Section (Primary Department) **Quality Management**		**SUBJECT (Document Title)** **EPSDT – Requirements for Coverage of Early Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 - CA**	
Effective Date 12/01/1995	**Date of Last Review** 12/19/2023	**Date of Last Revision** 12/19/2023	**Dept. Approval Date** 12/19/2023
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Missouri	☐ Ohio	☐ West Virginia
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

The Anthem Blue Cross Medicaid (Plan) ensures the provision and coverage of screening, preventive and Medically Necessary diagnostic and treatment services for all enrolled Medi-Cal members under the age of 21 in accordance with the current American Academy of Pediatrics (AAP)/Bright Futures Recommendations for Preventive Pediatric Health Care Periodicity Schedule, as referenced in the Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005 *Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21* (Supersedes APL 19-010). These services meet the requirements in Section 1905(r) of the Social Security Act and Title 42 of the United States Code (USC) Section 1396d(r)(5). The Periodicity Schedule indicates specific services that include but are not limited to health and developmental screening services, physical examinations, dental services, vision services, and hearing services that are to be provided to children at age-specific periodic intervals from birth to 21 years of age.

DEFINITIONS:

Medical Necessity (or Medically Necessary): any service that corrects or ameliorates defects, physical and mental illnesses or conditions:

- The service does not need to cure a condition to be covered by EPSDT.
- To ameliorate a condition or illness means to maintain or improve a child's current condition or to prevent adverse health outcomes.
- Additional services must be provided if they are determined to be Medically Necessary for an individual child.

Flat or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements and are not permitted.

PROCEDURE:

I. Preventive Care Screening Requirements (Medi-Cal)

All members under the age of 21 shall receive EPSDT preventive services that are designed to identify health and developmental issues as early as possible to ensure members have timely access to all Medically Necessary services. Appropriate diagnostic and treatment services shall be initiated as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up care.

The Plan covers all mandatory and optional services that meet these standards, unless otherwise carved out of the MCP Contract, regardless of whether the services are covered under California's Medicaid State Plan for adults (age 21 years and older), when the services are considered Medically Necessary. Carved out services include California Children's Services (CCS), pharmacy services, dental services, specialty mental health services, and substance use services.

Any qualified Medi-Cal provider, acting within their scope of practice, may conduct the screenings at physician offices, clinics, community health centers, local health departments, or schools. Families do not need to request these services and prior authorizations are not permitted.

The Plan must comply with the Americans with Disabilities Act mandate to provide services in the most integrated setting appropriate to members and in accordance with anti-discrimination laws.

Any screening/assessment/service refused by the member (if an emancipated minor or of age of majority) or parent or guardian of the child requires a signed refusal statement that is placed in the member's medical record as proof of voluntary refusal. If the responsible party refuses to sign the form, that refusal is noted in the member's medical record.

Case Management and Care Coordination

The Plan must ensure the provision of Comprehensive Medical Case Management services, including coordination of care for all Medically Necessary EPSDT services delivered both within and outside of the Plan's provider network. The Plan is responsible for the coordination of carved-out and linked services and referral to appropriate community resources and other agencies, regardless of whether the Plan is responsible for paying for the service.

The Plan shall provide case management and care coordination for all Medically Necessary EPSDT services, including Targeted Case Management (TCM) services. The Plan is responsible for determining whether a member under age 21 meets the eligibility criteria for TCM services. The Plan shall refer members who are eligible for TCM services to a Regional Center (RC) or local government health program, as appropriate for TCM services. If a member is receiving TCM services, the Plan is responsible for coordinating their health care with the TCM provider and for determining the Medical Necessity of diagnostic and treatment services covered under the Plan Contract that the TCM provider is recommending. If a member is determined to be ineligible for TCM services, the Plan shall ensure that the member's access to services is comparable to TCM services.

Appointment Scheduling and Transportation

The Plan shall provide appointment scheduling assistance and necessary transportation, including Non- Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) to and from medical appointments for the Medically Necessary EPSDT services pursuant to the Plan's Contract with DHCS. The Plan shall provide NMT for all Medically Necessary services, including for services that are carved out of the Plan's contract. The Plan shall have established procedures for members to obtain necessary transportation services.

II. Promotion of Services

For Members and their Families/Primary Caregivers:

The California Department of Health Care (DHCS) refers to the EPSDT Services benefit program as Medi-Cal for Kids & Teens. All member materials include the new title for

EPSDT Services. Members under the age of 21 years and their families or primary caregivers are informed that EPSDT services including all preventive care benefits, where and how to obtain these services, and that transportation and scheduling assistance are available to them. The Plan shall provide health education, including anticipatory guidance, to members under age 21 and their families or primary caregivers so they may effectively use these resources, including screenings and treatment. This information is provided annually to members and their families or primary caregivers in formats that meet language and accessibility standards such as translation into threshold languages, large print, and other format requirements per federal and state law, the MCP contract and DHCS all Plan Letters (APLs). Refer to policy CA_CLLS_018.

