HHS-CMS-CMCS
September 26, 2024
3:30pm ET

Coordinator: Welcome and thank you for standing by. At this time, I'd like to inform all participants that today's call is being recorded. If you have any objections, you may disconnect at this time. All lines have been placed in a listen-only mode for the duration of today's conference. I would now like to turn the call over to Ms. Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you and good afternoon and welcome everyone to today's All-State Call-In Webinar. I'll now turn to Anne-Marie Costello, our Deputy Center Director, for opening remarks. Anne-Marie?

Anne-Marie Costello: Thanks, Jackie, and hi, everyone, and welcome to today's ad hoc All-State Call. We're hosting today's special All-State Call to ensure that all States are aware of a critical piece of guidance, the Early and Periodic Screening, Diagnostic, and Treatment, or EPSDT, State Health Official letter that was released earlier today.

On today's call, we'll provide a brief overview of the EPSDT SHO letter. We plan to host a more in-depth presentation at the October 15 All-State Call. As you know, the EPSDT benefit provides comprehensive and preventive healthcare services for children under age 21 who are enrolled in Medicaid, and it's critical to ensuring that children and adolescents receive appropriate preventive dental, mental health, and specialty services. This new guidance

affirms CMS's commitment to improving care for children enrolled in Medicaid and CHIP.

As mentioned, today's meeting is intended to provide States with a brief overview of the newly released guidance. Additional detail and slides will be available during the All-State Call on October 15th. If you have questions, please put them in the chat. Because today's call is short, we may not be able to answer all of your questions. We can address the remaining questions during our All-State Call on the 15th.

Before we get started, I wanted to let folks know that we will be using the webinar platform to share slides today. If you're not already logged in, I suggest you do so now so you can see the slides for today's presentation. With that, I'm pleased to introduce and turn things over to Kirsten Jensen, Director of the Division of Benefits and Coverage in our Medicaid Benefits and Health Programs Group, to get us started. Kirsten?

Kirsten Jensen: Thank you, Anne-Marie. Good afternoon, everyone, and thank you for joining us today. As you are aware, today CMS issued a State Health Official letter that discusses policies, strategies, and best practices related to EPSDT. CMS is committed to improving health outcomes for children and youth enrolled in Medicaid by working with States as they comply with EPSDT requirements. Next slide, please.

EPSDT requirements are a cornerstone of the Medicaid program and ensure robust health coverage for eligible children under the age of 21. EPSDT is designed to ensure that children and youth can access the healthcare they need when they need it so that health problems are averted or diagnosed and treated as early as possible.

Section 1905(a)4(b) and 1905(r) of the Social Security Act, entitles eligible children under the age of 21 to Medicaid coverage of healthcare, screening, diagnostic services, treatment, and other measures described in Section 1905(a) that are medically necessary to correct or ameliorate defects in physical and mental illnesses and conditions. And this is true whether or not these services are covered under the State plan for adults.

States have the option of delivering some or all of these Section 1905(a) services through managed care plans, a State-administered fee-for-service system, or a combination of delivery systems. And I will discuss more about managed care requirements more fully a little bit later in this presentation. Next slide, please.

Just as a reminder, Section 11004 of the Bipartisan Safer Communities Act, charged CMS with identifying gaps and deficiencies regarding State compliance with EPSDT requirements, providing technical assistance to States to address such gaps and deficiencies, issuing guidance on Medicaid coverage requirements, including best practices for ensuring children and youth have access to comprehensive healthcare services, and then ultimately issuing a report to Congress.

As many of you know, and you may be participating in activities with our contractor on the gaps and deficiencies in technical assistance side, and then this SHO letter meets the requirements of the Bipartisan Safer Communities Act in terms of issuing guidance that includes best practices. We will continue to provide technical assistance webinars and other forms of technical assistance to States, so that States have the information and support they need to meet EPSDT requirements. Next slide, please.

In the SHO, we detail overall EPSDT requirements and describe how States

are currently implementing these requirements. To better understand States' implementation of EPSDT, we conducted a thorough review of States EPSDT beneficiary informing materials, provider materials, State-managed care contracts.

We held listening sessions with interested parties and reviewed various State coverage and provision of specific services provided under EPSDT. Based on this work, we identified three main topics that are included in the SHO. The first topic is promoting EPSDT awareness and accessibility.

The second topic is Expanding and using the children-focused EPSDT workforce. And the third topic is Improving care for children with specialized needs. Each of these main topics includes subtopics, and in those subtopics, it's where we outline policies and strategies and best practices for States to consider in meeting the requirements as established in those subtopics.

So, the first topic we address is - the first main topic we address is about promoting EPSDT awareness and accessibility. We discussed the importance of helping families and caregivers understand how their children's Medicaid coverage works and how to use their children's benefits. This is an important step to ensure that children get the care that they need.

