**HHS-CMS-CMCS**
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Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode. During the Q&A session, if you'd like to ask a question, you may press Star 1 on your phone. Today's call is being recorded. If you have any objections, please disconnect at this time. I'll now turn the call over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you and good afternoon and welcome everyone to today's All State call and Webinar. I'll now to Dan - turn to Dan Tsai, our Center Director for opening remarks, Dan?

Dan Tsai: Thanks, Jackie. Good afternoon everybody. Welcome to today's All-state call. We've got two topics that I'll quickly tee up and then turn it to our subject matter leads. But first, we're going have Dr. Jessica Lee, our Chief Medical Officer, provide some important updates on options for Medicaid coverage for firearm safety, counseling, and violence prevention-related services and reports. That was announced as part of an executive order released in September, and it really highlights some avenues that exist, options for state coverage, the counseling side for firearm safety and prevention on that.

And then second, as many folks know, we released a guidance 2.5 weeks ago,

cutting my days, on EPSDT, Early and Periodic Screening Diagnostic and Treatment, a state health official letter. We were directed by Congress to assess kind of the lay of the land and to put out that guidance. And our team will walk through that.

As I think folks know, EPSDT is a pretty special statutory construct that basically says that kids are entitled to comprehensive preventative health care services and other treatment services required that across the program. The words on that are much more specific, and the guidance outlines a lot of our interpretation for what that means and how to think about that in varying contexts -- behavioral health, kids with complex medical conditions 00 things of that sort. It's really important. It also has real operational things on the ground for states that we're well aware of. And so, we're looking forward to a lot of dialog and partnership on that. And Kirsten Jensen, who's the Director of our Division of Benefits and Coverage Group, will go through that before we get started.

As usual, you can log into the Webinar platform to share slides if you're not already logged in. I suggest you do so now, and you can see the slides for today's presentation and also submit questions as well. So, with that, I'm going to turn it over to Dr. Jessica Lee to get started on the first topic. So, Jessica, over to you. Thanks everybody.

Jessica Lee: Thanks so much Dan and thank you all for joining us. I'm going to give a very brief overview of Medicaid coverage of firearm safety counseling and violence prevention-related services and support and point to where you can get more resources. Next slide, please.

Firearm injuries and deaths are a significant public health problem causing more than 48,000 deaths in 2022. In September of this year, the administration

released an executive order to accelerate progress on two priorities, combating emerging firearm threats and improving school-based active shooter drills. There are also additional actions announced in the accompanying fact sheet which included these Medicaid items.

The US Surgeon General also issued an advisory declaring firearm violence to be a public health crisis, and there's a lot of different resources on that Web site as well. The Medicaid program gives states tremendous flexibility to tailor their benefits to best serve the needs of their populations including ways to prevent violence and support beneficiaries who have experienced violence. Next slide please.

Just highlighting how important this is, recent data showed that firearm injuries are now the leading cause of death for children and adolescents surpassing motor vehicle crashes in 2020. Given this, we want to review a range of services states can cover to prevent firearm-related injuries. Next slide please.

Medicaid provides for coverage of anticipatory guidance, which is health education and counseling to help parents and caregivers understand and improve the health and development of their children. As a result, states may reimburse for a healthcare provider counseling parents on firearm safety and injury prevention. For example, Bright Futures, the American Academy of Pediatric Guidelines, includes firearm safety guidance, such as safe storage guidance, as recommended anticipatory guidance for pediatricians to provide to parents. There are also other provider resources on how to frame these conversations with a focus on safety.

Next slide please. CMS has previously prevented guidance on opportunities under Medicaid to cover violence prevention-related services and supports,

such as hospital-based violence prevention programs. There are both mandatory and optional state plan benefits that could be helpful in covering violence prevention or related services, such as other licensed practitioner benefits, the preventive services benefits and the rehabilitative services benefits. These benefits are also part of the Early and Periodic Screening Diagnosis - Diagnostic and Treatment, or EPSDT, requirements that you'll hear more about on this call in general.

