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Guide to Leveraging Opportunities Between Title V and Medicaid for Promoting Social-Emotional Development

Kay Johnson Johnson Group Consulting, Inc.

David Willis **Stephanie Doyle** Center for the Study of Social Policy

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Interviews with Child Health Leaders: This project was designed to capture the wisdom of many state Title V and Medicaid leaders, as well as national experts and family leaders. Yet, just as we were beginning this project in March 2020, the COVID-19 pandemic had dramatic impact on state health and public health agencies, and hence their available time to engage in the project. Thus, we adopted our own extensive document review to understand what states are doing to help pediatric primary care providers do their part to improve social-emotional health. A small number of select interviews were conducted during the summer. The project team is grateful to all those who agreed to be interviewed.

Title V MHC Directors: Six state Title V Maternal and Child Health Program directors gave us time for an interview: Joan Brandt, PhD, MPH, RN, Minnesota; Breena Holmes, MD, FAAP, Vermont; Janis Gonzales, MD, FAAP, New Mexico; Rachel Hutson, MSN, Colorado; Cate Wilcox, MPH, Oregon; and Amy Zapata, MPH, Louisiana.

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About Us

The Center for the Study of Social Policy works to achieve a racially, economically, and socially just society in which all children and families thrive. To do this, we translate ideas into action, promote public policies grounded in equity, support strong and inclusive communities, and advocate with and for all children and families marginalized by public policies and institutional practices.

Johnson Group Consulting, Inc. is a small, woman-owned business with the capacity to study health policy questions and provide technical assistance to federal and state leaders. The mission of the Johnson Group is to advance policy and program developments that improve the health and well-being of women, children, and families.

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Executive Summary

The Pediatrics Supporting Parents (PSP) Initiative is focused on cultivating healthy social-emotional development in our country's youngest, most vulnerable children; valuing the central role parents play in that development; and seizing the opportunity for pediatricians to better support parents in this role. Research tells us that young children's social-emotional development is a key component of school readiness and is a key building block for cognitive development, learning, and future mental health. It is one of the four traditional key domains of young child development (i.e., physical, social-emotional, cognitive, and language development), and it is the outcome of positive, stimulating, and nurturing parent-child relationships in the context of safe and well-resourced families and communities.

The Center for the Study of Social Policy (CSSP) and Johnson Group Consulting, Inc. were asked by the PSP initiative to develop this *Guide to Leveraging Opportunities Between Title V and Medicaid for Promoting Social-Emotional Development*. The guide is designed to support state-level planning, action, and innovation aligned with the goals of the PSP initiative. This guide uses a framework for action across a continuum that stretches from promotion to screening to prevention to early intervention and treatment.

As the largest federal-state health programs serving young children, Medicaid and the Title V Maternal and Child Health Services (MCH) Block Grant present particularly important opportunities to catalyze transformation in pediatric primary care. We cannot achieve health equity for children without strong performance by these programs. Medicaid, together with the Children's Health Insurance Program (CHIP), covers about half of all births and more than 40 percent of infants and toddlers, birth to three. More than half of all children of color under age 19 are covered by Medicaid and CHIP. State Title V MCH programs anchor an array of services and supports for children with low income, as well as system structures that affect all pregnant women, children, and families.

Every state has the potential to improve the finance and delivery of pediatric primary care to better support parents and improve social-emotional development in ways that have lifelong impact. The specific policy, program, and practice opportunities described below for state Title V MCH programs, by state Medicaid agencies, and by the two in partnership are based on existing state innovations, research on how to promote social-emotional development, and federal law.

Major opportunities for change point in three directions: (1) expanding efforts in pediatric primary care to promote social-emotional development and relational health; (2) applying strategies used to support medical homes for children with special health care needs (CHSCN) to advance high performing medical homes for young children; and (3) focusing infant and early childhood mental health (IECMH) efforts to include more promotion and prevention efforts linked to primary care, in addition to treatment and consultation for those with identified conditions. Such changes will require action by state agencies, health plans, providers, and programs to support families. All should be undertaken with intentional efforts to advance equity, reduce provider bias, and eliminate the disparities driven by racism.

Last, but not least, through the PSP Initiative, CSSP has partnered with Family Voices—a national family-led organization that advocates for children's health care—to ensure that the experiences and perspective of families inform this guide and ongoing work. Listening to, supporting, and engaging families is at the heart of the work to be done. Families must be meaningfully engaged as partners in the care process, as well as in decisionmaking about health care systems.

Using Pediatrics to Support Parents and Improve Social-Emotional Development, Early Relational Health, and Future Well-Being: A Continuum of Support

Medical Home Structure	• Advance the medical home to align with guidelines • Develop and finance high performing medical homes for young children in Medicaid • Deliver well-child visits based on Bright Futures Guidelines & EPSDT prevention purposes
Promotion	• Use relational, family-centered, strengths-based, and culturally and linguistically competent approaches • Provide anticipatory guidance and parent education on health, developmental, and relational guidance • Use tools and approaches for family engagement, partnering with parents • Maximize opportunities for families to connect with peer support
Screening	• Screen for general development, social-emotional, maternal depression, and social determinents of health (SDOH), according to Bright Futures guidelines, identifying child medical risks, family social and economic risks, parental well-being concerns, and parent-child relational strengths and risks, ACES/PCES, and family well-being • Use 6R response to concerns identified in screening = Respect, Reinforce, Resource, Return, Refer, Resolve
Prevention & Support	• Use case management and relational care coordination, with tiered levels of intensity • Integrate family specialists (e.g., family development specialists, community health workers, family navigators) • Integrate strategies to support parents' well-being and mental health • Co-locate or link to prevention and an array of early intervention services related to social-emotional health • Link to family support services, including community-based parenting programs and home visiting
Early Intervention & Treatment	• Co-locate intervention services and models related to social-emotional-mental health in pediatric practice • Provide infant and early childhood mental health consultation to primary care providers • Connect families to Part C Early Intervention for infants and toddlers in need of developmental services, including social-emotional and mental health risks and conditions • Use the DC:0-5 assessment and diagnostic system • Make effective and efficient referrals to parent-child relational interventions • Link to parent-child dyadic mental health therapy • Implement integrated behavioral health, including for young children

Introduction

An array of scientific research tells us that young children's social-emotional development is a key component of school readiness and is a key building block for cognitive development, learning, and future mental health. Social-emotional development also has long-term effects on success in school, work, and relationships.[1] It is one of the four traditional key domains of young child development (i.e., physical, social-emotional, cognitive, and language development), and it is the outcome of positive, stimulating, and nurturing parent-child relationships in the context of safe and well-resourced families and communities. Children on track in terms of social-emotional development have greater capacity to form healthy relationships with peers and adults; to experience, regulate, and express emotions in socially and culturally appropriate ways; and to explore their environment and learn from their experiences. We also know from research that more could be done to promote social-emotional development, beginning in the earliest days of life and using strategies grounded in children's primary health care.

The National Academies of Medicine, Engineering, and Science report on *Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda* describes the importance of strategies designed to support a continuum of services and supports using a life-course, community, and population perspective.[2] In other words, we need more than individual or one-shot interventions. Numerous examples of evidence-based approaches are documented in research and described in this guide that stretch across the continuum from promotion and prevention to early intervention and treatment. For young children and their families, key strategies include: use of primary health care settings to promote social-emotional health, universal screening for risk and protective factors, services that support the mental health and well-being of parents, and use of two-generation, dyadic services for parents and children together. A separate National Academy of Medicine, Engineering, and Science report on *Vibrant and Healthy Kids* emphasizes:

> "*Scientific evidence shows that prevention and early intervention are effective for children on at-risk developmental trajectories. Recent advances in science, technology, data sharing, and cross-disciplinary collaboration present opportunities to apply this emerging knowledge systematically to practice, policy, and systems changes.*"[3]

Building on decades of research and recommendations, in 2017 several leading national foundations joined together to fund the Pediatrics Supporting Parents[4] (PSP) initiative with the goal of supporting partnerships between pediatric primary care providers* and parents to promote social-emotional development for young children and greater family well-being. The PSP initiative focuses on how pediatric primary care providers can foster nurturing parent-child relationships and help to build strong foundational relationships.[5]

* Throughout this report, we refer to pediatric primary care providers primarily as "providers," which includes anyone who provides primary medical care for children, such as pediatricians, family physicians, physician assistants, and nurse practitioners.

FIGURE 1

Common Practices

Nurture parents' competence and confidence

- Use strengths-based observations and positive, affirming feedback
- Model activities and use strengths-based observations
- Provide enhanced and tailored anticipatory guidance materials
- Partner with parents to co-create goals
- Create opportunities for families to connect with other families
- Integrate strategies to support the parents' well-being and mental health

Connect families to supports to promote SED and address stressors

- Standardize workflow to provide developmental, behavioral, and SDOH screenings, health promotion, support, and resources
- Cultivate community partnerships through clear processes and protocols
- Outreach to parents during pregnancy

Develop the care team and clinic infrastructure and culture

- Integrate new roles into the care team
- Foster care team communication and collaboration
- Provide ongoing learning and development opportunities
- Support care team well-being to prevent burnout/stress/fatigue and retention issues
- Create environments and structures that promote respectful relationships and positive patient experiences

Strong, strengths-based, trusting, and humble relationships among and between parents, the care team, and the community are essential

Working under the PSP initiative, the Center for the Study of Social Policy report on *Fostering Social and Emotional Health through Pediatric Primary Care: Common Threads to Transform Practice and Systems* provides detailed descriptions of 14 common practices used by innovative pediatric primary care settings that are implementing evidence-based or informed programs to promote the social-emotional development of young children (See Figure 1). The *Common Threads* report describes specific examples of these practices that are being implemented by exemplary programs and pediatric settings across the country. The *Common Threads* report also identifies the systemic barriers that prevent their widespread implementation and points to additional opportunities for the role of Title V and Medicaid in pediatric primary care transformation.

