
CMCS Informational Bulletin

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SUBJECT: Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth

The Center for Medicaid and CHIP Services (CMCS) is issuing this CMCS Informational Bulletin (CIB) to remind State Medicaid Agencies of the federal requirements for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. This CIB also provides State Medicaid Agencies, agencies administering the Children’s Health Insurance Program (CHIP), state behavioral health agencies, state developmental disability agencies, and other stakeholders with relevant existing federal guidance and examples on ways that Medicaid and CHIP funding, alone or in tandem with funding from other federal programs of the Department of Health and Human Services (HHS), can be used in the provision of high-quality behavioral health¹ services to children and youth. CMCS remains committed to providing information and technical assistance on leveraging funding opportunities to optimize beneficiary access to needed treatment.

Background

As the country continues to understand and grapple with the effects of the COVID-19 public health emergency (PHE), timely access to needed behavioral health services has never been more critical. Prior to the COVID-19 PHE, as many as one in six U.S. children between the ages of 6 and 17 had a mental health disorder.² Additional stressors related to the COVID-19 PHE, such as disruption of familiar routines, in-school learning, connectedness and socialization, as well as grief, loss, economic difficulties, and other impacts on families, have resulted in a surge of behavioral health concerns in children and youth. The Centers for Disease Control and Prevention (CDC) reports that from the beginning of the pandemic in March 2020 until October 2020, mental health-related emergency department visits increased 24 percent for children ages 5 to 11, and 31 percent for those ages 12 to 17 compared with pre-COVID-19 levels.³

¹ For purposes of this document, the term “behavioral health” means both mental health and substance use disorders.

² Whitney, D.G., Peterson, M.D., JAMA Pediatrics. (2019). US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children.

³ Leeb, R. T., et al., Morbidity and Mortality Weekly Report, Vol. 69, No. 45, 2020.

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Additionally, suicide remains a leading cause of death among young people. Youth ages 10–24 years die by suicide at a rate of 10.5 per 100,000, and it is the second leading cause of death for young people in this age group. In some minority groups, suicide among youth is particularly high. Non-Hispanic American Indians/Alaska Natives die by suicide at a rate of 33 per 100,000. Rates are also higher among youth who identify as lesbian, gay, or bisexual, with nearly a quarter of these high school students reporting an attempted suicide in the prior 12 months.⁴

Although the number of children and youth experiencing new or exacerbated behavioral health conditions continues to rise, the rate of mental health services utilization for children and youth under age 19 has continued to be lower than prior years' levels since the onset of the COVID-19 PHE.⁵ Between March 2020 and January 2022, this gap in the rate of services translated to nearly 27.3 million fewer mental health services furnished for children and youth during the COVID-19 PHE.⁶ This decline in utilization of mental health services would have been much higher if not for the exponential growth in the use of telehealth to continue service provision and minimize gaps in service delivery. There have been more than 17 million mental health services visits for children and youth delivered via telehealth since the onset of the COVID-19 PHE, representing an increase of more than 7,500 percent compared to the pre-PHE period. However, despite this growth in the utilization of telehealth, the gap between the need for and utilization of behavioral health services persists.

This gap in effective behavioral health treatment for children and youth could have costly and lifelong effects. Without treatment, children with behavioral health conditions face a range of problems in adulthood, including increased risk of criminal justice involvement and instability in employment and relationships.⁷ Untreated behavioral health conditions in children can also have an adverse effect on health in adulthood. For example, adverse childhood experiences (ACE), which are potentially traumatic events that occur in childhood, are linked to a number of chronic health problems in adulthood, including heart disease, cancer, diabetes, asthma, and kidney disease, as well as mental illness, suicide and substance abuse.⁸

This CIB is intended to help prevent the potentially lifelong consequences of unaddressed ACEs and other behavioral health problems by providing information about EPSDT requirements and other authorities available to states to deliver effective prevention and interventions through their Medicaid and CHIP programs.

⁴ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). Access at <http://www.cdc.gov/injury/wisqars/>.

