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Coordinator: Good afternoon and thank you for standing by. And welcome to the All State Medicaid and CHIP call held on October 17, 2023. Your lines are in listen-only mode until the question-and-answer session of today's conference. At that time, you may press star followed by the number 1 to ask a question. Please unmute your phones and state your first and last name when prompted. Today's conference is being recorded. If you have any objections, you may disconnect at this time.

It is now my pleasure to 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-In webinar. I will now turn to Dan Tsai, our Center Director for opening remarks. Dan?

Daniel Tsai: Thanks, Jackie. Today we are going to talk about a very deeply important and often misunderstood topic, EPSDT. And so hello, welcome to today's state - All State Call. We have the benefit of these all state call forums.

And I think - I'll describe in a sec what the team will walk through on EPSDT, but I - hopefully, our state partners received some advance notice around this

topic and have been able to gather subject-matter experts. If not, we will make sure there are many follow-up discussions around this.

So EPSDT, Early and Periodic Screening, Diagnostics, and Treatment. The core statutory benefit and entitlement for kids in the Medicaid program. The - and I'm going to say more about that in a sec, and I think our state colleagues here are well familiar with that, but The Bipartisan Safer Communities Act passed by Congress not too long ago required that CMS do a range of things on EPSDT, including working with states, identifying a range of gaps or not. And how EPSDT is delivered across the country in the Medicaid program and a range of other pieces, and that the statute directs CMS to do that by 2024.

And so there are a range of things that we, CMS, have begun and undertaken in order to fulfill that statutory obligation, and the discussion today is the kickoff for one set of those things. So EPSDT, you know, in short kids are special within the Medicaid program. As folks know, regardless of what is in the state's - state plan per se, or other authorities, kids are entitled by law to receive any screening, any treatment, any diagnostic care, and again importantly, any treatment that is medically necessary. Those are my words, and there's a formal statutory definition around that.

And for kids under 21, it really helps ensure that there is appropriate not only preventative care across physical health, mental health, dental care, and other behavioral health and such long-term services and supports, but there's also appropriate - medically appropriate treatment required. And I think one of the common misunderstandings on EPSDT is that it's focused just on screening or - and diagnostics.

Oftentimes, EPSDT services in various state systems were called out on a separate line more from the screening and diagnostics side versus core

underlying treatment, mental health services, access to clinicians around - continuing with kids.

And so what our team will go through shortly along with a few of our external partners, will be a little bit of an overview around the EPSDT benefit, what that actually looks like, and some of the examples of what to expect for some future discussion with CMS around that.

Hopefully this is a really important, critical, exciting and also challenging topic that we are diving into but it's really, really important. And so I'm glad that folks are starting that. I acknowledge all the things happening in the world that our state partners, providers, we, everybody is dealing with on the ground. This is also a core statutory entitlement right for kids, and we have congressional direction to do a set of things by 2024.

And so if folks are available, we encourage you to log into the webinar platform where you can see slides. And you can also ask and submit questions at any time during the presentation.

So, with that, I'm going to turn it to folks on our team, Susan, (Annese), Katherine, and Ashley to go through a little bit more on EPSDT, what's to come and there will be a Q&A after that. Thank you so much.

Susan Ruiz: Thank you. This is Susan Ruiz. Next slide, please. So before we get started on our EPSDT refresher, I want to take a minute and address some recent legislation as Dan mentioned.

The Bipartisan Safer Communities Act included these EPSDT provisions, which require CMS to review state implementation of EPSDT, identify any gaps in state implementation, and provide technical assistance to address these

gaps and issue guidance to states and a report to Congress. So we are working to meet these statutory timelines with the ultimate goal to improve children's health care. Next slide please.

So what is EPSDT? EPSDT stands for Early and Periodic Screening, Diagnostic and Treatment and consists of a full range of services that include screening, vision, hearing, diagnostic and other necessary health care services and treatment. We use it to mean the entire 1905(a) benefit package for children and screening is just one part.

It's a mandatory benefit for most individuals under 21 in Medicaid and an optional benefit for separate CHIP programs. It is not an additional program beneficiary have to sign up for.

Some states don't even call it EPSDT, which is fine. CMS does not require use of the acronym. Children's checkup or various state-specific names are commonly used when referring to EPSDT. While child visits, diagnostic services, and any medically necessary services that a state can cover under section 1905(a) of the Social Security Act are mandatory. And of course, the goal is for the right care to be delivered at the right time in the right setting. Next slide.

