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Using Medicaid to Help Young Children and Parents Access Mental Health Services*

RESULTS OF A 50-STATE SURVEY

*Updated March 2017



National Center for Children in Poverty

COLUMBIA UNIVERSITY | MAILMAN SCHOOL
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Using Medicaid to Help Young Children and Parents Access Mental Health Services: Results of a 50-State Survey

Acknowledgments

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Introduction	2
Screening with a Tool Designed to Identify Young Children Who May Need Further Evaluation for Social-Emotional and Behavioral Difficulties	4
Screening for Maternal Depression During Visits to a Pediatrician or Family Medicine Provider with Coverage Under the Child’s Medicaid	7
Services Provided by a Mental Health Clinician to Address a Child’s Mental Health Needs in a Pediatric or Family Medicine Setting	10
Services Provided by an Early Childhood Mental Health Specialist to Address a Child’s Mental Health Needs in Child Care and Early Education Programs	13
Services Provided by a Mental Health Clinician in the Home Setting to Address a Young Child’s Mental Health Needs	15
Dyadic (Parent-Child) Treatment	17
Parenting Programs Designed to Help Parents of Young Children Promote Children’s Social-Emotional Development and Address Child Mental Health Needs	19
Behavioral Health Case Management/Care Coordination for a Young Child (0-6 Years)	21
Summary	24
Recommendations	25
References	26

Introduction

An increasing number of states are investing in the well-being and success of young children by expanding mental health services in pediatric, home, and community settings. These efforts reflect substantial evidence about the central role that young children’s mental health plays in their early learning and school readiness, long-term school success and self-sufficiency, and future health and mental health outcomes.¹ As states work to strengthen supports for young children’s mental health, often with the goal of reducing the incidence of costly conditions at later ages, they face the question of how to finance new or expanded services.

This brief examines states’ use of Medicaid as a key source of funding for early childhood mental health (ECMH) services. It presents the results of a 50-state survey that gathered information from state administrators about Medicaid coverage of the following services for children from birth to age 6:

- Child screening for social-emotional problems
- Maternal depression screening in pediatric and family medicine settings
- Mental health services in a pediatric or family medicine setting
- Mental health services in child care and early education settings
- Mental health services in the home setting
- Dyadic (parent-child) treatment
- Parenting programs to address child mental health needs
- Case management/care coordination

In addition to asking about whether states cover each type of service, the survey also collected information about policies related to coverage. These included requirements that providers use evidence-based screening tools or treatment models, service eligibility criteria, and rules about the frequency or amount of service allowed. The results of the survey can help stakeholders from a variety of sectors, including advocates, Medicaid

administrators, and leaders in early childhood and philanthropy, examine options for improving Medicaid coverage of ECMH services and the quality of covered services.

The following sections present background information and survey results:

- Rationale for Medicaid Coverage of Key ECMH Services
- Survey Methods
- Survey Results
- Recommendations

Medicaid as a Key Source of Funding for ECMH Services

Under Medicaid’s Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit, health care providers are required to offer periodic developmental and behavioral health screenings, diagnostic assessments for children with positive screens, and treatment for identified conditions.² All medically necessary services must be covered, regardless of whether they are included in the state Medicaid plan. The Centers for Medicare and Medicaid Services (CMS) recommends the use of child screening resources from Birth to Five: Watch Me Thrive!, an initiative of the U.S. Departments of Education and Health and Human Services that includes a detailed guide to help pediatric health care providers establish regular behavioral health screening in their practices.³

Recent CMS guidance that highlights the prevalence of maternal depression and its harmful effects on young children informs states that they may allow pediatric health care providers to bill for maternal depression screening under the child’s Medicaid during well-child visits.⁴ This guidance also tells states that Medicaid can cover treatment related to maternal depression under the child’s Medicaid if the child is present and if the treatment directly benefits the child. An example of this type of intervention is dyadic

(parent-child) treatment, which is available in several evidence-based models.⁵

Overall, CMS rules and guidance convey strong support for Medicaid coverage of key ECMH services. The EPSDT screening requirements and provision that requires medically necessary services even when services are not included in a state plan might suggest that states do not need to consider the scope of covered child behavioral health services in their state plan. However, EPSDT rules have fallen short of ensuring the delivery of needed prevention and treatment services to children.⁶ When health care providers must “make the case” for a service not covered in a state plan, service delivery can be stalled, and providers who do not know about the EPSDT provision are not likely to offer services outside of the state plan. As the survey results will show, many states are including key ECMH services in their state Medicaid plans, moving toward strong alignment with the goals of EPSDT while reducing barriers to the delivery of mental health services for young children.

Survey Methods

The Early Childhood Mental Health (ECMH) Medicaid Survey was administered as a telephone interview to respondents. Interviewers were National Center for Children in Poverty (NCCP) research staff and third-year law students in a health policy course at Brooklyn Law School who were trained to conduct the survey. Interviewers contacted Medicaid directors in each state with a standard description of the survey and an invitation to participate or to designate an appropriate person in the Medicaid office to participate. Through one or more communications by e-mail and phone, an appropriate respondent was identified in 48 states and the District of Columbia who agreed to participate. Respondents included administrators from various offices within the states’ Medicaid agencies, including EPSDT and behavioral health services.

Survey participants received a copy of the survey prior to a scheduled phone interview. Many participants completed the survey in advance of the call, and confirmed or expanded on answers during the call. Phone interviews lasted from 45 to 90 minutes. In several states, respondents consulted with others outside the phone call and invited colleagues to take part in the phone interview to help ensure that they would be able to provide accurate and comprehensive information.

The survey asked participants about Medicaid payment, through fee-for-service and managed care, for key services: child screening for social-emotional problems; maternal depression screening in pediatric settings; mental health services in pediatric settings, early care and education settings, and the home; dyadic (parent-child) treatment; parenting programs; and behavioral health case management and care coordination. For each service, additional questions were asked about specific policies related to service access and quality. These included questions about whether there are limits on the amount of the Medicaid-covered service that can be provided; whether providers are required to use evidence-based screening or assessment tools, treatment models, and practices; specific services covered under broad treatment categories; places where the service can be provided; and factors used to determine eligibility for the service. Open-ended questions within sections about particular services asked respondents to clarify or expand on their responses, as needed.

After the interview, NCCP research staff reviewed the surveys and made notes of any responses that seemed unclear or inconsistent. These were typically minor. States were then contacted again and asked to review their survey responses for accuracy and to respond to any questions resulting from the NCCP staff review of responses. Several reminder calls were made to key contacts in states until the majority of states (44 states or 92 percent) provided confirmation of the accuracy of their responses.

Survey responses were analyzed to provide descriptive statistics about most responses. States selected for follow-up calls (Michigan, Minnesota, Oregon, and the District of Columbia) provided additional information about Medicaid-covered services, supports for implementation, and selected policies by phone and through e-mail exchanges.

Survey Results

The next sections provide results of state administrators’ responses to questions about whether their state’s Medicaid plan provides coverage for six key early childhood mental health (ECMH) services and questions about related policies. The results are presented for each ECMH service included in the survey. A summary of states’ coverage of ECMH services through Medicaid fee-for-service and managed care is provided in Figure 9 at the end of the report.

Screening with a Tool Designed to Identify Young Children Who May Need Further Evaluation for Social-Emotional and Behavioral Difficulties

State administrators were asked if the state Medicaid plan covers social-emotional screening for young children with a tool specifically designed for this purpose.

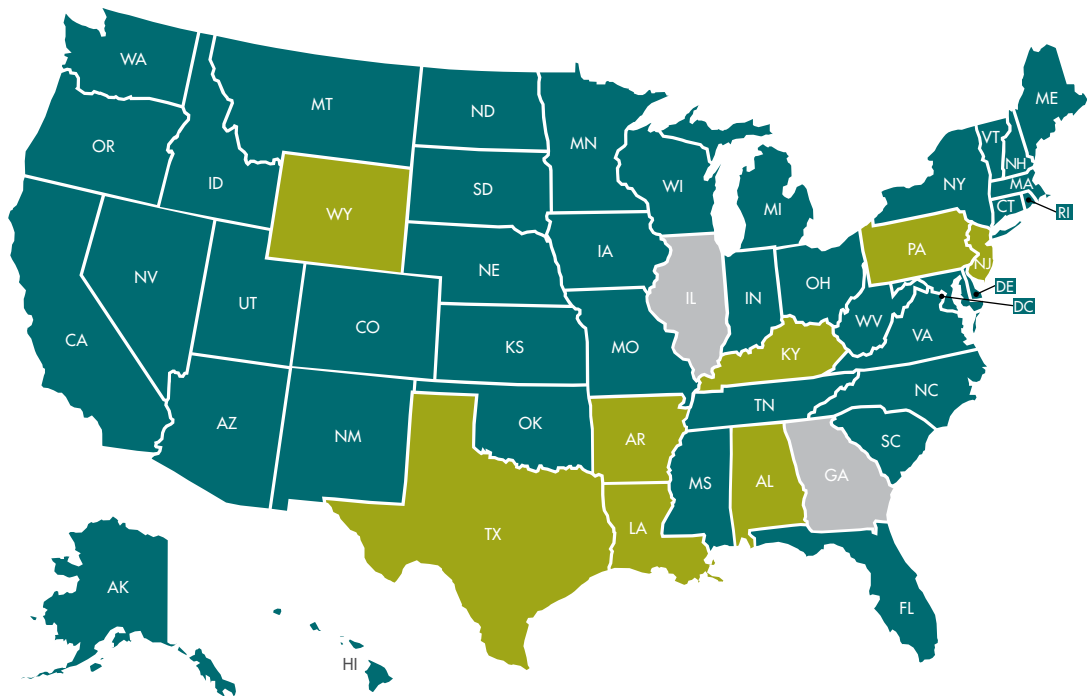
- 41 states (84 percent) reported that Medicaid covers social-emotional screening of young children with a specific tool; 8 states (16 percent) do not cover this screening

The availability of a separate service code (known as a CPT or Current Procedural Terminology code) for social-emotional screening allows states to track providers' delivery of this service,

including the percentage of children at different ages who are screened. Because social-emotional screening with a valid instrument can identify more young children at-risk of behavioral health problems than general developmental screening, states may have a special interest in tracking the social-emotional screening of young children.⁷ The District of Columbia's Department of Healthcare Finance is developing a new code for mental health screening that will help the District track the number of social-emotional screenings conducted and the number of positive screens (see *Support for Pediatric Practices to Conduct Mental Health Screening: District of Columbia*).

