(b) Nothing in paragraph (a) permits a State to provide, under its plan, services that are not reasonable in amount, duration, and scope to achieve their purpose.

[56 FR 8851, Mar. 1, 1991]

§ 441.40 End-stage renal disease.

FFP in expenditures for services described in subpart A of part 440 is available for facility treatment of end-stage renal disease only if the facility has been approved by the Secretary to furnish those services under Medicare. This requirement for approval of the facility does not apply under emergency conditions permitted under Medicare (see §482.2 of this chapter).


Subpart B—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21

SOURCE: 49 FR 43666, Oct. 31, 1984, unless otherwise noted.

§ 441.50 Basis and purpose.

This subpart implements sections 1902(a)(43) and 1905(a)(4)(B) of the Social Security Act, by prescribing State plan requirements for providing early and periodic screening and diagnosis of eligible Medicaid recipients under age 21 to ascertain physical and mental defects, and providing treatment to correct or ameliorate defects and chronic conditions found.

§ 441.55 State plan requirements.

A State plan must provide that the Medicaid agency meets the requirements of §§441.56±441.62, with respect to EPSDT services, as defined in §440.40(b) of this subchapter.

§ 441.56 Required activities.

(a) Informing. The agency must—
(1) Provide for a combination of written and oral methods designed to inform effectively all EPSDT eligible individuals (or their families) about the EPSDT program.

(2) Using clear and nontechnical language, provide information about the following—
(i) The benefits of preventive health care;
(ii) The services available under the EPSDT program and where and how to obtain those services;
(iii) That the services provided under the EPSDT program are without cost to eligible individuals under 18 years of age, and if the agency chooses, to those 18 or older, up to age 21, except for any enrollment fee, premium, or similar charge that may be imposed on medically needy recipients; and
(iv) That necessary transportation and scheduling assistance described in §441.62 of this subpart is available to the EPSDT eligible individual upon request.

(3) Effectively inform those individuals who are blind or deaf, or who cannot read or understand the English language.

(4) Provide assurance to HCFA that processes are in place to effectively inform individuals as required under this paragraph, generally, within 60 days of the individual’s initial Medicaid eligibility determination and in the case of families which have not utilized EPSDT services, annually thereafter.

(b) Screening. (1) The agency must provide to eligible EPSDT recipients who request it, screening (periodic comprehensive child health assessments); that is, regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. (See paragraph (c)(3) of this section for requirements relating to provision of immunization at the time of screening.) As a minimum, these screenings must include, but are not limited to:
(i) Comprehensive health and developmental history.
(ii) Comprehensive unclad examination.
(iii) Appropriate vision testing.
(iv) Appropriate hearing testing.
(v) Appropriate laboratory tests.
(vi) Dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age. An agency may request from HCFA an exception from this age requirement
§ 441.57 Discretionary services.

Under the EPSDT program, the agency may provide for any other medical or remedial care specified in part 440 of this subchapter, even if the agency does not otherwise provide for these services to other recipients or provides for them in a lesser amount, duration, or scope.

§ 441.58 Periodicity schedule.

The agency must implement a periodicity schedule for screening services that—

(a) Meets reasonable standards of medical and dental practice determined by the agency after consultation with recognized medical and dental organizations involved in child health care;

(b) Specifies screening services applicable at each stage of the recipient's life, beginning with a neonatal examination, up to the age at which an individual is no longer eligible for EPSDT services; and

(c) At the agency's option, provides for needed screening services as determined by the agency, in addition to the otherwise applicable screening services specified under paragraph (b) of this section.

§ 441.59 Treatment of requests for EPSDT screening services.

(a) The agency must provide the screening services described in § 441.56(b) upon the request of an eligible recipient.

(b) To avoid duplicate screening services, the agency need not provide requested screening services to an EPSDT eligible if written verification exists that the most recent age-appropriate screening services, due under the agency’s periodicity schedule, have already been provided to the eligible.

§ 441.60 Continuing care.

(a) Continuing care provider. For purposes of this subpart, a continuing care provider means a provider who has an
agreement with the Medicaid agency to provide reports as required under paragraph (b) of this section and to provide at least the following services to eligible EPSDT recipients formally enrolled with the provider:

(1) With the exception of dental services required under §441.56, screening, diagnosis, treatment, and referral for follow-up services as required under this subpart.

(2) Maintenance of the recipient's consolidated health history, including information received from other providers.

(3) Physicians' services as needed by the recipient for acute, episodic or chronic illnesses or conditions.

(4) At the provider's option, provision of all or part of the transportation and scheduling assistance as required under §441.62. The provider must specify in the agreement the transportation and scheduling assistance to be furnished. If the provider does not choose to provide some or all of the assistance, then the provider must refer recipients to the agency to obtain the transportation and scheduling assistance required under §441.62.

