EPSDT Guidance: State Implications and Approaches to Behavioral Health for Children and Youth

STATE Health & Value STRATEGIES | *Driving Innovation Across States*

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Introduction

On September 26, 2024, the Centers for Medicare & Medicaid Services (CMS) released a State Health Official (SHO) letter to states on federal Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements (hereafter referred to as the "2024 EPSDT SHO"). A cornerstone of the Medicaid program, EPSDT establishes federal benefit standards in Medicaid designed to ensure that children and youth under age 21 have access to a comprehensive set of services that are medically necessary, which means that states must provide services that are needed to correct and ameliorate a child's health condition. Building on previous guidance, the 2024 EPSDT SHO reiterates and consolidates the federal statutory requirements for EPSDT and offers states strategies and best practices for complying with EPSDT requirements.[1]

The guidance arrives at a critical moment. States are wrestling with a major behavioral health crisis affecting children and youth (see Box 1 below). States are responding through a range of interventions, including by expanding services such as mobile crisis and youth and family peer support, increasing provider reimbursement rates, and working to integrate behavioral health into pediatric primary care settings.

Medicaid is a key tool for responding to the behavioral health crisis among America's children and youth. It provides 30 million children and youth with Medicaid coverage, more than two-thirds of whom are Black, Latino/a and American Indian/Alaska Native (AI/AN). Further, Medicaid covers half of all children with special healthcare needs and nearly all children involved in the child welfare system.[2] Under federal law, Medicaid guarantees access to a comprehensive continuum of behavioral health services for these children and youth. But as occurs among commercially insured as well, many of these children and youth do not necessarily receive the services that they need. In 2021, one in seven Medicaid-enrolled children (ages 3 through 17) that needed behavioral health services did not receive them.[3] Given the sharp increase of mental health challenges among children and youth—the leading cause of disability and poor outcomes among youth as they age—it is critical that states expand access to early intervention and treatment. In response to the behavioral health crisis among children and youth throughout the country, many states are working to improve behavioral healthcare services.

Box 1: The Impact of the Behavioral Health Crisis on Children and Youth

Illustrative Statistics

- *Childhood neurodevelopmental, emotional, and behavioral health disorders have broad and serious adverse impacts on psychological and social wellbeing. Children and youth with these disorders require significant additional support from families and educational systems; the disorders frequently persist into adulthood. These children and youth are more likely to experience a compromised developmental trajectory, with increased need for medical and disability services, as well as increased risk of contact with law enforcement agencies.*
- *In 2023, 40% of students experienced persistent feelings of sadness and hopelessness, 29% experienced poor mental health, 20% seriously considered attempting suicide, and 10% had attempted suicide.*
- *The fragmented and underfunded mental healthcare system produces disparities in access to mental health services, diagnoses, and treatment of mental health conditions, quality of care, and health outcomes. For example, from 2021 through 2022, 19% of U.S. children aged 2 to 8 years had one or more mental disorders. Of these children, 9% reported not receiving any needed healthcare in the previous 12 months, and of these, 46% reported not receiving mental health services when needed (e.g., due to problems getting an appointment, issues due to cost, and/or lack of nearby providers).*
- *Children and youth in the U.S., particularly uninsured, Black and Latino/a children and youth, are being sent to emergency departments for mental health conditions at increasing rates for reasons frequently judged as clinically inappropriate.*
- *Black children and youth are more likely to be diagnosed with stigmatizing disruptive disorders.*
- *The suicide rate among Black adolescents is increasing faster than other racial and ethnic groups. Further, combining years 2009 through 2018, suicide rates per 100,000 population among non-Hispanic AI/AN adolescents were two to four times higher than those of adolescents of other races and ethnicities.*
- *From 2018 through 2022, the rates of adolescents dying of substance-use-related fatalities more than doubled. In 2023, despite some encouraging news that the crisis might be ameliorating, the data continued to indicate a situation far worse than in earlier times.*
- *Lesbian, gay, bisexual, transgender, queer, plus (LGBTQ+) youth and young adults (between ages 13 and 24) are more likely to experience behavioral health needs than their peers. 41% of LGBTQ+ young people considered suicide in 2023; and 56% of LGBTQ+ young people seeking mental health treatment could not access care.*

