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Medicaid Early and Periodic Screening, Diagnosis and Treatment As A Source of Funding Early Intervention Services

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"All children are born wired for feelings and ready to learn."
National Research Council and Institute of Medicine (2000)

Introduction

The term "early intervention services" refers to formal attempts by persons outside of the family to work with the child and family to address cognitive, emotional, and resource limitations that exist in the child's environment. These services target the first few years of life and include health, education, and social services. Health services include comprehensive diagnostic screenings; nutrition services; behavior therapies; physical, speech and occupational therapies; day treatment; family support services; and health education describing expected developmental milestones.

Congress has provided for the coverage of early intervention services in a number of federal statutes. For example, the Individuals with Disabilities Education Act provides federal funding for developmental and behavioral services infants and children under age three who have developmental delays or are at risk of delays.[1] The Title V Maternal and Child Health Services Block Grant allows federal funding to ensure maternal and child access to quality health services and to increase the numbers of young children who receive check ups and needed follow-up care.[2] This issue brief focuses on Medicaid, particularly the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, as an important, but underused source of federal funding for early intervention services. It will summarize the importance of early childhood intervention and then discuss how early intervention services can be provided as EPSDT.

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[1] *See* 20 U.S.C. § 1431 *et seq. See also, e.g.*, Sarah Somers, *FAQs: Introduction to IDEA,* 205 HEALTH ADVOCATE 3 (Summer 2001).

[2] 42 U.S.C. § 701(a)(1). S*ee also, e.g.,* SARA ROSENBAUM, ET AL., USING THE TITLE V MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT TO SUPPORT CHILD DEVELOPMENT SERVICES (Jan. 2002)*, available at* www.cmwf.org.

The Importance of Early Childhood Intervention Services

The National Research Council and Institute of Medicine recently issued a voluminous report, *From Neurons to Neighborhoods,* that presents scientific evidence showing the importance of early childhood development and early intervention services.[3] It finds that the brain and nervous system undergo their most dramatic development during the first few years of life. From birth to age five, children develop foundational linguistic, cognitive, emotional, social, and moral capabilities upon which subsequent development builds.[4] The differences among what children know and can do are obvious by kindergarten. These differences are strongly associated with social and economic circumstances, and are predictive of subsequent academic performance. Redressing these disparities through early intervention services is critical, both for the child and for society.[5] Parents and other regular caregivers are "active ingredients" of environmental influence during a child's early years.[6] The report also finds that very young children can experience deep and lasting grief, sadness, and emotional impairment. Given the short- and long-term risks that accompany early mental health impairments, there is an urgent need to address the severe shortage of programs and professionals with the necessary expertise.[7]

Though this report provides crucial support to proponents of early intervention services, the effectiveness of these services has been previously documented in a variety of studies. For example:

- Breast-feeding is recommended by pediatricians to help infants grow and to anchor mother-infant interactions. A survey by The Commonwealth Fund found that mothers are much more likely to breast feed when educated and encouraged to do so by their doctor or nurse and when they receive post partum home visits by nurses.[8]

- Consistent reading times and daily home-life routines have been shown to influence healthy brain development in very young children. The majority of

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[3] NATIONAL RESEARCH COUNCIL AND INSTITUTE OF MEDICINE, FROM NEURONS TO NEIGHBORHOODS: THE SCIENCE OF EARLY CHILDHOOD DEVELOPMENT (Jack P. Shonkoff and Deborah A. Phillips eds., 2000).

[4] *Id.* at 185-86.

[5] *Id*. at 5. *See also, e.g.,* LYNN A. KAROLY ET AL., INVESTING IN OUR CHILDREN: WHAT WE KNOW AND DON'T KNOW ABOUT THE COSTS AND BENEFITS OF EARLY CHILDHOOD INTERVENTIONS 65-68 (Rand Corp. 1998) (finding the provision of early intervention services can positively affect a child's development during and after the first years of life).

[6] NATIONAL RESEARCH COUNCIL AND INSTITUTE OF MEDICINE, FROM NEURONS TO NEIGHBORHOODS: THE SCIENCE OF EARLY CHILDHOOD DEVELOPMENT 7 (Jack P. Shonkoff and Deborah A. Phillips, eds. 2000).

[7] *Id.* at 5.

[8] KATHRYN TAAFFE YOUNG, KAREN DAVIS, AND CATHY SCHOEN, THE COMMONWEALTH FUND SURVEY OF PARENTS WITH YOUNG CHILDREN (Aug. 1996).

low-income parents surveyed by The Commonwealth Fund wanted information from providers on how to optimize their child's development, including information on how to discipline the child, toilet training, and sleep habits. (Unfortunately, the vast majority of low-income families reported these matters were not discussed during visits with providers.)[9]

- Educating parents about infant communication has resulted in significant differences between the intervention group and the control group regarding sensitivity to communication cues and social-emotional growth-fostering behaviors.[10]

- Guidance from the pediatrician during office-based visits has resulted in intervention group infants showing advanced vocal imitation compared with the control group and the intervention mothers being rated higher on their interactions with their children.[11]

- Education and assistance provided to mothers in an intensive care unit nursery had a significant effect on the cognitive development of low birth weight infants, to the point where their development approximated that of normal birth weight infants.[12]

- Home-based parent-training of low-income, African-American, teenage mothers of pre-term infants resulted in their infants rating higher on standardized intervention tests than control group infants.[13]

- The children of mothers who participated in a high-risk prenatal/early infancy home visitation program of health education experienced fewer accidents and emergency room visits, compared to a control group. These mothers initiated breast feeding more frequently and improved the home environment more frequently than the control group.[14] A fifteen year follow-up of the children,

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[9] *See* Kathryn Taaffe Young, *Listening to Parents: A National Survey of Parents with Young Children*, 152 ARCHIVES OF PEDIATRIC AND ADOLESCENT MEDICINE 255-62 (Mar. 1998).

[10] *See* Leitch, DB, *Mother-Infant Interaction: Achieving Synchrony*, 48 NURS. RES. 55-58 (Jan.-Feb. 1999) (reporting results of videotaped educational information).

[11] *See* Casey, PH and Whitt, JK, *Effect of the Pediatrician on the Mother-Infant Relationship*, 65 PEDIATRICS 815-20 (Apr. 1980).

[12] *See* Rauh VA *et al.*, *The Mother-Infant Transaction Program: The Content and Implications of an Intervention for the Mothers of Low-Birth weight Infants*, 17 CLIN. PERINATAL 31-45 (Mar. 1990).

[13] *See* Field TM *et al.*, *Teenage, Lower-class, Black Mothers and Their Preterm Infants: An Intervention and Intervention Follow-Up*, 51 CHILD DEV. 426-36 (June 1980).

