REPORT | NOVEMBER 2018

How States Use Medicaid to Cover Key Infant and Early Childhood Mental Health Services:

RESULTS OF A 50-STATE SURVEY (2018 UPDATE)

Sheila Smith | Maribel R. Granja | Uyen Sophie Nguyen | Kavita Rajani

National Center for Children in Poverty

COLUMBIA UNIVERSITY | MAILMAN SCHOOL of PUBLIC HEALTH

The National Center for Children in Poverty (NCCP) is a non-partisan public policy research center at Columbia University's Mailman School of Public Health. Founded in 1989 with endowments from the Carnegie Corporation of New York and the Ford Foundation, NCCP is dedicated to promoting the economic security, healthy development, and well-being of America's low-income children and families. Using research to inform policy and practice, the center seeks to advance family-oriented solutions and the strategic use of public resources at the state and national levels to produce positive outcomes for the next generation.

How States Use Medicaid to Cover Key Infant and Early Childhood Mental Health Services: RESULTS OF A 50-STATE SURVEY (2018 UPDATE)

Acknowledgments

The authors are very grateful for the many Medicaid administrators who generously gave their time to participate in the survey update and respond to follow-up questions. The authors also wish to thank Cindy Oser at ZERO TO THREE for developing questions about states' use of DC:0–5. Several individuals gave valuable expert feedback on an early draft of the original survey: Julie Cohen, Cindy Oser, Charles Bruner, Lisa Honigfeld, Catherine Wright, Olivia Golden, Dr. Bill Beardslee, Celeste Putnam, and Sally Nadols. A special thanks to the Alliance for Early Success for supporting the 50-state IECMH Medicaid survey update and report.

Suggested Citation

Smith, S., Granja, M.R., Nguyen, U., Rajana, K. (2018). How States Use Medicaid to Cover Key Infant and Early Childhood Mental Health Services: Results of a 50-State Survey (2018 Update). New York: National Center for Children in Poverty, Mailman School of Public Health, Columbia University.

Introduction

There is now substantial evidence that young children's mental health plays a critical role in their early learning and school readiness, long-term school success and self-sufficiency, and future health and mental health outcomes.[1] Fortunately, many states are working to strengthen supports for infants' and young children's mental health. This brief examines states' Medicaid coverage for key infant and early childhood mental health (IECMH) services, along with policies that contribute to service access and quality. It presents the results of an updated 50-state survey that gathered information from state administrators about Medicaid coverage and policies related to 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
- Developmentally appropriate diagnosis using DC:0–5
- Family navigators to help families access services
- Mental health services in pediatric, child care and early education, and home settings
- Dyadic (parent-child) treatment
- Parenting programs to address child mental health needs

Results of an earlier survey were reported in a 2017 publication. A comparison of results from that survey and those presented in this brief can be found in the Appendix. In addition to asking about whether states cover key services, both surveys collected information about related policies. 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 updated 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 IECMH services and the quality of covered services.

The following sections present background information and survey results:

- Rationale for Medicaid coverage of key IECMH services
- Survey methods
- Survey results
- Recommendations

Medicaid as a key source of funding for IECMH 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) recommend 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 pediatric health care providers can 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 IECMH 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. 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 IECMH 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.

Methods

The Infant Early Childhood Mental Health (IECMH) Medicaid Survey update was completed on Qualtrics, a secure online data collection system. National Center for Children in Poverty (NCCP) research staff contacted the Medicaid respondents who had completed the original survey in each state via email asking them to review and update their state's original responses on Qualtrics. If the original respondents could not be reached, NCCP staff contacted other administrators from offices within the states' Medicaid agencies, including EPSDT and behavioral health services. An appropriate respondent was identified in 48 states and the District of Columbia.Respondents from Arkansas and Ohio were not able to update the survey this year because both states were in the process of making changes in their Medicaid-funded behavioral health services. However, their previous responses are included in this report. Therefore, the report describes responses from 51 states (DC treated as a state).

Survey participants received a link to review and update their state's responses in Qualtrics. Some participants completed the survey in collaboration with colleagues to help ensure that they would be able to provide accurate information. NCCP research staff facilitated requests from those who needed to complete the survey update with multiple colleagues. As the surveys were submitted, research staff reviewed the responses and made notes of any missing or unclear responses. These were typically minor. States were contacted again to provide or clarify responses. Follow-up phone calls were scheduled with some states to discuss responses and to gather additional information. Outreach to key contacts in states by phone and email continued until the majority of states (48 states and DC) completed the review of their state's survey.

The survey asked participants to review responses about Medicaid payment for key services and responses concerning policies related to service access and quality. Open-ended questions within sections about particular services asked respondents to clarify or expand on their responses, as needed. The following items were added to the updated survey: 1) Questions about whether state rules encourage or allow providers to use DC:0–5 (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, or the previous version, DC:0–3R); 2) Questions about whether states have Medicaid-funded coordinators who can help connect either a young child or a parent to appropriate services, and 3) A question about whether services could be provided when there are risk factors, but no child diagnosis.

Analyses of survey responses provided descriptive statistics for most survey items. Additional qualitative information to clarify responses and for states highlighted in boxes were obtained through phone calls and email communication.

Results

The next sections provide results of state administrators' responses to questions about Medicaid coverage for key IECMH services and questions about related IECMH policies. A summary of states' coverage of IECMH services through Medicaid fee-for-service and managed care is provided in Figure 8 at the end of the report. As discussed in the summary and recommendations section, these responses do not show the extent of states' promotion and implementation of the reported coverage and policies. Some states, for example, might have recently issued general guidance encouraging providers to screen for maternal depression and bill under the child's Medicaid, but not yet developed additional supports to promote this practice. However, states' reported policies offer an important starting point for understanding current strengths and gaps in supports for infants' and young children's mental health.

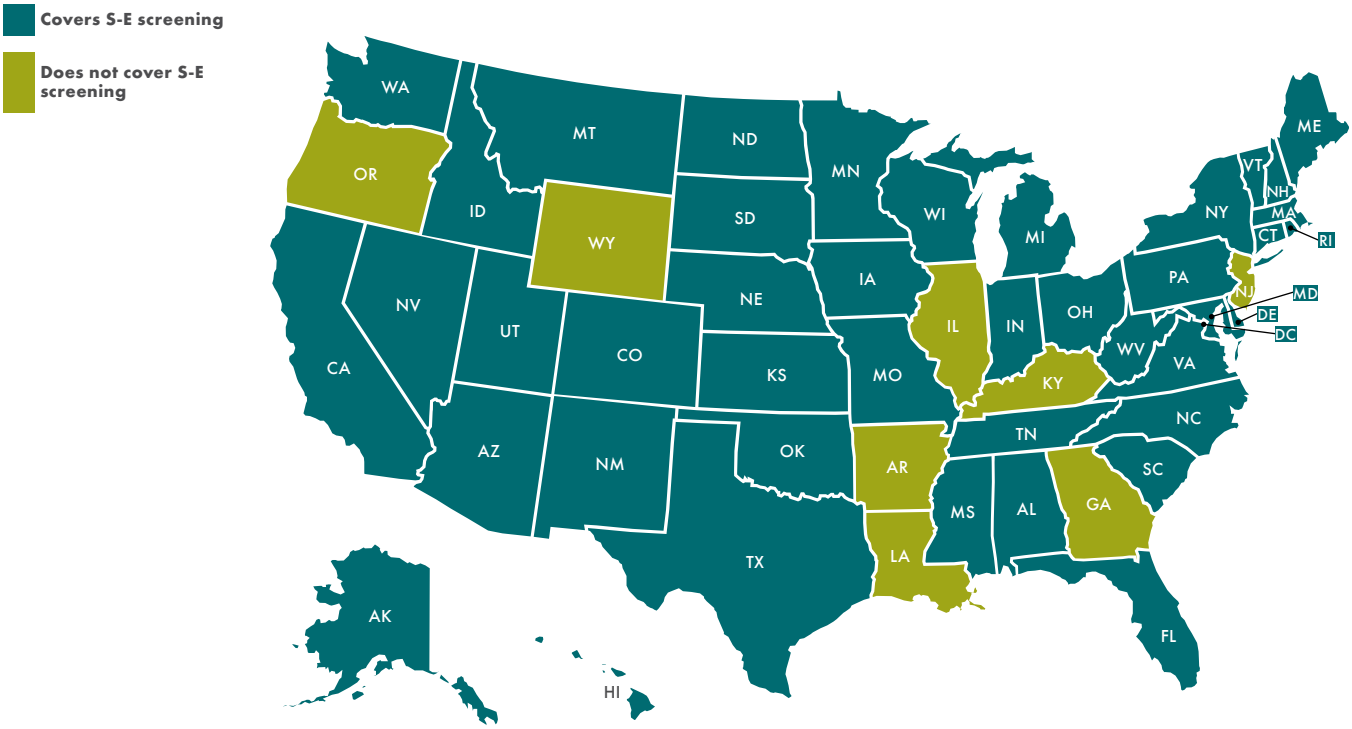
Screening with a tool designed to identify young children who may need further evaluation for social-emotional and behavioral difficulties

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

- 43 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 uses a modifier for mental health screens that helps the District track positive screens (see *Support for Pediatric Practices to Conduct Mental Health Screening: District of Columbia*).

States with Medicaid-covered social-emotional screening



- Among states that cover social-emotional screening, 23 states (53 percent) reported having a separate code for this service: CO, CT, DC, DE, IA, IN, KS, MA, ME, MI, MN, MS, NC, ND, NV, OK, SC, SD, TX, VA, VT, WA, 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, 34 states (79 percent) reported that same-day social-emotional and developmental screenings are permitted: AL, AZ, CO, CT, DC, DE, HI, IA, ID, KS, MA, MD, ME, MI, MN, MS, NC, ND, NE, NH, NM, NV, NY, OH, OK, RI, SC, SD, TN, UT, VA, VT, WA, 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 (63 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:
  - 23 states (85 percent): home or foster home
  - 22 states (81 percent): Part C Early Intervention session in home or community setting
  - 21 states (78 percent): early care and education program
  - 20 states (74 percent): shelter (e.g., homeless shelter, domestic violence shelter)
  - 20 states (74 percent): other community setting (e.g., family resource center, WIC clinic)

Support for pediatric practices to conduct mental health screening and referrals: District of Columbia

DC Mental Health Access in Pediatrics (DC MAP) helps providers in pediatric settings conduct age-appropriate screening for mental health problems and respond effectively to positive screens. In 2014, DC MAP's parent organization, DC Collaborative for Mental Health in Pediatric Primary Care, conducted a 15-month learning collaborative that 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 area. Providers received up to 54 hours of continuing medical education credits. Screening rates rose from 1 to 73 percent in the practices that fully participated in the collaborative.