Health home services, home and community-based service waivers and state plan authorities and 1115 demonstrations may also provide states with flexibilities and opportunities for violence prevention services.

I'll end with saying that CMS stands at the ready to provide technical assistance to states who want to strengthen their violence prevention strategies and that we appreciate your continued partnership. And with that, I'll turn it over to Krista.

Krista Hebert: Hi everyone. I am Krista Hebert, and you may know me from my role in facilitating the all state calls. However, I've stepped into a new role as the Acting Deputy Director in the Division of State Coverage Programs which oversees the Children's Health Insurance Program, Basic Health Program, and the Connecting Kids to Coverage Grants here at CMS.

Before we get started on today's EPSDT presentation, I want to make a quick announcement that beginning in 2025, we will be highlighting the EPSDT show as a way to reinvigorate the Children's Coverage TAG, otherwise known as CCTAG.

CCTAG was established to provide a forum for open dialog and policy discussion and for states and territories to offer CMS feedback on issues

related to children's health in Medicaid and CHIP. Meetings address technical and operational issues related to Medicaid and CHIP policy, enrollment, EPSDT, quality measurement, health outcomes, and financing with a focus on learning and sharing best practices across states. The CCTAG also helps to inform and advise CMCS as we develop policy and prepare guidance on issues impacting children's coverage.

A new calendar series will be sent out to the CCTAG listserv and be published on our Web site soon. If you would like to be added to the listserv, please send us an email at cctags@cms.hhs.gov. With that, I'll turn things over to Kirsten Jensen to get started on today's EPSDT presentation. Kirsten?

Kirsten Jensen: Thank you Krista and good afternoon and thank you for joining us today to everybody who's on this call. Next slide please.

As you know, last month we issued a state health official letter on EPSDT and best practices to hearing to EPSDT requirements. Today I'll provide a detailed overview on the contents of that show. We recognize that this show included a tremendous amount of material and then we expect it may take some time, now even some time with some glide paths, for states to make progress towards implementing changes in their program.

As you know, EPSDT entitles eligible children to a full range of services that include prevention, screening, diagnostic and treatment services, and is ultimately a cornerstone of the Medicaid program to ensure that children receive robust healthcare coverage. Under EPSDT rules, states are required to provide these services to children under the age of 21 who are enrolled in Medicaid and who are eligible for EPSDT.

However, states have the option to cover a package of services that adhere to

Medicaid EPSDT requirements for beneficiaries who are enrolled in a separate CHIP. And currently 16 states have elected this option.

CMS is committed to improving health outcomes for children and youth enrolled in Medicaid and CHIP by working with states as they comply with EPSDT requirements. This includes offering technical assistance and Webinars for states that the CCTAG that Krista was just talking about, for states that are participating in our activities that we're undertaking with NORC. We will have a number of different opportunities under that - under those - under that contract to provide technical assistance and learning opportunities for - and also for states to talk with other states. Next slide please.

EPSDT requirements were added to the Social Security Act in 1967 and requires states to inform eligible beneficiaries and their families about the availability of EPSDT to cover screening, diagnostic, and treatment services and to report annually to CMS information about services provided under EPSDT. EPSDT statute requires states to cover comprehensive services which includes all services that could be covered under Section 1905(a) in the Act that are needed to correct or ameliorate health conditions for EPSDT-eligible children. So this includes both the mandatory 1905(a) coverage categories and the optional 1905(a) coverage categories.

And so this means if an EPSDT-eligible child has an ear infection, a broken arm, a vision change, or a mental health episode, or if an EPSDT-eligible child has an intellectual or developmental disability, for example, the state must cover medically necessary Section 1905(a) services from a qualified provider to correct or ameliorate the condition regardless of whether the condition was present and identified during a well-child visit.

States can deliver some or all of these services through managed care plans or through a fee-for-service delivery system or a combination of the two. And regardless of the delivery system, the state retains ultimate responsibility for assuring compliance with EPSDT requirements. Next slide please.

