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

# EPSDT in California: Desk Review Report

## Executive Summary

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements for children enrolled in Medicaid are intended to ensure the availability and accessibility of required health care services and to help children and their families use them effectively. Sections (§) 1905(a)(4)(B) and (r) of the Social Security Act (the Act) entitle eligible children under the age of 21 years to Medicaid coverage of health care, diagnostic services, treatment, and other measures described in §1905(a) that are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions, whether or not such services are covered under the state plan.

Section 11004 of the Bipartisan Safer Communities Act (Public Law (PL), 117-159) requires the Centers for Medicare & Medicaid Services (CMS) to review states' implementation of EPSDT requirements. In 2025, CMS conducted a desk review of California's EPSDT operations, including reviewing documents; interviewing state officials, managed care plans (MCPs), and pediatric providers; holding a focus group with beneficiary advocates; and analyzing Transformed Medicaid Statistical Information System (T-MSIS) data. This report details our findings.

EPSDT is an important part of California's Medicaid program, which is called Medi-Cal. California is an expansive state with a population of over 39.5 million individuals,[1] around 13 million of whom rely on Medi-Cal for their health care coverage.[2] According to the CMS 416 report, in 2023 there were 6,069,250 children and youth zero to 20 years of age enrolled in Medi-Cal.[3] This represents all EPSDT-eligible children enrolled during the year and thus reflects a larger number than point-in-time enrollment reporting. This enrollment represents a significant portion of California's youth population, with Medicaid providing essential and comprehensive health coverage to nearly half of the state's children.[4]

According to California's Child Core Set and Form CMS-416 reporting from 2023, the most recent year for which data were available, the state's results on Well-Child Visit (WCV) measures varied by age group. The Form CMS-416 report indicates that the percentage of children who received a WCV in California was slightly lower than the national percentage for every age group except for children under one, in which California performed considerably lower (California: 83%, National: 91%).

[1] US Census Bureau, California - Census Bureau Profile
[2] CMS, July 2025 Medicaid/CHIP Eligibility Operations & Enrollment Snapshot
[3] CMS, EPSDT Data
[4] KFF, Fact Sheet Medicaid CA

| 2023 Core Sets Well-Child Visits | | |
|---|---|---|
| **Age Group** | **CA (%)** | **National Median (%)** |
| First 15 Months | 44.3 | 59.2 |
| 15-30 Months | 64.6 | 64.8 |
| 3-11 Years | 59.4 | 53.3 |
| 12-17 Years | 54.7 | 48.5 |
| 18-21 Years | 36.1 | 22.4 |
| 3-21 Years | 53.2 | 45.3 |
| **2023 CMS 416 Report Well Child Visits** | | |
| **Age Group (Year(s))** | **CA (%)** | **National Average (%)** |
| All Ages (0-20) | 47 | 51 |
| <1 | 83 | 91 |
| 1-2 | 77 | 78 |
| 3-5 | 61 | 63 |
| 6-9 | 46 | 48 |
| 10-14 | 46 | 49 |
| 15-18 | 38 | 40 |
| 19-20 | 18 | 19 |

During our review, we identified several promising practices in California to facilitate the delivery of services to EPSDT-eligible children:

- Most notably, the state used a variety of methods, including soliciting direct stakeholder input, to develop and revise EPSDT informing materials, particularly the Medi-Cal for Kids & Teens Toolkit, which consists of a child- and teen-focused brochure, a "Know Your Rights" letter, and a provider training. The Medi-Cal for Kids & Teens toolkit and Know Your Rights letter are distributed to all eligible beneficiaries. The state's informing materials are clear and detailed and are a model for other states.
- The state assures transportation benefit by allowing directly enrolled transportation providers to provide services to Medi-Cal FFS members as well as MCPs to work with a broad array of service modalities to provide services to Medi-Cal managed care members, including taxis, wheelchair vans, public transit, and rideshare. Despite having a significant number of EPSDT-eligible children across an expansive area, California has few service complaints for transportation.
- California made operational decisions that reduced barriers to care for children—e.g., the state has distinct medical necessity criteria for children that explicitly incorporate EPSDT's "correct or ameliorate" standard.

- California's prior authorization policy does not appear to be a barrier to care for children in Medi-Cal. The state and MCPs approve most services without prior authorization and have a clear medical review process to ensure that children's services are reviewed according to EPSDT standards when prior authorization is required.

Our review also raised several concerns, which are listed below with recommendations.

- A small but historically vulnerable population of children, primarily those in foster care or former foster care, still receive benefits through fee-for-service (FFS) delivery system. We found few mechanisms in place to ensure these children receive the screenings and services to which they are entitled. Additionally, advocates reported that the care coordination provided to children in foster care varies substantially by county. This care coordination is provided by individually enrolled Medi-Cal FFS providers as part of their clinical practices as well as the Health Care Program for Children in Foster Care (HCPCFC), which is a partnership between the state Medicaid agency and the California Department of Social Services (CDSS). California offers multiple case management and care coordination programs for children, including Enhanced Care Management (ECM) for Medi-Cal managed care members, the California Children's Services (CCS)/Whole Child Model (WCM), and the aforementioned HCPCFC. The number of programs may confuse beneficiaries and fragment services, resulting in inconsistent support or gaps in available support. In response, CMS recommends the state:
    - Evaluate implementation of the HCPCFC and determine whether Medi-Cal enrolled children in foster care are receiving appropriate care coordination services and if there are any opportunities for improvement.
    - Integrate services to streamline pathways and avoid duplication in case management, especially for Enhanced Care Management (ECM) for Medi-Cal managed care members, members in the California Children's Services (CCS)/Whole Child Model counties, and the HCPCFC for Medi-Cal FFS beneficiaries.
- The state invests considerable resources to evaluate exceptions to the state's network standards permitted at 42 CFR § 438.68(d). When an Alternative Access Standard (AAS) is approved, beneficiaries are generally expected to use network providers. Some of these approved AAS for MCPs, may be unreasonable for pediatric beneficiaries. For instance, beneficiaries may travel 2.5 hours or more to see a pediatric primary care physician instead of allowing beneficiaries the option to access out-of-network care that is much closer. In response, CMS recommends the state:
    - Discontinue approving AASs for pediatric primary care, which would allow beneficiaries to access out-of-network providers when care is not available within state established standards.
    - Provide robust oversight of "good faith efforts" for network contracting and differentiate between areas that lack providers and areas where providers will not accept Medicaid.
- In California, children who are ages one to two appear to receive a higher rate of well-child visits (WCV) than infants under age one. This may partly result from challenges with timely newborn enrollment and using a mother's Medi-Cal identification number for a newborn's enrollment and billing. To help address newborn enrollment concerns, California recently implemented the Newborn Gateway,

which is a new deemed eligibility pathway for participating hospitals to assist with expedited enrollment of newborns into Medi-Cal through the inputting of information about births. Additionally, MCPs described quality initiatives that resulted in hiring a pediatrician at a clinic and opening limited Saturday hours, which may indicate routine pediatrician shortages or limited business hours. Any or all of these factors could contribute to California's low rates of WCVs. CMS recommends the state:

  - Prioritize improving MCP performance on basic markers of children's care, such as WCVs.
  - Investigate whether MCPs that include some providers with weekend and evening hours have higher utilization rates for WCVs.
  - Develop interim mechanisms to ensure timely newborn enrollment into Medi-Cal until the Newborn Gateway is functioning and prioritize correcting Newborn Gateway issues to facilitate newborn enrollment.
  - Ensure that all MCPs follow technical specifications for the child core set measures, including WCVs.
  - Focus on improving quality of claims and encounter data to improve appropriate data capture of WCV performance.
  - Add a section to the Comprehensive Quality Strategy to specifically focus on how to improve EPSDT and children's health.
  - Consider having the External Quality Review Organization (EQRO) do a focused study on WCVs.
  - Consider developing a statewide EQRO performance improvement plan (PIP) that focuses on improving WCVs by a certain percentage each year. If feasible, the PIPs should be county specific for MCPs that operate in multiple counties.

- Families may find it challenging to navigate California's large and complex Medicaid program. For instance, children have multiple opportunities to receive case management and care coordination, but these programs and responsibilities are spread across county departments, community organizations, and MCPs. Children enrolled in Medi-Cal would greatly benefit from clear communication explaining who is responsible for helping families know when their child is due for a WCV, contacting families if their child is overdue for a WCV, finding specialists for diagnostic and treatment services when follow-up care is needed, and providing assistance to overcome barriers to necessary health care. In response, CMS recommends the state:
  - Ensure MCPs are providing appropriate care coordination services, including basic care coordination for children without complex needs.
  - Continue to explore additional opportunities to ensure that providers can more easily find information on EPSDT policies in the provider manual, particularly including the ability to request children's services that are listed in the "non-benefit" section.
  - Undertake efforts to ensure that adult medical necessity standards are not inappropriately applied to children and, if necessary, remove barriers that would impede children's access to medically necessary care.

# Introduction

## Objective, Scope, and Methodology

Between December 2024 and July 2025, the Center for Medicaid and CHIP Services (CMCS) conducted a review of California's implementation of EPSDT requirements to determine how the state is complying with federal statutes, regulations, and other applicable requirements. We focused on the state's EPSDT policies, procedures, and documents that were in effect between January 1, 2023, and May 31, 2025.

To complete the review, we developed state-, plan-, provider-, and beneficiary-specific interview guides and questions regarding the successes and challenges of implementing EPSDT requirements in California. It was not feasible to interview every Medi-Cal MCP operating in California, so we selected two representative MCPs to examine in more depth, based on geography and plan type. We also met with pediatric providers and beneficiary advocates to discuss EPSDT and children's health services in the state.

In addition, we reviewed the following documents:

- California's approved Medicaid state plan and 1115 California Advancing & Innovating Medi-Cal (CalAIM) section 1115 demonstration
- Provider manuals and beneficiary informing materials for the state and two sample MCPs
- Managed Care Boilerplate Contract
- California's EPSDT and dental periodicity schedules
- California's historic Form CMS-416 reports and Child Core Set results
- California's managed care program annual reports (MCPAR)
- California's network adequacy and access report (NAAR)
- California's external quality review (EQR) reports and California's quality strategy
- Other publicly available state-issued documentation (e.g., All-Plan Letters)

Lastly, we analyzed T-MSIS data to identify patterns of beneficiaries who were not receiving well-child visits and other services at the state, county, and plan levels. See Appendix A for more details on the T-MSIS analysis methodology.

