



Georgetown University
McCourt School *of* Public Policy
CENTER FOR CHILDREN
AND FAMILIES

Medicaid's Role in Child and Adolescent Behavioral Health in Connecticut

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Anne Dwyer, Associate Research Professor*

Outline

- Medicaid's role in children's behavioral health care
- General EPSDT background
- BSCA and recent administrative actions
- Brief overview of recent lawsuits
- State data dashboards and other efforts

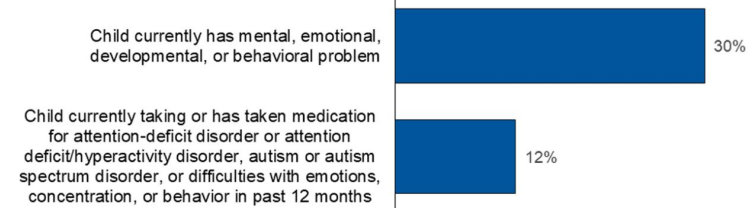
Why Medicaid?

- **Behavioral Health Care:** Single largest payer of behavioral health care, which encompasses mental health and substance use treatment services.
- Provides health coverage (along with CHIP) to about **half** of all children in the US
 - More than half of Black, Hispanic, and American Indian or Alaska Native children due to economic disadvantages and income
 - Covers over 75% of low-income children **under the age of 6**
- **About a third** of children enrolled in Medicaid or CHIP had a mental, emotional, developmental, or behavioral problem

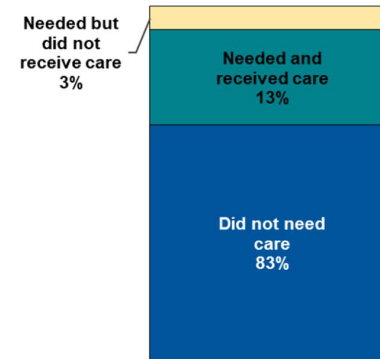
Mental Health Status of Children Enrolled in Medicaid or CHIP, 2021

Population: Non-institutionalized beneficiaries ages 3 to 17 with any public insurance coverage

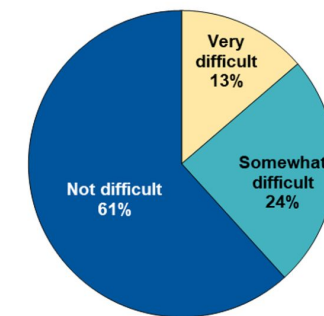
Parent-Reported Current Mental Health Status of Children



Children's Need for and Receipt of Mental Health Care Within Past 12 Months



Difficulty Obtaining Mental Health Care Among Children Who Received Care



Notes:
Data include non-institutionalized children ages 3 to 17 covered by public insurance (alone or in combination with private insurance). All indicators are based on parent report. To qualify as having a mental, emotional, developmental, or behavioral problem, the child must qualify on the Children with Special Health Care Needs (CSHCN) Screener criteria for ongoing emotional, developmental or behavioral conditions and/or have any of 10 conditions currently (Tourette Syndrome, anxiety problems, depression, behavioral and conduct problem, developmental delay, intellectual disability, speech or other language disorder, learning disability, autism or ASD, ADD or ADHD). Receipt of mental health care is defined as receiving any treatment or counseling from a mental health professional. Level of difficulty obtaining care is among those who needed and received care. Totals do not sum to 100 as <2% of respondents indicated both that their child needed and received care and that it was not possible to obtain care. Responses of missing in error (≤3% of responses for each indicator) are excluded.

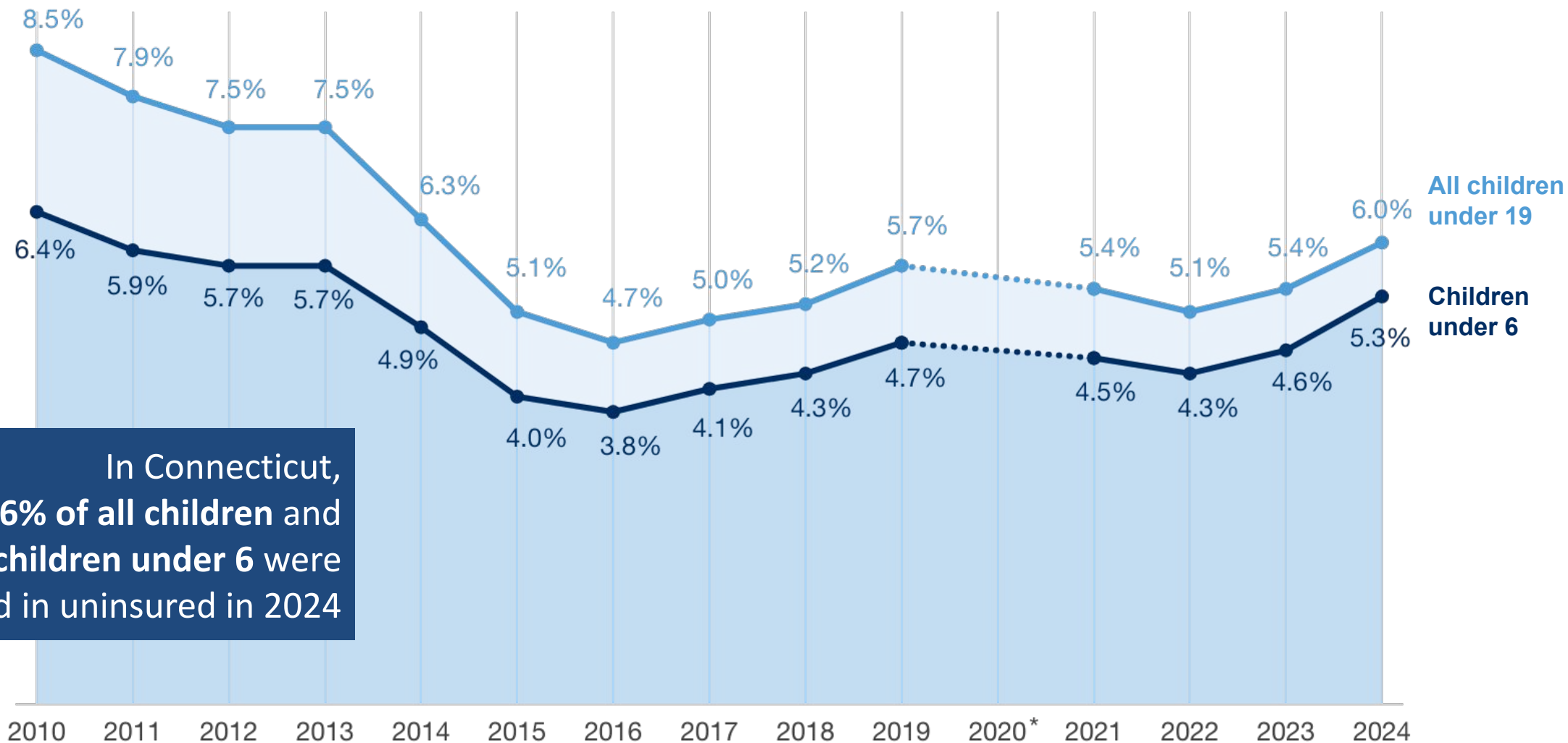
ADD = Attention-Deficit Disorder; ADHD = Attention Deficit/Hyperactivity Disorder; ASD = Autism Spectrum Disorder

