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Using Medicaid to Ensure the Healthy Social and Emotional Development of Infants and Toddlers

by *Elisabeth Wright Burak and Kelly Rolfes-Haase*

Executive Summary

Each child's social and emotional development underpins overall development and greatly influences his or her lifelong trajectory. Infants and toddlers experience a period of rapid brain development marked by great possibility and vulnerability, depending on their family and community contexts. The first years of life are particularly crucial to a child's development of a sense of security and attachment with others, foundational activities that undergird subsequent social and emotional development. Prolonged stress brought on by trauma—parental substance abuse, poverty, and other family, social, and/or environmental factors—places healthy development at great risk. Nurturing relationships with parents and caregivers can mitigate these risks, especially with early identification and support for young children's mental health needs along with those of their parents. But when such stress gets in the way of consistent caring and responsive parent-child relationships, it can lead to a host of health, behavioral, social, and emotional difficulties for the child throughout his or her life.

Young children's social and emotional development, also called [infant and early childhood mental health](#) (IECMH), lays the foundation for lifelong success.¹ Many interventions to prevent and treat young children's emotional health, often focused on relationships with their parents or caregivers, are available and effective. Yet federal and state health care, mental health and early childhood policies do not reflect the evidence base for IECMH.²

Medicaid provides health insurance to nearly half of all infants and young children.³ While Medicaid alone cannot solve broader system challenges, such as stigma or the need for more qualified mental health providers, it can be a leader for improvements across payers and systems. The program's comprehensive pediatric benefit, known as Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT), is designed to meet the preventive care and treatment needs of young children, including their mental health. EPSDT is not well understood or consistently applied, but it holds much potential to strengthen access to IECMH services. The opportunity to reach young children, along with their parents and caregivers, as early as possible can prevent conditions from escalating and requiring more complex, expensive interventions. To ensure the youngest children and their families in Medicaid receive the support they need to ensure strong mental health, states can:

1. Improve preventive screenings based on expert-recommended schedules and guidelines.
2. Adopt diagnosis guidelines specific to young children's mental health.
3. Update or clarify payment policies and processes for needed IECMH services.
4. Consider new settings or provider types appropriate for IECMH services.
5. Include IECMH in broader Medicaid improvements and reforms.



Introduction

A baby's brain forms more than 1 million new neural connections every second.⁴ This extraordinary rate of development allows infants to process new stimuli and to begin to master languages, social behaviors, and cultural norms within their first few years of life. At the same time, the ever-expanding neural networks that enable children's brains to take in vast amounts of information also make them especially vulnerable. Stressful family experiences—such as illness or family death, parent mental health (e.g., maternal depression) or substance abuse, abuse, neglect, parental absence, discrimination, or exposure to other trauma—can impede children's healthy development. The greater number of adverse childhood experiences (ACEs) children encounter, the higher their risk for physical and mental health problems (heart disease, depression, suicide risk) as adults. ACEs are also linked with poorer school readiness and educational outcomes and involvement with the juvenile justice system.⁵ These poor outcomes not only cost families and communities, they cost taxpayers: Poor health outcomes associated with ACEs cost the nation nearly \$100 billion annually in expenses for cardiovascular care and more than \$85 billion in mental health disorders.⁶

Many who need mental health treatment do not receive it. Research suggests that as many as one in five U.S. children suffers from some kind of emotional impairment or disorder, including an estimated 10 to 14 percent of children under age 6.⁷ Yet between half and two-thirds of those identified as needing mental health services do not receive timely treatment.⁸ Treatment gaps tend to be larger among those who develop a mental health condition at a very young age or who come from rural and/or minority backgrounds.⁹

Medicaid support to strengthen IECMH services can go a long way to improving children's long-term success. Medicaid serves most low-income young children and includes a robust pediatric health benefit designed to ensure that children's developmental needs are met and that diseases or delays are addressed as early as possible. In the earliest years, there is a tremendous opportunity to respond much earlier and more proactively to children at risk of or showing signs of emotional, social, and developmental needs and delays.

This paper outlines state opportunities to address children's mental health earlier and more effectively through Medicaid. A variety of factors influence this work, including social determinants of health and broader promotion and prevention efforts. This paper does not address these areas comprehensively, as many of the resources referenced throughout provide a more comprehensive take on these topics.¹⁰ Instead, it offers a starting place to inform Medicaid discussions that will require additional attention to the full range of family and environmental factors that influence a child's development.

Audience Matters: Talking About Healthy Social and Emotional Development in Young Children

Advocates and other stakeholders should be mindful of their audience when selecting terms and crafting messages about IECMH. A number of terms are used to describe this concept: social and emotional development, emotional health and wellbeing, and others. States, and even specific sectors or agencies within states, use varying terminology based on their roles. For example, health or mental health stakeholders may use terms such as “early childhood mental health” or “behavioral health,” while early learning and education stakeholders may use “social emotional development.”

Research suggests that while mental health experts and providers may prefer IECMH, parents, pediatricians, and the general public may be more comfortable with terms like social and emotional development.¹¹ In this paper, “IECMH” is used most often to specifically call attention to screening, diagnosis, and treatment services that may be supported in Medicaid. “Social and emotional health” or “emotional development” refer more broadly to promotion and prevention activities.



