SAVE THE DATE: Friday, May 12, 2006
Colorado Leadership Workshop: 
Advancing a Collaborative Agenda to Improve the Health and Development of Young Children

Co-sponsored by the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. DHHS

Invitees: Colorado’s leaders in child health policy and programs.

Objective: To develop a shared action agenda that maximizes new federal law, existing state goals, and current early childhood health and mental health initiatives in Colorado (e.g., Project Bloom, medical home, EPSDT).

Discussion Topics:
- Maximizing the Potential of EPSDT to Promote Early Childhood Health and Mental Health Development.
- Linking and Monitoring Outcomes in the Context of Early Childhood Systems Development.
**State Leadership Workshop on EPSDT & Title V Collaboration**

**May 12, 2006**

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**EPSDT & Title V Policy Overview**

Since 1967, Medicaid has included a special child health benefit known as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. From its beginning it has been linked in mission and policy to Title V.

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**Project Goal**

- Provide technical assistance to six selected states through State Leadership Workshops that will foster successful coordination between State Title V, Medicaid, and partner agencies, with the aim of increasing the number of eligible children receiving screening, diagnosis, and necessary treatment services through EPSDT.

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**New Web-based Module**

**www.hrsa.gov/epsdt**

Content related to:
- EPSDT & Title V policy
- Opportunities for collaboration
- Examples of data, family support, provider and other collaborative projects
- Links to federal and other resources

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**What do we know about children served by Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)?**

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**Eligibility**

- Federal law mandates:
  - Infants and children to age 6 up to 133% of poverty
  - Children ages 6-18 up to 100% of poverty
- State options to cover:
  - Children in Medicaid at any income level
  - SCHIP > 200% of poverty
  - Children with disabilities and special needs > 300% of poverty

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**Overview of Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Benefit**

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Prepared by Kay Johnson. Project sponsor MCHB-HRSA
EPSDT GOALS

- Created in 1967 during Johnson Administration
  - "to discover, as early as possible, the ills that handicap our children" and
  - to provide “continuing follow up and treatment so that handicaps do not go neglected.”
- Sweeping guarantee for comprehensive health coverage unlike any other in US health policy
  - To locate poor children, assess their health status, and ensure that they received the continuous and comprehensive medical care they need. (Rosenbaum and Johnson, 1986)

EPSDT Framework

Follow the letters:
- **E**arly - starting before problems worsen
- **P**eriodic - at regular intervals & as needed
- **S**creening - comprehensive well child exams
  - including developmental, physical, and mental screens
  - plus separate vision, hearing, dental screening
- **D**iagnosis - as appropriate
- **T**reatment - all Medicaid services (covered under federal law), as medically necessary for child’s condition

The Dual Nature of EPSDT

“The EPSDT program consists of two mutually supportive, operational components:
- Assuring the availability and accessibility of required health care resources
- Helping Medicaid recipient and their parents or guardians effectively use these resources.”
- Fulfilling each continues to be challenging.

Medicaid Benefits

- States must cover:
  - Inpatient hospital services
  - Outpatient hospital services
  - Physician services
  - Nurse midwife and pediatric / family nurse practitioner services
  - Medical & surgical dental care
  - Laboratory & x-ray services
  - EPSDT services
  - Family planning services
  - Rural health clinic and federally-qualified health center services
  - Home health & nursing facilities

- Optional, covered for children as necessary:
  - Prescription drugs
  - Dental services
  - Optometrist & eyeglasses
  - Mental health services
  - Prosthetic devices
  - Intermediate nursing facility / mental retardation services
  - Nursing facility for < age 21

EPSDT “Medical Necessity”

“Medically necessary” services covered
- EPSDT definition broader than most private plans
- EPSDT covers prevention & early intervention
- Thus, a service is medically necessary:
  - if service will prevention condition,
  - if service will improve health or ameliorate condition, or
  - if service will cure or restore health.

EPSDT - OBRA 1989 Reforms

- EPSDT was recodified in 1989 to strengthen and clarify federal law
  - Mandated full range of Medicaid benefits permitted under federal law (1905(a)), as medically necessary
  - Ended arbitrary limits on benefits or type of screen type (e.g. regular vs. interperiodic)
  - Ended arbitrary limits on provider type
  - Allowed for provision of specific (unbundled) services
  - Set 80% screening performance “benchmark”
Colorado EPSDT Report, FY 2003

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<th>Participation ratio</th>
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Title V and EPSDT Collaboration

Medicaid rules for Title V Linkages

- Establish Title V-Medicaid agreements which provide for maximum utilization of Title V services and improved child health.
- Reimburse Title V providers, even if services are provided free of charge to low-income uninsured families.

