

Medicaid Policies to Help Young Children Access Key Infant-Early Childhood Mental Health Services:

RESULTS FROM A 50-STATE SURVEY

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Introduction

The mental health needs of our nation's children are currently receiving greater attention as a result of the COVID-19 pandemic.¹ Many circumstances that negatively affect children's well-being have become more common during the pandemic, including increased parent stress, social isolation of children and their families, and personal loss.² While efforts to expand supports for the mental health of all children are needed, it is especially important to examine current policies that can promote the mental health of infants and young children, and to consider opportunities to strengthen these policies and their implementation. Positive mental health in the first five years makes a significant contribution to outcomes that help children thrive throughout childhood and beyond. These outcomes include a reduced risk of serious mental health problems, better health-related behavior, and success in school.³

Most infants and young children experience positive mental health and social-emotional development. Positive mental health in the early years is evident in children's curiosity and desire to explore, ability to express a range of emotions, and enjoyment of play, communication, and nurturing interactions with trusted caregivers.⁴ A smaller yet sizable portion of infants and young children experience social-emotional delays and mental health problems that, if not adequately addressed, lead to bigger challenges in later years. Signs of possible infant-early childhood mental health problems are varied and include difficulties in relationships with caregivers, persistent emotional distress, and disruptions in sleeping or feeding.⁵ Mental health problems in very young children can interfere with daily activities that provide opportunities for learning and development, increasing children's risk of future behavior and academic problems.⁶ Estimates of children who show behavior difficulties in the first five years range from 15 to 26 percent.⁷

Fortunately, research points to practical ways to identify infants and young children with mental

health problems and effective interventions to address these problems.⁸ At a time when there is grave concern about both children's mental health and learning loss during the pandemic, it is important to focus on policies and practices that can support the mental health of infants and young children as a powerful strategy for helping ensure children's capacity for long-term learning, school success, and well-being.

This report presents results of a 50-state policy survey conducted by the National Center for Children in Poverty, Georgetown University McCourt School of Public Policy Center for Children and Families, and Johnson Policy Consulting. The survey asked state Medicaid agency leaders about Medicaid policies related to screenings and services designed to identify, prevent, and treat infant-early childhood mental health problems. The results and recommendations presented in this report can help mental health and early childhood leaders take stock of current Medicaid policies and their potential to support infant-early childhood mental health.

WHAT IS IECMH?

Infant-early childhood mental health (IECMH) refers to young children's growing capacity in the first five years to form close, secure relationships with caregivers and peers; experience, manage and express a full range of emotions; and explore and engage with the environment. The growth of these capacities is also called "social-emotional development," and it occurs in the context of caregiver-child relationships, culture, and community. IECMH has impacts on all other domains of development and therefore has central importance to children's opportunity to thrive. (See also: [Planting Seeds in Fertile Ground: Actions Every Policymaker Should Take to Advance Infant and Early Childhood Mental Health.](#))

Why Medicaid?

Medicaid, and its smaller companion, Children's Health Insurance Program (CHIP), have unparalleled reach to children and their families. At least three-fourths of low-income children under age 6 rely on Medicaid or CHIP for health coverage.⁹ The program's reach to historically marginalized children and families also helps promote health equity: Medicaid is the predominant payer in US births, including 65 percent of births to Black women and 60 percent of births to Hispanic women in 2019.¹⁰ More than half of Black, Hispanic, and American Indian or Alaska Native children in the United States are covered by Medicaid or CHIP.¹¹

Medicaid's child health benefit, called Early Periodic Screening Diagnostic and Treatment (EPSDT), requires states to finance screening, diagnostic services, and any medically necessary treatment resulting from screening or diagnostic assessments. The EPSDT benefit is designed to prevent or address problems early, before they become more serious and difficult to treat.¹² (See box on EPSDT.)

Managed care is a major player in the delivery of Medicaid financed health and mental health services for young children. In most states and for the majority

of children nationwide, health care is provided through managed care organizations or similar entities. Private or non-profit managed care plans contract with state Medicaid agencies to provide comprehensive care and are typically paid based on a per-member, per-month rate.¹³ In addition, many states provide Medicaid services to children with special health care needs, such as children in foster care or in separate managed care organizations.¹⁴

Young children covered by Medicaid are growing up in low-income families that have always been more likely to experience multiple sources of stress related to financial insecurity.¹⁵ These families have confronted even greater adversities during the pandemic, making parents and children more vulnerable to mental health problems.¹⁶ This report shows how Medicaid IECMH-related policies can be leveraged to offer families with infants and young children equitable access to supports that are essential to children's healthy development in the early years and beyond.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)

EPSDT, Medicaid's child health benefit, is designed to provide coverage for a comprehensive array of preventive, diagnostic, and treatment services for enrolled children ages birth to 21 years, and includes screening and services related to developmental and mental health.

Federal guidelines require that states finance Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions. States vary in the processes they use to ensure timely screening visits and to give approval for medically necessary treatments. In the face of current concerns about children's mental health, the Centers for Medicare & Medicaid Services (CMS) **issued a bulletin** last year to remind states that EPSDT requires coverage of mental and behavioral health services.

Federal guidance states: "The goal of EPSDT is to assure that individual children get the health care they need when they need it—the right care to the right child at the right time in the right setting."

Methods

The Infant-Early Childhood Mental Health (IECMH) Medicaid Survey was administered through Qualtrics, a secure online data collection system. An invitation to complete the survey, along with a survey link, was sent by email to State Medicaid directors using contact information in a publicly available list created by the **National Association of Medicaid Directors**. When the Medicaid director's contact information was not available, research staff searched for other Medicaid agency staff (e.g., administrators from EPSDT and behavioral health services) on the state's Medicaid website and consulted with state advocacy organizations to identify an appropriate contact to receive an invitation to complete the survey. Most participants completed the survey using the online link they received, but a few states opted to complete the survey on a Word document. In several states, respondents consulted with colleagues within their Medicaid agency.

All states received a PDF copy of their completed survey and were given two weeks to review their survey responses for accuracy. Project staff had follow-up calls with Medicaid contacts in several states to obtain additional information about Medicaid-covered services, supports for implementation, and selected policies. Descriptive information from the survey and these calls is provided in the next section. The reported results are based on the 46 states, including DC, that completed the survey. Five states (DE, FL, NE, NH, and WI) were unable to complete the survey. All of the reported percentages are based on the number of responding states, which vary by item. Please note that it is not possible to reliably compare results of an earlier 2018 **report** to those in this report due to changes in the most recent survey and differences in the states that responded.

THE ROLE OF HEALTH CARE CODES IN IECMH

The survey asked about codes used for different types of IECMH screening and treatment services. In the US health insurance system, coding systems provide a means for health care practitioners to document observations or the provision of specific services, and may be tied to reimbursement. **Two popular coding systems** in pediatric primary care are the Current Procedural Terminology (CPT®) and International Classification of Diseases (ICD-10). These coding systems help providers document medical necessity for services, screenings, assessments, and treatments provided, as well as diagnoses.