What is Infant and Early Childhood Mental Health (IECMH) and Why is it Important?

Infant and early childhood mental health (IECMH) is a young child's ability to experience, express, and regulate emotions; form close, secure interpersonal relationships; and explore his or her environment and learn, within the context of family and cultural expectations.¹² The expanding evidence base of brain science and child development suggests the following:

Young children's mental health needs can be successfully addressed early on, but must be more broadly embraced.

IECMH is not as widely understood and does not look the same as mental health challenges for older children or adults.¹³ Warning signs among young children include excessive crying, developmental delays, failure to seek comfort from caregivers, or lack of curiosity.¹⁴ Left untreated, these early signals can escalate into more serious mental health disorders (e.g. Depressive Disorder of Early Childhood, Anxiety Disorders, Posttraumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, etc.) that can upend lifelong health, as well as educational and economic success.¹⁵ The good news is that effective, evidence-informed, and promising interventions to support infant and toddlers' mental health are available.

Parents and caregivers influence babies' brain development from the start. Babies who feel loved, comforted, and have the freedom to play form more brain connections, which increases their ability to trust, relate, communicate, and learn.

Parent/caregiver well-being is key to their children's social and emotional development. Parents and caregivers influence babies' brain development from the start. Babies who feel loved, comforted, and have the freedom to play form more brain connections, which increases their ability to trust, relate, communicate, and learn. Strong, nurturing relationships between children and their parents and caregivers can protect children from adversity and help them recover. Added stressors on parents (financial, mental health or substance abuse, health conditions or others) get in the way of their ability to fully respond to their own mental health needs and their children's needs, which can impede their children's development. Interventions to support IECMH necessarily must also support and engage their primary caregiver to protect and nurture these relationships.

An explicit focus on children's social and emotional development may prevent or minimize more costly, complex and/or overutilized services. Expanding the availability of IECMH services offers new intervention pathways to meet each child's unique needs and prevent more costly and complex treatments down the line. It also has the potential to limit use of available, overutilized strategies that raise risks or concerns (see box).

Extending access to IECMH in Medicaid could support state efforts to limit psychotropic use in young children

Many states are taking a closer look at medication prescribing practices for children or sub-groups in Medicaid, especially for psychotropic medications. Medication, in conjunction with psychotherapy, may be appropriate for some conditions if other interventions have not helped, particularly for older children. Experts warn, however, that the practice of medicating young children should be reserved for those with severe conditions and only after careful consideration of alternative approaches. Yet studies have shown an upward trend in the prescription of psychotropic medications in recent years, with an estimated 1 to 2 percent of Medicaid-covered children under age 4 receiving prescriptions for at least one psychotropic drug, and higher rates for children diagnosed with specific mental or behavioral conditions such as ADHD or autism. Research is lacking on how these drugs may affect children's long-term neurological and behavioral development, making the increased use of psychotropic medications for young children a concern. In addition, many young children who take these medications do so without having received complete mental health assessments or oversight from a psychiatrist. Providers may be responding to a lack of availability or awareness of alternative treatment options, such as child psychotherapy. The increasing prevalence and potential risks of psychopharmacological treatment in children underscores the need for broader efforts to promote healthy emotional development and prevent and treat mental health problems in young children. Extending access to IECMH treatment can offer a broader range of options for providers seeking to help children and their families.

Young Children’s Mental Health is Often Overlooked in Policy and Practice

Despite the important role that mental health plays in children’s long-term development, federal and state policies could do more to promote IECMH.²⁴ Federal law, most recently under the Affordable Care Act (ACA), requires health payers, including Medicaid,²⁵ to ensure that access to mental health care is equal to that of physical health.²⁶ However, the move to a fully responsive and integrated mental health care system—while growing—is still nascent.²⁷ Even within mental health policy and systems, IECMH is often overlooked.²⁸ Attention to young children’s social and emotional health is growing, but the following obstacles, many related to broader health and mental health system challenges across public and private coverage sources, remain:

▶ Awareness

Some caregivers and primary healthcare providers may not be trained to recognize mental health disorders for young children, feel reticent to diagnose young children with mental health issues due to lack of familiarity with developmentally-appropriate diagnostic approaches or perceived stigma, and/or be unaware of the effective treatment options that are available (described below).²⁹ They may also be reticent to identify early warning signs for compromised healthy development because they do not feel equipped to offer any positive actions or response.

▶ Access

Even when pediatricians or other providers are able and willing to diagnose or refer for IECMH disorders, they may encounter challenges finding pediatric mental health professionals. A Substance Abuse and Mental Health Services Administration (SAMHSA) report highlights the lack of sufficient child and adolescent psychiatrists to meet the projected need for these services, especially in rural and low-income communities.³⁰ This shortage extends across disciplines to psychologists and other clinicians with specialized IECMH training.

▶ Accounting

If a child is referred to a mental health clinician for treatment, the provider may encounter challenges in obtaining reimbursement. Although all “medically necessary” services, including mental health, must be provided under EPSDT for Medicaid children, state definition and application of the medical necessity standard varies. In addition, lack of specific codes or clearly-defined billing procedures for a needed service creates confusion and administrative barriers for providers seeking reimbursement.