Source:
Mathematica analysis of National Survey of Children's Health, 2021 Public Use Data files.

Available at:
<https://www.census.gov/programs-surveys/nsch.html>



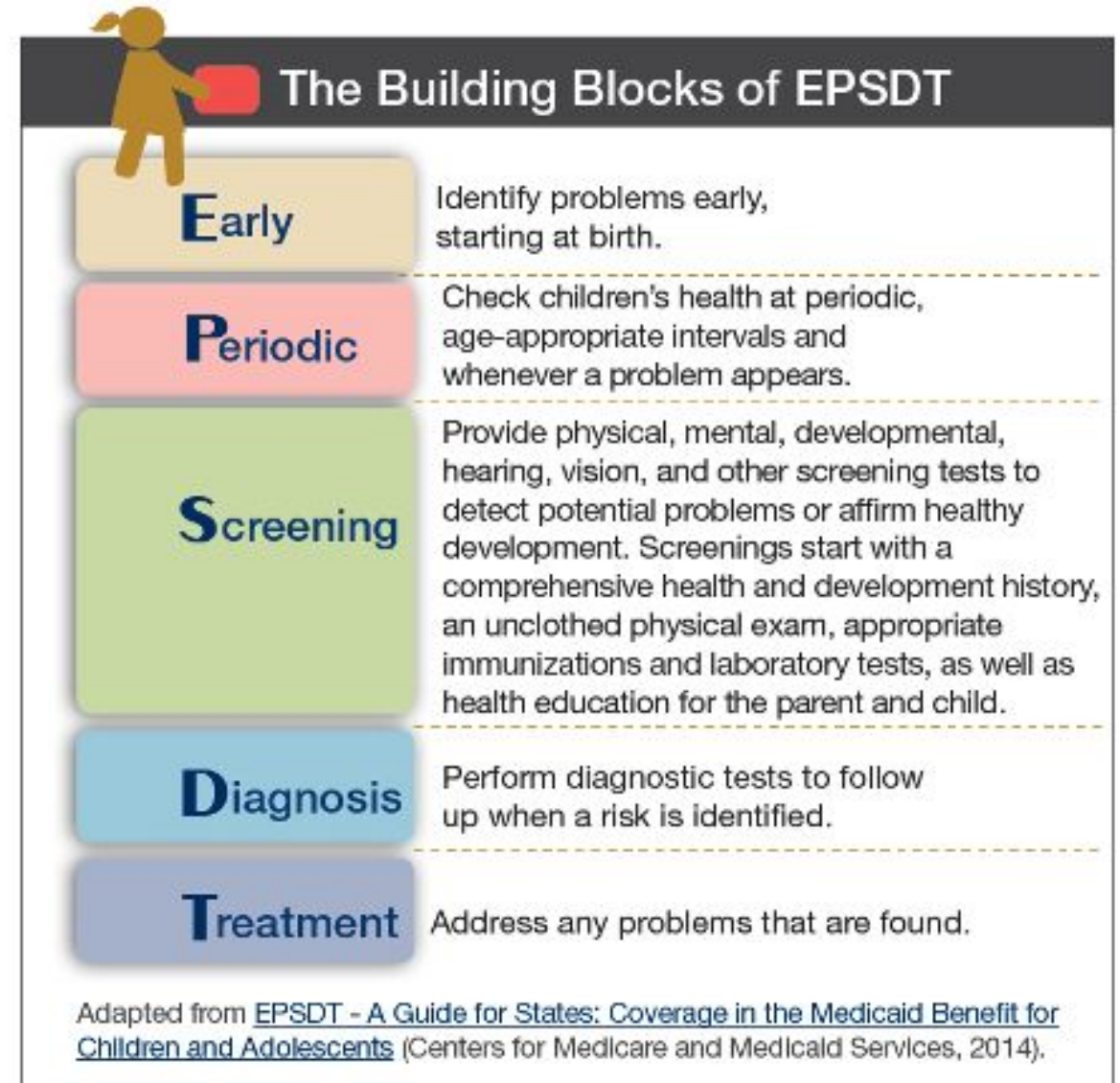
Rate of Uninsured Children in the U.S., 2010-2024



**In Connecticut,
2.6% of all children and
1.5% of children under 6 were
uninsured in 2024**

* Due to pandemic-related data quality issues, the U.S. Census Bureau did not release standard 1-year ACS estimates in 2020.