[14] *See* David Olds *et al.*, *Improving the Delivery of Prenatal Care and Outcomes of Pregnancy: A Randomized Trial of Nurse Home Visitation,* 16 PEDIATRICS 77 (1986).

> when compared to control groups, showed them to have experienced fewer instances of running away and fewer arrests, lifetime sex partners, cigarettes a day, and days having consumed alcohol.[15]

Findings such as these establish the following potential benefits of early intervention services for low-income children: improved emotional and cognitive development, improved educational outcomes, increased economic self-sufficiency for the parent and later the child, and improvements in health-related indicators such as reproductive health and substance abuse.[16] While only a few studies have compared the costs and benefits of these services, a 1998 study by researchers at the RAND Corporation concluded that early childhood intervention services are a potential source of cost savings.[17]

Unfortunately, many children are not receiving the early intervention services they need. Ignorance about funding sources has been one impediment. Many states and health care providers operate under the impression that only limited early intervention services can be covered through Medicaid. To the contrary, the Medicaid Early and Periodic Screening, Diagnosis and Treatment service can be used to cover a broad array of early intervention services.[18]

Identifying At-Risk Children Through EPSDT Screens

Medicaid-eligible children and youth under age 21 are entitled to receive EPSDT.[19] EPSDT is a comprehensive benefit that includes: screening, diagnosis, and treatment services and outreach. Four separate screening services—medical, vision, hearing, and dental—must be offered at pre-determined, periodic intervals. From birth through age five, the American Academy of Pediatrics recommends fourteen medical screening visits.[20] For Medicaid-eligible

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[15] *See* David Olds *et al.*, *Long-term Effects of Nurse Home Visitation on Children's Criminal and Anti-Social Behavior: 15-year Follow Up of a Randomized Controlled Trial,* 280 JAMA 1238-44 (Oct. 1998).

[16] *See* LYNN A. KAROLY ET AL., INVESTING IN OUR CHILDREN: WHAT WE KNOW AND DON'T KNOW ABOUT THE COSTS AND BENEFITS OF EARLY CHILDHOOD INTERVENTIONS (Rand Corp. 1998).

[17] *Id.* at 84-88.

[18] For in-depth background, *see, e.g.,* NATIONAL HEALTH LAW PROGRAM, REPRESENTING CLIENTS WHO NEED MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (Sept. 2001) (available from NHeLP, Los Angeles, CA); NATIONAL HEALTH LAW PROGRAM, TOWARD A HEALTHY FUTURE: EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT FOR POOR CHILDREN (forthcoming December 2002) (available from NHeLP, Los Angeles, CA); NATIONAL HEALTH LAW PROGRAM, CHILDREN'S HEALTH UNDER MEDICAID: A NATIONAL REVIEW OF EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (Jan. 22, 2002, update) (Aug. 1998) (available from NHeLP, Los Angeles, CA).

[19] *See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

[20] *See* American Academy of Pediatrics, *Recommendations for Preventive Pediatric Health*

children, the medical screen must include:

- a comprehensive health and intervention history which assesses both physical and mental health;
- a comprehensive, unclothed physical examination;
- appropriate immunizations;
- laboratory tests (including lead blood testing at 12 and 24 months and otherwise according to age and risk factors); and
- health education, including "anticipatory guidance to the child (or the child's parent or guardian)."[21]

The EPSDT screen is an essential early intervention service. Properly focused, this screen can be used to diagnosis developmental problems and risks and to provide health education to the child and family about expected developmental milestones and activities for maximizing the child's early growth. Therefore, it is critical for health care providers who are treating young children to know the full scope of EPSDT. A variety of avenues can be used for disseminating this information, including regulations, Medicaid managed care contract requirements,[22] provider manuals, provider bulletins, provider training, and EPSDT screening forms.

The EPSDT screening form is a pre-printed, uniform encounter form that a number of states have developed for providers to record and track activities that occur during a child's visit. Copies of the completed form typically are placed in the child's medical record and may also be sent to the Medicaid agency. Use of these forms has been associated with improved well-child visits.[23] In recent years, some states have developed sets of screening forms that focus on age-appropriate activities.[24]

Care, *available at* http://www.aap.org.

[21] H.R. Rep. No. 101-247, at 399 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2125. *See also* 42 U.S.C. § 1396d(r)(1)(B)(v).

[22] For examples of state Medicaid managed care contract provisions addressing EPSDT, *see* GEORGE WASHINGTON UNIVERSITY CENTER FOR HEALTH SERVICES RESEARCH AND POLICY, NEGOTIATING THE NEW HEALTH SYSTEM: A NATIONWIDE STUDY OF MEDICAID MANAGED CARE CONTRACTS at Table 2.1, 2.4, 2.8 (4th ed. undated), *available at* http://www.gwu.edu/%7Echsrp/Fourth_Edition/fourthe.html.

[23] *See* OFFICE OF INSPECTOR GENERAL, MEDICAID AND MANAGED CARE 8 (May 1997) (finding "more complete EPSDT documentation when providers used preprinted forms that detail the appropriate services for a child at a given age").

[24] For example, Arizona, Maine, and Texas use such forms. The District of Columbia has pilot tested age-appropriate EPSDT screening forms and plans to roll out general use later this year.

At least 27 states have developed EPSDT screening forms for participating providers.[25] The National Health Law Program recently reviewed these screening forms to determine the extent to which they target early intervention services. Table 1 shows that a number of states' forms place at least some emphasis on early intervention. In particular, the following should be noted:

- **Diagnostic assessment.** All of the forms specifically required a diagnostic assessment.[26] Nine states included age-specific prompts (e.g. Arizona, Maine, and Texas). For example, for the 15 month visit, some forms ask whether the toddler can point to one or more body parts, walk well, feed self with fingers, listen to a story, put blocks in a cup, and wave bye-bye.

- **Nutritional Assessment.** All of the forms included reference to nutritional assessment. Fourteen included a question about the Women Infant and Children (WIC) program, and ten specifically addressed breast-feeding and formula.

- **Vision, Hearing, Speech, and Dental Assessments.** All of the forms required vision and hearing assessments. The majority also included either a dental assessment or a referral to dental care. Nine of the forms included a speech assessment.

For examples of model forms, please contact the National Health Law Program's Chapel Hill, NC office.

[25] The following states use EPSDT screening forms: AL, AK, AZ, AR, CA, CO, CT, FL, GA, IA, KS, ME, MD, MO, NV, NJ, NM, ND, OK, PA, SC, TX, WA, WV, WI, and WY. The District of Columbia has pilot tested age-appropriate screening forms and plans to roll out general use later this year. Many of the remaining states have used screening forms in the past. The most frequent reasons given for discontinuing their use were, first, the state is using the HCFA Form 1500 reporting form (which does not include prompts for a full EPSDT medical screen, let alone early intervention services) and, second, that providers would not want to participate in EPSDT if they had to complete additional paper work.

