The Role of Medicaid Continuous Enrollment in Improving Children's Health and Wellbeing: State Toolkit

Prepared by Manatt Health

December 2024

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

Support for this toolkit was provided by the Robert Wood Johnson Foundation.
The views expressed here do not necessarily reflect the views of the Foundation.

About Manatt Health

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 www.manatt.com/ManattHealth.aspx

Toolkit Objectives

This toolkit is intended to support states in leveraging 12-month and multi-year continuous enrollment (CE) for Medicaid/Children's Health Insurance Program (CHIP)-eligible children and youth to promote access to care, ensure delivery of critical preventive and behavioral health services, and monitor child health outcomes in partnership with key stakeholders.

States may use this toolkit to inform:

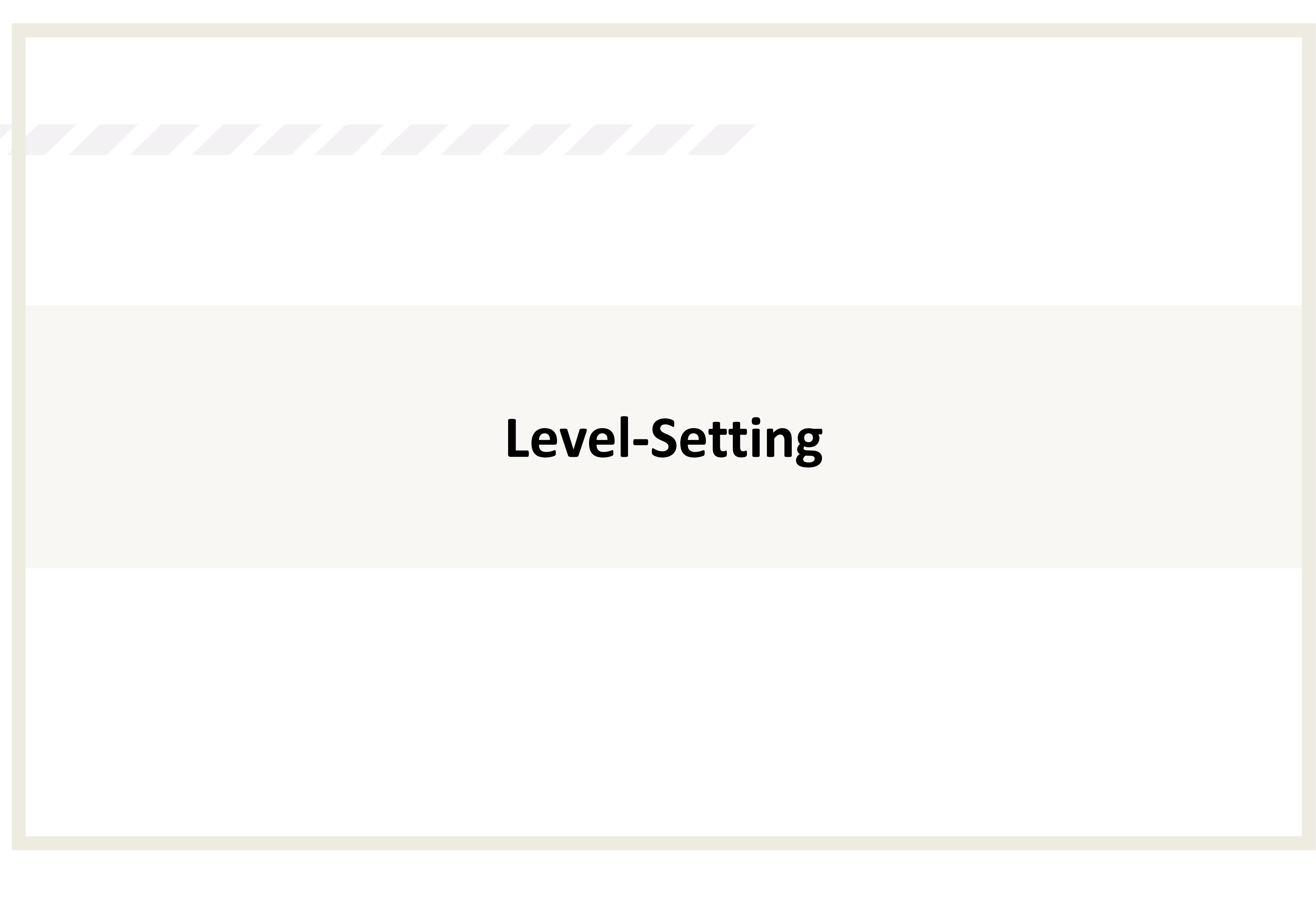
Planning related to implementation of CE policies.

Adoption of alternative payment models (APMs) to encourage providers to embrace innovative pediatric care delivery practices.

Development of an oversight and quality improvement strategy to promote improved health and wellbeing outcomes for young children.

Table of Contents

- **Level-Setting**
- **Spreading Awareness of CE**
- **Improving Access to Care**
- **Provider Care Model and Payment Strategies**
- **State Monitoring and Oversight Strategies**


Level-Setting

CE Policies and Health Equity

Black and Hispanic households are more likely to experience income volatility and other changes in circumstances resulting in higher rates of churn. CE promotes **health equity** by reducing churn rates in groups disproportionately impacted by procedural disenrollment and the subsequent gaps in care that exacerbate poor health outcomes.

CE reduces administrative and psychological burdens for enrollees (e.g., application reprocessing).

Benefits of CE Policies for Children

Continuity of Care	Health Outcomes	Costs
▪ **Children and youth with CE are more likely to access medically appropriate preventive care,** rather than emergency care. ▪ CE improves connection to treatment and reduces disruptions in care for **children and youth with chronic conditions.**	▪ CE is associated with **better health**, **reduced school absenteeism**, and **higher academic achievement for children; translating to higher rates of employment and earnings as adults.** ▪ CE ensures coverage for **early detection of developmental delays** and access to needed treatments to improve lifelong outcomes.	▪ Longer coverage periods through CE are associated with **lower monthly Medicaid expenditures**. ▪ CE contributes to increased **provider tax revenues and reduced spending** on public assistance programs. ▪ **CE creates administrative efficiencies** and lessens associated costs and burdens for states and providers (e.g., application reprocessing, resubmitting claims, rescheduling missed appointments and treatments).

Source: Georgetown University Center for Children and Families. Medicaid and Chip Continuous Coverage for Children. Ku et al, Improving Medicaid's Continuity of Coverage and Quality of Care, Association of Community Health Plans; Congressional Budget Office, Exploring the Effects of Medicaid During Childhood on the Economy and the Budget; Office of the Assistance Secretary for Planning and Evaluation, Medicaid: The Health and Economic Benefits of Expanding Eligibility.