The principles for a medical home[6] and the Bright Futures Guidelines[7] for preventive pediatric health care developed and endorsed by the American Academy of Pediatrics (AAP)[8] and the federal Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS)[9] emphasize the need for child health to respond holistically and relationally in the context of the child's family and community. Beginning in 2010 and updated in 2018, federal law has used the Bright Futures schedule and recommendations as the standard for preventive, well-child visits to be provided without cost-sharing.[10] Yet too many children, especially poor children and children of color, do not have a medical home. Additionally, too few providers have the resources to fully implement the Bright Futures Guidelines.

Primary care for young children is undergoing a transformation, broadening from a focus on treating disease and managing health conditions toward more holistic care that promotes optimal health and development for each child while supporting the resources and well-being of their families. Pediatric primary care providers are expanding their role in identifying and responding to social determinants of health (SDOH) in addition to bio-medical factors. In *A Sourcebook on Medicaid's Role in Early Childhood: Advancing high performing medical homes and improving lifelong health*,[11] Johnson and Bruner proposed a the state-of-the-art design for a "high performing medical home" for young children in Medicaid, which would include: team-based care, more support for and engagement of parents, emphasis on identifying and addressing social risk factors, better integration of evidence-based tools and models, and effective linkages and coordination with other services (e.g., early childhood mental health, home visiting, developmental interventions). The 14 common practices identified by CSSP fit into the design for and are at the heart of a high performing medical home.

In 2020, the Center for the Study of Social Policy (CSSP) and Johnson Group Consulting, Inc. were asked by the PSP initiative to develop this *Guide to Leveraging Opportunities Between Title V and Medicaid for Promoting Social-Emotional Development*. The guide is designed to support state-level planning, action, and innovation aligned with the goals of the PSP initiative. As the largest federal-state programs serving young children, the Title V Maternal and Child Health (MCH) Services Block Grant and Medicaid offer opportunities to catalyze transformation in pediatric primary care.

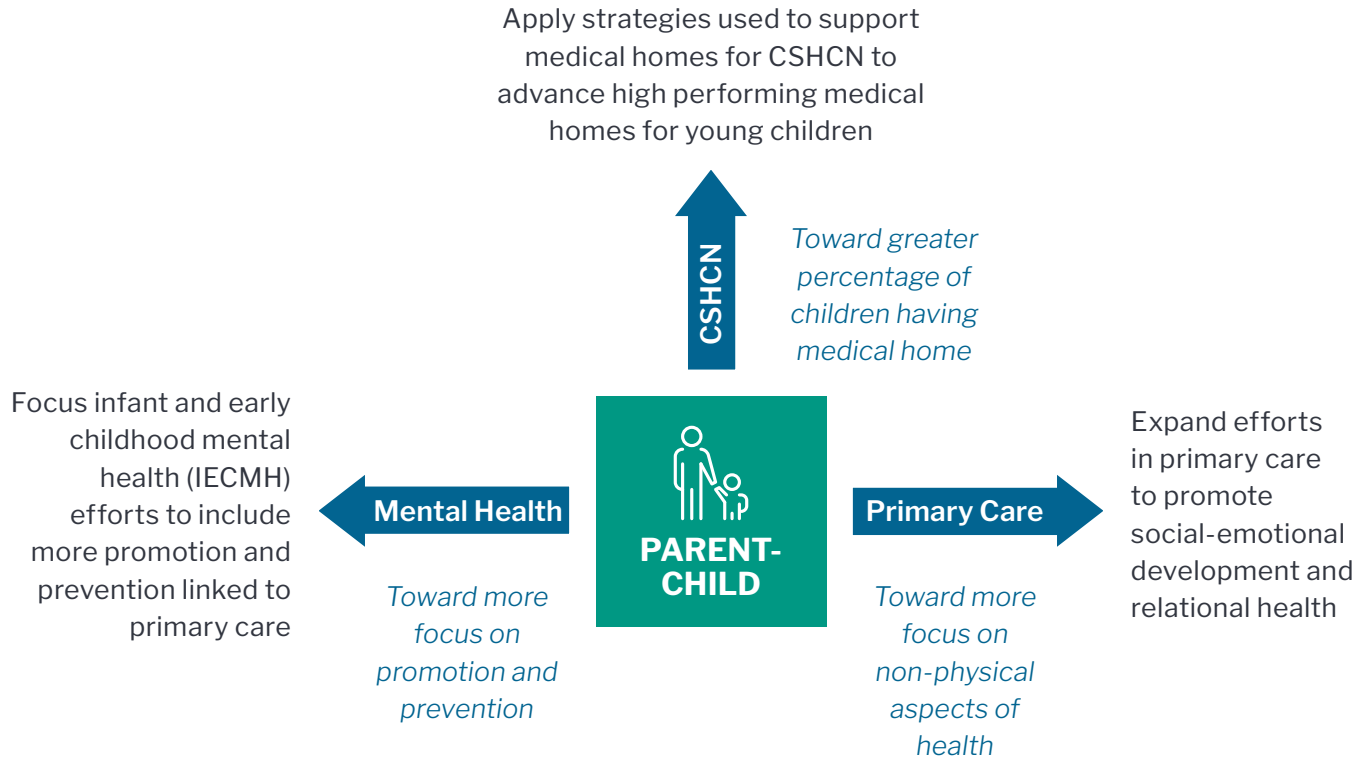
In sum, this guide builds upon the:

- 14 common practices identified by Doyle and others in CSSP's *Common Threads* report;[12]
- Medicaid strategies identified by Cohen Ross, Guyer, and others in the PSP *Blueprint* report;[13]
- elements of the high performing medical home for young children in Medicaid as advanced in the *Sourcebook*[14] by Johnson and Bruner;
- report on *Promoting Young Children's (ages 0-3) Socioemotional Development in Primary Care*[15] by the National Institute for Children's Health Quality (NICHQ), Ariadne Labs, and the Einhorn Family Charitable Trust; and
- Bright Futures Guidelines, as supported by the American Academy of Pediatrics and Maternal and Child Health Bureau.

With state Title V MCH programs submitting new five-year plans in 2020, now is the time to leverage the opportunities of the Title V and Medicaid partnership in alignment with the goals of the PSP initiative. This guide brings detailed attention to the elements of the high performing medical home embedded in an early childhood system that supports social and emotional development of young children and their families. The specific policy, program, and practice opportunities described below for action by state Title V MCH programs, by state Medicaid agencies, and by the two in partnership are based on existing state innovations, research on how to promote social-emotional development, and on what is called for in federal law.

FIGURE 2

Three Directions for Change



As shown in Figure 2, major opportunities for change and improvement exist in three directions: (1) expanding efforts in pediatric primary care to promote social-emotional development and relational health; (2) applying strategies used to support medical homes for children with special health care needs (CHSCN) to advance high performing medical homes for young children; and (3) focusing infant and early childhood mental health (IECMH) efforts to include more promotion and prevention efforts linked to primary care, in addition to treatment and consultation for those with identified conditions. Such changes will require action by state agencies, health plans, providers, and programs to support families. All should be undertaken with intentional efforts to advance equity, reduce provider bias, and eliminate the disparities driven by racism.

Every state has the potential to improve the finance and delivery of pediatric primary care to better support parents and improve social-emotional development in ways that have lifelong impact. This guide uses a framework for action across a continuum that stretches from the basic structure of the medical home to promotion to screening to prevention to early intervention and treatment.

The Essential Power of Title V & Medicaid Partnership

Title V and Medicaid are the largest federal-state health programs serving young children and, under existing federal law, these programs have important opportunities to catalyze transformation in pediatric primary care and dramatically improve child and family health outcomes. With state Title V MCH programs submitting new five-year plans, the timing is right to leverage the Title V and Medicaid partnership to advance the elements of the high performing medical home embedded in an early childhood system that will improve social-emotional development among young children.

Overview of the Title V Maternal and Child Health Services Block Grant

The Title V Maternal and Child Health Services (MCH) Block Grant program is the oldest federal-state grant program focused on health. The Title V MCH Block Grant program is a federal-state partnership that aims to improve the health of pregnant women, mothers, and children.[16] The program is authorized under Title V of the Social Security Act and administered by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services (HHS). The statutory purpose of Title V is to improve the health of all mothers and children consistent with national health objectives and goals. The Title V program structure includes State Formula Block Grants (to 59 States, territories, and other jurisdictions collectively referred to here as states), Special Projects of Regional and National Significance (SPRANS) grants, and Community Integrated Service Systems (CISS) grants. **States are required to use at least 30% of their Title V MCH Block Grant funds for preventive and primary care services for children, and at least 30% for services to children with special health care needs (CSHCN)**. Generally, a portion of the remaining block grant funds awarded to states are used to improve the health and outcomes of pregnant women and infants. Title V MCH Block Grant funds are distributed for the purpose of supporting four categories of activities in states, including: 1) direct health care; 2) enabling services (e.g., case management, outreach); 3) population-based services; and 4) infrastructure building.

