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Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

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

Part III: Medicaid and IECMH

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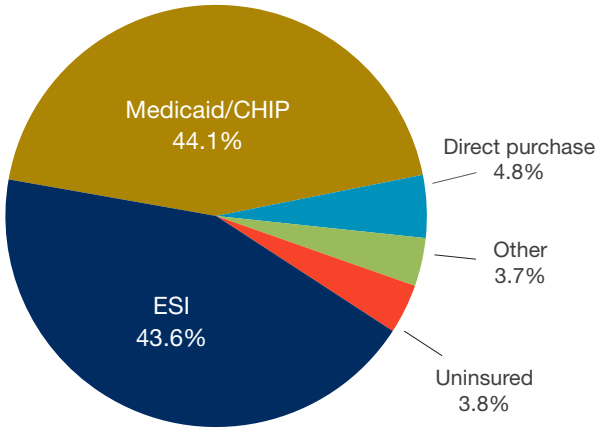
Medicaid is Well-Positioned to Advance Infant and Early Childhood Mental Health (IECMH)

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. 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. 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.

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

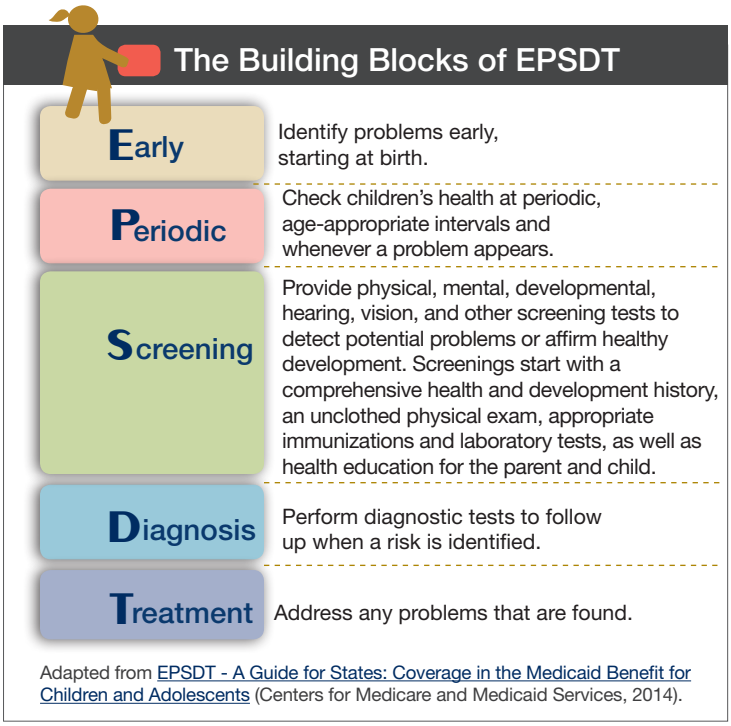
Medicaid's pediatric benefit, called Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT), guarantees a comprehensive array of services for all children under age 21. Each Medicaid-eligible child is entitled to recommended preventive screens, follow-up diagnostic assessments and, in turn, any resulting services a medical professional considers essential to prevent, treat, or improve the diagnosed condition. This includes services considered "optional" for adults in Medicaid. 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). Statutory clarifications, federal guidance, and legal decisions against state Medicaid programs have clarified the inclusion of mental health services under EPSDT.

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.



Adapted from EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents (Centers for Medicare and Medicaid Services, 2014).

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. 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). 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. 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.

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 The majority of children in Medicaid are enrolled in MCOs, and the number is increasing as more states shift to managed care. 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.

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.

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. 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.

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). 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. While states and/or Medicaid MCOs define the scope and process for pediatric medical necessity determinations in Medicaid, states must use the following parameters:

- 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.

State officials or MCOs may hesitate to approve a particular service due to a perceived or real lack of evidence on improved health outcomes. 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.

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. 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.

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. Several common evidence-based interventions[59] include: Parent-Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP), Attachment Biobehavioral Catch-up (ABC), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). For billing purposes, states may classify such treatments as individual and family therapy (**Florida**), family psychotherapy (**Minnesota**) or similar descriptions.

See the full report at https://ccf.georgetown.edu/2018/11/21/using-medicaid-to-ensure-the-healthy-social-and-emotional-development-of-infants-and-toddlers/. This report is a collaboration between Georgetown Uninversity's Center for Children and Famlies, and the Think Babies campaign, a project of ZERO TO THREE.