(b) Reports. A continuing care provider must provide to the agency any reports that the agency may reasonably require.

(c) State monitoring. If the State plan provides for agreements with continuing care providers, the agency must employ methods described in the State plan to assure the providers' compliance with their agreements.

(d) Effect of agreement with continuing care providers. Subject to the requirements of paragraphs (a), (b), and (c) of this section, HCFA will deem the agency to meet the requirements of this subpart with respect to all EPSDT eligible recipients formally enrolled with the continuing care provider. To be formally enrolled, a recipient or recipient's family agrees to use one continuing care provider to be a regular source of the described set of services for a stated period of time. Both the recipient and the provider must sign statements that reflect their obligations under the continuing care arrangement.

(e) If the agreement in paragraph (a) of this section does not provide for all or part of the transportation and scheduling assistance required under §441.62, or for dental service under §441.56, the agency must provide for those services to the extent they are not provided for in the agreement.

§441.61 Utilization of providers and coordination with related programs.

(a) The agency must make available a variety of individual and group providers qualified and willing to provide EPSDT services.

(b) The agency must make available a variety of individual and group providers qualified and willing to provide EPSDT services.

(c) The agency must make appropriate use of State health agencies, State vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/crippled Children's Services). Further, the agency should make use of other public health, mental health, and education programs and related programs, such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC), to ensure an effective child health program.

§441.62 Transportation and scheduling assistance.

The agency must offer to the family or recipient, and provide if the recipient requests—
§ 441.100
(a) Necessary assistance with trans-
portation as required under § 431.53 of
this chapter; and
(b) Necessary assistance with sched-
uling appointments for services.

Subpart C—Medicaid for Individ-
uals Age 65 or Over in Institu-
tions for Mental Diseases

SOURCE: 44 FR 17940, Mar. 23, 1979, unless
otherwise noted.

§ 441.100 Basis and purpose.
This subpart implements section
1905(a)(14) of the Act, which authorizes
State plans to provide for inpatient
hospital services, skilled nursing serv-
ces, and intermediate care facility
services for individuals age 65 or older
in an institution for mental diseases,
and sections 1902(a)(20)(B) and (C) and
1902(a)(21), which prescribe the condi-
tions a State must meet to offer these
services. (See § 431.620 of this sub-
chapter for regulations implementing
section 1902(a)(20)(A), which prescribe
interagency requirements related to
these services.)

§ 441.101 State plan requirements.
A State plan that includes Medicaid
for individuals age 65 or older in insti-
tutions for mental diseases must pro-
vide that the requirements of this sub-
part are met.

§ 441.102 Plan of care for institutional-
ized recipients.
(a) The Medicaid agency must pro-
vide for a recorded individual plan of
treatment and care to ensure that in-
stitutional care maintains the recipi-
ent at, or restores him to, the greatest
possible degree of health and inde-
pendent functioning.
(b) The plan must include—
(1) An initial review of the recipient's
medical, psychiatric, and social
needs—
(i) Within 90 days after approval of
the State plan provision for services in
institutions for mental disease; and
(ii) After that period, within 30 days
after the date payments are initiated
for services provided a recipient.
(2) Periodic review of the recipient's
medical, psychiatric, and social needs;
(3) A determination, at least quar-
terly, of the recipient's need for contin-
ued institutional care and for alter-
native care arrangements;
(4) Appropriate medical treatment in
the institution; and
(5) Appropriate social services.

§ 441.103 Alternate plans of care.
(a) The agency must develop alter-
nate plans of care for each recipient
age 65 or older who would otherwise
need care in an institution for mental
diseases.
(b) These alternate plans of care
must—
(1) Make maximum use of available
resources to meet the recipient's med-
ical, social, and financial needs; and
(2) In Guam, Puerto Rico, and the
Virgin Islands, make available appro-
priate social services authorized under
sections 3(a)(4) (i) and (ii) or
1603(a)(4)(A) (i) and (ii) of the Act.

§ 441.105 Methods of administration.
The agency must have methods of ad-
ministration to ensure that its respon-
sibilities under this subpart are met.

§ 441.106 Comprehensive mental
health program.
(a) If the plan includes services in
public institutions for mental diseases,
the agency must show that the State is
making satisfactory progress in devel-
oping and implementing a comprehen-
sive mental health program.
(b) The program must—
(1) Cover all ages;
(2) Use mental health and public wel-
fare resources; including—
(i) Community mental health cen-
ters;
(ii) Nursing homes; and
(iii) Other alternatives to public in-
stitutional care; and
(3) Include joint planning with State
authorities.
(c) The agency must submit annual
progress reports within 3 months after
the end of each fiscal year in which
Medicaid is provided under this sub-
part.