⁵ COVID-19 Medicaid and CHIP Data Snapshot. Access at <https://www.medicaid.gov/state-resource-center/downloads/covid-19-medicaid-data-snapshot-01312022.pdf>.

⁶ COVID-19 Medicaid and CHIP Data Snapshot. Access at <https://www.medicaid.gov/state-resource-center/downloads/covid-19-medicaid-data-snapshot-01312022.pdf>.

⁷ Neufeld SAS, Jones PB, Goodyer IM. Child and adolescent mental health services: longitudinal data sheds light on current policy for psychological interventions in the community. *J Public Ment Health*. 2017;16(3):96-99. Access at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5868550/>.

⁸ CDC Vital signs (2019). Adverse Childhood Experiences. Access at <https://www.cdc.gov/vitalsigns/aces/pdf/vs-1105-aces-H.pdf>.

This guidance is one of several steps CMS is taking to support access of children and youth to Medicaid behavioral health services. Section 11004 of the Bipartisan Safer Communities Act (P.L. 117-159) builds upon the efforts CMS has underway, and specifies several actions for the Department of Health and Human Services (HHS) to take in support of this goal.

EPSDT

A hallmark of the Medicaid program is the mandatory EPSDT benefit described in section 1905(r) of the Social Security Act (the Act).⁹ EPSDT requires the provision of screening, vision, dental, hearing, and “such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) [of the Act] to correct or ameliorate defects and physical *and mental illness and conditions discovered by the screening services*, whether or not such services are covered under the [s]tate plan.” (emphasis added).^{10 11} A service does not need to “cure” a condition to be covered under EPSDT. Services that maintain or improve the child’s current health condition are also required to be covered because of the “ameliorate” provision in the statute.

CMS also notes that the obligation to provide all medically necessary care under EPSDT extends to prevention, screening, assessment and treatment for mental health and substance use disorders (SUDs). Behavioral health services are available under several benefit categories under section 1905(a) of the Act, such as physician and clinic services, federally qualified health center and rural health clinic services, inpatient and outpatient hospital services, rehabilitative and preventive services, and services of other licensed practitioners. These services must be provided pursuant to EPSDT when necessary to treat an identified behavioral health condition.

While EPSDT is not a required benefit for separate CHIPs, many states have elected to provide this benefit under their CHIP state plan.¹² States that have not elected to provide EPSDT have several types of benefit packages to choose from, such as benchmark and Secretary-approved coverage benefit packages, consistent with section 2103(a) of the Act. However, regardless of a state’s benefit package, all separate CHIPs are required to provide a broad array of mental health and SUD services per section 2103(c)(5) of the Act.

States are encouraged to leverage a comprehensive array of Medicaid providers, including schools, in meeting EPSDT coverage obligations:

- Most beneficiaries under age 21 are entitled to EPSDT services, regardless of whether they are enrolled in a managed care plan or receive services in a fee-for-service (FFS) delivery system.
- Determinations of medical necessity are made by the state or, under delegated authority, by the managed care plan and must be made on a case-by-case basis, considering the individual

⁹ All references to the Medicaid program are meant to encompass traditional Medicaid, as well as Medicaid-expansion CHIPs.

¹⁰ For example, private duty nursing services may not be covered under the state plan for adults but must be covered when medically necessary for EPSDT-eligible children.

¹¹ Section 1905(r)(5) of the Act

¹² See footnote 9.

child's or adolescent's particular needs and guided by information from the child's health providers.