CE: A Catalyst for a New Culture of Children's Health

CE, particularly multi-year, alleviates the adverse consequences of coverage gaps and is a catalyst for culture change at all levels to improve children's healthcare access and outcomes.

CE provides families the ability to seek care at the right time and right place, without fear of unexpected out-of-pocket costs. **Culture change for families means they understand their child's coverage isn't going away, they learn how to use their health coverage when and where their child needs it, and they learn what their child is entitled to in Medicaid and CHIP.**

CE gives states (1) a new incentive/lever to require managed care organizations (MCOs) and providers to focus on children's health and educating families and (2) a new opportunity to strengthen a system of whole child care by "connecting the dots" across disparate family-facing state agencies, efforts and stakeholders.

CE provides more stable funding to MCOs for enrollees who are children, and therefore more opportunity to **improve utilization of preventive care, early detection and follow up, care management for children and youth with special healthcare needs**, and more. MCOs have new incentives to retain continuously eligible children and youth in their plans.

Relatedly, with CE, pediatric providers also benefit from stabilized payment for their patients and have more flexibility and resources to **adopt innovative care models**, such as dyadic care (where caregiver and child are treated together) and integrated care, and **participate in APMs** geared toward improving child and family health.

Federal CE Requirements and Options for States

Effective January 1, 2024, federal law requires 12-months of CE for children and youth up to age 19.

Since 1997. Optional for states to provide 12 months of CE for children and youth in Medicaid and CHIP.

March 2020. The Families First Coronavirus Response Act required CE for Medicaid enrollees through the public health emergency (PHE).

March 2023. The Consolidated Appropriations Act (CAA) requires 12 months of CE for children and youth up to age 19 effective January 2024.

Fall 2023. CMS released guidance on the CAA requirement.
****SHVS' summary of the SHO letter is available here.***

January 2024. Implementation of the CAA CE requirement.

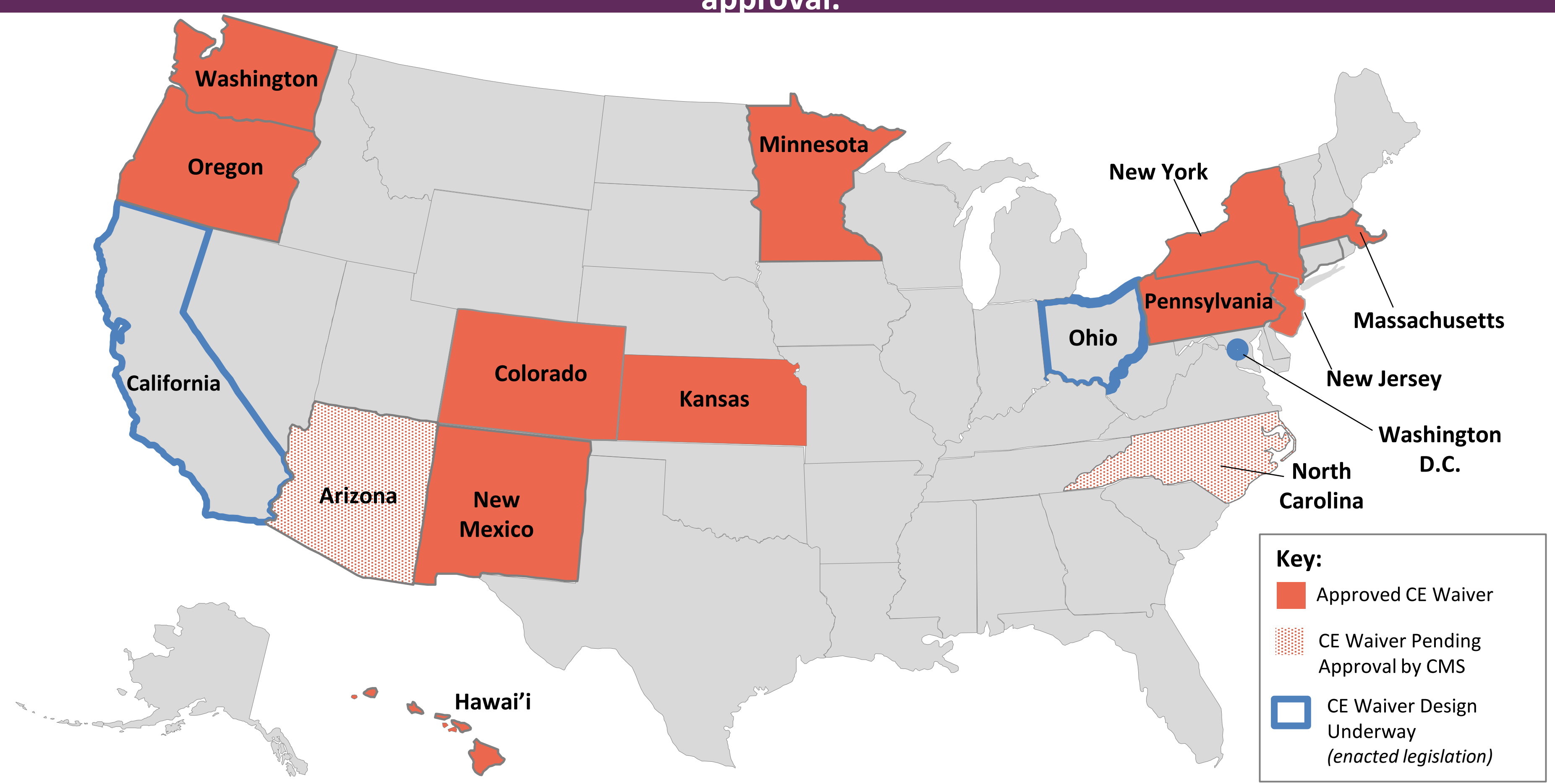
March 2024. The Biden administration proposed new options for states to provide CE for youth in the President's Fiscal Year 2025 Budget.

States may seek section 1115 waiver authority to implement multi-year CE for children and youth and single or multi-year CE for adults.