Title V rules for EPSDT Linkages

- Establish coordination agreements with Medicaid
- Assist with coordination of EPSDT
- Provide a toll-free number for families seeking providers
- Provide outreach and facilitate enrollment
- Share data collection responsibilities
- Provide/finance services for CSHCN not covered by Medicaid

Partnerships to Support Families

- Outreach & enrollment initiatives
  - Application assistance
  - Hotlines, parent information centers
- EPSDT Coordination
  - Some states use Title V funding to support local EPSDT coordinators (CO, IA)
- Case management
  - Medicaid service categories
    - Pregnant women and young children
    - Children with special health care needs
  - Note definition change under DRA

Provider-related EPSDT/Title V Partnerships

- Provider-related activities
  - Recruit & train providers
  - Standards and guidelines
    - Clinical guidelines & screening protocols
    - Develop standards of care and periodicity schedules
    - Bright Futures
  - Track provider participation
- Activities related to managed care
  - Monitor adequacy of provider networks
  - Development of managed care contracts
    - GWU purchasing specifications
    - HRSA Managed Care Technical Assistance project
Data & Monitoring

❖ All states:
    ■ Determine screen ratio and participation rates (required) www.cms.hhs.gov/medicaid/epsdt/416inst.asp
    ■ Report on percent referred & receiving follow up treatment
❖ Where Medicaid managed care is common:
    ■ Require MCOs to submit encounter data for EPSDT screens
    ■ Contract for performance monitoring and quality improvement projects

Title V role in EPSDT Quality Monitoring

❖ Tracking participation
    ■ Collect & publish data required by Title V
    ■ Assist in tracking screening ratio
❖ Provider-related activities
    ■ Collaborate to train through AAP, AAF, etc.
    ■ Promote use of clinical tools
      • e.g. developmental screening tools
❖ Activities related to managed care
    ■ Assist in conducting focus studies
    ■ Develop joint quality improvement projects

Medicaid Managed Care and Child Health

In or out of contract?

❖ Contract should specify what will be covered by MCO and what is “wraparound.”
    ■ MCOs need to know exactly what services they are responsible for covering.
    ■ Families of enrolled children need to know what services they are entitled to receive from the MCO and what services they are entitled to that will be otherwise financed by the state Medicaid program.
❖ Similar situation may apply with benchmark benefit packages under DRA.

Deficit Reduction Act of 2005 (DRA)

❖ Eligibility
❖ Premiums and cost-sharing
❖ “Benchmark” coverage
❖ Targeted case management

Post DRA: Family Opportunity Act (Effective 1/1/2007)

❖ New State option allows families of children with severe disabilities to “buy-into” Medicaid
  ■ Age:
    ○ Target group children birth to age 19 (qualified for SSI)
    ○ Phased-in, starting with younger children under age 6
  ■ Income:
    ○ Up to 300% FPL;
    ○ At higher income levels with state funds only
  ■ Premium caps:
    ○ 5% cap <200% FPL, 7.5% cap 200-300% FPL
  ■ Employer-sponsored family coverage:
    ○ If eligible must enroll + 50% of premium paid by employer
    ○ Premium subsidy at option of state
❖ Parent-to-Parent Information Centers (Title V)
Post DRA: Premiums & Cost Sharing
Effective January 1, 2007
- For mandatory groups of children no premiums and cost sharing
- For child/family income below 150% FPL
  - No premiums
  - Cost sharing limited to 5% of income
  - Co-insurance to 10% of cost for service
- For child/family income above 150% FPL
  - Premiums and cost sharing limited to 5% of income
  - Co-insurance to 20% of cost for service
- For new disability optional group
  - For child/family income 100-200% FPL, premiums and cost sharing limited to 5% of income
  - For child/family income 200-300% FPL, premiums and cost sharing limited to 7.5% of income