States are increasingly looking to 'Z' codes (also called V codes in different classification systems) to document issues that affect a patient's health. When documenting the need for IECMH services, Z codes are sometimes used to indicate risks, such as parent depression or social needs, that may show the child's need for additional services even in the absence of a formal diagnosis. In this way, Z codes allow practitioners to help families access specific services that may prevent, delay, or mitigate a later diagnosis for a child. **Studies show** that state policies play a role in the degree to which providers and health systems use these Z codes.

As IECMH policies and practices evolve across the states, it will be important for Medicaid leaders, IECMH practitioners, and other stakeholders to consider how codes can be used to promote equitable access to needed IECMH services. Given this changing landscape, there is also a need for ongoing, clear guidance from Medicaid agencies to help practitioners and other stakeholders understand new policies related to codes and IECMH services.

Results

SCREENING

Most states use the **Bright Futures Guidelines** for preventive care visits, the guidance on children’s preventive services provided by the American Academy of Pediatrics and federal Health Resources and Services Administration. These guidelines include a **periodicity schedule** that calls for regular child social-emotional screening for children beginning in early infancy and a series of maternal depression screenings in the first year. The schedule also indicates that a social-emotional screening may include questions about social determinants of health.

The survey asked whether Medicaid provides a supplemental payment for three types of screening: child social-emotional, maternal depression, and social determinants of health screening. Supplemental payments offer one way to incentivize particular types of screenings. For child and parent screenings, survey respondents could indicate that they offer a supplemental payment or that the screening is considered part of a well-child visit payment. In the case of a screening for social determinants of health (SDOH), states were given a third option indicating the screening is “not covered” by Medicaid; this option was given because SDOH screening is relatively new, and it was assumed that some state Medicaid agencies might not cover screening for SDOH. The survey also asked about screening billing codes and whether the state requires or recommends the use of a specialized social-emotional screener or uses standardized tools for maternal depression and social determinants of health screening. (See box on health care codes.)

Child Social-Emotional Screening

The early identification of possible IECMH problems that may require evaluation and treatment is now widely viewed as a pillar of best practice in pediatrics. Bright Futures calls for **regular** social-emotional (SE) screens of children in the first five years (separate from broad developmental screens) and the use of **validated SE screening tools**. A little over one-third of the states (17) reported that they provide a supplemental payment for child SE screening. (See Table 1).

OREGON IS FIRST IN THE NATION TO ADOPT A KINDERGARTEN READINESS METRIC FOCUSED ON IECMH

As part of its efforts to promote health system contributions to kindergarten readiness, Oregon began offering incentive payments in 2022 to Coordinated Care Organizations (CCOs, the state’s unique community-based, comprehensive service approach to Medicaid managed care), to adopt a **kindergarten readiness incentive metric** focused on early childhood social-emotional health. With the goal of moving to a child-specific measure in later years, the first phase of the incentive uses a systems-level metric that requires CCOs to conduct comprehensive community outreach and planning. These systems-level initiatives are intended to develop needed capacity, resources, and service linkages that will strengthen supports for early childhood social-emotional health and achieve greater health equity for historically marginalized communities.

(See also: [Moving Toward Prevention: Oregon Launches Kindergarten Readiness Metric.](#))

TABLE 1

States Provide Supplemental Payment for Child SE Screening

17 states provide supplemental payment	AZ, CA, CO, CT, GA, IN, KS, MA, MD, ME, MI, ND, OH, OK, SC, SD, WA
29 states cover as part of well-child visit	AK, AL, AR, DC, HI, IA, ID, IL, KY, LA, MN, MO, MS, MT, NC, NJ, NM, NV, NY, OR, PA, RI, TN, TX, UT, VA, VT, WV, WY

Among the 17 states that provide a supplemental payment for social-emotional screening, 11 states have a billing code specifically for a social-emotional screening (not for a general developmental screening): GA, KS, MA, MD, ME, MI, ND, OK, SC, SD, and WA. Most other states use a code for general developmental screening.

The survey asked if the program has policy or guidance that “requires” or “recommends” a standardized SE screening tool specifically designed to identify children who may have social-emotional delays or conditions. As shown in Table 2, two-thirds of states (31) recommend or require this practice. The use of a separate code specifically for SE screening and a requirement or recommendation to use a specialized SE screener helps to distinguish SE screening from broad developmental screening. Research has shown that compared to broad developmental screeners, the use of screening tools specifically designed to screen for SE concerns appropriately identify more children in need of further evaluation for conditions in this domain.¹⁷

Maternal Depression Screening

In 2016, CMS issued **guidance** encouraging state Medicaid agencies to promote maternal depression screening and allow billing for this screening under the child’s EPSDT Medicaid benefit. CMS highlighted the benefits of early identification of maternal depression and provision of needed interventions for children, citing this condition’s potential for causing serious, long-lasting harm to children’s development. Over half of the states (25) reported that Medicaid provides a supplemental payment for maternal depression screening under the child’s Medicaid.

Among the 25 states that provide a supplemental payment for maternal depression screening, 16 states reported using a billing code for caregiver-focused risk screening: AL, AZ, CO, GA, IN, KS, LA, ME, ND, OK, OR, PA, SC, SD, TX, and WA. Most other states use a code for general developmental screening.

As shown in Table 4, nearly 75 percent of the states (34) reported that use of a standardized tool for maternal depression screening is required or recommended.

TABLE 2

States Require/Recommend Specialized Tool for SE Screening	
14 states require	AZ, CT, GA, HI, KS, MA, ME, MS, NC, NM, OH, OR, TN, TX
17 states recommend	IA, IN, KY, LA, MD, MI, MN, MT, ND, NV, NY, OK, SC, VT, WA, WV, WY
13 states do not require or recommend	AL, AR, CA, CO, DC, ID, IL, MO, NJ, RI, SD, UT, VA

(Table 2 is missing a response from AK and PA)

TABLE 3

States Provide Supplemental Payment for Maternal Depression Screening	
25 states provide supplemental payment	AL, AZ, CO, CT, DC, GA, ID, IN, KS, LA, MA, MD, ME, MI, MO, MS, ND, NY, OK, OR, PA, SC, SD, TX, WA
21 states cover as part of well-child visit	AK, AR, CA, HI, IA, IL, KY, MN, MT, NC, NJ, NM, NV, OH, RI, TN, UT, VA, VT, WV, WY

TABLE 4

States Require/Recommend Standardized Tool for Maternal Depression Screening	
17 states require	AZ, CA, GA, HI, ID, KS, LA, MA, ME, MI, MS, NJ, OK, OR, PA, SD, TX
17 states recommend	CO, CT, IA, IL, IN, KY, MD, MN, MT, NC, ND, NM, NY, SC, VT, WA, WV
12 states do not require or recommend	AK, AL, AR, DC, MO, NV, OH, RI, TN, UT, VA, WY

Screening for Social Determinants of Health

Recognition that pediatric health care providers can play a role in identifying and addressing social-determinants of health (SDOH) has grown in recent years.¹⁸ SDOH, such as housing instability, severe financial hardship, and food insecurity, create family stress and risk of harm to parents’ and children’s health and mental health.¹⁹ The American Academy of Pediatrics added a **recommendation** to include questions about SDOH as part of a family-centered preventive health check in 2017 and currently offers **resources** to help providers conduct a SDOH screening and respond to family needs.

