Part Five

Medicaid Financing for Other Needed Services
Promote Healthy Child Development Within and Beyond the Medical Home
Part Five / Key Takeaway Messages

- Many pediatric primary care practices are augmenting their services or increasing linkages with other community providers to better address risks and concerns related to child development, emotional-behavioral factors, or social determinants of health. Evidence-based models to augment primary care — such as HealthySteps and Project DULCE — are being used in practices across the nation.

- Promoting social-emotional health and well-being, beginning in early childhood, is a nationwide priority. Medicaid is financing an array of preventive and therapeutic services for young children, including ones where the services themselves are directed to ameliorating parent risks that affect child health.

- The social-emotional, mental, and behavioral health of young children is a core foundation for the healthy growth and development of young children and is strongly associated with school readiness, achievement, and lifelong health and well-being. EPSDT includes preventive, diagnostic, and treatment services related to mental health and physical health equally. Integrating mental/behavioral health services into primary care is another trend, for children and adults. Early childhood mental health clinicians offer the opportunity to intervene more effectively in the earliest years of life; effective approaches recognize social and emotional concerns at much younger ages than those for traditional mental health diagnoses.

- Medicaid plays a role in financing home visiting and early intervention services. Dedicated federal funding through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program and the IDEA Part C Early Intervention Program provide a foundation and infrastructure for needed services but themselves have insufficient funding to cover all children in need. Many states are using Medicaid to finance some of the cost for delivery of these services, particularly when related to improving child health outcomes, which falls within the scope of Medicaid and its EPSDT benefit. Even though federal funds cannot be used as a match for Medicaid, state or local funds directed to these programs can.

- Medicaid also provides opportunities for financing other services around parenting training, education, and group interventions that respond to developmental, social, and emotional risks. This generally requires that primary child health practitioners or other medical clinicians provide authorization for such services, that staff are appropriately credentialed to provide the services, and that the goals for and documentation of the services are clearly enumerated and are based on the child’s identified health needs.

Augmenting Primary Health Care to Address Bio-Medical and Social Determinants of Health

As discussed throughout this sourcebook, primary care practices are moving toward becoming high-performing medical homes by restructuring their offices and well-child visits and incorporating screening and care coordination as essential elements of their practices. There are such exemplary practices in virtually every state on which to build.

In addition to these features, both states and exemplary practices also are expanding the coverage under Medicaid for additional needed services, sometimes with these services directly incorporated into the practice office and sometimes through practitioner referrals and authorizations for services outside the office. Specific service models have developed a strong evidence base on their effectiveness and have been supported for broad diffusion. Not all services that young children need will be eligible for Medicaid reimbursement (housing subsidies and basic child care, for instance), yet many do fit the Medicaid and
EPSDT benefit, particularly those directed toward improving children’s healthy development through training and enhancing parental skills in advancing the child’s development. Anticipatory guidance and health education is recommended and covered to promote positive parenting, as well as social-emotional, physical, and cognitive development and any special health care needs. Such services defy neat categorization, but there is a growing body of evidence that suggests they can be integrated into the primary care practice, with financing from Medicaid. Most are evidence-based; many have been shown to have a high return on investment.¹

The other needed services and supports discussed here focus on engaging parents and children to improve the health and development of young children through more positive parenting, home safety and security, and early interventions to address social and bio-medical determinants of health.

**Augmenting Primary Health Care Office Responses by Incorporating Additional Services within the Practice Setting**

Building such capacity within the pediatric primary care medical home is one highly promising strategy. Typically, this is done by adding a staff person who has developmental knowledge and clinical skills. Evidence-based program models (e.g. HealthySteps and Project DULCE) are being implemented across the country. In addition, other types of staff may be added to provide preventive services and support parents within the practice or in the community. These strategies make particular sense for larger private practices and for federally qualified health centers and other clinics, where patient volume is likely to be sufficient to keep a staff person fully deployed. Smaller practices also may be able to have such onsite staff, however, particularly on a rotating basis across several sites, where the staff are available for specific days or times during the week. Below are examples.