States with Medicaid-Covered Social-Emotional Screening

- Covers S-E screening
- Does not cover S-E screening
- Not included in survey



- Among states that cover social-emotional screening, 18 states (44 percent) reported having a separate code for this service: CA, CO, CT, DE, IA, IN, KS, MA, MN, MS, NC, ND, NV, OK, SC, VA, VT, and WV

The survey asked whether Medicaid rules allow social-emotional screening on the same day as a general developmental screen. The opportunity to screen young children for both social-emotional and other developmental problems on the same day allows providers to better understand children’s needs. They might, for example, identify social-emotional problems *and* language or other developmental delays that would be important to document in a referral for evaluation by the Part C Early Intervention or Part B Preschool Special Education Program.

- Among states with Medicaid coverage for social-emotional screening, 29 states (71 percent) reported that same-day social-emotional and developmental screenings are permitted: AZ, CA, CO, CT, DC, DE, HI, IA, ID, KS, MA, MI, MN, MS, NC, ND, NH, NM, NV, NY, OH, OK, RI, SC, TN, UT, VA, VT, and WV

A high percentage of states that pay for social-emotional screenings cover these screenings when they are conducted outside of medical settings.

- 27 states (66 percent) reported that a social-emotional screening can be administered in a nonmedical setting; states reported a variety of allowed nonmedical settings for social-emotional screening:
 - 22 states (81 percent): home or foster home
 - 21 states (78 percent): early care and education program
 - 20 states (74 percent): Part C Early Intervention session in home or community setting
 - 19 states (70 percent): shelter (e.g., homeless shelter, domestic violence shelter)
 - 19 states (70 percent): other community setting (e.g., family resource center, WIC clinic)

Support for Pediatric Practices to Conduct Mental Health Screening: District of Columbia

Health care providers often need guidance and support when they begin to increase social-emotional screening under Medicaid. In the District of Columbia (DC), a public-private partnership known as the DC Collaborative for Mental Health in Pediatric Primary Care led a 15-month learning collaborative to train pediatric providers in the use of mental health screening tools, beginning in early 2014.

The learning collaborative featured monthly webinars about how to integrate screenings into well-child visits, discuss mental health issues with families, and refer families for services. Practices also received technical assistance delivered on-site and by telephone, and resources to help them conduct and use the results of screenings to respond to children’s mental health needs, including the Ages & Stages Questionnaire: Social-Emotional starter kit, the American Academy of Pediatrics Mental Health Toolkit, and an online compendium of community-based behavioral health resources in the DC.

Providers received up to 54 hours of continuing medical education credits and American Board of Pediatrics or American Board of Family Medicine Part-IV

Maintenance of Certification credits. In the 10 practices that participated actively throughout the entire 15-month learning collaborative, chart review data showed that mental health screening rates rose from 1 to 73 percent.

Since the end of the learning collaborative in 2015, DC Mental Health Access in Pediatrics (DC MAP) has taken the lead in offering DC pediatric practices training and support concerning mental health screening. DC MAP delivers information and guidance through webinars, newsletters, and phone consultations provided by a multidisciplinary staff of behavioral health specialists. Pediatricians who call DC MAP with concerns about child mental health issues, including results of a positive screen, receive a consultation within 30 minutes.

DC Medicaid recently increased the rate of reimbursement for mental health screenings conducted during a well-child visit to encourage providers to conduct them. Currently, DC Medicaid is developing modifiers for the codes providers use for billing that will indicate a child had an elevated screening score or received a referral as a result of the screen.

SOURCE Colleen Sonosky, Associate Director, Division of Children’s Health Services, Health Care Delivery Management Administration, DC Dept. of Health Care Finance (July 2016)

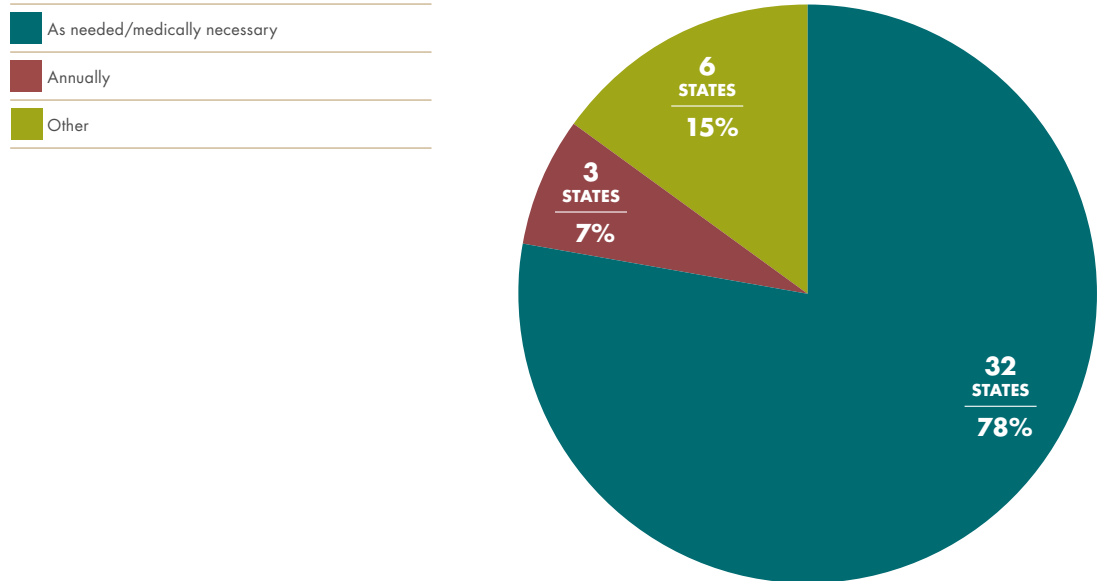
18 states have a separate code for social-emotional screening of young children. States can track the delivery of social-emotional screening with a separate code to see if goals set by state child mental health plans or initiatives designed to increase rates of screening are being met. DC is developing codes for social-emotional screening that will show whether a screen was positive and resulted in a referral for evaluation.

States that cover social-emotional screening reported on whether providers are required to use specific types of screening tools.

- 17 states (41 percent) require a validated social-emotional screening tool
- 9 states (22 percent) allow only specific tools (e.g., ASQ-SE, DECA, SWYC)⁸
- 15 states (37 percent) allow any social-emotional screening tool

When asked about the allowed frequency of social-emotional screening covered by Medicaid, the majority of states (32 states or 78 percent) reported that this screening can be administered “as needed” or based on medical necessity, 3 states (7 percent) allow annual screening, and the remaining 6 states (15 percent) place various limits on the number of allowed screenings (e.g., covered screenings are tied to EPSDT visits, vary by age). See Figure 1.

FIGURE 1 How Often Can a Social-Emotional Screening Be Conducted?



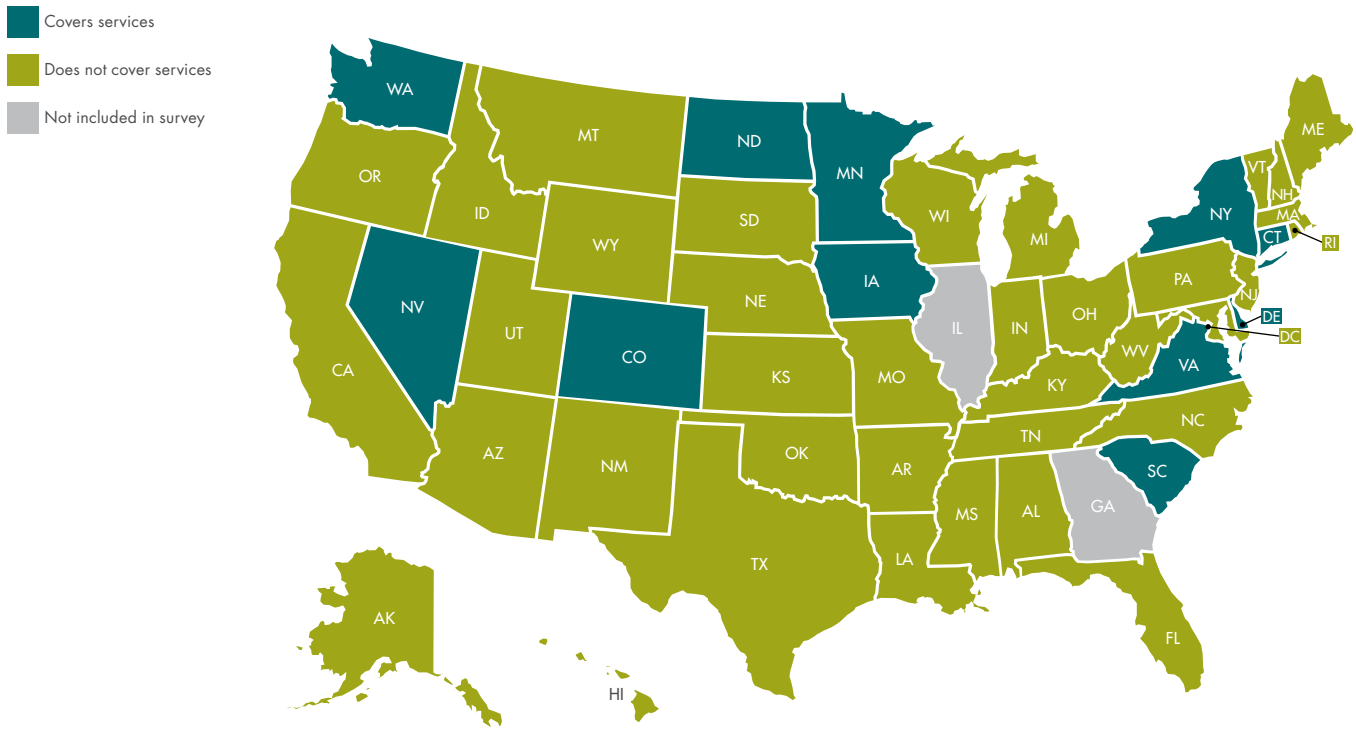
Screening for Maternal Depression During Visits to a Pediatrician or Family Medicine Provider with Coverage Under the Child's Medicaid

State administrators were asked whether Medicaid covers maternal depression screening in pediatric and family medicine settings, under the child's Medicaid. This question specified coverage under the *child's* Medicaid because this coverage helps ensure the widest screening; in a well-child visit, pediatricians and other providers have ready access to the child's Medicaid information for routine billing, plus not all mothers will be covered by Medicaid. This is the case for mothers in the 19 states that still have not expanded Medicaid under the Affordable Care Act and for mothers who may lose coverage due to a

lower income threshold for Medicaid eligibility following pregnancy.⁹

- 11 states (22 percent) reported that Medicaid pays for maternal depression screening during pediatric or family medicine visits, under the child's Medicaid; 38 states (78 percent) reported they do not cover maternal depression screening under the child's Medicaid
- Among states covering maternal depression screening, 4 states also pay for depression screening of other primary caregivers (CO, IA, MN, and WA)

States That Cover Maternal Depression Screening Under Child's Medicaid



States that cover depression screening under the child’s Medicaid reported on whether providers are required to use specific types of depression screening tools.