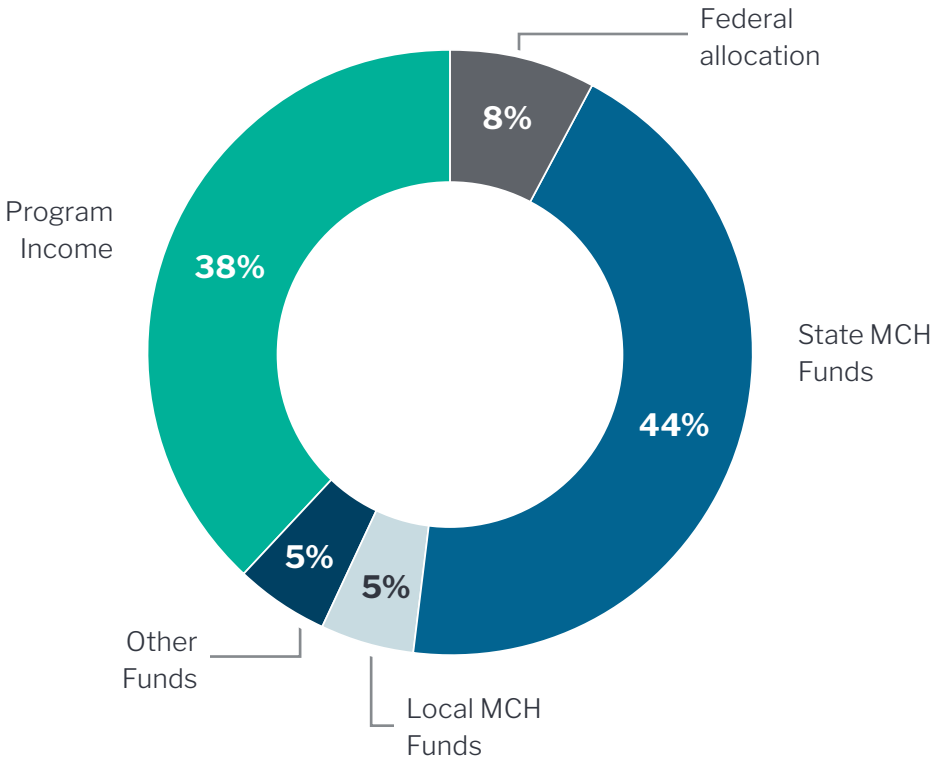
In line with the focus of this guide, one of the prime statutory purposes of Title V funding is to support access to children's preventive and primary health care services (Section 501 [42 U.S.C. 701] (b)). Federal law requires that at least 30% of Title V Block Grant dollars allocated to states are to be used for preventive and primary care services for children (Section 505 [42 USC 705] (3)(A)). The statute also calls for state Title V MCH programs to increase health assessment and follow-up diagnostic and treatment services, especially for children with low income. And Title V-supported efforts related to children's preventive and primary health care services are to be done in collaboration with Medicaid and without duplication of effort in terms Medicaid financed services (e.g., no duplicate payments).

States have broad flexibility in how Title V MCH Block Grant funds are used to support a wide range of activities that address needs. States determine the actual services provided under this block grant. At the same time, planning and reporting on activities and priorities is required. The Title V legislation requires states to submit an annual report and to complete a statewide, comprehensive needs assessment every five years. States are required to include an assessment of the need for preventive and primary care services for children (Section 505 [42 U.S.C. 705] (a)(1)(B)).

States must match every $4 of federal Title V MCH Block Grant funds they receive by at least $3 of state and/or local money (i.e., non-federal dollars). Many states provide funding beyond the required match, which results in more than $6 billion being available for maternal and child health programs at the state and local levels. As shown in Figure 3, for Federal Fiscal Year (FFY) 2018, the total federal-state partnership supported $6.5 billion in expenditures, with 8% being federal Title V MCH Block Grant dollars, 44% being state MCH funds, 38% program income (e.g., Medicaid reimbursements, other insurance payments), and about 10% being local or other funds.

FIGURE 3

Title V MCH Federal-State Partnership Expenditures, by Funding Source, FFY 2018



In short, state MCH programs have broad authority to use their federal and state MCH funding to improve child health, have an obligation to use 30% of their Title V MCH Block Grant funds to promote primary and preventive care services for children, and can set priority on improving access to the medical home and promoting the social-emotional development of young children.

Overview of the Role of Medicaid and EPSDT in Child Health

Medicaid, together with the Children's Health Insurance Program (CHIP), provides health coverage to more than one-quarter of U.S. children. (A large majority of those in CHIP are covered through Medicaid.) In April 2020, Medicaid and CHIP together covered 35 million children, and children represented half (50.5%) of total Medicaid and CHIP program enrollees.[17] More than half of the nation's children of color, particularly Black and Hispanic/Latinx children, are covered by Medicaid and CHIP.[18]

Medicaid is an even more important source of financing of child health services for young children. In 2018, more than one in four (43.6%) infants and toddlers under age 3 were enrolled in Medicaid and CHIP.[19] While Medicaid and CHIP coverage rates for children—particularly for the youngest children—declined in recent years, these programs remain central and essential sources of children's health coverage.[21] Notably, Medicaid also covers a growing percentage of the parents of young children (approximately one in five).[21]

EPSDT

For more than 50 years, Medicaid's Early Periodic Screening, Diagnostic, and Treatment (EPSDT) child health benefit has been evolving to fit the standards of pediatric care and to meet the unique physical, mental, dental, and developmental needs of children. Since 1967, the purpose of the EPSDT benefit has been "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."[22]

> "Medicaid can have major impact on addressing equity. We need payment for the things pediatricians want and need to do such as screening for social determinants of health. And we need Title V to help set the agenda, create ways to advance the patient-centered medical home."
>
> **— Dennis Kuo, MD, FAAP (interview)**

Medicaid's EPSDT benefit design provides comprehensive health coverage for all children under age 21 who are enrolled (See Figure 4). Required in every state using Medicaid, EPSDT finances a wide array of appropriate and necessary pediatric services.[24] While children enrolled in a state's CHIP program through Medicaid are entitled to the EPSDT benefit, those in separate, private CHIP plans are not.*

* States have the option to operate a separate CHIP, a Medicaid-CHIP, or a combination CHIP. Only 13 states operate separate CHIP, and a majority operate combination programs.

Since approximately half of infants and high proportions of children ages 1 to 6 are covered by Medicaid and CHIP, the EPSDT benefit structure offers a way to ensure that young children receive appropriate physical, developmental, mental health, and dental services—from prevention to treatment. Any effort to improve the health and development of young children should intentionally involve Medicaid. Moreover, Medicaid and its EPSDT benefit provide states with the opportunity (and in some instances obligation) to provide coverage and financing for services within the context of well-child visits that promote social-emotional development. In addition, EPSDT covers further assessment, diagnosis, early intervention, and treatment services needed by families with young children who have risks, delays, and diagnosed conditions.

Prevention and Well-Child Visits

At the core of the EPSDT benefit are comprehensive well-child visits to detect physical, mental, and developmental conditions. These well-child visits are covered at established intervals (based on "periodicity schedules") and whenever a problem is suspected (generally known as "interperiodic" screens). The so called "screening" visits in EPSDT are, in effect, comprehensive well-child visits that must include: 1) a comprehensive health and developmental history that assesses physical and mental health; 2) developmental screening; 2) an unclothed physical exam; 3) appropriate immunizations; 4) appropriate laboratory tests; and 5) education including anticipatory guidance to parents. In addition, dental, vision, and hearing services are required, including appropriate screening, diagnostic, and treatment.[25] Referrals for diagnostic and treatment services are required when a problem is identified during the well-child check-up screening visit.

FIGURE 4

EPSDT Benefit

Early	Assess and identify problems early, starting at birth
Periodic	Check children's health at periodic, age-appropriate intervals in comprehensive well-child visits, including health education
Screening	Provide physical, dental, mental, developmental, hearing, vision, and other screening or laboratory tests to detect potential problems
Diagnosis	Perform diagnostic tests and assessments to follow up when a risk is identified during screening and examinations
Treatment	Control, correct, or ameliorate any problems that are found

Beyond well-child visits, many states use Medicaid to finance other prevention and early intervention services for families with young children. This may include, but is not limited to home visiting services, parenting education, and community health worker preventive services and supports. These services may be delivered in health care practices, in homes, or in other community settings. Nothing in Medicaid law prohibits the delivery of services in an array of settings if the child is enrolled, the provider is enrolled, and the service is covered in their Medicaid state plan.

Services that support family participation in preventive services and well-child visits are also an important element of the EPSDT benefit. All children in enrolled in Medicaid are entitled to EPSDT and states have an obligation to inform families, "*effectively describing what services are available under the EPSDT program; the benefits of preventive health care, where services are available, how to obtain them; and that necessary transportation and scheduling assistance is available*" (CMS, State Medicaid Manual Section 5121). Children also have coverage for general case management services, typically referred to as care coordination.

Medically Necessary Treatment in EPSDT

Under EPSDT, Medicaid not only covers preventive, comprehensive well-child visits, it also covers medically necessary services to intervene for or treat identified physical, dental, developmental, and mental health conditions. The term "medical necessity" can be confusing. In conventional, private health insurance, medical necessity is usually defined by the provider (physician), the managed care organization, and/or the insurance company. When used to discuss Medicaid/EPSDT, medical necessity is defined by federal law (Social Security Act § 1905(r)(5); 42 U.S.C. § 1396d) and implemented by states.[26,27] Since 1989, federal law has required that, for children, state Medicaid programs cover all "medically necessary" services within the categories of mandatory and optional services, regardless of whether such services are covered for adult beneficiaries. Examples of services that are typically optional for adults but are mandatory when medically necessary under EPSDT for a child include: developmental screening and services, parent education/anticipatory guidance, mental health treatment, and case management/care coordination.

EPSDT determinations of medical necessity are made by the state within the parameters of federal law, but these must be made on a case-by-case basis, taking into account the needs of the individual child and guided by information from the child's health providers. While states can set limits based on medical necessity determinations for an individual child (i.e., amount, scope, and duration), states and managed care organizations may not impose fixed limits across the board on specific services, and coverage cannot be arbitrarily limited for all children (e.g., only six physical therapy visits, one pair of eyeglasses per year). States and Medicaid managed care organizations can require prior authorization for particular services to safeguard against unnecessary use of services, but prior authorization is specific to a child's needs and cannot result in a delay or denial of medically necessary services. Moreover, when a problem is identified through screening and diagnostic services, "EPSDT requires states to '*arrang[e] for… corrective treatment*,' either directly or through referral to appropriate providers or licensed practitioners, for any illness or condition detected…" (CMS, State Medicaid

Manual Section 5124). Effective implementation of the medical necessity provision requires a state definition that reflects the purposes of EPSDT to prevent, correct, or ameliorate physical, developmental, or mental conditions (CMS, State Medicaid Manual Section 5122 E-F). A recent review of each state's medical necessity definition used for coverage under EPSDT found that 41 states specifically included language about preventive services and interventions.[29]

> "[T]he 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…"
>
> **— Centers for Medicare and Medicaid Services**

In sum, under the EPSDT benefit, Medicaid pays for a wide range of preventive services, comprehensive well-child visits, and needed diagnostic and treatment services. In addition to these clinical services, EPSDT must provide funding for required assistance in scheduling appointments, arranging for treatment, and financing for transportation to keep appointments (42 U.S.C. Sections 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r)). As described in federal rules, states are required to: "*[a]ssure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly,… that informing methods are effective,… [and] that services covered under Medicaid are available*" (CMS, State Medicaid Manual Sections 5010, 5121, 5310).