The DHCS materials on Medi-Cal for Kids & Teens and the "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter are published on the Anthem member and provider websites. These materials include:

- DHCS-developed child-focused (birth to 12 years) and teen-focused (12 to 21 years) brochures that offer an overview of EPSDT, including covered service, how to access these services, and the importance of preventive health care.
- The "Medical for Kids & Teens: Your Medi-Cal Rights" letter that explains steps to take if Medi-Cal care is denied, delayed, reduced, or stopped including who to contact, how to file grievances and appeals, and how to access other enrollee assistance resources.
- The DHCS-supplied outreach and education brochures and letter cannot be modified, except for the addition of the Anthem logo.
- Beginning on June 1, 2023, Anthem will mail the DHCS-supplied outreach and education materials consisting of the age-appropriate brochures (Child version for ages birth to 12 years and Teen to Young Adult version for ages 12 to 21 years) and the "Medi-Cal for Kids & Teens: Your Medical Rights" letter to all existing members under age 21.
- The Medi-Cal for Kids & Teens brochures and Medi-Cal Rights letter will be mailed or shared electronically by January 1, 2024, and then annually thereafter for all existing members under age 21.
- The Plan will mail or share electronically, the DHCS supplied outreach and education materials within 7 calendar days of enrollment in the plan for new members and then on an annual basis for existing members under the age of 21.

For Providers:

Starting in January 2024, the Plan will ensure that all network providers complete EPSDT-specific training no less than every two years.

- To reduce duplicative trainings by shared Network Providers, Anthem may share training records with other partner MCPs.
- By February 15 of each calendar year, Anthem submits to DHCS a comprehensive plan to ensure that all Network Providers receive proper education and training regarding EPSDT.
- The Annual Comprehensive training plan includes an attestation that Anthem's Provider Network follows the EPSDT training requirements and includes a list of all Network Providers who have completed training in the past 12 months.
- The Annual Comprehensive plan also includes:
    - How many Network Providers serve members under the age of 21.
    - How many Network Providers are NOT in compliance.
    - An outline of steps the Plan has taken to ensure Network Providers are fully compliant.
- The Plan is required, at a minimum, to use the Provider training developed by DHCS to promote a more uniform and shared understanding of the EPSDT benefit throughout the state. Additional information must be submitted to DHCS for review and approval prior to use.

The Plan ensures Primary Care Providers actively promote EPSDT screenings and AAP Bright Futures Recommendations for Preventive Pediatric Health Care services to caregivers and members under the age of 21 years.

The Plan will identify members under age 21 years who have not received EPSDT services based on the AAP Periodicity schedule age band and provide culturally and linguistically appropriate outreach to those caregivers or members to inform about and offer assistance in scheduling appointments to complete the services. The Plan utilizes vendors to send SMS and IVR messages to these identified members. Members and families/caregivers may contact Customer Service representatives for assistance with their PCP assignment, scheduling appointments, and/or transportation concerns.

III. Children's Preventive Care Services (EPSDT Services)

The Plan ensures that Primary Care Providers (PCPs) schedule examinations per the American Academy of Pediatrics (AAP) periodicity schedule required by the lower age nearest to the current age of the child. Appointments shall also be scheduled per Initial Health Appointment guidelines (IHA), within 120 calendar days following the date of enrollment for members 18 months and older or within the AAP Bright Futures periodicity timeline based on age at enrollment for children younger than 18 months of age.

PCPs shall schedule an appointment for preventive services within 10 business days of request by the member (if an emancipated minor or of age of majority), parent(s) or guardian., or by a referral from the local CHDP program.

At each PCP non-emergency office visit with members under the age of 21 years, the member (if an emancipated minor or of age of majority), or the parent(s) or guardian of the member will be advised which preventive services are due if the member had not received children's preventive services in accordance with AAP preventive standards for children of the member's age. Documentation of the visit will indicate:

- Receipt of the preventive services in accordance with the AAP/Bright Futures standards, or
- Proof of voluntary refusal of these services in the form of a signed statement by the member (if an emancipated minor or of age of majority), or the parent(s) or guardian of the member. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.

EPSDT Services

Screenings - regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and adolescents.

Comprehensive screenings are provided in compliance with the American Academy of Pediatrics (AAP) /Bright Futures periodicity schedule.