For all of these reasons, states may want to review the EPSDT guidance with an eye towards how they can continue to improve coverage, access, and quality of behavioral healthcare for children and youth enrolled in Medicaid and the Children's Health Insurance Program (CHIP). While the guidance was issued under the Biden administration, the requirements it reiterates and reinforces are established by Title XIX of the Social Security Act (SSA) and, therefore, not likely subject to change absent Congress amending the statute. Moreover, the commitment to addressing the youth behavioral health crisis has been apparent in states across the country and not associated with any one political party.

Action Steps for States to Improve Behaviorial Health Services for Children and Youth

The guidance offers insight into states' EPSDT obligations, as well as a set of recommended strategies to improve the services they provide to children and youth. It builds upon and is consistent with strategies provided by CMS in previous bulletins in 2014, 2017, and 2022 regarding children and youth with significant behavioral health needs. While it is not the purpose of the guidance, states may find that adhering closely to its requirements and taking advantage of the options and opportunities it outlines will improve care and outcomes for children and youth and help them thrive as they grow, but may also potentially help them to assess and mitigate risk of litigation.

Step 1: Explore Opportunities to Strengthen the Behavioral Health Continuum of Care for Children and Youth

The guidance reiterates states' statutory obligation to "provide coverage for an array of medically necessary mental health and SUD [substance-use disorder] services along the care continuum in order to meet their EPSDT obligation." Specifically, the statute requires, and the guidance confirms, all states must cover any behavioral health service that is medically necessary for a child that is coverable under section 1905(a) of the SSA, even if it is not covered for adults.

To ensure compliance, states can review their existing Medicaid state plan benefit package, Medicaid clinical coverage policies, and Medicaid managed care contracts to confirm they cover a comprehensive set of services. While CMS does not provide a detailed list of required services, it identifies several key categories of services that need to be provided to children and youth:[i]

1. Screenings, assessments, and referrals.
2. Services to address early signs or symptoms of concern with or without a diagnosis.
3. Community-based services at varying levels of intensity necessary to correct or ameliorate a wide range of behavioral health, acute, and/or chronic conditions.
4. Services to address urgent and crisis needs.
5. Inpatient care when clinically indicated and not as a default due to gaps in other services.

The services covered within these broad categories must be available to any child and youth with a behavioral health need when medically necessary, including children and youth with co-occurring medical or developmental disabilities. Consistent with the Olmstead Supreme Court decision, states are required to ensure that behavioral health services are provided in the most integrated setting appropriate for the child or youth, including clinics, homes, and schools. In recent years, states have used multiple tools to increase access to behavioral health treatment for children and youth, including continuum of care expansions, use of school-based services, behavioral health and primary care integration, and provider rate increases.[4] In 2024, at least 12 states were working to expand behavioral health services for children and youth, including for those involved in child welfare.[5]

In assessing whether states are meeting EPSDT obligations, states may want to consider conducting a comprehensive review to determine whether their continuum of behavioral health services for children and youth is sufficiently comprehensive and accessible to all children and youth, including those of color, living with special healthcare needs, involved in the child welfare system, and who are LGBTQ+, and in alignment with EPSDT requirements across these broad categories. For example, California conducted a comprehensive assessment of its behavioral health continuum for children, youth, and adults in 2021. The report analyzed Medicaid coverage policies, data on provider networks and access to care, and incorporated feedback from stakeholders across the state. California used the findings from the assessment to guide the design and implementation of behavioral health initiatives, including the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration.

i Sec 1902(a)(1) of the Social Security Act requires states to provide statewide coverage for services included in their Medicaid State Plan. "State plan for medical assistance must—(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them."