In the survey, under 10 percent of states (4) reported that they provide a supplemental payment for SDOH screens (See Table 5). Perhaps reflecting the relatively recent introduction of SDOH screening in pediatric settings and the challenges health care providers may face in their efforts to address identified needs, 20 states reported that this service is not reimbursed by Medicaid.

TABLE 5

States Provide Supplemental Payment for SDOH Screening	
4 states provide supplemental payment	CO, IA, ME, SC
21 states cover as part of well-child visit	AL, AZ, CA, GA, IN, KS, KY, MA, MN, MS, ND, NJ, NM, NV, OH, OR, RI, TN, VA, VT, WY
20 states do not reimburse for this service	AK, AR, CT, DC, HI, ID, IL, LA, MD, MI, MO, MT, NC, NY, OK, PA, SD, TX, UT, WA

(Table 5 is missing a response from WV)

SOCIAL DETERMINANTS OF HEALTH SCREENING AND RESPONSE: ARIZONA

Arizona has developed a statewide social determinants of health (SDOH) closed loop referral system, called **CommunityCares**. This system allows healthcare and community service providers to track screening, referrals, and service delivery for SDOH-related social and educational services, such as housing, food, transportation, child care and employment. It is integrated with existing health IT systems (e.g., electronic health records, patient portals, and case management systems), and can deliver personalized referrals in response to family needs based on location, language, and eligibility requirements.

Arizona Medicaid uses two mechanisms for incentivizing healthcare providers to conduct SDOH screening and refer families to CommunityCares. As part of its Section 1115 Waiver, Arizona Medicaid has a program called **Targeted Investments 2.0**, which offers incentive payments for meeting targets to participating providers, including pediatric primary care providers. These targets include annual SDOH screenings with a tool covering at least food insecurity and homelessness/housing instability and, in the case of positive screens, making referrals through CommunityCares. Examples of SDOH tools mentioned include the **Income, Housing, Education/Employment, Legal Status, and Personal and Family Stability and Safety (I-HELP) Social History Tool** and the **Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE)**. The second mechanism, for providers not participating in Targeted Investments 2.0, is called a **Differential Adjusted Payment (DAP)**. The DAP is an incentive payment to providers for meeting certain targets. To receive the 1 percent incentive payment for contract year 2024, providers must be enrolled with CommunityCares and facilitate at least 10 referrals per month resulting from use of a SDOH screening tool.

States reported using a variety of billing codes for SDOH screening, including caregiver-focused and child-focused risk screening as well as behavior and developmental screening. As shown in Table 6, a little more than one-third of the states (16) require or recommend the use of a standardized tool for SDOH screening.

ASSESSMENT AND DIAGNOSIS

The identification of mental health conditions in young children requires developmentally tailored assessment and diagnostic methods. Multiple visits with a mental health clinician are typically needed to understand a child’s functioning and behavior in different settings and situations, features of the parent-child relationship, family stressors that may affect parenting and child well-being, and co-occurring conditions, such as a disability, that may affect parenting and the child’s behavior. The survey asked about the number of visits permitted for a child’s mental health diagnostic assessment and the number of visits allowed for any reason without a diagnosis. In addition, the survey asked about the Medicaid agency’s requirement or recommendation to use the **DC:0-5™** (or DC:0-3R), a developmentally-based diagnostic system for infants and young children.²⁰

As shown in Table 7, nine states reported limiting coverage for a diagnostic assessment to two or fewer visits, although comments by some states indicate that additional visits might be authorized; 10 states cover between three and eight visits; and 20 states allow as many visits as needed.

TABLE 6

States Require/Recommend Standardized Tool for SDOH Screening	
4 states require	AZ, LA, ME, and OH
12 states recommend	CA, HI, IA, IN, KY, NC, ND, NM, OR, SC, VT, and WV
30 states do not require or recommend	AK, AL, AR, CO, CT, DC, GA, ID, IL, KS, MA, MD, MI, MN, MO, MS, MT, NJ, NV, NY, OK, PA, RI, SD, TN, TX, UT, VA, WA, WY

TABLE 7

Number of Visits Allowed for Diagnostic Assessment	
5 states: 1 visit	AK, CT*, HI*, NC*, RI
4 states: 2 visits	AR, MA, OK, TX
3 states: 3 visits	KY, NY, SD
6 states: 4 to 6 visits	AL, ID, MN, NM, WA, WV
1 state: Up to 8 visits	IL
20 states: As many as needed**	AZ, CA, CO, DC, GA, IA, MD, ME, MO, MT, ND, NJ, OH, OR, SC, TN, UT, VA, VT, WY

*Authorization for additional visits is possible under some circumstances

**Several states noted that these visits are based on medical necessity

(Table 7 is missing a response from PA and limits could not be determined by the survey responses from 6 states: IN, KS, LA, MI, MS, and NV)

A child without a diagnosis might benefit from visits with an infant-early childhood mental health (IECMH) provider in a variety of circumstances. For example, an IECMH provider might provide a brief intervention, such as guidance to a parent about child behavior concerns or might need several visits to determine whether a full assessment is warranted. To investigate the flexibility of coverage under these and similar circumstances, state administrators were asked whether a licensed mental health provider could bill for a certain number of visits with a child aged 0-6 years without a mental health diagnosis for these purposes. Table 8 shows that over half of the states (27) allow this practice, with nine states permitting one to six visits, eight states allowing seven or more visits, and five states indicating that the number of visits is based on medical necessity.

USING THE DC:0-5™ (OR DC:0-3R) DIAGNOSTIC CLASSIFICATION SYSTEM

The DC:0-5 is the only diagnostic system for supporting a developmentally appropriate mental health assessment of children under age 5. State administrators were asked if their state’s Medicaid policy or guidance “requires” or “recommends” the use of DC:0-5™ or DC:0-3R (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood) for diagnosis of infant and early childhood mental health conditions. As shown in Table 9, one-third of the states (15) reported that the DC:0-5™ (or DC:0-3R) is recommended or required.