Birth to 6 Ages 6 -18

More Resources
- For general use
  - www.cms.gov
  - https://www.cms.hhs.gov/medicaidgrANTS/default.asp
g  
  - www.cms.hhs.gov/EPSTDentalC
  
  - http://www.hrsa.gov/medicaidprim
e/epstdentalcoverage.html
  - www.kff.org
  - www.ku.edu/phs/healtn/poli
    cy/chisp/newsps
  - www.ncms.org
  - www.mch.library.info/KnowledgePa
    ths
  - www.chcs.org
  - www.mchpolicy.org
- For families
  - www.family-    network.org
  - www.partoparvt.org
  - www.healthconsumer or
    g/200Lepstd.pd
  - www.familyvoices.org
  - www.wapas-rights.org
  - For providers
    - www.aap.org
    - www.brightfutures.org/
       moneypeds.html
    - www.brightfutures.org/ 
      moneypeds.html
    - www.medicalhomeinfo.o
      rg/tools/screening.html

Putting it together: An example of early childhood mental health

Post-DRA: Benefit Rules
(Effective 3/31/2006)
- States option to use a “benchmark” benefit package for certain groups.
  - Can be done with State Plan Amendment
  - Similar to non-Medicaid SCHIP programs.
  - “Benchmark” Plans: State Options
    - FEHP standard Blue Cross/Blue Shield PPO
    - State employee benefit plan
    - Coverage through HMO with largest commercial, non-Medicaid enrollment in the state
    - Another benefit package approved by HHS

Post DRA: Wrap-around benefits
(Effective 3/31/2006)
- For children, states may supplement with “wrap-around” EPSDT coverage
  - Benefits as defined since 1989 in Sec. 1905(r) of Medicaid law
  - Obligation to provide comprehensive children’s services appears to be maintained.
    - Unclear if this applies to all groups of children.
  - CMS guidance expected

Source: McClelland, letter to Medicaid Directors; Rosenbaum and Markus. 2006.

Post DRA: Case Management
(Effective 1/1/2006)
- Definition clarified
  - Assessment
  - Development of care plan
  - Referrals
  - Monitoring and follow-up
- Excludes from the definition
  - Direct delivery of referred medical, educational, social, or other services
  - Foster care administrative supports
- Potentially related to Part C, home visiting, mental health, child development, etc.
Why don’t children get services?

1. Lack of screening.
2. Weak linkages among systems of care serving children and their families.
3. Limits on funding for services to children without diagnosed conditions.
4. Too few providers have the motivation, skills, or information they need.

Examples of ECMH Services

- Screening to detect social-emotional delays and risks
  - Child development advice from pediatric care providers.
- Repeat EPSDT (interperiodic) screen of development.
  - Mental health consultation in home visits, child care and other early childhood learning programs.
- Treatment for children with mental health problems.
  - Parent-child relationship therapy.
  - Substance abuse treatment for parents, which includes a child-centered component.

See: Neurons to Neighborhoods; NCCP; Bright Futures; Zero to Three Policy Center; Bazelon Center.

Opportunities to Maximize EPSDT

- Recommend age appropriate screening and diagnostic tools in EPSDT.
- Cover services delivered in a range of settings.
- Separate billing for development screening and diagnostic evaluation (unbundle).
- Reimburse for parent-child (family) therapy.
- Match funds for child care MH consultation.
- Use appropriate diagnostic codes.

Lessons from ABCD II Projects

- Payment not greatest barrier
- Providers are willing to use recommended screening tools
- Parents and providers want and appreciate information
- Referral and consultation resources must be available
- Billing codes are available
- Serving “at-risk” without diagnosis still tough

Medicaid Lessons Learned: ECMH

No major barriers in:
- Billing codes
- Screening in pilot primary care practices
- DC:0-3 crosswalks
- Payment for services delivered in non-clinical settings (e.g. child care)

Many services are grounded in primary care, i.e., not part of behavioral health carve outs to managed care or community mental health centers.

Savings might be achieved through appropriate utilization.