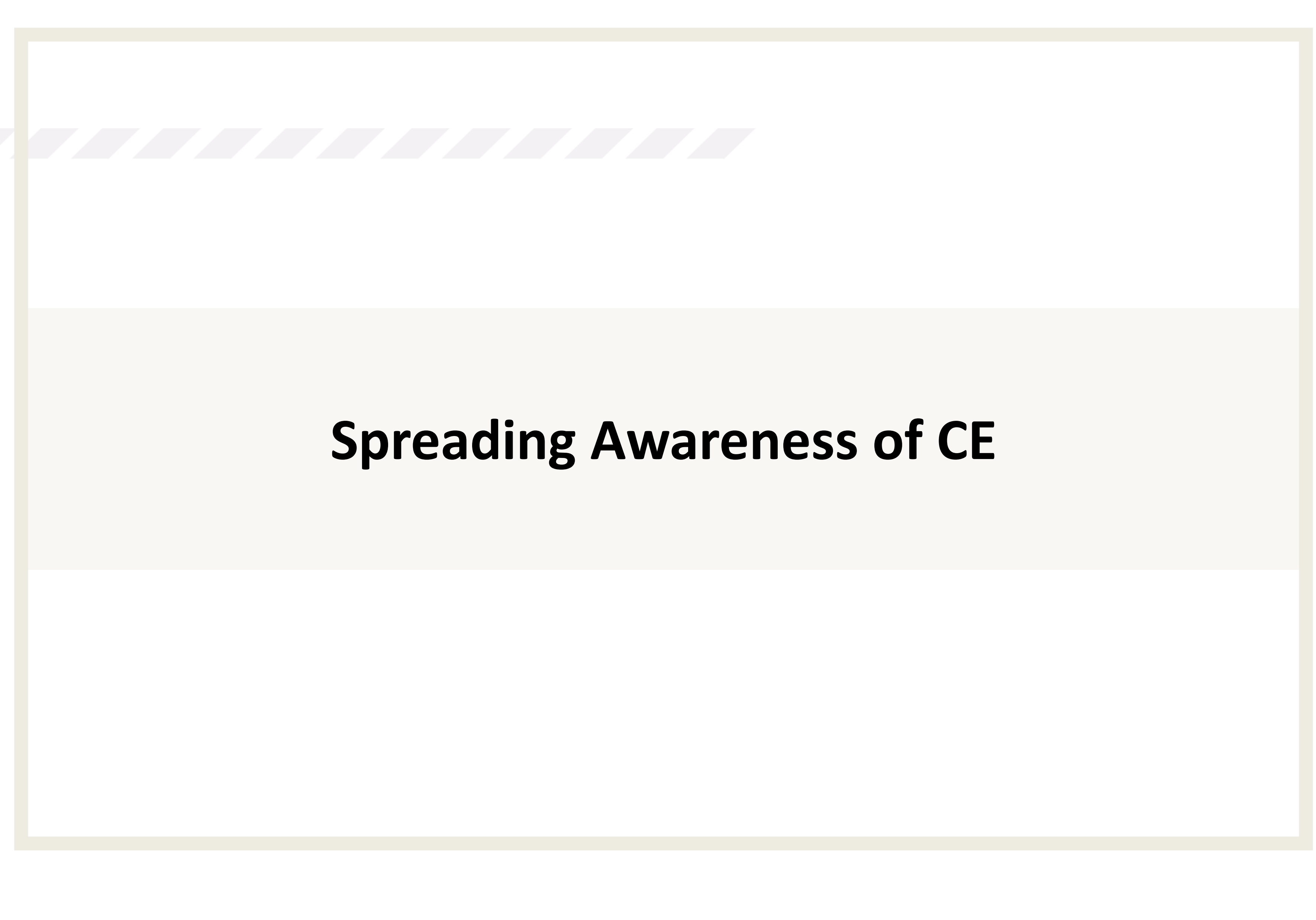
Source: CMS, State Health Official Letter. CMS, CE FAQs. Fiscal Year 2025 Budget in Brief.

State CE Activity

As of November 2024, 11 states have received approval to implement CE demonstrations, two states have pending waivers, and three states have enacted legislation authorizing the state to seek waiver approval.



Source: KFF, Section 1115 Waiver Watch: Continuous Eligibility Waivers and Manatt analysis; See Appendix for detail.


Spreading Awareness of CE

Key Messengers

States may collaborate with a variety of partners to spread awareness of the availability of CE and drive utilization of critical primary and behavioral healthcare services:

Pediatric Providers – Such as federally qualified health centers (FQHCs); rural health centers; private practices; etc.

Family-Facing State Agencies – Governor's Office; departments of children and families; departments of public health/local health departments; Maternal/Child Health Offices; Women, Infant, and Children's (WIC) Program; etc.

MCOs

Education System – Departments of education; early childhood educators; Head Start programs; schools; etc.

Advocacy and Community-Based Organizations – Childcare; navigators/assisters; faith-based organizations and leaders; community centers; youth sports programs; barbershops; nail salons; beauty salons; and public libraries; etc.

Strategies to Help the Message Reach Families (1/2)

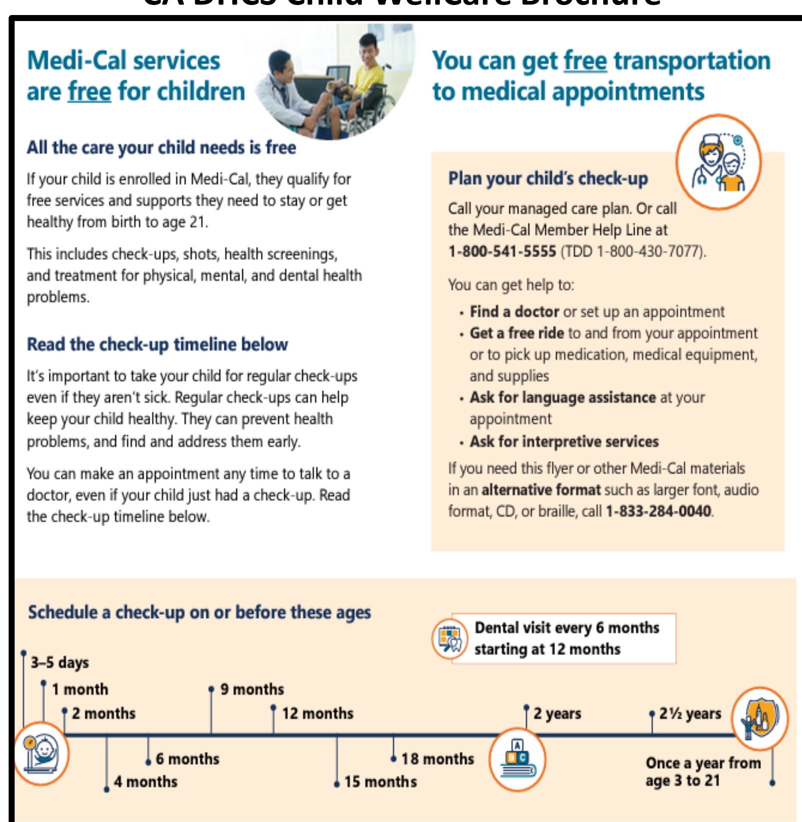
Consult with advisory groups and/or consumer-based organizations on how best to spread the word directly to families.