TABLE 8

Number of Visits Allowed Without Diagnosis for Varied Reasons	
7 states: 1-3 visits	IN, KY, MD, NM, SD, TX, WV
2 states: Up to 6 visits	MA*, NC
8 states: 7 or more visits	KY, NY, SD
5 states: Based on medical necessity determination	CA, IL, ME, MO, MS*, OK, SC, WY
18 states: Do not allow visits	GA, ND, NJ, NY, OR

*Authorization for additional visits is possible under some circumstances (Table 8 is missing a response from PA and limits could not be determined by the survey responses from AZ, DC, MT, OH, and VT)

TABLE 9

States Require/Recommend the Use of DC:0-5™ (or DC:0-3R)	
7 states require	AK, AR, MN, NM, OK, WA, WV
8 states recommend	CO, GA, ID, MA, ME, MI, MT, OR

(Table 9 is missing responses from PA and LA)

CHILD-SPECIFIC INFANT-EARLY CHILDHOOD MENTAL HEALTH (IECMH) CONSULTATION

Child-specific IECMH consultation is a service delivered by a mental health professional to another provider, such as a pediatrician, to help that provider address the mental health needs of an infant or young child. For example, a mental health clinician might offer consultation to a pediatrician to help determine if a particular child needs a diagnostic assessment for a mental health condition. As shown in Table 10, less than one-third of the states (10) reported Medicaid reimbursement for child-specific IECMH consultation as defined in the survey. States that cover this service reported using a variety of billing codes, including interprofessional consultation (four states).

TABLE 10

Reimbursement for Child-specific IECMH	
10 states reimburse	CA, GA, ME, MI, MN, OR, SD, UT, VT, WV
36 states do not reimburse	AK, AL, AR, AZ, CO, CT, DC, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, MO, MS, MT, NC, ND, NJ, NM, NV, NY, OH, OK, PA, RI, SC, TN, TX, VA, WA, WY

DC:0-5™: MASSACHUSETTS

In recent years, IECMH stakeholders in Massachusetts, including state agencies, Medicaid, and the partnership between Massachusetts Society for the Prevention of Cruelty to Children (MSPCC) and Massachusetts Association for Infant Mental Health (MassAIMH), have engaged in efforts to support widespread use of DC:0-5™ across the state. In 2020, the state Medicaid agency, MassHealth, funded a cohort of eight clinicians to participate in the DC:0-5™ train-the-trainer series. These trainers offer DC:0-5™ clinical training three to four times a year, which in FY2023 are funded by the state Department of Mental Health.

To ensure that the more than 500 professionals who have received DC:0-5™ clinical training are able to effectively use the DC:0-5™, the state DC:0-5™ coordination team, comprised of staff from the Department of Mental Health and the MSPCC/MassAIMH partnership, deliver a range of supports. After each clinical training, the trainers provide two two-hour reflective case consultations open to current and past trainees. In addition, topic-based, 90-minute communities of practice are offered three or four times a year and are intended to build a supportive community for addressing practical challenges related to billing, documentation in medical records, and implementation. MassHealth, other state agencies, and the MSPCC/MassAIMH partnership developed a **state-specific crosswalk** between DC:0-5™ diagnoses and ICD codes. MassHealth has issued **guidance** to its providers on behavioral health diagnosis and assessment, including encouragement to the use of the DC:0-5™ and crosswalk.

Among the 10 states reporting that Medicaid reimburses for child-specific mental health consultation, five reported that a medical necessity determination, but not a mental health diagnosis, is required for this service (CA, GA, ME, OR, and WV). The other five states indicated that a mental health diagnosis is required (MI, MN, SD, UT, and VT).

All states may wish to review policy related to mental health consultation between an IECMH Medicaid provider and a pediatric provider in light of recent CMS guidance. This [guidance](#) explains that Medicaid now allows direct billing by and reimbursement to the consultant and to the provider receiving the consultation.

While the survey asked about *child-specific* IECMH consultation, it is important to note that IECMH consultation delivered in early care and education settings and other programs (e.g., home visiting and Early Intervention) often provides a broader array of supports, including consultation targeting improvements in the program and classroom (in the case of early care and education settings), providers’ skills in addressing children’s mental health needs, and providers’ ability to maintain their own well-being.²¹ This broader form of IECMH consultation is not typically reimbursed by Medicaid. However, Michigan provides an example of a state that has specific provisions for Medicaid coverage of child-specific IECMH consultation in child care programs through a preventive service model.²²

PARENT-CHILD DYADIC TREATMENT

Several models of evidence-based, parent-child dyadic treatment have been developed to improve very young children’s mental health and strengthen the parent-child relationship.²³ The following definition of this service was provided in the survey:

In parent-child dyadic treatment, a clinician treats a parent and infant/young child together using methods to reduce mental health and behavior difficulties that include interventions to help the parent respond to the child’s needs and interact with the child in ways that promote a healthy, nurturing parent-child relationship. Evidence-based models of parent-child dyadic treatment include Child-Parent Psychotherapy (CPP), Parent-Child Interaction Therapy (PCIT), and Attachment Biobehavioral Catch-Up (ABC).

The survey asked about whether the state’s Medicaid program pays for dyadic treatment, the type of billing code used, whether there are requirements or recommendations for the use of an evidence-based dyadic treatment model, and eligibility criteria for coverage.

A high percentage of states (38) pay for dyadic treatment with most states (35) reporting the use of a family therapy code (See Table 11).

TABLE 11

States Cover Dyadic Treatment

38 states cover	AK, AL, AR, AZ, CA, CO, DC, GA, HI, IA, ID, IL, KY, LA, MA, MD, ME, MI, MN, MS, MT, NC, ND, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WV
8 states do not cover	CT, IN, KS, MO, NJ, NM, SD, WY

A little over one-third of the states (14) reported that a mental health diagnosis is not required for coverage of parent-child dyadic treatment. (See Table 12). Among these states, over two-thirds (10) cited a medical necessity determination as an eligibility criterion, while over half of the states (8) indicated that family or child risk factors alone, such as being in foster care or having a parent with depression, could qualify a child to receive Medicaid-covered dyadic treatment.

TABLE 12

States Do Not Require Child Diagnosis for Coverage of Dyadic Treatment

14 states do not require	AK, AZ, CA, GA, IL, MA, MS, MT, ND, NY, OH, OK, RI, SC
24 states require	AL, AR, CO, DC, HI, IA, ID, KY, LA, MD, ME, MI, MN, NC, NV, OR, PA, TN, TX, UT, VA, VT, WA, WV

A little more than half of the states (21) require or recommend the use of an evidence-based dyadic treatment model (See Table 13).

TABLE 13

States Require/Recommend Use of an Evidence-based Dyadic Treatment Model

7 states require	AR, DC, GA, ID, ME, OR, WV
14 states recommend	AK, AL, AZ, CO, IA, KY, LA, MI, MT, OK, SC, UT, VT, WA
17 states do not require or recommend	CA, HI, IL, MA, MD, MN, MS, NC, ND, NV, NY, OH, PA, RI, TN, TX, VA

Across the states that reimburse for dyadic treatment, several evidence-based models are used, including Parent-Child Interaction Therapy (PCIT) (AR, AZ, DC, IA, ID, LA, ME, MN, MT, OR, PA, SC, TN, VT, WA, and WV); Child-Parent Psychotherapy (AR, AZ, GA, ID, LA, MA, MI, MN, MT, OR, SC, TN, VT, WA, and WV); and Attachment Biobehavioral Catch-Up (AZ, DC, ID, MA, MN, SC, TN, WA, WV).