Framework for Systems Approach

1. Improve screening and diagnostic evaluation.
2. Do more outreach and monitoring for high-risk children and their families.
3. Improve access to appropriate services.
4. Develop clear, functional eligibility definitions.
5. Enhance professional training and workforce capacity.
6. Strengthen infrastructure to reduce administrative and policy barriers.
State Leadership:

Clarify rules & regulations

❖ Adopt clear guidance & billing codes for:
  • Developmental checklists & screens (SCREENING)
    ▪ EPSDT periodicity schedules based on AAP recommendations
    ▪ State may choose to recommend several tools
    ▪ Broad range of providers may screen and bill
    ▪ Link Part C Early Intervention “child find” to your approach
  • Developmental assessment (DIAGNOSIS)
    ▪ Specific types of providers, consider qualifications
    ▪ Use age appropriate diagnostic codes (e.g., DC:0-3)
    ▪ Decide what happens when child has no clear diagnosis

State & Local Leadership:

Maximize Available Funding

❖ Blend and braid
❖ Match state general revenues already being spent (Vermont)
❖ Encourage local matching (Cuyahoga County-Cleveland Ohio, San Francisco)
❖ Clarify eligibility and payment rules

State and local leadership:

Interagency Coordination

❖ Model behavior desired
❖ Develop MOU/MOA to clarify agreements
❖ Issue joint guidance & publications
❖ Host meetings for cross-training
❖ Develop and finance service strategies that bridge the gap between medical and non-medical services

State leadership:

Request additional funding

❖ Request / appropriate targeted dollars for early childhood mental health projects
  ▪ New appropriations to use for Medicaid state share
  ▪ Small amounts of grant funding to jump start local pilots
❖ Call for increased federal funding to states
  ▪ IDEA Part C and Part B Preschool programs
  ▪ Medicaid federal share
  ▪ Expansion to children with disabilities under

Top Ten Things To Do Now

1. Convene an interagency group to review funding.
2. Maintain and/or improve current programs.
4. Mobilize resources to serve identified at-risk children.
5. Blend dollars for “cross-training” professionals.
6. Use flexibility of smaller federal grant programs.
7. Clarify eligibility and payment mechanisms among Medicaid, Part C, Title V, mental health, etc.
8. Adopt billing mechanisms for developmental services.
9. Target one high-risk population.

Spending Smarter means:

❖ Capturing dollars that already exist in federal funding streams.
❖ Maximizing efficiencies through systems approaches.
❖ Blending and braiding funds.
❖ Leveraging both smaller grant funds and entitlement dollars.
❖ Using flexible funds to fill gaps in systems of care.
❖ Paying for appropriate services.
4. Tools from the Field

Asking Key Questions

Vermont has been a leader in children's mental health, working to create a system of care, to enhance early childhood mental health prevention services, and to include mental health as part of larger early childhood initiatives. Strategies for developing and sustaining the Vermont system of care for children's mental health include blended funding, local decision making, family involvement, and a wraparound model of service delivery. The state focused on early childhood through a legislative study and a task force on mental health needs of young children and their families. These focused discussions led to the development of the Children's UPstream Services (CUPS) project, which provides behavioral health and other community-based services for families with young children age 0-6 and mental health consultation for the system of early childhood care and education (using a federal grant from the Substance Abuse and Mental Health Services Agency –SAMHSA – as a base). Still Vermont providers remained confused by the maze of rules and restrictions in Medicaid. In the past year, early childhood providers (e.g., family centers, early intervention programs) have engaged in an ongoing dialogue with state officials about how early childhood services are financed. Their questions may help guide providers in other states.

- What services are covered (e.g., case management, diagnostic assessment, child care consultation, intensive home visits, family center-based parent-child counseling)?

- What children are eligible for these services? What diagnostic labels are required?

- Who can be a qualified provider that can be paid for delivering these services? Is special supervision or delegation (e.g., by a physician or psychiatrist) required?

- Who needs to “sign off” – that is, who needs to give referral, approval or authorization?

- What are the fees (payment rates) for such services and where do we find the billing codes?

- What special financing arrangements are used (e.g., providers as subcontractors for community mental health agencies, providers as subcontractors to managed care organizations, or state grants with year-end reconciliation of annual billing)?

- What is the source for the non-federal share, commonly called “matching” funds (e.g., existing state funding categories, newly appropriated state general revenues, local taxes or levies dedicated to children or mental health, local education funding, private dollars)?