- **Preventive Services Delivered by Non-Physicians.** At their option, with a state plan amendment, states can choose to reimburse preventive services “recommended by a physician or other licensed practitioner...within the scope of their practice under State law” (42 CFR §440.130(c)). Medicaid can provide reimbursement for preventive services staffed by a broad array of health and related staff. Those include community health workers, parent educators, early childhood specialists, and nutrition counselors and lactation consultants.²

- **Project DULCE (Developmental Understanding and Legal Collaborations for Everyone)** is an evidence-based effort that uses a protective factors approach. It incorporates components of the Medical-Legal Partnership model to ensure that families have access to the resources they need. Initially established as a research program at Boston Medical Center, Project DULCE improved parental knowledge of child development, better met family needs for concrete services, and successfully engaged and produced substantial gains in parental resiliency for families determined to be at risk.³ Based at the infant’s primary care medical home and supporting families for the first six months, a DULCE family specialist joins the health care team and provides additional support on healthy child

---

¹ Primary care practices are moving toward becoming high-performing medical homes by restructuring their offices and well-child visits and incorporating screening and care coordination as essential elements. There are such exemplary practices in virtually every state on which to build.

²

³
development and parenting support by helping parents connect to both formal and informal community resources. The Center for the Study of Social Policy and city and county partners are testing the adoption and adaptation of DULCE in localities across the United States.

- **HealthySteps for Young Children (HealthySteps)** is an evidence-based model that originated in 1996 with partnerships formed with 24 pediatric and family practice sites across the country. The goal of HealthySteps was to design and test a new approach to primary care for young children that would focus on supporting parents in nurturing their child’s development. HealthySteps specialists—nurses, nurse practitioners, child development specialists, or social workers—are integrated into the primary practice to respond to the family’s needs for information and support about their child’s healthy development. The 2003 national evaluation of more than 4,500 children served by 15 HealthySteps sites showed impressive gains in improving timely well-child visits, childhood immunizations, developmental screening, family engagement in primary care, breastfeeding, safe sleep, positive mother-child activities, the sensitivity of parents to their children's cues for attention, as well as in reducing the use of harsh disciplinary practices. HealthySteps participation is associated with better social-emotional status and reduced child behavior problems. Through a national resource center operating at Zero to Three, HealthySteps continues to be replicated across the country and adapted and further evaluated for its impacts.

**Medicaid Financing to Support Early Childhood Social-Emotional-Mental Health**

Screening for social-emotional-mental health risks, as well as developmental and social determinants of health, should be part of routine well-child visits. In fact, EPSDT requires screening for physical and mental conditions.

The social-emotional, mental, and behavioral health of young children is a core foundation for the healthy growth and development of young children and is strongly associated with school readiness, school success, social relationships with peers, and lifelong health and well-being. EPSDT includes preventive, diagnostic, and treatment services related to mental health and physical health equally. According to the Centers for Medicare & Medicaid Services, the EPSDT benefit assures that health problems, including mental health and substance use issues, are diagnosed and treated early and before they become more complex and their treatment more costly.

Medicaid finances various types of services using different mechanisms. As discussed above, screening for social-emotional-mental health risks, as well as development and social determinants of health, should be part of routine well-child visits. Under federal law, EPSDT requires screening for physical and mental conditions.

For early childhood mental health interventions and treatment, most states require a determination of medical necessity prior to approval of Medicaid billing. This may or may not include a diagnosed condition of the child. Criteria related to risk factors are considered sufficient for determining medical necessity in many cases. The professional judgement of a health professional should be considered sufficient grounds on which to base a medical necessity determination, given that nothing in federal law requires a diagnosis. In addition, some programs (e.g. evidence-based parenting support) might be generally approved, avoiding the need for individual medical necessity determinations. Mental and behavioral health care coordination/case management services also are billable services in a majority of states.
Some states have used Medicaid to support early childhood social-emotional-mental health interventions, but this aspect of the EPSDT benefit has not been fully implemented in most states. A 2017 survey of the 50 states by the National Center for Children in Poverty, Using Medicaid to Help Young Children and Parents Access Mental Health Services, documented how states are using a variety of partnerships, mechanisms, training, and funding approaches, to increase access to early childhood mental health services. (The state counts for 2016 in this section are based on this survey.) For example, in 2016, state Medicaid agencies covered early childhood mental health services provided by a mental health clinician when delivered in the home (46 states), in primary care (45), or via case management/care coordination (44), although the extent of financing and eligibility for the services vary substantially.