As part of their assessment, states can review their state plan, clinical coverage policies, billing procedures, education and provider networks, and prior authorization requirements (detailed in Step 2 below) to determine where they are on covering and ensuring access to the following services:

- **Screenings, assessments, and referrals for ongoing treatment, as needed.** States must "develop or adopt a schedule of recommended screenings to determine the existence of physical or mental illnesses or conditions for EPSDT-eligible children [and youth]." States may rely upon or modify the Bright Futures periodicity schedule, which includes recommended screening timeframes for maternal depression; behavioral, social, and emotional screenings; depression and suicide risk; and tobacco, alcohol, or drug use. States are required to ensure that children and youth receive timely access to services for behavioral health needs identified through a screening. To better increase access to treatment for children and youth who are identified as having behavioral health needs, states can develop policy and reimbursement strategies to support pediatricians and other primary care providers in screening children and youth for behavioral health needs and referring them for further assessments and treatment, ideally using a closed loop referral process to ensure that the primary care provider can track and confirm that children and youth receive follow-up services.

- **Medically necessary services to address early signs or symptoms of concern with or without a diagnosis.** States are required under EPSDT to provide "early intervention" services that aim to avert the onset of or lessen the progression of a child's or youth's behavioral health needs. States can review their existing clinical coverage policies and billing procedures to ensure that their access or diagnostic criteria supports children and youth in receiving needed services. States can explicitly eliminate a requirement that children and youth must have a diagnosis to receive medically necessary behavioral health services, as California and Colorado have done. Indeed, the 2024 EPSDT SHO says: "States should avoid requiring an EPSDT-eligible child to have a specific behavioral health diagnosis for the provision of services, as screenings may identify symptoms that require attention but do not meet diagnostic criteria." By intervening early, states may also help reduce behavioral health diagnoses among children and youth and address the disparities in diagnoses among children and youth of color. CMS also notes that "waiting for an illness to develop rather than addressing symptoms when they arise" is "not consistent with section 1905(a))." For example, a child or youth who exhibits the onset of symptoms of stress and anxiety during a pediatric mental health screening should promptly receive behavioral health services to prevent the symptoms from worsening.

- **Community-based services at varying levels of intensity necessary to correct or ameliorate a wide range of behavioral health acute and/or chronic conditions.** States are required to cover and ensure access within their Medicaid programs to a spectrum of community-based services equipped to treat children and youth with mild to moderate and more intensive needs. As CMS highlights, states can integrate behavioral healthcare into primary care settings to treat children and youth with mild to moderate needs. These services can include outpatient therapies and medications. Among states that are seeking to integrate primary and behavioral healthcare, Massachusetts now supports the Transforming and Expanding Access to Mental Health in Urban Pediatrics model, an integrated care model based in federally qualified health centers where primary care clinicians, mental health clinicians, and community health workers provide prevention, early intervention, access to mental health services, and psychiatric consultations for children and youth with higher needs. EPSDT also requires states to cover intensive home-based services for children and youth with more specialized needs to allow them to remain in their homes and communities. Often, children and youth who are involved in multi-child serving systems (e.g., child welfare, juvenile justice, and intellectual/developmental disabilities systems) benefit from these interventions. As noted above, courts consistently have required states to cover a core set of home- and community-based services as part of resolving litigation (see Box 2).

Box 2: Behavioral Health Services Required by Courts

Among states that have been sued under the federal Medicaid statute and the Americans with Disabilities Act (ADA) for issues with their behavioral health services for children and youth, courts consistently have required that any settlement includes the following core services:

- *Intensive care coordination.*
- *Mobile crisis.*
- *Intensive in-home service.*
- *Therapeutic mentoring.*
- *Family peer support.*

In addition, some, but not all, courts have required states to provide services such as youth peer support and respite care, which allows caregivers to take a break from providing constant care that many children and youth with significant mental health concerns and/or SUDs require. While EPSDT does not require states to provide respite care because it is not a state plan service, states can cover respite care under section 1915(i) and 1915(c) authorities for children and youth with more intensive needs, including those who may be involved in multi-child serving systems.