Since the end of the learning collaborative, DC MAP has continued to offer webinar-based and in-person training on screening and referral for mental health concerns to DC pediatric practices. Recently, DC Medicaid increased the rate of reimbursement for mental health screenings conducted during a well-child visit to encourage providers to conduct them. Between 2013 and 2017, Medicaid claims for social-emotional screening of children 0 - 5 years in DC have risen 375 percent. Providers use a modifier to indicate a positive screen, allowing the DC Department of Health Care Finance to track rates across the city.

Pediatric providers who call DC MAP with concerns about child mental health issues, including results of a positive screen, receive a consultation within 30 minutes. Consultations are used to identify options for follow-up, including referral to evaluation, parent support, dyadic treatment and adult mental health providers, and other family resources.

In May 2018, DC MAP launched a Cross-Sector Mental Health Quality Improvement Learning Collaborative. This initiative aims to improve effective referrals across primary care, early childhood mental health providers, and early childhood education providers to identify and address young children's mental health problems.

SOURCE Colleen Sonosky, Associate Director, Division of Children's Health Services, Health Care Delivery Management Administration, DC Dept. of Health Care Finance (2016, 2018), and Penelope (Pennie) Theodorou, Early Childhood and Maternal Mental Health Program Coordinator at Children's National Health System (2018)

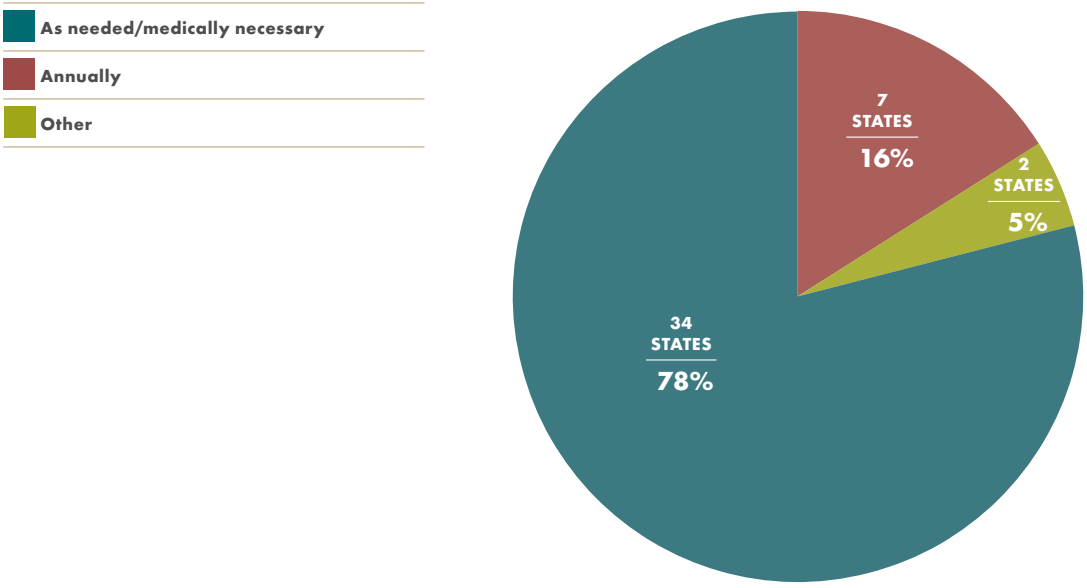
States can track the delivery of social-emotional screening with a separate code to see if goals set by state child mental health plans or initiatives designed to increase rates of screening are being met.

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

- 20 states (47 percent) require a validated social-emotional screening tool.
- 10 states (23 percent) allow only specific tools (e.g., ASQ-SE, DECA, SWYC).[8]
- 13 states (30 percent) allow any social-emotional screening tool.

When asked about the allowed frequency of social-emotional screening covered by Medicaid, the majority of states (34 states or 79 percent) reported that this screening can be administered "as needed" or based on medical necessity, 2 states (5 percent) allow annual screening, and the remaining 7 states (16 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?

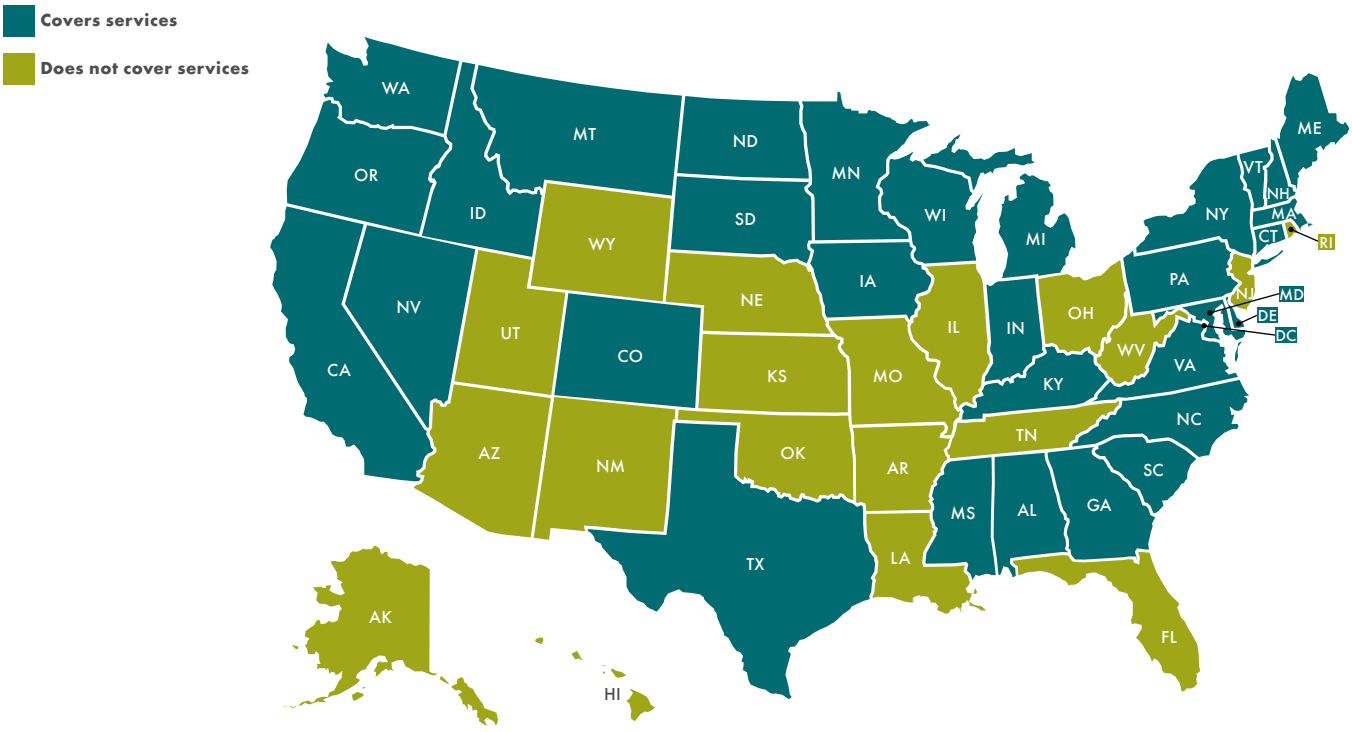


Screening for maternal depression during visits to a pediatrician or family medicine provider with coverage under the child's Medicaid

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 18 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]

- 32 states (63 percent) reported that Medicaid pays for maternal depression screening during pediatric or family medicine visits, under the child's Medicaid; 19 states (37 percent) reported they do not cover maternal depression screening under the child's Medicaid.

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.

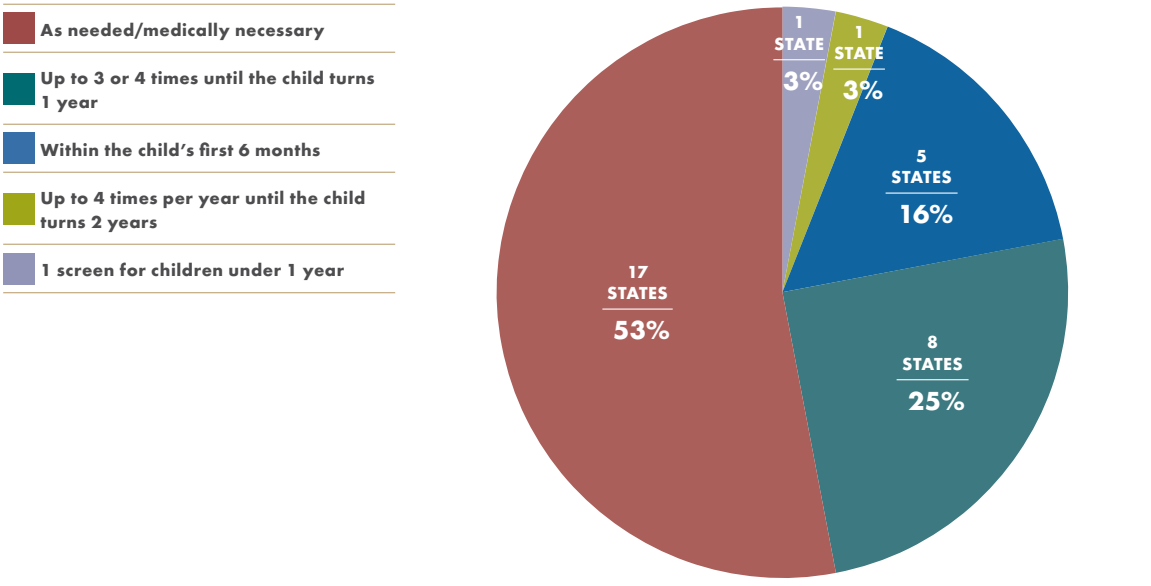
- 20 states (63 percent) require the use of a validated depression screening tool.
- 9 states (28 percent) only allow the use of specific tools (e.g., Edinburgh Postnatal Depression Scale, Patient Health Questionnaire-2, Patient Health Questionnaire-9).
- 3 states (9 percent) allow the use of any depression screening tool.