ACCESS TO EVIDENCE-BASED PARENT-CHILD DYADIC TREATMENT: CALIFORNIA AND MASSACHUSETTS

In both California and Massachusetts, Medicaid has recently increased families’ access to evidence-based parent-child dyadic therapy by covering preventive treatment prior to diagnosis. Citing the impact of the COVID-19 pandemic on children’s well-being, Massachusetts issued guidance requiring managed care plans to cover medically necessary preventive behavioral health services that include parent-child dyadic treatment. Children are eligible for these services if they have a positive behavioral health screen or, in the case of infants, a positive maternal depression screen. Managed care plans must cover up to six sessions of services without prior authorization. If the provider determines that additional services are needed after the initial six sessions, managed care plans may require providers to complete a diagnostic assessment and document the appropriateness of continued services.

Similarly, California allows children in Medicaid to receive up to five parent-child dyadic family therapy sessions before a mental health diagnosis is required. Additionally, children with risk factors for mental health disorders can receive parent-child dyadic family therapy without the five-session limit. These risk factors, which are indicated by billing with diagnostic ICD-10 code Z65.9, include separation from a parent (due to incarceration, immigration, or military deployment), death of a parent, foster home placement, food insecurity, housing instability, exposure to domestic violence or other traumatic events, or maltreatment. A child is also eligible, using the same diagnostic Z-code, if their parent or guardian has a history of incarceration, depression or other mood disorder, Post-Traumatic Stress Disorder or other anxiety disorder, psychotic disorder under treatment, substance use disorder, job loss, a history of intimate partner violence or interpersonal violence, or is a teen parent.

IECMH-FOCUSED GROUP PARENTING PROGRAMS

Group parenting programs can provide both social support and guidance about parenting practices that benefit young children’s development and mental health.²⁴ Several research-informed parenting programs have been designed to promote close, nurturing parent-child relationships and positive child behavior in the first five years.²⁵ The following definition of this service was provided in the survey:

In group parenting programs that address infant-early childhood mental health (IECMH), a clinician or trained facilitator meets with a group of parents over multiple sessions to discuss ways that parents can support a healthy, nurturing parent-child relationship, and respond to children’s needs and behaviors in ways that promote children’s social-emotional development and reduce behavior difficulties. Evidence-based or research-informed group parenting programs focused on IECMH include Triple P, Incredible Years, and Circle of Security.

The survey asked whether the state’s Medicaid program pays for this service, the type of billing code used, and whether there is a requirement or recommendation for the use of an evidence-based group parenting model, and eligibility criteria for coverage.

Almost 40 percent of states (17) report that Medicaid pays for participation in group parenting programs, as shown in Table 14. More than half of these states (10) use a family psychoeducation billing code. Other reported billing codes included “family training and counseling for child development” and “multiple family group therapy.” As shown in Table 15, a little over one-third of the states (6) that pay for group parenting programs do not require a child diagnosis for parents’ participation.

States that do not require a child diagnosis cited different factors that would make a parent eligible for Medicaid-covered participation in a group parenting program. These included medical necessity determination (AZ and NY); family or child risk factors, such as child in foster care, parent depression, or child expulsion from child care due to challenging behavior (AZ, MA, RI); and child having an IDEA Part C Early Intervention Individualized Family Services Plan (RI).

States reported that participation in a variety of parenting program models is covered by Medicaid: Triple P (AZ, CO, ME, MI, RI, WA, and WV); Incredible Years (AZ, CO, ME, MI, RI, WA, and WV); Circle of Security (AZ, CO, MI, RI, and WV) and Nurturing Families (AZ, CO, MI, and WV), and Parent Management Training (MI)

As shown in Table 16, among the 17 states that cover participation in a group parenting program, over half of states (10) require or recommend the use of an evidence-based group parenting program.

TABLE 14

States Cover Group Parenting Programs

17 states cover	AR, AZ, CO, ID, KY, LA, MA, ME, MI, MN, NY, OR, RI, UT, VA, WA, WV
29 states do not cover	AK, AL, CA, CT, DC, GA, HI, IA, IL, IN, KS, MD, MO, MS, MT, NC, ND, NJ, NM, NV, OH, OK, PA, SC, SD, TN, TX, VT, WY

TABLE 15

States Do Not Require a Child Diagnosis for Coverage of Group Parenting Programs

6 states do not require	AZ, KY, LA, MA, NY, RI
10 states do require	AR, CO, ID, ME, MI, MN, UT, VA, WA, WV

(Table 15 is missing a response from OR)

TABLE 16

States Require or Recommend Evidence-based Group Parenting Programs

3 states require	ID, ME, WV
7 states recommend	AZ, CO, MI, OR, RI, UT, WA
7 states do not require or recommend	AR, KY, LA, MA, MN, NY, VA

Summary

CHILD SCREENING

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) calls for regular well-child visits based on current standards of care. Most states follow the standards in **Bright Futures** which recommend social-emotional/mental health screening at each well-child visit. EPSDT also requires coverage of diagnostic services to help identify conditions in children as early as possible and before they become serious. Several states have policies that can promote effective SE screening, including supplemental payments and policies favoring the use of a standardized SE screening tool.

- A little over one-third of the states (17) reported that they provide a supplemental payment for child social-emotional (SE) screening. Eleven of these states use a code specifically for SE screening.
- Two-thirds of states (31) recommend or require use of a standardized SE screening tool specifically designed to identify children who may have social-emotional delays or conditions.

MATERNAL DEPRESSION SCREENING

Screening for maternal depression (MD) can help identify mothers who may need further evaluation and treatment to improve the mother's well-being and to prevent or help address impairment in the mother-child relationship and the child's mental health and development. Many states reported supplemental payments to promote maternal depression screening and a requirement or recommendation to use a standardized tool.

- Over half the states (25) reported that Medicaid provides a supplemental payment for maternal depression screening under the child's Medicaid; among these 25 states, 16 states reported using a code for caregiver-focused risk screening.
- Nearly 75 percent of the states (34) reported that use of a standardized tool for maternal depression screening is required or recommended.

SCREENING FOR SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH), such as severe financial problems and food insecurity, pose a significant risk to parent and child well-being. A small number of states currently have policies that promote screening for SDOH.

- Under 10 percent of states (4) reported that they provide a supplemental payment for SDOH screenings; states reported using a variety of billing codes for SDOH screening, including caregiver-focused and child-focused risk screening.
- A little more than one-third of the states (16) require or recommend the use of a standardized tool for SDOH screening.

ASSESSMENT AND DIAGNOSIS

Young children stand the best chance of receiving appropriate services and treatment to address their mental health needs when Medicaid policies support effective, developmentally based assessments and diagnostic services. States' use of the DC:0-5™ (or DC:0-3R) diagnostic system and payment for multiple visits, which can be used for assessment or brief interventions without a diagnosis, are still not universal.