THE Pediatric Benefit in Medicaid: Early Periodic Screening Diagnostic and Treatment (EPSDT)



How did we get such a comprehensive pediatric benefit in Medicaid?

“The program’s origin can be traced to a government study...titled ‘One Third of a Nation: A Report on Young Men Found Unqualified for Military Service.’ The report revealed that half of the young men drafted into military service in 1962 were rejected due to preventable and treatable physical, mental, and developmental health conditions. This discovery demonstrated the need for children and adolescents’ access to preventive medical services starting from an early age, eventually leading up to one of the hallmarks of the Medicaid program, the EPSDT benefit.”

DISCLAIMERS

- Medicaid benefits (EPSDT) is subject to legal interpretation.
- Medicaid is administered differently in each state.

For more information, see:

- National Health Law Program resources, such as [*EPSDT Legal Landscape and Implementation History*](#)
- Medicaid and CHIP Payment and Access Commission (MACPAC): [*EPSDT in Medicaid*](#)

Medicaid Benefits & EPSDT

Mandatory services - examples:

- Inpatient/outpatient hospital
- Physician and certified pediatric nurse practitioner services
- Family planning services and supplies

Optional services - examples:

- Prescription drugs
- Clinic services
- Dental services
- Occupational and physical therapy

AMERICAN ACADEMY OF PEDIATRICS RECOMMENDED CHECKUPS



EPSDT* (Children)

- Identify problem **early**, starting at birth
- Check children's health and development at **periodic** intervals
- Provide appropriate **screenings** to detect problems
- Perform **diagnostic** tests to identify risks
- Provide **treatment** for any problems found

*Most separate state CHIP programs adopt or align with EPSDT

EPSDT is the Medicaid program's federally guaranteed benefit for all Medicaid enrollees under age 21. Under EPSDT, Medicaid must provide a comprehensive array of preventive, diagnostic, and treatment services.



Early and Periodic Screenings

- **EPSDT screening = comprehensive well child visit**
- Regularly scheduled comprehensive well child visits and screening
- Comprehensive unclothed physical exam
- Developmental screening
- Appropriate vision and hearing testing
- Appropriate immunizations (according to recommendations age and history)
- Appropriate laboratory tests (including lead screening)
- Dental screenings and referrals to a dentist (for children beginning at age 1)
- Health education/anticipatory guidance for parents, children, and youth



Diagnostic Services

Diagnostic services when a risk is identified, including follow-up testing, evaluation, and referrals



Treatment Services

- States must provide timely treatment services based on risks and conditions identified
- Health care or treatment services include those that are **medically necessary** to correct or ameliorate defects and address physical and behavioral health conditions

Getting to the T (Treatment)

EPSDT Requirements Create a Strong Legal Standard of Coverage for Children

Medical Necessity

Definition unique to children: Medicaid must cover treatments or procedures necessary to “correct or ameliorate defects and physical and mental illnesses and conditions”

Scope of Services

Scope of services unique to children: Medicaid must cover all medically necessary services that *could be covered under Medicaid, regardless of whether they are covered under the State Plan*

Medicaid Covered Services for Children– Statute Says...

Mandatory Services

- Family planning services and supplies
- Federally Qualified Health Clinics and Rural Health Clinics
- Home health services
- Inpatient and outpatient hospital services
- Laboratory and X-Rays
- Medical supplies and durable medical equipment
- Non-emergency medical transportation
- Nurse-midwife services
- Pediatric and family nurse practitioner services
- Physician services
- Pregnancy-related services
- Tobacco cessation counseling and pharmacotherapy for pregnant women