State Interagency Collaboration Between Medicaid/EPSDT and Title V MCH Programs

From the beginning, Medicaid's EPSDT benefit was linked to the Title V Maternal and Child Health Program. Title V of the Social Security Act was enacted in 1935 as the first program to provide grants to states to improve health. Medicaid was enacted in 1965. When EPSDT was adopted in 1967, simultaneous amendments to Medicaid and Title V law were added to create a partnership with shared responsibilities.[30] In addition, between 1967 and 1989, Congress enacted a number of amendments to Title V with requirements for state Title V MCH programs to work closely with and assist Medicaid in a number of activities.

Thus, Title V and Medicaid are required under federal law to engage in coordination and partnerships in order to improve access to health services for children. In particular, coordination between Title V and EPSDT is required to ensure better access to screening, diagnosis, and treatment services.[31] These relationships are so central that one core statutory responsibility of a state Title V MCH program is to participate in coordination of activities between Title V and EPSDT to ensure that the programs are carried out without duplication of effort (Section 505 [42 U.S.C. 705] (a)(5)(F)(i)). While both the federal Medicaid/EPSDT and Title V laws call for coordination between the programs, the language governing each program is somewhat different as shown below. Table 1 summarizes these requirements.

Interagency agreements, a requirement in both the Medicaid and Title V statute and regulations, are the primary mechanism for structuring coordination and partnerships. (To download state Medicaid-Title V interagency agreements, visit https://mchb.tvisdata.hrsa.gov/Home/IAAMOU). The purpose of these interagency agreements—sometimes referred to as Memoranda of Understanding (MOUs)—is to describe the cooperative arrangements, mutual objectives, and responsibilities between Medicaid and Title V (42 CFR §431.615(d)). While payment by Medicaid for services delivered by public health clinics and other Title V-supported providers are typically a major element of these agreements, other elements such as data sharing, outreach, and coordination of services are also frequently included.[32,33]

> "Let's revisit the intent of interagency agreements. The time is right to think about how Title V agencies can work better with Medicaid or how they cultivate readiness to do that. Some current interagency agreements are more like a contract for a specific service."
>
> **— Amy Zapata, Louisiana Title V Director (interview)**

Title V Requirements for Interagency Collaboration

Current Title V federal law (statute, regulations, and guidance) requires that state MCH programs do the following:

- As part of Title V plans submitted to the federal government, include the latest version of the Title V-Medicaid interagency agreement. Also, five-year needs assessments must assess how service delivery systems meet the population's health needs by examining existing systems and collaborative mechanisms with Medicaid and other programs (Title V guidance).
- Assist with coordination of EPSDT to ensure programs are carried out without duplication of effort (Section 505 [42 U.S.C. 705] (a)(5)(F)(i) and Section 509 [42 U.S.C. 709] (a)(2)).
- Establish coordination agreements with their state Medicaid programs (Section 505 [42 U.S.C. 705] (a)(5)(F)(ii).
- Assist in coordination with other federal programs including supplement food programs, related education programs, and other health and developmental disability programs (Section 505 [42 U.S.C. 705] (a)(5)(F)(iii).
- Provide, directly or through contracts, outreach and assistance with applications and enrollment of Medicaid-eligible children and pregnant women (Section 505 [42 U.S.C. 705] (a)(5)(F)(iv).
- Provide a toll-free number for families seeking information about Title V or Medicaid providers or other health and related services (Section 505 [42 U.S.C. 705] (a)(5)(E).
- Projects designed to increase the participation of obstetricians and pediatricians under Title V or Medicaid (Section 501 [42 U.S.C. 705] (a)(3)(B)).

- Share data collection responsibilities, particularly related to services provided for pregnant women and infants eligible for Medicaid or CHIP (Section 565 [42 U.S.C. 705] (a)(3)(D)).
- Not use Title V MCH Block Grant dollars for services to individuals or entities excluded from Medicaid (Title XIX), Social Services Block Grant (Title XX), or Medicare (Title XVIII) (Section 504 [42 U.S.C. 705] (b)(6)).

Medicaid/EPSDT Requirements for Interagency Collaboration

Federal Medicaid/EPSDT law (statute, regulations, and guidance) requires the following:[34]

- Establishment of written state MCH-Medicaid interagency agreements which provide for maximum use of Title V-supported services, effective use of Medicaid resources, and aim to improve child health status (42 CFR 431.615 and Social Security Act §1902(a)(11)).
- Medicaid state plans that provide for arrangements with Title V grantees under which the Medicaid agency will use Title V to furnish covered services (42 CFR 431.615(c)(2)).
- Reimbursement of Title V providers for services rendered, even if such services are provided free of charge to uninsured families with low income. Medicaid is the payer of first resort for services provided to Medicaid-enrolled individuals if such services are included in the Medicaid state plan. [§1902(a)(11)(B)(i) and (ii)] Payment mechanisms include reimbursement for costs, capitation payments, or prospective interagency transfers with retrospective adjustments (42 CFR 431.615(c)(3) and (4) and (42 CFR 431.615(e)).
- Cooperative and collaborative relationships at the state level that might include methods for: early identification of children under 21 in need of medical or remedial services, reciprocal referrals, coordinating plans for services provided or arranged for Medicaid beneficiaries, exchange of reports and data, periodic review and joint planning, continuous liaison between the agencies, and joint evaluation of policies (42 CFR 431.615(d)).

TABLE 1

Summary of Requirements for Title V and Medicaid Partnerships

Federal Medicaid Law	**Requires Medicaid agencies to:** • Develop and enter into interagency agreements • Use Title V programs to provide services • Reimburse Title V providers for services to Medicaid beneficiaries • Coordinate and share information and data
Federal Title V Law	**Requires Title V agencies to:** • Develop and enter into interagency agreements • Coordinate EPSDT services • Assist in outreach to and enrollment of beneficiaries • Coordinate and share information and data • Report on coordination and numbers of Medicaid-eligible people served by Title V • Ensure no duplication of effort

Promoting Social-Emotional Development in Pediatric Primary Care: A Continuum of Action

The pediatric medical home and well-child visits offer unique opportunities to promote children's social-emotional development and early relational health. Pediatric primary care providers are the professionals and the service entities most likely to see and serve the overwhelming majority of young children, particularly those under the age of 3. National data show that nine out of 10 young children see a health provider for a well-child, preventive visit at least annually, and for the 10 well-child visits recommended by Bright Futures within the first two years of life for infants and toddlers. Each well-child visit offers opportunities for improving health and developmental outcomes during childhood that can have impact for a lifetime. In addition, the delivery of recommended well-child visits across a community brings important opportunities to improve community and population health.

> "If everyone goes to pediatric primary care, that is where we have to begin to promote social-emotional development."
>
> **— Neal Horen, PhD, Georgetown University (interview)**

The promotion and prevention efforts for social-emotional development in pediatric primary care builds beyond the field of infant and early childhood mental health (IECMH). Often, IECMH refers to more specific efforts to provide early childhood mental health consultation, diagnostic assessment, intervention, or treatment services—in other words, the components of mental health services.[35] This guide and the continuum it suggests includes such efforts, and we recognize the importance of state efforts to expand and strengthen IECMH services and professional capacity, which often involve state Title V MCH programs. At the same time, the PSP initiative and this guide focus on a much broader continuum of services and supports, beginning with promotion and prevention, particularly those that can be based in, co-located with, or explicitly linked to pediatric primary care and the child's medical home. In this way, the guide focuses on upstream, two-generation promotion and prevention efforts of early relational health in order to build individual healthy social-emotional health—encompassing a broad preventive mental health strategy.

FIGURE 5

Using Pediatrics to Support Parents and Improve Social-Emotional Development, Early Relational Health and Future Well-Being: A Continuum of Support

Medical Home Structure

- Advance the medical home to align with guidelines
- Develop and finance high performing medical homes for young children in Medicaid
- Deliver well-child visits based on Bright Futures Guidelines & EPSDT prevention purposes

Promotion

- Use relational, family-centered, strengths-based, and culturally and linguistically competent approaches
- Provide anticipatory guidance and parent education on health, developmental, and relational guidance
- Use tools and approaches for family engagement, partnering with parents
- Maximize opportunities for families to connect with peer support

Screening

- Screen for general development, social-emotional, maternal depression, and social determinents of health (SDOH), according to Bright Futures guidelines, identifying child medical risks, family social and economic risks, parental well-being concerns, and parent-child relational strengths and risks, ACES/PCES, and family well-being
- Use 6R response to concerns identified in screening = Respect, Reinforce, Resource, Return, Refer, Resolve

Prevention & Support

- Use case management and relational care coordination, with tiered levels of intensity
- Integrate family specialists (e.g., family development specialists, community health workers, family navigators)
- Integrate strategies to support parents' well-being and mental health
- Co-locate or link to prevention and an array of early intervention services related to social-emotional health
- Link to family support services, including community-based parenting programs and home visiting

Early Intervention & Treatment

- Co-locate intervention services and models related to social-emotional-mental health in pediatric practice
- Provide infant and early childhood mental health consultation to primary care providers
- Connect families to Part C Early Intervention for infants and toddlers in need of developmental services, including social-emotional and mental health risks and conditions
- Use the DC:0-5 assessment and diagnostic system
- Make effective and efficient referrals to parent-child relational interventions
- Link to parent-child dyadic mental health therapy
- Implement integrated behavioral health, including for young children

Figure 5 and Table 2 show opportunities for action in pediatric primary care to improve social-emotional development. These actions all assume the context of a family-centered, community-based medical home,[36] with team-based care, a focus on relational health, and approaches that are strengths-based. As discussed below, a pediatric primary care setting able to deliver the elements described in this framework would be a high performing medical home[37] and should be financed at a level above standard care.