## EPSDT in California

California's Medicaid program is called Medi-Cal. The program primarily uses a managed care delivery system that operates under the CalAIM § 1915(b) waiver, comprising: Medi-Cal managed care, dental managed care, specialty mental health services, and the Drug Medi-Cal Organized Delivery System.[5] Medi-Cal Managed Care operates at the county level and may operate among one of five managed care plan model types selected by the county and approved by the state. Two of the models (single plan and county-organized

[5] DHCS, CalAIM 1915b Approval Letter

health systems) enroll beneficiaries in one MCP. The remaining three models (regional, two-plan, and geographic managed care) offer beneficiaries a choice of at least two MCPs.[6] Table 1 below describes the five managed care models and how many counties and Medi-Cal beneficiaries are served by each. About 72% of Medi-Cal enrollees have plan choice while 28% (approximately 4 million people) do not have plan choice.[7]

In addition, Kaiser Foundation Health Plan, Inc. (Kaiser) operates as an alternate health care service plan (in accordance with AB 2724 (Chapter 73, Statutes of 2022)) in 32 counties and is directly contracted with DHCS and licensed by the Department of Managed Health Care. Enrollment in Kaiser is restricted to certain members who have had prior enrollment with Kaiser or have family linkage. Importantly, however, there are no restrictions for foster youth/former foster youth: Any foster youth/former foster youth residing in Kaiser's service areas can enroll in Kaiser's Medi-Cal managed care plan.

**Table 1: Medi-Cal Managed Care Models**

| Plan Model Type | Description [8] | Plan Choice? | # of Counties [9] | # beneficiaries as of May 2025 [10] |
|---|---|---|---|---|
| Single Plan Model | Beneficiaries are enrolled in a single plan | No | 3 | 900,340 |
| County-Organized Health System Model | Beneficiaries are enrolled in a single plan run by a county government entity | No | 34 | 3,067,578 |
| Regional Model | Beneficiaries choose between two commercial plans serving contiguous rural regions | Yes (two plans) | 5 | 43,424 |
| Two Plan Model | Beneficiaries choose between a plan administered by a county government entity or a commercial plan | Yes (two plans) | 14 | 8,411,482 |
| Geographic Managed Care Plan Model | Beneficiaries choose between multiple commercial plans serving clearly defined geographical areas | Yes (more than two plans) | 2 | 1,550,629 |

In August 2024, 21 participating commercial and local health plans[11] served 93.9% of the state's nearly 15 million Medi-Cal enrollees.[12] Managed care procurement differs between county and managed care model: commercial plans operating in geographic managed care counties, regional, and two-plan counties are competitively bid. In single-plan and COHS counties, a county's Board of Supervisors establish, by ordinance, a commission to negotiate a COHS contract with DHCS. These are not established through a competitive procurement process.[13] For plans that are competitively bid, the state considers quality measures

[6] DHCS, Medi-Cal Managed Care Plan Model Fact Sheet
[7] DHCS, Medi-Cal Managed Care Enrollment Report May 2025
[8] DHCS, Medi-Cal Managed Care Plan Model Fact Sheet
[9] DHCS, Medi-Cal Managed Care Models
[10] DHCS, Medi-Cal Managed Care Enrollment Report May 2025
[11] DHCS, MCP Procurement FAQs
[12] DHCS, CA Fast Facts August 2024
[13] CMS, CalAIM 1915b Waiver page 18-19

during the competitive procurement process and is not required to award contracts to low-performing plans.[14]

State regulations codify EPSDT under Title 22, California Code of Regulations, § 51184 to cover all medically necessary services listed in the Social Security Act § 1905(a) regardless of whether these services have been approved under a state plan amendment.[15] Some services are excluded from comprehensive Medi-Cal MCP contracts, including pharmacy services, specialty mental health services, specialty substance use disorder treatment services,[16,17] and dental services in all but Health Plan of San Mateo. In most of the state, dental care is covered under FFS. However, dental services must be covered under a separate Prepaid Ambulatory Health Plan (PAHP) that has mandatory enrollment for enrollees in Sacramento County and a PAHP in Los Angeles County that has voluntary enrollment for enrollees.

The state's Title V Children with Special Health Care Needs program, called California Children's Services (CCS), provides comprehensive case management services for children with qualifying complex health care needs.[18,19] The CCS "classic" model is a partnership between DHCS and county health departments, in which services related to a child's CCS qualifying condition are covered under a FFS delivery system coordinated by CCS and other services are covered under an MCP. CCS services delivered to CCS eligible children by CCS qualified providers receive a 39.7% rate enhancement. In counties that use this traditional model, MCPs are expected to have MOUs in place with local health departments administering CCS to ensure a process is in place to coordinate and deliver appropriate care and follow up. In 21 counties, California integrates CCS into existing comprehensive MCP contracts under what is known as the WCM Program.[20] In these counties, MCPs assume full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services including, but not limited to, referrals, service authorization activities, claims processing and payment, case management, and quality oversight. Further, MCPs are expected to have MOUs in place with local health departments to support eligibility and enrollment into the CCS program.

To prevent beneficiaries from losing health care services or coverage as they transition between child and adult systems, children begin transitioning to adult care programs at age 14.[21] This multi-year CCS transition planning[22] process considers beneficiaries' needs at various ages and provides step-by-step tasks for transition to an adult care program.

Additionally, certain populations may be excluded from mandatory Medi-Cal managed care, most notably current and former foster youth and adoption assistance. According to T-MSIS[23] data from 2023, approximately 250,000 children received services in a FFS delivery system; the state noted that the vast

[14] Cal Procure, Medi-Cal Managed Care Plans RFP 2022
[15] DHCS, APL 2023 | Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21
[16] Some substance use disorder services are covered under Medi-Cal's non-specialty mental health benefit, which is a MCP and FFS provider responsibility that is not carved out to the county behavioral health delivery system.
[17] DHCS, APL 2023 | Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21
[18] CCS is a state program to help children with complex needs get the care they need. As of September 2024, 14,153 youth were enrolled in CCS. See California Children's Services for more information.
[19] DHCS, CCS Program Overview
[20] DHCS, CCS Whole Child Model
[21] DHCS, CCS Transition of Care FAQ
[22] DHCS, CCS Transition of Care FAQ
[23] The Transformed Medicaid Statistical Information System (T-MSIS) collects Medicaid and Children's Health Insurance Program (CHIP) data from U.S. states, territories, and the District of Columbia into the largest national resource of member information. Transformed Medicaid Statistical Information System (T-MSIS)

majority of these beneficiaries are not permanently in FFS but are awaiting enrollment into a MCP.[24] The state noted that children in foster care constitute the majority of the FFS population.

In counties with no plan choice (e.g., county-organized health systems or single-plan model counties), newly eligible beneficiaries are automatically enrolled in the county's MCP on the first day of the month following enrollment in Medi-Cal. In counties with plan choice, beneficiaries have FFS coverage and approximately 30 days to select a MCP after they are determined to be Medi-Cal eligible; if they do not select an MCP, the member is assigned to a managed care plan in their county of residence utilizing prior plan linkage family linkage or the DHCS Auto Assignment Incentive Program.[25,26,27] California's Newborn Gateway allows participating hospitals to enroll newborns into Medi-Cal and the mother's MCP at birth to reduce delays in Medicaid eligibility and MCP enrollment. Otherwise, MCPs receive information on births directly from a parent/caregiver or from the hospital's claim submitted for the birth. In counties without plan choice, MCPs receive daily enrollment files from the state and a monthly reconciliation file. In counties with plan choice, MCPs receive a weekly enrollment file from the state's enrollment broker, effective the first day of the following month.

Beneficiaries newly enrolled in an MCP have 30 days to choose a primary care provider (PCP), after which time, the MCP chooses one for them.[28] Auto-assigning members to a PCP is a plan-specific process, although the state requires plans to incorporate utilization data or other data sources in their algorithms when selecting a PCP for a member. Members may change their PCP at any time.[29] MCPs submit monthly PCP assignment files to the state as a part of the state's monitoring to ensure that all members have selected or been assigned a PCP. MCPs are required to contact new members and provide the Evidence of Coverage (Member Handbook) and the Medi-Cal for Kids and Teens brochures and "Know Your Rights" letter annually, which explains EPSDT. MCPs are also required to send out the Medi-Cal for Kids and Teens brochures and "Know Your Rights" letters within seven calendar days of enrollment into the plan. Additional outreach efforts vary by plan.

# Findings, Insights, and Recommendations

## Informing Families of EPSDT Services

### Applicable Statute, Regulation, and Policy

*Sections 1902(a)(43) of the Act and 42 Code of Federal Regulations (CFR) § 441.56(a) require states to employ effective methods to ensure that all eligible individuals and their families are informed of the benefits of preventive health care, the services available under EPSDT and where and how to obtain those services; that the services provided under EPSDT are without cost to eligible individuals; and that necessary transportation and scheduling assistance is available. States are required to use a combination of written and oral methods to inform beneficiaries and their families about the services available to EPSDT-eligible*

[24] Some of the approximately 250,000 children who received services under a FFS delivery system were waiting to be enrolled in an MCP.
[25] DHCS, my Medi-Cal Handbook
[26] DHCS, 2024 Managed Care Boilerplate Contract page 200
[27] DHCS, Comprehensive Quality Strategy 2022 page 85
[28] DHCS, APL 2023 | Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21
[29] DHCS, APL 2023 | Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21

*children (42 CFR § 441.56(a)(1)). States must also effectively make EPSDT informing materials available to children and families who are blind or deaf, or who cannot read or understand the English language (42 CFR § 441.56(a)(3)).*

*In states that delegate EPSDT informing to an MCP, the state's contract with the MCP must include plans to meet the specific timelines and standards required under EPSDT (CMCS CIB, 2017). MCPs must use a state-developed model enrollee handbook to define which benefits are covered under the MCP and how to access these benefits (42 CFR § 438.10(c)(4)). This handbook must provide information on how and where to access benefits covered by the state, including how transportation to these benefits is provided (42 CFR § 438.10(g)(2)(ii)). MCP handbooks are required to be provided in an accessible format, in prevalent non-English languages, and in alternative formats upon request and at no cost to the enrollee (42 CFR § 438.10(a-d), 42 CFR § 438.10(c)-(d)).*

## Implementation

California developed comprehensive beneficiary informing materials that include information about: regular checkups and preventive and treatment services; services that must be covered if needed, without limits, in plain language; transportation, care coordination, and language interpretation; a definition of medical necessity; what to do if care is denied, delayed, reduced, or stopped, including information on appeals, hearings, and grievances for beneficiaries receiving care through both managed care and FFS.[30] Examples of these comprehensive informing materials include the Medi-Calf or Kids and Teens brochures and provider training, and the "Know Your Rights" letter which are distributed annually, and are distributed by MCPs to new members within seven calendar days of enrollment in the MCP. The All-Plan Letter (APL 23-005) contains the Medi-Cal for Kids and Teens materials. MCPs are required to ensure all their Network Providers complete the Medi-Calf or Kids and Teens training no less than every two years. These materials are available on the DHCS MCKT website in English and 19 other languages and were updated in 2025. DHCS confirmed that the toolkit and other informing materials are updated annually. California originally employed a consultant to improve the MCKT toolkit (brochures, KYR letter, and provider training), which was updated in meaningful ways and integrated feedback from beneficiary focus groups as well as stakeholder input.