Optional Services

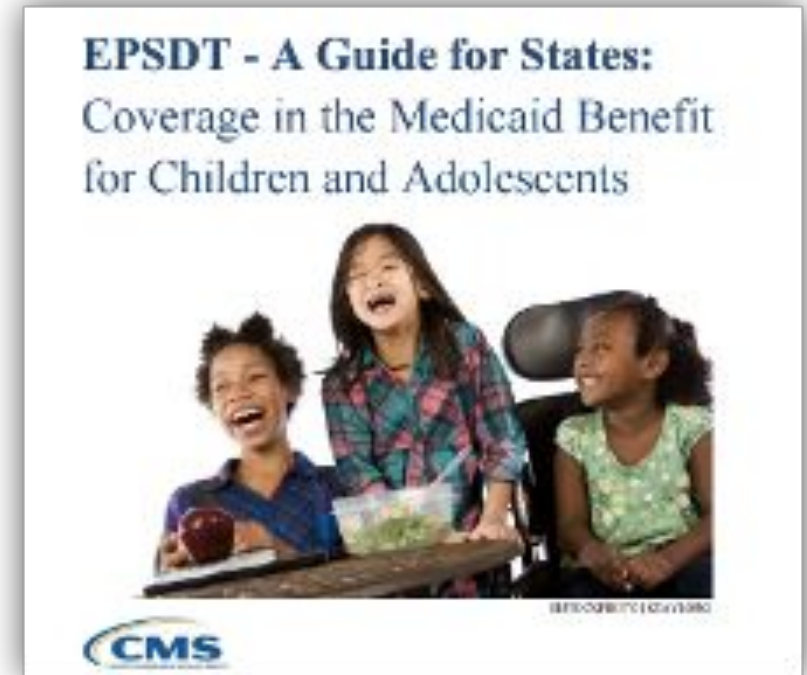
- Community supported living arrangements
- Chiropractic services
- Clinic services
- Critical access hospital services
- Dental services
- Dentures
- Emergency hospital services (in a hospital not meeting certain federal requirements)
- Eyeglasses
- State Plan Home and Community Based Services
- Inpatient psychiatric services for individuals under age 21
- Intermediate care facility services for individuals with intellectual disabilities
- Optometry services
- Other diagnostic, screening, preventive and rehabilitative services
- Other licensed practitioners' services
- Physical therapy services
- Prescribed drugs
- Primary care case management services
- Private duty nursing services
- Program of All-Inclusive Care for the Elderly (PACE) services
- Prosthetic devices
- Respiratory care for ventilator dependent individuals
- Speech, hearing and language disorder services
- Targeted case management
- Tuberculosis-related services

Under EPSDT, states must cover all medically necessary services, including those that are “optional” for adults.

What about Mental and Behavioral Health Services?

“Treatment for mental health and substance use issues and conditions is available under a number of Medicaid service categories, including **hospital and clinic services, physician services, and services provided by a licensed professional** such as a psychologist. States should also make use of rehabilitative services.” (Page 10+)

- Parity laws and guidance strengthen the standard



EPSDT “Medical Necessity”

Broad Definition

EPSDT medical necessity definition is broader than most private plans

“Determination of whether a service is medically necessary must be made on a case-by-case basis, taking into account a particular child’s needs.” — CMS

Key Determinations

- Must be individualized
- Made by states with health provider input

Purpose: Prevention & Early Intervention

A service is necessary if it will:

- Prevent a condition
- Improve health or ameliorate condition
- Cure, maintain, or restore health

Limitations on EPSDT

Permitted

- Utilization controls, such as prior authorization for some services or “soft limits”
- Experimental treatment is not required but can be covered if it would address a child’s condition
- Relying on the latest scientific evidence to inform coverage decisions
- Considering cost when assessing alternatives
- Covering services in cost-effective manner if as good or better than alternative

Prohibited

- Prior authorization for screenings
- Using utilization controls that delay the provision of necessary treatment
- Hard limits (service caps)
- Denying treatment due to cost alone

Making EPSDT Work for Kids

Common Challenges

- State variability in application of medical necessity
- Provider access
- Ensuring families know their rights
- Ensuring providers understand EPSDT requirements
- Process and billing guidance for providers, new services

Opportunities

- Enabling new interventions and therapies to be incorporated into Medicaid coverage for children

Bipartisan Safer Communities Act & EPSDT Developments

Bipartisan Safer Communities Act of 2022

- **Certified Community Behavioral Health Clinic Demonstration (CCBHC)**
 - National expansion
 - On average, about 23% of clients in original 8 demo states were children or adolescents
- **Telehealth**
 - Mandated guidance and technical assistance to states
- **Medicaid & Schools**
 - Mandated guidance and technical assistance center
 - \$50 million in grants to states to support school-based services
- ****EPSDT Technical Assistance & Oversight****
 - Mandated reviews of state EPSDT implementation, technical assistance, guidance, report to Congress and Government Accountability Office report



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The Bipartisan Safer Communities Act: Where Things Stand on the Medicaid and CHIP Provisions

by Anne Dwyer

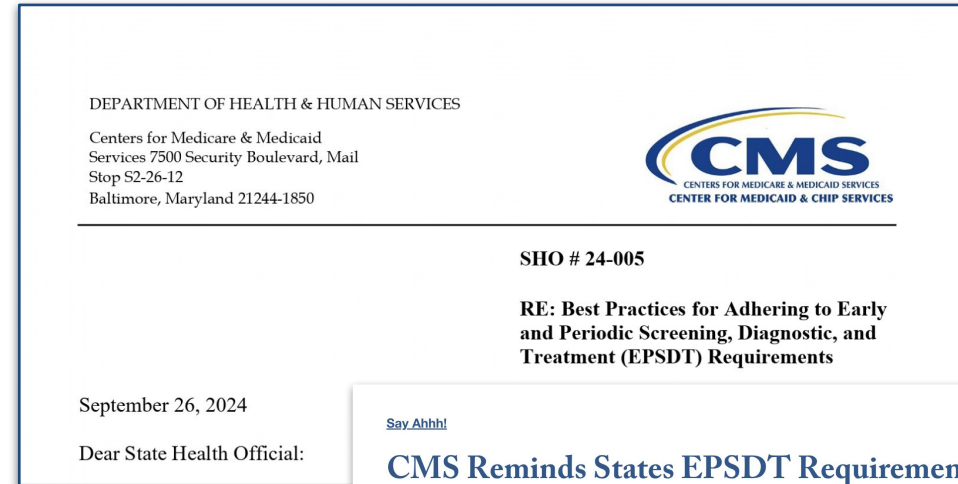
On June 25, 2022, President Biden signed into law the Bipartisan Safer Communities Act (P.L. 117-159).¹ The Bipartisan Safer Communities Act included a number of provisions related to Medicaid and the Children's Health Insurance Program (CHIP) including expanding the Certified Community Behavioral Health Clinic Medicaid demonstration program as well as mandated guidance, technical assistance, and other resources and requirements related to telehealth, school-based Medicaid services, and Medicaid's Early and Periodic Screening, Diagnostic and Treatment benefit.²