Two specific approaches for providing such services—early childhood mental health consultation and parent-child (dyadic) therapy—are discussed below.

- **Early childhood mental health consultation** is a multi-level preventive intervention that connects mental health professionals with people who work with young children and their families to improve the child’s social-emotional and behavioral health and development. Many states have early childhood mental health consultation programs, often delivered through early care and education settings but also sometimes through primary care settings. States and communities use a variety of funding sources, including mental health (e.g. Project LAUNCH), child care, Title V MCH, and Medicaid dollars to fund such efforts. In 2016, 34 states reported that Medicaid paid for an early childhood mental health specialist to provide services to address a young child’s mental health needs in early care and education programs. Medicaid generally is used only when the service is provided for individual children. No states yet are reported to cover consultation to improve program staff skills or other training.

- **Parent-child (dyadic) therapy** for mental health conditions acknowledges that for young children, mental and behavioral concerns can best be addressed by treating both the parent and the child, increasing parenting capacity to be responsive, nurturing, promote positive behavior, and appropriately interact with the child. Several evidence-based models of parent-child therapy have been developed and are in use nationwide. In 2016, a substantial share of states (38) explicitly covered parent-child dyadic therapy. States vary regarding the settings and type of providers and/or therapy models that may be used, with a majority permitting billing by mental health clinics (37) and primary care practices (29). Some states (12) use specific billing codes for these services, while others use different rules. States generally require a determination of medical necessity for these services. Most states do not set limits on the number of visits, which would be consistent with EPSDT requirements for providing services as determined medically necessary for individual children.

- As an example, Florida’s Medicaid agency changed the service description for “individual therapy,” renaming it “individual and family therapy” to extend coverage to parent — child dyadic therapy, as well as therapy with the parents alone without the child present or therapy with the child alone. If the child is the Medicaid recipient, therapy with the parent must be focused on the relationship with
the child, and the child’s benefit must be documented. As a result, the service can be used for many different therapeutic approaches and the establishment of a specific service code for dyadic therapy was unnecessary for this state.10

One challenge states and practitioners may cite to providing behavioral health services is that young children may not yet have clearly defined or diagnosable mental or behavioral health conditions. Very young children may exhibit abnormal development, poor attachment to caregivers, or other early signs of serious risk that do not fit into the Diagnostic Classification of Mental Disorders (DSM-V). This means that age-appropriate diagnostic codes are needed for young children. The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (originally DC:0-3 and now DC:0-5) supports clinicians in diagnosing and treating mental health problems in the earliest years. Crosswalks have been developed to aid providers in converting DC:0-5 into the diagnostic codes used for adults by most health insurance plans to receive compensation for their services. In some states (e.g. Florida and Minnesota), Medicaid uses several mechanisms for increasing access to early childhood mental health services, including adoption of the DC:0-5 for diagnostic purposes.

Integrating mental/behavioral health services within the medical home is another trend for both children and adults. EPSDT and Bright Futures guidelines call for mental health screening, but there is a shortage of pediatric mental and behavioral health providers for children, particularly for young children.11 As a result, many children and families who need prevention and intervention services do not receive them. Referral to appropriate behavioral health services can be challenging for families and primary care pediatricians. Integration of behavioral health care within pediatric primary care offers a unique opportunity for early intervention to prevent behavioral health problems from worsening.