The state provides MCPs and providers with comprehensive informing guidance and materials, but they delegate distribution of these MCKT materials to MCPs for managed care enrollees and network providers. As noted above, MCPs are required to distribute DHCS' MCKT materials within seven calendar days of enrollment in the MCP and annually to EPSDT-eligible beneficiaries.[31] Along with the MCKT materials, MCPs are also required to send additional materials to managed care enrollees, including Member Handbooks, and any other documentation the MCP chooses to send. FFS enrollees receive informing materials directly from the state. To assist FFS beneficiaries in finding a DHCS FFS provider, the state created an online Lookup tool. At the time of our interview, the system was not working correctly for FFS providers and DHCS indicated ongoing work on the tool.

Despite California's comprehensive informing materials, providers and advocates highlighted gaps in informing efforts. Advocates reported an overall lack of knowledge among families about the services, such as transportation and care coordination, that are available under EPSDT. Advocates also noted inconsistency

[30] DHCS, DHCS Medi-Cal Rights Letter for Kids & Teens
[31] DHCS, APL 2023 | Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21

in MCPs' outreach efforts to beneficiaries and families, with some MCPs sending reminders when WCVs are due and others having minimal engagement. In addition, providers reported varying degrees of familiarity with EPSDT requirements. Many providers rely on care coordination, population health, or quality improvement staff in their clinics to initiate informing efforts, although they reported using a number of outreach strategies such as notices for overdue WCVs and appointment reminders via emails, phone calls, and text messages. However, they reported barriers to contacting families, including outdated phone numbers and/or changed addresses as well as relatively high rates of "no show" appointments.

### Recommendations

- Prioritize functional use of the Lookup tool to assist FFS beneficiaries in locating a provider.

### State's Response:

The State appreciates and agrees with your comments. As a follow-up, the State recently undertook efforts to enhance the existing Provider Finder, which is one of the State's primary FFS provider locator resources. Specifically, the State adjusted the filters from the source data to reduce the content for the map to distill it down to only the most relevant content for FFS members, which means it now only includes Medi-Cal enrolled providers operating within the State as well as approved "border community" providers. In the public-facing version of the tool, FFS members or their parents/caregivers can search for Medi-Cal enrolled providers in several different ways, including by provider name and/or county, and also by zooming into a particular geographic area of the map. Each Medi-Cal enrolled provider entry will include the following: provider name, provider NPI, provider type (e.g., physician, certified nurse practitioner, audiologist, federally qualified health center/rural health clinic, hospital, etc.), and legal address on record. Please note that all source data for this tool comes directly from a resource titled, "Profile of Enrolled Medi-Cal FFS Providers – Dataset", which is available on the California Health and Human Services' Open Data Portal. The State would note that this publicly available dataset is another resource that can be used to locate Medi-Cal enrolled providers. This dataset can be downloaded in an Excel format and filtered by provider name, provider type, specialty, geographic location (e.g., city or county within California), and more. The State is hopeful that the enhancements to the Provider Finder will improve the functionality and uptake of the tool and, when coupled with the availability of the publicly available dataset, will assist FFS members in more easily identifying Medi-Cal enrolled FFS providers. On a go-forward basis, the State will also continue to look for additional opportunities for improvement and enhancements to this tool and other companion resources in this space.

### CMS Response:

We appreciate your attention to the Provider Finder and enhancing its functionality.

## Periodicity and Screening (Periodic and Interperiodic)

### Applicable Statute, Regulation, and Policy

*Sections 1905(a)(4)(B) and 1905(r) of the Act require states to adopt or develop periodicity schedules to assure that at least a minimum number of health examinations occur at critical points in a child's life. In*

*addition, section 1905(r) of the Act requires that medically necessary interperiodic screens be provided. By statute, these visits are comprehensive and include age-appropriate screenings; referrals to diagnostic and specialty services; and referrals to establish ongoing dental, vision, and hearing care. States are required to develop or adopt a schedule of recommended screenings in accordance with reasonable standards of medical practice and to provide interperiodic screenings at other intervals as medically necessary (§ 1905(r)(1)(A); 42 CFR § 441.56(b)). Most states have adopted the Bright Futures periodicity schedule developed by the American Academy of Pediatrics or a modified version of it. States are also required to develop or adopt a separate dental periodicity schedule; most states have adopted the American Academy of Pediatric Dentistry's dental periodicity schedule.*

## Implementation

California follows the Bright Futures model for periodicity,[32] and they provide a provider training to ensure that beneficiaries receive periodic, comprehensive child health screenings.[33] MCPs must also ensure that beneficiaries have access to comprehensive medical case management services that include coordination of care for all medically necessary EPSDT services.[34] California managed care contracts require MCPs to actively promote EPSDT screenings to beneficiaries and their families.[35] MCPs are also required to identify beneficiaries not using EPSDT screening services and to conduct outreach in a culturally and linguistically appropriate manner.[36]

To ensure eligible children and youth receive appropriate screenings, the state monitors MCP utilization and quality metrics, develops policy (e.g., setting standards for medical necessity, care coordination, and provider/MCP responsibilities), oversees contracts, collaborates with other agencies (e.g., facilitating memoranda of understanding [MOUs] with counties, schools, and other agencies), monitors data and quality oversight (e.g., managed care accountability set measures, audits, performance improvement reports), and engages beneficiaries.

To improve WCV rates, the state hosts quality improvement collaboratives with MCPs, improves data collection (especially for measures like developmental screening), and proactively coordinates with community health care providers. MCPs typically ask providers to send appointment reminders and conduct outreach related to WCVs, and providers noted that they typically send text messages, make phone calls, and schedule MCVs during other office visits. However, some of the providers indicated they do not have the resources to send regular reminders. Providers also reported that beneficiaries may not be available for WCVs during clinic hours, and one of the MCPs interviewed noted that clinics that offer evening and weekend hours had better WCV rates.

Since 2020, Medi-Cal has covered Adverse Childhood Experiences (ACE) screenings for children and adults under age 65, and the state recognizes the importance of trauma-informed care principles to integrate these screenings into routine health care visits. Providers must first undergo training on ACEs, trauma-informed care, and health conditions that may be ACEs-related. The state tracks results by billing code, with different codes for high and low risk and for children and adults. Clinics assist children with high ACEs scores with

[32] DHCS, Periodicity Schedules
[33] DHCS, https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Documents/DHCS-EPSDT-Provider-Training.pdf Provider Information | Medi-Cal for Kids & Teens and EPSDT Provider Training -June 2024
[34] DHCS, APL 2023 | Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21
[35] DHCS, 2024 Managed Care Boilerplate Contract, section 2.210(A)2
[36] DHCS, 2024 Managed Care Boilerplate Contract, section 2.210(A)3

interventions such as connecting the children to trauma-informed care teams, referring them to school-based models or community-based organizations, and providing patient education.

Despite specific contract requirements to actively promote EPSDT screenings to beneficiaries and to identify and outreach to those not utilizing EPSDT screening services, MCPs seemed to vary widely in these efforts. Advocates noted that some MCPs send reminders whereas others have minimal engagement. In addition, providers had varying degrees of familiarity with EPSDT requirements.

Many providers rely on care coordinators, population health-focused nurses or staff, or quality improvement staff in their clinics to initiate outreach or to send WCV reminders. MCPs and providers noted that they try to contact beneficiaries using a variety of methods, including sending overdue WCV notices and appointment reminders via emails, phone calls, and text messages.

However, outdated phone numbers and/or address changes create barriers to contacting families and, despite the MCPs' and providers' efforts, "no show" appointments remain relatively high.

## Recommendations

- Encourage or require MCPs to increase the number of network providers that offer expanded evening and weekend hours to potentially increase utilization rates for WCVs.
- Increase oversight of MCPs' adherence to contract requirements to actively promote EPSDT screenings to beneficiaries and to identify and contact beneficiaries who are not utilizing EPSDT screening services.

## State's Response:

The State appreciates your comments and recommendations. The State is committed to continuing to work with Medi-Cal MCPs and providers to identify opportunities for increasing WCV utilization rates. Currently, DHCS monitors pediatric WCVs and provides quality oversight and enforcement via three measures included in the Managed Care Accountability Set – WCV, W30-6+, and W30-2+. Expanded evening and weekend clinic hours for pediatric WCVs is a best practice and DHCS is working to spread and scale this through a longitudinal quality improvement collaborative run in partnership with the Institute for Healthcare Improvement (IHI) in which all 22 Medi-Cal MCPs are participating.

## CMS Response:

We appreciate DHCS' ongoing efforts to improve MCP performance. MCP contracts contain specific requirements to actively promote EPSDT screenings to beneficiaries and to identify and outreach to those not utilizing EPSDT screening services. MCPs seemed to vary widely in these efforts, and we continue to encourage DHCS to closely monitor these contract provisions to ensure all MCPs engage in specific identification of and outreach to beneficiaries who are due and overdue for screening services.

