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

Part IV: Recommendations and Conclusion

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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. 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. Even among states with recommendations similar to *Bright Futures*, specific screening schedules and reimbursement policies vary.

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. 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. 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). At least two states (Alabama and Arizona) do not require universal psychosocial/behavioral assessments. Alabama does not require universal developmental screenings. (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. 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.

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. 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. 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.
- **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.

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. Other states, including North Carolina and Oregon, use pre-diagnosis billing codes to reimburse interventions for young children at risk of mental health disorders. 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. 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.
- **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. 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).

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.

IECMH Approach or Service	No. of States Reimbursing in Medicaid
Child social-emotional screenings with a specific screening tool	43
Maternal or caregiver depression screening under child’s Medicaid enrollment during a well-child visit	32
Home visiting 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 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:

“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. 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. 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. 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.
- **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.

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.

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.

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. 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.

- **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. 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. Many promising pediatric primary care models, for example, seek to support parents in nurturing their children's healthy development. 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. Strong care coordination is one key element of successful behavioral health-pediatric primary care integration. Most states (44) allow case management in Medicaid for IECMH. 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.

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. But states or MCOs

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.

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 University’s Center for Children and Families, and the Think Babies campaign, a project of ZERO TO THREE.