As was mentioned, there was some statute passed in 2022 called the Bipartisan Safer Communities Act and just wanted to review what was included as part of that Act. One aspect of the Act was to identify gaps and deficiencies regarding state compliance with EPSDT requirements. We've done a lot of research in the background on that particular topic, provide technical assistance to address such gaps and deficiencies. And we are actively engaging in that with our contractor and will continue to be available to provide states with technical assistance.

We were required to issue guidance on Medicaid coverage requirement, including best practices for ensuring children and youth have access to comprehensive health care services. The EPSDT show that we issued is meeting this requirement. And finally, we will be issuing a report to Congress on the activities, findings and actions taken based on the review of the findings. Next slide please.

For some states implement EPSDT in varying ways due to different Medicaid program designs, payment methodologies, delivery systems, and state licensure laws and regulations. And given that, to better understand how states are operationalizing EPSDT requirements and to identify best practices for the EPSDT show, we reviewed EPSDT documents, held listening sessions with interested parties, and reviewed various states' coverage and provision of certain services provided under EPSDT. And this was all as part of the direction that we undertook from the Bipartisan Safer Communities Act. Next slide.

So looking, you know, both at the work that's - that we have done to date and 2025 and beyond we wanted to just remind folks that we are providing quarterly technical assistance Webinars on various topics. Our next one will be at the end of October, on October 29, and we will dig into state questions about this guidance. We are also providing one-on-one technical assistance with states.

We will be beginning reviews of selected states, EPSDT implementation. This will be a total of ten states over the course of three years. We will also be issuing a Children's Behavioral Health Toolkit and issuing an update to the EPSDT Coverage Guide which I know a lot of states find very helpful when implementing their programs. Next slide please.

And we are working on an awful lot of other initiatives related to children and access to services. We are working with the Department of Education to expand school-based health services. We are supporting states' implementation of the requirements in the access regulation. We're providing states with support as they prepare for the first year of mandatory reporting on the Child CORE set of quality measures for Medicaid and CHIP. And we're providing technical assistance, the new Certified Community Behavioral Health or CCBHC services for states that was added as an optional 1905(a) benefit. Next slide please.

But as I mentioned previously, today we would like to focus on the show that we issued which is number 24-005. And this show identifies best practices for adhering to EPSDT requirements. I hope at this point you've had some time to read it and become familiar with it.

So this slide just details the outline of the show which starts with an overview

of EPSDT requirements that lay the groundwork for the policies and best practices we describe later in the letter. We broke the topics into three main topics. The first one is promoting EPSDT awareness and accessibility, the second one is expanding and using the children-focused workforce, or EPSDT workforce for short, and the third is improving care for children with specialized needs.

Within each of these three topics, they're further broken down into subtopics and it's within these subtopics where we describe the specific policies, strategies, and best practices. And I'll talk a little bit more about each of these a little bit later in the presentation. Next slide please.

So as I just mentioned, this is the outline within each of the subtopics and I'll skip over the overview at this point and so that I can discuss the next section on maximizing healthcare access and improving health outcomes. Within various topics and subtopics of this section we identified relevant policies, strategies, and best practices based on our research and used tables like the one here shown to present this information.

We hope that you have found it helpful in the way that we've grouped this information together so that it's written down in one place with - where CMS has defined the policies, applicable statutes, regulations, interpretations of these statutes and regulations. The strategies are examples of how states are currently meeting these federal requirements, and the best practices sections are modeled strategies that states can use to potentially meet federal requirements. Next slide please.

Under the first topic, 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 as an important step to ensure that children get the care that they need. This section consists of five subtopics identified here, including, for example, using managed care to improve awareness of and accessibility to services available under EPSDT.

For the presentation today, I'll provide a high-level overview of the policies relevant to each subtopic in the show, And for the purposes of time, we'll highlight one of the best practices we identified for each subtopic. However, I want to make sure to note that the show includes a wealth of strategies and best practices for each of the subtopics. So we encourage you to continue to review the show for additional ideas on how to implement EPSDT. Next slide please.