- Hard, fixed, or arbitrary limits on coverage for services (e.g., based on dollar amounts, standard deviations from the norm, or lists of specific diagnoses) are not permitted; however, states may set reasonable limits based on criteria such as medical necessity or appropriate utilization control, *see* 42 C.F.R. § 440.230(d).
- Medicaid-covered services must fit under an applicable state plan benefit category or waiver or demonstration authority and must be furnished by a Medicaid-participating provider who meets the provider qualification requirements associated with the particular benefit.
- If a state pays for services of a particular provider type, that Medicaid provider type should meet certification, registration, credentialing, education, training, and other state-specific requirements consistent with the rules of the benefit category.
- Providers of therapy services (physical therapy, occupational therapy, speech therapy, audiology) must meet federal provider requirements in 42 C.F.R. § 440.110, regardless of the section 1905(a) benefit category under which these services are covered.
- CMS shares with states the same goal of ensuring that Medicaid services, including those provided in the schools, are of high quality; states should establish qualifications of school providers consistent with those of providers in the community.
- States should work with State Education Agencies (SEAs) and Local Education Agencies (LEAs) to determine specific federal and state requirements regarding provider qualifications specific to participation in the Medicaid program, procedures for enrollment with the state Medicaid agency, and the scope of practice laws for provider types furnishing school-based services.
- Medicaid-participating practitioners in school-based settings are also subject to the screening requirements in section 1866(j)(2) of the Act and 42 C.F.R. §§ 455.400 – 455.470. *See* section 1902(a)(77) and (kk) of the Act.
- Claims for payment for Medicaid-covered items or services that were ordered or referred for a beneficiary must include the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services.

Other Medicaid and CHIP Coverage Authorities

States can also leverage other Medicaid and CHIP authorities to design a comprehensive array of services and supports to meet the unique needs of children and youth with behavioral health needs.

Health Services Initiatives - States also have the option under title XXI to develop state-designed Health Services Initiatives (HSIs) to improve the health of low-income children and youth. Several states have used HSIs for behavioral health initiatives, including to provide opioid overdose reversal kits, train public school employees to administer opioid overdose reversal drugs, and support consultation and collaboration between pediatric primary care and mental health specialists. HSIs are permitted under section 2105(a)(1)(D)(ii) of the Act and are defined in regulations at 42 CFR § 457.10. HSI expenditures (including administration of the HSI itself) are subject to a cap that also applies to administrative expenses. Under section 2105(c)(2)(A) of the Act, claims for HSIs and administrative expenses cannot exceed 10 percent of the total amount of title XXI funds claimed by the state each quarter.

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Home and Community-Based Services - As states consider the unique needs of their children and youth, they are encouraged to think strategically about how home- and community-based services (HCBS) can complement or wrap around EPSDT-required behavioral health services. Individuals with complex needs, such as those with co-occurring mental health conditions and developmental or intellectual disabilities, are best served with a robust array of primary, acute, preventive, behavioral health, and home and community-based services. States have considerable flexibility in shaping their Medicaid-funded home and community-based services (HCBS) programs, authorized at section 1915(c) of the Act for HCBS waivers, 1915(i) for HCBS state plan services, and 1915(k) for Community First Choice state plan services. States determine the services to cover, the qualifications of providers delivering the services, service planning, and the coordination of HCBS with behavioral health services. HCBS such as respite care, supported employment, non-medical transportation and habilitation could be provided to children and youth with behavioral health needs to supplement the array of EPSDT-required services. Each HCBS authority has criteria defining who is eligible for services. For example, both 1915(c) waivers and 1915(k) state plan programs require individuals to meet an institutional level of care. The 1915(i) state plan option does not require an institutional level of care determination. States are encouraged to leverage the HCBS authorities to provide an array of services to as many children and youth as possible.

Strategies and State Examples in the Provision of High-Quality Behavioral Health Services for Children and Youth

State Medicaid Agencies and other stakeholders should consider the following list of strategies for providing high-quality behavioral health services to children and youth. In addition to the strategies outlined below, CMCS encourages states to increase behavioral health provider reimbursement rates to ensure adequate access to high-quality behavioral health services. When assessing reimbursement for behavioral health services, states must consider federal mental health parity requirements, as applicable. For instance, as part of a state’s mental health parity analysis, reimbursement rates should be assessed as a non-quantitative treatment limit to ensure that policies and procedures related to reimbursement for behavioral health are comparable to and applied no more stringently than in reimbursement for physical health services.