Screening services must also be provided in accordance with reasonable standards of medical and dental practice as determined by State regulatory requirements and

recognized medical and dental organizations involved in child health care (i.e., AAP, American Academy of Family Physicians, American Academy of Pediatric Dentistry, Centers for Disease Control and Prevention, and US Preventive Services Task Force).

EPSDT screenings are to be performed by providers qualified by the state to perform EPSDT services. At a minimum, these screenings must include, but are not limited to:

- A comprehensive health and developmental assessment, updated at each screening examination.
- Assessment of Nutritional Status and complete physical evaluation and identification of unusual eating habits, accurate measurement of height and weight, laboratory testing to screen for iron deficiency.
- A comprehensive unclothed physical exam
- Immunizations appropriate to age and health history as recommended by ACIP (see section IV. Immunizations for further details on this requirement)
- Appropriate laboratory tests, lead toxicity screening at twelve (12) and twenty-four (24) months
- Health education, including anticipatory guidance and counseling.
- Vision and hearing screening
- Tuberculosis screening
- Dental/oral health screening services (see section VII. Oral Health Dental Screening and Referral to a Dentist for further details)

PCPs shall also screen children for risk of developmental disorder, behavioral and social delays using a standardized screening tool at the 9-, 18-, and 30-month visits. The 30-month screening can be completed at the 24-month visit. In addition to the developmental screening, an Autism Spectrum Disorder (ASD) screening shall be documented in the medical record using standardized screening tools at the 18- and 24-month visits. Documentation in the medical record must include all of the following:

- A note indicating the date on which the test was performed.
- The standardized tool used for Developmental Screening and Autism Screening
- Evidence of a screening result or screening score
- Follow-up interventions (treatment/referrals)

(See AAP recommendations for more information on tools and process)

Health care services include, at a minimum, services identified above and include, but are not limited, to the following Medically Necessary services:

- Chiropractic
- Behavioral Health Treatment (BHT) Services
  - Dyadic Services-and Family Therapy
  - Maternal Depression Screening at child's 1-, 2-, 4-, 6-month well child visits
  - ABA Services (Applied Behavior Analysis)
- Nutrition counseling
- Audiology, including:
  - Hearing screening
  - Audiological assessments; electrophysiological measures such as auditory brainstem response (ABR)
- Examination, fitting, and purchase of hearing aids, including hearing aid accessories and supplies.
- Private duty nursing services including:
  - An initial assessment and development of a plan of care by a registered nurse
  - On-going private duty nursing services delivered by a licensed practical nurse or a registered nurse.
  - Offer Case Management Services for Care Coordination, when needed. If needed, Anthem shall use one or more Home Health Agencies, Individual Nurse Providers or any combination thereof, in providing Case Management Services as set forth in the Medi-Cal contract to plan enrolled EPSDT eligible Medi-Cal beneficiaries approved to receive Private Duty Nursing services, including, upon that member's request, Case Management Services to arrange for all approved Private Duty Nursing services desired by the member, even when the Plan is not financially responsible for paying for the approved Private Duty Nursing services.
- Durable medical equipment (DME), including assistive devices.
- Occupational, physical, and speech therapy services, for either habilitative or rehabilitative treatment if the services are not:
  - Specified in the member's individualized education plan (IEP), or
  - Specified in the member's individualized family service plan (IFSP) and delivered in the schools or through Children's Medical Services community-based providers.

- The health plan provides referrals for services not covered for members, including appropriate referrals to:
  - Head Start Programs
  - The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
  - School Health-Related Special Education Services
  - Vocational rehabilitation
  - Maternal and Child Health Services located at local health departments

IV. Immunizations

The Plan ensures members have access to immunization services in accordance with DHCS MMCD All Plan Letter 18-004. The Plan informs PCP of their responsibility to ensure children receive necessary immunizations at the time of any health care visit. PCPs are held to the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP). The Plan informs the PCPs regarding the Vaccines For Children (VFC) program during the initial and subsequent facility site and medical record reviews, as well as through the Provider Manual, which reinforces the requirement to enroll and maintain participation in the VFC program. Furthermore, the plan promotes the VFC program through the Provider website Resources tab and enrollment support is offered by the Facility Site Review Nurses as needed.