Reminder: States are required, by July 9, 2025, as part of the Access final rule to set up a Beneficiary Advisory Council (BAC) and a Medicaid Advisory Committee (MAC). These forums can help advise on policy implementation strategies.

Leverage existing communications channels and resources e.g., back-to-school; Early and Periodic Screening, Diagnostic and Treatment (EPSDT); Medicaid unwinding; postpartum coverage extension.

State Spotlight: The CA Department of Health Care Services (DHCS) created family-facing brochures (*see excerpt, right*) for families of adolescents and young children that include key messages on available Medicaid/CHIP benefits and reminders to schedule critical preventive care. States may revise materials like these to include notice of CE.

CA DHCS Child WellCare Brochure



Medi-Cal services are free for children

All the care your child needs is free

If your child is enrolled in Medi-Cal, they qualify for free services and supports they need to stay or get healthy from birth to age 21.

This includes check-ups, shots, health screenings, and treatment for physical, mental, and dental health problems.

Read the check-up timeline below

It's important to take your child for regular check-ups even if they aren't sick. Regular check-ups can help keep your child healthy. They can prevent health problems, and find and address them early.

You can make an appointment any time to talk to a doctor, even if your child just had a check-up. Read the check-up timeline below.

You can get free transportation to medical appointments

Plan your child's check-up

Call your managed care plan. Or call the Medi-Cal Member Help Line at **1-800-541-5555** (TDD 1-800-430-7077).

You can get help to:

- **Find a doctor** or set up an appointment
- **Get a free ride** to and from your appointment or to pick up medication, medical equipment, and supplies
- **Ask for language assistance** at your appointment
- **Ask for interpretive services**

If you need this flyer or other Medi-Cal materials in an **alternative format** such as larger font, audio format, CD, or braille, call **1-833-284-0040**.

Schedule a check-up on or before these ages

Dental visit every 6 months starting at 12 months

3–5 days, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 2½ years, Once a year from age 3 to 21

Strategies to Help the Message Reach Families (2/2)

Adapt eligibility determination notices to clearly indicate, at an individual level, eligibility for CE.

Launch a statewide communications campaign.

Provide training on CE to the member-facing workforce (e.g., enrollment assisters, community health workers, doulas, patient navigators).

State Spotlight: MA and a state advocacy organization, Health Care For All, developed an infographic (*right*) for MassHealth enrollment assistors on the state's CE policy for different populations.

State Spotlight: The District of Columbia (DC) associate director of the Division of Children's Health Services is responsible for ensuring what DC's Medicaid program offers to children and youth is being carried out in accordance with federal law. This includes, but is not limited to, overseeing EPSDT education and training, data and monitoring, MCO requirements, and coordination with other child-serving state agencies.

Continuous Eligibility

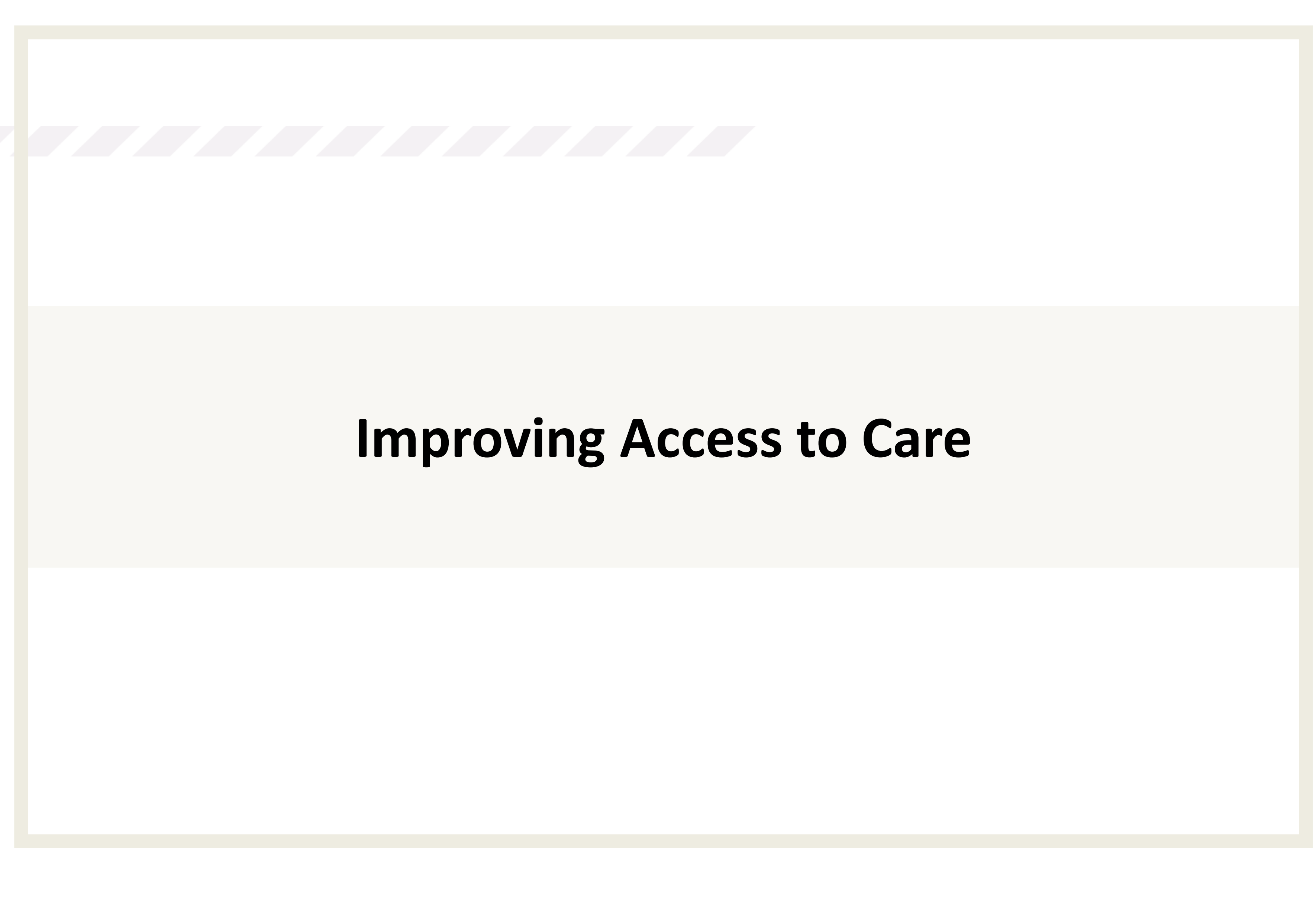
(as of Jan. 1, 2024)

Continuous eligibility refers to the length of time in which a MassHealth member will have coverage without redetermining their eligibility.