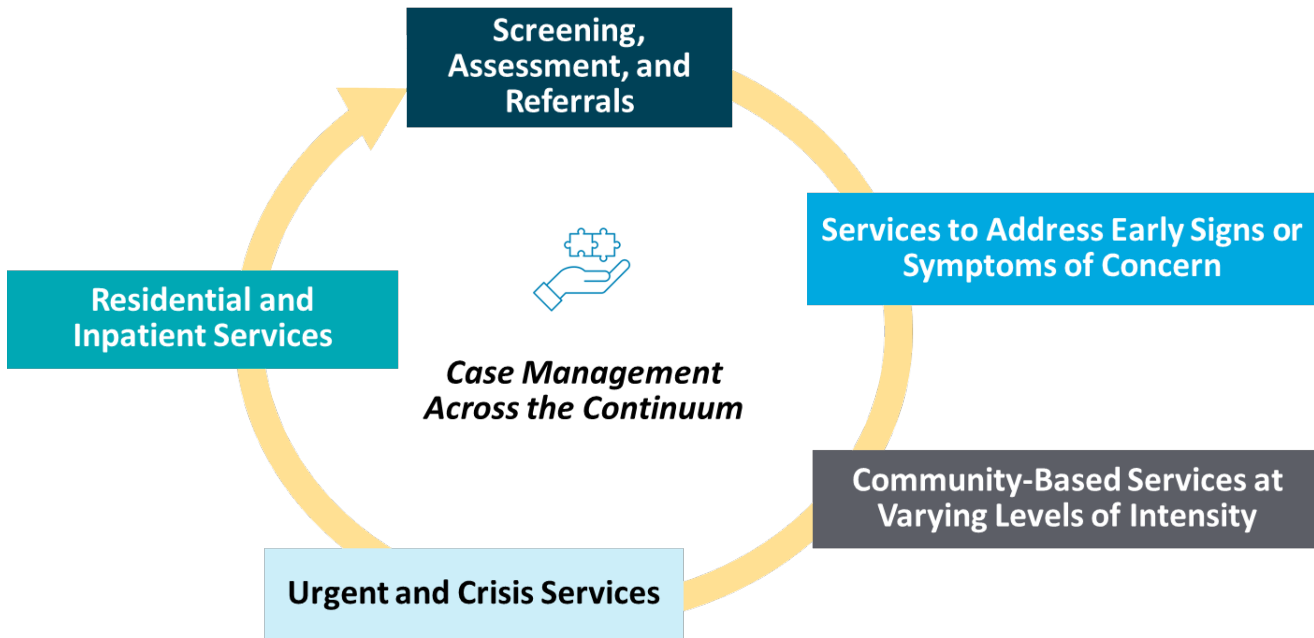
- **Urgent and crisis services tailored to address the needs of children and youth.** As CMS states in its guidance, states are required to include "services to address urgent and crisis needs" as part of the mandatory continuum of behavioral health services. CMS does not elaborate on what such services might be, providing states with discretion to decide. To determine whether its program provides sufficient coverage of crisis services for children and youth, states can consider strategies outlined in CMS' 2021 SHO letter on community-based crisis services. For example, states can incorporate a "range of staffing models," into their mobile crisis services, including mobile response and stabilization services. As follow-up to the initial mobile response, stabilization services offer intensive in-home services for several weeks after the initial crisis event.

- **Residential and inpatient treatment when clinically appropriate and not as a default due to gaps in other services.** CMS' guidance emphasizes "inpatient and residential levels of care must not be the default treatment setting, either explicitly or because of a lack of capacity of services offered in integrated settings, including for children and youth with severe needs, and should be reserved for children and youth with acute needs on a short-term basis." To ensure compliance with EPSDT requirements, Medicaid programs may want to clarify that inpatient and residential treatment can only be used to treat children and youth with acute clinical needs consistent with ADA and Olmstead requirements. Recent federal oversight reports of residential services for children and youth, including the Senate Finance Committees' 2024 report, suggest that states should ensure that community-based services are available and build guardrails so that residential and inpatient care is used sparingly, and that their residential and inpatient facilities provide high quality care.