California AB 1797 requires all California healthcare providers who administer immunizations and/or perform tuberculosis (TB) testing to enter this information into the California Immunization Registry (CAIR) OR Healthy Futures/RIDE as part of the statewide Immunization Information System (IIS) to enter and track administered vaccines for children and adults. Healthy Futures/RIDE is the registry in the following counties: Alpine, Amador, Calaveras, Mariposa, Merced, San Joaquin, Stanislaus, and Tuolumne. In addition to immunization information, providers are required to enter race and ethnicity information for each patient in the registry to support assessment of healthcare disparities in immunization coverage. Providers who perform tuberculosis tests are required to enter the test results. DHCS strongly recommends that all MCP network providers report immunization information within 14 days of administration. Reports must be made following a member's Initial Health Appointment (IHA) and after all other health care visits that result in an immunization. Immunizations shall also be documented in the medical record, either in the progress notes or an immunization

record. Members are encouraged to bring copies of their previous immunization cards to their PCP in order to update the medical record and CAIR. All attempts to provide immunizations, instructions on how to obtain necessary immunizations, dates of administered vaccines and provision of the Vaccine Information Statement (VIS) and VIS publication dates shall be documented in the medical record and CAIR OR Healthy Futures/RIDE. Member (if an emancipated minor or of age of majority), or parent(s) or guardian voluntary refusal of the vaccination must be documented in the medical record in the form of a signed statement. If the responsible party refuses to sign this statement, that refusal shall be noted in the member's medical record.

The member (if an emancipated minor or of age of majority), or parent(s) or guardian is instructed to schedule a follow-up appointment with the PCP if the immunization cannot be given at the time of the current visit.

Upon Federal Food and Drug Administration (FDA) approval and upon the recommendation of ACIP and following the Medi-Cal fee-for-service guidelines, the PCP must have VFC vaccines for administration. The Plan informs the PCPs regarding the VFC program during facility site and medical record reviews, as well as through the Provider Manual.

Members can access Local Health Department (LHD) clinics for immunizations regardless of whether the LHD is in-network or out-of-network, without prior authorization. The Plan is required to provide updated information on the status of the member's immunizations to the LHD clinic. The Plan shall reimburse local health departments for the administration fee for immunizations given to members after receipt of claims and supporting immunization records. However, the Plan is not required to reimburse the local health department for an immunization provided to a member who was already up to date.

Providers must document each member's immunization needs for ACIP-recommended immunizations as part of all regular health visits, including but not limited to the following types of encounters:

- Illness, care management, or follow-up appointments
- Initial Health Appointments
- Prenatal and postpartum care
- Pre-travel visits

- Sports, school or work physicals
- Well-patient checkups for preventive care

V. Blood Lead Screens

Blood lead level (BLL) screening tests will be performed in accordance with the Centers for Disease Control and Prevention guidelines and Department of Health Care Services (DHCS) MCQMD APL 20-016 for all eligible members.

Federal law requires states to screen children enrolled in Medicaid (Medi-Cal in California) for elevated (BLLs) as part of required prevention services offered through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program.

Providers (i.e., physicians, nurse practitioners, and physician assistants) who perform periodic health assessments on children between the ages of six months to six years (i.e., 72 months), must comply with current federal and state laws and industry guidelines for health care providers issued by the California Department of Public Health's California Childhood Lead Poisoning Prevention Branch (CLPPB) including any future updates or amendments.

- Providers must provide oral or written anticipatory guidance to the parent or guardian of a child that, at a minimum, includes information that children can be harmed by exposure to lead, especially from deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time a child begins to crawl until 72 months of age. This anticipatory guidance must be performed at EACH periodic health assessment from 6 months until 72 months of age. It must be documented in the medical record for the child.
- Providers must perform BLL screening tests on all children:
    - At 12 months and at 24 months of age
    - When the health care provider performing a periodic health assessment becomes aware that a child 12 to 24 months of age has no documented evidence of BLL screening test taken at 12 months of age or thereafter.
    - When the health care provider performing a periodic health assessment becomes aware that a child 24 to 72 months of age has no documented evidence of BLL screening test taken.
    - Whenever the health care provider performing a periodic health assessment of a child 12 to 72 months of age becomes aware of a change

in circumstances that has placed the child at increased risk of lead poisoning, in the professional judgement of the provider.
    - When requested by the parent or guardian.
    - When following CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued Guidelines.
- The health care provider is not required to perform BLL screening tests if:
    - A parent or guardian of the child, or other person with legal authority to withhold consent for the child refuses to consent to the screening.
    - If in the professional judgment of the provider, the risk of screening poses a greater risk to the child's health than the risk of lead poisoning.

Providers *must* document the reasons for not performing a BLL screening test in the child's medical record. In cases where consent has been withheld, the Plan ensures that the network provider documents this in the child's medical record by obtaining a signed statement of voluntary refusal. If the network provider is unable to obtain a signed statement of voluntary refusal because the party that withheld consent 1) refuses or declines to sign it or 2) is unable to sign it (e.g., when services are provided via a telehealth modality), the network provider must document the reason for not obtaining the signed statement of voluntary refusal in the child's medical record. DHCS will consider the above-mentioned documented efforts that are noted in the child's medical record as evidence of the Plan's compliance with the blood lead screening test requirements.