Clarifying Medicaid Guidelines
Clarifying Medicaid Guidelines

Leadership from inside and outside of government together stimulated changes in Florida. Senior policy makers have advanced early childhood mental health in Florida. Under the Administration of Governor Bush and legislative leadership of Senate President McKay, Florida has taken dramatic and important steps to improve the mental health and emotional wellness of children birth to five years. Florida's early childhood mental health multi-year strategic planning process brought together representatives from key state agencies, universities, foundations, the judicial system, providers, and private organizations concerned with the health and well being of young children. Their product -- Florida's Strategic Plan for Infant Mental Health (www.cpeip.fsu.edu) -- is the blueprint for developing a comprehensive system to prevent, identify and treat emotional and behavioral disorders in families with children birth to age five.

Florida's strategic plan called for improvements in Medicaid. In 2001, Florida made changes to Medicaid regulations and updated its “Community Mental Health Services Coverage and Limitations Handbook” to clarify existing policies, implement new policies, and revise definitions related to early childhood mental health. Together these changes improve the ability of community mental health services providers to deliver appropriate, efficient, and effective services. Among other things, Florida's revised Medicaid guidance:

- Clarified that coverage for therapy applies to individuals AND families;
- Extended Medicaid provider qualifications to permit a broader array of mental health service providers (i.e., non-physician providers) to enroll as treating providers and authorize services on a treatment plan (when employing or contracting with a licensed psychiatrist);
- Applied targeted case management in mental health to include children in foster care; and
- Added a new section specifically addressing services provided to children ages 0 to 5. More specifically, the new guidance states that: "For children 0 through 3 years of age, Medicaid encourages use of the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC: 0-3) for assistance in determining the infant or child's ICD-9-CM diagnosis".

State agency leaders wanted to adopt policies that make it possible for providers to address the mental health needs of young children in an appropriate manner. As described by one state official: "Medicaid has changed its community mental health services program policy to make terms, definitions, and coverage more relevant to young children, to take into account the symptoms and needs of young children.... The new strategy for 0-5 behavioral health assessment will become mandatory and, along with other Medicaid financing modifications, drive our system of care for young children toward prevention and early intervention."

### 7. Assess Your Community Resources and Strategies

The eight examples below (taken from real situations) each has a set of specific questions. Also, ask yourself the following general questions for each situation:

A. How would these children and their families be served in your area?
B. What supports and resources are available when no clear mental health diagnosis or disability is present?
C. How might the services for child and family be financed?
D. What agencies or programs would take lead responsibility?

#### 1. Home visitor serving infant with depressed, teenage mother.
Dante, a 6-month-old infant of a teenage, single mother, is enrolled in a special home visiting program that targets high-risk mother’s living in public housing. The home visitor, a para-professional trained to teach the mother parenting skills, is very worried about both the baby and the mother, and perceives a lack of bonding between them. The baby is very fussy, difficult to feed and soothe, and the mother seems very unhappy or depressed. The home visitor is supposed to adhere to a curriculum, but feels that it does not address the real problems that exist for this family.

- In your community, what resources and supports would be available to the home visitor as she continues to work with this family?
- Where might the home visitor refer the mother and infant for a screen or assessment of their bonding? How would such a service be financed?
- Is there a parent support group or play group with mental health professionals involved where the mother and infant could gain skills to improve their relationship?
- What steps would be necessary to refer the mother for mental health counseling?

#### 2. Family resource center serving socially isolated family with toddler.
Lian is a quiet toddler, age 18 months. She and her mother are considered “at-risk” and “socially isolated.” The father has returned to China for a period of six months. Lian and her mother attend classes at a neighborhood family resource center. The mother told center staff that she feels sad and doesn’t enjoy playing with the baby. Observations suggest that Lian is behind on language development, but, when tested, she was not found eligible for the early intervention program. The family resource center staff are concerned and are looking for ways to do more to help.

- In your community, what resources and supports would be available to through the family resource center?
- Are mental health professionals available to enhance the services of family resource centers?
- Is there a parent support group or play group with mental health professionals involved where the mother and infant could gain skills and improve their relationship?
- Where could Lian receive services to improve her language development? How would these services be paid for if she is only “at-risk” and not diagnosed with a developmental/language delay?