# Diagnostic and Treatment Services

## Applicable Statute, Regulation, and Policy

*When indicated, states must provide follow-up diagnostic and treatment services within the scope defined by §§ 1905 (a) and (r) of the Act. Diagnostic services include testing and evaluation of the physical or mental condition identified, whereas treatment services must ensure that health care is provided to correct or ameliorate the identified physical or mental condition. These services are limited by what is coverable under § 1905(a) of the Act but must not be limited to services included in a state's Medicaid plan. Although services available to adults may include limits on the amount, duration, and scope of services (i.e., a "hard limit"), states are not permitted to apply limits to any section 1905(a) services in either a FFS or managed care delivery system. Similarly, if an optional section 1905(a) service is not covered for adults in a state's Medicaid plan, that section 1905(a) service must be made available to EPSDT-eligible children when it is medically necessary.*

*States may impose—and may permit MCPs to impose—utilization controls to safeguard against unnecessary use of care and services in a manner that is consistent with EPSDT requirements (42 CFR § 440.230). For example, a state or MCP may establish limits on the amount, duration, or scope of services that may be exceeded with prior authorization and/or a medical necessity review (i.e., a "soft limit") (42 CFR § 438.210); however, the state must ensure that such limits can be exceeded consistent with EPSDT requirements. States have responsibilities to identify, define, and specify the EPSDT services that the MCP is required to cover in the MCP's contract (§ 1932(e)(1)(a) of the Act; 42 CFR §§ 438.66 and 438.700).*

*State Medicaid agencies must exercise appropriate oversight of their Medicaid fair hearing system to ensure that fair hearing decisions correctly apply all relevant federal and state laws, regulations, and policies, including the EPSDT "correct or ameliorate" standard (42 CFR § 431.10(c)(3)(i)-(ii) and 42 CFR § 431.205(a)). Fair hearing officials must have access to agency information necessary to issue a proper hearing decision, including information concerning state policies and regulations, including EPSDT.*

## Implementation

Although Medi-Cal covers most services for adults and children enrolled in Medi-Cal, some services are limited for adults but clearly noted to be available without limitations for EPSDT-eligible beneficiaries (including physical health, vision, dental, hearing, and mental health services, as well as substance use disorder services and medications).[37] California defines services as medically necessary if "they correct or ameliorate defects and physical and mental illnesses and conditions discovered through screening," in accordance to Title XIX of the Act § 1905(r)(5).[38] In the state plan, managed care guidance, and beneficiary informing materials, the state clearly indicates that services and treatments cannot be limited for children and youth up to 21 years of age if the services are determined to be medically necessary.[39] This is true even for medically necessary services that exceed what is recommended in the Bright Futures periodicity schedule.[40,41]

[37] DHCS, Your Medi-Cal Rights
[38] DHCS, Medicaid Provider Manual--EPSDT
[39] DHCS, Medicaid State Plan, Limitations to Attachment 3.1-A
[40] DHCS, Medi-Cal Rights Letter for Kids & Teens
[41] DHCS, APL 2023 | Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21

California does not require a treatment authorization request (TAR) or prior authorization for a majority of services under EPSDT. The state noted that pediatric TARs are typically only needed for audiology, specialty nutrition, nursing services, orthodontia, or durable medical equipment. In FFS, providers submit EPSDT-specific TARs in the state's TAR system. A special handling code routes EPSDT-related requests directly to a clinical consultant for review based on the state's medical necessity standard. The clinical consultant either approves the TAR or refers it back to the provider for more information (within 72 hours for urgent requests or, typically, four business days for standard requests).

Although MCPs can establish their own systems for prior authorization, the MCPs we interviewed rely on processes very similar to what the state uses for FFS beneficiaries. Both MCPs reported that trained staff review all children's prior authorization requests, that the requests are not subject to an approval algorithm, and that physicians review all denials and appeals. Overall, there are high approval rates for EPSDT prior authorization requests in the Medi-Cal program and a low volume of appeals; most appeals stem from administrative issues, such as missing documentation, with durable medical equipment being the service most commonly appealed.

Providers can submit requests for noncovered services for consideration, as outlined in the "non-benefit" section of the provider manual. Providers generally reported receiving approval for EPSDT services they believe are medically necessary, although only four of the 15 interviewed providers knew about the "non-benefit" section of the manual. Providers noted that denials are rare, but described a few concerns regarding diagnostic and treatment services, including time lags in referral processing. Advocates noted several instances where adult standards have been applied to CCS children as certain MCPs transition to the WCM program and administering CCS directly. Advocates described examples of MCPs limiting the number of diabetic test strips and flavors of enteral nutrition that are available to beneficiaries, and indicated that the MCPs were placing a significant burden on providers to furnish adequate documentation for these relatively rarely needed benefits.

## Recommendations

- Improve providers' awareness of EPSDT policies, particularly their ability to request children's services that are described in the "non-benefit" sections of the provider manual.
- Review areas in which adult medical necessity standards are being inappropriately applied to children to ensure access to medically necessary care.

## State's Response:

The State appreciates your comments and recommendations. The State is also committed to continuing efforts to increase provider and member awareness of EPSDT policies.

Specific to the State's non-standard benefit policy, the State recently undertook considerable efforts to make improvements to the "Non-Standard Benefits" sections of the Medi-Cal Provider Manual, which include adding clearer definitions of each benefit restriction as well as clearer instructions for providers regarding how to request "non-standard" services for any all Medi-Cal members—including those under age 21 pursuant to EPSDT -- and how to submit prior authorization requests (called TARs in the Medi-Cal FFS delivery system) and bill for services rendered. The State believes these updates will function to address and resolve historical confusion and inconsistent

policy application by providers. The State anticipates that these updates will be published in January 2026 and is very hopeful that these updates will not only improve provider awareness but also help to standardize the approach taken by providers, particularly regarding Medi-Cal members under age 21 pursuant to EPSDT. To help further increase awareness in this space and address common questions from Medi-Cal MCPs, the State also provided training to Medi-Cal MCPs on how the State applies its non-standard benefit policy, inclusive of expectations that all Medi-Cal MCPs are making individualized, case-by-case medical necessity determinations for Medi-Cal members under age 21 pursuant to ESPDT.

While the State appreciates some advocates raising concerns about adult medical necessity standards being misapplied to children in some WCM counties, the State is not aware of any systemic policy and/or access to issues in this regard as policy guidance in both the Provider Manual and applicable All Plan Letter(s) clearly articulates the EPSDT "correct or ameliorate" medical necessity standard and that it is distinct and more expansive for children than the comparable standard for adults. As a result, the State will engage directly with advocates to learn more about this concern to see if there are opportunities to further clarify in policy guidance. Additionally, the State will monitor potential service authorization barriers by continuing to monitor grievance and appeals data submitted by Medi-Cal MCPs.

### CMS Response:

We appreciate the name change from "non-covered" to "non-standard" benefits and expect this to immediately reduce confusion regarding these benefits. We also appreciate the state's commitment to engage with advocates to identify potential further areas for clarification of the state's medical necessity standards.

## Support Services

### Applicable Statute, Regulation, and Policy

*States are required to ensure that beneficiaries have adequate assistance in obtaining needed Medicaid services by offering and providing, if requested and necessary, assistance with scheduling appointments and nonemergency transportation (42 CFR §§ 441.61, and 441.62). Under section 1902(a)(4)(A) of the Act and 42 CFR § 431.53, states are required to assure beneficiaries have access to necessary transportation to and from providers.*

### Implementation

Transportation services are provided by the state for FFS enrollees and by MCPs for managed care enrollees. The state covers both nonemergency medical transportation (NEMT--ambulance, wheelchair van, etc.) and nonmedical transportation (NMT--taxis, public transit, etc.).[42] FFS beneficiaries access this benefit using an online scheduling tool and managed care beneficiaries use their MCP's scheduling procedures. Beneficiaries must have a prescription for NEMT, which can remain in effect up to one year. To receive NMT, beneficiaries or their families must attest that all other available resources have been "reasonably exhausted."[43] The state confirmed that MCPs are responsible for ensuring transportation to covered services (e.g., specialty mental health and dental appointments) even if the Medi-Cal services are not covered by the

[42] DHCS, Transportation Services Overview
[43] DHCS, Medi-Cal Transportation General FAQ

MCPs. The state explained that dental providers are notified of transportation benefits via all-provider bulletins and the provider handbook and behavioral health providers are notified via contract provisions and Behavioral Health Information Notices. Providers can assist in the coordination of transportation services, although awareness of the benefit varied among the interviewed providers.

California maintains beneficiary-facing materials (e.g., Medi-Cal for Kids and Teens brochure[44]) that describe how beneficiaries and their families can access assistance with scheduling appointments. The state keeps providers informed of their requirement to support beneficiaries in receiving care (e.g., scheduling assistance, transportation, case management, and care coordination) through its boilerplate MCP contract,[45] All-Plan Letters,[46] and other provider resources.[47] However, although California's beneficiary[48] and MCP[49,50] resources on assistance and transportation are accessible, gaps exist in the information on support services. Although one MCP's plan-specific provider information tool describes how to assist beneficiaries with appointment scheduling,[51] the state's transportation website and EPSDT Manual[52] do not provide specific information on how to access transportation for services that are excluded from the managed care contracts (e.g., dental or specialty mental health services).

The state also suggested that although mileage reimbursement is available, upfront costs for beneficiaries may pose a barrier, especially for beneficiaries in rural areas who need to travel long distances to access providers. The state also indicated that MCPs sometimes deny transportation when a member is traveling to a provider if another provider is closer. DHCS conducts focused audits (most recently in 2023) to monitor the quality of transportation benefits and holds quarterly meetings with MCP Transportation Liaisons to discuss best practices and improve quality.

California requires Medicaid providers to offer scheduling assistance and ensure transportation for EPSDT services.[53] Additionally, FFS beneficiaries can use the state's member helpline for assistance in scheduling transportation.[54] The state trains providers on EPSDT benefits and instructs them to inform patients of the right to scheduling support. For enrollees in managed care, the MCPs provide scheduling assistance when requested. The MCPs interviewed noted that they emphasize that beneficiaries can reach out to their MCP's member services unit or call their MCP to get help with finding providers and scheduling appointments. One MCP also noted that they proactively reach out to beneficiaries who have recently been discharged from the hospital to offer support in scheduling follow-up appointments.

## Recommendations

- There are no recommendations for this area.

[44] DHCS, Medi-Cal for Kids & Teens Well Care Brochure
[45] DHCS, 2024 Managed Care Boilerplate Contract
[46] DHCS, APL 2023 | Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21
[47] DHCS, Medicaid Provider Manual--EPSDT
[48] DHCS, Medi-Cal for Kids & Teens Well Care Brochure
[49] DHCS, APL 2023 | Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21
[50] DHCS, 2024 Managed Care Boilerplate Contract
[51] Partnership Health Plan, EPDST Medi-Cal for Kids and Teens Provider Newsletter
[52] DHCS, Medicaid Provider Manual--EPSDT
[53] DHCS, Medicaid Provider Manual--EPSDT
[54] DHCS, Medi-Cal for Kids & Teens Well Care Brochure

### State's Response:

The State appreciates your comments. Despite no specific recommendations, the State will nevertheless continue to look for opportunities to increase awareness of available transportation services to all Medi-Cal covered services, including looking at its existing guidance documents or resources (for example, the EPSDT Provider Manual, APL 22-008 or subsequent guidance, BHIN 22-031 or subsequent guidance, Member Handbook, and DHCS website).