Screening may be conducted using either the capillary (finger stick) or venous blood sampling methods; however, the venous method is preferred because it is more accurate and less prone to contamination. All confirmatory and follow-up BLL testing must be performed using blood samples taken through the venous blood sampling method. Providers must follow the CLPPB guidelines when interpreting BLLs and determining appropriate follow-up activities. When there is a discrepancy in requirements between DHCS APL 20-016 and CLPPB guidelines, providers must follow CLPPB guidelines.

The Plan:

- Ensures that all child members under the age of 6 years (i.e., 72 months) who have no record of receiving a BLL screening test as required by Title 17 CCR Section 37100 will be identified on a quarterly basis. The Plan will identify the

age at which the required BLL screening test was missed and include children without any record of a completed BLL screening test.

- Will notify the network provider responsible for the care of an identified child member of the regulatory requirements to test that child and provide the required written or oral anticipatory guidance to the parent or guardian of, or other person with legal authority for the child.
- Will maintain records, for no less than 10 years, of all child members identified quarterly as having no record of receiving a required BLL screening test and provide those records to DHCS, at least annually as well as upon request.
- Will educate network providers, including laboratories, about the appropriate Common Procedure Terminology (CPT) coding to ensure accurate reporting of all BLL screening tests.
- Will utilize the CMS-1500/UB-04 claim forms, or their electronic equivalents (837-P/637-I), to report confidential screening/billing to comply with Health Insurance Portability and Accountability (HIPAA) requirements.
- Will ensure that BLL screening encounters are identified using the appropriate indicators as described in the most recent DHCS Companion Guide for X12 Standard File Format.
- Will submit complete, accurate, reasonable, and timely encounter data per its contract with DHCS and APLs 14-019 and 17-005.

California law requires laboratories and health care providers performing blood lead analysis on blood specimens in California to electronically report all results to CLPPB along with specified patient demographics, ordering physician and analysis data on each test performed. The Plan will ensure that network providers report all BLL screening test results to CLPPB, as required.

Assembly Bill (AB) 2276 (Chapter 218, Statutes of 2020) added blood lead related requirements to state law to impose various contractual requirements on the Plan; require DHCS to develop and implement procedures to ensure Plan compliance with the requirements; authorize DHCS to impose sanctions for any violation of the requirements; provide DHCS with express authority to implement, interpret, or make specific the requirements of the bill by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions without taking any further regulatory action.

VI. Tuberculosis (TB) Screening

All child members shall be assessed for risk of exposure to tuberculosis at 1, 6, and 12 months and annually thereafter. TB testing shall be performed with a TB skin test (Mantoux) or TB blood test, QuantiFERON-TB Gold Plus. Follow up with current CDC and American Thoracic Society guidelines. California AB 1797 requires providers who perform tuberculosis testing to submit TB test information to the immunization registry that includes the test results.

VII. Oral Health Screening and Referral to a Dentist

Dental services are carved out of the Plan's Contract; however, the Contract requires that the Plan ensures members have access to dental services. Primary care providers must conduct an oral health assessment at eruption of first tooth or at minimum at the 6-, 9-, 12-, 18-, 24-, and 30-month well child visits and annually thereafter. Per the American Dental Association and the American Academy of Pediatrics, every child member shall visit a dentist by age one or as soon as a first tooth appears. Providers shall assess if the child member has access to dental services and refer the member to the Medi-Cal Dental program if a dentist is needed. Providers must provide anticipatory guidance to the parent(s) explaining the importance of an early dental checkup.

The Plan shall cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetist but may require prior authorization for medical services required in support of dental procedures.

Primary Care Providers shall prescribe oral fluoride supplementation starting at age 6 months to 16 years for all child members whose water source is deficient in fluoride. Providers shall ensure that fluoride varnish is applied to the primary teeth of all infants and child members starting at the age of primary tooth eruption to 5 years of age by the medical or dental provider up to 4 times per year.

VIII. Screening for Sexually Transmitted Infection (STI) and, Human Papillomavirus (HPV) Vaccine

The Plan ensures that members have prompt access to STI prevention, screening, counseling, diagnosis, and treatment services in accordance with DHCS MMCD Policy Letter 96-09. STI services do not require prior authorization, and the member can select

a practitioner other than the PCP for confidential care. Out of network practitioners will be reimbursed for STI services provided to members. Minors aged 12 and older can access STI services without parental consent.

Follow-up of positive results must be documented in the medical record and reported to the local Public Health Department per CA Department of Public Health regulations.