These challenges are not unique to young children but there is additional urgency to address their mental health needs. Expanding awareness and availability of IECMH services in the broader health and mental health systems offers an important opportunity to reduce or mitigate more complex and costly challenges later in life. Policymakers can promote healthy social and emotional development and improve IECMH promotion, prevention and treatment services for the young children and families who need them today.³¹



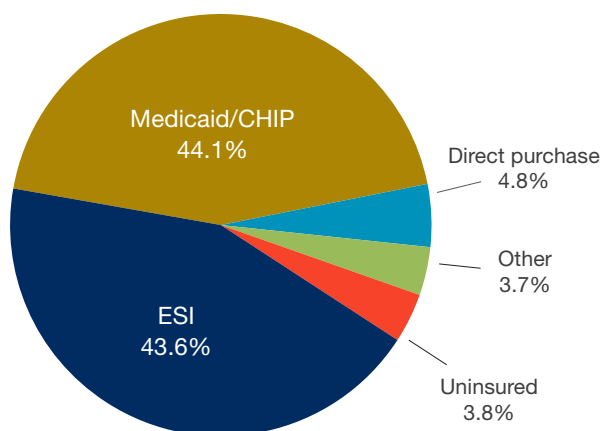
Medicaid is Well-Positioned to Advance Infant and Early Childhood Mental Health (IECMH)

As the primary health insurance source for young, low-income children, Medicaid is the logical system to reach them with their families before they enter school.³² More than one-third of all children rely on Medicaid and CHIP for health coverage, and the programs play an even greater role for the nation’s youngest children (See Figure 1). One in five parents of children aged 3 and younger were enrolled in Medicaid in 2016, a rate that will likely increase as more states take up the ACA option to expand Medicaid to low-income adults.³³ Medicaid’s purchasing power, along with state flexibility in program administration, provide an opportunity to lead broader health and mental health reforms that include attention on young children’s emotional development.³⁴

Medicaid’s Pediatric Benefit (EPSDT): A Pathway to Improved IECMH Services

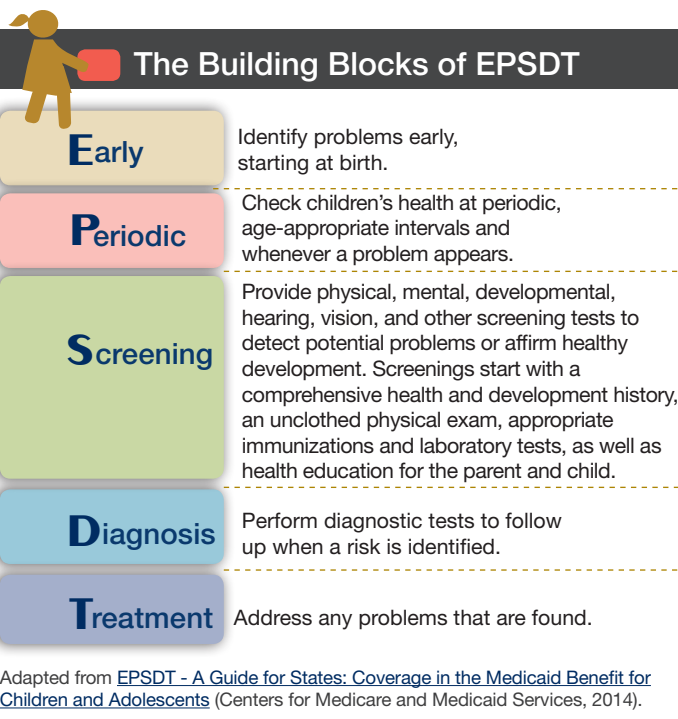
Medicaid’s pediatric benefit, called Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT), guarantees a comprehensive array of services for all children under age 21.³⁵ Each Medicaid-eligible child is entitled to recommended preventive screens, follow-up diagnostic assessments and, in turn, any resulting services a medical professional considers essential to prevent, treat, or improve the diagnosed condition.³⁶ This includes services considered “optional” for adults in Medicaid.³⁷ While the Medicaid statute itself does not specify mental health on the list of required services, it may be captured under a number of benefits categories, including physician services, clinic services, services provided by a licensed mental health or related professional, rehabilitation services, case management, and/or others (see Appendix A).³⁸ Statutory clarifications, federal guidance, and legal decisions against state Medicaid programs have clarified the inclusion of mental health services under EPSDT.³⁹

Figure 1. Sources of Health Coverage for Children Under Age 6, 2016



Source: Georgetown University Center for Children and Families tabulations of the 2016 U.S. Census ACS data from IPUMS.

Note: “Medicaid/CHIP” includes children covered by Medicaid or CHIP alone or in combination with other coverage sources.