Continuous eligibility for special populations:

12 Months	24 Months

• Recently incarcerated individuals
• Birthing People
  ◦ 12 months postpartum
• Children under 19
	• Individuals Experiencing Homelessness
	  ◦ Confirmed status of homelessness for 6 months in state homeless database


Improving Access to Care

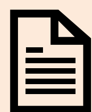
EPSDT: Medicaid/CHIP’s Commitment to Children

EPSDT requirements are the foundation for Medicaid/CHIP-enrolled children’s access to care.

- Under EPSDT, states must provide **all medically necessary services** that could be covered under Medicaid/CHIP even if not covered for adults or identified in the state plan.
- The EPSDT pediatric **medical necessity definition** includes a **focus on correcting or ameliorating conditions that can affect children’s growth and development**.
- States and MCOs can **require prior authorization (PA) for particular services, but PA may not cause delay or denial of medically necessary services.**
- **States/MCOs may not impose hard or fixed limits** on specific services.
- States must **offer services that promote access to healthcare** (e.g., scheduling assistance for appointments, necessary transportation to and from appointments, related travel expenses, and language assistance services for individuals with limited English proficiency).

Scope of EPSDT

Early: assessing and identifying problems early.
Periodic: checking children’s health at age-appropriate intervals.
Screening: providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.
Diagnostic: performing diagnostic tests to follow up when a health risk is identified.
Treatment: correcting, reducing, or controlling health problems.



CMS released an informational bulletin in 2022 reminding states of their obligation to cover screenings and medically necessary treatment for children’s behavioral health, mental health, and substance-use disorder care.

Source: Manatt, Robert Wood Johnson Foundation, Lucile Packard Foundation. Keeping Medicaid’s Promise: Strengthening Access to Services for Children with Special Healthcare Needs.

EPSDT State Health Official Letter

On September 26, CMS released comprehensive guidance that reinforces EPSDT requirements and highlights strategies and best practices to support states in ensuring that Medicaid/CHIP children and youth receive the full range of healthcare services they need.

The guidance focuses on three key topics:

- Promoting EPSDT awareness and accessibility, including increasing access to supports like scheduling assistance, transportation, care coordination, and case management.
- Expanding the EPSDT workforce by broadening provider qualifications, using telehealth and interprofessional consultation, and incentivizing provider participation.
- Improving care for children and youth with specialized needs, including children and youth with behavioral healthcare needs, involved in the child welfare system, and/or living with disabilities or other complex health needs.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS — CENTERS FOR MEDICARE & MEDICAID SERVICES — CENTER FOR MEDICAID & CHIP SERVICES

SHO # 24-005

RE: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements

September 26, 2024

Dear State Health Official:

Executive Summary

Page 3 – SHO - Best Practices for Adhering to EPSDT Requirements

access to comprehensive health care services, including children without a mental health or substance use disorder (SUD) diagnosis."[9]

To meet this directive, CMS completed an extensive document review of state EPSDT beneficiary-informing materials, state provider manuals, and managed care contracts, including looking for examples of optimal EPSDT implementation. CMS also considered internal and external EPSDT subject matter expertise, the relevant academic literature, data from and evaluations of CMS programs, and feedback from parents and other caregivers of EPSDT-eligible children, as well as other interested parties.

This guidance is intended to provide an overview of EPSDT requirements and how states can meet the goal of EPSDT: the right care, to the right child, at the right time, in the right setting. The guidance discusses policies, strategies, and best practices to maximize health care access and utilization for EPSDT-eligible children. It is divided into three broad topics:

- **Promoting EPSDT awareness and accessibility** to ensure eligible beneficiaries have comprehensive coverage, are aware of their coverage, know how to access Medicaid benefits, and have supports like transportation and care coordination to facilitate getting the care that they need.
- **Expanding and using the child-focused (EPSDT) workforce** by broadening provider qualifications, using telehealth, encouraging the use of interprofessional consultation, and using payment methodologies to address provider shortages and to help assure that there are an adequate number of health care providers available to meet the needs of beneficiaries.
- **Improving care for EPSDT-eligible children with specialized needs**, with a particular focus on how EPSDT requirements relate to the unique needs of children with behavioral health conditions, children in foster care, and children with disabilities or other complex health needs.[10]

Each section of the guidance summarizes federal requirements, followed by strategies and best practices to support states' implementation of those requirements. CMS recognizes that what works in one state may not be feasible in another; we are not requiring states to adopt best practice examples, nor are the best practice examples exhaustive. However, these best practices have proven to be effective avenues utilized by states to comply with EPSDT requirements and we encourage states to consider adopting, as appropriate, the strategies and best practices in this guidance to help improve care and health outcomes for children. For comprehensive information about EPSDT requirements, please refer to *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*.[11]

[9] Pub. L. 117-159.
[10] Throughout the letter, we use the term "behavioral health conditions" to encompass mental health conditions and substance use disorders.
[11] See: https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf.

3

CMS is planning a multi-pronged approach to support state adherence to EPSDT by increasing oversight and compliance, holding technical assistance webinars, issuing future guidance for states, and drafting an upcoming report to Congress.

Source: CMS, SHO #24-005.

State Access Strategies and Examples

States may consider the following policies and strategies through both the fee-for-services (FFS) and managed care delivery systems to promote children's access to care.

Consider whether Medicaid reimbursement rates for primary, behavioral health, dental, and vision care are sufficient to ensure provider participation.

Identify a child/adolescent health lead within the state Medicaid agency (and potentially require the same at each MCO) and consider standing up a **child wellbeing advisory group**.

State Example: Oregon has a Children's System Advisory Council to advise on the administration of child and family programs.

Remove diagnosis codes as a pre-requisite for accessing care.

State Example: California updated its non-specialty mental health services provider manual in 2022 to enable eligibility for family therapy based on certain life experiences (regardless of a mental health diagnosis).

Add new provider types to the Medicaid state plan to enable flexibility as to where services may be provided (i.e., schools, childcare centers) and provide families with resources to obtain/maintain coverage.

State Example: 24 states pay for community health workers through Medicaid (3 are in the process of implementing coverage).

Leverage Non-Emergency Medical Transportation (NEMT)/Non-Medical (Personal) (NMT) Transportation policies to provide transportation supports for families.

State Example: Illinois' approved section 1115 demonstration enables NMT to and from health-related social needs (HRSN) services.

Strengthen oversight of network adequacy standards.

The Managed Care/Access final rules include new requirements related to appointment wait time standards, secret shopper surveys, and issuing remedy plans.

MCO Access and Outcome Improvement Strategies and Examples

States can drive improvements in child health through a variety of managed care-based levers.

Require MCOs to **develop and submit a child wellbeing strategy** or action plan to improve children's health.

Encourage or require MCOs to support provider adoption of evidence-based models through incentive payments/enhanced rates (e.g., home visiting, dyadic care).