EPSDT was an early effort at well-child exams to prevent or correct problems early. Until 1989, states could choose to provide additional 1905(a) benefits to children but were not required to do so. Section 1905(a) lists and defines Medicaid by benefit, including those furnished by certain providers but doesn't generally define benefits by condition. So while you'll see physician services and inpatient and outpatient care hospital services, you may not see mention of specific conditions. Next slide please.

As you all know EPSDT isn't just one thing but a wide-ranging benefit for children. Here's the relevant statutory citations that address benefits and administrative requirements which we'll get more into later. Next slide.

So while the goal of EPSDT is to provide the right care at the right time in the right setting, this rests on a broad foundation that begins with the requirements in 1902(a) (43). Families need to know about their benefits in order to be able to use them. This section of statute requires states to inform families about the EPSDT benefit package including in the family's requested language. Transportation and scheduling assistance must be made available as families request it.

States need to address - states need to arrange or provide screening services and arrange for corrective treatment as well as report to CMS annually on the CMS Form 416. The youth foundational blocks ensure that families know about and can access screening services in order to identify and diagnose any conditions and to provide the treatment services the children need. Next slide.

All the bullet points here are included in the statute, a comprehensive and developmental history, a comprehensive unclosed physical, immunizations on the ASIP schedule, lab tests including blood lead testing, and health education. Statute lays out the components of an EPSDT screening, and many people use well-child visit interchangeably with EPSDT screening.

The statute also requires inter-periodic screening, which are screenings that occur off the schedule of well-child visits when medically necessary. States must ensure that children and families know about and have access to screening, which is a key part of EPSDT and a focus of performance measures.

The statute also requires vision services including eyeglasses, hearing services including hearing aids, and dental services including restoration of teeth and maintenance of dental health. Next slide.

While states are required to adopt a periodicity schedule, we don't require states to use any particular one but most states now use Bright Futures. Bright Futures is a widely accepted national guideline developed by the AAP that delineates how often children should be seen and what these visits should contain. Age-appropriate vision and hearing screenings should happen during each well-child visit, and states have separate periodicity schedules for dental care.

Many states use the American Academy of Pediatric Dentistry's guidelines in which a referral to a dentist usually begins at age 1. Check your state's periodicity schedule. Next slide.

When a screening examination including an interperiodic screen indicates the need for further evaluation, the child should be appropriately referred for diagnosis without delay. CMS doesn't define without delay, but states should have guidelines about timeframes and ensure children receive timely care. States must ensure that providers are aware of the referral process and any relevant timeframes. Next slide.

EPSDT is more than a well-child screening. EPSDT requires the provision of all medically necessary services that could be covered under Section 1905(a) of the Act, whether or not the state covers the services for other beneficiaries. These services may correct, maintain, or improve a condition. It is not required that a treatment cure a condition as long as it ameliorates the condition.

Respite care and structural changes like remodeling a bathroom to make it accessible or examples of things a child might need but are not covered under EPSDT or 1905(a). Conversations about EPSDT can be confusing at times because if a state covers a benefit only for EPSDT-eligible children, they likely consider it an EPSDT benefit.

So for example, if your state hasn't opted to cover dental for adults, you may consider it an EPSDT benefit. But if your neighboring state covers full dental for everyone, nobody in your state may think of dental as an EPSDT benefit. From our perspective, if it is a 1905(a) benefit, and it's medically necessary, it must be provided under EPSDT. Next slide.

Medical necessity criteria are determined by the state and are typically based on practice guidelines for the specific medical service. These guidelines should consider the child's individual needs. The treating health care provider makes a recommendation and if there's a difference of opinion, the state makes a decision based on the evidence. Correct or ameliorate is a high standard that's intended to be broad and inclusive.

In many cases, different providers have different recommended courses of treatment. A common misunderstanding is that EPSDT means that any service requested must be improved. This is not the case. Next slide.

States may not set hard limits on services for EPSDT-eligible children. A hard limit is just what it sounds like, a limit that may not be exceeded. Because we require an individualized determination, EPSDT doesn't allow arbitrary limits, whether those are a number of visits limit or a financial cap like some states have for other beneficiaries.