The HPV vaccine is considered a Medically Necessary preventive service for males and females. Administration of HPV vaccine based on the most current ACIP pediatric recommendation schedule shall be documented in the medical record.

IX. Behavioral Health

Providers shall screen mothers of infants for maternal depression at the 1-,2-,4-, and 6-month infant visits using a standardized screening tool. Providers shall screen all child members annually starting at 12 years of age for depression and suicide risk using a standardized screening tool. In addition, providers shall assess each child member's psychosocial and behavioral needs, including social-emotional health, care-giver depression, and social determinants of health.

As described in DHCS APL 22-029 *(Revised)*, Dyadic Services and Family Therapy is a family- and caregiver-centered model of care intended to address developmental and behavioral health conditions of children as soon as they are identified. During medical well child visits, a child and parent or caregiver can be screened for behavioral problems, interpersonal safety, tobacco and drug misuse, social determinants of health (SDOH), such as food insecurity and housing instability with referrals provided for appropriate follow-up care.

Providers shall perform Adverse Childhood Experiences (ACEs) screening to evaluate children and adults for trauma that occurred during the first 18 years of life. The ACEs questionnaire for adults (age 18 and older) and Pediatric ACEs and Related Life-events Screener (PEARLS) tools for children (ages 0 to 19) are both forms of ACEs screening. Both the ACEs questionnaire and the PEARLS tool are acceptable for use for Members ages 18 or 19. The ACEs screening portion (Part 1) of the PEARLS tool is also valid for use to conduct ACEs screenings among adults age 20 and older.

Starting at age 11, all child members shall be screened for sexual activity, alcohol, drug, and tobacco use with appropriate follow-up action including testing for sexually transmitted infections,

The Plan is responsible for the provision of EPSDT services for beneficiaries Birth to 21 years of age including Medically Necessary Behavioral Health Treatment (BHT) services. This includes Medically Necessary, evidence based BHT services that prevent or minimize behavioral conditions and promote, to the maximum extent practicable, the functioning of a member, in accordance with DHCS MCQMD APL 19-014.

X. Necessary Referrals for Examination of Identified Health Issues

The Plan must do the following when another entity has overlapping responsibility for providing services to a member under age 21:

- Assess the level of EPSDT Medically Necessary services the member requires,
- Determine the level of service (if any) that is being provided by other entities, and
- Co-ordinate the provision of services with the other entities to ensure that the Plan and the other entities are not providing duplicative services, and that the Member is receiving all Medically Necessary EPSDT services in a timely manner.

The Plan has the primary responsibility to provide all Medically Necessary EPSDT services, including services which exceed the amount provided by LEAs (Local Education Agencies), RCs (Regional Centers), CCS (California Children Services), local government health programs, or other entities as the primary provider of Medically Necessary EPSDT services. The Plan is the primary provider of such medical services except for those services that have been expressly carved out.

The PCP will refer eligible Medi-Cal enrollees to other specialty care providers as appropriate, if the need for such services is indicated including diagnosis of and treatment for defects or deficits in vision, hearing and dental. Members also identified during the screening for developmental, behavioral, and social delays, including ASD, shall be referred to local regional center or appropriate specialist.

The Plan is responsible for determining if services for eligible members are Medically Necessary and is financially responsible for providing all follow-up diagnostic and treatment services deemed Medically Necessary to ameliorate or correct a problem

discovered during a preventive care screening examination. If additional services are identified, the Plan's Utilization Management (UM)/Case Management (CM) staff authorizes those services and/or referrals that are Medically Necessary following pre-service authorization review guidelines. These services may be an expansion of covered services.

Children with Special Health Care Needs (CSHCN) are identified and managed as described in policy *CA_CAXX_119 Children with Special Health Care Needs-Services for.*

XI. Member Engagement

Access to primary care, outreach, education, care coordination, navigation, and referrals are delegated to the PCP whenever feasibly possible. All PCPs shall review their monthly eligibility list and proactively contact their newly assigned members to schedule an Initial Health Appointment according to the AAP Periodicity schedule for members 18 months of age and younger and within 120 days of enrollment for new members age 24 months to 21. Providers are required to offer appointment scheduling assistance and ensure necessary transportation to and from medical appointments for EPSDT services. To facilitate member engagement with primary and other healthcare services, the Medi-Cal member handbook instructs members to call the Customer Care Center for assistance with scheduling an appointment, how to make transportation arrangements through ModivCare, available wellness and prevention programs, disease management programs, and about their EPSDT benefit.