[26] Medicaid can pay for individual family service and education plan assessments. *See* HEALTH CARE FINANCING ADMINISTRATION, MEDICAID AND SCHOOL HEALTH: A TECHNICAL ASSISTANCE GUIDE (Aug. 1997). Often, the diagnostic assessments for these plans will be performed by a multi-disciplinary team and may include developmental, psychological, speech/language, occupational therapy, and physical therapy assessments. There are issues regarding how Medicaid will reimburse these assessments. The Centers for Medicare and Medicaid Services determined that Missouri's proposal to pay for multi-disciplinary assessments on a prospective basis violated of a CMS policy against "bundling." *See* HCFA Administrator Decision, In Re: Missouri State Plan Amendment No. 99-29, Docket No. 01-09 (Feb. 12, 2002). Bundling is characterized by a single rate for one or more of a group of different services furnished to an eligible individual during a fixed period of time.

- **Health Education.** Virtually all of the forms referred to health education, counseling, and/or anticipatory guidance. Ten included age-specific prompts (e.g., postpartum adjustment, reading to the child). For example, for the three year visit, some forms ask about reading to the child, dental care, limiting TV, eating healthy foods, and/or referrals to Head Start.

- **Social Service Referrals.** Fourteen forms suggested a referral to the WIC program. Several forms, and most notably West Virginia's form, included referrals to other social service agencies, including early intervention, family planning, further health education, and Head Start.

In sum, the effectiveness of EPSDT screening forms has been well documented. A number of states have included information on these forms to prompt EPSDT medical screeners to provide age-appropriate early intervention screening and make needed referrals for follow up services and treatment.

Covering Early Intervention Services as EPSDT Treatment Services

If an illness or condition is diagnosed during a screen, EPSDT requires state Medicaid agencies to "arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment."[27] EPSDT benefits include all of the services that the state can cover under § 1396d(a) of the Medicaid Act, whether or not such services are covered for adults.[28] Table 2 lists these services. In addition, the Medicaid Act says the service must be covered for a child if it is "necessary . . . to correct or ameliorate defects and physical and mental illnesses and conditions[.]"[29]

The Medicaid Act, § 1396d(a), does not uniformly list covered services using the terminology that health care providers may use when describing an early intervention need. In these cases, it must be determined whether the service described by the provider fits within a category that is included in the Medicaid Act. *In other words, Medicaid can cover the early intervention service only to the extent that the service fits within a Medicaid service category*.

Table 3 lists a range of early intervention services, showing which Medicaid service category, if any, the service may be coverable through and whether the Centers for Medicare and Medicaid Services (CMS) has issued any specific statements regarding coverage of the service. Table 3 shows that CMS has approved EPSDT coverage of a number of early intervention services, including:

- intervention assessment of the child,

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[27] 42 U.S.C. § 1396a(a)(43)(C).
[28] *Id.* at § 1396d(r)(5).
[29] *Id.*

- assessment of home life and of parent/child relations,
- nutritional assessment and diet instruction,
- health education and anticipatory guidance to the child and family,
- basic living and social skills development,
- child and family counseling,
- parent skills training, and
- case management.

In addition, CMS has recognized Medicaid coverage to fund preparation and use of pocket-sized records for young children (sometimes called "health passports"); health diaries for new mothers; telephone support services to children and their families; brochures, videos, and newsletters that are explicitly directed at assisting Medicaid-eligible individuals to access Medicaid services; and home visiting programs that include parent education. CMS has discussed limits, however:

- **Medical necessity**. The service must be medically necessary; in other words, it must be needed to "correct or ameliorate" a physical or mental condition.[30]

- **Focus on the child.** Family members may be included in health education, case management, counseling, and therapy; however, the services must be directed exclusively toward the treatment/benefit of the child. For example, if directed exclusively to the treatment of the child, mental health services can include individual, family, and group skills training, family psychotherapy, and family skills training. However, the services cannot extend to a point where they become a means of treating persons other than the Medicaid-eligible child. As recently noted by CMS in reference to case management services, "[P]olicy permits contacts with non-eligible … individuals to be considered Medicaid case management activity, and to be billed to Medicaid, when the purpose of the contact is directly related to the management of the eligible individual's care. It may be appropriate to have family members involved in all components related to the eligible individual's case management.… On the other hand, contacts with non-eligibles … that relate directly to the identification and management of the non-eligible['s] … needs and care cannot be billed to Medicaid."[31]

[30] 42 U.S.C. § 1396d(r)(5).

[31] Centers for Medicare and Medicaid Services, *Dear State Child Welfare and State Medicaid Director* (Jan. 19, 2001) (SMDL #01-013), *available at*

- **Health education.** Health education is not considered by CMS to be a separate billable Medicaid service. Rather, it is considered an essential component of every health visit.

Case Study: ***Pediatric Specialty Care v. Arkansas Dep't of Human Services***

A recent case, *Pediatric Specialty Care v. Arkansas Dep't of Human Services,*[32] illustrates EPSDT's required coverage of early intervention services. The case concerns the Arkansas' Medicaid program. In recent years, Arkansas has provided early intervention diagnostic and therapy services to Medicaid-eligible children between the ages of six months and six years who have, or are at risk of developing, chronic physical, developmental, emotional or behavioral problems. This includes children with a diagnosis of AIDS, cystic fibrosis, Down Syndrome, lead poisoning, congenital heart disease, autism, visual or hearing impairment, cerebral palsy, cognitive disorders, learning disabilities, or mental retardation. Early intervention services for these children has included diagnostic evaluations; nutrition services; behavior therapies; physical, speech and occupational therapies; and day treatment to reinforce the skills the child learns in individual therapies.

Citing a budget shortfall, Arkansas announced a plan to eliminate early intervention treatment services as an EPSDT benefit. While diagnostic services would be maintained, children would be referred to other federally and state funded programs for treatment. Thereafter, child providers and parents filed the lawsuit and obtained an injunction from the district court.

On appeal, the Eighth Circuit held that "a Medicaid eligible individual has a federal right to early intervention day treatment when a physician recommends such treatment."[33]

> [W]e believe that the State [Medicaid] Plan need not specifically list every treatment service conceivably available under the EPSDT mandate. The State Plan, however, must pay part or all of the cost of treatments to ameliorate conditions discovered by the screening process when those treatments meet the definitions set forth in [the statute].[34]

Here, the early intervention day treatment services met the definition of rehabilitation services set forth in § 1396d(a)(13) (defining medical assistance reimbursable by Medicaid as "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services … recommended by a physician … for the maximum reduction of physical and mental

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http://www.cms.hhs.gov/states/letters/smd119cl.asp.

[32] 2002 U.S. App. LEXIS 11041 (8th Cir. June 10, 2002).