Require coordination between MCO and Early Head Start/Head Start entities.

Align managed care quality requirements with child health priorities.

State Example: North Carolina's withhold program heavily weights payment according to both overall improvement and disparities reduction related to childhood immunization.

Encourage or require plans to invest in initiatives to address HRSNs.

State Examples: Nebraska created the Medicaid Managed Care Excess Profit Fund in 2020 to set aside excess MCO profits that can be reinvested by the state to "provide for services addressing the health needs of adults and children," such as home visiting. Arizona's managed care contract requires MCOs to invest a percentage of net profits/net income into local communities. Additional state examples are available here.

Allow or require MCOs to cover HRSNs (e.g., nutrition, housing services) through in lieu of services, waiver, or state plan authorities. *See here for more information.*

MCO Accountability Strategies and Examples

States can hold MCOs accountable for investing in early child systems of care and children's health:

Require MCOs to develop annual child wellbeing progress reports, with required data elements (potentially inclusive of data from outside of the healthcare system, such as from the education and juvenile justice systems).

Review MCO contracts to determine if obligations for follow-up care, care management, and outcome reporting should be strengthened.

State Example: Increasingly, states are adding specific definitions for children and youth with special healthcare needs (CYSHCN) to their MCO contracts and evaluating the care provided to CYSHCN using measures accounting for their needs.

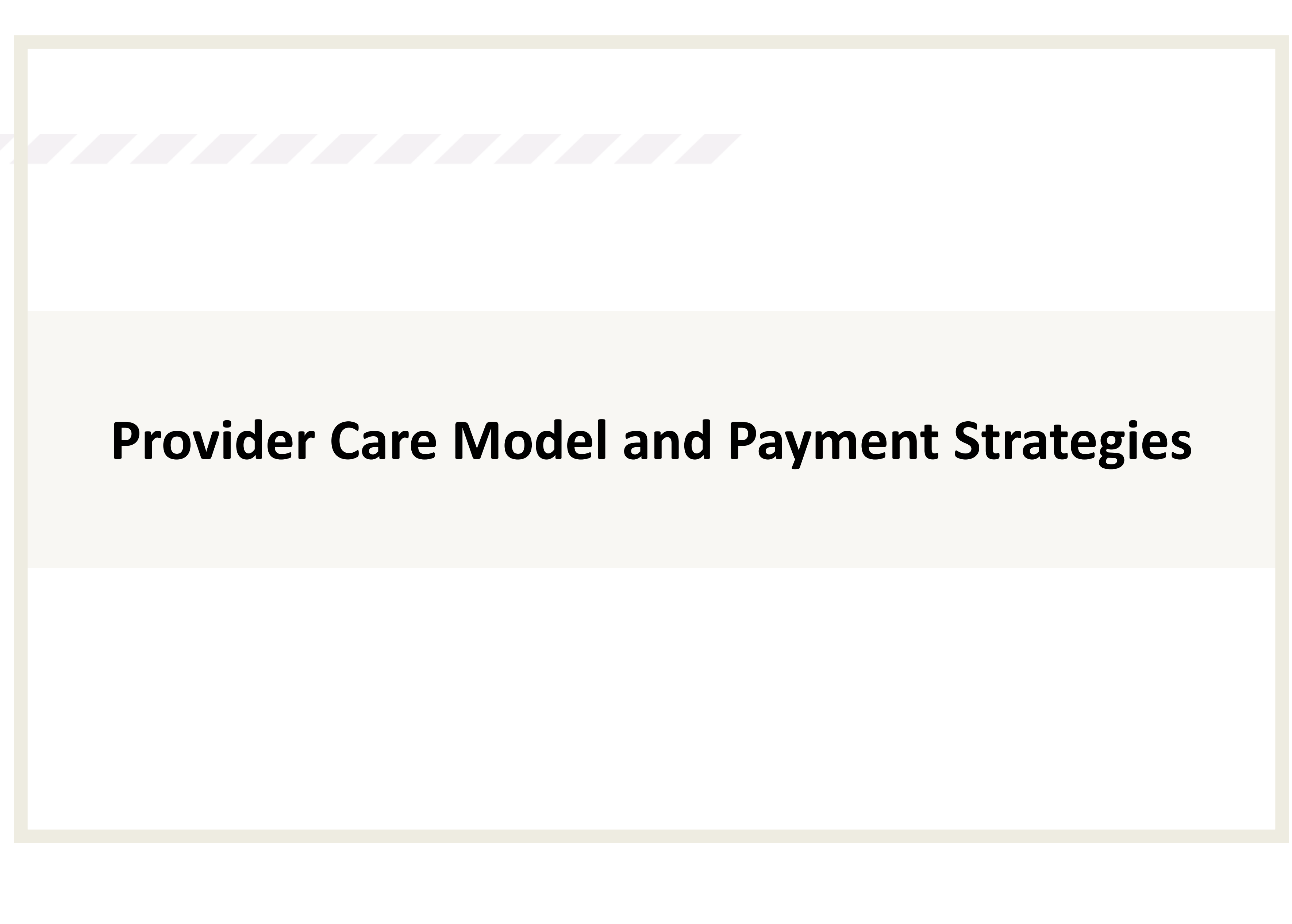
Convene regular meetings with MCOs to review and address issues with key performance metrics, such as developmental screenings.

Requiring MCOs to tailor their models of risk stratification to children and youth rather than integrating into adult models, so more children and youth are identified earlier for enhanced support.

Require MCOs to convene regularly with providers, local health departments, community-based organizations and child health advocacy organizations to build early childhood referral networks to ensure children/youth and families receive the resources they need.

Strengthen contract language around liquidated damages for failure to achieve standards related to child health.

State Example: The majority of Ohio's reported financial sanctions were imposed for failure to meet provider panel requirements for network adequacy and failure to meet performance measure benchmarks.


Provider Care Model and Payment Strategies

Care Delivery Best Practices for Children/Youth and Families

CE provides a stable revenue stream to providers to adopt innovative, evidence-based care delivery models, such as home visiting and other team-based models:

Model	Overview	Key Outcomes
Healthy Steps	▪ Supports children (age 0-3) by integrating an expert in early childhood development and behavioral health prevention into the primary care team. ▪ Operational in 25 states.	▪ Improved screening and connection to services. ▪ Lower healthcare costs. ▪ Patient and provider satisfaction.
Developmental Understanding and Legal Collaboration for Everyone **(DULCE)**	▪ Supports infant development and family wellbeing by addressing HRSNs through an integrated, interdisciplinary team (e.g., family specialist, medical provider, legal partner, and others). ▪ Operational in seven states.	▪ Accelerated access to supports. ▪ Improved completion rates for well-child visits and immunizations. ▪ Reduced use of emergency department care.
Transforming and Expanding Access to Mental Health Care in Urban Pediatrics **(TEAM UP)**	▪ A Boston-based model utilizing a fully integrated, multidisciplinary care team of behavioral health clinicians, community health workers, and primary care providers. ▪ The team focuses on promotion, prevention, early identification of emerging behavioral health issues, and access to care.	▪ Promotes strength-based parenting and access to early childhood education. ▪ Enhanced screening and navigation to Early Intervention and community-based services.
Collaborative Care Model	▪ A collaborative team, inclusive of a primary care provider, care management staff and psychiatric consultant, deliver a systemic and measurement-based approach to care. ▪ Medicaid reimbursable in at least 16 states.	▪ Improve early identification and treatment of mental health conditions, across settings and payment models.