Provisions Covered in this Brief: Background and Status

- ▶ Certified Community Behavioral Health Center Medicaid Demonstration Program
- ▶ Medicaid and CHIP Telehealth Guidance
- ▶ Medicaid and School-Based Services: Guidance, Technical Assistance Center, and Grants to States
- ▶ EPSDT: State Implementation Review and Oversight Requirements

Status: EPSDT Requirements

- ✓ **GAO report on EPSDT and managed care**
 - Released June 2025; did not include any formal recommendations to Congress
- ✓ **HHS report to Congress**
 - Issued December 2025
- ? **Ongoing review of state implementation of EPSDT including technical assistance to states to address gaps and deficiencies**
- ✓ **Issue guidance to states**
 - CIB on Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth (Released August 2022)
 - SHO on Best Practices for Adhering to EPSDT Requirements (Released September 2024)
 - **Behavioral Health Toolkit** (released February 2026)



Toolkit: Reaffirming Behavioral Health is Covered Under EPSDT

A State-Oriented Resource: Provides 100+ pages of actionable strategies to help states meet their EPSDT obligations

The Mandate: Reiterates that states are obligated to cover all medically necessary mental health and substance use disorder (SUD) services for children under 21 as part of EPSDT

Why It Matters:

- Medicaid covers nearly half of all children in the U.S.
- 30% of children with public health coverage reported mental or emotional challenges in recent years.
- The toolkit reaffirms that states must cover the full continuum of care, from early signs to intensive community-based services.

CMS Releases Long-Awaited EPSDT Behavioral Health Toolkit for States



February 24, 2026 Anne Dwyer



Say *Ahhh!* readers will recall that when we **blogged** about the behavioral health section of the Center for Medicare & Medicaid Services (CMS) landmark 2024 EPSDT guidance, we noted that **CMS** had an additional EPSDT behavioral health resource in the works — an EPSDT Behavioral Health Services Toolkit. Now, over two years later, that toolkit has finally arrived.

Four Pillars of the Behavioral Health Toolkit

The toolkit is organized around four main pillars to help states strengthen their delivery systems:

- 1. Delivery System Support:** Developing a continuum that meets a range of needs, prioritizing community-based services over institutional care.
- 2. Promoting Early Intervention:** Expanding access to services that address behavioral health needs before they escalate.
- 3. Service Coordination & Integration:** Improving access through case management and integrating behavioral health into primary care settings.
- 4. Workforce Capacity:** Broadening the provider base (i.e., covering non-licensed professionals and establishing sufficient reimbursement rates to attract providers)

Behavioral Health Service Array

According to CMS, such an array *includes, but is not limited to:*

1. Screening and assessment;
2. Services to address early signs or symptoms of behavioral health conditions, 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, including routine community-based services as well as services to meet more intensive needs;
4. Services to address urgent and crisis needs; and
5. Inpatient care only when medically necessary.

Toolkit Highlight: Infant and Early Childhood Mental Health

Focus on prevention: The toolkit reinforces that behavioral health development begins at birth, requiring proactive screening and prevention rather than reactive crisis management.

- **Use of Specialized Assessment Tools**
 - i.e., Georgia's IECMH Billing Guide for Preventive Services, which provides a list of covered services, along with the appropriate billing codes.
- **Early Intervention Early Intervention Strategies:**
 - Implementing evidence-based home visiting models (e.g., HealthySteps and Maryland example) to integrate behavioral health into primary pediatric care.
 - Conducting universal evaluations to identify emotional or mental health needs before they escalate.
 - Addressing early symptoms of concern with or without a formal diagnosis to ensure timely care

State Medicaid & CHIP Toolkit for Children's Behavioral Health Services and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Requirements

Strategy 2.6: Support early intervention for behavioral health conditions by covering infant and early childhood mental health (IECMH) services.

The earliest years of life are a critical window to promote a strong foundation for mental health and prevent and address emerging concerns.¹²⁹ Infant and early childhood mental health (IECMH) includes a range of supports and services to help children from birth to age 5 to express a range of emotions and to enjoy playing, communicating, and interacting with trusted caregivers.¹³⁰ When children develop these important skills early on in life, they experience a higher likelihood of school success and reduced risk of mental health and behavior problems in later childhood and beyond.

States can cover IECMH services, and add these services to MCP contracts, to improve outcomes for children, build capacity for caregivers, and facilitate early identification and treatment of behavioral health concerns before they develop into serious behavioral health conditions.¹³¹ Medicaid-coverable IECMH services and supports include social-emotional screenings for infants and young children, parental/caregiver screenings, IECMH consultation, parents supports, assessment and diagnosis, treatment interventions, and case management.^{132, 133}

Toolkit Highlight: Removing Clinical and Administrative Barriers

- **Services Without a Formal Diagnosis:** Allowing behavioral health billing based on symptoms alone, ensuring children receive care while a diagnosis is being determined.
 - State Examples: Alaska, California, and Colorado implement "diagnosis-free" billing for certain children's services.
- **Protections from Utilization Limits:** Under EPSDT, medical necessity criteria cannot impose "hard limits" on the amount, duration, or scope of behavioral health services.
- **Case-by-Case Prior Authorization:** States are reminded that prior authorizations must be conducted individually and cannot delay necessary treatment.
 - New York, for example, prohibits prior authorization for the first 14 days of psychiatric inpatient admissions for youth.