Under our first subtopic, improving awareness of available services through EPSDT informing requirements, we note the EPSDT requirement that states must use a combination of written and oral methods to inform beneficiaries and their families about the services available to EPSDT-eligible children.

One of the best practices we identified to meet this requirement is to use clear language in provider and family handbooks to describe the breadth of services available under EPSDT. For example, our review found provider handbooks that included statements such as, services are covered even if the services are not covered for adults. Or, another example, child beneficiaries are entitled to a broader scope of services than adults. This kind of clear language can help ensure EPSDT-eligible children and their families understand the entirety of services available under EPSDT and that the use of the EPSDT acronym is not required to request these services. Next slide please.

In this slide, we'll be talking about providing required EPSDT support services. We focus on how scheduling assistance and transportation can help

promote EPSDT awareness and accessibility. The scheduling assistance, we note that federal regulations require state Medicaid agencies to offer necessary assistance with scheduling appointments or services.

To meet this requirement, one state requires managed care plans to provide a proactive outreach and assistance to members, including requiring the managed care plans to inform their members about services available under EPSDT requirements. In some cases, these managed care plans are contractually required to use information from the Medicaid agency's monthly data retrieval to identify all enrollees who are due or overdue for a well-child visit. These enrollees are then contacted by their respective managed care plans and assisted with scheduling the service as soon as possible.

While this best practice was identified in a managed care delivery system, proactive outreach and scheduling assistance has been implemented in fee-for-service and could be modified for use by states with primary care case management as well. Next slide please.

For transportation, states are required to ensure every Medicaid beneficiary who has no other means of getting to an appointment has access to transportation and needed to receive covered care. States must also inform EPSDT-eligible children and their families that this assistance is available. To fulfill these requirements, one state uses a transportation broker model to increase oversight of the transportation benefit and to simplify the process for beneficiaries.

Initially, the new system caused significant disruption due to increased demand but ultimately led to improved access and dramatically reduced costs per trip. Under this mode, the broker is paid a fixed monthly risk-based payment for all eligible beneficiaries, and the contract includes a performance

withhold of 3% contingent on the broker's service delivery performance scorecard. Additionally, the broker is required to provide data dashboards that allow the state to review near real-time trip details and to develop an app for beneficiaries to use to schedule trips. Next slide please.

States can also promote EPSDT accessibility and can improve health care continuity by using care coordination and case management. While Medicaid regulations do not define care coordination, states can cover it if it meets the definitions and requirements of existing Medicaid authorities. We often see this covered as part of a rehabilitative service, for example.

Case management, on the other hand, is a Section 1905(a) service in Medicaid. And while not every child needs case management, every EPSDT child must have access to case management when it is medically necessary. One state's best practice for using care coordination to improve EPSDT accessibility is to provide that coordination on a tiered basis depending on a child's level of need.

For children with typical care coordination needs, managed care plans deliver limited care coordination. For children who need moderate or intensive care coordination, the state utilizes community-based care management entities whose care coordinators develop a care plan that is guided and driven by the child and their family. This level of care coordination is more extensive and frequent and involves links to services and resources and coordination with providers. Care management entities, in this example, have a number of responsibilities including identifying the formal and informal resources in their geographic area so they can be incorporated into care coordination plans. Next slide please.

A critical component of ensuring EPSDT accessibility is ensuring the state's

Medicaid policies and procedures related to medical necessity criteria, prior authorization requirements, and Medicaid fair hearings all take EPSDT requirements into consideration. For example, children entitled to EPSDT must have access to services that can be covered under Section 1905(a) of the Act when those services are necessary to correct or ameliorate an identified medical need.

As a result, a limit on the amount, duration, or scope of a service that cannot be exceeded is not - by medical necessity, is not permitted to apply to any service covered under EPSDT. You'll hear us talk sometimes about there can be no hard limits on EPSDT services, and that is what this bullet is referring to.