As said, this section has five subtopics, and they are, EPSDT informing requirements, EPSDT requirements regarding scheduling assistance and transportation, improving healthcare accessibility using care coordination and case management, considering EPSDT and States Medicaid policies and procedures, such as in prior authorization and fair hearings, and meeting requirements related to EPSDT and managed care.

I'm going to take a moment here to talk a little bit about the managed care subtopic here. We know that's one that's of great interest to States and others working in EPSDT. We do lay out in this guidance relevant statutory and regulatory requirements here, and just a couple of high notes here. When a managed care delivery system is used to deliver some or all services required under EPSDT, States must identify, define, and specify the EPSDT services that the managed care plan is required to cover in the managed care plan's contract.

When States include some EPSDT-covered services in their managed care contracts but exclude others, the contract must clearly state that the managed care plan is required to cover all medically necessary 1905(a) services, except those that are explicitly excluded. States should not treat EPSDT as if it only includes screening, as it is a much broader benefit than that.

The State maintains the obligation under the EPSDT requirements to ensure a child receives coverage of any medically necessary 1905(a) service that is excluded from the managed care plans contract. The SHO identifies a number of best practices to help States implement these managed care policies, including how to use and enforce managed care contract language to require managed care plans to actually use best practices. Next slide, please.

The next main topic is about expanding and using the children-focused or EPSDT workforce. And here, we acknowledge the difficulty States have reported in enrolling providers in some regions and for some services and for some specializations. And we discussed some creative ways States have been working to help alleviate some of these issues.

The four subtopics included in this workforce section are about broadening provider qualifications using telehealth, encouraging the use of

interprofessional consultation where appropriate, and using payment methodologies to incentivize EPSDT provider participation.

Just, you know, highlighting an example here in the broadening the provider qualification subtopic, we note that States have broad flexibility in establishing reasonable provider qualifications related to the fitness of the provider to perform the services. And States can also require that managed care plans use network providers that meet these standards. States may expand the range of existing providers of Medicaid-covered services by providing training and support to expand the pool of available providers.

And we also talk about a best practice where States can support and incentivize general practitioners to serve younger children, and the particular example we used was around increasing availability of dental practitioners, where one State provided training, support, and enhanced payment to general dentists to increase their ability to serve younger children. And in this case, you know, the youngest children in a dental practice may require some specialized instruments and behavioral support and such. And this practice, while it highlights dental services, we do believe it could be expanded to other providers as well.

The third big topic that we discussed is about improving care for children with specialized needs. This is obviously of high interest to many people. The three subtopics in this space is about focusing on children with behavioral health conditions, children in foster care, and children with disabilities or other complex health needs.

Given the complexity of these subtopics, we'd like to take some time to provide a little bit more information about each one, because these are obviously very, very important. Under the subtopic on children with

behavioral health conditions, we acknowledge that delivering mental health and SUD treatment services poses challenges unlike those in other areas of care, and we have identified policies, strategies, and best practices to help States ensure they are meeting these children's needs.

We note in the policies - sorry, I forgot to advance the slides there. I apologize. For example, we note in the policies section that consistent with Section 1905(r)5 of the Act, States must provide coverage for an array of medically necessary mental health and SUD services along a care continuum in order to meet their EPSDT obligation.

A service array of behavioral healthcare that is consistent with EPSDT requirements includes, but may not be limited to, screening and assessment, services to build skills for mental health and/or to address early signs or symptoms of concern with or without a diagnosis, 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 community-based services to meet more intensive needs, services to address urgent and crisis needs, and then inpatient care only when medically necessary.

It helps States ensure that they are meeting all of the requirements discussed in the SHO under this subtopic. We identify the best practice to create a seamless and comprehensive behavioral health system for children. And again, this may not be the solution for every State, but we are highlighting best practices where we are trying to help States identify areas where they can use the best practice, use parts of the best practice, or come up with other ideas to help enhance the service availability for mental health and substance use services in their State.

One State created a behavioral health system that provides a seamless and comprehensive array of behavioral health services with a single point of entry. The State Medicaid agency establishes payment and coverage policy, pays for services, and creates and monitors a contract with an administrative services organization, or an ASO, for which the State claims federal administrative match.

Among other things, the ASO provides streamlined implementation and coordination of the range of youth behavioral health services, and acts as a single point of entry to the system through a toll-free number staffed by clinicians who provide assessment and triage, as well as utilization management.

The State uses a range of authorities, including Section 1905(a) of the Act, which is required as part of EPSDT, but they also look at using other State plan authorities, such as 1915(i) and Section 1115 demonstration opportunities, to really enhance that care continuum in their State.

I'd also like to note here that children with intellectual and development disorders may also have a co-occurring mental health or substance use disorder, and should receive treatment for those disorders as well. There should be no barriers to them receiving appropriate care.

Children in foster care. So, children in foster care represent less than 2% of all children enrolled in Medicaid, and they are an especially vulnerable population whose safety and well-being are the legal responsibility of the State. Children in foster care have higher rates of physical and behavioral healthcare needs compared with children without a history of foster care involvement, and they may not live close to their home communities, or may move from place to place, and this disrupts their relationship with primary

care, dental, and other providers.