XII. Monitoring and Reporting

The Plan performs ongoing monitoring of the provision of services for members under the age of 21 years including, but not limited to medical record reviews, member engagement reports, utilization of children's preventive health and screening, timely access to services, and data collection in support of HEDIS. Utilization reports for EPSDT services for members less than 21 years of age shall be reviewed at least quarterly to identify members and families/caregivers who have not completed EPSDT services per the AAP Bright Futures periodicity timeline.

The Plan analyzes EPSDT services related data to identify underutilization trends to inform our strategies and interventions. We work with our providers, coordinate with CCS, local agencies and schools, and CBOs that support children's social and behavioral

health needs across the state. Reviews of feedback from our Community Advisory Committees (CAC), Public Policy, and Health Equity Advisory Committee meetings to identify barriers in specific communities allows for a customized approach to interventions. We implement targeted member outreach through CHWs and live calls in areas with low rates of well-child visits and immunizations to assist with scheduling appointments and arranging transportation.

CMS-416 Annual EPSDT Report: Medicaid Statute of Social Security Act 1902 (a) (43) establishes a report that provides basic information on participation in the Medicaid child health program. The statute requires that States provide the Center for Medicare & Medicaid Services (CMS) with the following: 1) Number of children provided child health screening services, 2) Number of children referred for corrective treatment, 3) Number of children receiving dental services, 4) State's results in attaining goals. The information is used to assess the effectiveness of State EPSDT programs in terms of the number of children, by age and Medicaid eligibility, who are provided child health screening services, are referred for corrective treatment, and the number receiving dental services. For purposes of reporting on this form, child health services are defined as initial or periodic screens required to be provided according to the State's screening periodicity schedule.

XIII. Policy and Procedure Update

The Plan ensures that Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including All Plan Letters and Policy Letters. The Plan also ensures all Plan Policies and Procedures (P&Ps) as well as any P&Ps and practices of the Plan's Subcontractors and Network Providers comply with these EPSDT requirements and APL 23-005.

REFERENCES:

- 17 CCR §§ 37000 – 37100
- AB 1797 Immunization Registry FAQs (ca.gov)
- Bill Text – AB-1797 Immunization registry. (ca.gov)
- Bright Futures Periodicity Schedule: https://brightfutures.aap.org/Pages/default.aspx
- CA_PCXX_003 Initial Health Appointments for Children and Adults – CA

- CLPPB for Post-Arrival Refugees: https://www.cdc.gov/immigrantrefugeehealth/guidelines/lead-guidelines.html
- CMS 42CFR441- Subpart B
- DHCS All Plan Letter 18-004 Immunization Requirements
- DHCS All Plan Letter 19-018 Proposition 56-Directed Payments for Adverse Childhood Experiences Screening Services
- DHCS All Plan Letter 20-016 (*Revised 11/02/2020*) Blood Lead Screening of Young Children
- DHCS All Plan Letter 22-024 Population Health Management Policy Guide (Supersedes APLs 17-012 and 17-013)
- DHCS All Plan Letter 22-029 Dyadic Services and Family Therapy Benefit
- DHCS All Plan Letter 22-030 Initial Health Appointment (Supersedes APL 13-017 and Policy Letters 13-001 and 08-003)
- DHCS All Plan Letter 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (Supersedes APL 19-010)
- DHCS All Plan Letter 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members under the Age of 21
- DHCS CalAIM Population Health Management Policy Guide Updated May 2023
- DHCS Medi-Cal Operational Readiness Contract Exhibit A Attachment III (SOW)
- DHCS MMCD Policy Letter 96-09 Sexually Transmitted Disease Services in Medi-Cal Managed Care
- https://www.aap.org
- https://www.cdc.gov/tb/topic/testing/default.htm
- https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-Pediatric-TB-Risk-Assessment.pdf
- Medi-Cal for Kids & Teens Provider Training

RELATED POLICIES AND PROCEDURES:

- CA_CAXX_119 Children with Special Health Care Needs-Services for – CA

Section (Primary Department) **Quality Management**	**SUBJECT (Document Title)** **EPSDT – Requirements for Coverage of Early Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 - CA**

RESPONSIBLE DEPARTMENTS:

Primary Department: Quality Management

Secondary Department(s): Corporate Clinical Quality Management (CCQM)
Customer Care Center
Health Care Management - Utilization Management & Case Management
Health Education
Medicaid Compliance Governance

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
12/19/2023	• Annual review • Updated Procedure, References, and Related Policies and Procedures sections • Added AB 1797 TB info. to the TB section • Updated immunization section to include provisions of CA AB 1797 regarding entry of immunizations into the CA registries, race and ethnicity of members, and TB test results • Updated Immunization section to reflect Vaccines For Children (VFC) program support and participation requirements • Added AB 1797 Bill Text and FAQ links to the reference section
08/18/2023	• Off-Cycle Review • Updated Procedure section— ▪ Added IHA guidelines language under Children's Preventive Care Services (EPSDT Services) Section to satisfy DHCS Artifact R.0122 AIR ▪ Added language under Monitoring and Reporting section to satisfy DHCS R.0122 AIR ▪ Added language under Promotion of Services Section to satisfy