State Levers for Change

States have wide flexibility in Medicaid program administration, above federal minimum requirements. Core state Medicaid functions include eligibility and enrollment, delivery system, payment, and quality improvement.⁴⁰ Functions most directly related to IECMH include:

▶ Delivery system

States determine how Medicaid services are provided, and have a variety of system design options. Most states contract with managed care organizations (MCOs) to ensure enrolled Medicaid beneficiaries receive needed care (see box).⁴¹ In these cases, the MCO, not the state, pays providers for services. Some states use fee-for-service arrangements (FFS) for some or all Medicaid beneficiaries, where the Medicaid agency reimburses providers directly. Certain services, such as mental health, may be carved out of managed care and provided by FFS or a separate MCO plan as a “wraparound” benefit.⁴² Beyond the movement toward managed care, many states are actively engaged in delivery system reforms, such as integration of primary care and behavioral health, an area ripe for IECMH.⁴³

▶ Payment and reimbursement

States set payment standards (e.g. rate ceilings or floors) for MCOs and providers. MCO and provider manuals often outline EPSDT requirements, including pediatric medical necessity, services, payment and approval processes. States can also designate additional types of professionals that may provide and bill for certain services, under specific circumstances, either through FFS or managed care.

▶ Quality and Performance Improvement

States oversee or conduct quality measurement and performance improvement activities and have the option to prioritize specific services or outcome measures.⁴⁴ States must require MCOs to have information systems that meet federal minimum standards and have the option to determine if additional data must be collected. State MCO contracts must specify data reporting and quality improvement requirements, including the establishment of a Quality Assessment and Performance Improvement Plan (QAPI) that includes performance improvement projects (PIP) and External Quality Review (EQR) activities.⁴⁵

Medicaid Managed Care: The Role of Managed Care Organizations (MCOs)

In most states, some or all Medicaid beneficiaries are enrolled in Medicaid managed care organizations (MCOs), private health plans that contract with the state under a capitated, or fixed, rate.⁴⁶ The majority of children in Medicaid are enrolled in MCOs, and the number is increasing as more states shift to managed care.⁴⁷ Medicaid MCOs often have latitude over decisions such as payment rates to network providers, utilization controls (e.g. prior authorization or service limits), and provider networks.⁴⁸

States have ultimate responsibility for ensuring Medicaid beneficiaries receive the care they need and are key to lasting systems-level change.

MCOs can be important change partners for stakeholders, child health advocates, and others seeking to increase access to IECMH. MCOs, for example, can pilot new projects or initiate changes that can impact access to care for children they enroll. But states have ultimate responsibility for ensuring Medicaid beneficiaries receive the care they need and are key to lasting systems-level change. State requests for proposals (RFPs) and contracts play a key role in ensuring MCOs adhere to EPSDT requirements. State contracts with MCOs, and MCO sub-contracts with providers, should clearly specify the responsibilities of each actor under EPSDT, including outreach to families, ensuring preventive screens and medically necessary services, and data reporting and performance requirements.⁴⁹

The Medical Necessity Standard for Children

Under EPSDT states must ensure each child receives any medically necessary treatment that results from screenings and/or diagnoses to “correct or ameliorate” a condition (See Appendix A).⁵⁰ Medical necessity is defined and applied inconsistently across Medicaid and private plans, and is often intended to be generalizable across populations served, which could miss addressing children’s unique developmental needs.⁵¹ While states and/or Medicaid MCOs define the scope and process for pediatric medical necessity determinations in Medicaid, states must use the following parameters:⁵²

- Decisions must be made on a case-by-case basis.
- States may not impose hard limits on pediatric services.
- States or plans may impose tentative “soft” limits on services (e.g. frequency or cap on treatments) pending an individualized medical necessity determination.
- Medicaid MCOs must not use a definition of medical necessity for children that is more restrictive than that used by the state.⁵³

State officials or MCOs may hesitate to approve a particular service due to a perceived or real lack of evidence on improved health outcomes.⁵⁴ Examples of services related to IECMH that may require additional justification for medical necessity include: behavioral health services, early intervention for developmental disabilities or other “educational” programs, rehabilitative services, and psychological testing.⁵⁵

What IECMH Services May Be Considered Medically Necessary?

Research supports specific IECMH diagnostic tools and interventions that can help to prevent or treat mental health disorders in infants and young children. Common diagnosis tools and systems used in the health system, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM), are geared toward older children and adults and do not reflect what is known about mental health disorders that may be first diagnosed in infancy and early childhood.⁵⁶ The DC:0-5™: *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*

provides research-based diagnostic criteria specific to young children. Its adoption and use can improve accuracy of age-appropriate diagnoses and allow for a common language for child-serving professionals.⁵⁷

A growing base of evidence also outlines the effectiveness of specific services. Dyadic interventions (i.e., involving the parent and the child together) are particularly effective in addressing mental health of infants and young children, especially when the child or family has experienced serious trauma.⁵⁸ Several common evidence-based interventions⁵⁹ include: Parent-Child Interaction Therapy (PCIT),⁶⁰ Child-Parent Psychotherapy (CPP),⁶¹ Attachment Biobehavioral Catch-up (ABC),⁶² and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).⁶³ For billing purposes, states may classify such treatments as individual and family therapy (Florida⁶⁴), family psychotherapy (Minnesota⁶⁵) or similar descriptions.