Adopting APMs to Promote Provider Innovation

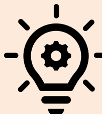
States may adopt APMs, such as capitation and/or bundle payments, to ensure providers have the financial flexibility to implement care delivery best practices.

Massachusetts Primary Care Subcapitation Model

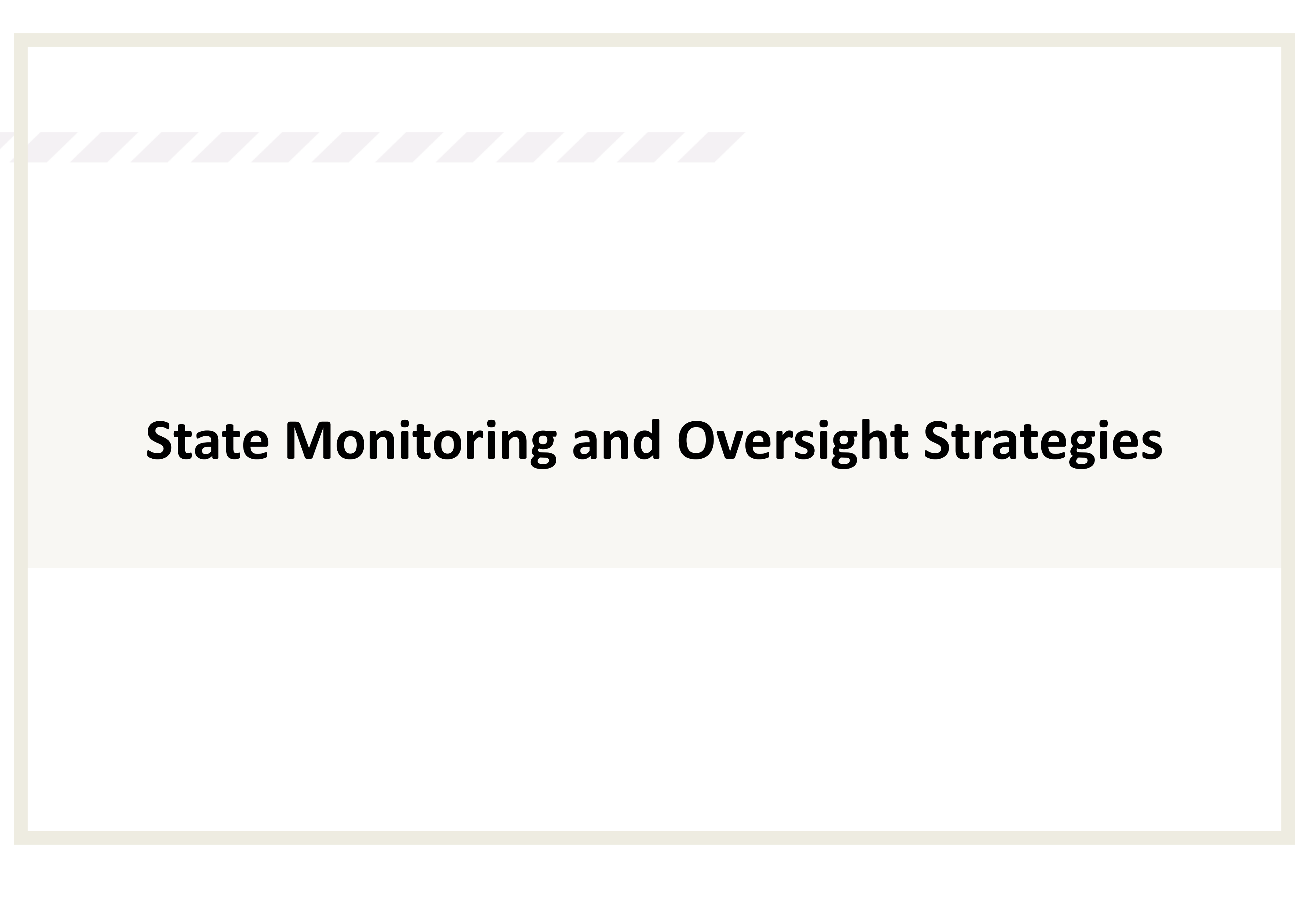
- MassHealth pays a fixed per-member per-month payment to primary care providers participating in an Accountable Care Organization.
- Participating providers must meet a set of minimum care delivery standards and may receive enhanced payment for providing more advanced services.
- Since implementation in 2023, more than 100 practices in the state have since expanded or advanced the clinical services provided in their practices (e.g., integrating behavioral health services, offering after hours/weekend access).

Colorado Alternative Care Model 1

- Enrolled providers (i.e., FQHCs and primary care practices with more than 500 attributed members) are paid based on their performance on quality measures and payments are redistributed from lower performers to higher performers.
- Providers select quality measures to be evaluated on annually: three are mandatory and seven are selected by the provider.



APMs also encourage providers to hire and embed community health workers and patient navigators, implement new/update existing technology to improve engagement with families, spend additional time with families during the visit, extend hours/weekend access, and deploy mobile clinics.

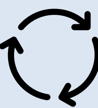


State Monitoring and Oversight Strategies

Leveraging Available Data and Tools

States may use the following data inputs to track whether the state's goals for children's health are being met.