- About one-third of states (15) reported that the DC:0-5™ (or DC:0-3) is recommended or required, although others indicated that it is "permitted."
- Nine states reported limiting coverage for diagnostic assessments to two or fewer visits, although comments by some states indicate that additional visits might be authorized; 10 states cover between three and eight visits; and 20 states allow as many visits as needed.

CHILD-SPECIFIC INFANT-EARLY CHILDHOOD MENTAL HEALTH PROVIDER CONSULTATION (IECMHC)

Child-specific IECMH consultation was defined in the survey as a service provided by a mental health professional to another provider (e.g., pediatrician or home visitor) to help that provider address the mental health needs of an infant or young child. Recent CMS [guidance](#) highlights the benefits of child-specific consultation to help pediatricians and other providers secure diagnostic assessment and other services for children with mental health needs.

- Under one-third of the states (10) reported Medicaid reimbursement for child-specific IECMH as defined in the survey; states that cover this service reported using a variety of billing codes, including interprofessional consultation.
- Half of the states (5) that reported Medicaid reimbursement for child-specific consultation indicated that medical necessity but not a mental health diagnosis is required for this service.

PARENT-CHILD DYADIC TREATMENT

A high percentage of states reported Medicaid coverage of parent-child dyadic treatment, which can address or reduce risk of difficulties in the parent-child relationship and child behavior problems.

- More than 80 percent of the states (38) pay for dyadic treatment, with most reporting the use of a family therapy code.
- A little over one-third of these states (14) reported that a mental health diagnosis is not required for coverage, with over two-thirds of states (10) citing medical necessity, and over half of the states (8) indicating that family or child risk factors alone could qualify a child to receive Medicaid-covered dyadic treatment.
- A little more than half of the states (21) that pay for dyadic treatment require or recommend the use of an evidence-based dyadic treatment model.

IECMH-FOCUSED GROUP PARENTING PROGRAMS

Several evidence-based or research-informed group parenting programs are designed to address infant-early childhood mental health (IECMH) needs by providing support for parenting that promotes a nurturing parent-child relationship and positive, non-punitive parenting practices to address children's challenging behavior.

- Almost 40 percent of states (17) reported that Medicaid pays for participation in group parenting programs; more than half of these states (10) use a family psychoeducation billing code; and (10) require or recommend the use of evidence-based models.
- A little over one-third of the states (6) that pay for group parenting programs do not require a child diagnosis for parents' participation; instead, they permit a medical necessity determination or risk factors, such as foster care placement or expulsion from an early care and education program, to qualify a child's parent for participation.

Recommendations

The survey's results show that Medicaid policies supporting infants' and young children's access to high-quality IECMH services can be found in a growing number of states in every region of the country. Yet, the actual impact of these policies depends on many factors, including a **shared understanding** among Medicaid leaders and providers about these policies, **guidance** to foster this understanding, and **workforce capacity**. The use of **payment incentives** and **data showing the provision of IECMH services** may also affect whether and how providers deliver IECMH services. Moreover, many states still have Medicaid policies that fall short of promoting high-quality IECMH screening and services for children 0-6 (e.g., rules that do not recognize payment for certain services or that fail to encourage or require the use of evidence-based services and a developmentally based diagnostic system). Recognizing that Medicaid policy is an important but not sufficient driver of IECMH supports for infants and young children, we offer the following recommendations for using the results presented in this brief.

Use results in stakeholder meetings with cross-sector representatives, including Medicaid, pediatricians and mental health specialists, Part C Early Intervention, Child Welfare, and Home Visiting, to address the following questions:

- Is there a shared understanding of how Infant-Early Childhood Mental Health (IECMH) services are reimbursed and what criteria qualify a child for coverage (e.g., risk factors, medical necessity)?
- Are services under the policy available and being used? What information is available about the receipt of services (e.g., rates of social-emotional screening of infants and young children, use of dyadic treatment)?
- How can implementation be strengthened (e.g., through provisions of managed care contracts, guidance for providers, incentive payments, recommendations to use evidence-based or research-informed models, training and workforce development)? For example, [Washington State Health Care Authority](#) developed detailed billing implementation guides on DC:0-5™ and hosts trainings and office hours for Medicaid providers.
- How can gaps in coverage or policy be addressed? Consider evidence about the benefits of services, examples from other states and leveraging Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) rules. (See box for resources.)

RESOURCES

[Using Medicaid to Ensure the Healthy Social and Emotional Development of Infants and Toddlers](#)

[Promoting Research-informed State IECMH Policies and Scaled Initiatives](#)

[A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health](#)

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

Strengthen policies to help identify children who may need IECMH services and ensure access to mental health and related services for young children and parents. For example:

- Use guidance and incentives to encourage the use of specialized social-emotional screening tools and standardized parent depression and social-determinants of health screening tools
- Broaden criteria for access to IECMH services beyond a requirement for a child diagnosis; consider child and family risk factors that could qualify a child for IECMH services
- Expand the use of interprofessional IECMH consultation to build providers' capacity to address IECMH needs and access specialized supports (e.g., diagnostic assessment and treatment)
- Reimburse and provide guidance on preventive services that help ensure the identification of infants and young children in need of IECMH assessment and treatment services, and connect families to supports for mental health and basic needs (e.g., services provided by Healthy Steps, Doulas, and Community Health Workers)

USING DOULAS TO PROMOTE MATERNAL WELL-BEING AND IECMH: MULTIPLE STATES

A growing number of states are covering doula services for Medicaid participants, including CA, MI, MN, NV, MD, OR, NJ, RI, VA, Washington, DC. Doulas (sometimes called birthworkers), visit parents before, during, and after the birth of a child to provide physical and emotional support and information, including ways to connect with community resources to meet family needs. Doula training emphasizes maternal self-care and wellness and covers maternal mental health and IECMH-related topics, such as maternal depression, child well-being, early relational health, and family relationships. Doulas can help birthing parents connect with doctors and other professionals about mental health concerns and family needs. A recent [evidence review](#) found that doula services are associated with greater maternal responsiveness to infant distress and more playful engagement with infants. Low reimbursement rates in some states have led to difficulties recruiting and retaining doulas. **Several states** have significantly increased or announced plans to raise reimbursement rates for doula services. For example, Oregon's Health Authority recently gave [public notice](#) that it will raise its rate from \$350 to \$1,500 per pregnancy. (See also [Doula Care and Maternal Health](#)).

Prioritize IECMH in broader system reform efforts, including improvements in coverage for maternal health care and mental health care, and in payment and delivery systems. Medicaid is often at the center of federal and state health reform efforts due to its prominent role as a healthcare payer. National and state-level reforms in the following areas are only a few examples of areas where IECMH should be represented at decision-making tables.