Recommendations

Without clear guidance or intentional effort to incorporate the unique developmental needs of young children, health and mental health systems often apply practices tailored for adults that may be inappropriate in pediatric care. And as knowledge and evidence about IECMH has grown, it has not fully translated to widespread system change. Medicaid agencies can ensure policies and practices match the latest evidence and meet the promise of EPSDT to not only ensure the right treatment but also catch problems early and prevent conditions from escalating. Recommendations below offer a starting place, but each state's beneficiaries and their families, providers, and others serving families in need will have the strongest sense of the opportunities and barriers in the Medicaid system. (Also see "Getting Started" on page 12.)

1. Improve preventive screenings based on expert-recommended schedules and guidelines.

States determine their own policies and guidelines for preventive care in Medicaid, including a periodicity schedule, or the state's reimbursement timetable for preventive screens. The AAP *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*⁶⁶ sets the standard for preventive care, providing an evidence-based template for well-child visits. Medicaid programs in 40 states and the District of Columbia use *Bright Futures* as the preventive care standard or use a similar standard.⁶⁷ Policies in 11 states do not align with *Bright Futures*, because their policies specify fewer well-child visits for young children and/or do not fully reflect preventive screening guidance.⁶⁸ Even among states with recommendations similar to *Bright Futures*, specific screening schedules and reimbursement policies vary.⁶⁹

Bright Futures recommends developmental screenings, maternal depression screenings, and social-emotional assessments for all young children. The most recent addition of expanded emphasis on identifying and responding to social determinants of health.⁷⁰ Actions states may consider specific to IECMH include:

- **Require Bright Futures-recommended IECMH-related screenings or assessments.** Most states adhere to *Bright Futures* universal screening/assessment recommendations in their preventive care guidelines with a few exceptions noted below for

children under age 4.⁷¹ At least six states do not specify or require universal screening for maternal depression in a well-child visit (Alabama, Massachusetts, Minnesota, Rhode Island, Utah, Wisconsin).⁷² At least two states (Alabama and Arizona) do not require universal psychosocial/behavioral assessments.⁷³ Alabama does not require universal developmental screenings.⁷⁴ (Note: Whether a state requires a particular assessment or screening is separate from how or whether the specific service is reimbursed. States may reimburse for a service that is not universally required, for example.)

- **Adopt clear guidelines and processes for referrals and follow-up services.** When a screen shows a need for further evaluation, a uniform tracking system from screening to diagnosis and any resulting treatment could help ensure consistency across providers and the potential for better data. States can streamline referral processes that indicate clear cross-sector responsibilities and feedback loops can aid understanding of whether children receive necessary referrals and follow-up care when a screen identifies a need. Thirty-three states promote standardized referral processes in at least one system to connect children or families to follow-up services such as early intervention.⁷⁵ States must set network adequacy standards to assure timely access to care. Validation of network adequacy is a required component of an External Quality Review (EQR) process.⁷⁶

2. Adopt diagnosis guidelines specific to young children's mental health.

Mental health disorders present differently in very young children and must be understood in the context of their relationships. To better ensure assessments and any resulting diagnoses most accurately reflect research and best practices with regard to young children's developmental stages, states can:

- **Encourage or require providers to use infant and early childhood mental health and developmental disorders (DC:0-5™).** Specific diagnoses, when appropriate, may be necessary to access the right type or amount of needed treatment. Adopting DC:0-5™ in Medicaid policy is an important, tangible step to improve assessment and diagnosis consistency across



providers and MCOs.⁷⁷ Seven states (Arkansas, Arizona, Colorado, Michigan, Minnesota, Nevada, and Oregon) require or recommend use the DC:0-5™ to diagnose and refer for services to support young children’s mental health.⁷⁸ Other states, like New Mexico, help build the state provider knowledge base by providing training on DC:0-5 to a range of health and early childhood professionals.⁷⁹

- **Allow multiple sessions for assessment or prevention services before making a diagnosis.** States should also allow sufficient time for preventive care and evaluation before a diagnosis is necessary. DC:0-5™ recommends a minimum of three to five sessions of at least 45 minutes for a full evaluation.⁸⁰ Colorado recently started allowing all Medicaid beneficiaries to receive mental health treatment in the primary care setting for up to six visits without a diagnosis.⁸¹ Other states, including North Carolina and Oregon, use pre-diagnosis billing codes to reimburse interventions for young children at risk of mental health disorders.⁸² This approach allows the needed time for mental health professionals to observe parent-child interactions over multiple visits, ideally in a range of settings including the home, to make the most accurate diagnosis.