### CMS Response:

Thank you for your ongoing monitoring and promotion of transportation services.

## Coordination of Care

### Applicable Statute, Regulation, and Policy

*Sections 1902(a)(43)(B) and (C) of the Act require states to provide or arrange for provision of screening services and arrange for corrective treatment. This affirmative obligation is unique to EPSDT, and states may meet it through a variety of methods and authorities.*[55] *Regardless of how they are delivered, case management services are a means of increasing program efficiency and effectiveness by assuring that needed services are provided timely and efficiently, and that duplicated and unnecessary services are avoided (section 5010.B. of the SMM).*

*Ideally, one specific individual or organization should be responsible for locating, coordinating, and monitoring necessary and appropriate services in EPSDT (SMM 5310D). Regulations require Medicaid managed care organizations to coordinate health care services for each enrollee, between settings of care and from other providers. They must also ensure that MCPs make a best effort to screen each new enrollee within 90 days of the effective date of enrollment, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful (42 CFR § 438.208(b)).*

### Implementation

California's approach to coordinating care for children and their families is complicated. MCPs are subject to basic care coordination expectations, for all children including those who are low risk for complex conditions and those with higher care needs. California uses a population health management strategy for the provision of care coordination. Additionally, MCPs select "populations of focus" to receive Enhanced Care Management (ECM), where a designated case manager coordinates medical services and may provide funding for housing or other social services. Counties also have the choice of participating in five targeted case management groups, as long as they can provide the non-federal matching funds. Finally, the California Department of Social Services provides administrative case management to children and youth in out-of-home placements, which is funded in part by DHCS, through the Health Care Program for Children in Foster Care (HCPCFC). The availability of care coordination and case management for any individual child in California depends on their place of residence and the decisions made by their county or MCP. MCPs must

[55] For more information on ways to deliver these services, please see Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements

ensure care coordination for low-risk child beneficiaries, and these responsibilities are outlined in the state's guidelines for population health management.[56] The state's coordination model seeks to match beneficiaries to the needed level of care coordination. MCP contracts require them to identify and contact beneficiaries who are not utilizing EPSDT screening services.[57] Additionally, MCPs and providers (for FFS beneficiaries or as instructed by MCPs) are responsible for sending out reminders for overdue or missing WCVs. Some MCPs produce gap lists of children who are overdue for WCVs that providers can use to outreach to beneficiaries.

Despite these requirements to coordinate basic care and EPSDT services, MCPs report limited availability and/or uptake of these services. One MCP noted that, as of June 2025, only two beneficiaries had requested EPSDT care management. The other MCP reported some success with proactive care coordination through a population health initiative,[58] but noted that this initiative ends at 6 years of age. Overall, the CMS review team saw no evidence that MCPs were prioritizing contractual provisions to identify and contact beneficiaries who are overdue for WCVs.

Children with more complex needs have additional options for care coordination and case management, including targeted case management, coordination of services through California Children's Services (CCS), Enhanced Care Management (ECM), and the Health Care Program for Children in Foster Care.

ECM is a statewide managed care benefit authorized under federal Medicaid managed care regulations as part of the core coordination and continuity of care responsibilities of MCPs. California's 1915(b) waiver. There are seven populations of focus, including people with serious mental health or substance use needs, individuals transitioning from incarceration, those experiencing homelessness, and CCS children with non-medical needs.[59] Children may exist within populations of focus, such as people experiencing homelessness or people with serious mental health conditions, but this benefit is not available to all children and is delivered outside of EPSDT. The state noted that 31,100 children receive ECM, and as of 2024, 3,400 children received ECM with eligibility for CCS.

The state has five targeted case management groups[60] that may serve children, including one for children under 21 years old at risk for negative health outcomes.[61] Counties opt in to provide targeted case management, but must first determine if a child is eligible for ECM, which is provided whenever possible. Children who qualify for targeted case management but are not within an ECM priority population selected by their MCP receive targeted case management through the county, via local government agencies under

[56] DHCS, Policy Guide July 2025
[57] DHCS, 2024 Managed Care Boilerplate Contract, section 2.210(A)3
[58] The Growing Together Program through Partnership Health Plan offered members supports throughout the stages of pregnancy at no extra cost. The program is offered in three parts: the Prenatal Program, the Postpartum Program, and the Health Baby Program, each designed to encourage and incentivize appropriate care for both the member and their baby.
[59] DHCS, Medi-Cal Transformation: Enhanced Care Management Fact Sheet
[60] Case management services are established in 1905(a) of the Act and defined in regulation as "services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services" (Section 1905(a)(19) of the Act and 42 C.F.R. § 440.169(a)). Therefore, case management services must be available to EPSDT-eligible children who meet medical necessity criteria for this service. States have additional flexibility under section 1915(g) to target these case management services to a subgroup of Medicaid beneficiaries, such as Medicaid beneficiaries in foster care. In these instances, case management is referred to as "Targeted Case Management" (TCM). Using TCM authority, states do not need to comply with federal requirements for statewideness and comparability of services, enabling them to target case management to an area within the state and/or to defined subgroups of Medicaid beneficiaries (the targeted population) (Section 1915(g)(1) of the Act and 42 C.F.R. § 440.169(b)). Because the TCM flexibility is defined in section 1915 (and not 1905(a)), it does not fall under EPSDT requirements. As a result, while every EPSDT-eligible child must have access to section 1905(a) case management services when medically necessary, states are not required to ensure availability of TCM for EPSDT-eligible children. See CMS, SHO # 24-005: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements for more details.
[61] DHCS, Targeted Case Management Program Overview

contract with DHCS.[62] The state's MCP Contract and All Plan Letter (APL) 23-029 require MCPs to make good faith efforts execute a Memorandum of Understanding (MOU) with various third-party entities, including those that impact care for children such as local health departments, county child welfare agencies, the Women, Infants and Children Supplemental Nutrition Program (WIC), First 5 County Commissions and county-based targeted case management. The purpose of the MOUs is to enable MCPs and third parties to build partnerships to support care coordination and access to community-based resources, and MCPs unable to execute these MOUs are subject to quarterly reporting to DHCS. To ensure that MCP contract provisions for each MOU type are standardized across entities, the state developed MOU templates.[63]

The state also provides care coordination under the Health Care Program for Children in Foster Care (HCPCFC). The programs vary by county, but generally, public health nurses located in county child welfare service agencies and probation departments coordinate health services for children and youth in out-of-home placement. The HCPCFC is administered by counties and jointly funded by DHCS, the California Department of Social Services (CDSS), and local entities through a cost allocation plan. Counties can also add funds to create a more robust HCPCFC. While Medicaid partially reimburses for these services, DHCS does not have direct oversight to ensure robust statewide availability or uniformity of this care coordination. CDSS develops regulations relating to the program.

Information about care coordination for FFS beneficiaries is sparse and unclear. Advocates noted that FFS beneficiaries are essentially "on their own" until they find a provider to help them coordinate services. For FFS dental services, DHCS indicated that the dental fiscal intermediary contract includes a care coordination component.

The multitude of case management and care coordination services available for child beneficiaries may result in service fragmentation and confusion, creating inconsistent support or gaps in available support. Providers reported that despite all the available case management services, they rely heavily on their clinic for care coordination for beneficiaries; some even mentioned doing it themselves. Providers also mentioned a lack of coordination between MCPs and providers.

## Recommendations

- Ensure MCPs are providing appropriate care coordination services according to their contract, including basic care coordination for children without complex needs.
- Prioritize execution of MOUs between MCPs and counties that provide targeted case management.
- Ensure that children remaining in FFS have an entity to help coordinate their care.
- Evaluate implementation of the HCPCFC and whether Medi-Cal enrolled children in foster care are receiving appropriate care coordination services.

## State's Response:

The State appreciates your comments and recommendations. Relative to Medi-Cal MCP contractual responsibilities, the State wants to clarify that the current annual medical audit program assesses whether

[62] DHCS, Targeted Case Management Program Overview
[63] DHCS, APL 23-029

MCPs are delivering appropriate care management services in accordance with the MCP contract and Population Health Management Policy Guide.

The State also wants to clarify that it is aware of many quality improvement efforts previously undertaken and continuing to be implemented to improve WCV rates, including contacting members overdue for WCVs and partnering with local clinics to contact members who are overdue for well visits.

Additionally, the State continues to monitor progress towards execution of all required MOUs, including those that impact children, such as those with county-based targeted case management, local health departments, county child welfare agencies, WIC agencies, and First 5 County Commissions. The State also provides technical assistance to MCPs, and other agencies as needed to assist with successfully building partnerships and executing MOUs. As of December 2025, the State has received 25 of 27 executed MOUs between Medi-Cal MCPs and counties operating targeted case management.

In addition, DHCS is continuing to partner with CDSS to provide additional education to MCPs and child welfare agencies about the MOUs as well as the MCP child welfare liaison role that is required by the MCP Contract. The MCP Contract and APL 24-013 require MCPs to designate staff to serve as a child welfare liaison, which assists staff who coordinate care on behalf of children and youth involved in child welfare, including, but not limited to HCPCFC public health nurses, to ensure the health care needs of these Members are met and to resolve escalated issues as needed.

DHCS works in close partnership with CDSS relative to HCPCFC, including working with county partners who oversee activities at the local level under agreements with CDSS. For example, DHCS worked with CDSS to release a comprehensive HCPCFC Program Manual[64] in 2024 as a resource for public health nurses to support their care management efforts. Looking forward, DHCS will continue to work with CDSS to promote the use of these resources and explore additional opportunities to help ensure Medi-Cal members in foster care are receiving appropriate care coordination services through HCPCFC.

## CMS Response:

We appreciate your attention to the first 2 recommendations. Regarding care coordination for children in FFS, while FFS is a small part of California's enrolled child beneficiaries, it includes historically vulnerable populations. We continue to recommend that the state ensure that these children have an entity to coordinate their care.

With regards to the HCPCFC, we understand that the DHCS works in partnership with CDSS to implement HCPCFC. Ultimately, however, it is DHCS that is responsible for ensuring coordination of and access to Medicaid-covered services for children in foster care served by this program. We continue to recommend that DHCS evaluate implementation of care coordination through HCPCFC and enact any necessary changes to the Medi-Cal portion of this program.