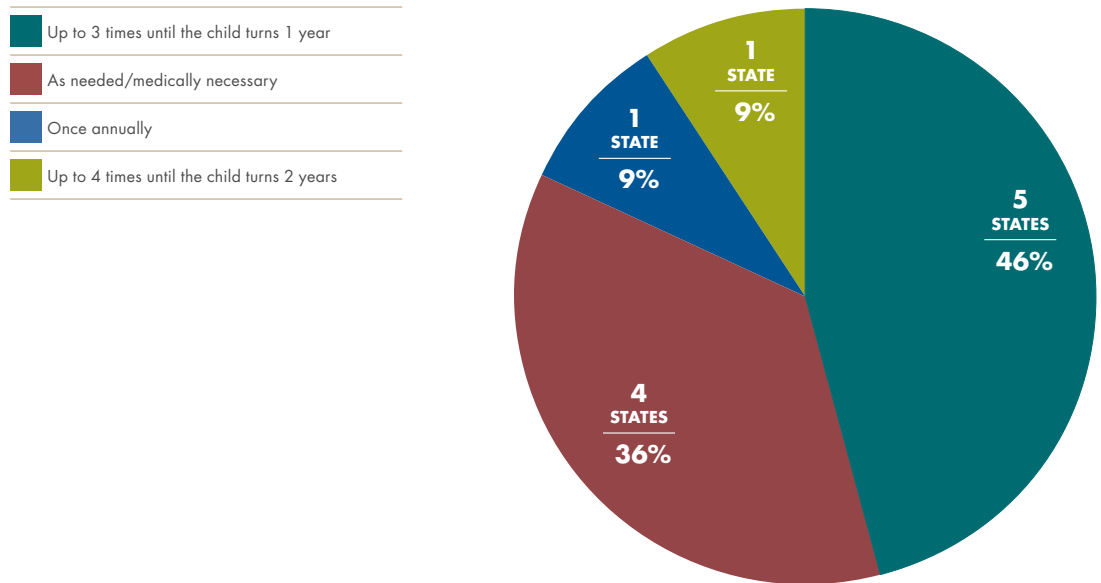
- 6 states (55 percent) require the use of a validated depression screening tool
- 3 states (27 percent) only allow the use of specific tools (e.g., Edinburgh Postnatal Depression Scale, Patient Health Questionnaire-2, Patient Health Questionnaire-9)
- 2 states (18 percent) allow the use of any depression screening tool

Among the states that pay for depression screening under the child’s Medicaid, 4 states (36 percent) allow screening on an “as needed” or “medically necessary” basis; IA, WA, DE and CT; 1 state (9 percent) limits screening to once a year; and the remaining 6 states (55 percent) place various limits on the number and duration of allowable depression screening (see Figure 2).

Most of the states that cover maternal depression screening under the child’s Medicaid in pediatric and family medicine settings also report that screening in nonmedical settings is allowed.

- 6 states (55 percent) reported that maternal depression screening can be administered in nonmedical settings; the following are settings where depression screening can be provided and paid for by Medicaid:
 - 5 states (83 percent): home/foster home
 - 5 states (83 percent): shelter (e.g., homeless shelter, domestic violence shelter)
 - 5 states (83 percent): other community setting (e.g., family resource center, WIC clinic)
 - 4 states (67 percent): early care and education program
 - 4 states (67 percent): Part C Early Intervention session in home or community setting

FIGURE 2 How Often Can a Maternal Depression Screening Be Conducted?



Minnesota: Maternal Depression Screening

In November 2015 the Minnesota Department of Health (MDH) released clinical guidelines for implementing universal postpartum depression (PPD) screenings in well-child visits. The guidelines provide information about the importance of screening for PPD during well-child visits, an outline and example of an ideal work flow, potential interventions, documentation practices for PPD screening in well-child visits, scripts to guide staff and providers on the PPD screening and referral process, advantages and disadvantages to consider when deciding on which well-child visits to schedule PPD screenings, factors to consider when selecting a validated tool, Minnesota Medicaid billing information, and information on resources for parents and providers. The guidelines also provide specific instructions for how the provider should respond to different screening results, including guidance about how to connect a parent with a mild or moderate score to a mental health care provider and critical steps to take when a parent or caregiver has a high or “crisis” score.

PPD screening is a recommended practice in Minnesota’s Early Periodic Screening and Treatment (EPSDT) program and is covered under the child’s Medicaid, up to 6 times for any caregiver of a child less than 13 months old when providers use any of the following evidence-based tools: Patient Health Questionnaire-9 (PHQ-9), Edinburgh

Postnatal Depression Scale (EPDS), and Beck Depression Inventory (BDI). The clinical guidelines also highlight the need for heightened attention to the social-emotional and developmental needs of children whose parents’ or caregivers’ screenings indicate potential mental health concerns, and suggest screening in both of these domains at each well-child visit.

The MDH trains providers to implement PPD screenings in well-child visits through group trainings, webinars, and technical assistance. In the summer of 2016, MDH launched a third cohort of the Postpartum Depression Screening Quality Improvement Project (PPDQIP), a 12-month learning collaborative that supports universal maternal depression screening. Clinics interested in starting universal screening for depression attend 2 4-hour, in-person sessions, participate in technical assistance phone calls and 2 webinars, and receive technical assistance site visits. They also submit monthly data on the number of completed screens, number of screens with a positive score, and number of people with positive scores who received an intervention. The 13 clinics that participated in the first 2 cohorts of the PPDQIP screened 2,885 parents; this represented a significant improvement for all of the clinics since none had conducted universal screening prior to participating in the project.

SOURCES Minnesota Department of Health: Maternal and Child Health section. Clinical Guidelines for Implementing Universal Postpartum Depression Screening in Well Child Checks. November 2015. www.health.state.mn.us/divs/cfh/topic/pmad/content/document/pdf/ppdguide.pdf

Tessa Wetjen, Principal Planner, Minnesota Dept. of Health, Maternal and Child Health. (July 2016)

11 states reported they pay for maternal depression screening under the child’s Medicaid. States that allow billing under the child’s Medicaid ensure the widest access to maternal depression screening because pediatricians and other providers have ready access to the child’s Medicaid information for routine billing, plus mothers not covered by Medicaid can still be screened.

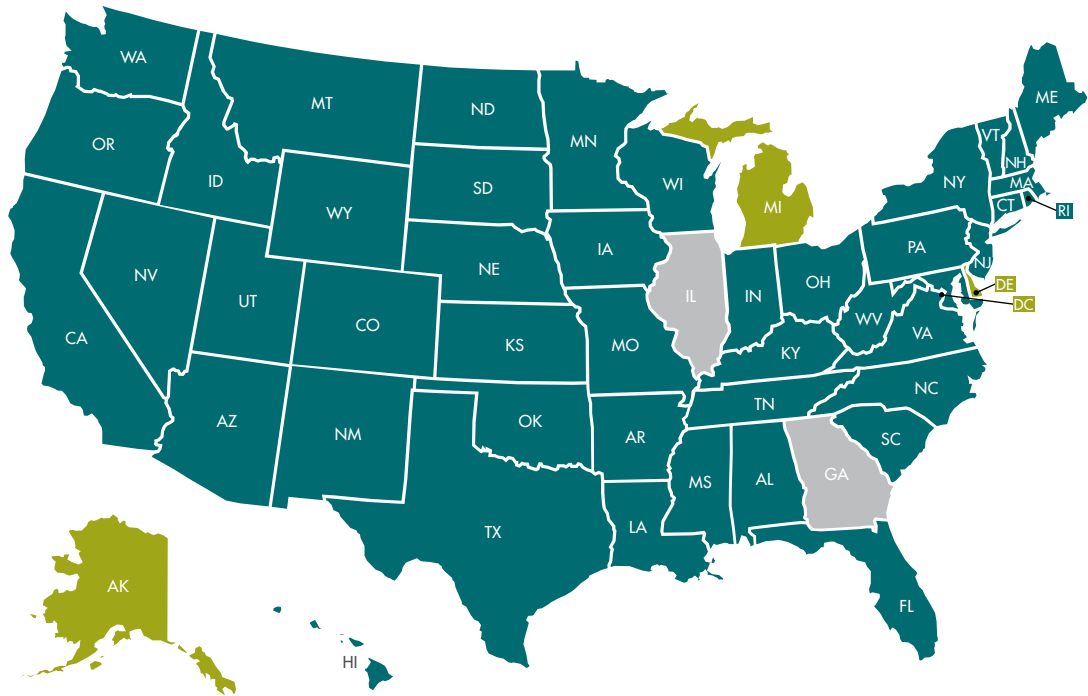
Services Provided by a Mental Health Clinician to Address a Child’s Mental Health Needs in a Pediatric or Family Medicine Setting

The survey asked whether Medicaid covers the services of a mental health clinician, working in a pediatric or family medicine setting, to address a child’s mental health needs. This type of coverage allows for the integration of health care and behavioral health care, a model that can greatly increase children’s access to mental health services.¹⁰

■ 45 states (92 percent) reported that Medicaid pays for a mental health clinician to address a child’s mental health needs in a pediatric or family medicine setting; 4 states (8 percent) reported that they do not cover this service

States With Medicaid-Covered ECMH Services in a Pediatric/Family Medicine Setting

- Covers services
- Does not cover services
- Not included in survey



Medicaid-covered services of a mental health clinician in a pediatric or family medicine setting can help ensure that children's mental health needs receive prompt attention. 42 states cover treatment and 24 states cover parent guidance provided by a clinician in these settings.

Among states that cover a mental health clinician in a pediatric or family medicine setting, treatment, screening, and diagnostic assessment were covered by nearly all states while a little over half paid for consultations with parents about a positive social-emotional screening and a parent's concern about the child's behavior or mental health.

- 42 states (93 percent) cover treatment
- 41 states (91 percent) cover screening and diagnostic assessment
- 24 states (53 percent) cover consultation with the parent about results of a positive screen
- 24 states (53 percent) cover parent guidance when the parent has a concern about the child's behavior or mental health
- 14 states (31 percent) cover consultation given to another professional/provider (preschool teacher, pediatrician)

Evidence-based practices are required in about a quarter of the states that pay for mental health clinicians in pediatric or family medicine settings and almost three-quarters place no limits on the number of visits.