#### 3. Family day care home with two-year-old who has been a victim of abuse.
Kirsten, age two, and her parents were living together when she started at the family day care home. But during the following few months, the

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**Using EPSDT to Promote Early Childhood Mental Health: Idea Kit**
The Georgetown University Center for Child and Human Development, July 2003
child care provider became aware that her father was physically abusing her mother and sexually abusing her. With assistance, the mother found a temporary shelter with counseling and legal aid for women. Now that the mother and daughter are safe and living in their own apartment, her caregivers are concerned about Kirsten’s mental health. She cries easily, never sleeps at nap time, eats little, and seems withdrawn.

- How might the family day care home provider arrange for mental health consultation at the center?
- Would mental health consultation be more readily available for a child care center than a family day care home?
- What about ongoing mental health counseling and treatment for mother and daughter?

4. Child care center with a teacher competency problem. Mrs. Jones, the teacher in Red Rock Child Care Center’s group for 3-year-olds has asked the director to remove two boys from her classroom because she finds their behavior too difficult to control. The director is concerned because a similar request, made by Mrs. Jones last year, resulted in the removal of one child from the center and two others to another classroom. These children are all African American, and Mrs. Jones is white. The assistant teacher in the classroom has charged that Mrs. Jones is a racist. The director does not know how to sort out these problems and has called the Community Mental Health Center for help.

- What kind of support could the director expect to receive from the Community Mental Health Center?
- Does this community have resources to help the teacher improve her cultural competency?
- Is a mental health program consultant available for child care centers? How would these services be financed?

5. Child care center serving three-year-old with emotional-behavioral problems. Gregory is three years old and has been attending a quality child care center for five months. He loses his temper easily and has very little impulse control. Sometimes he engages in behaviors that seem almost compulsive, such as wringing his hands constantly or repeated shaking his head. His mother is a single parent, who recently started work after four years at home when she had Gregory and received cash assistance (welfare). His mom is extremely anxious about leaving him with others and about going to work. The caregivers in the center are concerned about Gregory and are uncertain how to handle his behavior.

- Where in your community can the child care staff turn for mental health program consultation? What about family services?
- Is the TANF program linked to mental health services for families in the transition from welfare to work?
- Where could Gregory go for an assessment financed through Medicaid?
- If he needs treatment, is there a mental health provider who is appropriate for a three-year-old and who accepts Medicaid?

6. Head Start program serving four-year-old who recently came from a refugee camp. Dahoud is a tall, bright four-year-old boy who survived the past two years in a refugee camp. There he witnessed violence and was separated from his parents for about six months. His parents also survived and were able to find him. Now the family is pleased to be living together in the United States. With the help of a refugee resettlement agency, both of his parents just found much needed employment. Dahoud attends Head Start, but staff are concerned because he doesn’t play well with other children and seems afraid of being separated from adults. The Head Start program is looking for a mental health consultant to help.

- Is mental health program consultation available for the Head Start staff? How might it be financed?
- Is an appropriate family mental health consultation available? How might it be financed?
- What other services and supports might be available in your community for this family?
7. **Family physician caring for a four-year-old with mother in substance abuse treatment program.** Angelo is nearly four years old. He is very small for his age and seems to have stopped growing. His mother is now in treatment and recovering from substance abuse. However, for the prior two years she was heavily using drugs. During that time the family lived in a motel room, where Angelo was witness to many events related to drugs, violence, and prostitution. Although Angelo has a cheerful disposition and is interested in learning, his family practice physician at the community health center is concerned about his growth and emotional well-being.

- Are mental health services available for children with mothers in substance abuse treatment? How are they financed?
- Where could the doctor refer this child for further assessment to determine the cause of growth retardation? Is a pediatric endocrinologist available?
- Would funds from the Title V Program for Children with Special Health Care Needs be available to help finance treatment for growth retardation caused by biological and/or psychological factors?

8. **Child care center serving five-year-old with severe emotional-behavioral problems.** At age five, Nathan has already failed at school. After attending developmental day care for three years, he was found to be “not socially ready” after the first few weeks of public kindergarten. Enrolled in another child care center that has a kindergarten curriculum for five-year-olds, he frequently exhibits troubling behavior. Teacher/caregivers report that when he loses his temper he might throw chairs, hit others, or scream loudly. His single mother reports that she is exhausted from working two jobs and doesn’t know how to handle him.