[33] *Id. at* *19: The Court also applied the traditional three-prong test to decide that the plaintiffs could enforce the federal EPSDT provisions. *See Blessing v. Freestone,* 520 U.S. 329, 340 (1997).

[34] *Id.* at *18.

disability and restoration of an individual to the best possible functional level"). Therefore, the Court held that when the physician prescribes early intervention day treatment as a rehabilitative service under EPSDT, the Arkansas Medicaid agency must reimburse the treatment. It is not enough to simply refer the recipient to another source of federal or state funding for the service.

The Court closed its decision with a reminder to the state that EPSDT provisions (§ 1396a(a)(43)) obligate it

> to inform recipients about the EPSDT services that are available to them and that it must arrange for the corrective treatments prescribed by physicians. The state may not shirk its responsibilities to Medicaid recipients by burying information about available services in a complex bureaucratic scheme.[35]

Conclusion

Research has shown that, once on the Medicaid program, low-income children are more likely to have a routine source of care. This is important for the provision of early childhood intervention services because it means that these provider visits offer increased opportunities to provide needed services.

Health care practitioners need to be paid for the early intervention services they provide. Unfortunately, the provision of these services has been hampered by lack of knowledge of funding sources. The Medicaid EPSDT program exists to provide comprehensive and continuous care to America's poor children and children with special health care needs. EPSDT screening forms have been developed that cue providers to early intervention services that should be provided during the screening encounter and that identify children needing follow up intervention services. As recently illustrated by a federal circuit court of appeals, EPSDT is also a significant source of funding for the provision of early intervention treatment services that young children need.

[35] *Id.* at *20.

Table 1: Developmental Services and EPSDT Screening Forms

	AL	AK	AZ	AR	CA	CO	CT	FL	GA	IA	KS	ME	MD	MO	NV	NJ	NM	ND	OK	PA	SC	TX	WA	WV	WI	WY
Patient Medical History	●	●	●		●	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●			
Perinatal/Birth History									●		●	●	●	●	●							●			●	
Family Medical History	●							●	●		●		●	●	●					●		●			●	
Social History		●					●					●	●	●						●			●			
Parental Concerns													●	●			●					●			●	
Physical Assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Mental Health Assessment*			●					●		●			●			●	●	●	●	●		●	●	●	●	●
Developmental Assessment*	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
► Age-Specific Prompts			●				●		●			●	●	●								●	●		●	
► Tools (e.g. Denver II)		●	●								●			●						●		●		●		
Nutritional Assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
► Breast Feeding/Formula			●				●		●		●	●	●	●			●					●			●	
► WIC Referral/Prompt		●	●		●		●	●	●		●	●				●	●	●		●		●		●		
Vision Assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hearing Assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Speech Assessment			●					●					●	●			●	●		●				●	●	
Dental Assessment/ Referral	●		●	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Health Education/ Counseling/ Anticipatory Guidance	●	●	●	●	●	●	●	●	●	●	●	●	●	●		●	●	●	●		●	●	●	●	●	●
► Age-Specific Prompts	●		●				●		●			●	●	●								●	●		●	
Assessment of Parent/ Child Relationship									●																●	
Laboratory Tests	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Lead Assessment	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Immunizations	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Treatment Referral		●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●	●		●		●

- There was little agreement among the states as to what constitutes a behavioral assessment and what constitutes a developmental assessment. Some states required both.

Table 2: Medicaid Services (42 U.S.C. § 1396d(a))

Mandatory services:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic services
- Federally-qualified health center services
- Laboratory and X-ray services
- Nursing facility services for adults
- EPSDT services
- Physician services
- Family planning services and supplies
- Physician services
- Medical and surgical services furnished by a dentist (with limitation)
- Nurse-midwife services
- Pediatric nurse practitioner or family nurse practitioner services
- Home health services for persons eligible to receive nursing facility services

Optional services:

- Home health care services (includes nursing services, home health aides, medical supplies and equipment, physical therapy, occupation therapy, speech pathology, audiology services)
- Private duty nursing services
- Clinic services
- Dental services
- Physical therapy and related services
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level
- Intermediate care facility for the mentally retarded services
- Inpatient psychiatric hospital services for individuals under age 21
- Hospice care
- Case-management services
- TB-related services
- Respiratory care services
- Personal care services
- Primary care case management services
- Any other medical care, and any other type of remedial care recognized under state law, specified by the secretary