- 13 states (29 percent) have a requirement that mental health clinicians use evidence-based practices: AZ, CA, FL, HI, MS, ND, NE, NV, OH, OK, OR, TX, and WI
- 33 states (73 percent) have no limits on the number of visits from a mental health clinician in a pediatric/family medicine setting; most states citing limits mentioned that additional visits were possible under EPSDT and a determination of medical necessity

States' eligibility criteria for specific ECMH services play a key role in children's access to services. When asked about eligibility requirements for services from a mental health clinician in a pediatric or family medicine setting to address child mental health needs, survey participants cited multiple

Oregon: At-Risk Codes

Health care providers often see children who do not meet the full criteria for a mental health diagnosis, but who are experiencing conditions and family circumstances that place them at high risk for the development of significant mental health disorders. Starting January 1, 2016, Oregon's health care providers have been able to bill Medicaid for children's mental health services under a new code indicating the presence of family and environmental factors that place the child "at risk" of a mental health disorder. The Oregon State Medicaid office approved the use of the ICD-10 code, Z63.8, for children who are experiencing significant changes in their immediate family environment that present risks for the development of a mental health condition. The situations included in the code are family discord, family estrangement,

high expressed emotional level within the family, inadequate family supports and/or resources, and inadequate or distorted communication within the family.

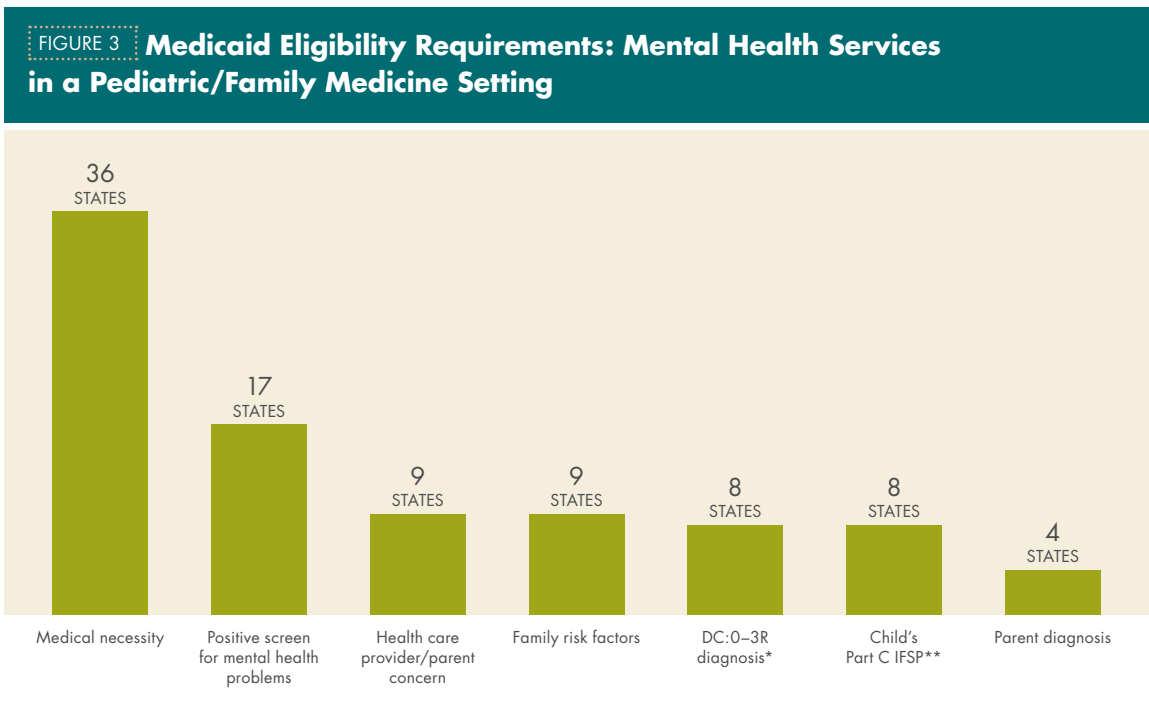
Other codes were added for children experiencing symptoms related to abuse and neglect. These include codes for children who have a history of maltreatment: physical and sexual abuse (Z62.810), psychological abuse (Z62.811), and neglect (Z62.812). The codes for children who have experienced recent abuse and neglect (Z69.010 and Z69.020), previously under adjustment disorders, were also revised to eliminate age restrictions. The use of all of these codes will help the state of Oregon address children's mental health needs early in an effort to reduce the development of serious mental health conditions.

SOURCE Laurie Theodorou, Program and Policy Development Specialist, Department of Human Services and Oregon Health Authority (July 2016)

Oregon recently developed a new “at risk” code that will enable children to receive a broad array of early childhood mental health services even when they do not fully meet criteria for a mental health diagnosis.

factors, as shown in Figure 3. Medical necessity was the most frequently identified requirement (36 states). It is notable that several states reported that they cover the services of a mental health clinician in a pediatric or family medicine setting to address a child’s mental health needs under conditions that suggest risk to the child’s well-being: when a parent or provider has a concern (9 states); when a child has a positive social-emotional screen (17 states); when family risk factors exist (9 states);

when a parent has a diagnosis (4 states). But the survey does not provide enough information to determine whether children in any of these states can receive ECMH services on the basis of risk conditions alone. However, Oregon recently developed a new “at risk” code that will enable children to receive a broad array of early childhood mental health services even when they do not fully meet criteria for a mental health disorder (see *Oregon’s At-Risk Codes*).



* The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood is a classification system focused on developmental issues unique to infancy and toddlerhood. www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs16_148135.pdf
 ** Part C Early Intervention Individual Family Service Plan (IFSP)

Services Provided by an Early Childhood Mental Health Specialist to Address a Child’s Mental Health Needs in Child Care and Early Education Programs

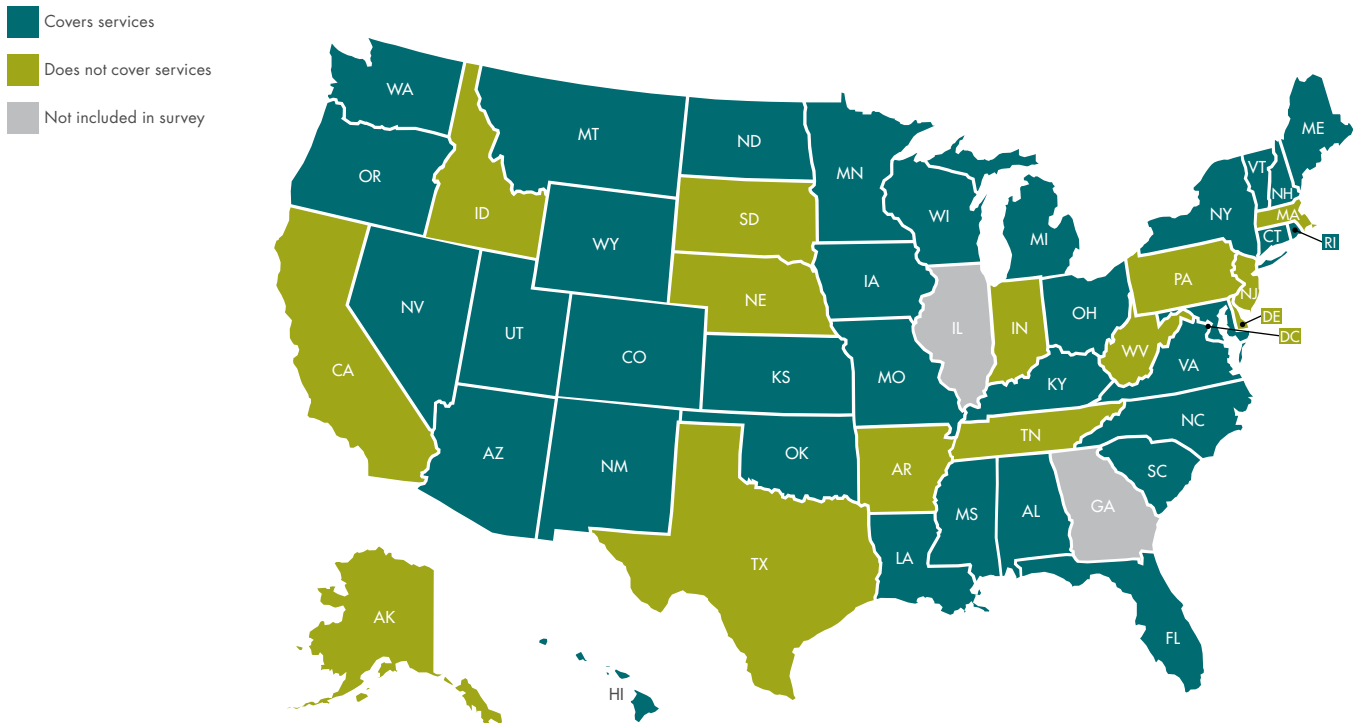
A growing number of states are expanding early childhood mental health (ECMH) consultation, which typically includes 3 types of supports: training and consultation to help teachers use practices that promote the social-emotional growth of all children in a class; consultation and guidance to help teachers address the needs of individual children with challenging behavior or mental health needs; and consultation with parents to help them respond effectively to their children’s social-emotional needs and behavior problems.¹¹ Survey participants were first asked a general question about Medicaid coverage for services provided by an early childhood mental health specialist in early care and education settings. They were then asked whether Medicaid covers some

of the services typically offered in ECMH consultation as well as screening, diagnosis, and treatment.