- **Case management for children and youth with varying levels of behavioral healthcare needs.** As CMS highlights in its guidance, "Case management is a section 1905(a) service in Medicaid [,]" which means that under EPSDT, states are required to ensure that "every child must have case management available to them when it is medically necessary." States have many ways to meet this requirement, including use of managed care organization (MCO) care coordination (a requirement for all health plans contracting with Medicaid programs), Primary Care Case Management, Targeted Case Management, and Health Homes.

Figure 1. Continuum of Care

Graphic developed based on the 2024 EPSDT SHO's description of a service array of behavioral healthcare, consistent with EPSDT requirements.



Step 2: Ensure Access to Needed Services

States are responsible for ensuring that services are accessible to children and youth. States can ensure that their engagement with families and their child/youth medical necessity, prior authorization, and network adequacy policies comply with EPSDT requirements and do not delay or impede a child's or youth's access to care. States can train their staff on EPSDT requirements and consider how to provide the necessary behavioral health services to children and youth who have a behavioral health issue but do not have a diagnosis. CMS emphasizes in its guidance that states are responsible for ensuring their Medicaid program's compliance with EPSDT, including for behavioral health services, regardless of the delivery system. This means that states that carve behavioral health services out or allow their MCOs to delegate behavioral health services to administrative services organizations or county-run plans must ensure that children and youth have access to medically necessary services through those specific delivery systems. For example, Ohio requires Aetna, the managed care plan that operates OhioRISE, the state's specialized managed care program for children and youth with complex behavioral health needs, to report on a range of performance measures, including self-reported youth satisfaction with services, initiation, and engagement with substance-use related treatment, as well as access to a range of behavioral health services.

In assessing whether children and youth have sufficient access to behavioral health services in alignment with EPSDT requirements, states may want to consider evaluating the following:

- **Member Engagement and Education.** States can work to engage families and children and youth directly in the process of assessing and improving their behavioral health systems, including compliance with EPSDT. States can ensure their policies are geared toward helping families, including those with children and youth of color and those who are LGBTQ+, understand EPSDT and how they can access required screenings and services by incorporating behavioral health into their new Beneficiary Advisory Councils required under the updated Medicaid Access Rule. Specifically, families must be informed in an accessible manner about the

services (including screenings) available to children and youth under EPSDT within 60 days of their child's initial Medicaid determination. Families must also be informed of how to access these services on an annual basis for children and youth who have utilized EPSDT services consistent with federal requirements. In written enrollee handbooks, the state or MCO must detail in an accessible, understandable format for non-English speakers and enrollees with a disability how enrollees can access these services, including assistance with scheduling appointments and the provision of transportation.

- **Medical Necessity and Prior Authorization Criteria.** States can ensure that their MCOs and fee-for-service (FFS) providers use the unique medical necessity standard established by Title XIX of the SSA for children and youth when they arrange or authorize services. That definition requires that services that help improve or prevent additional behavioral health conditions are provided and does not allow the imposition of any hard limits for services (e.g., programs or plans cannot impose an across-the-board limit on the number of therapy sessions a child can receive). For services other than preventive screenings, states and MCOs can establish "soft" service limits that then trigger prior authorization. If the state imposes prior authorization requirements, they must ensure that they use the child-specific medical necessity definition, not the one used for adults, and that they do not delay the delivery of services. As states review their medical necessity standard applicable to children and youth enrolled in Medicaid, they may also want to review their MCO contracts and monitor MCO performance to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). MHPAEA seeks to equalize access to behavioral health services with medical and surgical services.[6] Under the law, states and their MCOs cannot impose treatment limitations, including prior authorization or other soft limits on behavioral health services that are more restrictive than those in place for comparable medical and surgical services.