The strategies, tools, and models identified in Table 2 are based on an extensive review of the literature regarding promotion of social-emotional well-being, as well as prevention, early intervention and treatment for social-emotional-behavioral-mental health conditions.[38,39,40,41] An effort was made to include only those that met the criteria for evidence-based or evidence-informed best practices by an authoritative body such as a federal agency, a contractor of a federal agency, or a report by the National Academies of Medicine, Engineering, and Science. The strategies, tools, models, and programs listed in this table are shown as only examples and are not intended as endorsements or recommendations. We are aware that some communities innovate and adapt from these models based upon their local community context. Without question, a medical home might have to use various tools, or even adopt multiple tools within the same practice to address the unique needs of their community. Thus, providers, communities, and states have made investments in different strategies depending upon the match of models and programs to the community, level of resources available, needs assessments, and other factors. No endorsements are intended by including a tool, model, or program in this table.

TABLE 3

Using Pediatrics to Support Parents and Improve Social-Emotional Development, Early Relational Health, and Future Well-Being: A Continuum of Support

Continuum	Examples of Primary Care / Medical Home Action	Examples of Tools, Models, and Programs
Align with and Advance Use of Guidelines	• Deliver well-child visits based on Bright Futures Guidelines and EPSDT.[43,44,45]	• American Academy of Pediatrics Bright Futures Periodicity Schedule.[46]

Advance Use of High Performing Medical Homes	• Develop advanced, high performing medical homes for young children in Medicaid.[47]	• Apply the design for a high performing medical home to augment primary care, with improvements in well-child visits, care coordination, and other services, in a medical home that is team-based and family-centered, as well as more holistic, strengths-based, relational, and culturally and linguistically competent.
		  ◦ Provide comprehensive well-child visits, including recommended screening, exams, and family engagement.
		  ◦ Use tiered care coordination, including more intensive, relational care coordination to serve families with identified risks and need for additional support.
		  ◦ Improve integration into primary care and linkages in community to evidence-based models, other programs, and a range of services.

Continuum	Examples of Primary Care / Medical Home Action	Examples of Tools, Models, and Programs
Promotion *Universal promotion*[48]	• Use relational, strengths-based, culturally appropriate approaches.[49] • Provide anticipatory guidance and education for parents on general health, developmental, relational, and mental health.[50] • Use tools and approaches for partnering with and coaching parents, encouraging early relational health.[51,52,53] • Use tools and models for family engagement.[54,55] • Maximize opportunities for families to connect with other families for peer-to-peer support.[56]	• Well-Visit Planner™ and Cycle of Engagement[57,58,59] • Pre-visit tools in Bright Futures[60] • Family Engagement in Systems Toolkit and Assessment Tool (FESAT)[61] • Parent-focused Redesign for Encounters, Newborns to Toddlers (PARENT)[62,63] • Strengthening Families framework • Reach Out and Read (ROR)[64] • Play and Learning Strategies (PALS) Infant, Toddler[65,66,67,68] • Promoting First Relationships in Primary Care • The BASICS[69] • Mind in the Making[70]
Screening for strengths and risks	• Screen for general development. (Bright Futures schedule calls for screens at 9, 18, 24, and 30-month well-child visits).[71,72,73,74] • Screen for social-emotional (SE) development with objective and validated tools (recommended in all 15 visits birth to 5th birthday).[75,76,77,78,79,80,81,82,] • Screen for maternal depression in pediatric visits (Bright Futures schedule calls for four screens in the first year of infant life).[83,84,85] • Screening for Autism Spectrum Disorder (ASD) with objective and validated tools (recommended in visits 18 months and 24 months). • Screen for social determinants of health (SDOH) (Bright Futures schedule calls for screens at all 15 visits birth to 5th birthday).[86,87,88,89,90,91,92]	• Ages & Stages Questionnaire (ASQ)[96,97] • Ages & Stages Questionnaire: Social Emotional (ASQ:SE) • Pediatric Symptom Checklist (PSC)[98,99] • Maternal depression screening tools (e.g., Edinburgh,[100] PHQ[101]) • SDOH tools (e.g., CAHMI,[102] PRAPARE,[103] AHC[104,105]) • Promoting Healthy Child Development Survey (PHDS)[106,107,108] • ACE/PCE screening[109,110] (e.g., PEARLS[111]) • Survey of Well-being of Young Children (SWYC)[112,113] • Safe Environment for Every Kid Parent Questionnaire (SEEK-PQ)[114,115,116]

Continuum	Examples of Primary Care / Medical Home Action	Examples of Tools, Models, and Programs
Screening for strengths and risks	• Standardize workflow to provide developmental, behavioral, and SDOH screenings, health promotion, support, and resources.[93,94] • Use 6R response to concerns identified through screening = Respect, Reinforce, Resource, Return, Refer, and Resolve.[95]	• Help Me Grow[117] system for responding to parental needs, positive developmental screening results, and provider concerns related to early childhood development.
Prevention and Support *Universal preventive interventions*[118,119]	• Basic level care coordination/ case management for all served in medical home. • Integrate family specialists trained in child-family development and relational care coordination as part of the medical home team. • Integrate strategies to support parents' well-being and mental health.	• DULCE[120] • WE CARE (Well Child Care, Evaluation, Community resources, Advocacy, Referral, Education)[121] • CenteringParenting[122,123]
Prevention and Support *Selective preventive interventions*[124,125]	• Provide case management/ relational care coordination, with tiered levels of intensity.[126,127,128,129] • Co-locate prevention and early intervention services and models related to social-emotional-mental health in pediatric practice. • Link to prevention and early intervention services and models related to social-emotional-mental health. • Link to family supports and services for intervening early (including community-based parenting education programs and play groups, parent support groups).	• Healthy Steps[130,131,132,133] • Help Me Grow[134] • Peer support, including parents, community health workers, promatoras, and others[135,136] • Family developmental specialists/family service workers as part of models or otherwise[137,138] • Medical-Legal Partnerships[139,140] • Family Check-Up • Home visiting programs providing general prevention and support (e.g., NFP, HFA, PAT, Family Connects)[141]

Continuum	Examples of Primary Care / Medical Home Action	Examples of Tools, Models, and Programs
Early Interventions and Mental Health Treatment	• Co-locate intervention services and models related to social-emotional-mental health in pediatric practice.[142] • Provide infant and early childhood mental health (IECMH) consultation to primary care providers.[143] • Use virtual mental health interventions. • Use DC:0-5 assessment and diagnostic system. • Make effective and efficient referrals to link families to parent-child relational interventions. • Link to parent-child dyadic mental health therapy. • Implement integrated behavioral health, including appropriate services for young children. [144]	• Part C Early Intervention[145,146] • Incredible Years (infant and toddler)[147,148] • Video Interaction Project (VIP)[149] • Positive Parenting Program (Triple P)[150] • Child First[151,152] • Circle of Security-Parenting (COS-P)[153] • My Baby and Me[154] • Parent-Child Interaction Therapy (PCIT)[155,156,157] • Child-Parent Psychotherapy (CPP for infants and toddlers)[158] • Attachment and Biobehavioral Catch-up (ABC)[159,160,161] • Project LAUNCH (various local designs)[162,163,164,165,166,167,168]

Understanding the Framework and Continuum

This framework and continuum fits with the overall purposes and design of Medicaid's EPSDT benefit. It describes the potential to promote social-emotional development by using advanced, high performing medical homes that offer: family engagement, recommended visits, promotion and prevention activities, recommended screening to identify risks and concerns, effective responses to risks and concerns identified, and interventions and treatment as necessary. The framework also aims to advance equity by more fully engaging with parents, enhancing the cultural competency and congruence of the care team, and including more systematic efforts to use effective communication and develop trusting relationships with families that can, in turn, lead to improved outcomes. Such high performing medical homes intentionally co-design developmental and relational goals with families through discussions about parenting, development, and family strengths, as well as factors such as unmet concrete needs, trauma, and racism. When these elements come together, families have a much greater likelihood to optimize early relational health and social emotional development for their children.

Guidelines, Medical Home, and Well-Child Visits

Guidelines

The Bright Futures Guidelines for preventive pediatric health care (developed and endorsed by the American Academy of Pediatrics (AAP) and the federal government) set out a recommended schedule for well-child visits,[169] guidelines on the content of well-child care, and tools for providers and families. The guidelines are updated every few years to reflect changes in scientific knowledge, best practices, and medical science. The current Fourth Edition of Bright Futures gives greater emphasis to health promotion, to promoting livelong health for families and communities, and to risk factors as well as to strengths and protective factors. Social determinants of health (SDOH) are a more prominent theme and related topics to address social determinants are embedded in guidelines for the content of many visits for children birth to 21.

The Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) are the standard for child preventive services.[170,171] The schedule is regularly updated with the latest evidence and it is reserved for preventive services with the highest degree of supporting evidence (e.g., Grade A and Grade B recommendations by the U.S. Preventive Services Task Force).[172,173] For example, in line with recent evidence, universal maternal depression screening was added to the schedule in 2019 and updated in 2020.