Table 3: Fitting Behavioral Health Services into the Medicaid Listings

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Developmental assessment	Developmental assessment, § 1396d(r)(1)(B).	The agency must provide regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. 42 C.F.R. § 441.56(b). The agency must implement a periodicity schedule that specifies screening services applicable at each stage of the recipient's life, beginning with a neonatal examination. 42 C.F.R. § 441.58(b). Included a range of activities to determine whether an individual's developmental processes fall within a normal range of achievement according to age group and cultural background. Included as part of every periodic examination. HCFA, State Medicaid Manual § 5123.2.A (Apr. 1990). In younger children, assess at least: gross and fine motor development; communication skills or language development, focusing on expression, comprehension, and speech articulation; self-help and self-care skills; social-emotional development, focusing on ability to interact with other children and parents; and cognitive skills. HCFA, State Medicaid Manual § 5123.2.A (Apr. 1990). While no list of specific tests is prescribed, the following principles must be considered: acquire information from the child, parent, or other familiar person; incorporate and review this information, be culturally sensitive; do not use premature labels; refer to appropriate development resources. HCFA, State Medicaid Manual § 5123.2.A (Apr. 1990). Also includes professionals to whom children are referred for structured tests and instruments after potential problems identified by the screen. HCFA, State Medicaid Manual § 5123.2.A (Apr. 1990).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Screening tools for family	Screening services, § 1396(d)(r)(1)(B).	The agency must provide regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Screenings must include a comprehensive health and developmental history. 42 C.F.R. § 441.56(b). Obtain comprehensive health and development history from the parent or other responsible adult who is familiar with the child's history, including assessment of both physical and mental health development. HCFA, State Medicaid Manual § 5123.2 (Apr. 1990).
Assessment of home life	Screening services, § 1396d(r)(1)(B).	The agency must provide regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Screenings must include a comprehensive health and developmental history. 42 C.F.R. § 441.56(b). "Acquire information on the child's usual functioning, as reported by the child, parent, teacher, health professional, or other familiar person." HCFA, State Medicaid Manual § 5123.2.A (Apr. 1990).
Assessment of parent/child relation	Screening services, § 1396d(r)(1)(B).	"It is desirable that a parent or other reasonable adult accompany the child to the examination. When this is not possible, arrange for a follow-up worker, social worker, health aide, or neighborhood worker to discuss the results in a visit to the home or in contacts with the family elsewhere." HCFA, State Medicaid Manual § 5123.1.B (Apr. 1994).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Health education and anticipatory guidance	Health education, including anticipatory guidance, § 1396d(r)(1)(B)(v).	Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understand what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention. HCFA, State Medicaid Manual § 5123.2.E (Sept. 1998). Health education should be considered an essential component of every health care encounter, not a separate service. Therefore, HCFA opposes classifying someone who only provides health education as a screening provider. Memorandum from Christine Nye, Director HCFA Medicaid Bureau, to Regional Admin., Dallas (Aug. 8, 1991).
Nutrition assessment	Screening services, § 1396d(r)(1)(B).	The agency must provide regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. 42 C.F.R. § 441.56(b). Question dietary practices to identify unusual eating habits or deficient diets; during physical exam pay special attention to pallor, apathy, irritability; measure height and weight, screen for iron deficiency; if possible screen children over age one for serum cholesterol determination. If information suggests a deficiency, further assessment is indicated including family, socioeconomic factors; determining quality of diet; further exams, preventive treatment and follow-up services, including dietary counseling and nutrition education. HCFA, State Medicaid Manual § 5123.2 (Aug.1996).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Vision	Vision services, § 1396d(r)(2).	Screenings must include appropriate vision testing. The agency must provide diagnosis of and treatment for defects in vision, including eyeglasses. 42 C.F.R. §§ 441.56(b), 441.56(c). Administer an age-appropriate vision assessment. HCFA, State Medicaid Manual § 5123.2.F (Sept. 1998).
Hearing	Hearing services, § 1396d(r)(4).	Screenings must include appropriate hearing testing. The agency must provide diagnosis of and treatment for defects in hearing, including hearing aids. 42 C.F.R. §§ 441.56(b), 441.56(c). Administer an age-appropriate hearing assessment. HCFA, State Medicaid Manual § 5123.2.F (Sept. 1998).
Dental	Dental services, § 1396d(r)(3).	The agency must provide dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health. Screenings must include dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age (or up to 5 years, if the state obtains a waiver). 42 C.F.R. §§ 441.56(b), 441.56(c). Although an oral assessment may be part of a physical exam, it does not substitute for examination through direct referral to a dentist. Direct referral is required for the periodicity schedule. Administer an age-appropriate dental assessment. HCFA, State Medicaid Manual § 5123.2.G (Oct. 1993).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Laboratory tests	Laboratory tests, § 1396d(r)(1)(B)(iv); Other laboratory services, § 1396d(a)(3).	Screenings must include appropriate laboratory tests. 42 C.F.R. § 441.56(b). Identify the minimum laboratory tests to be performed for particular age or population groups, including consideration of hematocrit, urinalysis, TB skin testing, STD screening, screening for sickle cell disease. Suggests using "Bright Futures," AAP, and CDC guidelines. With the exception of lead toxicity screening, physician providing screening services use their medical judgment in determining the applicability of the laboratory tests to be performed. HCFA, State Medicaid Manual § 5123.2.D (Sept. 1998).
Lead blood assessment	Lead blood level assessment, § 1396d(r)(1)(B)(iv).	All children are at risk for lead poisoning and must be screened. All children must receive a screening blood lead test at 12 months and 24 months of age. Children under 72 months must receive a test if they have not previously been screened. Lead screening consists of a verbal risk assessment and a lead blood test. HCFA, State Medicaid Manual, § 5123.2D (Sept. 1998). Includes follow-up tests and investigations of the primary residence to determine the source of the lead, but not testing of substances. Providers should coordinate with WIC, Head Start, and other private and public resources. HCFA, State Medicaid Manual § 5123.2.D (Sept. 1998).
Immunizations	Immunizations, § 1396d(r)(1)(B)(iii).	The agency must provide appropriate immunizations. If it is determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time. 42 C.F.R. § 441.56(c). Provide immunizations as recommended by the Advisory Committee on Immunization Practices. HCFA, State Medicaid Manual § 5123.2.C Aug. 1996).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Referral for diagnosis/treatment	Such other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered during screens, § 1396d(r)(5).	Refer to appropriate child development resources for additional assessment, diagnosis, treatment or follow-up when concerns or questions remain after the screening process. HCFA, State Medicaid Manual § 5123.2.A (Apr. 1990). Refer for additional diagnosis without delay. You must make available to recipient diagnostic services which are necessary to fully evaluate defects and physical or mental illnesses or conditions discovered by the screening services. HCFA, State Medicaid Manual § 5124 (Apr. 1990). You must make available health care, treatment or other measure to correct or ameliorate defects and physical and mental illnesses or condition discovered by the screening services. Service may be limited it is not safe, effective, or considered experimental. HCFA, State Medicaid Manual § 5124 (Apr. 1990).
Coordination with related programs	Referrals to appropriate agencies, § 1396a(a)(43)(C); WIC referral, § 1396a(a)(53).	The agency must make appropriate use of State health agencies, State vocational rehabilitation agencies, and Title V grantees. Further, the agency should make use of other public health, mental health, and education programs and related programs, such as Head Start, Title XX programs, and WIC, to ensure an effective child health program. 42 C.F.R. § 441.61(b).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Pre-pregnancy risk education; prenatal care for adolescents	Health education/anticipatory guidance, § 1396d(r)(1)(B)(v); Family planning services and supplies, § 1396d(a)(4)(C); Rural health clinic services, § 1396d(a)(2)(B); Federally-qualified health center services, § 1396d(a)(2)(C); Physician services, § 1396d(a)(5)(A); Clinic services, § 1396d(a)(9); Case-management services, § 1396d(a)(19); Certified pediatric nurse practitioner or certified family nurse practitioner services, § 1396d(a)(21); Nurse midwife services, § 1396d(a)(17).	A state plan must cover pregnancy-related services, including prenatal care, delivery, postpartum care, and family planning services, and services for conditions that might complicate the pregnancy. 42 C.F.R. § 440.210. The plan must provide that each recipient is free from coercion or mental pressure and free to choose the method of family planning to be used. 42 C.F.R. § 441.20. "Just as it can provide enhanced services for at-risk infants, EPSDT can link at-risk adolescents to pre-pregnancy risk education, family planning, pregnancy testing and prenatal care." HCFA, State Medicaid Manual § 5124.B.3 (July 1990).
Transportation	Any other medical care and any other type of remedial care recognized under state law, § 1396d(a)(27); Such other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered during screens, § 1396d(r)(5).	The agency must offer to the family or recipient, and provide if the recipient requests it, necessary assistance with transportation. 42 C.F.R. § 441.61; *See also* 42 C.F.R. § 441.56(a) (informing); 42 C.F.R. § 440.170 (travel expenses include the cost of ambulance, taxicab, common carrier, or other appropriate means, the cost of meals and lodging, and the cost of an attendant to accompany the recipient, and salary for the attendant if the attendant is not a family member). Offer and provide, if requested and necessary, assistance with transportation and scheduling appointments. Offer both transportation and scheduling assistance prior to each due date of a child's periodic examination. HCFA, State Medicaid Manual § 5150 (Apr. 1995). Transportation to school is primarily for education and Medicaid funds not available. Memorandum from Rozann Abato, Acting Director HCFA Medicaid Bureau, to All Associate Regional Administrators (Aug. 25, 1993).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Behavioral health services	Outpatient hospital services, § 1396d(a)(2)(A); Rural health clinic services, § 1396d(a)(2)(B); Federally-qualified health center services, § 1396d(a)(2)(C); Physician services, § 1396d(a)(5)(A); Medical care or any other type of remedial care furnished by licensed practitioners, § 1396d(a)(6); Home health care services, § 1396d(a)(7); Clinic services, § 1396d(a)(9); Other diagnostic, screening, preventive, and rehabilitative services, § 1396d(a)(13); Case-management services, § 1396d(a)(19); Certified pediatric nurse practitioner or certified family nurse practitioner services, § 1396d(a)(21); Personal care services, § 1396d(a)(24); Anticipatory guidance, § 1396d(r)(1)(B)(v).	Includes counseling, basic living skills development, intensive in-home, individual and family therapy services, behavioral management services, individual and family crisis intervention services, crisis support in residential settings, and crisis stabilization for conditions associated with mental illness, substance abuse, and/or drug dependency. Letter from Robert J. Taylor, Associate Regional Administrator, to Ann Stottlemyer, Director West Virginia Office of Medicaid Services Approving State Plan Amendment (July 8, 1993). Outpatient mental health services approved in Pennsylvania, for delivery by psychiatrists, psychologists, family-based rehabilitation service providers, and psychiatric certified registered nurse practitioners, include mobile therapy, therapeutic staff support, behavioral specialist consultant, diagnostic intellectual evaluation, individual diagnostic personality evaluation, comprehensive neuropsychologic evaluation with personality assessment and cognitive retraining psychological evaluation. Commonwealth of Pennsylvania, Medicaid Assistance Bulletin (Jun. 1, 1994).