Among the states that pay for depression screening under the child's Medicaid, 17 states (53 percent) allow screening on an "as needed" or "medically necessary" basis: CA, CT, DE, GA, IA, ID, MA, ME, MT, NH, NV, OR, PA, TX, VT, WA, and WI (CT, MT and TX allow screening as needed during the child's first year); and the remaining 15 states (47 percent) place various limits on the number and duration of allowable depression screening (see Figure 2).

Many 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.

- 13 states (41 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:
  - 10 states (77 percent): other community setting (e.g., family resource center, WIC clinic)
  - 9 states (69 percent): home/foster home
  - 9 states (69 percent): shelter (e.g., homeless shelter, domestic violence shelter)
  - 9 states (69 percent): early care and education program
  - 8 states (62 percent): Part C Early Intervention session in home or community setting

FIGURE 2 How often can a maternal depression screening be conducted?



Maternal depression screening policy and supports for implementation in North Carolina and Minnesota

North Carolina Medicaid pays for up to four maternal depression screenings in the child's first year and providers can bill for the screenings under the child's Medicaid. Community Care of North Carolina (CCNC), the organization responsible for Medicaid service delivery, developed a maternal depression toolkit on screening, referral, and follow-up. The toolkit provides background on the value of maternal depression screening (MDS), information on tools, and an algorithm for deciding when and how to respond to elevated scores. The toolkit's guidance highlights the need for follow-up social-emotional screening of the child, in response to a positive parent screen, and if needed, referral of the dyad for relationship-based treatment and a case management program called CC4C.

North Carolina Medicaid also helps providers improve their practices by offering an on-line course on MDS. This five-session course provides maintenance of certification credit and covers screening policies and procedures, the negative impacts of maternal depression on the infant, and referral practices for the mother and the mother-infant dyad. Another critical support provided by CCNC is feedback to providers. Each quarter, providers receive their MDS rates so that they know their performance on this indicator. The system's quality improvement specialists also visit practices and can help providers increase their rates by encouraging their use of the toolkit and course, and providing individualized assistance.

The suite of supports for MDS has produced high rates of screening in North Carolina. In a 14-month period ending in March, 2018 MDS ranged from 72 percent to 87 percent.

In November 2015 the Minnesota Department of Health (MDH) released clinical guidelines for implementing universal maternal depression screenings (MDS) in well child visits. The guidelines provide information about the importance of screening, potential interventions, documentation practices for screening in well-child visits, scripts to guide staff and providers on the PPD screening and referral process, screening tools, and 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.

MDS 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 one of several validated tools. 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.

As part of the Postpartum Depression Screening Quality Improvement Project, MDH conducted three cycles of a learning collaborative that supports MDS. Participating clinics attended 2 in-person sessions, and received technical assistance through phone calls, 2 webinars, and site visits. The 13 clinics that participated in the first 2 cohorts of the learning collaborative 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. Across the state MDS rates nearly doubled between 2014 and 2017.

SOURCES Marian Earls, MD, MTS, FAAP; Director of Pediatric Programs, Deputy Chief Medical Officer, Community Care of North Carolina; Tessa Wetjen, formerly at MN Department of Health (2016); Susan Castelanno, Maternal and Childhood Health Director, Minnesota Department of Health (2018)

Using the DC:0-5 or DC:0-3R diagnostic classification system

The DC:0–5 Diagnostic Classification System helps providers identify and understand mental health conditions that occur in children ages birth to five years.[10] The DC:0–5 was developed by a work group comprised of infant-early childhood mental health experts, including specialists within ZERO TO THREE, the organization that sponsored and led the work that created this system. State administrators were asked if their agency or Medicaid policy requires, recommends, or allows providers to use DC:0–5 (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, or the previous version DC:0–3R) to conduct mental health/behavioral health diagnostic classification for infants and young children through 5 years.

- 13 states (25 percent) allow providers to use DC:0–5: AK, CT, DC. DE, ID, LA, MA, ME, PA, TN, VT, VA, and WA.
- 5 states (10 percent) recommend, but do not require, that providers use DC:0–5: AZ, CO, MI, MN, and OR.
- 1 state (2 percent) requires providers to use DC:0–5: NV.
- 30 states (59 percent) reported none of the above.

States that allow, recommend, or require provider to use DC:0–5 reported on the mechanisms they use to support the use of DC:0–5.

- 6 states (32 percent) developed a crosswalk between DC:0–5 and ICD codes and/or other guidance documents to facilitate providers' use of the DC:0–5 for billing purposes.
- 6 states (32 percent) support provider training in using the DC:0–5 diagnostic assessment tool.
- 2 states (11 percent) formally recognizes use of the DC:0–5 in state Medicaid policy.

Helping families connect with services using health navigators

One significant challenge faced by health care providers is making appropriate referrals that can help families obtain needed evaluations and mental health services, especially when a child or parent screen is positive. Even when providers are knowledgeable about where to refer families, they may lack the resources to assist families in making an actual connection to the service. North Carolina providers can refer infants and young children to a Medicaid-covered case-management program, Care Coordination for Children, when a parent has a positive depression screen or other serious risk factors are present. To learn about the capacity of other states to offer similar assistance, the survey asked state administrators if the state Medicaid plan covers the services of a health navigator who can help connect either a young child or a parent to appropriate services following a child's positive social-emotional screen and/or a parent's positive depression screen.

- 9 states (18 percent) reported that Medicaid pays for a health navigator: AZ, HI, NC, NM, NV, OR, RI, VT, and WY; 40 states (78 percent) reported that they do not cover this service.

States that pay for health navigators reported on where they could be located.

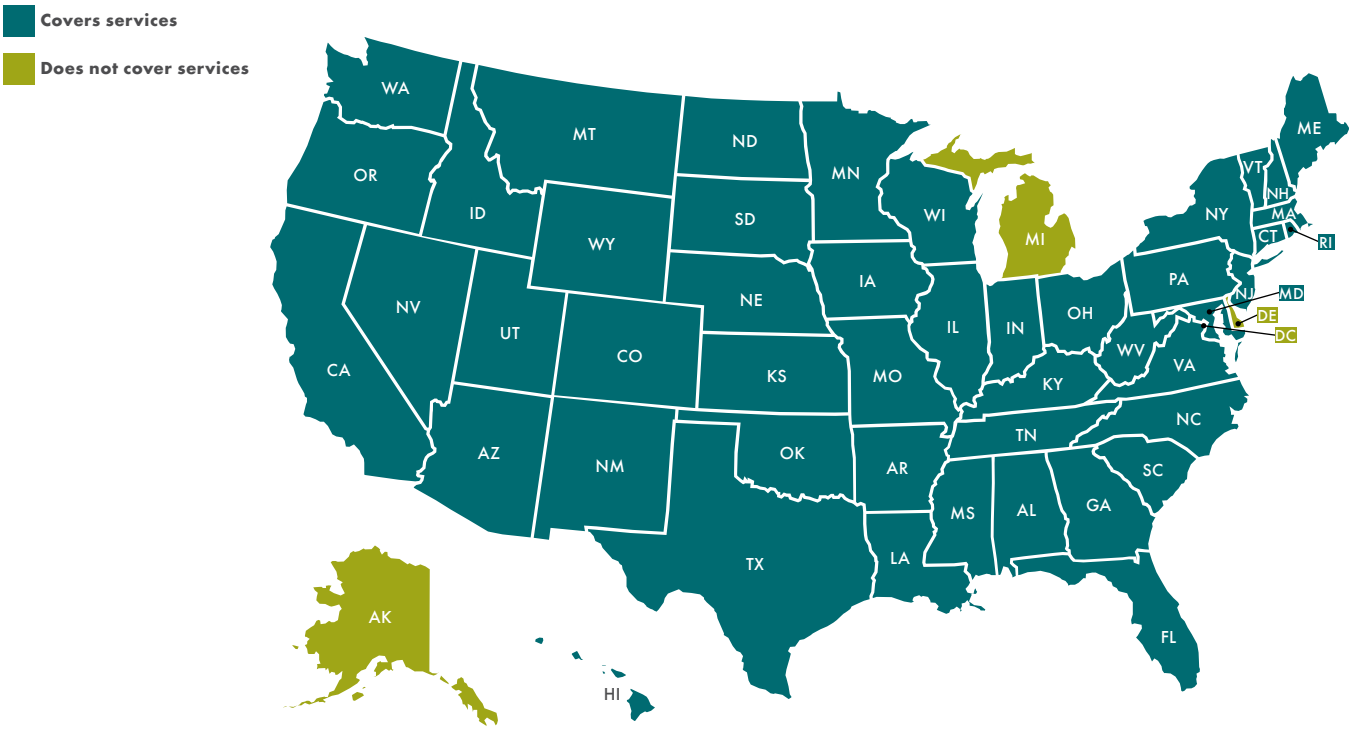
- 7 states (78 percent): in both the health provider's office and in the community (e.g., mental health clinic, Help Me Grow site)
- 2 states (22 percent): in the community

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.[11]

- 47 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 IECMH services in a pediatric/family medicine setting



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. 44 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.

- 45 states (96 percent) cover screening and diagnostic assessment.
- 44 states (94 percent) cover treatment.
- 26 states (55 percent) cover consultation with the parent about results of a positive screen.
- 24 states (51 percent) cover parent guidance when the parent has a concern about the child's behavior or mental health.
- 13 states (28 percent) cover consultation given to another professional/provider (preschool teacher, pediatrician).

Evidence-based practices are required in over 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.

- 14 states (30 percent) have a requirement that mental health clinicians use evidence-based practices: AZ, CA, FL, GA, HI, MS, ND, NE, NV, OH, OK, OR, TX, and WI.
- 35 states (74 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 IECMH 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 factors, as shown in Figure 3. Medical necessity was the most

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

Other codes can be used 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 helps the state of Oregon address children's mental health needs early in an effort to reduce the development of serious mental health conditions.