Data	Example Metrics
Claims	• Claims/encounter reviews to identify access to care variation across plans
Enrollment	• Changes in Medicaid enrollment by key demographic variables (e.g., age, gender, race/ethnicity) • Changes in WIC, Supplemental Nutritional Assistance Program (SNAP) and other family-focused program enrollment
Child Core Set (available here)	• Child and adolescent well care visits • Childhood immunization status • Immunizations for adolescents • Developmental screening in the first three years of life • Screening for depression and follow-up plan • Oral evaluation, dental services • Topical fluoride for children
CMS 416 (available here)	• Screening ratio (actual number of initial and periodic screens over the expected number of screens) • Total eligibles receiving at least one initial or periodic screen • Total eligibles referred for corrective treatment
HRSN Screening	• Food insecurity rates • Housing insecurity rates • Measures of referral and receipt of services



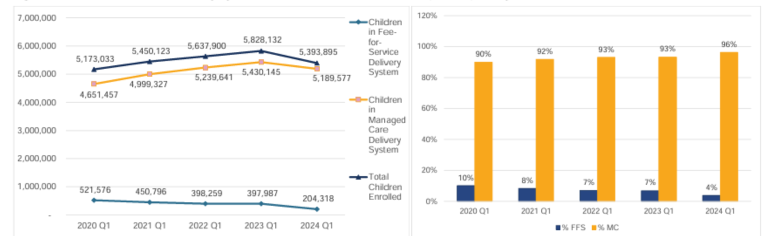
States may also consider opportunities to create a feedback loop to elevate issues identified by the BAC/MAC and key stakeholders (e.g., pediatric providers, WIC offices), as well as data from care gap reports, secret shopper surveys, and patient-reported outcomes survey results.

State Dashboards

States may consider developing a family-facing dashboard to publicly report child health outcomes and other key indicators. Some examples include:

California

Provides disaggregated breakdowns of enrollment and Child Core Set metrics (both managed care and FFS systems).



Louisiana

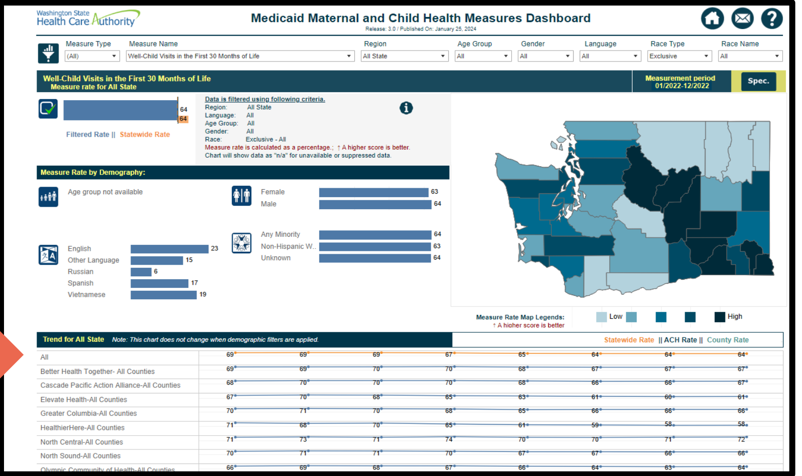
Includes performance on Child Core Set metrics over time, overall, and by managed care plan.

Oregon

Developing a dashboard specific to CE metrics in addition to their detailed Medicaid enrollment report.

Washington

Enables an interactive view of maternal and infant health quality metrics disaggregated by language, region, and race/ethnicity.



Source: Georgetown University Center for Children and Families, A Round-Up of Current Child Health Dashboards.

Longer Term Strategies

States can consider longer term strategies to improve oversight of child health and wellbeing, which may require additional resources to adopt.

- **Develop data collection processes and metrics to reflect system-level impact,** such as reductions in family financial hardship, family/child wellbeing, provider engagement with families, and decreased administrative burden.

- **Develop state-specific child health outcomes measures.**

State Spotlight: Oregon adopted a Kindergarten Readiness measure in 2022, a four-part measure that emphasizes preventive dental and well-child visits, social-emotional health, and developmental screening/ follow-up. Families, as well as healthcare and community leaders from across the state, participated in the development of the metric. Oregon's 16 Coordinated Care Organizations will receive financial incentives for meeting benchmarks related to the social-emotional health metric.

State Spotlight: North Carolina's Integrated Care for Kids (NC InCK) model links data from the Medicaid program and the Department of Education on Kindergarten Readiness to evaluate the impact of reforms related to enhancing well-child visits. As part of data use agreements, MCOs and health systems receive an annual data summary on how their members/patients perform on Kindergarten Readiness assessments.

- **Create a state MCO approval or certification program** for plans that meet child health-specific benchmarks, and award plans through favorable procurement scoring and auto-assignment policy.
    - **This strategy can extend to pediatric offices as well**, to reflect adoption of evidence-based models such as Healthy Steps or Reach out and Read. Plans can support providers in implementing these models and reflect these distinctions in provider directories (i.e., practices that deliver dyadic care, have received training in cultural competency, and are multi-language accessible).

Appendix

Approved CE Demonstrations

State	Multi-Year CE for Young Children	CE for Adolescents/Adults	CE for Special Populations
Colorado	Ages 0-3		12 Months for Individuals Released From Correctional Facilities
Hawaii	Ages 0-6	24 Months CE 6-19	
Kansas		12 Months CE for Parents and Other Caretaker Relatives	
Massachusetts		12 Months CE for Adults 19+ *[based on Modified Adjusted Gross Income (MAGI) or non-MAGI]*	• 12 Months CE for Individuals Released From Correctional Facilities • 24 Months CE for Individuals Experiencing Homelessness
Minnesota	Ages 0-6	12 Months Ages 19-21	
New Jersey		12 Months CE for Adults *(based on Modified Adjusted Gross Income)*	
New Mexico	Ages 0-6		
New York	Ages 0-6	12 Months CE for Adults *(based on MAGI)*	
Oregon	Ages 0-6	Age 6+ for 24 months	24 Months CE for YSHCN Ages 19-26
Pennsylvania	Ages 0-6		12 Months for Individuals Released From Correctional Facilities
Washington	Ages 0-6		

Pending CE Demonstrations

State	Waiver Status	Multi-Year CE for Young Children	CE for Adolescents/Adults	CE for Special Populations
Arizona	***Submitted and Pending Approval by CMS***			**Multi-Year CE for Former Foster Youth Ages 18-26**
North Carolina		**Ages 0-6**	**Ages 6-18 for 24 Months**	**Multi-Year CE for Former Foster Youth Ages 18-26** (aged out prior to 1/1/23)
California	***State Designing Waiver (Enacted Legislation)***	**Ages 0-5 (2026)**		
DC		**Ages 0-6**		
Ohio		**Ages 0-4**		

Sources

Approved CE Demonstrations	Pending CE Demonstrations	Enacted CE Legislation
Hawai'i *(Source)* **Colorado** *(Source)* **Kansas** *(Source)* **Massachusetts** *(Source)* **Minnesota** *(Source)* **New Jersey** *(Source)* **New Mexico** *(Source)* **New York** *(Source; Source)* **Oregon** *(Source)* **Pennsylvania** *(Source)* **Washington** *(Source)*	**Arizona** *(Source)* **North Carolina** *(Source)*	**California** *(Source)* **DC** *(Source)* **Ohio** *(Source)*