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Counseling	Outpatient hospital services, § 1396d(a)(2)(A); Rural health clinic services, § 1396d(a)(2)(B); Federally-qualified health center services, § 1396d(a)(2)(C); Physician services, § 1396d(a)(5)(A); Medical care or any other type of remedial care furnished by licensed practitioners, § 1396d(a)(6); Home health care services, § 1396d(a)(7); Clinic services, § 1396d(a)(9); Other diagnostic, screening, preventive, and rehabilitative services, § 1396d(a)(13); Case-management services, § 1396d(a)(19); Certified pediatric nurse practitioner or certified family nurse practitioner services, § 1396d(a)(21); Personal care services, § 1396d(a)(24); Anticipatory guidance, § 1396d(r)(1)(B)(v).	Includes meeting with, counseling with the child, family, legal guardian and/or significant other ... consultation with, and training others, can be necessary part of planning and providing care to patients... It can, however, devolve to a point where it becomes a means of treating others. States must make clear that services are only provided to or directed exclusively toward, the treatment of Medicaid eligible persons. Notes that reasons for services must be medical in nature and not to prevent a dysfunctional family life or family disintegration. Memorandum from Wilma M. Cooper, Acting Associate Regional Administrator (HCFA Region IV), to Acting Director Medicaid Bureau (Apr. 22, 1993). Includes counseling, social skills development. Meeting with family, guardian, significant other may be covered provided that the services are directed exclusively to the effective treatment of the recipient. E.g. Medicaid Regional Memorandum No. 92-80 (HCFA Region IX) (Aug. 10, 1992). Medicaid can cover counseling, psychology, and therapy services to be offered in a proposed student support center (to address drug and other problems that interfere with learning). Memorandum from Gale A. Drapala, HCFA Region VI Administrator, to Regional Director (June 18, 1992).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Early intervention services	Outpatient hospital services, § 1396d(a)(2)(A); Rural health clinic services, § 1396d(a)(2)(B); Federally-qualified health center services, § 1396d(a)(2)(C); Physician services, § 1396d(a)(5)(A); Medical care or any other type of remedial care furnished by licenses practitioners, § 1396d(a)(6); Home health care services, § 1396d(a)(7); Clinic services, § 1396d(a)(9); Physical therapy and related services, § 1396d(a)(11); Other diagnostic, screening, preventive, and rehabilitative services, § 1396d(a)(13); Case-management services, § 1396d(a)(19); Certified pediatric nurse practitioner or certified family nurse practitioner services, § 1396d(a)(21); Personal care services, § 1396d(a)(24); Anticipatory guidance, § 1396d(r)(1)(B)(v).	While Medicaid has no "early intervention' service, it can pay for many services that address early intervention needs, such as screening and assessment services, psychological services, physical therapy, speech pathology, and occupational therapy. E.g. HCFA Program Issuance Transmittal Notice (Region IV) (June 13, 1991). Includes services for children with identified handicap or at risk for developmental delays due to biological or environmental factors (including poor nutrition, lack of physical or social stimulation, psychotic, drug-dependent, or alcohol dependent family members). Services include clinical evaluations (office and home based), treatment plan developments (by a multi-disciplinary team) and individual, group and family interventions to be provided at a level of intensity and in settings determined by the treatment team. According to description provided by West Virginia, providers include clinical social workers, psychologist, professional counselor, nurse practitioners, registered nurses, licensed physical or occupation therapists, AHSA certified CFY speech pathologists or audiologists. Services include counseling, family therapy, behavioral therapy, professional consultation, supportive family intervention (home based counseling, parent skills training), intensive family preservation to diffuse crises, crisis intervention. Letter from Robert J. Taylor, Associate Regional Administrator, to Ann Stottlemyer, Director West Virginia Office of Medicaid Services Approving State Plan Amendment (July 8, 1993).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Case management	Case management services, § 1396d(a)(19).	Includes coordinating nutrition services with WIC and assisting individuals in gaining access to nutrition services. Dallas Regional Medical Services Letter No. 94-52 (HCFA Region VI) (July 14, 1994). Includes monitoring status of children (including observing the child in various settings). Includes discussions with recipients to make assessments and reassessment of need for services, including personal behavior and medication monitoring. But does not include escorting recipients to appointments (but may be covered as a transportation service); providing shopping or bill paying; delivering bus tickets or money. Medicaid Regional Memorandum No. 93-139 (HCFA Region IX) (Dec. 17, 1993). It may be medically necessary to provide case management for services that are not within Medicaid or medical in nature (e.g., helping an adolescent with an abusive alcoholic parent gain access to Alateen). Letter from Christine Nye, Director HCFA Medicaid Director, to Regional Administrator (HCFA Region III) (Aug. 7, 1991). May be used to reach out beyond the bounds of the Medicaid program to coordinate access to a broad range of medically necessary services; services do not have to be medical in nature or reimbursable through Medicaid. Letter from Christine Nye, Director HCFA Medicaid Director, to Lourdes Rivera and Sara Rosenbaum, CDF (May 21, 1992).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Speech therapy	Physical therapy or related service, § 1396d(a)(11); Other diagnostic, screening, preventive, and rehabilitative services, § 1396d(a)(13).	Federal financial participation is available for diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, of which a patient is referred by a physician or other licensed practitioner of ht healing arts within the scope of his or her practice under state and any necessary supplies and equipment. 42 C.F.R. §§ 440.2(b); 440.110(c). For Medicaid to cover teachers of speech and hearing impaired, a speech pathologist must be individually involved with the patient, accept ultimate responsibility for the actions of the personnel that he agrees to direct, see the patient at least once, have input into care provided, and review patient after treatment begins. HCFA Program Issuance transmittal Notice (Region IV) (Mar. 1, 1995).
Developmental Passport	Administrative costs necessary for the proper and efficient operation of the Medicaid program, § 1396a(a)(4).	The agency must maintain EPSDT records. 42 C.F.R. § 441.56(d). A continuing care provider means a provider who has an agreement with the Medicaid agency to provide services to EPSDT recipients, including maintenance of the recipient's consolidated health history, including information received from other providers. 42 C.F.R. § 441.60(a). Noting as an EPSDT "best practices," medical passport project to automate documentation of medical history for foster children. HCFA, Medicaid National Summary of EPSDT (draft) (Sept. 1993).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Home health	Home health care services, § 1396d(a)(7); Other diagnostic, screening, preventive, and rehabilitative services, § 1396d(a)(13); Personal care services, § 1396d(a)(24).	Federal financial participation is available for home health services, including, nursing services, home health aide services, medical supplies, equipment, and appliances, physical therapy, occupational therapy or speech pathology and audiology services. 42 C.F.R. §§ 440.2(b); 440.70. Home based mental health services for emotionally disturbed children at risk of out-of-home placement include individual, family, groups skills training to improve basic function, family psychotherapy and family skills training if directed exclusively to the treatment of the recipient. Letter from Charles W. Hazlett, Associate Regional Administrator (HCFA Region V), to Linda Webster, Minnesota Department of Human Services Approving State Plan Amendment (May 3, 1993).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Home visitation	EPSDT medical screening service, § 1396d(r)(1); Medical care or any other type of remedial care furnished by licensed practitioners, § 1396d(a)(6); Home health care services, § 1396d(a)(7); Other diagnostic, screening, preventive, and rehabilitative services, § 1396d(a)(13); Case-management services, § 1396d(a)(19); Any other medical care, and any other type of remedial care recognized under state law, § 1396d(a)(27); Administrative costs necessary for the proper and efficient operation of the Medicaid program, § 1396a(a)(4).	The agency must provide for methods designed to inform effectively all EPSDT eligibles (or their families) about the EPSDT program. 42 C.F.R. § 441.56(b). Federal financial participation is available for personal care services in a recipient's home means services prescribed by a physician in accordance with the recipient's plan of treatment and provided by a qualified individual, supervised by a registered nurse, who is not a member of the recipient's family. 42 C.F.R. §§ 440.2(b); 440.170(f). Medicaid recognizes, as an administrative cost, home visiting program that includes tracking of compliance with well child visits, providing scheduling and transportation assistance, helping parents enroll in WIC. Helping parents to identify when medical care is need, by teaching milestones of normal child health and development is parent education, or health education. Medicaid includes health education as a Medicaid service, specifically a component of the EPSDT screening services. Letter from Louis T. Schiro, Director Medicaid Operations Branch HCFA Region II, to Barbara Frankel, New York Maternal and Child Health Care (Nov. 9, 1994). Providers of nutritional, psychological, audiological or nursing services in group, individual, and home visiting sessions must meet all federal/state provider qualifications related to those services. Letter from Eugene A. Grasser, Associate Regional HCFA Administrator (Region IV), to Marshall E. Kelly, Director of Florida Medicaid (Mar. 25, 1994). Infant support services program in Michigan authorized to expand home visitation to families with a history of abuse and neglect, to parents who need parenting skills, and to premature or low birth weight babies, to include at-risk and nutritional assessments, health education, mental health services, and transportation. Services to be provided by social workers, nutritionists, nurses, infant mental health specialists upon recommendation of a physicians, nurse midwives, nurse practitioners. Memorandum from Charles Hazlett, Associate Regional Administrator Region V (Apr. 20, 1993).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Diet instruction; nutritional supplements	Health education, § 1396d(r)(1)(B)(v); Other diagnostic, screening, preventive, and rehabilitative services, § 1396d(a)(13); Medical care or any other type of remedial care furnished by licensed practitioners, § 1396d(a)(6); Case-management services, § 1396d(a)(19); Administrative costs necessary for the proper and efficient operation of the Medicaid program, § 1396a(a)(4).	Covered if part of a treatment plan, performed by a licensed nurse or registered dietician under orders from a physician, sole purpose of the service was for diet instruction. Wyoming Medicaid Program Physician and Other Practitioners Manual (July 1991). Nutritional supplements, per se, not covered but supplements that are medical in nature may be covered as part of other services, such as clinic services. Dallas Regional Medical Services Letter No. 92-77 (HCFA Region VI) (Aug. 5, 1992).
Telephone support	Health education, § 1396d(r)(1)(B)(v); Other diagnostic, screening, preventive, and rehabilitative services, § 1396d(a)(13); Medical care or any other type of remedial care furnished by licensed practitioners, § 1396d(a)(6); Case-management services, § 1396d(a)(19); Administrative costs necessary for the proper and efficient operation of the Medicaid program, § 1396a(a)(4).	Noting as an EPSDT "best practices," toll-free line in Oregon that provides information by public health nurses on well-child care and nutritional services. HCFA, Medicaid National Summary of EPSDT (draft) (Sept. 1993)