While states may impose and permit managed care plans to utilize utilization controls like prior authorizations or a medical necessity review, these utilization controls 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.

States must also have oversight of their fair hearing systems to ensure fair hearing decisions apply at all relevant requirements, including EPSDT's correct or ameliorate standard. In this show, we've identified a number of strategies and best practices in this area. But one to highlight here, the best practice of regularly reviewing decisions for prior authorization requests, managed care appeals, and state fair hearing requests for clinical appropriateness.

One state, upon evaluating data and decisions for prior authorization requests, decided to eliminate the requirement for prior authorization for certain services, while keeping the prior authorization process intact for other

services. States can perform the same type of review to ensure prior authorization processes are appropriate across managed care plans, and states have a variety of oversight mechanisms including state audits, post-payment reviews, reviews by external quality review organizations. And these can be used to ensure prior authorization requests and claims denials are clinically appropriate. Next slide please.

The majority of states deliver care through a managed care delivery system, and an overwhelming majority of children receive some or all care through managed care. Given that, our next subtopic focuses on using managed care to improve awareness of and accessibility to services available under EPSDT. The EPSDT policies applicable to services delivered in a managed care delivery system can be complex to navigate.

The 2024 Medicaid and Children's Health Insurance Program Managed Care Access Finance and Quality Rule, or otherwise known as the 2024 Managed Care Rule, will require states to implement additional policies in the coming years. This show includes a comprehensive summary of these policies to help states navigate these requirements. For the purposes of this presentation, we highlighted just a few of the policies here.

For example, we note that when states use managed care plans to deliver some or all EPSDT benefits, states must clearly delineate the managed care plan's responsibilities in the managed care contract to help ensure that the managed care plans understand the full scope of their obligations under EPSDT. EPSDT standards also require managed care plans to make determinations of medical necessity for services delivered to EPSDT-eligible children in a manner that is no more restrictive than what is used in the state's Medicaid program.

The 2024 Managed Care Rule will also eventually require states to develop and enforce appointment wait time standards for routine appointments for several different service categories including, for example, pediatric primary care services.

One of many best practices that states can implement when some or all services provided under EPSDT are delivered in a managed care delivery system include using and enforcing managed care contract language to require managed care plans to use a variety of practices. For example, states can use a managed care contract to implement contacting parents to assist with scheduling a well-child visit, tracking whether children are due or overdue for well-child visits, as well as whether they receive dental checkups in line with timeframes identified in the managed care contracts, issuing sanctions or financial incentives such as incentive arrangements based on the managed care plan's annual reports on pediatric metrics and tracking primary care providers' referrals to dentists. Next slide please.

In the next part of the EPSDT policies, strategies, and best practices section, we look at how states can expand and use the children-focused or the EPSDT workforce. We acknowledge the difficulties states have reported in enrolling providers in some regions and for some services and discuss the creative ways states have been working within federal requirements to expand their EPSDT workforce. Next slide please.

States may expand the range of existing providers of Medicaid-covered services by providing training and export - and support to expand the pool of available providers. One best practice for broadening provider qualifications comes from a state that supports and incentivize general practitioners, in this case general dentists, to serve younger children. General dentists may be hesitant to provide services to children younger than 5 who may require

specialized instruments and behavioral support for dental exams and treatment.

The state supports general dentists in providing services to young children by training the dentists in behavioral techniques and making enhanced payments for the extra time it may take to serve this population. While the best practice was identified with dentists, we believe this practice could also be applied with other providers and services as well. Next slide please.

Under the second subtopic, using telehealth to expand the EPSDT workforce, we further build out some ideas here. We have previously published a telehealth toolkit that assists states more intensively with information about telehealth. And as part of that, we have expressed that states have a great deal of flexibility when it comes to developing coverage and payment parameters for Medicaid services delivered via telehealth. And this includes services provided to EPSDT-eligible children.

States must continue to meet applicable federal requirements related to coverage of the services being delivered using telehealth, but there is broad flexibility for how states decide which services, which providers, which populations, reimbursement methodologies related to telehealth.