Additionally, section 1902(a)(30)(A) requires states to “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” While these requirements do not directly apply to managed care programs, there are similar requirements for network adequacy and access requirements for Medicaid managed care programs at 42 CFR §§ 438.68 and 438.206. States must ensure that all covered services are available and accessible to managed care enrollees and that managed care plans¹³ meet the state’s network adequacy standards. Additionally, 42 CFR § 438.210 requires that managed care plan contracts specify the amount, duration, and scope of each service that the managed care plan is required to cover and that those

¹³ Includes managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, as defined at 42 CFR § 438.2.

services must meet or exceed the amount, duration and scope of such services provided under FFS.

1. Improve Prevention, Early Identification and Engagement in Treatment

Prevention and early identification of health conditions is a key component of EPSDT. Early detection of mental health and substance use issues is crucial to the overall health of children and youth, and may reduce or eliminate the effects of a condition if detected and treated early.¹⁴ This makes routine screenings, early identification, and engagement in treatment as early as possible critical for children and youth. States are encouraged to implement the following strategies:

- Avoid requiring a behavioral health diagnosis for the provision of EPSDT services. States can determine that some services are medically necessary for children and youth without a diagnosed behavioral health condition.
 - *State Spotlight: California covers non-specialty mental health services (NSMHS) such as evaluations and individual, group, and family psychotherapy to individuals with potential mental health disorders not yet diagnosed. NSMHS are provided through Medi-Cal Managed Care Plans and the fee-for-service delivery system. California also covers a range of specialty mental health services (SMHS), including but not limited to targeted case management, crisis services, residential services, and a variety of specialty outpatient mental health services. SMHS are provided through county Mental Health Plans (MHPs). For children and youth, medically necessary SMHS are available to beneficiaries with a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness. In addition, for children and youth, medically necessary SMHS are available to beneficiaries who have a need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide, and a suspected mental health disorder that has not yet been diagnosed.*
- Increase access to behavioral health screenings by:
 - Incorporating age-appropriate, evidence-based behavioral health and developmental screenings into well-child examinations;
 - Increasing access to screenings and treatments through schools; and
 - Covering behavioral health screenings in primary care settings.
 - *State Spotlights:*
 - *Arizona and [Michigan](#) have seen substantial increases in the number of students who have received behavioral health services following state efforts to expand behavioral health services in schools.*
 - *Georgia promotes collaboration between community mental health providers and schools to provide school-based services and supports to children and youth.*

¹⁴ <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf>

- *Colorado’s family-focused preventive primary care model identifies and addresses early childhood mental health needs, including dyadic care where the infant/young child and caregiver are treated holistically.*
- Develop referral networks of mental health and substance use disorder providers, including through improved connections and data-sharing capabilities linking non-specialty health care providers and community organizations with mental health and substance use disorder providers.
- Utilize age-appropriate diagnostic criteria for young children, such as the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5). Age appropriate diagnostic criteria help practitioners more accurately identify diagnosis in young children who do not have language skills or exhibit the same symptoms as older children and adults. Effective assessment can help improve access to the right type and intensity of care and can reduce behavioral problems and difficulties in school and family life.
 - *State Spotlights: Georgia, Washington and Colorado all recognize or plan to recognize the DC: 0-5.*

2. Increase Access to Treatment Across the Continuum of Care

The goal of the EPSDT benefit is to ensure that individual children get the health care they need in the right place when they need it. States have broad flexibility to accomplish this by designing a robust benefit package across the continuum of care that meets the specific needs of children and youth.¹⁵ This includes coverage of intensive community-based services, crisis stabilization, and intensive care coordination to meet the needs of high-risk children and youth. CMCS encourages states and managed care plans to:

- Review existing policies to ensure coverage and reimbursement are available for services at an intermediate level of care, such as intensive in-home services, partial hospitalization services, and wrap around services, to correct or ameliorate identified behavioral health conditions.
 - *State Spotlight: Massachusetts, via the state’s [Children’s Behavioral Health Initiative](#), provides a comprehensive continuum of home and community based behavioral health services to children and youth with behavioral, emotional, and mental health needs and their families, including intensive care coordination, in-home behavioral health services, family support and training, therapeutic mentoring and mobile crisis intervention services.*
- Implement or expand access to crisis stabilization services and utilize Medicaid administrative claiming for implementation of crisis lines. States have broad discretion and