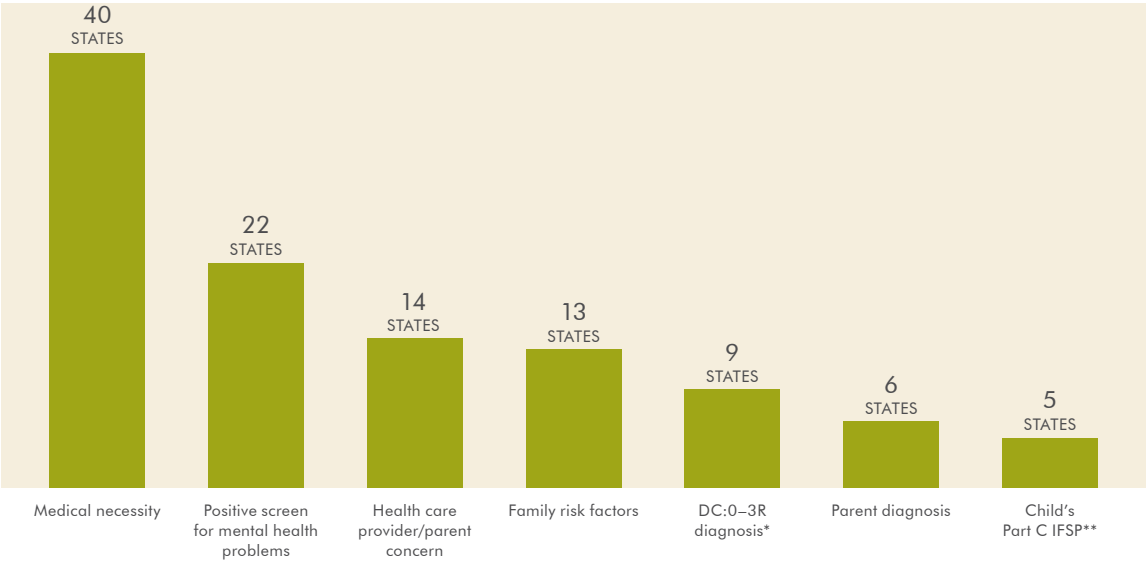
SOURCE Laurie Theodorou, Program and Policy Development Specialist, Department of Human Services and Oregon Health Authority (2016)

Oregon's use of "risk codes" associated with adverse circumstances such as child's exposure to severe family conflict or maltreatment allows providers to address young children's mental health needs early in an effort to prevent serious mental health conditions.

frequently identified requirement (40 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 (14 states); when a child has a positive social-emotional screen (22 states); and when family risk factors exist (13 states); when a parent has a diagnosis (6 states). 24 states (51 percent) offer treatment without diagnosis when there are family risk factors, including parent depression, that make it likely the child will experience a mental health condition.

Oregon was one of the first states to use an "at risk" code that enables 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: At-Risk Codes).

FIGURE 3 Medicaid eligibility requirements: mental health services in a pediatric/family medicine setting



*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. (Precursor to DC:0–5)

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

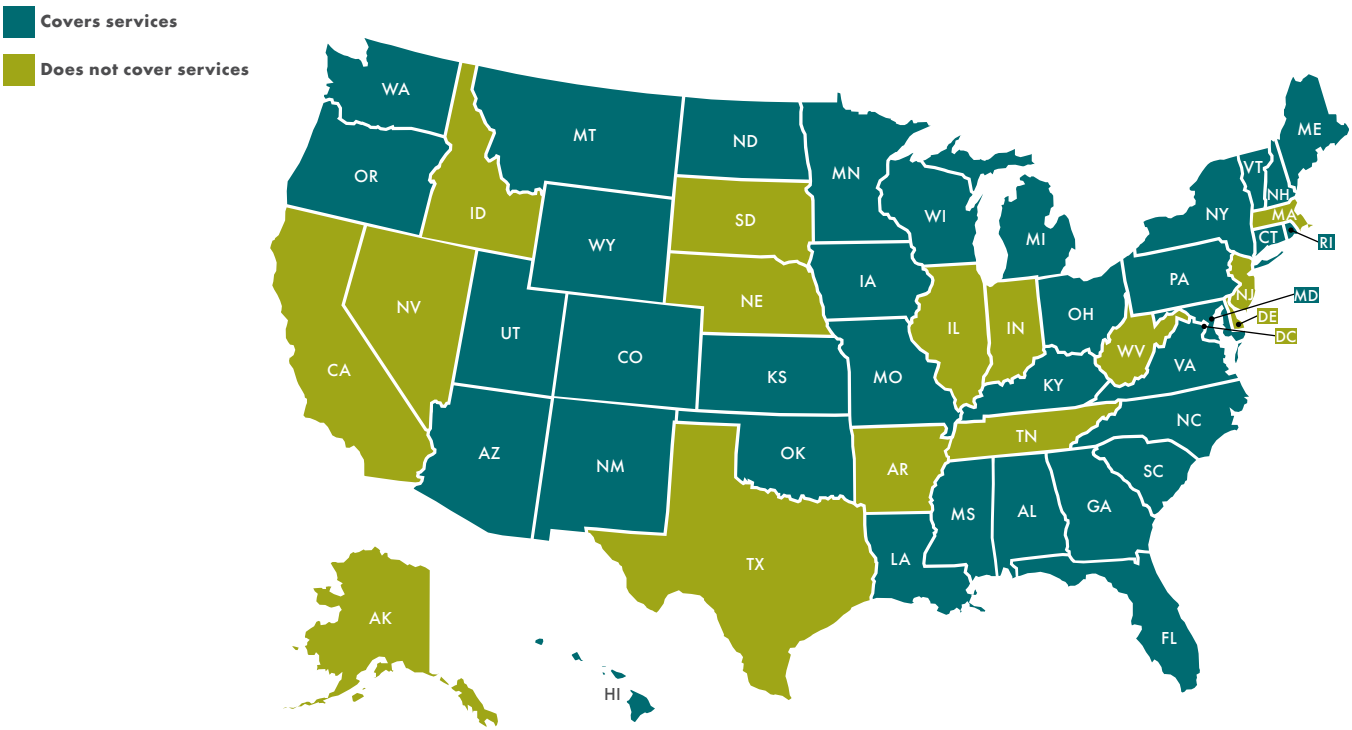
Services provided by an early childhood mental health specialist to address a child's mental health needs in child care and early education programs

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.[12] 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.

- 35 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; 16 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

States with Medicaid-covered IECMH services in early care and education settings



assessment, fewer than half cover consultation with 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, IECMH consultation or linked consultation and staff training can help reduce challenging behaviors in the classroom.[13] 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.[14]

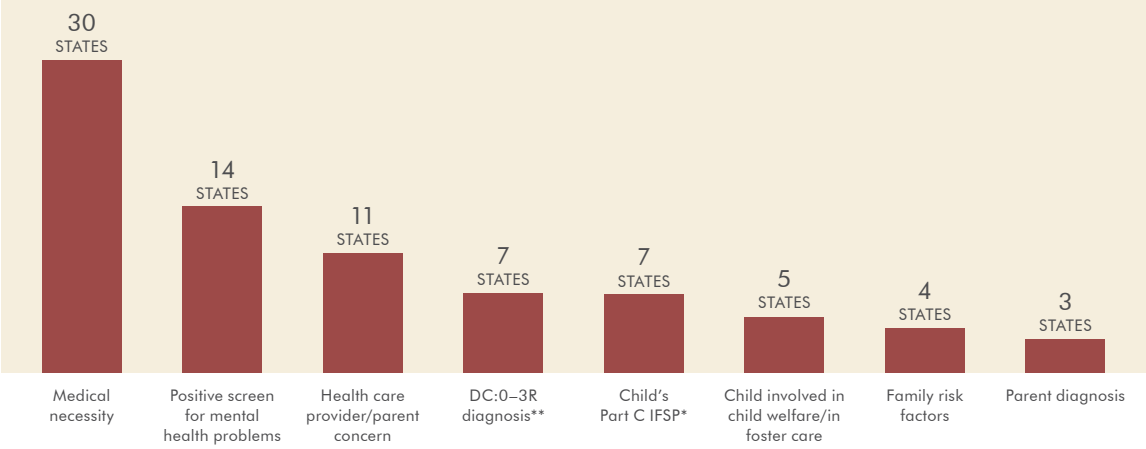
- 32 states (91 percent) cover treatment (e.g., child groups, parent-child treatment).
- 32 states (91 percent) cover screening or diagnostic assessment of the child for mental health problems.
- 14 states (40 percent) cover consultation with parent about concerns regarding an individual child.
- 13 states (37 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 a quarter reported that they place no restrictions on the number of visits for these services.

- 15 states (43 percent) require the use of evidence-based tools or practices: AL, AZ, FL, GA, IA, LA, MI, MS, ND, OH, OK, OR, SC, VT, and WI.
- 26 states (74 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 (14 states); involvement in child welfare (5 states); parent diagnosis (3 states); and provider or parent concerns (11 states).