One state uses these flexibilities to allow out-of-state providers to deliver services via telehealth under a border status policy. This policy allows certain providers such as providers in the state that physically borders the state and all out-of-state independent laboratories regardless of location to potentially enroll in the state's Medicaid program. All of these providers are subject to the same provider requirements as in-state providers, that the state has figured out how to bring these out-of-state providers into their program. And you can read more about that in the show. Next slide please.

Another approach to expand the EPSDT workforce shortages includes interprofessional consultation. Interprofessional consultation is when a patient's treating physician requests the opinion or treatment advice of another physician or qualified practitioner with specialty expertise to assist the treating physician with the patient's care. This occurs without the patient having face-to-face contact with the consulting practitioner.

Interprofessional consultation services may be covered under a number of Medicaid state plan benefits, and in order to use these services, both the treating practitioner and consulting practitioner must be enrolled in Medicaid or CHIP. One best practice in this area is to adopt evidence-based collaborative care model, one of the components of which is interprofessional consultation.

This model which requires a team of providers has demonstrated success in expanding access in improving outcomes in behavioral health care. Under the model, a primary care provider works with a behavioral healthcare manager who is integrated in the provider's primary care office location. The primary care provider and care manager regularly consult with a psychiatric consultant to collaboratively manage a caseload of children with behavioral health conditions often using telehealth to facilitate. This improves beneficiaries' access to psychiatrists and increases the caseloads that can be managed by a limited behavioral health workforce. Next slide please.

Finally, under the fourth subtopic in this area, we describe how states can use payment methodologies to incentivize EPSDT provider participation. Medicaid authorities provide states with considerable flexibility to develop payment methodologies, which includes payment incentives for services delivered to EPSDT-eligible children.

Under a fee-for-service delivery system, among other things states must assure that their payments are sufficient to enlist enough providers so that care and services are available at least to the extent available to the general population in that area. To attract providers, states commonly set different fee-for-service provider rates in different geographical regions where care may be scarce and managed care plans may negotiate provider payment rates based on specific needs.

States that utilize managed care may require managed care plans to participate in service payment models that intend to recognize value or outcomes over volume of services or that incentivize performance improvement. States and managed care plans may also consider different provider rates based on the age of the child or complexity of care or for pediatric sub-specialists or other difficult to recruit providers. Some states have enhanced fee-for-service provider rates for primary care services for EPSDT-eligible children, while others pay quality incentives based on managed care plans or practice performance on child and adolescent well-child visits quality measures. Next slide please.

Under the third topic of the show, we discuss how children with specialized needs face unique health care issues that may impact their development. Because early detection and treatment in these situations is particularly important for achieving optimal health for children with increased or complex health needs, EPSDT can be a crucial tool in addressing the needs of these children. This topic focuses on three specific groups of children with specialized needs, including children with behavioral health conditions, children in foster care, and children with disabilities or other complex health needs. Next slide please.

Under the subtopic on children with behavioral health conditions, we acknowledge that delivering mental health and substance use disorder services poses challenges unlike those in other areas of care and have identified policies, strategies, and best practices to help states ensure they are meeting these children's needs.

For example, we note in the policies section that consistent with Section 1905(r5) of the Act, states must provide coverage for an array of medically necessary mental health and sub-services along the continuum of care in order to meet their EPSDT obligations. A service array of behavioral healthcare that is consistent with EPSDT requirements includes but is not limited to screening and assessment, services to build skills for mental health and/or to address early signs or symptoms of concerns 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 inpatient care only when medically necessary.

States have an obligation to assess the availability of 1905(a) services to meet EPSDT-eligible children's individualized assessed needs, ensure that there are an array of services to meet those needs, and establish and apply medical necessity criteria. But states do have some flexibility in how they meet this obligation. Next slide please.