States may set soft limits, which are limits that can be exceeded in some circumstances, like a limit over which prior authorization is required. States may consider cost-effectiveness as one part of the prior authorization process.

EPSDT doesn't require coverage of experimental services, so these may be covered if effective to address the child's condition. EPSDT doesn't require coverage of services not generally accepted as effective or services for caregiver convenience. And of course, children age out of EPSDT when they turn 21.

And here I'm going to hand it over to Annese to provide more information about 1905(a) benefits. So this is my colleague, (Annese Abdullah-McLaughlin) in the division of Benefits and Coverage. Annese? Next slide.

(Annese Abdullah-McLaughlin): Thanks, Susan. Hi everyone, and thank you again for joining our call today. I'm going to round out the EPSDT overview and start with the 1905(a) Medicaid benefits required under EPSDT.

The slide that you're currently seeing is a list of all of the 1905(a) Medicaid benefits. As you'll see, one side is mandatory and one side notes the optional benefits. However, we wanted to make sure to hone in on this point that all of the optional services listed here become mandatory benefits for an EPSDT child when medically necessary.

The following services are not mandated under EPSDT since they are not specifically identified in 1905(a), and exist in other authorities. Those are the 1915(i), which are state-planned home and community-based services, 1915(j), which are self-directed personal assistance services, 1915(k), which is community first choice option, and Section 1945, which is health homes for enrollees with chronic conditions.

In the next few slides, we're going to highlight a few benefits that are high priorities for CMS, and where there have been issues that - with access that are noted from the - for the EPSDT population, excuse me. For these - each of these benefits, we're going to reiterate and reinforce the EPSDT requirement. Next slide, please.

So one of our top focus areas for EPSDT is mental health services. Screening for mental health risks and conditions are included in the Bright Futures' guidelines. CMS recommends a state use age-appropriate, standardized screening form. A full range of mental health services required to correct or ameliorate a beneficiary's condition, including early detection and intervention, must be provided.

Typically, mental health services are provided as a rehabilitative service as defined in Medicaid statutes, and often include community-based type services. However, mental health services can be provided under various other benefits in 1905(a), like inpatient hospital services, outpatient hospital services, inpatient psych under 21, et cetera.

Mental health services include behavioral health services, substance abuse disorders, and other types of mental illness. Mental health service provision to children under EPSDT is a CMS priority. Mental health issues in children have skyrocketed over the past few years.

CMS understands the challenges to meet the need and demand for quality mental health services due to access and provider availability issues. We are committed to helping ensure that children receive adequate and timely screening, diagnosis, and treatment for mental health issues. States can

determine that some services are medically necessary for children and youth without a diagnosed behavioral health condition. Next slide, please.

We are also focused on children with complex health care conditions. Children with these complex conditions have access to various 1905(a) services regularly utilized by this population, such as personal care services, home health, or private duty nursing benefits. However, these children are to receive all medically necessary 1905(a) services.

Additionally, children may receive other services provided under other authorities mentioned on the - on a couple of previous slides, which is 1915(c), 1915(l), 1915(j), and 1915(k) - I mean 1915(i), I'm sorry not 1915(l). 1915(c), 1915(i), 1915(j), and 1915(k).

As previously noted during the Medicaid benefit discussion, these services provided under these authorities are not mandated under EPSDT. However, children who are eligible for both EPSDT and the 1915 service benefit are able to get the 1915 services in addition to the 1905(a) services, and we consider those wraparound services. The reason for the allowance of this is to allow and make sure that children's healthcare care needs are met. Next slide, please.

The last special focus area that I'm going to discuss is non-emergency medical transportation. CMS recently released the Medicaid Transportation Coverage Guide on September 29, 2023. We are very proud of this guide and encourage you all to review and refer to the guide as needed. There is a link in this slide, and you guys will be able to access that once you get a copy. I'm going to just highlight a few important areas today.

Per 42 CFR 431.53, states are required to assure that beneficiaries have transportation necessary to access covered medical services. The Medicaid EPSDT benefit further specifies in 42 CFR 441.62 that states must offer and provide beneficiaries of EPSDT services with the necessary assistance with transportation as required under Section 431.53.

As part of the informing process under EPSDT, states must inform beneficiaries and families in a clear and non-technical manner that necessary assistance with transportation is available. Next slide, please.