- 34 states (69 percent) reported that Medicaid pays for an early childhood mental health specialist to provide services to address a child’s mental health needs in child care and early education programs; 15 states (31 percent) reported that they do not cover this service

States that cover services in these programs reported coverage only for services targeting the needs of individual children. While almost all the states cover treatment, screening, and diagnostic assessment, fewer than half cover consultation with

States With Medicaid-Covered ECMH Services in Early Care and Education Settings



parents or teachers to address the needs of an individual child. No state covers services that aim to benefit an entire classroom or group of children through consultation or group training activities. Although these services do not explicitly target individual children, ECMH consultation or linked consultation and staff training can help reduce challenging behaviors in the classroom.¹² The potential value of these services to individual children is suggested by recent research showing that classrooms with high proportions of young children experiencing challenging behavior can have negative effects on their peers' mental health.¹³

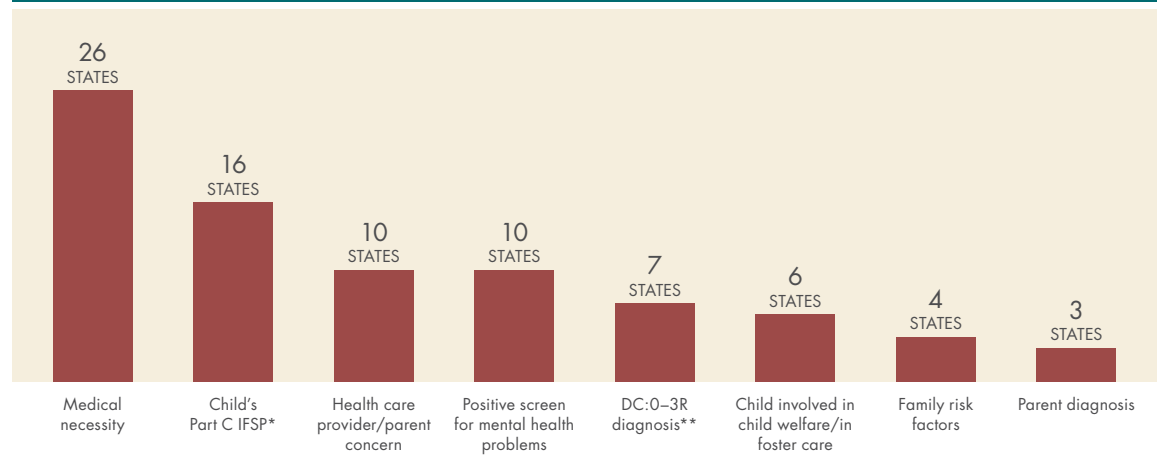
- 31 states (91 percent) cover treatment (e.g., child groups, parent-child treatment)
- 31 states (91 percent) cover screening or diagnostic assessment of the child for mental health problems
- 14 states (41 percent) cover consultation with parent about concerns regarding an individual child
- 13 states (38 percent) cover consultation with teachers about interventions and supports to address an individual child's behavioral and mental health needs
- 0 states cover consultation with teachers and program directors to help strengthen practices that promote young children's mental health and social-emotional growth
- 0 states cover group training of staff on supporting young children's social-emotional growth and addressing mental health needs of children

Among states with Medicaid-covered services to address young children's mental health needs in early care and education settings, fewer than half reported that they require the use of evidence-based screening, diagnostic, or treatment tools and practices, while more than two-thirds reported that they place no restrictions on the number of visits for these services.

- 14 states (41 percent) require the use of evidence-based tools or practices: AL, AZ, FL, IA, LA, MS, ND, NV, OH, OK, OR, SC, VT, and WI
- 24 states (71 percent) reported that there are no restrictions on the number of visits; most states that indicated limits mentioned that additional visits were possible when medically necessary

States most frequently reported medical necessity as the factor determining a child's eligibility for Medicaid services in an early care and education setting. A number of states also cited factors reflecting the risk of a mental health problem, including a positive screen (10 states); involvement in child welfare (6 states); parent diagnosis (3 states); and provider or parent concerns (10 states). Close alignment between Medicaid and the state's Part C Early Intervention program is suggested by 16 states' reported coverage of mental health services in early care and education settings for children whose Early Intervention Individual Family Service Plans call for these services.¹⁴

FIGURE 4 Medicaid Eligibility Requirements: Mental Health Services in Child Care/Early Education Programs



* Part C Early Intervention Individual Family Service Plan (IFSP)

** The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood is a classification system focused on developmental issues unique to infancy and toddlerhood. www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs16_148135.pdf

Services Provided by a Mental Health Clinician in the Home Setting to Address a Young Child’s Mental Health Needs

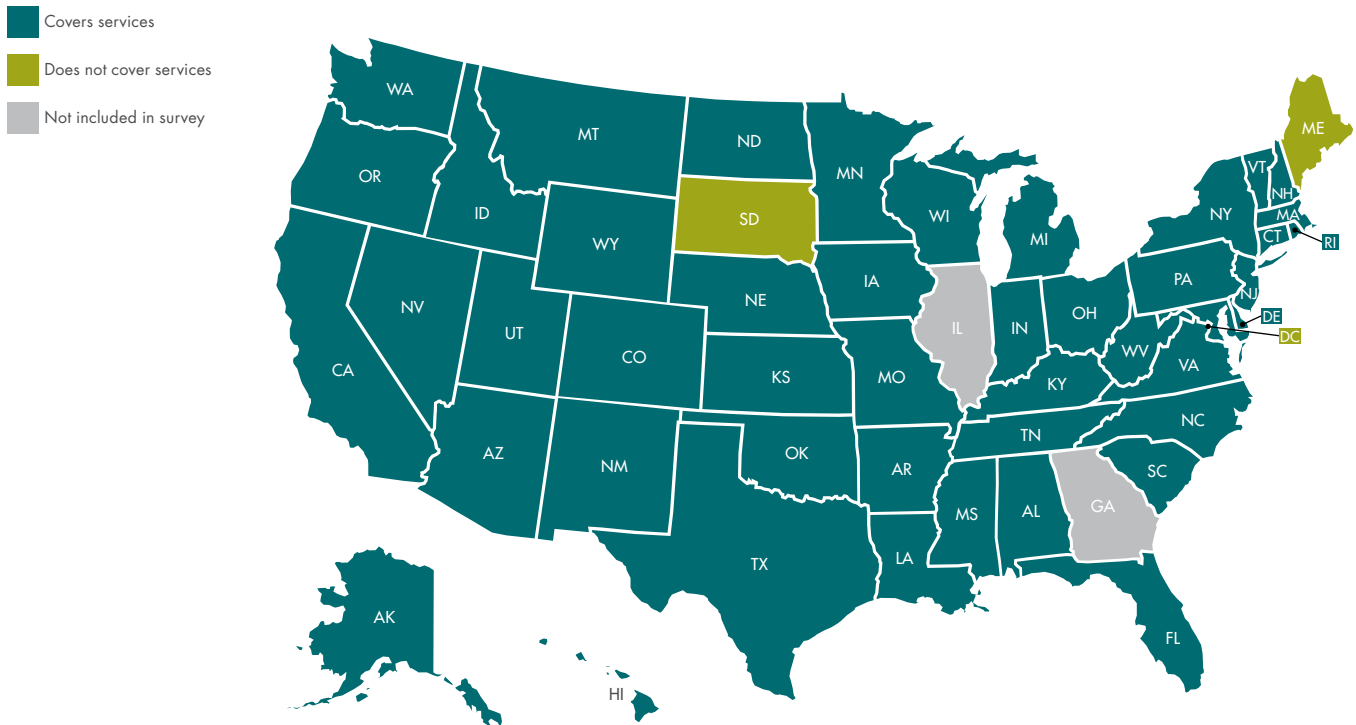
For many families, the home is the best place for receiving early childhood mental health services. Families with very young children may have difficulty traveling to a clinic for services and some parents will feel more comfortable meeting with a mental health specialist at home. Almost all of the survey respondents reported that their states’ Medicaid program covers services to address a young child’s mental health needs in the child’s home.

- 46 states (94 percent) reported that Medicaid pays for a mental health clinician to provide services in the home to address a young child’s mental health needs; 3 states (6 percent) reported that they do not cover this service

Among states with Medicaid-covered home-based mental health services, states reported that the following services are covered:

- 41 states (89 percent) cover child treatment, including parent-child dyadic therapy
- 39 states (85 percent) cover screening or diagnostic assessment
- 28 states (61 percent) cover parent guidance when parent has a concern about child’s behavior or mental health
- 15 states (33 percent) cover consultation given to another professional/provider
- 3 states (7 percent) cover treatment for parent depression under child’s Medicaid

States With Medicaid-Covered ECMH Services in the Home



In some states, Medicaid-covered early childhood mental health services are delivered within state home-visiting programs. When this occurs, common components of many home-visiting programs, such as supports for a nurturing parent-child relationship and parents' well-being, may help amplify the benefits of the mental health intervention. This approach also addresses the challenge that home visitors face when they encounter behavioral health issues that they are not trained to address in their work with families.¹⁵ The survey asked whether Medicaid-covered services in the home to address the child's mental health needs are delivered as part of a state home-visiting program.

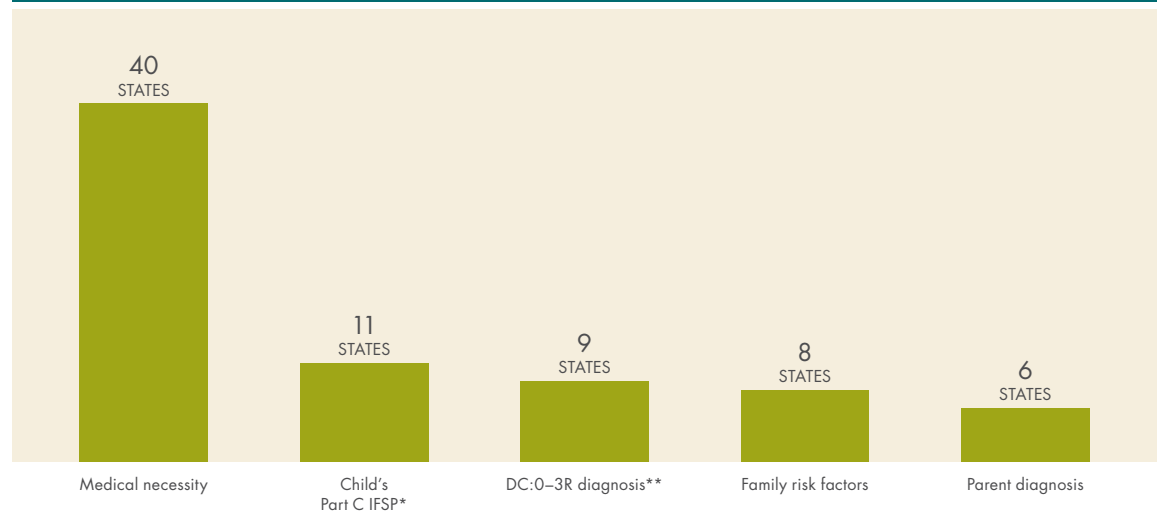
- 10 states (22%) reported that these services are sometimes provided as part of a state home-visiting program: CO, FL, IA, KY, LA, MT, NM, NC, OR, and RI; in MS, these services are always provided as part of a state home-visiting program

Evidence-based screening, diagnostic, or treatment tools or practices are required by a little over one-third of the states that offer home-based mental health services, and about two-thirds do not place limits on the number of visits families receive from the mental health clinician.