One state created a - in terms of best practices, one state created a behavioral health system that provides a seamless and comprehensive array of behavioral health services with a single point of entry to help ensure they are meeting the needs of children with behavioral health conditions. The state Medicaid agency establishes payment and coverage policy, pays for services and creates

and monitors a contract with an Administrative Services Organization 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), and they also have incorporated at other Medicaid state plan authorities such as 1915I and Section 1115 demonstration authorities. And they use all of these authorities to cover a care continuum to meet the behavioral health needs of children with mental health and substance use disorders.

Since adoption of this model, the state's out-of-home placements have been reduced by 60% and most children are able to receive care while remaining in their current living situation. And just as one note here, and this is something I mentioned in the rollout calls is that children - we'd like to make specific note of children with intellectual and developmental disorders, that these children may also have co-occurring mental health and/or yet substance use disorder and should receive treatment for those disorders, and there should be no barriers to them receiving appropriate care. Next slide please.

Under the subtopic on children in or formally in foster care, we note that while children in foster care represent less than 2% of all children enrolled in Medicaid, they are an especially vulnerable population whose safety and well-being are the legal responsibility of the state. These children have higher rates of physical and behavioral healthcare needs compared with children without a history of foster care involvement and may not live close to their home communities or may move from place to place which disrupts their relationship with their providers.

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 ensure that they have access to Medicaid-covered services to which they are entitled. Within a few days of placement in foster care, or as defined under statute, states should ensure these children receive an initial physical and behavioral health assessment and followed by a more comprehensive visit similar to a well child visit. Additionally, the state child welfare agency must develop a healthcare coordination and oversight plan for these children. And in this plan should include input from the state Medicaid agency. Next slide please.

In terms of best practices, in one state with a managed care delivery system, the state enrolls children in foster care into the same managed care plan as other children, but requires each managed care plan to have a foster care liaison and trauma-informed case managers assigned to these children. These dedicated staff coordinate with the state's child welfare agency, Medicaid agency, and providers, and perform additional outreach to and education for foster parents. These case managers also provide transitional assistance as youth age out of foster care or return home. Next slide please.

Under the subtopic on children with disabilities or other complex health needs, excuse me. (Unintelligible). We note that else children often have a combination of functional limitations, chronic health conditions, ongoing use of medical technology, and or high resource need and use. And usually require a robust set of 1905(a) services provided by primary care and pediatric sub-specialists as well as numerous therapists.

To meet EPSDT obligations and the needs of these children, states should for example, have an adequate number of enrolled providers, and managed care

plans should have sufficient provider networks including sub-pediatric specialists - pediatric specialists and children's hospitals, wherever possible to deliver the Section 1905(a) medically necessary covered 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 or out-of-state providers to ensure that EPSDT-eligible children receive timely access to providers.

Additionally, while doing so is not required under EPSDT, states may develop approaches to cover services in addition to those that could be covered under Section 1905(a) with the goal of maintaining children with disabilities or other complex health needs in integrated home - and community-based settings or helping them to return to their community. This includes, for example home and community-based service waivers under Section 1915(c) of the Social Security Act and state-planned home and community-based services under Section 1915(i) of the Social Security Act.

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 recoverable as Section 1905(a) services under EPSDT obligations before covering them under a 1915 CHCBS waiver program or under state plan options such as 1915(i). As a result, any 1915C waiver program services and state plan 1915(i) services that could be covered under a Section 1905(a) benefit must be covered first as a Section 1905(a) service for EPSDT-eligible children. Next slide please.

To ensure children with disabilities or other complex needs receive the care they need, one state coordinates several programs focused on addressing the

needs of these children and youth by locating them all in a single administrative unit to create a cohesive system of care. The state also convenes an advisory council made up of parents of these children and youth, state and county agency staff, advocates and providers to provide insight into the common and challenges that families of these children encounter.

Additionally, the state operates a statewide Section 1915(c) waiver program that provides a broad range of services tailored to the needs of these children. And finally, the state implemented programs to help families navigate the system of care such as paying qualified hospitals for targeted case management provided by a team that includes a provider, a nurse, and a care coordination assistant. Next slide please.