Depending on state law, an unmet transportation need may include, One, lacking a valid driver's license or working vehicle; Two, being unable to travel to or wait for services alone; or Three, having a physical, cognitive, mental or developmental limitation. Most states determine whether benefits - whether beneficiaries have an unmet need for transportation by requiring them to self-attest that they need a ride to medical care and have no other means of transportation. Excuse me, so some states require a medical provider to document this at a section. Next slide, please.

Now for the next few slides, I'm going to provide a quick overview of some requirements for EPSDT and the delivery systems for EPSDT services, namely fee-for-service and managed care. So I'm going to start with fee-for-service, and the following statutes and regulations apply. I'll also mention one that does not apply.

So the first one we're going to talk about is state-wideness. So per 1905(a) (1) and 42 CFR 431.50, states must provide that Medicaid services be in effect in all political subdivisions of the state and if administered by them, be mandatory upon them.

The next regulation that is required is free choice of providers. So under 1902(a) (23) and 42 CFR 431.51, states have to ensure that information on free choice of provider is took - that the beneficiaries know that they may choose any provider who is able and qualified to provide them the medical service that they need without restriction.

So comparability does not apply to EPSDT. Comparability per 1902(a) (10) (G) and 42 CFR 440.250(b), basically notes that beneficiaries under - basically, it notes that adults are supposed to receive the services in the same amount duration and scope. However, for beneficiaries under age 21, we noted earlier that they are to receive all medically necessary 1905(a) services regardless of whether the state covers the services in the state plan or not. Next slide, please.

So now we're going to talk a little bit about managed care. So it's important to note that all EPSDT requirements must be adhered to regardless of delivery system. And the managed care beneficiaries are entitled to -- at a minimum -- the same services that are available in the fee-for-service program. And 42 CFR 438.206 notes that the contractor must maintain and monitor a sufficient network of appropriate providers to provide access to services in a timely manner.

If the network is unable to provide the service, then the contractor has to adequately and timely cover the services out of network as long as they remain unavailable within the network. And the contractor is also required to meet the standards for timely access to care. Next slide, please.

Continuing on with managed care. States whose children's services are provided through a - an MCO must ensure that the medical necessary criteria

for an appropriate service is not more restrictive than the medical necessity criteria in the fee-for-service Medicaid state plan.

We will provide more detailed information on subsequent webinars about this, as well as the other topics we talked about as Dan noted initially. But we want to just make sure that the states are providing the EPSDT medically necessary services as required. Next slide, please.

So here we're going to ask you all two poll questions. And if - I'm assuming they can just respond with the answer in the chat, I'm not sure. But I wanted to ask the first question is that CMS defines medical necessity. Is that question true or false? I'll give you a minute or so to answer - a few seconds. Next slide, please.

The answer is false. States define medical necessities. And again as mentioned before, we will talk a little bit more in depth about that as we go on with our webinar series to talk about EPSDT and the requirements per statute and regs. Next slide, please. We have one last poll question.

A state can place soft limitations on the number of behavioral health visits for a child if they also state that coverage of medically necessary services can exceed those limitations based on prior authorization. Is that true or is that false? Next slide, please.

The answer is true. A state can place soft limits with a prior authorization process based on medical necessity criteria on services covered under EPSDT, including behavioral health services.

So that comes - that brings us to the end of the EPSDT overview, and I'm going to turn it over to Ashley Palmer with NORC.

Ashley Palmer: Hi, everyone. My name is Ashley Palmer. I'm a Senior Research Scientist at NORC. And I want to talk to you a little bit about the EPSDT project that NORC is helping to support CMS with, including providing some very high-level overview of some of the results from our first year of the environmental scan. Next slide.

So as I mentioned, NORC is supporting CMS in the activities required under the Bipartisan Safer Communities Act, Section 11004 that Susan talked about earlier today. The project activities include a national environmental scan, which has been our major activity for the first year of the project. And today I'll provide a very high-level overview of the results of the environmental will scan and will provide more information about the results of the environmental scan in future TA sessions.

In this year of the project --- which we're just starting our second year of the project -- we're also going to be doing some case studies or blueprints, which will focus on how 12 states are implementing specific aspects of EPSDT. Those blueprints will be available as examples to other states who are interested in improving those aspects of their benefit and will be used to inform the technical assistance that we'll be providing.

We will also be providing technical assistance which begins with the kickoff of this webinar and that will include one-on-one opportunities, peer learning opportunities, and webinars.