Thus, the Bright Futures periodicity schedule has become a standard for most state Medicaid agencies and private insurance plans. The Affordable Care Act calls for first-dollar coverage without deductibles, copays, or other cost-sharing for preventive care services.[174] Beginning in 2010 and updated in 2018, federal law has used the Bright Futures/AAP Recommendations for Preventive and Pediatric Health Care periodicity schedule as the standard for preventive, well-child visits to be provided without cost-sharing.[175,176]

For children in Medicaid, federal law has long required that states consult with recognized medical professional organizational standards as they set the EPSDT periodicity schedule for well-child visits (as well as for the separate schedules for dental, hearing, and vision services). An increasing number of states have adopted the Bright Futures periodicity schedule, with 37 states and the District of Columbia doing so in 2018.[177] The differences in schedules most often affect young children birth to fifth birthday. Overall, the American Academy of Pediatrics (AAP) recommends 15 visits for young children prior to the sixth birthday (including the newborn visit often done in the hospital). The AAP maintains and updates a website which includes states' EPSDT state specific periodicity schedules for well-child visits.[178] The data on EPSDT performance by state is available from CMS.[179] For example, in 2018, among 50 states and the District of Columbia, half did not meet the standard for including seven well-baby visits on the periodicity schedule for infants from birth to the 11 months old (prior to the first birthday) and, of these, five states have only five infant visits on their states' schedule.

Medical Homes

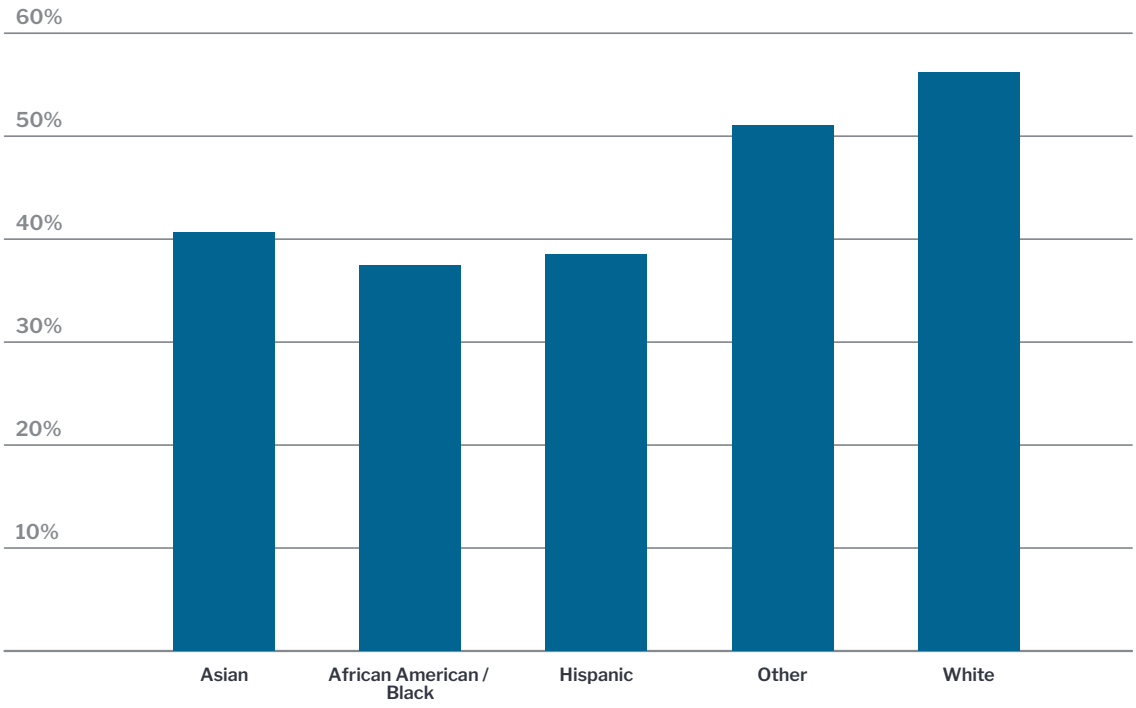
The medical home has been promoted as a model or approach for delivery of comprehensive primary care that facilitates partnerships between patients, clinicians, medical staff, and families.[180,181] A well-implemented and adequately financed medical home can help to achieve the triple aims of health care to improve the experience of care, improve population health, and reduce costs.[182,183,184] The AAP, HRSA-MCHB, and the federal Centers for Medicare and Medicaid Services (CMS) all recommend that each child have a patient/family-centered medical home.

An increasing body of research identifies the key characteristics of a medical home (also known as a patient- or family-centered medical home). According to the AAP and HRSA-MCHB, a pediatric medical home provides health care must be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.[185,186,187] In 2007 the four major organizations representing primary care providers—AAP, American Academy of Family Physicians, American College of Physicians, and American Osteopathic Association—developed the "Joint Principles of the Patient-Centered Medical Home (PCMH)."[188] These organizations adopted the National Center for Quality Assurance (NCQA) criteria for patient-centered medical homes as standards for practice for children and adults. Today, the shared principles are to deliver primary care that is: patient and family-centered , comprehensive, team-based, accessible, coordinated and committed to quality, safety, and equity.[189] Not always included in lists of the attributes of the medical home, equity was identified as one of the six core dimensions of a high-performing, high-quality health care system in the landmark Institute of Medicine report *Crossing the Quality Chasm*.[190]

Despite the documented advantages of having a medical home and its promotion by governmental, professional, and advocacy organizations, too few children have a medical home. While there is widespread agreement on the importance of the components and competencies of the medical home model, the need for improvement is great. Data from the 2017-2018 National Survey of Children Health show that only half of children ages 0-5 in the nation (ranging from 41 percent to 59 percent across the United States) were estimated to meet criteria for receiving coordinated, ongoing, comprehensive care within a medical home, which includes whether children have a personal doctor or nurse and usual source for well and sick care, and whether services are family-centered, connected to referral sources, and coordinated to support children and families. Figure 9 shows the percentage of all children under age 18 who in 2017-18 had care that met medical home criteria. CSHCN are more likely to have a medical home. Among children under age 18 without special health care needs, 58 percent of White, 40 percent of Hispanic, and 37 percent of Black children ages 0-17 had care that met the criteria for a medical home. Among children in this group who have publicly funded health coverage (primarily Medicaid/CHIP), 40 percent had a medical home, compared to 59 percent of those with private health insurance and 27 percent of those uninsured.[191]

FIGURE 9

Percentage of Children Under Age 18 Who Had Health Care that Met Medical Home Criteria, U.S., 2017-2018



High Performing Medical Homes

While all children should have access to a medical home, families with young children in Medicaid need additional support through what has recently been defined as a "high performing medical home."[192] A high performing medical home for young children in Medicaid would carry out functions beyond current standard practice and extend beyond the standard definition of the medical home. In particular, a high performing medical home would give more focus to promoting optimal development, including social-emotional development, and to engaging parents of young children with low income to achieve better outcomes. By operating as a high performing medical home, pediatric primary care providers can better achieve the quality and experience of primary care for young children and families with low income and reduce the incidence and cost of preventable health conditions across the lifespan. Importantly, high performing medical homes can help to promote equity and reduce racial/ethnic and income disparities in child health outcomes through greater emphasis on screening, early identification, and effectives referrals, as well as by expanding the care team with care coordinators, relational health workers, and embedding or linking to evidence-based models. The high performing medical home adds quality and value across three components.

1. **Provide comprehensive well-child visits, including expanded promotion and preventive services** based on *Bright Futures* and EPSDT standards, including screening, anticipatory guidance, and parent education. This includes engaging and partnering with families to screen for, identify, and respond to issues that extend beyond the physical/ bio-medical to include social-emotional and environmental factors that affect child health and development (e.g., maternal depression, food insecurity), with a two-generation emphasis.

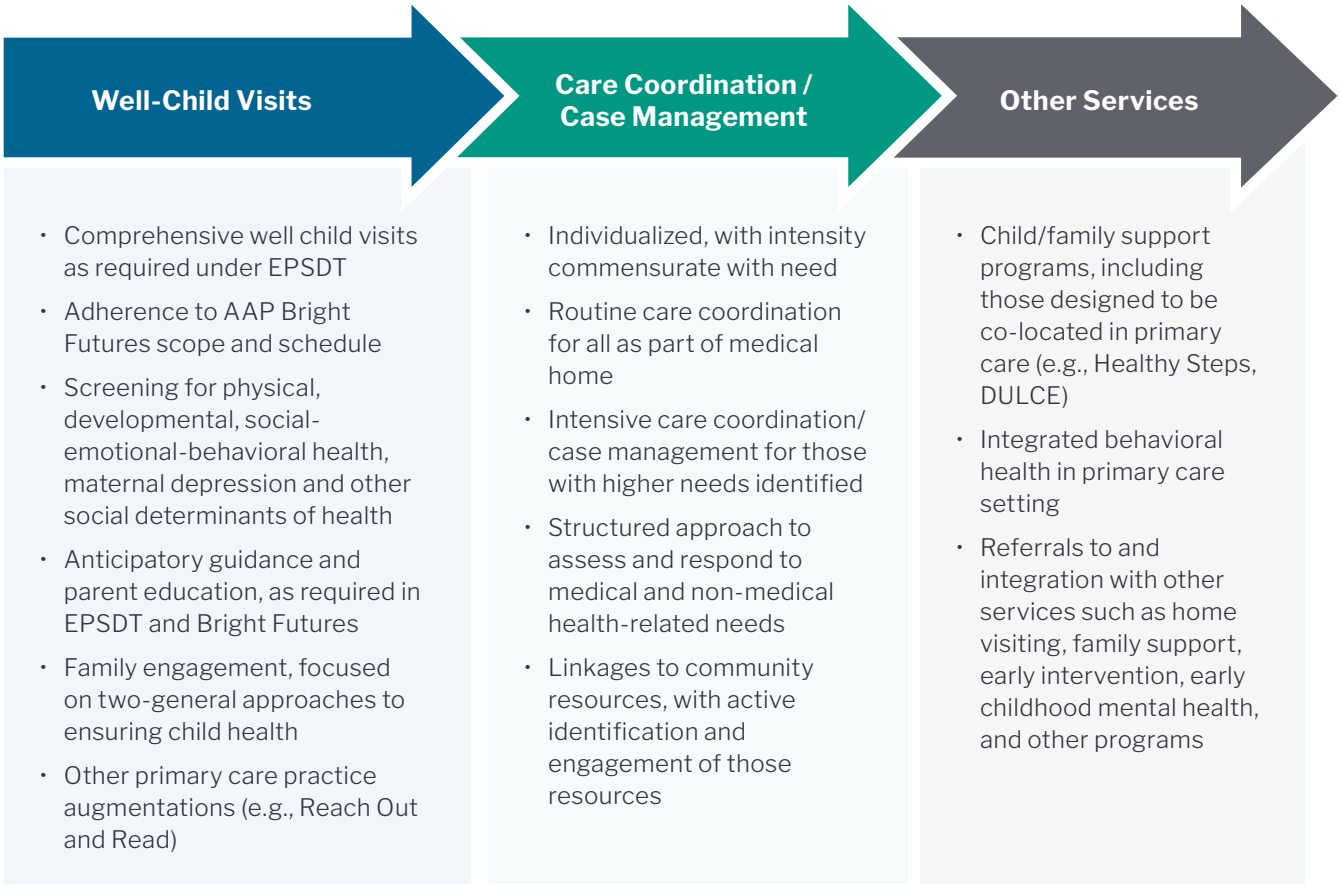
2. **Provide care coordination/case management at appropriate levels** (low, moderate, and more intensive levels), depending on child and family needs. At more intensive level, this would include a relational approach and care coordination staff. Ideally, this would include a warm "handoff" from the primary care provider to the care coordinator (based inside the medical home and/or in the community) to identify concerns, strengths, and needs and to ensure referral and follow-up that connects families with resources and services.