- Where could he be referred for an assessment?
- If he is diagnosed with an emotional-behavioral problem, what special education services might be available?
- Would school and child care staff be linked or work in a coordinated fashion?
BARRIERS TO SUPPORTING YOUNG CHILDREN’S HEALTHY MENTAL DEVELOPMENT

States interested in strengthening early childhood interventions and services that promote healthy mental development face a number of challenges, each of which can be overcome through changes in state policy and programs. These challenges include:

• **A focus on the provider setting rather than the service needed by the child.** The services described in the previous section can be provided in a variety of settings, but Medicaid services have traditionally been defined by setting and provider type. If a Medicaid agency has traditionally expected developmental screening to be provided by pediatricians, public health nurses might not provide such screens in home visits or child care centers. If Medicaid's rules state that social workers may only be paid if their services are billed by mental health centers, social workers working in pediatric offices may not be able to provide services. Essentially, many of the services needed to support young children's healthy mental development can be provided in a number of different settings by a number of different provider types. Medicaid agencies should consider new modes of practice in early childhood mental health when defining the service, the setting, and the fees.

• **The term “developmental services” is confusing.** Like the term case management, developmental services come in different types and may carry different provider and payment requirements. Thus, the Medicaid service category is often poorly defined and providers may be reluctant to provide the service if coverage (and payment) is not clear. Sometimes, for example, developmental services are routine screenings provided by pediatricians for well children and other times developmental needs trigger entitlement to services for developmental disabilities (e.g., IDEA Part C). States can start by clarifying the distinction between developmental screening and diagnostic assessment: EPSDT uses one term “developmental assessment” for these two distinct functions. States might want to create and apply additional separate billing codes/rates for different functions and definitions related to developmental services in early childhood.

• **The concept of “mental health services” to infants, toddlers, and preschool age children is new for many decision-makers,** but researchers have identified interventions and therapies that can prevent or ameliorate social, emotional, behavioral, and mental health conditions among young children. Many such interventions and therapies are now being covered by some Medicaid agencies under EPSDT or mental health. Recent research findings and states’ experiences in applying those findings can aid replication in other states.

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Many Medicaid agencies separate the mental and physical health sides of the program. As previously discussed, this separation may be created by establishing separate managed care programs or by administrative mechanisms, such as assigning responsibility for providing mental health to the mental health agency. Under these circumstances, it may be difficult to know if an early childhood service to promote emotional well being is covered by the medical or the mental health side. Regardless of this separation, Medicaid-enrolled children are covered for a range of services. State Medicaid agencies decide how the services will be covered (i.e., from which pot of funds).

Prevention and early intervention services for young children are different from those traditionally used/funded for older children with mental health diagnoses. Thus, Medicaid agencies may not have experience with financing needed services. For example, to be effective, early childhood services must be focused on the relationship between the child and his or her parent/caregiver; therapy is provided for the caregiver (parent) and child together. Medicaid agencies are not prohibited from covering “family” (parent-child) therapy as a service for the youngest children and their caregivers, even if only the child is eligible for Medicaid. Agencies, however, may not be currently paying for family therapy.

The diagnostic codes used for older children, youth, and adults may not fit the conditions identified for infants and young children. Young children may not yet have full-blown or clearly defined mental or emotional disturbances. Instead, the youngest children may exhibit abnormal development, poor attachment to caregivers, or other early signs of serious risk. A new set of diagnostic codes for children under age three (DC:0-3) has been developed by the national organization Zero to Three, but the set is not yet widely used. Florida has adopted the DC:0-3 for developmental services, and other states, such as Washington and Ohio, are piloting their use. Vermont and other states are using Medicaid “V” codes for certain early childhood mental health services. Such alternative diagnostic codes fit better with the conditions most often seen in early childhood. They also offer a diagnostic code that providers can use to bill for services without mislabeling a young child.

Among the youngest children, distinguishing between developmental, emotional, and physical conditions may be difficult. Thus, it may not be clear when a child qualifies for more than one program or source of funding. In most federal/state programs, however, the state has a responsibility to determine eligibility for multiple programs, and federal rules govern who pays for which services. In states such as Indiana, Maryland, North Carolina, Oregon, and Vermont, interagency planning has led to more systematic and collaborative approaches.


34 Amy Wishmann, Donald Kates, and Roxane Kaufmann. Funding Early Childhood Mental Health Services and Support, (Washington, DC: Georgetown University Child Development Center, 2001).