[64] See https://www.dhcs.ca.gov/services/HCPCFC/Documents/HCPCFC-Manual-2024.pdf

# Utilization of Providers and Coordination with Related Programs

## Applicable Statute, Regulation, and Policy

*States utilizing a FFS model must ensure that a Medicaid beneficiary may obtain covered services from any institution, agency, pharmacy, person, or organization that is qualified and willing to furnish the services to that beneficiary (§ 1902(a)(23)(A) of the Act and 42 CFR § 431.51(b). States have broad flexibility to establish reasonable provider qualifications related to the provider's fitness to perform covered medical services (42 CFR §§ 431.51(c)(2)) and states' FFS payments must be sufficient to enlist enough providers to provide state plan care and services "at least to the extent that such care and services are available to the general population in the geographic area" (§ 1902(a)(30)(A) of the Act).*

*States that contract with MCOs, PIHPs, and PAHPs must develop and enforce network adequacy standards in their managed care contracts. This mandates MCP compliance with the regulatory requirements and enables enforcement as indicated. Per 42 CFR § 438.206(b)(4) state managed care contracts must require that if the MCP's network is unable to provide necessary services covered under the contract, the MCP must cover medically necessary services out-of-network for as long as the MCP's provider network is unable to provide the medically necessary services.*

*State Medicaid agencies must coordinate with certain programs. Medicaid agencies are required to have an interagency agreement with their Title V agencies and may choose to develop interagency agreements with other state agencies and federally funded programs (e.g., Women, Infants, and Children [WIC] nutrition program, Head Start, school health programs) (42 CFR § 431.615).*

## Implementation

California legislatively enacted standards to evaluate network adequacy for MCPs, including specific provider-to-member ratios (one full-time physician to every 1,200 enrolled members) and timely access standards (e.g., acceptable length of time from request to appointment).[65] DHCS requires MCPs to submit annual network certification reports, participate in evaluations, and report major changes to their network that may impact the adequacy of capacity and services.[66] If MCPs fail to comply with set standards, they must submit alternative plans or face enforcement, such as sanctions and/or corrective action plans.[67,68] Corrective action plans are most often related to administrative deficiencies (e.g., failure to apply for appropriate alternative standards correctly). If an MCP has a corrective action plan, they must allow beneficiaries to access out-of-network providers, although when an AAS is approved, out-of-network care is not required.

In its 2023 MCPAR, the state acknowledges a shortage of providers in rural areas and notes that geographical attributes of particular regions may render it impossible for some MCPs to meet network adequacy standards for time or distance traveled.[69] In these scenarios, DHCS requires the MCP to confirm through an AAS request that they contract (or have attempted to contract) with the closest available

[65] DHCS, Medicaid Managed Care Final Rule: Network Adequacy Standards
[66] DHCS, Comprehensive Quality Strategy 2022
[67] DHCS, 2024 Managed Care Boilerplate Contract
[68] DHCS, 2021 Federal Network Certification Requirements for County MHPs and DMC-ODS
[69] DHCS, Managed Care Program Annual Report Managed Care 2023

providers.[70] AAS are completed at the provider type and ZIP Code levels, and more than ten thousand AASs have been approved across 58 counties within the state.[71] Some AAS approvals are for very long distances; for example, DHCS approved an AAS of 380 minutes or 225 miles for a pediatric PCP in Fresno County and an AAS of 230 minutes or 205 miles for a pediatric PCP in Mono County.[72] In both of these cases, if the AAS had not been approved, beneficiaries could have seen an out-of-network pediatric provider in a town or city significantly closer. The state attributed these lengthy AASs to provider shortages in the area, but advocates claimed that AASs are used to justify long travel distances instead of incentivizing MCPs to find a way to contract with closer providers.

MCPs are required to engage in "good faith efforts" to contract with any eligible Medi-Cal providers within the required time and distance standards. They must make multiple attempts to write or call the two closest out-of-network providers to discuss contracting. If an MCP cannot contract with a provider within time and distance standards, they then submit an AAS detailing the dates of contact and reasons contracting failed. DHCS may then approve a maximum time and distance travel threshold. DHCS noted that they verify a provider's location but have minimal oversight over what constitutes a "good faith effort" and that the department does not participate in or influence contract negotiations.

MCPs are required to monitor and enforce timeliness of care, including non-urgent appointments for primary care within 10 business days. However, the applicable waiting time for an appointment may be extended if the member's medical record notes that waiting will not have a detrimental impact on the member's health. This exception to the timeliness standard and the thousands of approved AASs for various types of care can counteract California's network adequacy standards. The largest number of grievances, as noted in the 2023 MCPAR, are related to timely access, provider availability, and geographic access, suggesting continued beneficiary concerns with access to care and provider availability.[73] Providers also noted that beneficiaries have issues with long wait times for appointments and limited provider availability for specialty services provided through other delivery systems or programs (e.g., dental, vision, mental health, and developmental services). DHCS explained that the state is seeking to reduce overall AAS approvals and is examining potential impacts of streamlining the "good faith efforts" reviews, cross-referencing provider networks among MCPs, and imposing monetary sanctions on MCPs that fail to meet timely access and network adequacy standards. To address the issues of provider shortages, the state discussed loan-repayment programs to incentivize medical school graduates to enroll as Medi-Cal providers and internal efforts to target payment rate increases for existing providers.

DHCS requires MCPs to establish MOUs with local WIC agencies and other child-serving programs so they can share data, identify barriers to enrollment, and develop best practices. The state noted that they established a data sharing agreement with the Department of Public Health to understand cross-eligibility for WIC and Medi-Cal. In California, Title V for children with special health care needs essentially operates as the CCS program.

[70] DHCS, Managed Care Program Annual Report Managed Care 2023
[71] DHCS, July 2021 & January 2022 Annual Network Certification AAS Report
[72] DHCS, July 2021 & January 2022 Annual Network Certification AAS Report
[73] DHCS, Managed Care Program Annual Report Managed Care 2023

## Recommendations

- Discontinue approving AASs for pediatric primary care providers, which would allow beneficiaries to access out-of-network pediatric primary care when such care is not available within state standards.
- Provide robust oversight of "good faith efforts" for network contracting and differentiate between areas that lack providers and areas where providers will not accept Medicaid.
- Ensure beneficiaries can go out of network for care if the MCP cannot provide care as required by 42 CFR 438.206(b)(4).
- Track the number of pediatric primary care appointments that don't meet the state's legislatively enacted standards.

## State's Response:

Thank you for your comments and recommendations. Overall, the State agrees with improving access to care within reasonable time or distance standards and is committed to improving its AAS process to this end. Specifically, the State plans to disapprove MCP's AAS requests for pediatric primary care providers as appropriate and ensure access to out of network pediatric primary care when state standards cannot be met. This is especially critical in rural areas when there is a pediatrician who is out of network but closer to the member and would substantially reduce travel time so as to meaningfully improve access. However, given that MCPs have specific obligations to designate a Primary Care Provider (PCP) for members and there are many related contractual requirements that pertain to a PCP, which by definition must be a Network Provider (e.g., Population Health Management policies, data sharing agreements), DHCS will need to consider how the designated in-network PCP will interact with the out-of-network pediatrician in these attenuating circumstances.

The State also appreciates the intent of the fourth recommendation to track appointments outside of legislative standards. The State's oversight of timely access standards is conducted through the EQRO's Timely Access Study, which does not track data at the individual member level. Implementing a process to track pediatric primary care appointments outside the state's legislatively enacted standards will require developing new monitoring systems and processes, potentially incorporating GIS and claims and/or utilization data. While this could offer some benefits, it would require significant additional resources and time to develop and implement any meaningful analysis could be conducted. DHCS will consider these implementation improvements as we also consider updates to comply with the *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Final Rule* (May 10, 2024) as there are potential interdependencies including EQRO work efforts.

## CMS Response:

CMS appreciates DHCS' willingness to change processes to improve children's access to care. Without monitoring appointments outside of timeliness standards, CMS is unclear how DHCS will be able to enforce timely access requirements in your MCP contracts. Tracking the number of pediatric primary care appointments that do not meet timeliness standards need not require cumbersome and expensive new reporting mechanisms; it could be as simple as requiring each MCP to report this number.

# Data for Monitoring and Quality

## Applicable Statute, Regulation, and Policy

*Section 1902(a)(43)(D) of the Act requires that each state report on EPSDT performance, which states do by submitting the CMS-416 report annually each federal fiscal year. Additionally, the Bipartisan Budget Act of 2018 § 50102(b) mandated annual Child Core Set reporting beginning in federal fiscal year 2024.*

*States with MCPs must develop and maintain a managed care quality strategy to set measurable targets and improve the state's Medicaid program's quality of care. States are required to have an annual evaluation of quality, timeliness, and access to health care services delivered by managed care plans completed by a qualified external quality review organization. States may leverage their external quality review organization to direct optional "focus studies" in their annual external quality review (EQR) to investigate specific areas of concern or establish a baseline for current utilization (42 CFR § 438.358(c)(5)). MCPs are required to engage in performance improvement projects in clinical and nonclinical areas each year to objectively measure performance, implement interventions, evaluate the effectiveness of these interventions, and initiate activities to sustain improvement (42 CFR § 438.330(d)). States must submit annual managed care reports to CMS, including the Managed Care Program Annual Report (MCPAR) (42 CFR § 438.66(e)) and the Access Standards Report (42 CFR § 438.207(d) and (e)).*

## Implementation

The state monitors delivery of EPSDT services in many ways, including children's health dashboards, Healthcare Effectiveness Data and Information Set (HEDIS) dashboards, and the Managed Care Accountability Set (MCAS). The MCAS is a set of performance measures selected by DHCS for annual reporting by comprehensive MCPs that fall within three quality focus areas: children's health, women's health, and chronic disease. DHCS sets a minimum performance level for key performance measures within MCAS. Comprehensive MCPs that fall below the minimum performance level may face financial penalties and be required to implement Corrective Action Plans to improve their performance. MCAS includes measures applicable to children, such as WCVs, lead screenings, immunization rates/status, and topical fluoride application.[74,75]

Despite comprehensive monitoring efforts, California's MCPs lag behind most other states. For 2022, only 38% of MCPs met DHCS's standard for the children's health domain of measures (50th percentile on 60% of measures), and only one MCP met the minimum performance level for all children's health measures.[76] Of 55 MCP reporting units,[77] six MCPs surpassed the national benchmark for Well-Child Visits in the first 15 months of life in 2022 (50th percentile); ten MCPs surpassed the national benchmark in 2023; and four MCPs were above the benchmark for both years.[78] For Child and Adolescent WCVs, 18 of 55 MCPs (33%) passed the benchmark in 2022, while 14 MCPs did so in 2023, and only 11 MCPs surpassed the benchmark

[74] DHCS, Medi-Cal Children's Health Dashboard 2024
[75] DHCS, Medi-Cal MCAS For Health Care Delivery Systems
[76] DHCS, Medi-Cal Managed Care Plans: 2022 Quality Scores by Domain
[77] This number includes regional plans attached to a larger MCO; for instance, Partnership has four plan reporting units designating the four regions of the state where they operate.
[78] DHCS, 2023-2024 Preventive Services Report

for both reporting years.[79] In 2024, 20 MCPs received sanctions for not meeting minimum performance levels on MCAS measures), including six MCPs that operate in counties without MCP choice.[80] Notably, in 2024, the MCP in 33 of 37 counties without MCP choice was sanctioned for at least two measures that did not meet minimum performance levels.[81]

The state's annual EQR includes the monitoring and reporting of the MCP-specific performance improvement projects and evaluations.[82] The state uses findings from the EQR to develop its quality strategy, as well as performance improvement project reporting and other measures. The state organizes quality improvement collaboratives to coach, improve, and facilitate the sharing of best practices among MCPs. In the future, the state intends to shift its monitoring of MCPs from the MCP level to an MCP/county combination level, in order to improve the usefulness of the reporting and to target sanctions.