State Examples

Alaska issued guidance¹¹⁶ for providers on using the International Classification of Diseases, Tenth Edition (ICD-10) "Z" codes as a primary code for certain behavioral health services. The ICD-10 "Z" codes signify a health or emotional well-being concern that warrants treatment but lacks a specific diagnosis.^{117, 118} Alaska's Native Health Tribal Association has a list of common "Z" codes¹¹⁹ that can be included on claims as part of the state's Behavioral Health Aide program.

California's FFS providers and MCPs are responsible for ensuring coverage of non-specialty mental health services, including individual, group, and family therapy, for children who have a potential mental health condition without a formal diagnosis.¹²⁰ In addition, using Section 1915(b) waiver authority, California's county mental health plans provide a range of specialty mental health services (e.g., intensive care coordination, intensive home-based services, therapeutic foster care, therapeutic behavioral services, etc.) for children without a behavioral health diagnosis if a child is high risk for developing such a condition.^{121, 122} High risk factors include, for example, traumatic exposure, child welfare or justice system involvement, or housing insecurity. Providers are made aware of this policy via the Medi-Cal for Kids and Teens EPSDT mandatory provider training.

Colorado's Department of Health Care Policy and Financing (HCPF), which administers the state's Medicaid program, is required by state statute¹²³ to allow providers to bill for a limited set of behavioral health services for EPSDT-eligible children without a clinical diagnosis. These services, which must be provided as part of the state's managed care system, include family, group, and individual therapies; services related to prevention, promotion, education, or outreach; evaluation, intake, case management, and treatment planning; and other services identified based on stakeholder feedback. As of October 2025, the state identified 18 specific behavioral health service codes that fall under this policy.¹²⁴

Toolkit Highlight: Workforce, Coordination, and Follow-Up Care

- **Broadening Workforce Capacity:** To address provider shortages, the toolkit suggests states cover a wider range of qualified professionals, including non-licensed practitioners (i.e., peer support specialists).
- **Tailored Case Management:** Coordination must be tiered based on the complexity of the child's needs.
 - i.e., Ohio's tiered care coordination model as an example of this integrated approach.
- **The Follow-Up Care Gap:** Data shows only 45% of children receive follow-up care within 7 days of a mental health hospitalization.
 - CMS encourages states to initiate care coordination *before* discharge

Care Coordination and Case Management	
State Examples	<ul style="list-style-type: none">• Ohio uses a section 1915(b) managed care waiver to cover care coordination that is organized into three tiers based on a child's intensity of need.²⁷⁸ Children are placed into one of the coordination tiers based on a standardized assessment.<ul style="list-style-type: none">◦ Tier 1. Limited care coordination is for children with less intense behavioral health needs. Coordination is provided directly by the Medicaid MCP, with a maximum of one care coordinator to 62 children.◦ Tier 2. Moderate care coordination is for children with moderately intensive behavioral health needs. Coordination is provided through a community-based care management entity²⁷⁹ under contract with the Medicaid MCP, with a maximum of one care coordinator to 25 children.◦ Tier 3. Intensive care coordination²⁸⁰ is for children with highly intensive behavioral health needs. Coordination is provided by a community-based care management entity under contract with the Medicaid MCP, with a maximum of one care coordinator to 10 children.• Colorado has four Regional Accountable Entities (RAE) and two managed care programs that support providers in coordinating and delivering behavioral health services.²⁸¹• In Connecticut, HUSKY Health offers administrative case management services to support providers with child visits.

Department of Health and Human Services
Office of Inspector General



Office of Evaluation and Inspections

September 2025 | OEI-07-23-00510

**Most Children Enrolled in Medicaid
Did Not Receive Timely Suicide-
Related Followup Care**

Recent Legal Settlements

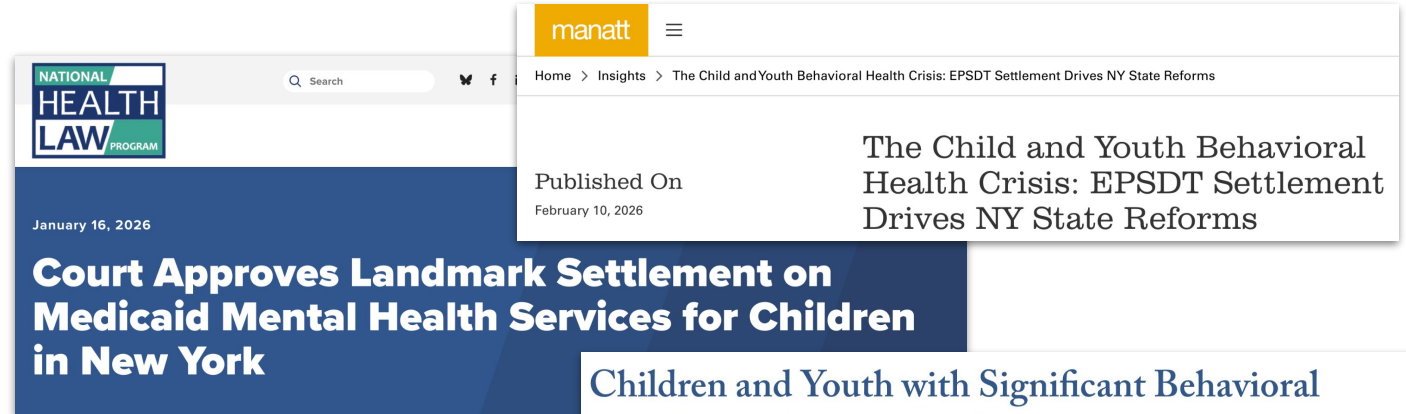
Recent federal court class action settlements (2025-2026) in:

- ☐ Michigan
- ☐ Colorado
- ☐ Iowa
- ☐ New York

“These agreements all share the following goals:

1. first, to ensure children and youth with serious behavioral health needs have access to intensive home and community-based services (IHCBS) statewide that will keep them at home with their families and caregivers;
2. second, to establish a standardized eligibility and assessment process and tool so that children are identified and connected with these services consistently and equitably;
3. third, to improve data collection and oversight to track services and outcomes; and
4. last, to implement continuous quality improvement measures to sustain progress and achieve better outcomes.”

- Kimberly Lewis, NHeLP



Children and Youth with Significant Behavioral Health Needs Will Benefit from New Legal Settlements by States Committing to Provide Intensive Home and Community Based Services



January 8, 2026 Kimberly Lewis

Opportunities in States

- Use state law to reinforce EPSDT guidance, create recommendations (e.g. MD)
- State child health data [dashboards](#) on Medicaid/CHIP quality metrics
- Analysis of utilization data (e.g. [CT359 analysis](#) of developmental screenings)
- Scan of gaps in Medicaid payment for best practices in child health, mental health
- ID opportunities to reiterate, clarify processes, educate or train providers

7 ↔ (a) The Behavioral Health Advisory Council and the Commission on Behavioral
8 Health Care Treatment and Access, through its workgroup on youth behavioral health,
9 individuals with developmental disabilities, and individuals with complex behavioral
10 health needs, shall ~~create a plan~~ provide recommendations to implement the
11 recommendations in Centers for Medicare and Medicaid Services State Health Official
12 letter #24-005: Best Practices for Adhering to Early and Periodic Screening, Diagnostic,
13 and Treatment (EPSDT) Requirements for children, including:

14 (1) screening and assessment of behavioral health conditions;

15 (2) the feasibility of implementing the DC:0-5 Diagnostic Classification of
16 Mental Health and Developmental Disorders of Infancy and Early Childhood as a
17 diagnostic tool for patients under the age of 5 years;

18 (3) community-based services to correct and ameliorate a wide range of
19 behavioral health conditions; and

20 (4) services to:

21 (i) ensure children's behavioral health;

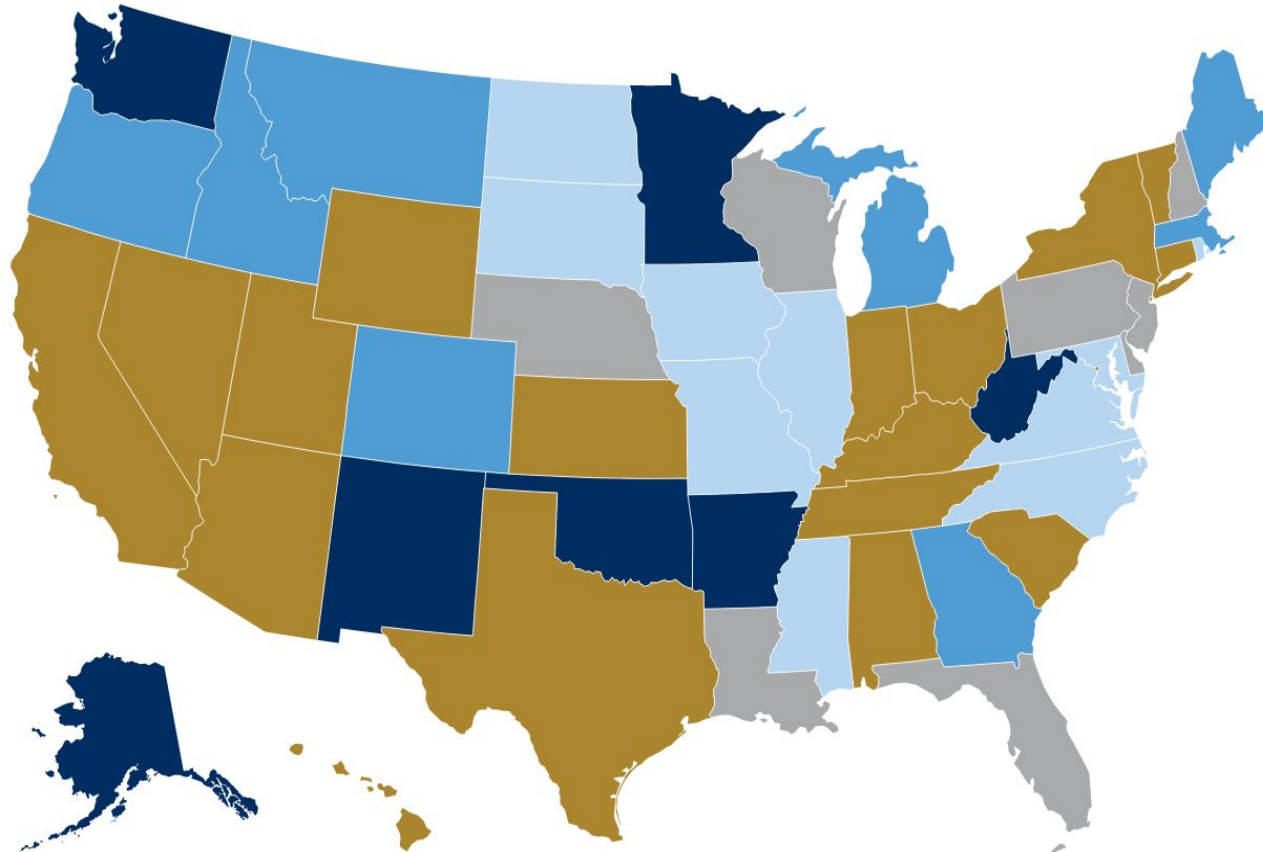
22 (ii) address early symptoms of concern, with or without a diagnosis;

23 and

24 (iii) address urgent and crisis needs.