3. Update or clarify payment policies and processes for needed IECMH services.

New and/or underutilized services may require explicit billing policy or guidance for providers from state Medicaid agencies or MCOs. State or MCO policy and procedure manuals or other resources for providers should explicitly signal an ability to bill for certain services. As they seek to clarify or update payment and billing processes, states should consider the following:

- **Add or adapt billing codes to aid tracking of service needs and use.** Sometimes states require billing codes for services, such as developmental screenings or psychotherapy, that do not capture the exact interventions specific to young children or their mental health. States or plans wanting to track IECMH-specific services may need to create new billing codes both to create financial incentives and provide for more accurate utilization.⁸³ At a minimum, states can provide detailed guidance to MCOs and provider about which codes should be used for certain IECMH interventions. For example, child advocates in

Virginia worked with state mental health and Medicaid agencies to map out current Medicaid reimbursable services and billing codes for young children to inform changes to MCO and provider billing manuals.⁸⁴

- **Support two-generation services that aid young children’s mental health.** Policymakers at all levels are increasingly identifying ways to promote approaches that nurture parent- or caregiver-child relationships central to children’s emotional health.⁸⁵ Recent federal guidance in outlines the ways states can use Medicaid to support services that aim to support a child’s healthy development through the quality of the parent-child relationship (see Appendix B).⁸⁶

States may also use a parent diagnosis to trigger eligibility for other supports or reimbursement for parent-child treatment. New York is developing additional guidance to clarify reimbursement for parent-child therapy under a child’s Medicaid eligibility when the parent or caregiver is diagnosed with a mood, anxiety, or substance abuse disorder. Michigan and Minnesota take a similar approach.⁸⁷

IECMH Approach or Service	No. of States Reimbursing in Medicaid
Child social-emotional screenings ⁸⁸ with a specific screening tool	43
Maternal or caregiver depression screening ⁸⁹ under child’s Medicaid enrollment during a well-child visit	32
Home visiting ⁹⁰ for pregnant/postpartum women and/or young children*	33
Dyadic/Parent-child treatment ⁹¹ (e.g. parent-child therapy) under child’s Medicaid enrollment	42
Parent programs ⁹² designed to help parents/caregivers promote their young children’s emotional development and address child mental health needs.	16

* Note: While it may include IECMH, home visiting encompasses services and supports that are broader than mental health.

Sources: S. Smith et al., “How States Use Medicaid to Cover Key Infant and Early Childhood Mental Health Services: 2018 update of a 50-state Survey,” (New York: National Center for Children in Poverty, 2018), and K. Gifford et al., “Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey” (Washington: Kaiser Family Foundation, April 2017).



- **Review the state definition and application of pediatric “medical necessity” to identify opportunities for improvement.** Understanding how the state’s pediatric medical necessity process works at the state, MCO, and provider levels may offer insight into possible treatment barriers. States set their own definitions and processes to determine pediatric medical necessity. For example, an AAP review of state pediatric medical necessity definitions found that forty states and Washington, D.C. incorporate a preventive care purpose into the definition they use, nine states do not, and one state does not have a pediatric medical necessity definition.⁹³

The AAP’s recommended definition of pediatric medical necessity offers an important standard that may guide states and MCOs:⁹⁴

“Health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals, such as the AAP, to promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities.”

4. Consider new settings or provider types for IECMH services to aid workforce challenges.

States have wide discretion, under federal parameters, to decide who is able to be reimbursed and where a service may be provided, especially under EPSDT.⁹⁵ While Medicaid alone can’t solve mental health workforce challenges, states can use their flexibility to broaden the range of trained and qualified mental health professionals or paraprofessionals as initial points for screening and early identification of possible needs. States could also require IECMH training or credentialing as a condition for reimbursement. States should consider the following settings or provider types for IECMH:

- **Improve access to IECMH services in early care and education settings.** Most states allow for IECMH services in home- and community-based settings and pediatric primary care practices.⁹⁶ States are also seeing the opportunity to connect to children and families in early care and education settings, where many children spend their days

while parents work. Thirty-five states allow individualized IECMH services to be provided by a qualified mental health specialist in early care and education settings, specific to treatment for an individual child and their family.⁹⁷ In thirteen of these states, mental health specialists may be reimbursed for consultations with early childhood teachers about specific interventions or supports to aid an individual child’s mental health needs.⁹⁸

- **Expand the range of qualified providers for IECMH.** States may consider new ways to expand the availability of trained providers to serve young children. In 2011, **Minnesota** began allowing doctoral- and masters-level clinical trainees, with adequate supervision, to provide IECMH services in Medicaid.⁹⁹

State agreements with managed care organizations (MCOs) can promote and prioritize IECMH

States use MCO request for proposals (RFPs) and contracts with individual plans to promote priorities. Increasingly states are using MCO RFPs and agreements to reflect and better track the young children’s social and emotional development. For example:

Virginia’s Medicaid agency included IECMH language in a request for proposals for plans competing to become Medicaid MCOs as well as the state’s model MCO contract.¹⁰⁰

As part of a statewide move to Medicaid managed care starting in 2019, **North Carolina** has worked to elevate support for young children through Medicaid MCO RFP language and supporting concept papers that will inform contracts. In the area of quality improvement, MCOs will be required to adopt three performance improvement projects based on a list of priority areas for the state, one of which is early childhood health and development.¹⁰¹



5. Include IECMH in broader Medicaid improvements and reforms.

Medicaid delivery and payment reforms are happening at the local, state and national levels. IECMH-trained professionals, child development experts, and other stakeholders should be invited to reform tables and consulted regularly to keep the mental health needs of young children front and center.