This year we're also going to be writing a report to Congress which was mandated under the Bipartisan Safer Communities Act, which will build on the environmental scan and the case studies and some of the other data collection activities that we've taken on. And we'll be updating the EPSDT, A

Guide for States. In remaining years of the contract, we'll be updating the EPSDT Behavioral Health Services Toolkit and a state - and we'll be providing a state EPSDT profile dashboard. Next slide, please.

So I want to talk to you a little bit today about the environmental scan that NORC conducted in the first year of our contract with CMS. The purpose of the environmental scan was to provide a broad understanding of the current EPSDT landscape for all 50 states, the District of Columbia, and three territories. So we were looking at how states set up their benefits, how they communicate about what the EPSDT benefit is, how information flows between the state, the managed care plan beneficiaries, and other stakeholders.

We did - we conducted some listening sessions to obtain stakeholder perspectives on what's going well and what's not going well, and we did some data analysis which gave us a broader perspective on service utilization for children among some different specific services that we looked at.

And this broad overview of the landscape helped us understand where there are some gaps and also where there are some best practices that other states can learn from. And it's the baseline that we're using to inform the developments of strategies to help you all improve your EPSDT performance. Next slide.

So in this slide, we provide an overview of all of the different data sources that we've reviewed as part of our environmental scan. You can see that we've reviewed a lot of data sources. We reviewed documents from all 50 states, D.C., and three territories, as I mentioned. All the resources that we reviewed were reviewed by two reviewers just to ensure the quality of those reviews and consistency among reviewers.

We started with the state plans to understand how states were administering their different benefits, and we also looked at managed care contracts to understand how states were delineating responsibilities for different benefits among themselves in their managed care plans.

We also looked at beneficiary informing materials and provider handbooks for both the state and one managed care plan in each state. That helped us understand how beneficiaries and providers were informed of their rights and responsibilities under EPSDT. We looked at specialty MCO beneficiary handbooks for any managed care plan that was a behavioral health specific MCO or MCOs that were focused on foster care or children and youth with special healthcare needs.

We also conducted six listening sessions with key stakeholders. Three of those were focused on screening, diagnosis, and treatment. And three of those were focused on behavioral health. And within those categories, we conducted listening sessions with states, caregivers, and legal advocates to obtain their perspectives on what was going well and where the gaps were.

We also conducted some quantitative analysis, which provided a broad perspective on how states were performing EPSDT-related services. Next slide, please.

Here, I just want to talk a little bit about how we selected MCOs to review their materials. As I mentioned, we looked at one MCO in each state. We chose the MCO that had the highest enrollment for a comprehensive MCO, so providing comprehensive services and also for which we could find the materials that we needed to review.

We also reviewed the beneficiary handbooks from all behavioral health MCOs where there was one in a state or foster care or children and youth with special healthcare needs MCOs as I mentioned. Next slide.

So this slide provides some of the key topic areas that we were looking into as we did our environmental scan. So we looked for the description of EPSDT. When we looked for the description of EPSDT, we were specifically looking for the clarity of that description and the breadth of that description.

So we were looking for references to screening, diagnosis, and treatment services all being available under EPSDT. We were also looking for mention of services being rendered when - at an early point in order to identify problems early and being provided periodically.

The EPSDT Guidance and Measurement. In this section, we were really looking more for alignment with the statute, and we were looking for some specific terms in the statute. We wanted to ensure that services were available to correct and ameliorate conditions, for example. And we wanted to make sure that there were no hard limits on services.

In the informing providers and beneficiaries about EPSDT section, we were looking for plain language. We wanted to know that the materials would be easy for a beneficiary to read and understand. We also looked for what languages the information was available in and were those languages appropriate to that state's population.

We were looking for information about beneficiary rights and protections, including information about how to file an appeal or a grievance. We also looked at some specific topics and what was available for behavioral health, dental, transportation, and interpreter services for children.

As we looked at those sections, we were looking at how states and managed care plans were informing beneficiaries and providers about the availability of those services under EPSDT, the process for determining coverage, whether there was enough information in provider manuals and beneficiary handbooks about how to access these services, and whether there were hard limits on any of these services.

And in the special population section, we looked at all of this above that I just spoke about for children with special healthcare needs and children in foster care. Next slide.