¹⁵ As indicated earlier, the EPSDT benefit requires coverage of all medically necessary services that are included within the categories of mandatory and optional benefits listed in section 1905(a) of the Act, regardless of whether such services are covered under the state plan.

are encouraged to require mobile crisis providers to receive training on the unique issues that arise when working with children and youth, such as ways to engage with parents and/or guardians who are on scene; special consent issues that arise with minors; and specific information on the facilities and providers that are most equipped to work with a child or youth in crisis. For qualifying community-based mobile crisis intervention services, states may receive an increased federal medical assistance percentage (FMAP) of 85 percent for 12 quarters during the period of April 1, 2022 through March 31, 2027.¹⁶

- *State Spotlight: [Oklahoma](#) through its Youth Crisis Mobile Response initiative provides rapid, community-based mobile crisis intervention services for children, youth, and young adults up to the age of 25 who are experiencing behavioral health or psychiatric crises. The state continually monitors the initiative and implements changes as needed for the 988 hotline rollout.*
- Consider telehealth options to increase access to care, including in school settings. It is important to note that states retain extensive flexibility in the utilization of telehealth within Medicaid outside of the COVID-19 PHE; states are encouraged to consult with provider and stakeholder communities in making longer-term decisions about the role of telehealth in behavioral health service delivery.
- Offer a broad array of recovery supports and services, such as supported employment and education programs, supportive housing, and peer and recovery support navigators.
- Provide enhanced care coordination services to children and youth with significant behavioral health needs through implementation of health homes, including health homes for medically complex kids.
 - *State Spotlight: New Jersey's behavioral health home (BHH) provides fully integrated enhanced care coordination and wraparound care planning for children and adults with serious emotional disturbance (SED), including co-occurring developmental disability and mental illness, co-occurring mental health and substance use disorder, and developmental disability with symptomology of SED, and their families. BHH providers are responsible for facilitating access to a full range of treatment and support services.*
- Develop systems to track which behavioral health providers are accepting Medicaid beneficiaries at different levels of care throughout the state, including outpatient, intensive outpatient, HCBS, and inpatient, and ensure that patients with Medicaid have access to information about where providers accepting Medicaid are located in their state and community.

3. *Expand Provider Capacity*

States have broad flexibility to utilize a provider network with a range of different qualifications that can best meet the disparate needs of children and youth. Licensed professionals, such as

¹⁶ <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf>

psychiatrists and other physicians, psychologists, social workers, and nurses can complement peer support specialists with lived experience, case managers, and community health workers¹⁷ to provide direct services and/or linkages to needed health care and community resources. It is important to note that different Medicaid benefit categories may have limitations regarding the scope of providers that can be authorized to deliver services; therefore, CMCS encourages states to reach out to us for technical assistance to ensure appropriate benefit utilization for both service provision and claiming purposes. CMCS encourages states and managed care plans to:

- Recognize an array of providers who together can maximize beneficiary access to needed behavioral health services, including school-based providers.
- Implement the following actions to facilitate provider recruitment and retention efforts:
 - Acuity-based rates where focused investments could be made to build capacity in areas where the system currently lacks capacity (e.g., intensive inpatient psychiatric capacity for individuals with acute psychosis).
 - Payment increases for outpatient clinics and other non-acute settings that are able to provide comprehensive behavioral health treatment, including:
 - Integrated mental health and SUD treatment / co-occurring treatment,
 - 24/7 open access or urgent care for behavioral health,
 - Evidenced-based treatment (including trauma-informed care),
 - Care coordination, and
 - Quality reporting.
 - Eliminate or reduce use of prior authorization for behavioral health services to enhance access and ensure any medical necessity criteria do not have the effect of unnecessarily hindering access or creating administrative barriers that discourage providers from serving Medicaid and CHIP enrollees; and
 - Eliminate administrative barriers to providers enrolling in Medicaid and CHIP (e.g., unnecessarily burdensome credentialing criteria for enrolling and duplicative and burdensome credentialing across managed care plans).
 - *State Spotlights:*
 - *Nebraska has increased reimbursement rates for behavioral health services by 15 percent on top of the an already scheduled 2 percent increase, for a total year over year increase for SFY22 to SFY23 of 17 percent.*
 - *Colorado has increased reimbursement rates for providers furnishing services at an intermediate level of care.*
- Leverage additional funding such as the 10 percentage point increase to the FMAP for a broad array of HCBS made available under section [9817](#) of the American Rescue Plan Act of 2021 (ARP; P.L. 117-2) to enhance community-based options for providing behavioral health treatment to children and youth. The period of increased FMAP expired on March 31, 2022, but states may continue to spend state funds equivalent to the amount of federal funds

¹⁷ Opportunities for states to utilize community health workers as providers of Medicaid services was discussed on a May 3, 2022, All-State Call; the presentation can be accessed here: <https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall05032022.pdf>

attributable to the increased FMAP until March 31, 2025.¹⁸ States also may elect to use the federal funds attributable to the additional 6.2 percentage point FMAP increase made available under the Families First Coronavirus Response Act (FFCRA; P.L. 116-127) for behavioral health stabilization and reform activities.

- *State Spotlights: [Alabama](#), [Michigan](#), [Rhode Island](#) and [Washington](#) ARP spending plans include investments to support and expand mental health services for children and youth.*
- Support [Project ECHO](#) (Extension for Community Healthcare Outcomes) training to build capacity to address children and youth behavioral health care needs by pediatricians, as well as other health care providers and social services personnel, including emergency room providers and community health workers.

4. Increase Integration of Behavioral Health and Primary Care

Increased integration of behavioral health and primary care can help ensure that individuals with a behavioral health condition are identified earlier and connected with appropriate treatment sooner. CMCS encourages states and managed care plans to adopt the following strategies:

- Implement care delivery models such as [patient-centered medical homes](#), [integrated care models](#), the [primary care behavioral health model](#), the [collaborative care model](#), and [health homes](#) for individuals with chronic conditions, and health homes for children with medically complex conditions.
 - *State Spotlight: Washington supports access to behavioral health treatment in primary care settings via the [collaborative care model](#).*
- Participate in the [pediatric mental health care access program](#).
- Support wider adoption of electronic health records by behavioral health providers.
- Reimburse pediatricians and other primary care practitioners for behavioral health services, *even in advance of a formal behavioral health diagnosis*, via:
 - Utilization of non-specific codes;
 - Reimbursement for treatment of more complex individuals (e.g., intensive care management codes and longer office visits);
 - Reimbursement of care coordination, including linkages of beneficiaries with needed behavioral health specialists;
 - Removal of prohibitions on same-day billing for behavioral health and primary care; and
 - Reimbursement parity for the same billing codes across primary care and behavioral health clinicians.

Existing Guidance

¹⁸ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd22002.pdf>

CMCS has issued multiple pieces of behavioral health-related guidance over time that remain on www.Medicaid.gov as resources for state and stakeholder awareness, and links to some of these guidance documents are listed below. In addition, federal HHS partners have also issued important guidance on other program resources that could be leveraged in the delivery of behavioral health services. While not an exhaustive list, the following resources could be useful as states make decisions about behavioral health services available for children and youth:

SUD services for newborns

- Neonatal Abstinence Syndrome and prenatal substance use
<https://www.medicaid.gov/federal-policy-guidance/downloads/cib090420.pdf>
- Residential pediatric recovery centers for infants with neonatal abstinence syndrome
<https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1007.pdf>
- Treatment and prevention of fetal alcohol spectrum disorders
<https://aspe.hhs.gov/fasd-research-briefs>