- **Maternal health.** Federal and state Medicaid leaders have made addressing the persistent maternal health crisis a priority, making changes in Medicaid coverage, benefits, and providers to more effectively reach and serve low-income pregnant and postpartum mothers. States now have the option to extend Medicaid coverage for pregnant women to 12 months postpartum, increased from the previous 60-day cap. With more than 31 states implementing extended postpartum coverage, many are identifying new ways to help address postpartum mental health.²⁶ The relationship between parent mental health and infant-early childhood mental health and development point to the value of a robust IECMH system that serves postpartum mothers and their infants together.²⁷

INTEGRATING IECMH INTO PRIMARY CARE: MARYLAND AND CALIFORNIA

In [Maryland](#), Medicaid has recently begun covering [HealthySteps](#), an evidence-based model that integrates supports that promote young children's development into primary care, including supports for social-emotional development. In HealthySteps programs, a child development expert, called a HealthySteps Specialist, supports families with young children in the pediatric primary care practice.

Maryland Medicaid requires participating MCOs to contract with at least one HealthySteps site. During the initial rollout in 2022, MCOs could receive an incentive payment for contracting with at least two sites. Since January 2023, accredited HealthySteps sites in Maryland pediatric primary care practices (and those with pending accreditation) can receive an enhanced reimbursement under Medicaid to offset the cost of implementing HealthySteps, such as the specialist's salary. The state share of the enhanced payment is currently funded through Maryland's [Total Cost of Care Model](#), which includes a focus on maternal and child health. Updating their Medicaid provider accounts with an attestation letter from [ZERO TO THREE](#) allows such practices to bill with an additional code (H0025), defined as a behavioral health prevention education service, alongside typical well-child visit codes. There are currently five eligible providers in Maryland.

California's Medicaid program, known as Medi-Cal, has established [important new policies](#) through the renewal and redesign of its waiver and managed care contract that aim to improve services for children, including services that promote mental health in primary care. Beginning in January 2023, Medi-Cal began covering what it calls dyadic (parent-child) services. This benefit is a family-focused model of care intended to address developmental and behavioral health conditions early and promote social-emotional well-being, developmentally appropriate parenting, and maternal mental health. Services are billed under the child's Medicaid and include preventive behavioral health services for children and caregivers. One of these services is ["dyadic behavioral health \(DBH\) well-child visits,"](#) which requires multiple components, including a parent-child interaction observation, social determinants of health screening, behavior-focused anticipatory guidance, and referrals and connections to community resources through care coordination. Models such as HealthySteps or [DULCE](#) may be financed as part of this benefit. The DBH well-child visit provider can also bill for a number of caregiver psychosocial health screenings and referrals to services that address maternal depression and problems related to alcohol and drug use.

- **Mental health.** National and state policymakers are actively working on ways to improve access to mental health services for children. Without explicit attention to infants' and young children's development, there is a risk that state policies designed to improve access to mental health services will miss opportunities to strengthen prevention and intervention services that support parent-child relationships in the early years that are critical to healthy development and mental health.²⁸
- **Payment or delivery system reforms.** Within broad federal rules, states set the parameters for Medicaid reimbursements, including payment rates, qualified service providers, and eligibility rules for receipt of services. With most children served in Medicaid managed care, states should explicitly include IECMH services in the contracts with managed care companies responsible for furnishing health care and making EPSDT work as intended. Without attention to the unique developmental and mental health needs of young children, reforms targeting adults and near-term cost savings may fail to include critical IECMH services that can prevent or lessen the impacts of serious, costly conditions children may experience as they grow older.

Monitor and report on the use and quality of IECMH services. The capacity of state Medicaid agencies to collect and publish data on providers' delivery of IECMH-related services is critical to ensuring equitable access to high-quality mental health care for infants and young children. For example, data on rates of child social-emotional and parent depression screening and the provision of services, such as evidence-based dyadic treatment, can show the extent to which preventive care and treatment of young children are being used at expected levels under IECMH policies, or the extent to which they appear to be under-used. Disaggregated data by plan, region, race/ethnicity, or other factors can help states identify gaps in care in specific locations or for sub-groups of families and can inform efforts to improve health equity. Apart from billing data, provider surveys and interviews can be helpful in learning about both the provision of IECMH-related services and the barriers providers face in delivering mental health care to infants and young children. The collection, analysis, and public reporting of data by race/ethnicity is critical to ongoing monitoring and improvement of equitable access to IECMH and related services.

REFERENCES

- 1 Spiner, T. (2022). *14 Emerging Trends*. American Psychological Association. apa.org/monitor/2022/01/special-emerging-trends
- Xiao, Y., Brown, T. T., Snowden, L. R., Chow, J. C. C., & Mann, J. J. (2023). COVID-19 policies, pandemic disruptions, and changes in child mental health and sleep in the United States. *JAMA Network Open*, 6(3).
- 2 RAPID. (2020). *An early childhood and family well-being survey (ongoing)*. Stanford University. rapidsurveyproject.com/aboutus
- 3 Briggs-Gowan, M. J., & Carter, A. S. (2008). Social-emotional screening status in early childhood predicts elementary school outcomes. *Pediatrics*, 121(5), 957-962.
- Domitrovich, C.E., Durlak, J.A., Staley, K.C. & Weissberg, R.P. (2017). Social-emotional competence: An essential factor for promoting positive adjustment and reducing risk in school children. *Child Development*, 88(2), 408-416.
- Graziano, P. A., Reavis, R. D., Keane, S. P., & Calkins, S. D. (2007). The role of emotion regulation in children's early academic success. *Journal of School Psychology* 45(1), 3-19.
- Jones, D. E., Greenberg, M., & Crowley, M. (2015). Early social-emotional functioning and public health: The relationship between kindergarten social competence and future wellness. *American Journal of Public Health*, 105(11), 2283-2290.
- Liu, A. (2019). Can non-cognitive skills compensate for background disadvantage? The moderation of non-cognitive skills on family socioeconomic status and achievement during early childhood and early adolescence, *Social Science Research*, 83, 102306.
- Rademacher, A., Goagoses, N., Schmidt, S., Zumbach, J., & Koglin, U. (2022). Preschoolers' profiles of self-regulation, social-emotional and behavior skills and its prediction for a successful behavior adaptation during the transitional period from preschool to elementary school. *Early Education and Development*, 33(7), 1137-1151.
- 4 ZERO TO THREE. (2017). *The basics of early childhood mental health: A briefing paper*. zerotothree.org/wp-content/uploads/2017/08/The-Basics-of-Infant-and-Early-Childhood-Mental-Health_-A-Briefing-Paper.pdf
- 5 Bricker, D., Davis, M. S., & Squires, J. (2004). Mental health screening in young children. *Infants & Young Children*, 17(2), 129-144.
- Zeanah, C. H., & Lieberman, A. (2016). Defining relational pathology in early childhood: The diagnostic classification of mental health and developmental disorders of infancy and early childhood DC:0-5 approach. *Infant Mental Health Journal*, 37(5), 509-520.
- 6 Ricciardi, C., Manfra, L., Hartman, S., Bleiker, C., Dineheart, L., & Winsler, A. (2021). School readiness skills at age four predict academic achievement through 5th grade. *Early Childhood Research Quarterly*, 57, 110-120.
- 7 Vasileva, M., Graf, R. K., Reinelt, T., Petermann, U., & Petermann, F. (2021). Research review: A meta-analysis of the international prevalence and comorbidity of mental disorders in children between 1 and 7 years. *Journal of Child Psychology and Psychiatry*, 62(4), 372-381.
- 8 Zeanah, C., & Zeanah, P. (2019). Infant mental health. *Handbook of Infant Mental Health*, 5-24
- 9 Georgetown University Center for Children and Families analysis of US Census Bureau 2021 American Community Survey (ACS) Public Use Microdata Sample (PUMS).
- 10 Kaiser Family Foundation. (2021). *Births financed by Medicaid*. kff.org/medicaid/state-indicator/births-financed-by-medicaid/
- Martin, J. A., Hamilton, B. E., & Osterman, M. J. K. (2020). Births in the United States, 2019. *NCHS DataBrief*, 387, 1-8.
- National Center for Health Statistics. (2023). *Health, United States, 2020-2021: Annual perspective*. DOI: dx.doi.org/10.15620/cdc:122044
- 11 Guth, M., & Artiga, S. (2022). *Medicaid and racial health equity*. Kaiser Family Foundation. kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity
- 12 U.S. Department of Health & Human Services. (2014). *EPSDT—A guide for states: Coverage in the Medicaid benefit for children and adolescents*. [medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf](https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf)
- 13 Hinton, E., & Stolyar, L. (2019). *10 things to know about Medicaid managed care*. Kaiser Family Foundation. kff.org/medicaid/issue-brief/10-things-to-know-about-medicicaid-managed-care/