3. **Increase use of other services and supports for optimal child development**. This may include augmented services located within the primary care setting, such as family development specialists (e.g., in models such as DULCE, HealthySteps, or other relational health staff) or models that provide integrated behavioral health. Medical home providers also should link to or integrate with other services for families with young children such as home visiting, parent-child dyadic mental health therapy, early intervention for developmental delays and disabilities, or parenting programs.

High performing medical homes would be certified or approved by Medicaid agencies or managed care plans and would report on specific measures to demonstrate their delivery of these components. (See Appendix D for a list of measures related to high performing medical homes). States would provide enhanced payments to pediatric primary care providers operating high-performing pediatric medical homes for young children, based on a fee-for-service, per capita, prospective payment, value-based, or other payment arrangement.

FIGURE 10

Design for High-Performing Pediatric Medical Homes in Medicaid



Johnson K, Bruner C. A sourcebook on Medicaid's role in early childhood: Advancing high performing medical homes and improving lifelong health. Child and Family Policy Center. 2018

Well-Child Visits

Families have much to gain by using well-child visits in the medical home to assure the health, development, and future well-being of their child. Beyond receiving the recommended basic series of vaccinations to protect against serious and still present infectious diseases (e.g., polio, diphtheria, tetanus, pertussis, measles, mumps, rubella, hepatitis, influenza, varicella/chickenpox, and others), well-child visits for young children allow the care team to view the health and development of the child from a holistic perspective—looking across domains of development (i.e., physical, social-emotional, cognitive, and language development)—and to discuss with families their strengths and the protective factors that support optimal development. Well-child visits offer opportunities for responding to parent questions and concerns, performing physical exams, and conducting recommended screening, as well as offering support, encouragement, and guidance.

In recent years, many studies have been conducted to understand how well-child visits can be improved to better support parents, identify problems early, address social determinants of health, and make effective responses when problems are identified.[193,194,195,196,197,198,199,200] The conclusions from these studies point to a need for child health transformation and the value of high performing medical homes for young children in Medicaid. As a result of this research and the shifts in the Bright Futures Guidelines, an increasing number of pediatric primary care providers, particularly those serving children with low income who have Medicaid coverage, are redesigning and transforming their practices.[201,202]

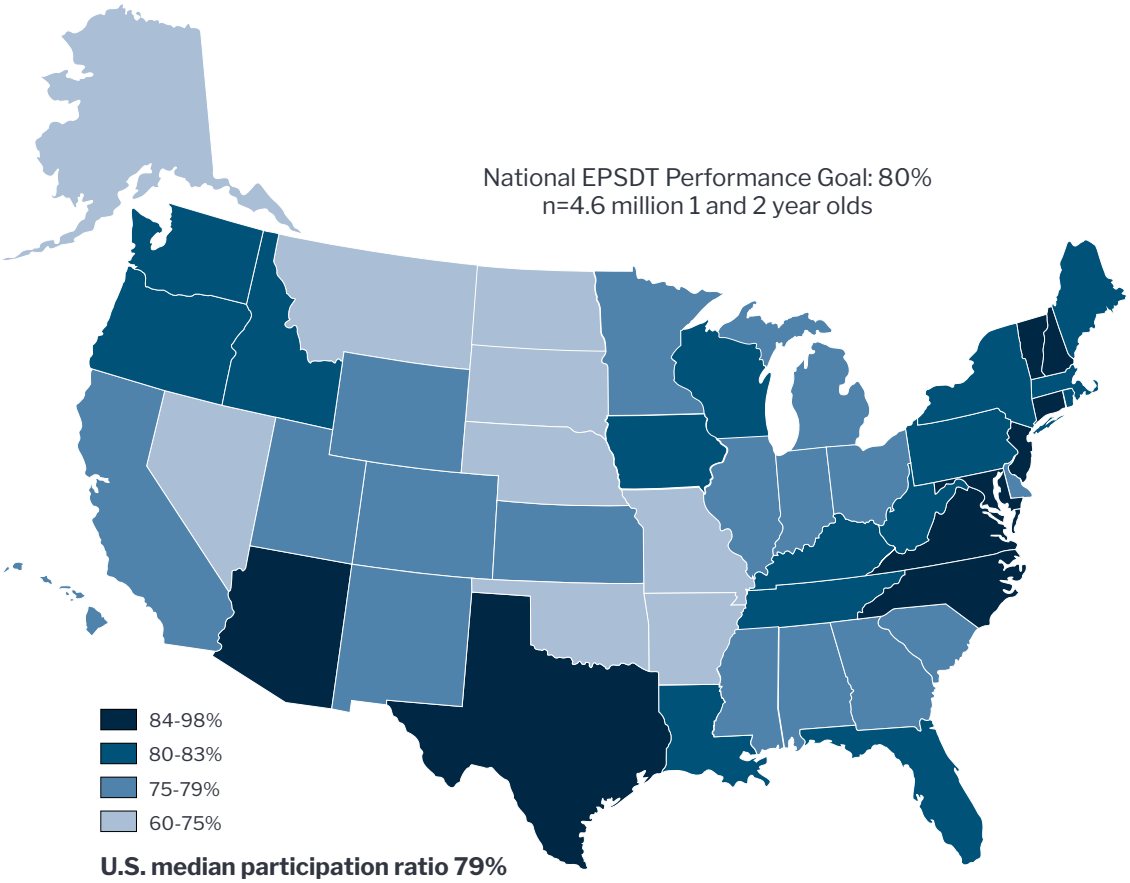
One example of transformation is the increased use of group visits. Group well-child visits have a long history of demonstrated value for families and providers and have had well-recognized champions. A group format for well-child visits increases the time for peer support, active parental participation, and patient education, as well as offering the primary care provider more time to observe parents interacting with their children. Satisfaction levels for families and providers has been well demonstrated. Some models, such as CenteringParenting,[203,204,205] show more parent acceptance, and an increasing number of efforts use approaches designed to advance equity and reduce bias. The challenges are related to having space, length of time required, scheduling a group, and lack of financing.

Performance on Well-Child Visits for Young Children

National and state data show the gaps in use of well-child visits among young children. Figure 7 shows the EPSDT participation ratio (reflecting the percentage of toddlers enrolled in Medicaid for at least 90 days who received at least one EPSDT well-child visit) for toddlers ages 1 and 2 years (12-35 months). In Federal Fiscal Year (FFY) 2018, the U.S. participation ratio was 79 percent among the nearly 4.6 million toddlers enrolled in Medicaid. This means that, despite the fact that the Bright Futures periodicity schedule[206] recommends five well-child visits for toddlers (i.e., visits at 12, 15, 18, 24, and 30 months of age), 21 percent of children nationally did not have even one well-child visit reported. As shown in the map, only half of states (25) met or exceeded the 80 percent EPSDT performance standard for this age group.