So, State Medicaid agencies can work with the State child welfare agency to identify and address the priority needs for children in foster care in their State, and to ensure that they have access to Medicaid-covered services to which they are entitled. This is especially important because within a few days of placement in foster care, or a statutorily obligated, State should ensure that children receive an initial assessment of acute physical and behavioral health needs, followed by a comprehensive visit similar to a well-child visit. There's further detail available in the SHO about this topic.

And finally, children with disabilities or other complex healthcare needs. We note that these children often have a combination of functional limitations, chronic health conditions, ongoing use of medical technology under high resource need and use, and usually require a robust set of Section 1905(a) services provided by primary care and pediatric subspecialists, as well as numerous therapists or other kinds of providers.

To meet EPSDT obligations and the needs of children with disabilities or other complex health needs, States should, for example, have an adequate number of enrolled providers, and managed care plans should have a sufficient provider network, including pediatric specialists and children's hospitals wherever possible, to deliver Section 1905(a) medically necessary services.

Because children with disabilities or other complex health needs can often require specialized care not available close to home, States and managed care plans should have clear procedures on how to access out-of-network and out-of-State providers and to ensure that EPSDT-eligible children receive timely access to these services.

And additionally, while doing so is not required under EPSDT, States may develop approaches to cover services in addition to those covered under 1905(a) for this population given the level of disability or other complex healthcare needs and in an effort to, you know, further integrate these children in the home and community or help them return to their community.

So, States often will establish Section 1915(c) home and community-based waivers or establish services under home and community-based services under Section 1915(i) of the Act. And we note that when providing services to EPSDT-eligible children under these authorities, States must determine whether any medically necessary services included on a child's home and community-based services person-centered service plan are coverable as Section 1905(a) services under EPSDT obligations, before covering them under a 1915(c) home and community-based waiver program, or under a State plan option such as 1915(i).

And so, as a result, any 1915(c) waiver program services and State plan 1915 services that could be covered under Section 1905(a) benefit, must be covered first as a Section 1905(a) service for the EPSDT-eligible children. Next slide, please. In conclusion, the collective effort and shared commitment of CMS, State Medicaid agencies, healthcare providers, is necessary and essential in advancing the coverage goal of EPSDT.

We want the right care, the right child at the right time to help ensure children in Medicaid have the opportunity to reach their full health potential. We will continue to host periodic technical assistance webinars for States, and we encourage States to reach out with questions or tailored assistance requests by emailing the EPSDT mailbox, which is in the SHO letter, but it is EPSDT@CMS.HHS.gov.

And we encourage you to also come to our next full-time webinar on October 15th. We will further describe more details from the guidance. And for States that are participating in our EPSDT contract, we'll also be discussing this SHO toward the end of October, and that date is to be determined, but probably sometime in the last week of October. So, with that, I will pass it over to Jackie, and we'll see if we have time for some questions and answers.

Jackie Glaze: Thank you, Kirsten, for your presentation. So, as Kirsten indicated, we do have time to take a few questions, and we'll just be using the chat-only function today. So, please start entering your questions, and then we will take them now. So, I'll turn now to you, (Krista).

(Krista): Thanks so much, Kirsten and Jackie. I'm seeing one question in the chat. Do you have suggestions for providing EPSDT and other screenings to juvenile justice youth?

Kirsten Jensen: Sure. This is Kirsten Jensen. As you know, we recently issued guidance on Section 5121 of the CAA, and that guidance is mandatory and effective 1/1 of 2025. And we are working with States - oh, and I'm being told it's the State Health Official letter 24-004. We are working with States at the moment to implement those provisions.

And in terms of best practices for how to provide screenings for those children, I think we'll have to maybe get back to you with some of those ideas, or we'll be reaching out to each State to talk to each State about their progress in meeting those provisions, and we can talk about some ideas there.

But under that guidance, in terms of providers that can provide those services, we're very flexible. They can be providers in the carceral system or providers

in the community, and screening is required as part of that provision. So, I'd say more to come. We just did an All-State Call on that topic Tuesday of this week. And so, that All-State Call should be available on our Web site as well fairly soon, if it's not already up.

(Krista): Thank you so much, Kirsten. At this time, I'm not seeing any additional questions in the chat.

Jackie Glaze: We'll give it another minute or two and see if we receive any more questions, and then we'll close out for the day. Do others have any questions they'd like to submit? Okay, I think with that, we will go ahead and close out for the day. Again, I'd like to thank Kirsten Jensen for her presentation.

And just as a reminder, we will be having a continued discussion on this topic on the October 15th All-State Call. If you do have questions that come up before our next call, please feel free to reach out to us, your State leads, or bring your questions to the next call. So, we do thank you for joining us today, and we hope everyone has a great afternoon. Thank you.

Coordinator: Thank you. That does conclude today's conference. You may disconnect at this time, and thank you for joining.

END