15 States Require or Recommend Use of DC:0-5 (2023)

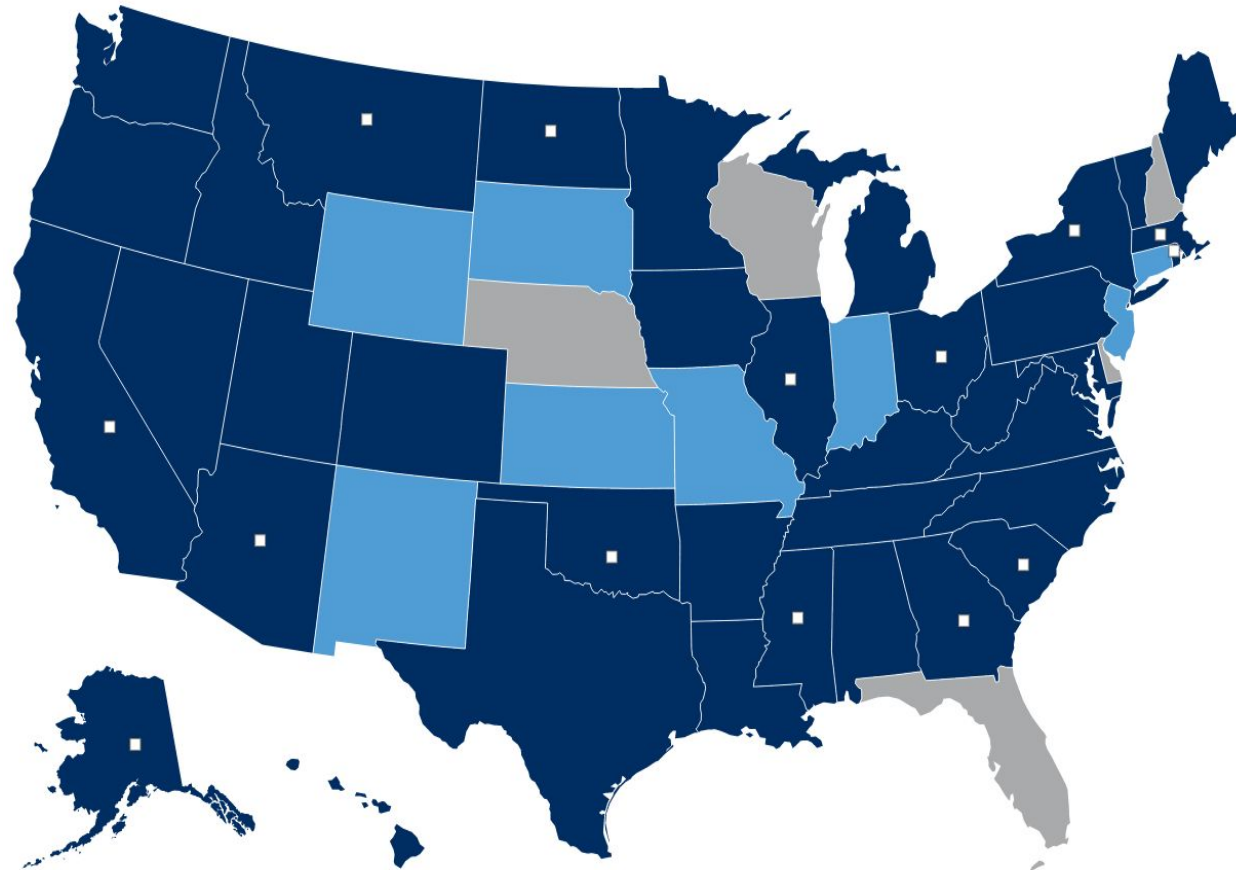
■ Require (7 states) ■ Recommend (8 states) ■ Permit (10 states) ■ Do not permit (17 states)
■ No response



The DC:0-5 is the only diagnostic system for supporting a developmentally appropriate mental health assessment of children under age 5

38 States Pay for Parent-Child Dyadic Treatment (2023)

■ Reimbursed (38 states) ■ Not reimbursed (8 states) ■ No response



14 states allow parent-child dyadic treatment without a mental health diagnosis

21 states require or recommend use of evidence-based models

Note: Square icon represents states that allow dyadic treatment without a child diagnosis.

For More Information:

Website/Say Ahhh! Blog:

<https://ccf.georgetown.edu/>

State Coverage Data, Info:

<https://kidshealthcarereport.ccf.georgetown.edu/>

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THANK YOU!

A photograph of two women smiling warmly at a baby. The woman on the left is wearing a white sweater and has her arm around the baby. The woman on the right is wearing a green top and is holding the baby's hands. The baby is wearing a white patterned onesie and is looking towards the camera. The background is softly blurred, suggesting an indoor setting with natural light.

Questions and Comments