So these are very high-level findings and as I said, we'll get into a little bit more detail in future sessions. But some key takeaways from our environmental scan was that every state had some gaps or areas where they could improve in terms of their materials or how they were talking about EPSDT or how they were setting up some of these benefits. And almost every state had some examples of best practices that we would want to put forward to other states and say, "Hey this is something that you should consider because this is an exemplary way of doing this." Next slide, please.

In terms of some examples of things that we would consider a best practice, we were looking for an indication that services should be tailored to the individual and that they should be person-centered and medical necessity determinations should really be based on what the child needed. So when we saw that, we flagged that as a best practice.

We also noted that there wasn't always really clear information about how to access particular services. So we thought that that was also a best practice. And we were also looking for timelines in materials for how soon a diagnosis

should be made or a treatment should be rendered or a referral should be made if - and if there's a positive screen. Next slide, please.

Opportunities for improvement. As my colleagues noted in the earlier parts of the presentation, the way that EPSDT is defined in materials often sort of lacked clarity or was described as being a well-child visit only without that breadth that we were looking for. So that's really a clear opportunity for improvement. And we also would like to see that language just be very clear, so that beneficiaries really know what they're eligible to receive under EPSDT.

We did find some examples of hard limits on services for children, so that's an opportunity for improvement. We also found some inconsistent references to periodicity, which could be confusing for beneficiaries. And there were some states that we could only find materials offered in English, so we want to make sure that the information about EPSDT is accessible to families that speak all different kinds of languages.

And now I will turn it over to my colleague, Katherine Vedete, who will talk a little bit about the technical assistance opportunities.

Katherine Vedete: The next slide. Thank you. So I'm Katherine Vedete. I'm a Senior Research Scientist at NORC and also the Director of this contract for CMS on EPSDT. I'm excited to share - to be here and kickoff our TA offerings to states. Next slide, please.

As Ashley mentioned, CMS is contracted with NORC for a bunch of things, including providing technical assistance to states based on findings from the environmental scan as well as the case studies which we are just starting to get into right now. The goal of the technical assistance to state just is to assist

states with how to inform providers and beneficiaries about EPSDT, which as - Ashley just described in detail is - was the primary we - what we looked at under the environmental scan.

We also want to assist states with implementing EPSDT and the various components of it. Next slide.

So we'll be providing over the next few years technical assistance to states. We'll be offering and hosting quarterly webinars for All State Medicaid agencies. We'll provide one-on-one technical assistance as requested by states. We hope to -- in the spring -- start convening topical work groups of states, so there's an opportunity for peer-to-peer learning.

And we will also be developing resources, a few of which Ashley described, we'll be updating the EPSDT guide for cover - Guide for States, and then also working on Behavioral Health Toolkit.

I want to make sure everybody knows that TA is for All State Medicaid agencies. We hope to identify two to three state contacts who will be the point of contact and those will then be - those state contacts will then be responsible for communicating internally about TA activities and sharing invitations and opportunities as needed. Next slide, please.

So this just prepares everybody for those upcoming quarterly webinars. Our next one will be in November or December of this year, where we'll dive deeper into the environmental scan results. And then quarterly thereafter, we will have other webinars that will - everyone invited to and those topics will be determined. They'll cover a lot of the topics that Ashley just covered in her presentation that we've addressed during the environmental scan and case

studies. So things like well-child visits, mental health, and transportation. Next slide.

So again, very excited to start offering one-on-one technical assistance to states now. If you can - if you want to email this email address, the epsdt@cms.hhs.gov. We'll receive those requests, and we'll follow up. And we can also - we will also - may also be contacting states to offer technical assistance individually. So we'll look forward to hearing from you. And the next slide.

So this is another poll question. If you are able to enter into the Q&A box, we'd love to just get an initial sense of where your state could use assistance regarding EPSDT. We have some options here that are based on the environmental scan section. So describing EPSDT, EPSDT measurement, informing providers and beneficiaries about EPSDT mental health services, dental services, transportation services, interpretation services, services for special populations, and EPSDT in managed care.

It would be great to hear, you know where you need TA in the Q&A, but also if any of these things excite you, would happy to get those requests via the email address, which is I believe on the next slide as well. Yes. So, you know, hopefully we'll be hearing from you either in the chat or at the Q&A box or via email with your TA needs in the near future.

And I think that is it for my presentation as well. Thank you.