- 17 states (37 percent) require the use of evidence-based tools or practices: AK, AZ, CA, CT, FL, ID, IN, LA, MS, MT, ND, NE, NV, OK, OR, TX, and WI
- 30 states (65 percent) reported that there are no limits on the number of covered visits; most states that indicated limits mentioned that additional visits were possible when medically necessary

States reported that medical necessity is the most common factor used to determine eligibility for receipt of services by a clinician to address the mental health needs of a child in the home setting; other factors, including risk conditions, were cited by fewer states (see Figure 5).

FIGURE 5 Medicaid Eligibility Requirements: Mental Health Services in the Home



* Part C Early Intervention Individual Family Service Plan (IFSP)

** The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood is a classification system focused on developmental issues unique to infancy and toddlerhood. www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs16_148135.pdf

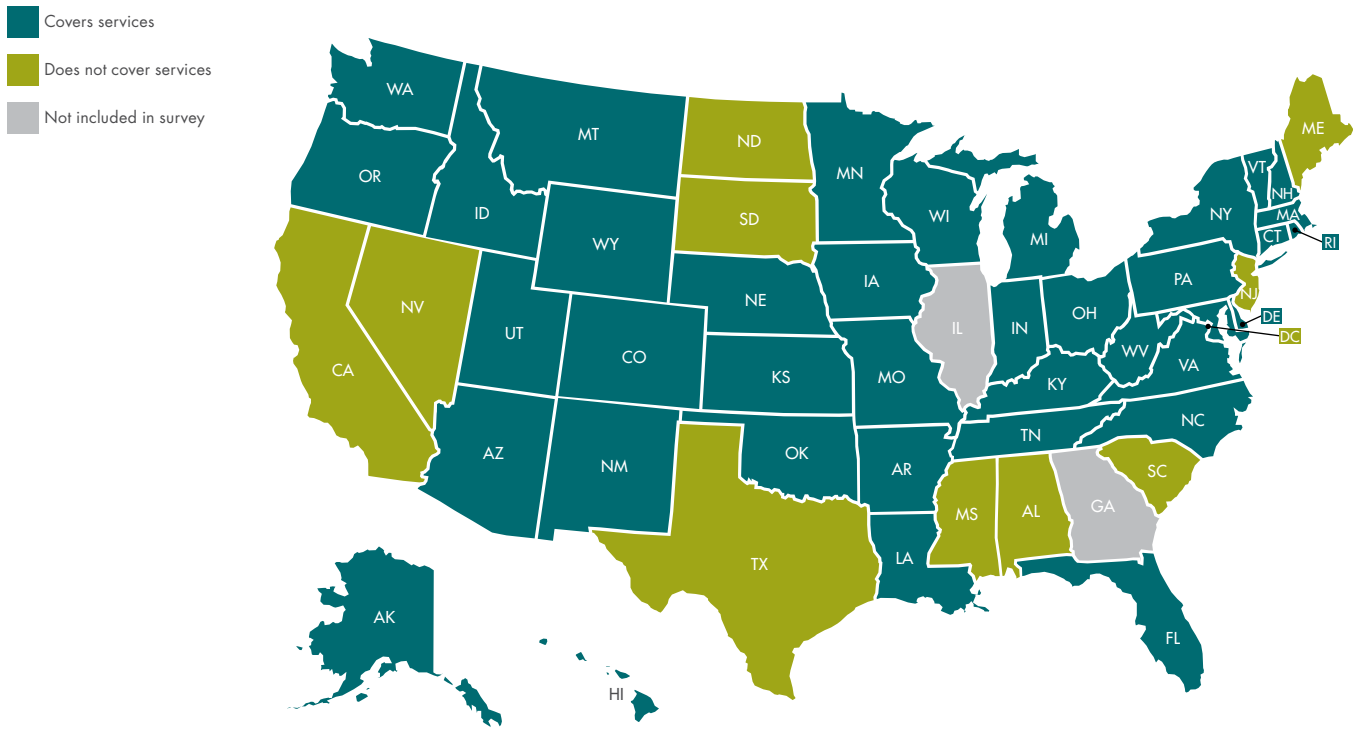
Dyadic (Parent-Child) Treatment

Several models of dyadic (parent-child) treatment have been developed to address mental health and behavioral problems of young children in the early years. These models target children from infancy through the early grades who may exhibit challenging behaviors (e.g., hitting, biting, refusing to cooperate) or difficulties engaging in positive interactions with the parent.¹⁶ Dyadic treatment can help parents develop responsive, nurturing styles of interaction with their child that promote positive behavior and a parent-child relationship that fosters the child's social-emotional growth. Most states reported Medicaid coverage for dyadic treatment.

- 38 states (78 percent) reported that Medicaid pays for dyadic treatment of young children and parents; 11 states (22 percent) reported that they do not cover this service

The use of a specific code for dyadic treatment would allow states to track the delivery of this service, which might be useful under certain circumstances. For example, a state might implement an initiative to expand provider training in evidence-based dyadic treatment models and promote the use of dyadic treatment or simply issue guidance about the appropriate use of this treatment and its billing code. In both cases, a separate

States With Medicaid-Covered Dyadic (Parent-Child) Treatment



code for dyadic treatment would allow the state to document changes in the delivery of this service.

- 12 states (32 percent) that cover dyadic treatment reported having a specific code for this treatment: AR, AZ, HI, LA, MA, MD, MI, MN, NM, RI, VT, and WA

Although states reported having a specific code for dyadic treatment, their descriptions of the treatment models and services covered under the codes they use for this service suggest that the codes allow rather than specify dyadic treatment, and would not permit an accurate count of dyadic treatment sessions. An exception is Washington State where health care providers who use an evidence-based dyadic treatment model bill for the delivery of this service using a required “evidence-based practice (EBP) code.” EBP codes were developed for many mental health services to help Washington’s Medicaid program track providers’ use of evidence-based practices across the state.

Among states that cover dyadic treatment, most reported that this treatment can be provided and paid for by Medicaid in a range of medical and nonmedical settings:

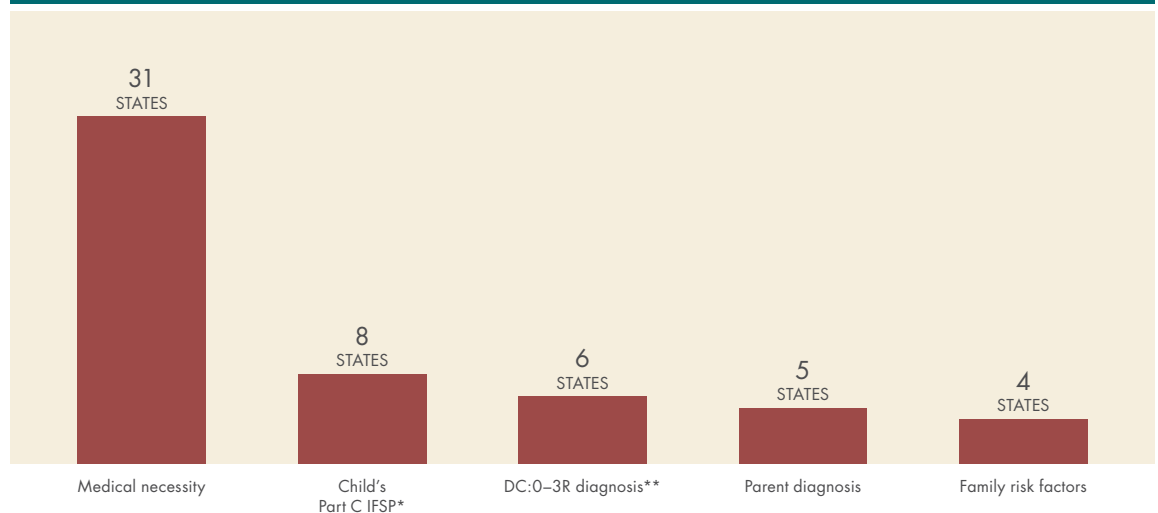
- 37 states (97 percent): mental health clinic
- 36 states (95 percent): home/foster home
- 29 states (76 percent): pediatric/family medicine care setting
- 25 states (66 percent): other community setting (e.g., family resource center, WIC site)
- 22 states (58 percent): child care or early education program

States that cover dyadic treatment generally set few conditions on the delivery of this service, with the exception of eligibility rules. Most did not require the use of an evidence-based treatment model and placed no limits on the number of dyadic treatment visits.

- 11 states (29 percent) require providers to use an evidenced-based dyadic treatment model: AK, AZ, DE, IA, ID, MI, NE, OK, OR, PA, and WI
- 29 states (76 percent) have no limits on the number of dyadic treatment visits; most states that indicated limits mentioned that additional visits were possible when medically necessary.

Most states cited “medical necessity” as an eligibility criterion; factors reported by fewer states included the child’s Part C Early Intervention Individual Family Service Plan and family risk factors (see Figure 6).

FIGURE 6 Medicaid Eligibility Requirements: Dyadic (Parent-Child) Treatment



* Part C Early Intervention Individual Family Service Plan (IFSP)

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Parenting Programs Designed to Help Parents of Young Children Promote Children’s Social-Emotional Development and Address Child Mental Health Needs

Evidence-based group parenting programs can help parents with young children acquire knowledge about children’s needs and increase their use of positive parenting behavior. Several models have been developed for parents of infants, toddlers, and preschoolers who are exhibiting behavior problems.¹⁷