FIGURE 4 Medicaid eligibility requirements: mental health services in child care/early education programs



*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. (Precursor to DC:0–5)

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

Services provided by a mental health clinician in the home setting to address a young child's mental health needs

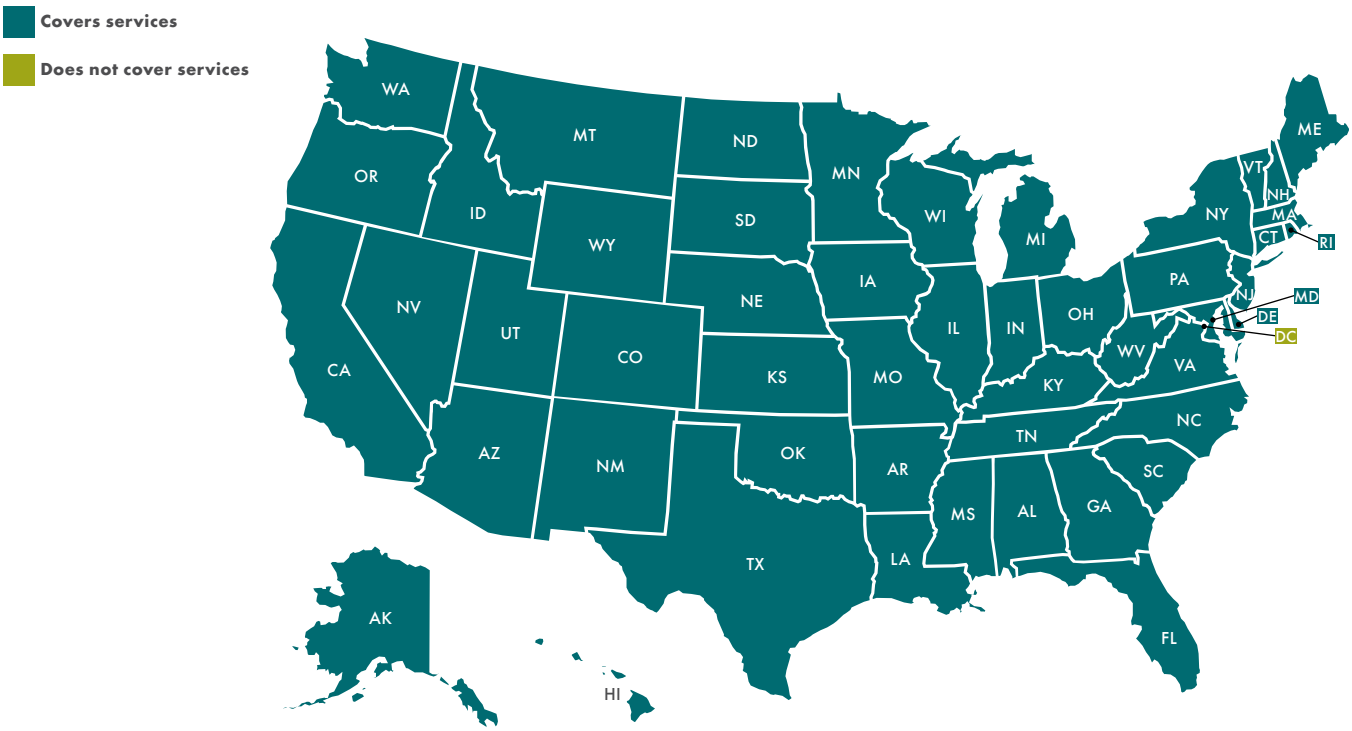
For many families, the home is the best place for receiving early childhood mental health services. Families with very young children may have difficulty traveling to a clinic for services, and some parents will feel more comfortable meeting with a mental health specialist at home. Almost all of the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

- 50 states (98 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; 1 state (2 percent) reported that it does not cover this service.

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

- 47 states (94 percent) cover screening or diagnostic assessment.
- 44 states (88 percent) cover child treatment, including parent-child dyadic therapy.
- 33 states (66 percent) cover parent guidance when parent has a concern about child's behavior or mental health.
- 15 states (30 percent) cover consultation given to another professional/provider.
- 3 states (6 percent) cover treatment for parent depression under child's Medicaid.

States with Medicaid-covered IECMH 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.

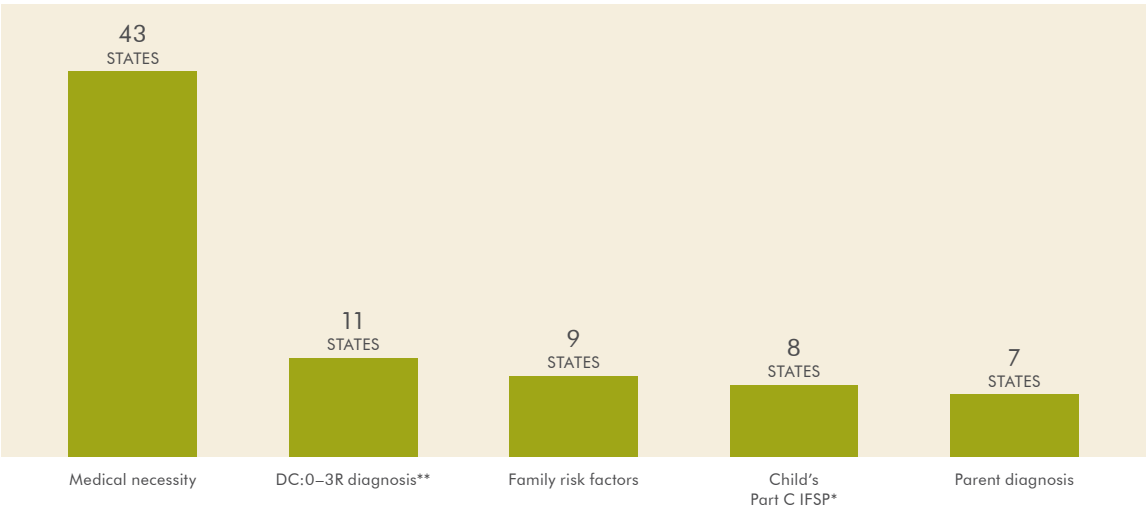
- 12 states (24 percent) reported that these services are sometimes provided as part of a state home-visiting program: CO, FL, HI, IA, KY, LA, MT, NM, NC, OR, RI and WV; in MS, these services are always provided as part of a state home-visiting program.

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 almost three-quarters do not place limits on the number of visits families receive from the mental health clinician.

- 19 states (38 percent) require the use of evidence-based tools or practices: AK, AZ, CA, CT, FL, HI, ID, IN, LA, MI, MS, MT, ND, NE, NV, OK, OR, TX, and WI.
- 36 states (72 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). Children without diagnosis can receive treatment in 23 states (46 percent) when there are family risk factors, including parent depression, that make it likely the child will experience a mental health condition.

FIGURE 5 Medicaid eligibility requirements: mental health services in the home



*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. (Precursor to DC:0–5)

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

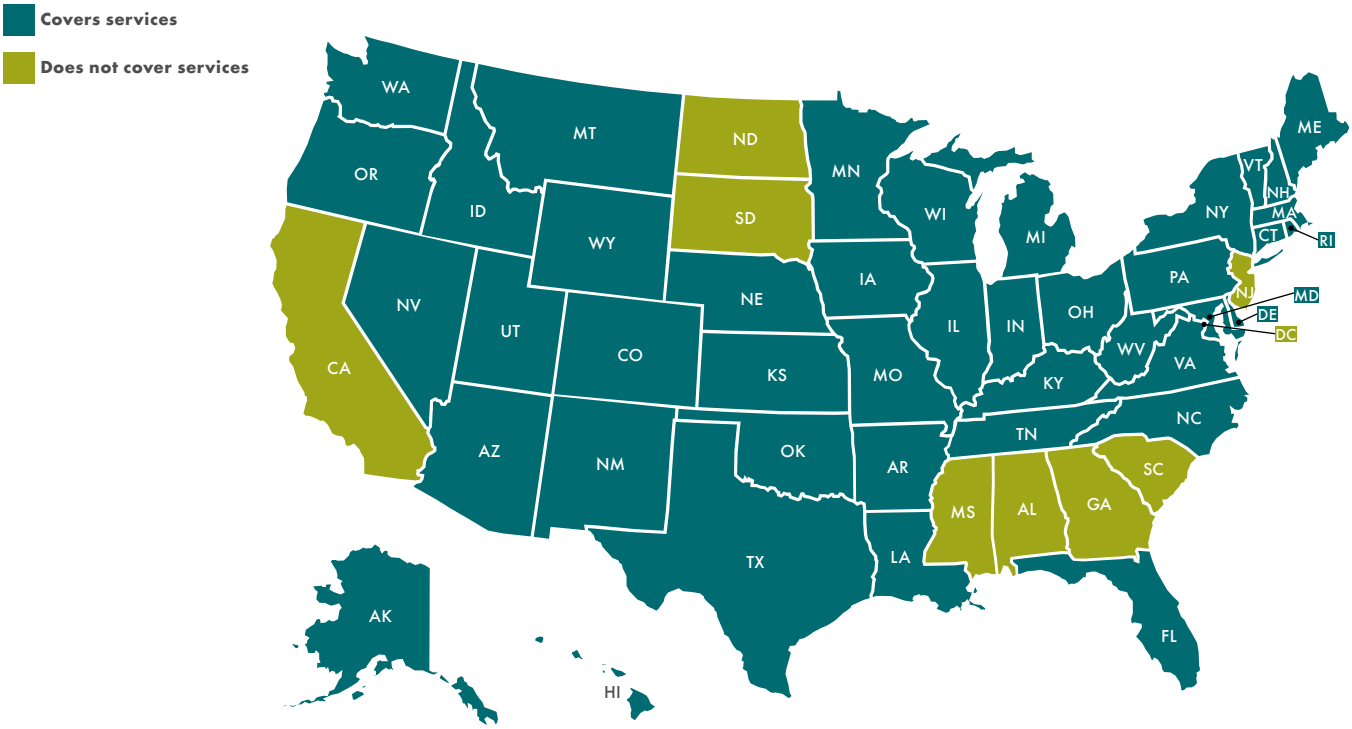
Dyadic (parent-child) treatment

Several models of dyadic (parent-child) treatment have been developed to address mental health and behavioral problems of young children. 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.

- 42 states (82 percent) reported that Medicaid pays for dyadic treatment of young children and parents; 9 states (18 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

States with Medicaid-covered dyadic (parent-child) treatment



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

- 11 states (26 percent) that cover dyadic treatment reported having a specific code for this treatment: AR, HI, LA, MA, MD, MI, MN, RI, UT, 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:

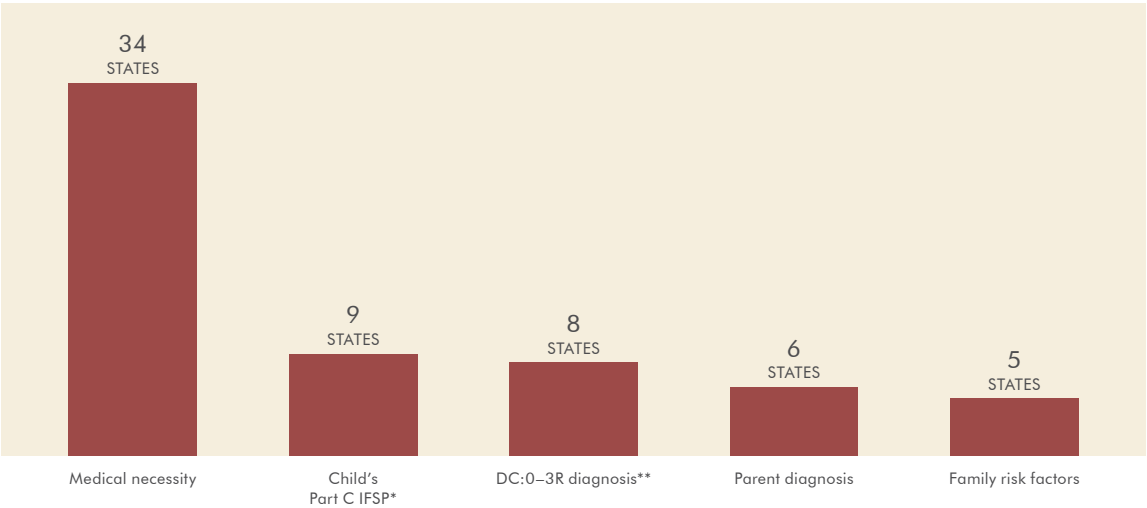
- 41 states (98 percent): mental health clinic
- 41 states (98 percent): home/foster home
- 35 states (83 percent): pediatric/family medicine care setting
- 28 states (67 percent): child care or early education program
- 7 states (17 percent): other community setting (e.g., family resource center, WIC site)

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.