The number innovative approaches for behavioral health integration (BHI) in pediatric primary care practice is increasing.12 Collocation of mental and behavioral health providers in the pediatric medical home is an important opportunity. Studies on pediatric behavioral health integration indicate that the strongest effect is with a team-based approach in which primary care providers, care managers, and mental health specialists coordinate care.13 Medicaid financing can make this type of primary care system enhancement possible, particularly for those medical homes serving high concentrations of children enrolled in Medicaid. Clear definitions, coverage rules, billing codes, adequate reimbursement rates, requirements for medical necessity where appropriate, and managed care contract provisions are needed as the practical mechanisms to finance integrated behavioral health. Often, as part of a medical team, a trained staff person who is not a licensed physician but has a mental health specialization can provide these services. Additional support sometimes can be provided through telemedicine or other means to access additional clinical expertise when needed.

Research is clear that the mental health of the parents, and particularly the mother, affects parent-child relationships and the mental health of the child.14 Further, this is particularly impactful in the earliest years of a child’s life, a time when some mothers experience post-partum depression. A CMS informational bulletin emphasizes the negative impact maternal depression can have on young child development and the role EPDST plays in addressing this condition. CMS encourages maternal depression
screening during EPSDT well-child visits and informs states that pediatric primary health care providers may be permitted to bill for maternal depression screening under the child’s Medicaid during well-child visits. (See discussion of screening in part four.) CMS states that Medicaid can cover treatment related to maternal depression under the child’s Medicaid enrollment if the child is present and if the treatment directly benefits the child. An example of this type of intervention is parent-child dyadic therapy.

“If a problem is identified as a result of an EPSDT screen, states have an obligation to arrange for medically necessary diagnostic and treatment services to address the child’s needs…. Consistent with current policy regarding services provided for the “direct benefit of the child,” such diagnostic and treatment services must actively involve the child, be directly related to the needs of the child and such treatment must be delivered to the child and mother together, but can be claimed as a direct service for the child.”

Additional treatment of the mother’s depression may be needed (including prescriptions for medication and therapies directed specifically for the mother), which can be covered under Medicaid if she qualifies. At the same time, much can be done under the child’s Medicaid coverage to identify maternal depression and strengthen the parent-child relationship, which often contributes to the mother’s health as well.

Medicaid Financing in Partnership with through Other State and Federal Programs

Medicaid is not the only federal source of financing for children’s health and development and early responses to developmental issues and concerns. Other federal programs—particularly those for home visiting and early intervention—are designed to address children’s health and development. Many states provide additional funding to these efforts. Even though federal funds cannot be used as the state match for Medicaid, state or community funds directed to these services can. Medicaid can play a substantial role in financing these other needed services.

Medicaid Financing for Home Visiting

Over the last decade, the knowledge base about home visiting has grown and more than 20 evidence-based models that provide voluntary, structured, home visiting services have been approved, based on federal review. Evidence-based home visiting can have a very strong return on investment, with programs such as the Nurse-Family Partnership shown to save $5.70 per $1 invested. Home visiting services, typically for at-risk families, emphasize prevention, often beginning during pregnancy, and have demonstrated impact on a range of maternal and child health outcomes, as well as improvements in parenting skills, economic self-sufficiency, safety, and well-being. Several models give greater emphasis to improving maternal, infant, and young child health, beginning during pregnancy, and show more impact on health outcomes. The AAP and others in child health have called for linkage and integration of the pediatric medical home and home visiting programs. Even though federal funds cannot be used as the state match for Medicaid, state or community funds directed to these services can. Medicaid can play a substantial role in financing these other needed services.
The federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program provides funding that is used in every state to finance evidence-based home visiting, with $400 million provided annually. However, current funding is sufficient to reach only a small share of families who might benefit from these services. Medicaid funding cannot be combined with federal funding from the MIECHV program, but Medicaid can be one among several sources of funds states use for home visiting services. Many states use multiple state and local funding streams (as well as federal funding streams, including MIECHV but also TANF, child welfare, and others) to support multiple models of home visiting and address a variety of family risks and needs. Often, states have specific state appropriations for home visiting, many of which predated MIECHV as a funding source. States may find it to their advantage to expand Medicaid to cover home visiting services and therefore draw down additional federal as well as state dollars for those services.