- **Network Adequacy and Workforce Development.** States are required to ensure that all children and youth have timely access to medically necessary behavioral health treatment. Acknowledging issues stemming from workforce shortages, the 2024 EPSDT SHO suggests various strategies for growing states' behavioral health workforces, including reviewing provider qualification requirements and relying on telehealth and consultative services to expand access to critical behavioral health services, particularly for children and youth of color and those who are LGBTQ+. To meet network adequacy requirements, states may need to strengthen their network adequacy policies and review their provider enrollment and payment policies. States can review and amend their existing policies, including Medicaid managed care contracts, MCO monitoring requirements, and reporting templates to:

  - Confirm that MCOs and FFS programs pay for and assure that children and youth, including those of color and those who are LGBTQ+, can access out-of-network providers when medically necessary, including out-of-state providers if necessary.
  - Ensure that MCOs are contractually obligated to comply with network adequacy standards, including appointment wait time standards for behavioral healthcare (updated under the 2024 Managed Care final rule, effective July 9, 2027).[7]

  States can also leverage utilization, oversight, and secret shopper data to provide insights into sufficiency of behavioral health networks to address the needs of all children and youth, including those of color and who are LGBTQ+, and where there might be gaps by:

  - Studying utilization data of intensive home-based outpatient services (e.g., partial hospitalization) and crisis services relative to inpatient, residential, and emergency department visits, including analysis of utilization among children and youth of color and those who are LGBTQ+.

- Reviewing monitoring data related to appointment wait times for behavioral health services and use of out-of-state providers for behavioral health services, including for children and youth of color and those who are LGBTQ+.

States that determine a need to build out their behavioral health networks can consider strategies that CMS describes in the 2024 EPSDT SHO. These changes will require changes to state policy, MCO contracts, and monitoring approaches, including:

- Expanding the types of providers who can deliver services to children, youth, and their families (e.g., to include peers, including those of color and who are LGBTQ+, and other non-licensed practitioner types).
- Encouraging the use of recovery and therapeutic group services to treat families and children and youth.
- Expanding access to primary care consultation for children and youth with mild to moderate needs as a distinct service for which the consulting behavioral health clinician can bill directly, consistent with CMS' SHO # 23-001.
- Expanding telehealth, particularly in rural and medically marginalized areas, for behavioral health services, including in primary care integration efforts using Pediatric Mental Health Care Access programs to provide child psychiatry consultation to primary care practices.

Conclusion

State Medicaid and CHIP programs have a crucial role in responding to the behavioral health crisis impacting America's children and youth. Increased alignment to and compliance with EPSDT requirements is a key lever that state Medicaid agencies can use to fully embrace that role. Building on EPSDT statute, regulation, and prior sub-regulatory guidance, CMS' 2024 EPSDT SHO reemphasizes that states are ultimately responsible for ensuring their Medicaid programs comply with EPSDT regardless of whether they use FFS or managed care delivery systems. It also clarifies key EPDST requirements and amplifies best practices for states to ensure coverage of and access to behavioral health services consistent with EPSDT.

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ABOUT MANATT HEALTH

This issue brief was prepared by Jocelyn Guyer, Ashley Traube, John O'Brien, Cindy Mann, and Patti Boozang. Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit https://www.manatt.com/health.

ENDNOTES

1. For a high-level review of the 2024 EPSDT SHO, see the SHVS expert perspective available here.
2. Medicaid and CHIP Payment and Access Commission (MACPAC). 2022. "Access in Brief: Experiences in Accessing Medical Care by Race and Ethnicity." MACPAC. https://www.macpac.gov/wp-content/uploads/2022/02/MACPAC-Access-in-Brief_Race-and-Ethnicity-Feb-2022.pdf.
3. Centers for Medicare & Medicaid Services (CMS). 2023. "2023 Medicaid & CHIP Beneficiaries at a Glance: Child & Adolescent Behavioral Health." CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/child-and-adolescent-behavioral-health-infographic.pdf.
4. Hinton, Elizabeth, Elizabeth Williams, Jada Raphael, *et al*. 2024. "As Pandemic-Era Policies End, Medicaid Programs Focus on Enrollee Access and Reducing Health Disparities Amid Future Uncertainties: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2024 and 2025." Kaiser Family Foundation and National Association of Medicaid Directors. https://files.kff.org/attachment/Report-Results-from-an-Annual-Medicaid-Budget-Survey-for-State-Fiscal-Years-2024-and-2025.pdf.
5. Ibid 4.
6. For more information, see SHVS' expert perspective here.
7. For more information, see the SHVS webinar on these provisions available here.