So that was a lot of information, and in conclusion I just want to say that states can help children address and overcome barriers in obtaining their comprehensive health care services by focusing on access and utilizing best practices to help those children get to the services to which they're entitled. The collective effort and shared commitment of CMS, state Medicaid agencies, healthcare providers, managed care plans, and caregivers is essential to help ensure that 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 at epsdt@cms.hhs.gov. And additionally, as I mentioned earlier, for states that are attending the Webinars through our EPSDT contract, we will be discussing this show further on October 29, and we're soliciting questions and topics that can be discussed during this call based on where states would like to dig into topics a little bit more. And that will - you will be receiving that in a separate communication.

And with that, I will hand it off to Jackie Glaze.

Jackie Glaze: Thank you so much Kirsten, for your presentation. So we're ready to take the state's questions at this time. So we'll begin as we normally do by taking your questions through the chat function. So you may begin submitting those now. And then we'll follow by taking questions through the phone lines. So I'll now turn to you, Krista.

Krista Hebert: Thanks so much Jackie. Our first question here is related to the firearm safety counseling and violence prevention presentation. The question is, "Will CMS be covering safe storage devices recommended during a client appointment?"

Jessica Lee: Hey, this is Jessica Lee. So I would that you reach out to your specific state needs so that we can talk about specific state coverage opportunities.

Krista Hebert: Thank you so much Jessica. The next question here is, "Does telehealth expansion include paying for e-consult?" And that's related to the EPSDT presentation.

Kirsten Jensen: This is Kirsten. I think, you know, there may be some specifics around that question, so I'm going to answer generally. But if there are more specifics, please also reach out to your state lead. They will get in touch with appropriate analysts in my division who can assist more fully.

The interprofessional consultation is allowed as part of - you know, as part of guidance that we issued probably about a year, year and a half ago. So if the e-consult meets those requirements, then it could be covered.

But if there are more specifics, that's a very general answer, if there are more

specifics around the question, please do contact your state lead so that we can give you proper technical assistance.

Krista Hebert: Thanks. This next one is also about the telehealth guidance. "Do we expect updated telehealth guidance to extend current flexibilities into 2025 and beyond?"

Kirsten Jensen: We issued a telehealth toolkit in earlier this year, in 2024. And if you search for telehealth on our medicaid.gov Web site, you should get to the page where it's located, and that is our guidance on telehealth that will be for today and beyond. We're not planning on issuing any additional guidance. That is our current guidance post-PHEs.

Krista Hebert: Thanks Kirsten. I'm not seeing any other questions in the chat right now. So, Jackie, maybe we want to turn to the phone line?

Jackie Glaze: Yes, yes, thank you. So (Ted), if you could please provide instructions for registering their questions, and then if you can open the phone lines please.

Coordinator: Yes, the phone lines are now open for questions. If you would like to ask a question over the phone, please press Star 1 and record your name. To withdraw your question, press Star 2. Thank you.

And again, if you would like to ask a question over the phone please press Star 1.

I'm currently showing no phone questions at this time.

Jackie Glaze: Thank you. Krista, are you seeing any questions through the chat?

Krista Hebert: I am not seeing any questions in the chat.

Jackie Glaze: Okay, so we'll give everyone a couple more minutes to see if they have questions, and then we may close early today. So (Ted) and Krista, let me know if there's any questions that you see.

Coordinator: Okay.

Jackie Glaze: Okay, still no questions?

Coordinator: I'm showing no phone questions.

Jackie Glaze: Okay Krista, anything on your end?

Krista Hebert: No, no other questions coming in through the chat.

Jackie Glaze: Okay great. So thank you. So in closing, I do want to thank Jessica Lee and Kirsten Jensen for their presentations today. If you do have questions 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 all for joining us today, and we hope that you all have a great afternoon. Thank you.

Coordinator: This concludes today's call. Thank you for your patience.

Woman: Goodbye.

Coordinator: You may disconnect at this time.

END