- 12 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.
- 32 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). 18 states (43 percent) offer treatment without a child's diagnosis when there are family risk factors, including parent depression, that make it likely the child will experience a mental health condition.

FIGURE 6 Medicaid eligibility requirements: dyadic (parent-child) treatment



*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. (Precursor to DC:0–5)

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]

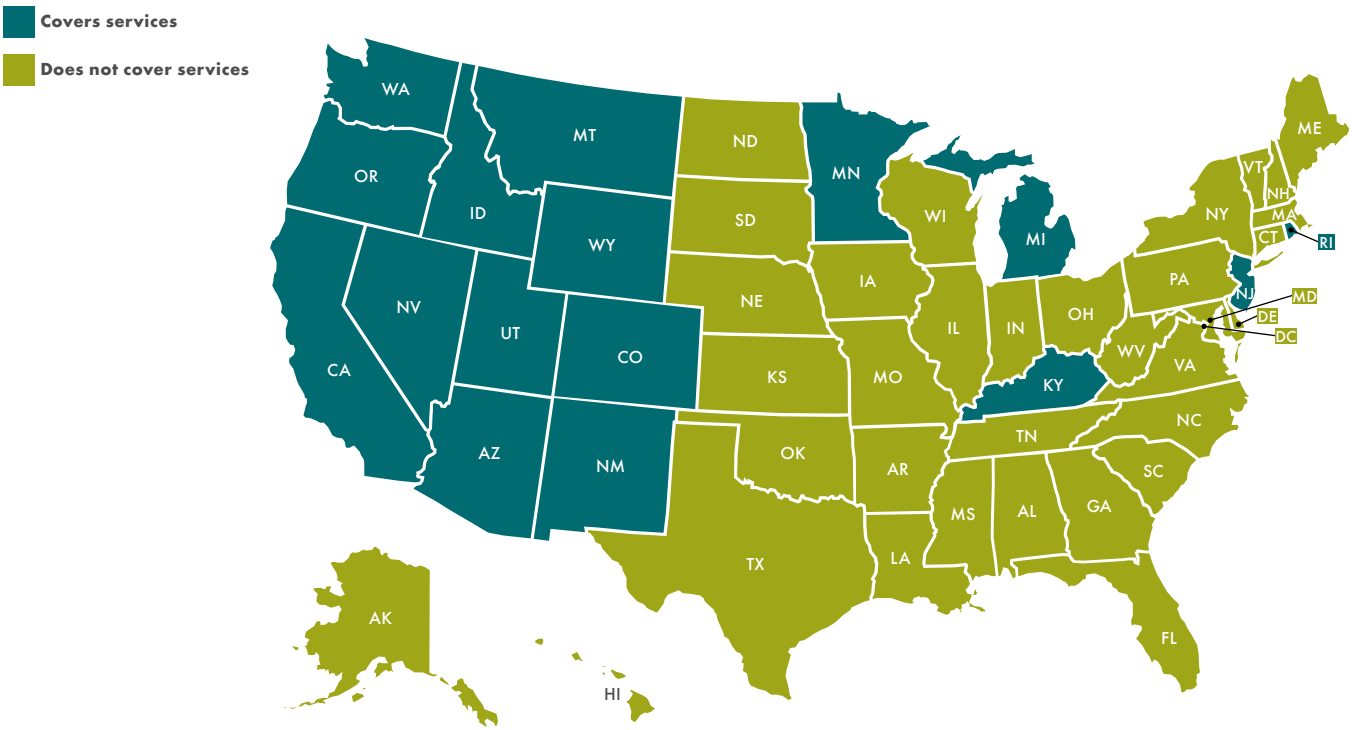
- 16 states (31 percent) reported that Medicaid pays for parenting programs designed to help parents of young children promote children's social-emotional development and address child mental health needs; 35 states (69 percent) reported that they do not cover this service.

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

- 15 states (94 percent): home/foster home
- 14 states (88 percent): mental health clinic
- 14 states (88 percent): pediatric/family medicine care setting
- 12 states (75 percent): other community setting (e.g., family resource center, WIC site)
- 10 states (63 percent): child care or early education program

Only 5 states, CO, ID, NV, OR, and WA, require providers to use an evidenced-based parenting

States with Medicaid-covered parenting programs



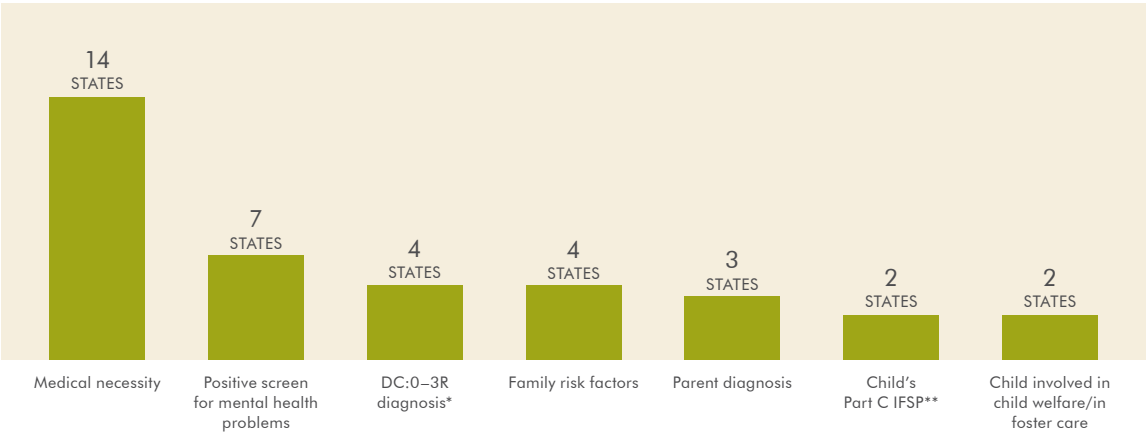
program. Medical necessity was reported to be an eligibility requirement by the largest number of states (14); one-quarter of the states or fewer cited the child's Part C Individualized Family Service Plan and risk factors, such as involvement in child welfare and parent diagnosis, as criteria used to determine eligibility for parenting programs (see Figure 7). 11 states (69 percent) offer treatment without diagnosis when there are family risk factors, including parent depression, that make it likely the child will experience a mental health condition.

Evidenced-based parenting program covered by Medicaid in Washington

A growing number of group parenting programs have demonstrated benefits for families with young children experiencing mental health problems, including improved parenting behavior, reduced child behavior problems, and strengthened parent-child relationships. In Washington state, Medicaid covers Triple P (Positive Parenting Program) for families with children as young as 18 months. The Triple P model offers different levels of intensity and can be tailored to families' needs. Sessions are conducted with individual families or groups of families in the home, community, or provider setting. The use of evidence-based models is encouraged in Washington and the state's Medicaid program requires providers to use a special code when billing for Triple P to indicate use of an evidence-based model.

SOURCES Rebecca Peters, Mental Health and ABA Program Manager (2018).

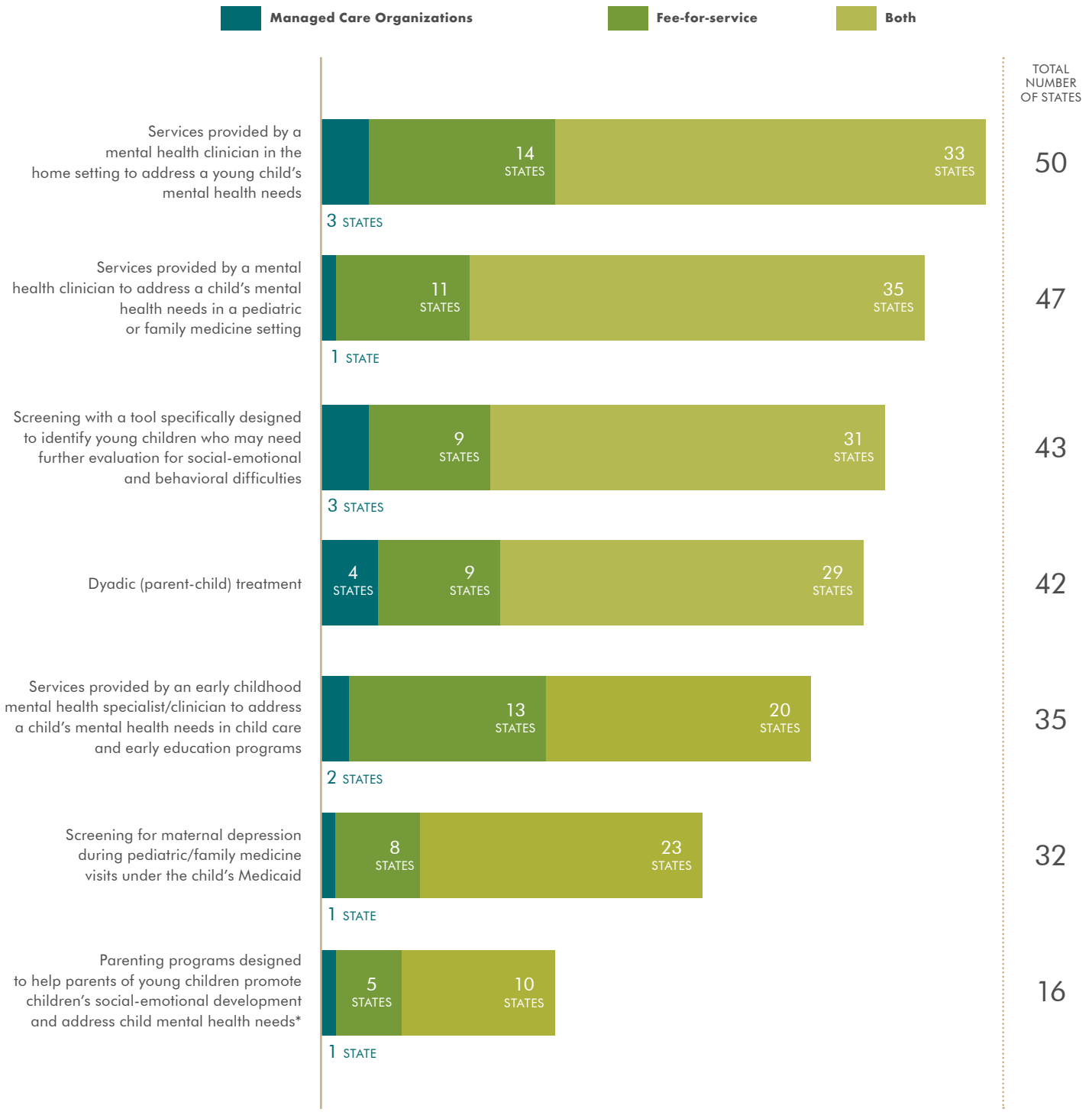
FIGURE 7 Medicaid eligibility requirements: parenting programs that promote children's social-emotional development and address child mental health needs