States have been using Medicaid to finance home visiting for over 20 years and continue to evolve in the approaches they use to provide coverage for vulnerable mothers and children. In 2016, Joint Informational Bulletin of the Centers for Medicare and Medicaid Services (CMS) and Health Resources and Services Administration (HRSA) affirmed the flexibility and opportunity states have to do so.

“Medicaid coverage authorities offer states the flexibility to provide services in the home.... However, home visiting programs may include some component services, which do not meet Medicaid requirements, and may require support through other funding options....state agencies should work together to develop an appropriate package of services... may consist of Medicaid-coverable services in tandem with additional services available through other federal, state or privately funded programs.”

Currently more than a dozen states are using Medicaid financing for home visiting through a variety of mechanisms. In most states, home visiting services are added through a Medicaid State Plan Amendment (SPA). Other states have made home visiting part of larger Medicaid Section 1115 or 1915(b) waivers (e.g. Maryland, South Carolina). Still others use current authority and existing benefits. Different states use fee-for-service, capitated, and managed care approaches. Typically, states pay for home visits on a per-visit unit, fee-for-service basis, but it also may be part of per member, per month capitated fees under managed care or provided as a bundled service covering the time period when the visits occur. As states develop Medicaid financing for home visiting, most provide a reimbursement rate that covers the full cost of providing that service, recognizing that all the aspects of providing home visiting (including direct time with the parent and child around child-specific developmental issues and the home visitor’s other time related to that work) are covered in the reimbursement. The examples below show the different ways that states have drawn down funding for home visiting.

- Oklahoma has a long history in home visiting policy and was one of the first states to use Medicaid to pay for home visiting. Oklahoma’s Nurse-Family Partnership program is known as Children First. By 1998, Oklahoma had an agreement between the Department of Health and the Medicaid agency (Oklahoma Health Care Authority) to finance Children First in all 77 counties. Services may be billed to Medicaid with codes for targeted case management (HCPC23 T1017) or nurse assessment (HCPC T1001). State officials report that Medicaid currently represents approximately 15-20 percent of
funding for Children First each year. In FY 2016, Children First served about 2,500 families in Oklahoma, with 90 percent receiving coverage through Medicaid. The Medicaid approach is supported by a strong and enduring partnership between the state's Medicaid agency and Department of Health. By 2016, more than 100 registered nurses who meet home visiting training requirements were certified by the Department of Health for this program.

- Michigan has been using Medicaid to finance home visiting for more than two decades. Multiple models are being used with state and MIECHV funding, but the centerpiece of their statewide effort is the Medicaid Maternal and Infant Health Program (MIHP). MIHP is administered by the state Medicaid agency. Michigan used maternal and infant case management programs from which to build MIHP as a strong, population-based home visiting program that is available to all pregnant women in Medicaid. MIHP has been shown through evaluation studies to improve utilization of prenatal care and well-baby visits; and to reduce the risk of adverse birth outcomes, particularly among black women. In 2017, after years of operation as a fee-for-service Medicaid program, MIHP was integrated into Medicaid managed care arrangements.

- Minnesota has been using Medicaid to finance home visiting for more than a decade. The state currently authorizes Medicaid managed care contracts with local health departments providing home visiting services. Multiple models of home visiting are being used (e.g. Nurse Family Partnership,
Healthy Families America, and Family Spirit). All of the managed care organizations contracting with the state have subcontracts with local agencies to provide home visiting services. However, local agencies have been individually contracting with managed care organizations and as a result home visiting agency reimbursement rates, responsibilities, and results are inconsistent across the state.