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Parenting education	Health education, § 1396d(r)(1)(B)(v); Other diagnostic, screening, preventive, and rehabilitative services, § 1396d(a)(13); Medical care or any other type of remedial care furnished by licensed practitioners, § 1396d(a)(6); Case-management services, § 1396d(a)(19); Administrative costs necessary for the proper and efficient operation of the Medicaid program, § 1396a(a)(4).	Helping parents to identify when medical care is needed, by teaching milestones of normal child health and development is parent education. Medicaid Act specifically includes health education as a component of EPSDT screening services. Letter from Louis T. Schiro, Director Medicaid Operations Branch HCFA Region II, to Barbara Frankel, New York Maternal and Child Health Care (Nov. 9, 1994). State can provide Medicaid services to children through their ineligible parents if, as defined, the services are medical in nature and directed exclusively to the treatment of the child. Letter from Gerald J. Spatz, HCFA Region V, to Champa Bhatia, Michigan Department of Social Services (Sept. 23, 1992). Services delivered to the family of an eligible child to improve the physical and mental well-being of the child who is failing to thrive due to neglect, abuse, or maternal deprivation may be covered if the services are directed exclusively to the effective treatment of the Medicaid-eligible individual, not the treatment of someone other than the child. In addition, the services must be medical in nature and cannot be social services. A registered nurse can for example, deliver the services. Letter from Christine Nye, Director Medicaid Bureau, to Deborah A. Randall, Arent, Fox, Plotkin, Kahn & Kintner (1991).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Brochures, newsletters, videos	Health education, § 1396d(r)(1)(B)(v); Administrative costs necessary for the proper and efficient operation of the Medicaid program, § 1396a(a)(4).	Initiative must be explicitly directed at assisting Medicaid eligible individuals to access Medicaid services; Medicaid will not fund a general public health initiative available to all persons. Dear state Medicaid Director Letter from Sally K. Richardson, Director HCFA Medicaid Bureau (Dec. 10, 1994). state Medicaid use of *Health Diary*, a self-help book for pregnant and parenting mothers from pregnancy to second year of life which encourages interaction between patients and their health care providers, is encouraged for MCH and Medicaid-eligible women and children. Letter from S.V. Cain, Chief Medicaid Operations Branch, to Mrs. Mary Dean Harvey, Director, Nebraska Department of Social Services (Aug. 6, 1993).
Health education campaigns, classes, and health fairs	Administrative costs necessary for the proper and efficient operation of the Medicaid program, § 1396a(a)(4); Any other medical care and any other type of remedial care recognized under state law, § 1396d(a)(27).	Medicaid will reimburse (at administrative rate) for conducting health education campaigns and health fairs if they are targeted specifically to Medicaid services for Medicaid eligible children. E.g., HCFA, Child Care and Medicaid: Partners for Healthy Children – A Guide for Child Care Programs (June 1998); Letter from Arthur J. O'Leary, Associate Regional Administrator, HCFA Region II, to Sue Kelly, Deputy Commissioner, New York Division of Health and Long Term Care (Dec. 1994).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Habilitation services	Outpatient hospital services, § 1396d(a)(2)(A); Rural health clinic services, § 1396d(a)(2)(B); Federally-qualified health center services, § 1396d(a)(2)(C); Physician services, § 1396d(a)(5)(A); Medical care or any other type of remedial care furnished by licensed practitioners, § 1396d(a)(6); Home health care services, § 1396d(a)(7); Clinic services, § 1396d(a)(9); Physical therapy or related service, § 1396d(a)(11); Other diagnostic, screening, preventive, and rehabilitative services, § 1396d(a)(13); Case-management services, § 1396d(a)(19); Certified pediatric nurse practitioner or certified family nurse practitioner services, § 1396d(a)(21); Community supported living arrangement services, § 1396d(a)(23); Personal care services, § 1396d(a)(24).	Habilitation services (to develop functional abilities of persons who never acquired them) are covered when provided by an intermediate care facilities for the mentally retarded, covered under a home and community based waiver, and when provided in community supported living arrangements. Some states provide habilitation by characterizing it as a rehabilitation or clinic service. Letter from Eugene Grasser, Associate Regional HCFA Administrator, to Marshall E. Kelly, Director of Florida Medicaid (Mar. 25, 1994).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Maintenance service	Outpatient hospital services, § 1396d(a)(2)(A); Rural health clinic services, § 1396d(a)(2)(B); Federally-qualified health center services, § 1396d(a)(2)(C); Physician services, § 1396d(a)(5)(A); Medical care or any other type of remedial care furnished by licensed practitioners, § 1396d(a)(6); Home health care services, § 1396d(a)(7); Clinic services, § 1396d(a)(9); Physical therapy or related service, § 1396d(a)(11); Other diagnostic, screening, preventive, and rehabilitative services, § 1396d(a)(13); Case-management services, § 1396d(a)(19); Certified pediatric nurse practitioner or certified family nurse practitioner services, § 1396d(a)(21); Personal care services, § 1396d(a)(24).	May be covered to the degree that they prevent conditions from worsening or prevent the development of additional problems. Requirement that services be provided at periodic intervals implies that recipients should receive whatever services are necessary to maintain his or her health in the best condition possible. E.g., Medicaid State Bulletin-231 (HCFA Region VIII) (Sept. 10, 1992).
Car seat	Prosthetic devices, § 1396d(a)(12).	Not coverable as a prosthetic device or medical equipment under home health because they are routinely used for healthy children, do not treat any specific medical condition, and are not specialized items differing from ordinary service. However, for a disabled infant or toddler, a restraint seat may be prescribed as medically necessary. E.g., Memorandum from Rozann Abato, Acting Director HCFA Medicaid Bureau, to Associate Regional Administrator, Dallas (June 14, 1993).