*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. (Precursor to DC:0–5)

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

FIGURE 8 Infant 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 infant early childhood mental health (IECMH) services and policies. While 2 states did not complete the update, we are counting their previous answers in this summary. 50 states and the District of Columbia (counted as a state in reported results) participated in the survey update. The following are key findings from the survey:

- A large number of states (35 to 50 states) report Medicaid coverage for 5 of the 7 IECMH services described in the survey: IECMH services in a home setting; IECMH services in a pediatric/family medicine setting; social-emotional screening of child; dyadic treatment; IECMH 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 fewer states (32 and 16, respectively). However, the number of states covering maternal depression screening has almost tripled in the past two years (see Appendix Table 2).
- Among states that cover child social-emotional and maternal depression screening under the child's Medicaid, many 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.
- Most states do not allow or promote the use of DC:0–5 for the diagnosis of infant and early childhood mental health conditions, even those this system is specially equipped to describe the mental health conditions that occur during this age period. Only 6 states require or encourage the use of DC:0–5.
- Only nine states reported Medicaid coverage for a health navigator to assist families in connecting with appropriate services when a child or parent has a positive screen.
- Fewer than one-third of the states that cover key IECMH services require the use of evidence-based practices or models; 12 of 42 states require the use of an evidence-based dyadic treatment model and 5 of 16 states require the use of an evidence-based parenting program.
- Among states that cover key IECMH 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 IECMH 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; more than 40 percent of states reported that family risk factors alone can qualify a child for IECMH services in the home and in a pediatric/family medicine setting, as well as for dyadic treatment.
- States appear to have a limited ability to determine trends in the delivery of certain IECMH services from the codes used for billing; only 23 states have a separate code for social-emotional screening of children and while 11 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 for 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 significant gaps between reported policy and service provision that can only be identified by further investigation.

Recommendations

Stakeholders and policymakers from a variety of sectors who are engaged in work that affects the mental health services available to young children can use the results presented in this report. These sectors include health and human services, early care and education, and philanthropy. The results can be used to examine options for improving Medicaid coverage for key early childhood mental health services, providers' ability to help families engage in services, and the quality of covered services. Below are recommendations for specific ways to use this report.

- Advocates and other stakeholders can meet with their state Medicaid officials to review the results of the survey, including the coverage of key IECMH 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 a state's Medicaid program is not currently covering one or more key services, encourage administrators and policymakers to 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 IECMH 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;

- For key services that 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. Information about how other states are helping providers deliver key covered services (e.g., through training, state guidance, case-management) can suggest ways to close the gap between policy and actual service delivery.

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 IECMH-related services, including maternal 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.

Appendix

TABLE 1 Screening with a tool designed to identify young children who may need further evaluation for social-emotional and behavioral difficulties

DATA ON STATES	NUMBER OF STATES		PERCENTAGE OF STATES	
	2017	2018	2017	2018
States included in the report	49	51	100%	100%
States covering social-emotional screens	41	43	84%	84%
States not covering social-emotional screens	8	8	16%	16%
States have a separate code for this service	18	23	44%	53%
Same-day social-emotional and developmental screenings are permitted	29	34	71%	79%
Social-emotional screening can be administered in a nonmedical setting	27	27	66%	63%
Home or foster home	22	23	81%	85%
Early care and education program	21	21	78%	78%
Part C Early Intervention session in home or community setting	20	22	74%	81%
Shelter (e.g., homeless shelter, domestic violence shelter)	19	20	70%	74%
Other community setting (e.g., family resource center, WIC clinic)	19	20	70%	74%
What screening tools must be used for a covered/reimbursed social-emotional screening?				
Any validated social-emotional screening tool	17	20	41%	47%
Only specific tools are allowed (e.g., ASQ-SE, DECA, SWYC)	9	10	22%	23%
Any social-emotional screening tool	15	13	37%	30%
How often can a social-emotional screening be conducted?				
As needed/medically necessary	32	34	78%	79%
Annually	3	2	7%	5%
Other	6	7	15%	16%
How is the service covered?				
Managed care organizations	4	3	10%	7%
Covered through fee-for-service	10	9	24%	21%
Both	27	31	66%	72%

TABLE 2 Screening for maternal depression during visits to a pediatrician or family medicine provider with coverage under the child's Medicaid

DATA ON STATES	NUMBER OF STATES		PERCENTAGE OF STATES	
	2017	2018	2017	2018
States included in the report	49	51	100%	100%
States covering depression screenings	11	32	22%	63%
States not covering depression screenings	38	19	78%	37%
What screening tools must be used for a covered/reimbursed screening?				
States require providers to use a validated depression screening tool	6	20	55%	63%
States only allow the use of specific tools (e.g., Edinburgh Postnatal Depression Scale, Patient Health Questionnaire-2, Patient Health Questionnaire-9)	3	9	27%	28%
States allow the use of any depression screening tool	2	3	18%	9%
How often can maternal depression screening be conducted?				
As needed/medically necessary	4	17	36%	53%
Within the child's first 6 months	N/A	5	N/A	16%
Up to 3 or 4 times until the child turns 1 year	5	8	45%	25%
Up to 4 times per year until the child turns 2 years	1	1	9%	3%
1 screen for children under 1 year	1	1	9%	3%
Limits screening to once a year	1	N/A	9%	N/A
Maternal depression screening can be administered in nonmedical settings	6	13	55%	41%
Home or foster home	5	9	83%	69%
Shelter (e.g., homeless shelter, domestic violence shelter)	5	9	83%	69%
Other community setting (e.g., family resource center, WIC clinic)	5	10	83%	77%
Early care and education program	4	9	67%	69%
Part C Early Intervention session in home or community setting	4	8	67%	62%
How is this service covered?				
Managed care organizations	1	1	9%	3%
Covered through fee-for-service	4	8	36%	25%
Both	6	23	55%	72%

TABLE 3 Services provided by a mental health clinician to address a child's mental health needs in a pediatric or family medicine setting

DATA ON STATES	NUMBER OF STATES		PERCENTAGE OF STATES	
	2017	2018	2017	2018
States included in the report	49	51	100%	100%
States covering child mental health services in a pediatric/family medicine setting	45	47	92%	92%
States not covering child mental health services in a pediatric/family medicine setting	4	4	8%	8%
What services are covered?				
Treatment	42	44	93%	94%
Screening and diagnostic assessment	41	45	91%	96%
Consultation with the parent about results of a positive screen	24	26	53%	55%
Parent guidance when the parent has a concern about the child's behavior or mental health	24	24	53%	51%
Consultation given to another professional/ provider (preschool teacher, pediatrician)	14	13	31%	28%
States require the use of evidence-based tools or practices	13	14	29%	30%
States have no limits on the number of visits from a mental health clinician in a pediatric/ family medicine setting	33	35	73%	74%
How is a child's eligibility determined?				
Medical necessity	36	40	80%	85%
Positive screen for mental health problems	17	22	38%	47%
Health care provider/parent concern	9	14	20%	30%
Family risk factors	9	13	20%	28%
DC:0–3R diagnosis	8	9	18%	19%
Child's Part C IFSP	8	5	18%	11%
Parent diagnosis	4	6	9%	13%
States offer treatment without a child's diagnosis when there are family risk factors	N/A	24	N/A	51%
How is the service covered?				
Managed care organizations	2	1	4%	2%
Covered through fee-for-service	12	11	27%	23%
Both	31	35	69%	74%

TABLE 4 Services provided by an early childhood mental health specialist to address a child's mental health needs in child care and early education programs

DATA ON STATES	NUMBER OF STATES		PERCENTAGE OF STATES	
	2017	2018	2017	2018
States included in the report	49	51	100%	100%
States covering child mental health services in child care and early education settings	34	35	69%	69%
States not covering child mental health services in child care and early education settings	15	16	31%	31%
What services are covered?				
Treatment	31	32	91%	91%
Screening and diagnostic assessment	31	32	91%	91%
Consultation with parent about concerns regarding and individual child	14	14	41%	40%
Consultation with teachers about interventions and supports to address an individual child's behavioral and mental health needs	13	13	38%	37%
Consultation with teachers and program directors to help strengthen practices that promote young children's mental health and social-emotional growth	0	0	0%	0%
Group training of staff on supporting young children's social-emotional growth and addressing mental health needs of children	0	0	0%	0%
States require the use of evidence-based tools or practices	14	15	41%	43%
States have no restrictions on the number of visits	24	26	71%	74%
How is a child's eligibility determined?				
Medical necessity	26	30	76%	86%
Child's Part C IFSP	16	7	47%	20%
Health care provider/parent concern	10	11	29%	31%
Positive screen for mental health problems	10	14	29%	40%
DC:0–3R diagnosis	7	7	21%	20%
Child involved in child welfare/in foster care	6	5	18%	14%
Family risk factors	4	4	12%	11%
Parent diagnosis	3	3	9%	9%
How is this service covered?				
Managed care organizations	2	2	6%	6%
Covered through fee-for-service	16	13	47%	37%
Both	16	20	47%	57%