- The Kentucky’s Health Access Nurturing Development Services (HANDS) program is administered by the Kentucky Department of Public Health. HANDS began as a pilot program in 1999 and was expanded to every county in the state by 2003. This expansion was fueled by Medicaid financing. In 2002, the state got a Targeted Case Management SPA approved to cover some HANDS home visiting; the state used State Tobacco Funds as the state match for federal Medicaid dollars. Kentucky covers HANDS services through a fee-for-service system even though the majority of Medicaid beneficiaries are enrolled in managed care.

The structure of these efforts depends primarily on the benefit category used.22 Under the Medicaid State Plan Authority there is no official benefit called “home visiting”; however, home visiting services can be covered under some benefit categories, typically targeted case management, expanded services to pregnant women, and EPSDT. Most states have used the Targeted Case Management benefit option to finance home visiting, which offers flexibility and fiscal controls. Using the Targeted Case Management benefit option requires that a state submit and CMS approve a Medicaid State Plan Amendment, in which the state may define risk criteria for family eligibility, set provider qualifications (e.g. select models), define the structure of the service, set payment rates, and even select specific geographic areas if it so chooses. The overlap between EPSDT prevention benefits and home visiting services offers an opportunity for EPSDT to be used as a permissible benefit pathway for the coverage of services.23 Typically, states use the EPSDT child health benefit combined with optional enhanced maternity benefits.

Under the Medicaid State Plan Authority there is no official benefit called “home visiting,” but home visiting services can be covered under some benefit categories.

In any case, states are not using medical necessity determinations or prior authorization limits related to Medicaid financing of home visiting. Instead, it is typically added as a covered service under an appropriate benefit category with risk criteria for eligibility generally aligned with the models used.

States using Medicaid to finance some home visiting services must continue funding staff training, evaluation, central intake, and similar home visiting system elements with MIECHV or other funds. Such activities would not typically qualify for Medicaid payment, even in the health system.

IDEA Part C Early Intervention Program for Infants and Toddlers

Children with confirmed disabilities—physical, developmental, or mental—generally qualify for programs that support their families’ efforts to care for them. In particular, Medicaid, the Supplemental Security Income and associated Medicaid eligibility, the Individuals with Disabilities Education Act (IDEA) Part C Early Intervention for Infants and Toddlers and Part B Special Education for children 3 to 21, and the Title V Children with Special Health Care Needs (CSHCN) programs operate in every state. Medical homes for children should play an important role in helping families identify risks, needs, and follow up interventions, including services provided in these federal programs.24
Part C of the IDEA provides grants to states for Early Intervention Programs for Infants and Toddlers with Disabilities (20 U.S.C §1435(a)(1), P.L. 108-446 §635(a)(1)) and requires that states provide early intervention services to children identified as qualifying for them. States must use a comprehensive outreach approach (known as “child find”) and referral system, as well as access to timely and comprehensive multidisciplinary evaluations to identify needs. States must assure that every eligible child and family will have early intervention services eligible to them and use Individualized Family Service Plans (IFSP) to specify and guide services, as well as care coordination services. Although the federal grant is a limited $347 million, it generally provides for the infrastructure for states to operate their Part C program. Most states provide substantial additional state, local, Medicaid, and private insurance funding to provide the services identified as needed under Part C.

Each state Part C program is required to establish eligibility criteria for serving, at a minimum, children who have: 1) a diagnosed physical or mental condition with a high probability of resulting in developmental delay; or 2) developmental delays in one or more of five domains (i.e. physical, cognitive, communication, social/emotional, and adaptive development). At their option, states are permitted to make eligible children who would be at risk of experiencing a substantial developmental delay if early intervention services were not provided to the individual. Also the state's option, at-risk infants and toddlers “may include those who are at risk of experiencing developmental delays because of biological or environmental factors that can be identified (including low birth weight, respiratory distress as a newborn, lack of oxygen, brain hemorrhage, infection, nutritional deprivation, a history of abuse or neglect, and being directly affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure).” Since 2005, states have had the flexibility to make Part C early intervention services available to children until they are eligible to enter kindergarten or elementary school, thereby offering families additional support and children enhanced services that would not typically be included in IDEA Special Education services for ages 3-5.