Jackie Glaze: Thank you, Katherine and team. And I'd just like to say that if states would like to send in their EPSDT request, they should use your email address because our chat function's really not set up for that. So I would just suggest if

you want to show the backup and show the slide that shows the email address once again, so individuals are aware of that. That would be helpful.

Okay. There it is. Okay. So with that, we're ready to take states questions. So we're happy to take questions about today's presentation or any other topics that you may have questions about. We'll begin with the chat function, so you can begin entering your questions at this time. And then we'll follow by taking your questions over the phone line. So I do see a couple questions now. So I'll turn to you, (Krista).

(Krista): Sorry, just scrolling through some of the responses to try to find the questions. Here we go. So I am actually only seeing one question in the chat right now which is, 1915(c) waiver services are not listed in the services that are not required to be provided to EPSDT-eligible children. Can you clarify whether a state must provide 1915(c) services as an EPSDT benefit when medically necessary?

Susan Ruiz: So this is Susan.

(Annese Abdullah-McLaughlin): And can you hear me? Can you all hear me?

Susan Ruiz: Yes.

(Krista): Yes.

(Annese Abdullah-McLaughlin): Okay. Good.

(Krista): We can hear you.

(Annese Abdullah-McLaughlin): So yes. So 1915(c) is not required for EPSDT. So what we were talking about in the actual, excuse me, slide presentation is that, you know, 1915(c), which is home and community-based services. If a state has a 1915(c) waiver and a child is eligible for services under that 1915(c), and I'm going to - anybody at CMS who wants to just make sure that I'm quoting this right. "If there is a 1915(c) waiver in a state, and they have - a child qualifies for that 1915(c) service, the child can get that service, but they also have to be eligible for EPSDT." So the 1915(c) service would be considered a wraparound service. And that - those services are not 1905(a) services that are, you know, typically required for - not typically, that are required for EPSDT. So I hope that made sense.

So the 1915(c) service would be like a wraparound service to the 1905(a) service that the child is required to get but again, 1915(c) services are not required under EPSDT.

Melissa Harris: And (Annese) this is Melissa Harris. And that's exactly correct. And we're seeing - given the scope of the benefits that can be authorized under 1905(a) and some of the HCBS authorities, it's not all that uncommon that there be services that could show up under both the EPSDT mandate and for example, a waiver benefit package. And so we are happy to provide technical assistance to the state based on the specifics of a particular scenario.

But because EPSDT is a mandate and given the statutory construct, it's those 1905(a) services that are the requirements and anything similar, you know, what - that is authorized under a waiver would in fact wraparound the EPSDT mandate.

There could be a lot of variations in terms of delivery models that are different across the state plan and a waiver. And so, you know, we're available for

technical assistance to really dig into those nuances but relationship-wise, you know, that's exactly correct between the mandate and some of the optional HCBS authorities. Thanks.

Kate Ginnis: Melissa, can I add one more thing to that? This is Kate Ginnis, which is that once - if kids become eligible for Medicaid because they are waiver eligible, they then are eligible for their - for EPSDT. And I think that's sometimes where confusion comes in. So once they have Medicaid, they are EPSDT eligible, even if their way into Medicaid was through waiver eligibility.

Melissa Harris: That's a great point. Yes. Great point.

Kate Ginnis: And one other piece of it that comes up with some frequency.

(Krista): I'm seeing a additional question here also related to the 1915(c) waivers. Is it worth making a distinction between the 1915(c) waivers and the Katie Beckett SPA? In the latter, more children qualify for more coverage. And by Katie Beckett SPA, I mean TEFRA.

Sarah deLone: Hi, this is Sarah deLone. I can maybe give a thought, I'm not sure exactly what that question is getting at. I mean, the Katie Beckett, as the policy says is a state plan group. It's not a state plan group that's identified in 1902(a) (10) (A), where most of the groups are. It's actually in 1902(e). I forget if it's (e) (1) or (e) (2). But - and it is specifically for kids who need an institutional level of care and - but for the provision of home and community-based services would be eligible for coverage because they've been in an institution and the parent's income doesn't count.

So, you know, they are EPSDT kids but they're not in a 1915(c) waiver. So I don't know if our waiver team can help parse out more what the person may

be asking. But I think it's a little bit of apples and oranges, even though they are kids that are getting home and community-based services.