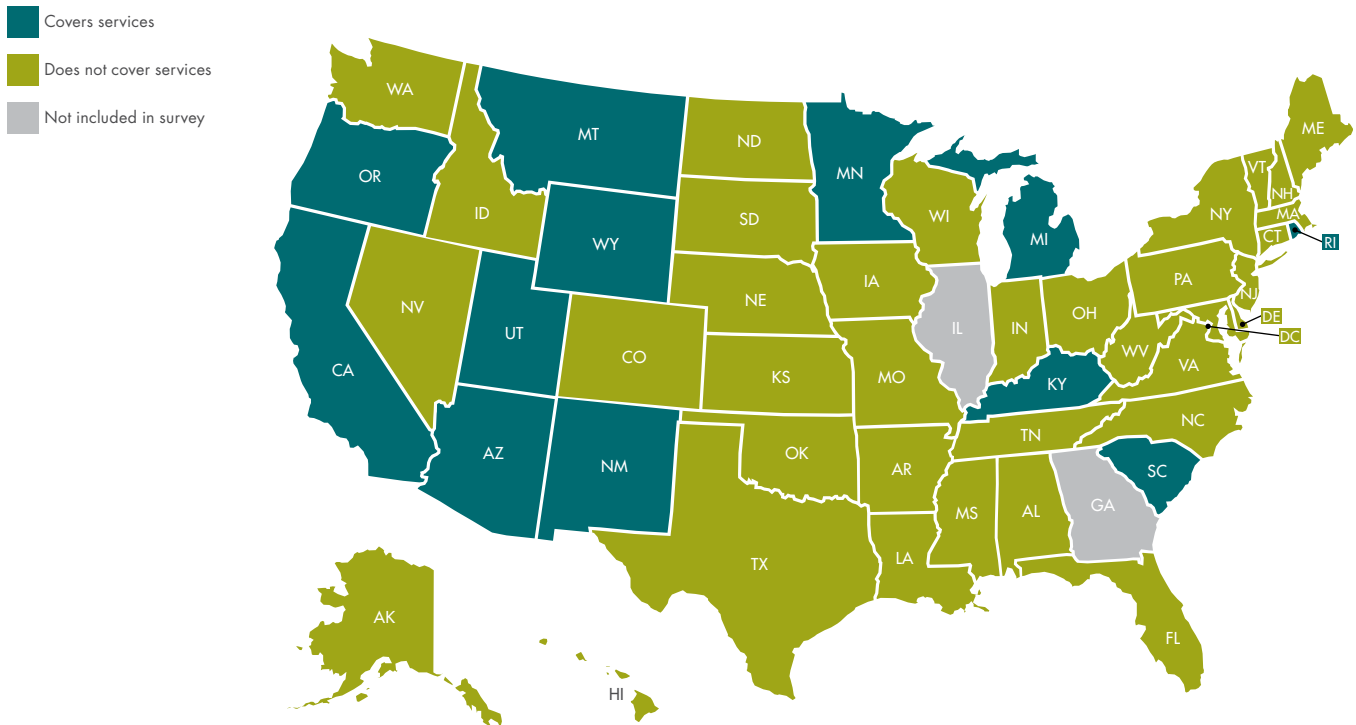
- 12 states (24 percent) reported that Medicaid pays for parenting programs designed to help parents of young children promote children’s social-emotional development and address child mental health needs; 37 states (76 percent) reported that they do not cover this service.

States reported that parenting programs can be provided and paid for by Medicaid in a range of medical and nonmedical settings:

- 10 states (83 percent): mental health clinic
- 9 states (75 percent): pediatric/family medicine care setting
- 9 states (75 percent): home/foster home
- 8 states (67 percent): other community setting (e.g., family resource center, WIC site)
- 8 states (67 percent): child care or early education program

Only 2 states, Michigan and Oregon, require providers to use an evidenced-based parenting

States With Medicaid-Covered Parenting Programs



program. Medical necessity was reported to be an eligibility requirement by the largest number of states (11); one-third of the states or fewer cited the child’s Part C Individualized Family

Service Plan and risk factors, such as involvement in child welfare and parent diagnosis, as criteria used to determine eligibility for parenting programs (see Figure 7).

Evidenced-Based Parenting Programs Covered by Medicaid: Michigan and Oregon

A growing number of group parenting programs have demonstrated positive outcomes, including improved parenting behavior, reduced child behavior problems, and strengthened parent-child relationships. Michigan and Oregon are two states that require the use of evidence-based models for Medicaid-covered group parenting programs designed to help parents of children 0 through 5 years promote children’s social-emotional development and address child mental health needs. In Michigan, a diagnosis is required to provide this service, but the diagnosis can be for the parent or child. Community Mental Health Services Programs in Michigan can choose the evidence-based parenting models they offer; 2 of the models currently in use are Nurturing

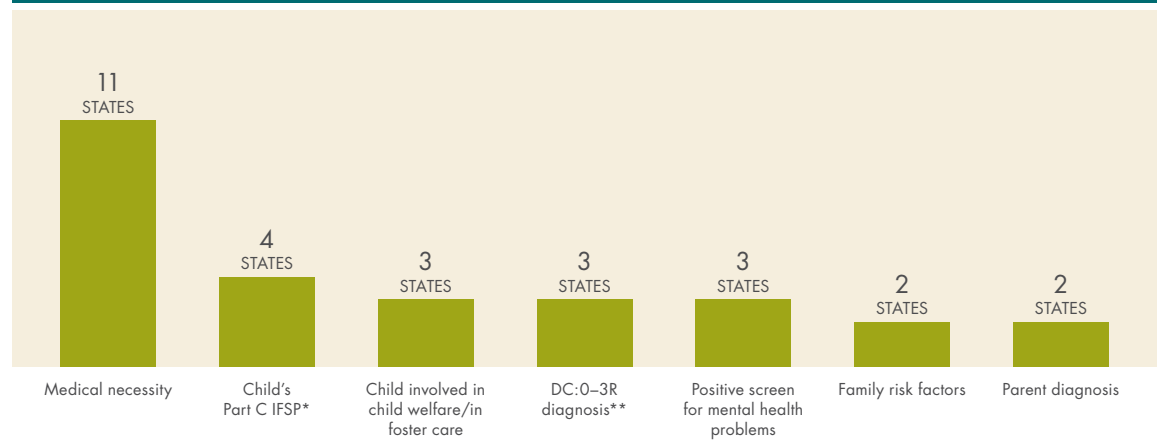
Parenting Program and The Incredible Years: Parents, Teachers, and Children’s Training Series.

In Oregon, a parenting program is provided when a child has a diagnosis and a parent training program is recommended as the best treatment for that diagnosis. In addition to The Incredible Years, Parent Management Training programs are the models used currently. Beginning in January 2016, parents in Oregon can also become eligible for participation in a parenting program if their child meets the criteria for being “at risk” of experiencing a mental health disorder as a result of family circumstances that increase the child’s chance of developing a significant mental health condition: See “Oregon’s At-Risk Codes.”

SOURCES Erin Emerson, Specialist, Medicaid Director’s Office, Michigan Department of Health and Human Services (July 2016)

Laurie Theodorou, Program and Policy Development Specialist, Department of Human Services and Oregon Health Authority (July 2016)

FIGURE 7 Medicaid Eligibility Requirements: Parenting Programs That Promote Children’s Social-Emotional Development and Address Child Mental Health Needs



* Part C Early Intervention Individual Family Service Plan (IFSP)

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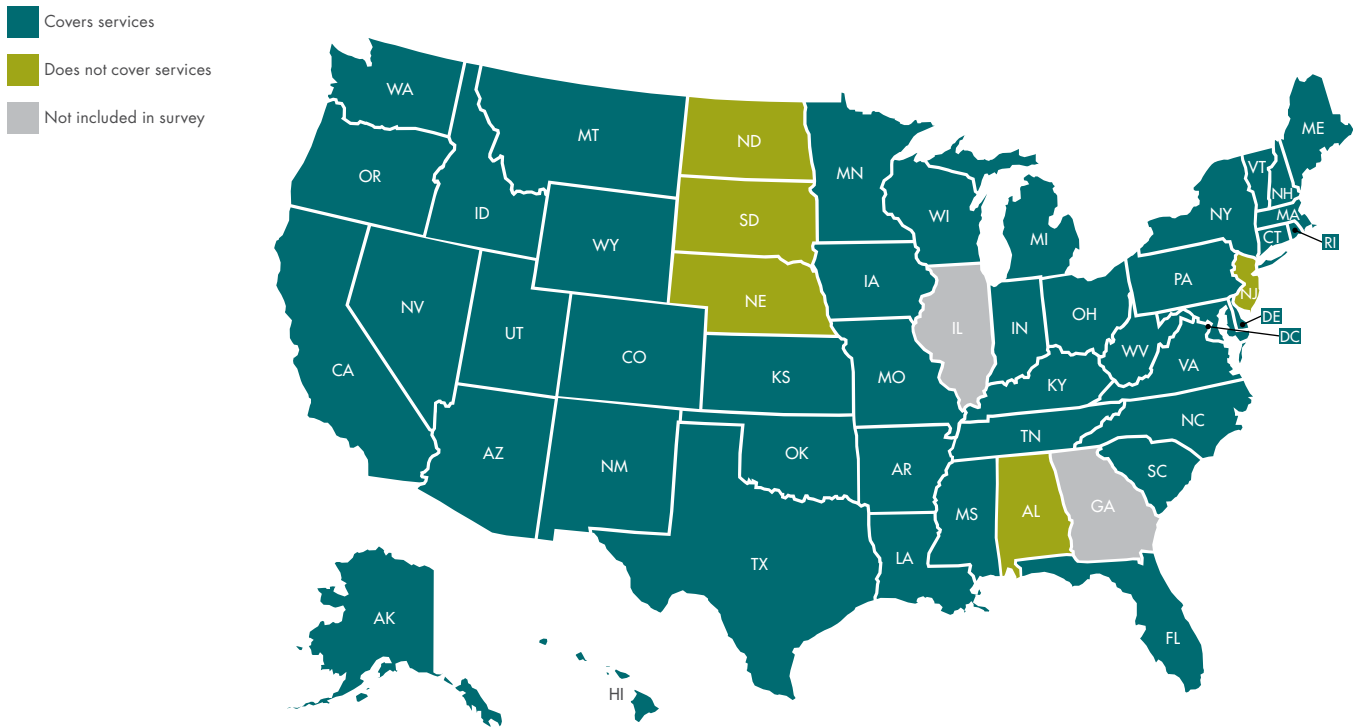
Behavioral Health Case Management/Care Coordination for a Young Child (0-6 Years)

The survey asked whether Medicaid covers case management and care coordination to address a young child’s mental health needs. This service might help a family secure more than 1 needed service (e.g., dyadic treatment and consultation with a teacher in an early care and education setting), ensure ongoing child social-emotional screening or assessment, or facilitate communication among service providers.