MCPs share data with enrolled providers (including WCV rates, enrollment data, beneficiaries due and overdue for WCVs, and contact information), but the type, frequency, and format of the data differ by MCP. Providers report relying on their own electronic health record data, although most find information from the MCPs, such as gap reports and measure progress, helpful.

According to an analysis of T-MSIS data on WCVs/screening in 2023,[83] California's rate of screenings and service use for children under 1 year of age (74.8%) was lower than the national average (90.4%). The state was unique in having higher utilization rates for children 1 to 2 years old (76.6%) compared to children under 1. The state hypothesized that difficulties enrolling newborns into Medi-Cal may contribute to the low rates for children under 1 year old. Timely newborn enrollment is an ongoing issue in the state, and the Newborn Gateway was implemented to help resolve this problem; however, not all hospitals are participating in the program and advocates noted that the system is unable to link the child with the mother at enrollment. The state noted that they are working to fix the data linkage issue and anticipate a resolution by early 2027, which may help improve data quality for children under 1 year old and expedite newborn enrollment.

To better understand how DHCS oversees its 25 MCPs, we interviewed and analyzed data from two MCPs. Both MCPs ranked in the bottom half of California's MCPs as measured by the percentage of eligible youth receiving at least one WCV.

Representatives from both MCPs described various quality initiatives related to WCV: deploying mobile provider vans across the county, purchasing lead screening machines for rural providers, rewarding families for completing a WCV, and piloting evening and weekend hours at two local clinics. They also described piloting a new strategy to complete timely newborn appointments by prioritizing connection with or assignment to a PCP.

One MCP updates performance metrics in a provider portal daily and meets with contracted providers monthly or bimonthly to discuss these metrics. The other MCP reported that in some service areas it is challenging for beneficiaries to access pediatric care, and they are working with local pediatric practices to understand the barriers.

[79] DHCS, 2023-2024 Preventive Services Report
[80] DHCS, Administrative and Financial Sanctions
[81] DHCS, Administrative and Financial Sanctions
[82] DHCS, External Quality Review
[83] Please see Appendix A for details on the methodology.

One MCP offers an improvement incentive for primary care providers to deliver specific preventive services (including WCVs) to beneficiaries. However, interviewed providers were split on the effectiveness of the incentives, with some stating that the incentive has been helpful while others said the minimum level of services required to attain the incentive was too aggressive to drive improvement. Previously, this MCP conducted a pilot project adding providers to a location on a temporary basis to boost access; based on the positive results, the clinic hired another pediatrician.

Of note, representatives from one MCP explained that they received approval from DHCS in 2024 to use a supplemental record review for purposes of reporting Child Core Set quality measures. While this increased the MCP's reported utilization, it deviated from the technical specifications for the core set measures, which rely only on administrative claims data. DHCS should ensure MCPs obtain complete claims information in order to submit Core Set data according to specifications. The MCP acknowledged the need for continued training with providers to improve the quality of claims data.

California's children in the FFS delivery system have much lower screening rates (18.3%) than children in managed care (51.2%). The state suggested this data may be skewed by children who are waiting to enroll in an MCP and may not represent the true, static FFS population. However, they did not dispute the lower screening rates for children in FFS. California indicated that most children who receive care in the FFS delivery system are in foster care, and these data may reflect a concerning gap in care for this vulnerable population.

## Recommendations

- Prioritize improving MCP performance on basic markers of children's care, such as WCVs, especially in areas with no plan choice.
- Develop interim mechanisms to ensure newborns are enrolled in Medi-Cal timely, and prioritize correcting Newborn Gateway issues to facilitate newborn enrollment.
- Ensure all MCPs follow technical specifications for the Child Core Set measures, including WCVs, and focus on improving quality of claims data and overall MCP performance.
- Add a specific section to California's Comprehensive Quality Strategy that focuses on how to improve EPSDT and children's health.
- Consider having the External Quality Review Organization (EQRO) do a focused study on WCVs.
- Consider developing a statewide EQRO PIP that focuses on improving WCVs by a certain percentage each year. If feasible, the PIPs should be county specific for MCPs that operate in multiple counties.
- Disaggregate the FFS population to identify beneficiaries who are receiving care via FFS and those who are waiting for MCP assignment.

## State's Response:

The State appreciates and is supportive of these recommendations to improve EPSDT data monitoring and quality improvement. In addition, the State would note the following:

- The State appreciates the stakeholder feedback around the Newborn Gateway and acknowledges that there were some early challenges, as is common with any new process. The State continues to undertake efforts to improve and enhance the Newborn Gateway and anticipates another set of system enhancements by early 2027. These enhancements should help address provider confusion, improve enrollment processes, and will likely also help improve data quality for children under age one. In addition, the State continues to analyze additional mechanisms to improve timely newborn enrollment into Medi-Cal for hospitals that are not currently participating in the Newborn Gateway.
- Through the Comprehensive Quality Strategy and designating children's preventive care as one of three priority clinical focus areas, the State is prioritizing improvement efforts to improve performance on children's preventive care services and WCVs in particular. All MCPs that serve children are currently working on a clinical Performance Improvement Project (PIP) to improve early childhood WCV performance (either W30-6 or W30-2). Moreover, all MCPs are required to participate in quality improvement collaborative in partnership with the Institute for Healthcare Improvement (IHI) in which Medi-Cal MCPs are deploying improvement interventions with local clinics throughout the state to improve WCV rates for children ages 0-3. Moreover, the State has recently begun participating in the CMS Early Childhood Affinity Group and is using this opportunity to drive improvements in early childhood well visits for ages 0-3, with a specific focus on ages 0-1. Focus areas include newborn enrollment into Medi-Cal, accurate and complete data capture for WCVs, and access to care and member care coordination.
- As part of prioritizing improving children's preventive care outcomes, the State published the 2022 Medi-Cal Strategy to Improve Health and Opportunity for Children and Families which includes strengthening the pediatric preventive and primary care foundation as a core priority area (including improving access to and awareness of EPSDT services. As follow on to this report, the State has incorporated these priorities as a section in the 2025 Comprehensive Quality Strategy, and can strengthen the focus on EPSDT for future iterations.
- In response to 2019 child preventive services audit, since 2020 our EQRO has published the annual Preventive Services Report which provides a more focused look at all childhood preventive care measures. While the report does include WCV data, the State can consider revising as a focused study on WCVs to more actionably inform data monitoring and quality improvement efforts for children's preventive care.

## CMS Response:

CMS appreciates the state's efforts and responsiveness, and commend the state for annually publishing the Children's Services Report. We note, however, that CA did not respond to our recommendation to ensure all MCPs follow technical specifications for the child core set measures. We continue to believe this is crucial to ensure MCP performance can be compared. Likewise, we continue to believe close monitoring of plan performance in areas of no plan choice, combined with sanctions or other corrective action, are important tools to drive performance improvement when beneficiaries cannot select a different plan.

CMS continues to have concerns about timely enrollment of deemed newborns into Medi-Cal. Delayed

enrollment of deemed newborns, without the ability to track services delivered to infants and billed to Medi-Cal, contributes to California's unique situation in which children between the ages of 1 and 2 have higher rates of WCVs than infants. We note for the state that the Medi-Cal identification number of the mother serves as the identification number of the deemed newborn for the purpose of submitting and paying claims for the newborn (with certain exceptions). The state must issue the newborn a separate Medi-Cal identification number by the newborn's first birthday, at the latest (see section 1902(e)(4) of the Social Security Act and 42 CFR 435.117(c)).

The Newborn Gateway is Medi-Cal's electronic portal to enroll deemed newborns, and it offers promise as a solution for the newborn deeming requirement. We urge California to require all Medi-Cal participating hospitals to use the state's Newborn Gateway to report births to individuals enrolled in Medi-Cal. This is the simplest way to increase timely enrollment of deemed newborns into Medi-Cal.

# Conclusion

EPSDT requirements ensure comprehensive and preventive health care for individuals under 21 years of age. Statutory requirements for EPSDT in § 1905(r)(5) of the Act mandate that any medically necessary health care service listed at § 1905(a) be provided to an individual under the age of 21 regardless of the availability under the state's Medicaid plan.

Overall, CMS found strengths and weaknesses in California's EPSDT implementation. We noted several promising practices, particularly regarding California's clear informing materials, which could be useful resources for other states seeking to improve their EPSDT informing. However, we also noted several concerns, particularly regarding newborn enrollment and data, a few seemingly unreasonable alternative access standards, and a complex and at times confusing case management system that may not be meeting all beneficiaries' needs. We made recommendations above for the state to consider in these and other areas.

We would like to thank California's Department of Health Care Services for its participation, cooperation, and efforts to provide us with documentation and information used to complete the review. We appreciate that California continues to work diligently to administer, operate, and oversee EPSDT within federal statutory and regulatory requirements. The findings, recommendations, and comments in this report apply to the evidence considered in the 2025 review and cover 2023 to 2025.