Service	Federal Statutory Authorization	CMS/HCFA Interpretation
Assistive communication devices, including computers	Home health care services, § 1396d(a)(7); Prosthetic devices, § 1396d(a)(12); Other diagnostic, screening, preventive, and rehabilitative services, § 1396d(a)(13).	May be covered only when used for a medical purpose. E.g. Letter from Rozann Abato, Acting Director Medicaid Bureau, to State Medicaid Directors (May 26, 1993). Medicaid coverage available for assistive devices listed in IEPs, IFSPs, including computer, TouchTalker with Minispeak, DynaVox. Title XIX State Agency Letter No. 93-25 (HCFA Region X) (Mar. 1993).
Development of IEP or IFSP		Not a Medicaid-covered service; rather, to be paid for by Department of Education. However, services described in the ISP or IFSP may be Medicaid-covered if they are medical in nature, among those listed in the Medicaid statute, and third party billing requirements have been satisfied. E.g., Dallas Regional Medical Services Letter No. 94-52 (HCFA Region VI) (July 14, 1994).
Investigation to determine the source of lead poisoning	Other diagnostic, screening, preventive, and rehabilitative services, § 1396d(a)(13).	May be covered if Medicaid eligible child has elevated lead blood level and physician recommends it, includes on-site investigation of children home conducted by a health professional (e.g. sanitarian employed by health department). Medicaid not available for testing of substances, investigation of non-primary residence, or lead removal. HCFA, State Medicaid Manual § 5123.2 (Sept. 1998).
Swimming classes, air conditioners, "beeper" systems	Other diagnostic, screening, preventive, and rehabilitative services, § 1396d(a)(13); Physical therapy or related service, § 1396d(a)(11).	May be covered where there is a medical necessity, e.g. for a child with cystic fibrosis, a child with a seizure disorder, a child with brain damage. E.g., Chicago Regional Letter No. 75-91 (HCFA Region V) (Nov. 1991).