- **Address IECMH in Medicaid quality improvement efforts.** A focus on young children’s social-emotional health in Medicaid should seek to improve data collection and reporting. A comprehensive effort on young children’s health quality improvement can help determine where gaps exist or where additional or revised data may be necessary—this is especially important for IECMH. The [Child Core Set](#), federal Medicaid measures standardized for consistent reporting across states, and other data sets based on health payment data have few measures specific to young children’s social and emotional health.¹⁰² But states or MCOs may aim to develop and test quality measures related to IECMH. States, for example, could require or encourage MCOs to have an explicit focus on IECMH through a performance improvement project or related initiative (See box above).

Medicaid quality improvement efforts require close engagement with other child-serving systems—all of which rely on a strong foundation of young children’s mental health. For example, in **Oregon** and **New York**, Medicaid and education agencies have committed to use the shared goal of school readiness to inform improvements and move toward shared accountability across child-serving

systems.¹⁰³ States should adopt cross-system goals, with accompanying measures to track improvements, that include an explicit emphasis on the social-emotional and behavioral health needs of young children as they craft and implement cross-system action plans.¹⁰⁴

- **Elevate IECMH in broader reforms.** Medicaid can help to spread and sustain practice changes that both elevate the mental health of young children and address conditions before they become costlier down the road.¹⁰⁵ Popular Medicaid and health system reforms in states, such as alternative payment models or behavioral health integration in primary care, should explicitly address the needs of young children.¹⁰⁶ Many promising pediatric primary care models, for example, seek to support parents in nurturing their children’s healthy development.¹⁰⁷ On such model, HealthySteps for Young Children, integrates IECMH promotion and prevention support for parents into well-child visits, demonstrating a number of positive outcomes for children and their families. Research on the model in Colorado suggests savings in avoidable costs, particularly related to parent interventions.¹⁰⁸ Strong care coordination is one key element of successful behavioral health-pediatric primary care integration.¹⁰⁹ Most states (44) allow case management in Medicaid for IECMH.¹¹⁰ Medicaid reforms can also advance enhanced pediatric primary models that seek to address the social determinants of health through strengthened linkages between primary care, mental health, and social services at the community level.¹¹¹

Conclusion

Medicaid can do more to promote, prioritize, and ensure support for services that address young children’s mental health. While Medicaid alone cannot solve broader system challenges, such as the stigma attached to mental health issues or the need for more qualified providers, it can be a leader for improvements across payers and systems. The structural changes necessary to improve access to IECMH

require strong partnerships between Medicaid and the many systems that serve children: mental and behavioral health, early childhood, public health, child welfare, and others. Medicaid is an essential player to helping to ensure children’s social and emotional development is addressed early and in the context of their families and communities.

Getting Started: What Can Medicaid Do in Your State to Promote Young Children’s Emotional Development?



There are many places to begin to assess a state’s potential to do more for Infant Early Childhood Mental Health (IECMH) in Medicaid. The following questions may help to uncover possible opportunities for action.

- ▶ Do state or MCO policies, guidance, and/or practice suggest that mental health services and/or a specific service are not allowable for young children? Are providers under the impression that they would not be reimbursed for mental health services to children under 6?
- ▶ Does the state have a medical necessity definition for children that is comprehensive, prevention oriented, and inclusive of mental health (e.g. AAP recommended)? What is the process for establishing medical necessity at the state and/or MCO levels? Are there problems with approval of a specific service that seemingly meets medical necessity criteria for children with a specific diagnosis? Does the state or MCO deny additional services beyond a specified limit, even if the provider deems them medically necessary?
- ▶ Does Medicaid require or allow use of DC:0-5 for diagnosis? If so, is it detailed in Medicaid provider and MCO plan manuals? Is the policy clear for children in both fee-for-service and managed care arrangements (as applicable)? Does the state offer training for Medicaid providers on its use?
- ▶ Are IECMH-related services explicitly included in EPSDT MCO plan and/or provider manuals?
- ▶ Are the provider billing, referral, and treatment processes explicit and well-understood for IECMH services?
- ▶ Does the state support dyadic/parent-child treatment under the child’s Medicaid eligibility?
- ▶ Are the state’s managed care plans incorporating IECMH in their promotion or quality improvement efforts (e.g. performance improvement plan, or PIP)? Would the state consider encouraging MCOs to develop PIPs with key measures to track improved access to IECMH for children/families in need?
- ▶ Do new provider types or settings need to be recognized in state Medicaid policy to strengthen access to IECMH services?
- ▶ In what ways are young children’s mental health needs addressed in broader Medicaid reforms (e.g. payment reforms such as value-based purchasing, or delivery system reforms such as primary care-behavioral health integration or health homes)?



For More Information

From Georgetown University Center for Children and Families:

[Promoting Young Children's Healthy Development in Medicaid and CHIP](#) (October 2018).