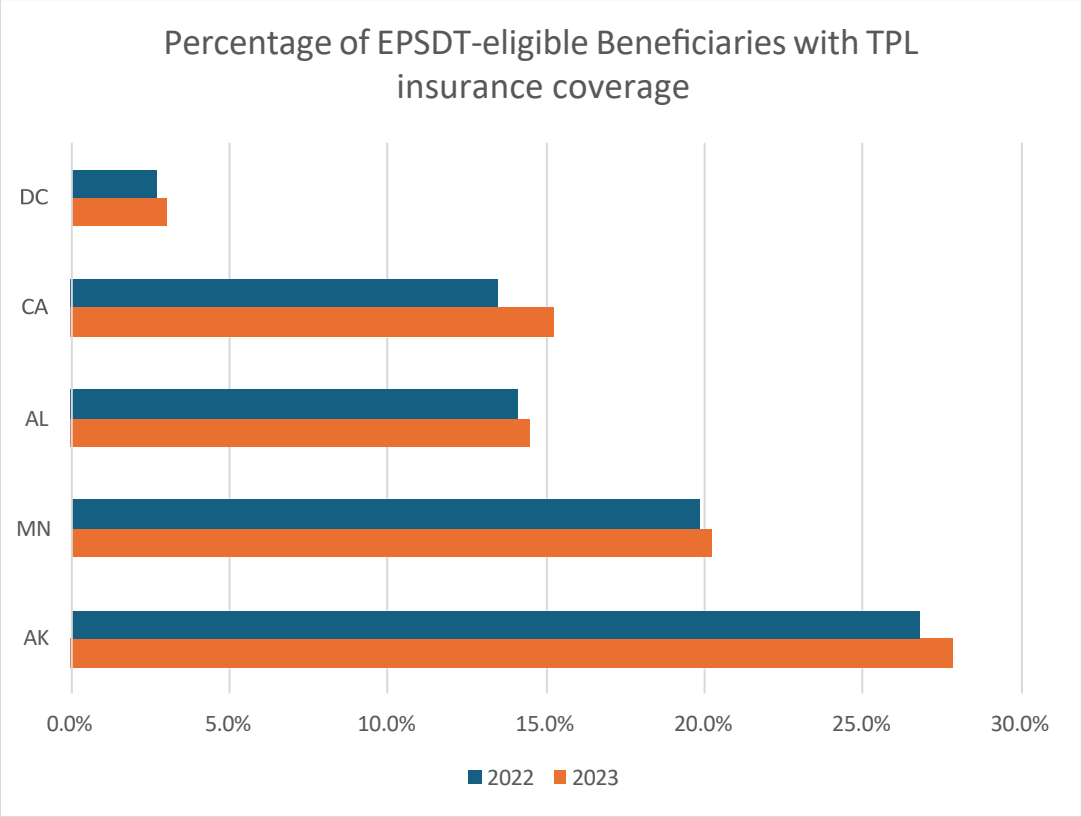
# Appendix A: Desk Review Data Tool Methods

All data in the desk review data tool are from NORC's analysis of T-MSIS data that was provided by CMS, as well as data submitted by states. We used T-MSIS Analytic Files (TAF) Research Identifiable Files (RIF) to count EPSDT-eligible beneficiaries and to measure their service use. TAF RIFs contain data on all beneficiaries, service use, service providers, managed care, program expenditures, and third-party liability for Medicaid and the Children's Health Insurance Program (CHIP).

## Finding and Counting EPSDT-Eligible Beneficiaries

We identified EPSDT-eligible beneficiaries and screenings by following instructions for Form CMS-416, the

annual EPSDT participation report. We defined our study population as individuals 0 to 20 years of age who were enrolled for at least 90 continuous days in Medicaid during the study period and who were eligible for full Medicaid benefits. Data were adjusted from federal fiscal years to calendar years (CY) 2022 and 2023.




To mitigate undercounting service use, the data excluded beneficiaries with any form of third-party liability coverage in the calendar year. The figure below shows the percentage of all EPSDT-eligible beneficiaries in each state excluded due to third-party liability.

## How Beneficiaries Were Categorized

The desk review data tool separates EPSDT-eligible beneficiaries into three non-overlapping groups:

- Beneficiaries in the "received screening" category had a record indicating receipt of an initial or periodic screening during the calendar year.
- Beneficiaries in the "other services" category had one or more records indicating that covered services were received, but that initial or periodic screening during the calendar year was not documented.
- Beneficiaries in the "no services" category had no records indicating receipt of a covered service during the calendar year.

# Definitions for Beneficiary Characteristics

**Age categories** for beneficiaries are consistent with those used in Form CMS-416. Beneficiary age reflects age as of December 31 of each year, not at enrollment or time of service.

Beneficiaries are **"Supplemental Security Income (SSI) Indicated"** if they are a recipient of SSI, an SSI-eligible spouse, or a blind or disabled individual in a § 209(b) state, based on their eligibility code(s) and SSI-specific indicators included in TAF demographic and eligibility record(s).

Beneficiaries who at any time during the year had a managed care enrollment indicator showing that they were enrolled in a comprehensive managed care organization or health insuring organization are categorized as **enrolled in a managed care organization**.

Beneficiaries eligible under Title IV Adoption Assistance, Foster Care or Guardianship Care, Formerly Foster Care Children, or Independent Foster Care Adolescents received "**Title IV/Foster/Guardianship"** status. This status was determined using their eligibility group code in TAF demographic and eligibility record(s).

We define **rurality** based on population density, urbanization, and primary commuting flows using Rural-Urban Commuting Area (RUCA) codes from the US Department of Agriculture's Economic Research Service. Beneficiaries living in a ZIP Code assigned a RUCA of 1 to 3 are defined as metropolitan; those assigned a RUCA of 4 to 6 are defined as micropolitan, and those assigned a RUCA of 7 to 10 are defined as rural.

Per CMS policy, we suppressed data for categories of fewer than 11 individuals or when values for a suppressed output could be calculated without excluding at least one additional data category. This approach sometimes leads to varying population totals when summing different demographic groups.

# Definitions of Service Use Measures

Consistent with the Form CMS-416 Replication User Guide, multiple records for the same type of service for the same beneficiary on the same day are counted as one service. For example, three claims for a screening on the same day count as one, not three.

**Inpatient stays** count unique acute care inpatient hospital stays for a beneficiary during the calendar year. We recorded acute care hospital stays using codes from the HEDIS Inpatient Stay Value Set for 2020 and excluded nonacute stays. We combined records with the same, overlapping, or contiguous start and end dates to avoid overcounting. The combined claims/encounters count as one unique stay spanning the earliest start date and the latest end date from those records.

**Outpatient emergency department (ED) visits** were identified using the HEDIS ED Value Set for 2020 from TAF RIF Other Services File. We counted only one visit when there were multiple ED records for the same beneficiary on the same date. To avoid counting ED visits that resulted in inpatient admissions, we excluded any ED visits with end dates that fell within the start or end date of an acute care inpatient stay (as defined above).

**Federally qualified health center (FQHC) visit** counts in the tool also include rural health clinic (RHC) visits. We identified records in the TAF RIF Other Services File that met any of the following criteria:

- Program type code = 03 (RHC) or 04 (FQHC)
- Bill type code = 071x (RHC), 073x (free-standing, provider-based FQHC), or 077x (FQHC); the "x" at the end of each code can be any letter or number
- Place of service code = 50 (FQHC) or 72 (RHC)
- Benefit type code = 003 (RHC) or 004 (FQHC)
- Title XIX service category code = 0016 (RHC) or 0028 (FQHC)
- Revenue center code = 0521 (clinic visit by member to RHC/FQHC), 0522 (home visit by RHC/FQHC practitioner), 0524 (visit by RHC/FQHC practitioner to member in a Medicare Part A skilled nursing facility stay), 0525 (visit by RHC/FQHC practitioner to member in a stay not covered by Part A in a skilled nursing facility, nursing facility, intermediate care facility, or other residential facility, or 0528 (visit by RHC/FQHC practitioner to other non-RHC/FQHC site)
- Procedure code = T1015 (clinic visit/encounter, all-inclusive)

Multiple claims or encounter records for FQHCs or RHCs for the same beneficiary on the same date(s) were counted as one unique visit.

**Indian Health Service (IHS)** records also include Tribal 638 facilities. To be counted, a claim or encounter must meet at least one of the following criteria:

- Program type code = 05 (IHS)
- Place of service code = 05 (IHS free-standing facility), 06 (IHS provider-based facility), 07 (Tribal 638 free-standing facility), or 08 (Tribal 638 provider-based facility)
- Type of service code = 127 (IHS family plan)
- Hospital type code = 06 (IHS hospital)
- Provider specialty code = A9 (IHS facility)
- Provider type code = 51 (IHS facility)

We counted only one IHS claim or encounter record per day. IHS visits were excluded from the District of Columbia report, as there are no IHS centers located in the District.

# Additional Notes

## County Identifiers

County-level data for Alaska, Alabama, California, and Minnesota reflect the last known address for each EPSDT beneficiary in the calendar year. This location could differ from where they lived at the time they received services or where they obtained those services. Beneficiaries with missing or out-of-state addresses

were excluded from county-level results, although they were included in the statewide views. Counties are identified using Federal Information Processing Standards codes, linked to patient ZIP Codes. To enable substate analysis in the District of Columbia, we mapped beneficiary ZIP Codes to the city's wards. Any ZIP Code spanning multiple wards was assigned to the ward with the larger total population.

## Managed Care Organizations

The initial managed care organization view shows data from all comprehensive MCPs, rolled up by the plan sponsor name. Plan sponsor names reflect the names used in TAF, absent any plan-specific identifiers. For example, "ABC Managed Care (plan 001)" and "ABC Managed Care (plan 002)" would be combined at the "ABC Managed Care" sponsor level. Selecting a plan sponsor brings up an additional view that provides data for each plan under that sponsor's name. Demographics and service use data are visible only at the sponsor level because of small sample sizes and data suppression required at the individual plan level. Approximately 2% of EPSDT-eligible beneficiaries were enrolled in two or more MCPs (fewer than 0.03% had more than two plans). In these cases, we assigned the beneficiary to the plan with the most months covered in the year, but the data reflect their demographic characteristics and service use over the full calendar year.

## National Results

National-level results shown in the tool reflect data for all EPSDT-eligible beneficiaries in the 50 states and the District of Columbia. These data exclude beneficiaries in the US territories. To be consistent with the Form CMS-416 national tables produced by CMS, we aggregated data for all EPSDT-eligible beneficiaries from all states and the District of Columbia. We then computed all measures shown in the tool, regardless of which state Medicaid program the beneficiary was enrolled in or which was paying for any services received. With this approach, the national totals generally reflect results for the largest states because they contribute a larger share of EPSDT-eligible beneficiaries nationwide.