(Krista): Thanks, Sarah. I saw some follow-up in the chat, thanking you for your response and no need to go deeper, Katie Beckett's SPA option might include some children as 1915(c) waivers with no waiting list. That was their response in the chat.

So I did also receive a couple of questions in the chat about access to these slides. And so I just figured it would be worthwhile sharing with everyone on the call that these slides and a recording from today will be posted within one week of the presentation on medicaid.gov.

But at this time, I'm not seeing any additional questions in the chat.

Jackie Glaze*:* Thank you, (Krista). So we'll turn to you (Michelle), if you could please provide instructions for how individuals can register their questions and then if you could also please open the phone lines.

Coordinator: Thank you. At this time, if you would like to ask a question, you may press star 1. Please unmute your phones and state your first and last name when prompted. Again, that is star 1 if you do have any questions or comments.

Once again, if you would like to ask a question, you may press star 1. I am showing no questions at this time.

Jackie Glaze*:* Thank you, (Michelle). We might toggle back and ask you once again. Are you seeing any additional questions, (Krista)? I'm not.

(Krista): I am not seeing any additional questions either.

Jackie Glaze: Okay. So we will just wait a few minutes and see if we do receive a couple more questions. And then (Michelle), if you could also let us know if you receive any questions through the phone lines.

Coordinator: I do have one question. One moment, please. Dr. Patricia Witherspoon, you may go ahead.

Patricia Witherspoon: Hi. Thank you for this call. Again, I was intrigued by much of the information but what I was hoping to hear is the EPSDT as it relates to medications, I thought that that was on an optional list. We are challenged with some medications not meeting the rule but we make the exception on medical necessity based on - the exception to the medication based on medical necessity.

We had a bit of a difference in opinion and interpretation within our medical and pharmacy department. Is that always going to be the case because it's optional or do you have some hard and fast rules for us?

Kirsten Jensen: This is Kirsten Jensen, and I'll kick this off and I'm sure others will want to weigh in as well. The slide that lists the mandatory and optional 1905(a) benefits, the title of the slide is basically that all of those services are mandatory for children. So the mandatory and optional list is - pertains to adults and the pharmacy benefit for adults is an optional service, although most states do cover it - all states cover it.

But for children all of those services are mandatory. So medication should be covered for children according to the rules as part of the 1905(a) Prescription Drug Benefit.

Patricia Witherspoon*:* Thank you for that. And can I ask one other question? What about nutritional foods?

Kirsten Jensen*:* We have certain requirements for nutritional foods. We do cover - and this is high level, we can get you very specific language but we do cover food that is necessary basically to live, if somebody has a condition where they can only take foods through a tube or, you know, other kinds of highly specialized medical foods. We can cover those under our Home Health Benefit, but we do not cover general nutrition or general food products for other purposes.

But if you'd like our specific language about that, you can send an email either to your state lead or to me, Kirsten Jensen at - kirsten.jensen@cms.hhs.gov, and we'll get you the exact language for the policy around that.

Patricia Witherspoon: Thank you very much.

Kirsten Jensen*:* You're welcome.

Coordinator: Thank you. Once again, that is star 1 if you do have any questions or comments. I am showing no further questions.

Jackie Glaze*:* Thank you, (Michelle). And before we close, I know Kate Ginnis, our Senior Policy Advisor for Children and Youth, would like to say a few words. Kate?

Kate Ginnis: Thanks, Jackie. Can you hear me?

Jackie Glaze: Yes. It's double muted.

Kate Ginnis: Okay. Sorry. I thought it was double muted. Just wanted to appreciate the fact that everyone participated today. And there's going to be - as my colleagues

and our colleagues from NORC said, there's going to be the first TA session probably in early December and then ongoing TA both available in those sessions as well as individually. So please don't hesitate to reach out to us any time.

We're really excited about this work happening and really the focus that it will give both for us at CMS and for you all around the country on kids and their needs. And so just wanted to thank everybody for attending today and looking forward to further engagement.

Jackie Glaze: Thank you, Kate. And also in closing, I would like to thank our team today for their presentation. And looking forward, we will provide the topic and invitation, so you'll know when the next call will be.

Of course, if you do have questions, please bring those to us. You can contact us. You can contact your state lead or bring them to the next call. So we do thank you again for your questions, for joining the call and we hope you all have a great afternoon. Thank you.

Coordinator: And thank you. This concludes today's conference call. You may go ahead and disconnect at this time.

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