Section (Primary Department) **Quality Management**	**SUBJECT (Document Title)** **EPSDT – Requirements for Coverage of Early Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 - CA**

Review Date	Changes
	DHCS Artifact R.0053 ▪ Revised "For Providers" section to satisfy DHCS APL 23-005 AIR • Updated Related Policies and Procedures section • Alphabetized Secondary Department(s) section
06/30/2023	• Off-Cycle Review • Updated policy name from "Services for Members under 21 years of age - CA" to "EPSDT - Requirements for Coverage of Early Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 - CA" • Updated Policy, Definitions, Procedure, and Related Policies and Procedures sections • Updated and alphabetized References section • Added APL 20-030 Initial Health Appointment • Added APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (Supersedes APL 19-010) • Added APL 22-029 Dyadic Services and Family Therapy Benefit • Added Medi-Cal for Kids & Teens link • Added language to Immunizations section to comply with DHCS 2024 Contract, Attachment III, 5.2.8.E (Network and Access to Care): Members access to LHD clinics for immunizations, whether in-network or out-of-network without prior authorization. Plan must provide updated information on member's immunization status. Plan will reimburse LHD clinics after receipt of claims and supporting immunization records. • Added Revised Comprehensive Medical Case Management services language to the Case Management and Care Coordination section due to 6/29/23 DHCS revision to APL 23-005 (language was inadvertently omitted from previous APL 19-010) • Removed references to APL 19-010 • Added "Health Education" as a secondary department • Added footer to match GBD Template; added policy number "CA_PCXX_009"
01/20/2023	• Annual Review • Updated Policy, Procedure, and References sections

Section (Primary Department) **Quality Management**	**SUBJECT (Document Title)** **EPSDT – Requirements for Coverage of Early Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 - CA**

Review Date	Changes
	• Alphabetized Related Policies and Procedures section
06/29/2022	• Off-Cycle Review • Changed Primary Department in header from Preventive Care to Quality Management • Revised Diagnosis to Diagnostic throughout the P&P • Added additional guidance for children less than 2 years of age to last sentence of XI. Practitioner Education section. • Added EPSDT – Corporate Outreach and Monitoring to Related Policies and Procedures section.
01/11/2022	• Annual review • Added additional preventive care guidelines and reference links • Updated policy • Updated procedure • Updated references and placed in alphabetical order
01/28/2021	• Annual review • Updated the procedure and references • Edits to Procedure Sections II through IV, VI through XI • Edit to “emancipated minors and of age of majority” throughout policy
11/11/2020	• Off-Cycle Review • Procedure and references updated • Updated language per new APL 20-016
02/06/2020	• Annual Review • Edit to procedure sections • Updated appointment timeframe per DHCS recommendations in the procedure section “Children’s Preventive Services” • Updated methods of communication in procedure section “Reminders and Notification of Screening Due Dates” • Updated DHCS APL in procedure section “Screening for Autism Spectrum Disorder (ASD)” • References updated
01/07/2019	• Annual Review • Update due to APL 18-017 Blood Lead Screening of Young Children • Update due to APL 18-006 Responsibilities for Behavioral Health

Section (Primary Department) **Quality Management**	**SUBJECT (Document Title)** **EPSDT – Requirements for Coverage of Early Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 - CA**

Review Date	Changes
	Treatment Coverage for Members Under the Age of 21
03/16/2018	• Annual review
03/31/2017	• Annual review • Added language related to Monitoring and Reporting
02/04/2016	• Annual review • Updated transportation assistance from CCC to LogistiCare • Revised contract references
03/13/2015	• Removed references to Healthy Families • Removed details about Blood lead level Testing • Added section about Autism Spectrum Disorder screening • Removed verbiage about inclusion of the program in the annual evaluation • Added reference to All Plan Letter 14-011
01/14/2014	• Removed reference to availability of immunization reports for providers
10/21/2013	• Changed information related to the PM-160 PHP • Added more detail about blood lead level (BLL) testing • Removed reference to the DHCS's collaboratives on chlamydia and lead testing
10/16/2012	• Added policy history • Changed SSB to Medicaid • Added roles of the Clinical Program Management and Clinical Program Development teams • Added reference to policy CA_CAXX_119 • Removed statement about availability of EPSDT information in the Plan's Perinatal programs