- 44 states (90 percent) reported that Medicaid pays for behavioral health case management/care coordination; 5 states (10 percent) reported that they do not cover this service

States reported that case management/care coordination can be provided and paid for by Medicaid in the following settings:

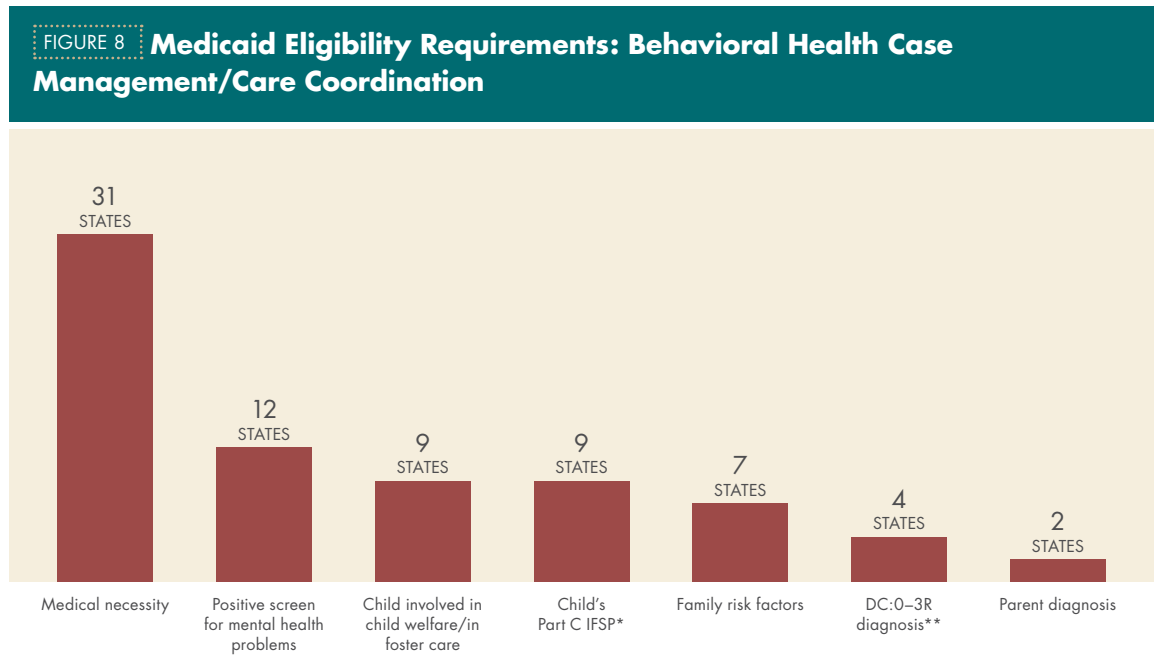
States With Medicaid-Covered Behavioral Health Case Management/Care Coordination



Medicaid coverage for young child mental health services in the home setting was reported by the largest number of states (46), while coverage for maternal depression screening under the child's Medicaid was reported by the smallest number of states (9).

- 38 states (86 percent): home/foster home
- 38 states (86 percent): mental health clinic
- 35 states (79 percent): pediatric/family medicine care setting
- 32 states (72 percent): other community setting (e.g., family resource center, WIC site)
- 31 states (70 percent): child care or early education program

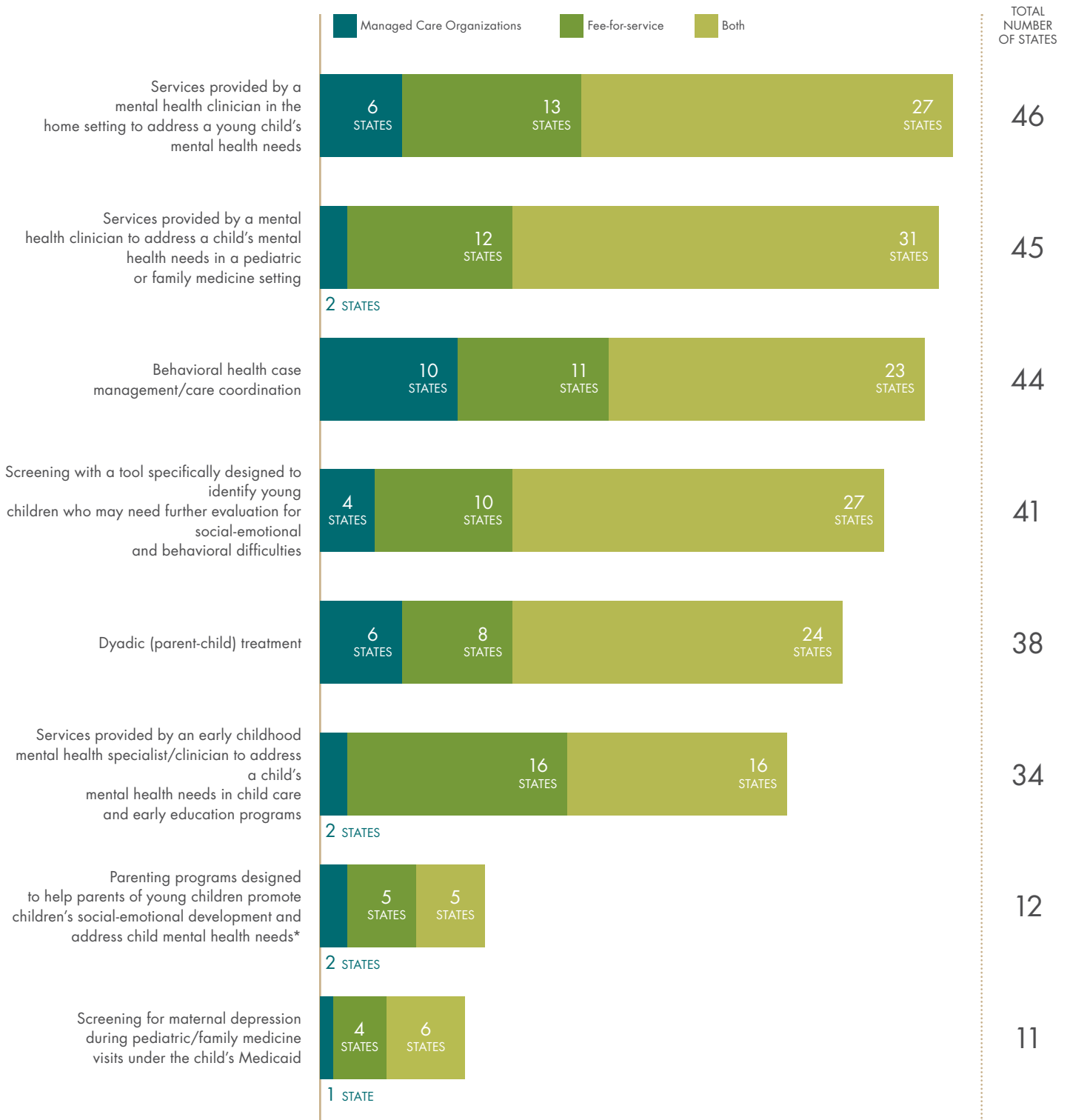
Children's eligibility for case management/care coordination is determined most often by medical necessity (see Figure 8). Involvement in child welfare, participating in Part C Early Intervention, and having family risk factors were also cited as eligibility criteria by several states.



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FIGURE 9 Early Childhood Mental Health Services Covered by Medicaid



* NM: Managed Care Organizations can provide parenting programs designed to help parents of young children promote children's social-emotional development and address child mental health needs, but they are not required to provide this service.

Summary

This report presents results of a 50-state survey that examined Medicaid coverage of key early childhood mental health (ECMH) services and policies. 48 states and the District of Columbia (counted as a state in reported results) participated in the survey, which was conducted as an interview with state Medicaid administrators. The following are key findings from the survey:

- A large number of states (34 to 46 states) report Medicaid coverage for 6 of the 8 ECMH services described in the survey: ECMH services in a home setting; ECMH services in a pediatric/family medicine setting; behavioral/health case management/care coordination; social-emotional screening of child; dyadic treatment; ECMH services in an early care and education setting
- Coverage under the child's Medicaid for maternal depression screening and for parenting programs designed to help parents of young children promote their social-emotional growth and address children's mental health needs was reported by notably fewer states (11 and 12, respectively)
- Among states that cover child social-emotional and maternal depression screening under the child's Medicaid, most states cover screening when it is administered in nonmedical settings, such as homeless shelters, family resource centers, Part C Early Intervention sessions, and WIC clinics
- Most states require providers to use validated child social-emotional and maternal depression screening tools
- Fewer than one-third of the states that cover key services require the use of evidence-based practices or models; 11 states require the use of an evidence-based dyadic treatment model and 2 states require the use of an evidence-based parenting program
- Among states that cover key ECMH services (with the exception of maternal depression screening), most place no limits on the number of screenings or treatment visits that can be provided
- Medical necessity is the ECMH service eligibility criteria cited most often by states; criteria reflecting risk factors were also cited by several states, including parent diagnosis and family risk factors but whether these alone can qualify a child for ECMH services cannot be determined from the survey
- States appear to have a limited ability to determine trends in the delivery of certain ECMH services from the codes used for billing; only 18 states have a separate code for social-emotional screening of children and while 12 states reported having a separate code for dyadic treatment, some of these states appeared to use this same code for a range of other services

Overall, an impressive number of states report Medicaid coverage of key mental health services in a range of settings, with few limitations on the number of screenings or treatment visits. However, as noted in the recommendations that follow, there may be gaps between reported policy and service provision that can only be identified by further investigation.

Recommendations

The survey results presented in this report can be used by stakeholders from a variety of sectors who are engaged in work that affects the mental health services available to young children, including administrators in state Medicaid and human service agencies, state legislators, and advocates and leaders in early care and education and philanthropy. These stakeholders can use the results to examine options for improving Medicaid coverage of key early childhood mental health services and the quality of covered services. Below are recommendations for specific ways to use the results.

- Advocates and other stakeholders can meet with their state Medicaid officials to review the results of the survey, including the coverage of key ECMH services and related policies that affect eligibility in their state and other states. This review may set the stage for further investigation of the state's current plan, how providers must deliver and bill for services, and potential enhancements to the state plan;
- If your state's Medicaid program is not currently covering one or more key services, examine evidence for the benefits of the services and options for expanding coverage to include these services through a State Plan Amendment or Waiver.¹⁸ Collaborations between Medicaid officials and other stakeholders with knowledge of research-based ECMH services can support this process;

- Consider how results of the survey suggest possible improvements to access and quality of covered services in your state. For example, results showing states' use of risk factors for eligibility criteria might suggest options for broadening service eligibility in your state. Similarly, the results highlight the option of setting requirements for the use of evidence-based treatment models to help ensure treatment effectiveness;
- If the survey shows that one or more key services are covered in your state, consider investigating whether the state has data on provider billing for the services in order to gain a better picture of how widely health care providers are actually delivering the services. This inquiry is especially important when a service is fairly new or perceived as challenging to implement (e.g., recently established maternal depression screening under the child's Medicaid), or when anecdotal evidence suggests that many health care providers may not know about Medicaid coverage of the service (e.g., dyadic treatment in some states). In cases where limited use of a covered service is found, further information gathering through focus groups or other interview methods could be used to learn why health care providers are not providing covered services.

An Invitation from NCCP

The authors would like to update the results of this survey over the coming year, and welcome information about changes in the status of Medicaid coverage of ECMH-related services, including parent depression screening, in your state and policies related to coverage. Please send updates or corrections to: ito@nccp.org. Questions about the results and requests for technical assistance can also be sent to this same address.

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