Kaiser Family Foundation. (2022). *Medicaid managed care penetration rates by eligibility group*. [kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/?activeTab=map¤tTimeframe=0&selectedDistributions=children&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D](https://www.kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/?activeTab=map¤tTimeframe=0&selectedDistributions=children&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)

- 14 Randi, O. and Honsberger, K. (2020). *States are increasing their use of Medicaid Managed Care for children and youth with special health care needs*. National Academy for State Health Policy.
- Thompson, V. (2022). *How state Medicaid programs serve children and youth in foster care*. National Academy for State Health Policy.
- 15 Duncan, G., & Le Menestrel, S. (2019). *A roadmap to reducing child poverty. Consensus Study Report*. National Academies Press.
- Masarik, A. S., & Conger, R. D. (2017). Stress and child development: A review of the family stress model. *Current Opinion in Psychology*, 13, 85-90.
- 16 EC Rapid Project. (2021). *On shaky ground: Unpredictability in ability to pay for basic needs affects family well-being*. rapidsurveyproject.com/our-research/unpredictability-in-ability-to-pay-for-basic-needs
- Fisk, E., & Russell, B. (2022). Patterns of stress and wellbeing among families enrolled in Early Head Start/Head Start during COVID-19. *Maternal and Child Health Journal*, 1-7.
- 17 Williams, M. E., Zamora, I, Akinsilo, O., Chen, A, H., and Poulsen, M. K. (2018). Broad developmental screening misses young children with social-emotional needs. *Clinical Pediatrics*, 57(7), 844-849.
- 18 Nerlinger, A. L., & Kopsombut, G. (2023). Social determinants of health screening in pediatric healthcare settings. *Current Opinion in Pediatrics*, 35(1), 14-21.
- 19 Cutts, D. B., Meyers, A. F., Black, M. M., Casey, P. H., Chilton, M., Cook, J. T., ... & Frank, D. A. (2011). US housing insecurity and the health of very young children. *American Journal of Public Health*, 101(8), 1508-1514.
- Johnson, A. D., & Markowitz, A. J. (2018). Food insecurity and family well-being outcomes among households with young children. *The Journal of Pediatrics*, 196, 275-282.
- 20 ZERO TO THREE. (2021). *DC:0-5™: Diagnostic classification of mental health and developmental disorders of infancy and early childhood* (Version 2.0).
- 21 Donovan, L. (2017). *Infant and early childhood mental health consultation: A briefing paper*. Washington, DC: ZERO to THREE. zerotothree.org/resource/infant-and-early-childhood-mental-health-consultation-a-briefing-paper/
- 22 Center of Excellence on Infant-Early Childhood Mental Health Consultation. (n. d.). *Funding infant and early childhood mental health consultation as a Medicaid prevention direct service: Michigan's approach*. iecmhc.org/wp-content/uploads/2021/06/CoE_Resource_MedicaidServices_Proof2.pdf
- 23 Shafi, R. M., Bieber, E. D., Shekunov, J., Croarkin, P. E., & Romanowicz, M. (2019). Evidence based dyadic therapies for 0-to 5-year-old children with emotional and behavioral difficulties. *Frontiers in Psychiatry*, 10, 677.
- 24 Morris, A. S., Robinson, L. R., Hays-Grudo, J., Claussen, A. H., Hartwig, S. A., & Treat, A. E. (2017). Targeting parenting in early childhood: A public health approach to improve outcomes for children living in poverty. *Child Development*, 88(2), 388-397.
- Taylor, Z. E., & Conger, R. D. (2017). Promoting strengths and resilience in single-mother families. *Child Development*, 88(2), 350-358.
- 25 National Academies of Sciences, Engineering, and Medicine. (2016). *Parenting matters: Supporting parents of children ages 0-8*.
- Webster-Stratton, C., & Reid, M. J. (2018). The Incredible Years parents, teachers, and children training series: A multifaceted treatment approach for young children with conduct problems. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 122-141). The Guilford Press.
- 26 Clark, M. (2023). *State trends to leverage Medicaid extended postpartum coverage, benefits and payment policies to improve maternal health*. Center for Children and Families. ccf.georgetown.edu/2023/03/20/state-trends-to-leverage-medicaid-extended-postpartum-coverage-benefits-and-payment-policies-to-improve-maternal-health/
- Kaiser Family Foundation. (2021). *Medicaid postpartum coverage extension tracker*. [kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/](https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/)
- 27 Clark, M & Burak, E. W. (2022). Center for Children and Families. *Opportunities to support maternal and child health through Medicaid's new postpartum coverage extension*. ccf.georgetown.edu/2022/07/15/opportunities-to-support-maternal-and-child-health-through-medicaids-new-postpartum-coverage-extension/
- 28 Burak, E. W. & Rolfes-Haase, K. (2018). *Using Medicaid to ensure the healthy social and emotional development of infants and toddlers*. Center For Children and Families. ccf.georgetown.edu/2018/11/21/using-medicaid-to-ensure-the-healthy-social-and-emotional-development-of-infants-and-toddlers/