Behavioral health services provided in schools

- “Free care” guidance
<https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf>
- CMS/Substance Abuse and Mental Health Services Administration (SAMHSA) joint guidance on addressing mental health and SUD in schools
<https://www.medicaid.gov/federal-policy-guidance/downloads/cib20190701.pdf>
- SAMHSA guidance on trauma-informed care services for educators
<https://www.samhsa.gov/child-trauma/learning-materials-resources#educators>
- SAMHSA guidance on mental health and SUD in schools
<https://store.samhsa.gov/product/talk-they-hear-you-student-assistance-guide-school-administrators/pep19-03-01-001>

Medicaid benefit utilization for behavioral health services

- American Rescue Plan Act of 2021 authorization of community-based mobile crisis intervention services
<https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf>
- American Rescue Plan Act of 2021 increased funding for HCBS
<https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf>

Behavioral health benefit design

- Prevention and identification of mental health conditions and SUD
<https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/CIB-03-27-2013.pdf>
- Coverage and design opportunities for mental health and SUD treatment
<https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-12-03-12.pdf>
- Early psychosis intervention services guidance
https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/cib-10-16-2015_26.pdf

- CMS/SAMHSA joint guidance on services for children and adolescents with significant mental health conditions
<https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf>
- EPSDT coverage of services for children and adolescents with an autism spectrum disorder
<https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-07-14.pdf>
- Coverage of peer supports
<https://www.medicaid.gov/federal-policy-guidance/downloads/SMD081507A.pdf>
- Mandatory medication-assisted treatment benefit
<https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf>
- CMS and SAMHSA joint guidance on coverage of SUD services for youth
<https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-01-26-2015.pdf>
- Service delivery opportunities for individuals with SUD
<https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-10-29-14.pdf>
- HHS Office for Civil Rights (OCR) resources on civil rights and opioid use disorder
<https://www.hhs.gov/sites/default/files/fact-sheet-nondiscrimination-and-opioid-use.pdf>
- Civil rights protections for individuals with an opioid use disorder (HHS OCR Video Presentation): <https://www.youtube.com/watch?v=7Me9cEjf8jo>
- Coordinating care provided by out-of-state providers for children with medically complex conditions
<https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf>
- Maternal depression screening and treatment
<https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf>
- EPSDT general information, including Strategy Guides to support states in effectuating required Medicaid coverage
<https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html>

Utilization of telehealth in service delivery

- State Medicaid and CHIP Telehealth Toolkit
<https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf>
- State Medicaid and CHIP Telehealth Toolkit: COVID-19 Supplement
<https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf>
- Utilization of telehealth in SUD services
<https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib040220.pdf>
- Telehealth and remote patient monitoring for pediatric populations in Medicaid
<https://www.medicaid.gov/medicaid/benefits/downloads/rtc-reducing-barriers-may-2020.pdf>

CHIP guidance

- Access to mental health and SUD services for children and pregnant women in CHIP
<https://www.medicaid.gov/federal-policy-guidance/downloads/sho20001.pdf>

- FAQ: Health Services Initiatives
<https://www.medicaid.gov/federal-policy-guidance/downloads/faq11217.pdf>

Joint HHS/Department of Education guidance

- Letter issued March 24, 2022
[March 24, 2022 -- Joint Letter with Secretary Xavier Becerra of HHS to Governors regarding School Based Health Services](#)
- Letter issued July 29, 2022
[July 29, 2022 -- Joint Letter with Secretary Xavier Becerra of HHS regarding Federal Resources for Student Mental Health](#)

Conclusion

CMCS and HHS remain committed partners in providing tools and resources to states, managed care plans and other stakeholders in the provision of needed behavioral health services to our nation's children and youth. All available Medicaid and CHIP funding streams, including enhanced funding opportunities made available through ARP and FFCRA, described above, should be leveraged to implement behavioral health system reforms. States should reach out to their CMCS state contacts for any needed technical assistance.

For additional information, please contact Melissa Harris, Deputy Director, Disabled and Elderly Health Programs Group, at melissa.harris@cms.hhs.gov.