub-Strategies.* Identifies various impact categories that could apply to each of the strategies and sub-strategies described in the toolkit. The impact categories (e.g., coverage policy, operational efficiency, etc.) 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.
- *Appendix C: Resources.* Identifies behavioral health-related guidance issued by CMS and other HHS federal agencies that states and stakeholders can leverage in the delivery of behavioral health services for children and youth.

Questions