Federal law requires that states use a “rigorous definition of the term ‘developmental delay’,” yet states set their own eligibility criteria for Part C. These vary widely and can require an identified delay of 25 percent or more to trigger eligibility, which often is difficult to meet, particularly for very young children. As a result, eligibility and enrollment varies widely among the states. National survey data indicate that the proportion of infants and toddlers who have conditions making them likely to be eligible for Part C services ranges from 2 percent to more than 50 percent — with the most cited study estimating that 12-28 percent of all children should qualify. As shown in the map in Figure 12, the proportion of infants and toddlers enrolled in Part C, however, ranges from across states from 1 percent to 9 percent.

Medicaid plays a particularly important role in financing services that help children with developmental disabilities or chronic medical conditions, including those in the IDEA Part C Early Intervention program. A majority of state Part C programs use Medicaid to fund some of the health-related services for infants and toddlers. Intervention services on behalf of Part C-enrolled children most likely to be funded by Medicaid are physical, occupational, and speech/language therapies. Psychological, nutritional, diagnostic medical, vision, developmental therapy, and assistive technology services also can be covered. Part C services generally involve extensive communication with the parents of the children, and support to them in providing home-based environments to improve their children’s development.
In many states, Medicaid has developed partnerships with Part C to maximize the funding for Part C services and improve outcomes. Medicaid financing is used by virtually all states to finance a portion of Part C Early Intervention services. Making referral, service delivery, and payment practices efficient and effective helps reduce cost and improve outcomes. Medicaid financing for Part C has been restructured in some states as more young children are enrolled in managed care arrangements.33

At the same time, an estimated 10 to 25 percent of young children with developmental risks or delays that have not yet resulted in disability do not qualify for Part C Early Intervention under the state definitions for eligibility. In many states, more than one-third of children with identified developmental concerns referred to Part C do not qualify. Many of these risks associated with later onset developmental delays and disabilities are related to social determinants described earlier in this sourcebook.34 State Medicaid agencies can structure and support a network of providers who have the capacity to serve children with or at risk of developmental delays who do not qualify for Part C. Doing so adheres to the Medicaid statute and its EPSDT benefit. Medicaid agencies, in partnership with Title V CSHCN programs in particular, have worked to develop such provider capacity. For example, Rhode Island developed the Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Reevaluation (CEDARR) program, which has been modernized to provide Medicaid health homes.35

Family First

On February 9, 2018, the Family First Prevention Services Act was signed into law as part of the Bipartisan Budget Act of 2018 (P.L. 115-123).36 The Family First Act includes major reforms intended to: avoid foster care placements by keeping children safely with their families; emphasize the importance of children growing up in families; and ensure children are placed in the least restrictive, most family-like setting appropriate to their needs when foster care is needed.37 Notably, children in foster care qualify for Medicaid, as do many other children at risk for entering foster care.

Setting a new direction, the Family First Act provides new optional Title IV-E funding for time-limited (one year) prevention services for mental health/substance abuse and in-home parent skill-based programs for candidates for foster care without regard to whether the child would be eligible for Title IV-E foster care, adoption, or guardianship, pregnant/parenting foster youth, and the parents/kin caregivers of those children and youth (sections 471(e), 474(a)(6) and 475(13) of the Act). Eligible groups include: 1) children who are “candidates” for foster care, meaning they are identified in a prevention plan as being at imminent risk of entering care but can safely remain at home or in a kinship placement if provided services that prevent entry into foster care or whose adoption or guardianship arrangement is at risk of disruption or dissolution that would result in entry into foster care; 2) children in foster care who are pregnant or parenting; and 3) parents or kin caregivers of candidates for foster care where services are needed to prevent the child’s entry into care or directly relate to the child’s safety, permanence or well-being. Eligible children, youth, parents and kin caregivers are eligible for prevention services and programs regardless of whether they meet the AFDC income-eligibility requirements required for Title IV-E reimbursement.