[EPSDT: A Primer on Medicaid's Pediatric Benefit](#) (Georgetown University Center for Children and Families, March 2017)

EPSDT Webinar Series (with the American Academy of Pediatrics)

- [EPSDT Education for Providers and Advocates](#) (July 2018)
- [Medical Necessity and EPSDT: Tools for Providers and Advocates](#) (September 2018)
- [When to Engage the Legal Community](#) (October 2018)

From ZERO TO THREE:

[Infant and Early Childhood Mental Health \(IECMH\) Policy Series](#)

[Planting Seeds in Fertile Ground: Steps Every Policymaker Should Take to Advance Infant and Early Childhood Mental Health](#) (May 2016).

[Advancing Infant and Early Childhood Mental Health: The Integration of DC:0-5™ Into State Policy and Systems](#) (July 2018)

[Expanding Infant and Early Childhood Mental Health Supports and Services: A Planning Tool for States and Communities](#) (February 2018).

Additional Resources:

[How States use Medicaid to Cover Key Infant and Early Childhood Mental Health Services: 2018 update of a 50-state Survey](#) (National Center for Children in Poverty, November 2018)

[A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health](#) (Child and Family Policy Center, October 2018)

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APPENDIX A: What Services Must Medicaid Provide to Children Under EPSDT?

Mandatory Services

- ✓ Family planning services and supplies
- ✓ Federally Qualified Health Clinics and Rural Health Clinics
- ✓ Home health services
- ✓ Inpatient and outpatient hospital services
- ✓ Laboratory and X-Rays
- ✓ Medical supplies and durable medical equipment
- ✓ Medication-assisted treatment*
- ✓ Non-emergency medical transportation
- ✓ Nurse midwife services
- ✓ Pediatric and family nurse practitioner services
- ✓ Physician services
- ✓ Pregnancy-related services
- ✓ Tobacco cessation counseling and pharmacotherapy for pregnant women

Other Services – Required under EPSDT

(Optional for adults, but required for children if deemed medically necessary based on a screening)

- ✓ Chiropractic services
- ✓ Clinic services
- ✓ Critical access hospital services
- ✓ Dental services
- ✓ Dentures
- ✓ Emergency hospital services (in a hospital not meeting certain federal requirements)
- ✓ Eyeglasses
- ✓ Home and Community Based Services
- ✓ Inpatient psychiatric services for individuals under age 21
- ✓ Intermediate care facility services for individuals with intellectual disabilities
- ✓ Optometry services
- ✓ Other diagnostic, screening, preventive and rehabilitative services
- ✓ Other licensed practitioners' services
- ✓ Physical therapy services
- ✓ Prescribed drugs
- ✓ Primary care case management services
- ✓ Private duty nursing services
- ✓ Prosthetic devices
- ✓ Respiratory care for ventilator dependent individuals
- ✓ Speech, hearing and language disorder services
- ✓ Targeted case management
- ✓ Tuberculosis-related services

* Time-limited (January 1, 2020 – September 30, 2025).

Sources: Social Security Act § 1905(a), 1905(r), Section 1006 (b) of P.L. 115-271.

APPENDIX B: Federal Medicaid Guidance and Opportunities Related to Children’s Social and Emotional Health

[Tri-Agency Letter on Trauma-Informed Treatment](#)

(Department of Health and Human Services, July 11, 2013).

[Prevention and Early Identification of Mental Health and Substance Use Conditions](#)

(Centers for Medicaid and CHIP Services, Informational Bulletin, March 27, 2013).

[EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents](#)

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[Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children](#)

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[The Early and Periodic Screening, Diagnostic and Treatment \(EPSDT\) benefit for children and youth in managed care](#)

(Centers for Medicaid and CHIP Services, Informational Bulletin, January 5, 2017).

[Neonatal Abstinence Syndrome: A Critical Role for Medicaid in the Care of Infants](#)

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[Integrated Care for Kids \(InCK\) Model](#)

(Centers for Medicare and Medicaid Services, August 2018).

[Maternal Opioid Misuse \(MOM\) Model](#)

(Centers for Medicare and Medicaid Services, October 2018).

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- ¹⁰¹ Each MCO will be required to undertake at least three performance improvement projects (PIPs) as part of the annual quality review and improvement efforts, as approved by the Medicaid agency. MCOs shall conduct at least one (1) non-clinical PIP will also be required to conduct two (2) clinical PIPs annually related to the following areas: a) Pregnancy Intendedness; b) Tobacco Cessation; c) Diabetes Prevention; d) Birth outcomes; e) Early childhood health and development; f) Hypertension; and g) Behavioral Health Integration. See p. 173 "[Addendum 1 - RFP 30-19029-DHB Section V. Scope of Services "Requests for Proposals \(RFPs\) and Requests for Information \(RFIs\)"](#)" (NC Department of Health and Human Services, 2018).
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¹⁰⁸ Buchholz et al., "Early Childhood Behavioral Health Integration Activities and Healthy Steps: Sustaining Practice, Averting Cost," *APA Clinical Practice in Pediatric Psychology*, Vol 6, No. 2 (2018), 140-151.

¹⁰⁹ E.T. Tyler et al., "[Behavioral Health Integration in Pediatric Primary Care: Considerations and Opportunities for Policymakers, Planners, and Providers](#)" (New York: Milbank Memorial Fund, March 2017).

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¹¹¹ K. Johnson and C. Bruner, *[A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health](#)* (Child and Family Policy Center, 2018).