TABLE 5 Services provided by a mental health clinician in the home setting to address a young child's mental health needs

DATA ON STATES	NUMBER OF STATES		PERCENTAGE OF STATES	
	2017	2018	2017	2018
States included in the report	49	51	100	100
States covering child mental health services in the home setting	46	50	94%	98%
States not covering child mental health services in the home setting	3	1	6%	2%
What services are covered?				
Child treatment, including parent-child dyadic therapy	41	44	89%	88
Screening and diagnostic assessment	39	47	85%	94
Parent guidance when the parent has a concern about the child's behavior or mental health	28	33	61%	66
Consultation given to another professional/ provider	15	15	33%	30
Treatment for parent depression under child's Medicaid	3	3	7%	6%
Services are provided as part of a state home-visiting program	10	12	22%	24%
States require the use of evidence-based tools or practices	17	19	37%	38%
States have no limits on the number of visits from a mental health clinician in the home setting	30	36	65%	72%
How is a child's eligibility determined?				
Medical necessity	40	43	87%	86%
Child's Part C IFSP	11	8	24%	16%
DC:0–3R diagnosis	9	11	20%	22%
Family risk factors	8	9	17%	18%
Parent diagnosis	6	7	13%	14%
States offer treatment without a child's diagnosis when there are family risk factors	N/A	23	N/A	46%
How is the service covered?				
Managed care organizations	6	3	13%	6%
Covered through fee-for-service	13	14	28%	28%
Both	27	33	59%	66%

TABLE 6 Dyadic (parent-child) treatment

DATA ON STATES	NUMBER OF STATES		PERCENTAGE OF STATES	
	2017	2018	2017	2018
States included in the report	49	51	100%	100%
States covering dyadic treatment	38	41	78%	82%
States not covering dyadic treatment	11	9	22%	18%
States have a specific code for dyadic treatment	12	11	32%	26%
In what settings can dyadic treatment be provided and paid for by Medicaid?				
Mental health clinic	37	41	97%	98%
Home/foster home	36	41	95%	98%
Pediatric/family medicine care setting	29	35	76%	87%
Child care or early education program	22	28	58%	67%
Other community setting (e.g., family resource center, WIC site)	25	7	66%	17%
States require providers to use an evidenced-based dyadic treatment model	11	12	29%	29%
States have no limits on the number of dyadic treatment visits	29	32	76%	76%
How is a child's eligibility determined?				
Medical necessity	31	34	82%	81%
Child's Part C IFSP	8	9	21%	21%
DC:0–3R diagnosis	6	8	16%	19%
Parent diagnosis	5	6	13%	14%
Family risk factors	4	5	11%	12%
States offer treatment without a child's diagnosis when there are family risk factors	N/A	18	N/A	43%
How is the service covered?				
Managed care organizations	6	4	16%	10%
Covered through fee-for-service	8	9	21%	21%
Both	24	29	63%	69%

TABLE 7 Parenting programs designed to help parents of young children promote children's social-emotional development and address child mental health needs

DATA ON STATES	NUMBER OF STATES		PERCENTAGE OF STATES	
	2017	2018	2017	2018
States included in the report	49	51	100%	100%
States covering parenting programs	12	16	24%	31%
States not covering parenting programs	37	35	76%	69%
In what settings can a Medicaid covered parenting program be delivered?				
Mental health clinic	10	14	83%	88%
Pediatric/family medicine care setting	9	14	75%	88%
Home/foster home	9	15	75%	94%
Child care or early education program	8	10	67%	63%
Other community setting (e.g., family resource center, WIC site)	8	12	67%	75%
States require providers to use an evidenced-based parenting programs	2	5	17%	31%
How is a child's eligibility determined?				
Medical necessity	11	14	92%	88%
Child's Part C IFSP	4	2	33%	13%
Child involved in child welfare/in foster care	3	2	25%	13%
DC:0–3R diagnosis	3	4	25%	25%
Positive screen for mental health problems	3	7	25%	44%
Family risk factors	2	4	17%	25%
Parent diagnosis	2	3	17%	19%
States offer treatment without a child's diagnosis when there are family risk factors	N/A	11	N/A	69%
How is this service covered?				
Managed care organizations	2	1	17%	7%
Covered through fee-for-service	5	5	42%	33%
Both	5	10	42%	60%

REFERENCES

[1] Jones, D. E., Greenberg, M., & Crowley, M. (2015). Early social-emotional functioning and public health: the relationship between kindergarten social competence and future wellness. *Journal Information*, 105(11).

Jones, D., Dodge, K. A., Foster, E. M., Nix, R., & Conduct Problems Prevention Research Group. (2002). Early identification of children at risk for costly mental health service use. *Prevention Science*, 3(4), 247–256.

Blair, C., & Raver, C. C. (2015). School readiness and self-regulation: A developmental psychobiological approach. *Annual Review of Psychology*, 66, 711–731.

[2] Early and Periodic Screening, Diagnostic, and Treatment. (n.d.). Retrieved from https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

[3] (Publication). (n.d.). Retrieved from www.acf.hhs.gov/sites/default/files/ecd/pcp_screening_guide_march2014.pdf

[4] CIB: Maternal Depression Screening and Treatment: A Critical Role for Medicaid. (n.d.). Retrieved July 28, 2016, from www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf

[5] Harden, B. J. (2015). Services for Families of Infants and Toddlers Experiencing Trauma. A Research-to-Practice Brief. OPRE Report 2015–14. *Administration for Children & Families*.

[6] Hull, P. C., Husaini, B. A., Tropez-Sims, S., Reece, M., Emerson, J., & Levine, R. (2008). EPSDT preventive services in a low-income pediatric population: impact of a nursing protocol. *Clinical pediatrics*, 47(2), 137–142.

Markus, A. R., & West, K. D. (2014). Defining and Determining Medical Necessity in Medicaid Managed Care. Pediatrics, 134(3), 516–522. Perry, C. D., & Kenney, G. M. (2007). Preventive care for children in low-income families: how well do Medicaid and state children's health insurance programs do? *Pediatrics*, 120(6), e1393–e1401.

Bringewatt, E. H., & Gershoff, E. T. (2010). Falling through the cracks: Gaps and barriers in the mental health system for America's disadvantaged children. *Children and Youth Services Review*, 32(10), 1291–1299.

[7] Sandra H. Jee, Szilagyi, M., Ovenshire, C., Norton, A., Conn, A.-M., Blumkin, A., et al. (2010). Improved detection of developmental delays among young children in foster care. *Pediatrics*, 25(2), 282–289.

[8] Squires, J., Bricker, D. D., & Twombly, E. (2015). *ASQ-SE-2 User's Guide*.

Perrin, E. C., Sheldrick, C., Visco, Z., & Mattern, K. (2016). *The Survey of Well-being of Young Children (SWYC) User's Manual*. Tufts Medical Center.

DECA technical manual reference—information on development and standardization of DECA, as well as results of studies examining DECA's reliability and validity.

LeBuffe, P. A., & Naglieri, J. A. (1999). *Devereux early childhood assessment: technical manual*. Kaplan Early Learning Company.

[9] A 50-State Look at Medicaid Expansion. Retrieved November 19, 2018, from https://familiesusa.org/product/50-state-look-medicaid-expansion

Special Populations: Pregnant Women Fast Facts for Assisters. (n.d.). Retrieved July 29, 2016, from https://marketplace.cms.gov/technical-assistance-resources/special-populations-pregnant-women.pdf

[10] ZERO TO THREE (2016) DC:0–5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: A Briefing Paper: Washington, DC: Author. Available at: https://www.zerotothree.org/resources/1953-dc-0-5-a-briefing-paper-on-diagnostic-classification-of-mental-health-and-developmental-disorders-of-infancy-and-early-childhood

[11] Tolan, P. H., & Dodge, K. A. (2005). Children's mental health as a primary care and concern: a system for comprehensive support and service. *American Psychologist*, 60(6), 601.

Guevara, J. P., Greenbaum, P. E., Shera, D., Bauer, L., & Schwarz, D. F. (2009). Survey of mental health consultation and referral among primary care pediatricians. *Academic pediatrics*, 9(2), 123–127.

[12] Hughes, M. A., Spence, C. M., & Ostrosky, M. M. (2015). Early Childhood Mental Health Consultation Common Questions and Answers. *Young Exceptional Children*, 18(3), 36–51.

[13] Perry, D. F., & Conners-Burrow, N. (2016). Addressing early adversity through mental health consultation in early childhood settings. *Family Relations*, 65(1), 24–36.

[14] Yudron, M., Jones, S. M., & Raver, C. C. (2014). Implications of different methods for specifying classroom composition of externalizing behavior and its relationship to social-emotional outcomes. Early Childhood Research Quarterly, 29(4), 682–691.

[15] Azzi-Lessing, L. (2011). Home visitation programs: critical issues and future directions. *Early Childhood Research Quarterly*, 26(4), 387–398.

[16] Willheim, E. (2013). Dyadic psychotherapy with infants and young children: *Child-parent psychotherapy. Child and adolescent psychiatric clinics of North America*, 22(2), 215–239.

Eyberg, S. M., Funderburk, B. W., Hembree-Kigin, T. L., McNeil, C. B., Querido, J. G., & Hood, K. K. (2001). Parent-child interaction therapy with behavior problem children: One and two-year maintenance of treatment effects in the family. Child & Family Behavior Therapy, 23(4), 1–20.

[17] National Center for Parent, Family and Community Engagement. (2015). Compendium of parenting interventions. Washington, D.C.: National Center on Parent, Family, and Community Engagement, Office of Head Start, U.S. Department of Health & Human Services

[18] Families USA, June 2012, State Plan Amendments and Waivers: How States Can Change Their Medicaid Programs. Washington: DC. https://familiesusa.org/sites/default/files/product_documents/State-Plan-Amendments-and-Waivers.pdf