The preventive services program emphasizes: 1) mental health and substance abuse prevention and
treatment services provided by a qualified clinician, and 2) in-home parent skill-based programs, which include parenting skills training, parent education and individual and family counseling. State agencies and child advocates are starting to envision programs that might use the 12-month funds to: increase the capacity to provide: parent-child dyad mental health therapy, trauma-informed services, maternal depression treatment, home visiting models designed for families whose young children are in or at risk of entering the child welfare system, interventions to reduce opioid exposure during pregnancy, and other services.

The potential exists for states’ child welfare and Medicaid agencies to work in partnership to maximize available funds, increase service capacity, and provide treatment services for pregnant women, infants, children, and youth. For example, if Family First time-limited funds were used to spread use of evidence-based child welfare interventions, Medicaid might be used in tandem to fund mental health, developmental, or substance use treatment services.

**Medicaid Financing to Support Effective Parenting**

Parents’ knowledge of how to meet their children’s basic physical and emotional needs has effects on parent-child relationships and, in turn, child health and development. The appropriateness and skill of parents in delivering discipline is equally important. Anticipatory guidance from the pediatric primary care practitioner is intended to help parents prepare for and address issues they may encounter as their child grows. *Bright Futures* guidelines recommend anticipatory guidance across a broad variety of topics that are focused on parental roles in their child’s health and development. As discussed throughout this sourcebook, some families need coaching, support, and guidance that goes beyond what can effectively be delivered in well-child visits. Evidence-based home visiting programs offer coaching and support for positive parenting and have been shown to have significant impact. Other evidence-based programs are designed to provide more intensive support to parents (e.g. Triple P Positive Parenting Program, The Incredible Years) and can be financed through Medicaid. These may be provided in clinical sites such as pediatric practice offices, community health centers, or hospitals or may be provided in other human service office sites. Two state examples point to opportunities.

- In Michigan, Community Mental Health Services Programs can choose the evidence-based parenting models they offer. Models used include: Nurturing Parenting Program and The Incredible Years. A diagnosis is required for billing Medicaid but the diagnosis can be for the parent or child.

- In Oregon, services within select parenting programs are covered when a child has a diagnosis and a parent training program is recommended as the best treatment for that diagnosis (e.g. The Incredible Years, Parent Management Training programs). Parents can participate in a parenting program if their child is “at risk” of experiencing a mental health disorder as a result of family circumstances that increase the child’s chance of developing a significant mental health condition. Oregon’s health care providers may bill Medicaid for children’s mental health services under a new code indicating the presence of family and environmental factors that place the child “at risk” of a mental health disorder (using the ICD-10 code, Z63.8).
States also have the option to use Medicaid to finance other parent support services available in their communities. Typically, referral from a primary care practitioner is required and the parent support programs must have structures (appropriately credentialed staff, protocols for providing service, and documentation systems) that enable them to be Medicaid providers.

Some of these parenting programs and services involve direct training and modeling (dyadic) activities with individual parents and those parents and their children, and there also are opportunities for group activities, and for peer interactions. This includes group medical visits (e.g., drop-in group medical appointments-DIGMAs) and patient support groups. These have been employed with respect to well-child visits and show promise of extending the range of topics and issues that can be covered. Patient support groups — often around specific conditions (such as children with autism or ADHD) can provide additional contacts and ties for children and their families that strengthen the overall environment for children.

Home-visiting programs like Child First build in such patient support groups, recognizing the value of peer-networking that provides additional opportunities for self-help, reciprocity, and the maintenance of social ties that also are associated with healthy child growth and development. Medicaid recently provided guidance to states on how patient support groups can be covered — and these can have specific applicability to young children and their families. Even though most of the services provided under Medicaid are done on an individual patient basis, Medicaid also provides coverage for group-based services, and these hold the potential for further responding to social determinants of health that impact children’s development.

References

9. Center of Excellence for Infant and Early Childhood Mental Health Consultation. Overview of the IECMHC approach within the early


32 IDEA Infant and Toddler Coordinators Association. Options and considerations when accessing Medicaid Early Periodic Screening,