FIGURE 11

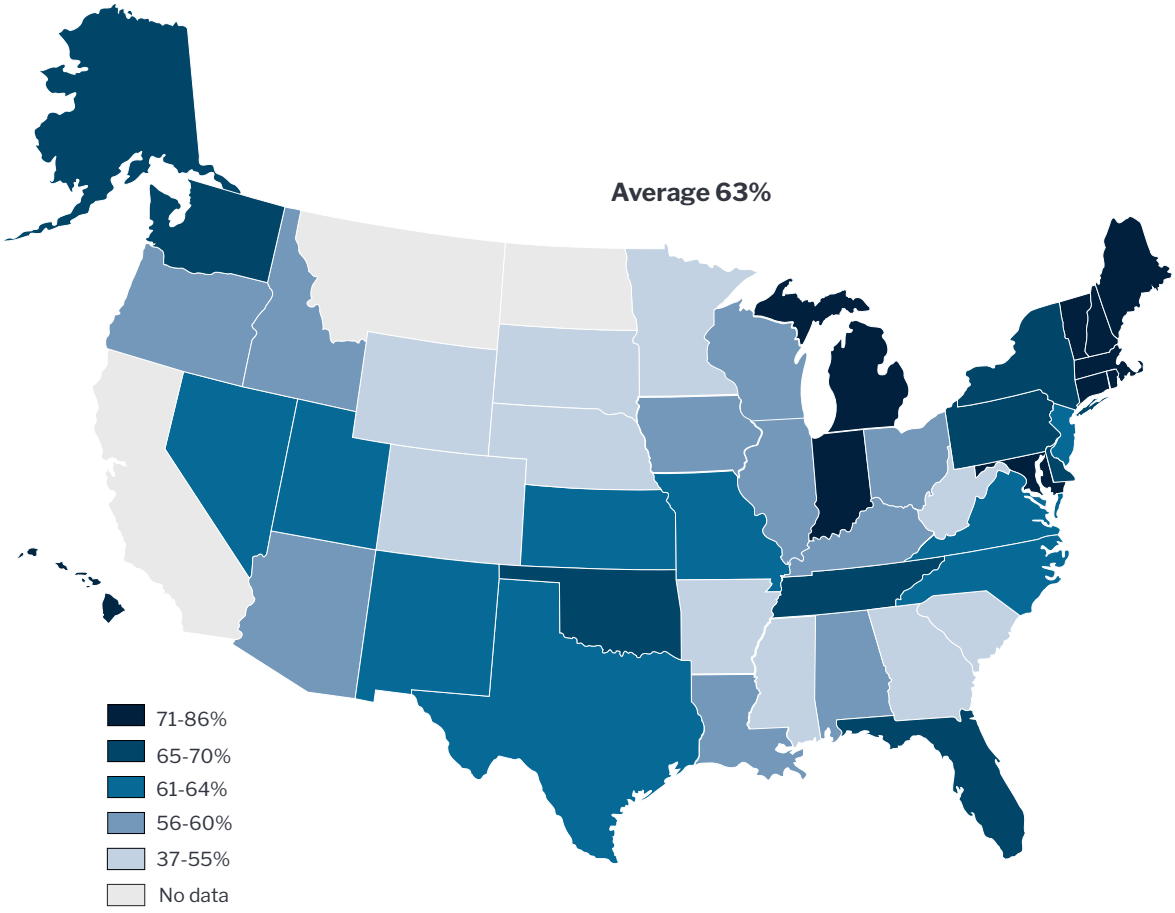
Percentage of Medicaid Eligible and Enrolled Toddlers Who Received at Least One EPSDT Well-Child Visit in Year (Participation Ratio), By State, FFY 2018



Looking deeper, the Medicaid/CHIP core child measure set and the Healthcare Effectiveness Data and Information Set (HEDIS®) both include a measure to assess the percentage of children having six or more well-child visits in the first 15 months of life. The Bright Futures schedule recommendation is for nine well-child (EPSDT) visits before age 15 months, but the measure for Medicaid/CHIP is for six or more visits by 15 months. Figure 8 shows the performance of states' Medicaid and CHIP programs in FFY 2018. The national average was only 63 percent, with states ranging from 37 percent to 86 percent. This means that many infants and toddlers had less than six well-child visits in the first 15 months of life and missed opportunities for recommended screening, immunizations, parent education, and other benefits of well-child visits. Notably, children in private commercial health plans are significantly more likely than those covered by Medicaid/CHIP to complete six or more visits in the first 15 months of life (80 percent and 63 percent, respectively in 2018).

FIGURE 12

Percentage of Children Receiving Six or More Well-Child Visits in First 15 Months of Life, Medicaid and CHIP,* By State, FFY 2018



* Twelve states show data for Medicaid only, not CHIP: Alabama, Arizona, Florida, Iowa, Michigan, Missippi, Nevada, North Carolina, Nevada, North Carolina, Tennessee, Texas, Utah, West Virginia, and Wyoming.

Source: Mathematica analysis of MACPro reports for federal fiscal year (FFY) 2018.

Promotion of Social-Emotional Well-Being

Universal Promotion

A central task of pediatric primary care is to promote health, development, and well-being of those it serves. Guidelines point to the central importance of promotion in each well-child visit. The framework used in this guide emphasizes the use of relational, strengths-based, and culturally appropriate approaches in services to young children and their families—strategies essential to promoting social-emotional development and well-being.

As recommended in Bright Futures and Medicaid/EPSDT, providers should offer anticipatory guidance and education for parents on general health, as well as developmental and social-emotional-mental health. Decades of research point to the importance of parental knowledge in children's development, particularly social-emotional development.[210] Partnering with and coaching parents to help them promote social-emotional development and early relational health is an essential part of each well-child visit for all young children served. Programs such as Reach Out and Read are designed to operate within pediatric primary care to promote positive relationships, development, early literacy, and the joy of reading aloud to young children. Other research offers pediatric primary care providers tools and strategies to guide transform their practice.

Tools have been developed that assist families more effectively engage and build shared decisionmaking into the care process. This includes the Well-Visit Planner™ and its use in a cycle of engagement that gives families an opportunity to assess how well providers and health plans are working to promote young children's development through the Promoting Healthy Development Survey.[211,212,213] The American Academy of Pediatrics has pre-visit tools for use by parents as part of the Bright Futures toolkit.[214] Other tools help parents assess the health care system.[215]

Promotion of social-emotional well-being within the medical home always begins with eliciting parent observations and concerns as the first effort to assess a child's developmental status during each well-child visit. As discussed in the next section, additional steps in well-child visits involve screening for all children at recommended intervals and specific ages using objective tools.

> "**Mental health promotion interventions:** Usually targeted to… a whole population. Interventions aim to enhance individuals' ability to achieve developmentally appropriate tasks (competence) and a positive sense of self-esteem, mastery, well-being, and social inclusion, and strengthen their ability to cope with adversity."
>
> **— National Academy of Sciences, 2009**

Screening and Response

Screening

Screenings for strengths and risks are a recommended element of well-child visits and part of the standard of care based on the American Academy of Pediatrics Bright Futures Guidelines. As shown in Table 4, for infants and toddlers birth to three, the recommended schedule includes screening with an objective and validated screening tool for: general development; Autism Spectrum Disorder; and maternal depression at select well-child visits. In addition, assessment for social determinants of health (SDOH) and for social-emotional development is recommended at all 15 visits from birth to the sixth birthday. The Bright Futures periodicity schedule notes that at each visit this should be family-centered and may include an assessment of child social-emotional health and social determinants of health. Yet, even for general development, national surveys indicate that less than half of young children receive a parent-completed developmental screening.[217] Specific studies suggest that the rates of screening for social-emotional development, maternal depression, and SDOH are improving but remain far from routine recommendations.[218] In addition, much more could be done to use information gleaned from screening for various factors that influence health and development.[219]

TABLE 4

Screening for Developmental and Behavioral Health as Recommended for Children Under Age 3 in Bright Futures Periodicity Schedule 2020

Topic	Newborn	3–5 Days	By 1 Mo.	2 Mos.	4 Mos.	6 Mos.	9 Mos.	12 Mos.	15 Mos.	18 Mos.	24 Mos.	30 Mos.
Developmental Screening							●			●		●
Autism Spectrum Disorder screening										●	●	
Psychosocial (SDOH) assessment	●	●	●	●	●	●	●	●	●	●	●	●
Social-emotional screening	●	●	●	●	●	●	●	●	●	●	●	●
Maternal depression screening			●	●	●	●						

The federal Medicaid/EPSDT regulations call for screening young children for at least physical, social-emotional, language, self-help, and cognitive development in the context of the well-child visit (Part 5. Section 5123.2(A)(1)(a)), along with referral to appropriate child development resources for additional assessment, diagnosis, treatment, or follow-up when concerns are identified.

The National Academy for State Health Policy tracks Medicaid developmental screening policies.[220] The National Center for Children in Poverty tracks Medicaid financing for social-emotional development screening.[221] The American Academy of Pediatrics maintains lists of validated screening tools across various areas of development.[222]

The current AAP STAR Center project, Addressing Social Health and Early Childhood Wellness (ASHEW)[223] seeks to improve the health, wellness, and development of children through practice and system-based intervention to increase rates of early childhood screening, counseling, completed referrals, with focus on developmental and social-emotional milestones, maternal depression, and social determinants of health.

> "Pediatricians need to be compensated for the time to do screening for development, social determinants of health, maternal depression… this all adds up. Practices in Medicaid managed care need more incentives and reimbursement for screening."
>
> **— Janis Gonzales, MD, FAAP, New Mexico Title V director (interview)**

Some studies of screening have validated tools and measures specifically for social-emotional development screening young children.[224,225,226,227,228,229] Several states have shown outstanding leadership in efforts to improve screening and early identification of social-emotional development (e.g., Iowa 1st Five Initiative,[230] and North Carolina ABCD[231,232,233]). As part of the Improving Screening Connections with Families and Referral Networks (I-SCRN) project, 19 pediatric primary care practices were identified that demonstrate the potential for using a QI collaborative approach.[234]

Response to Screening

Screening for general development, social-emotional development, maternal depression, or SDOH requires a provider response. Child health leaders convened in 2020 by the Child and Adolescent Health Measurement Initiative proposed that primary care providers draw from a set of "6R responses" when a concern or risk is identified through screening. The 6Rs include:

1. **Respect.** Show respect for the family's right to feedback and engage in a respectful discussion related to the results of the screening.
2. **Reinforce.** Give feedback about the family's strengths and opportunities to take action regarding concerns and risks.
3. **Resource.** Provide resources and information through both oral and written communication, including handouts, Internet content, etc.
4. **Return.** Ask the family to make a return visit in near future, particularly if the status of risk and needs are unclear based on the screen results.
5. **Refer.** Make a specific referral to another provider, service agency, or community resource.
6. **Resolve.** Complete the process, with follow-up continuing until the immediate need is resolved, referral completed, or additional services secured.[235]

As discussed in the *Common Threads* report, exemplary practice sites have devoted time and attention to adopting strategies that make screening more effective and help them achieve high performance in terms of screening. This includes maximizing electronic information systems, electronic health records, shifts in workflow, and adjustments in staff capacity.

Notably, pediatric primary care providers have identified concerns over their capacity to make effective referrals, lack of knowledge of referral resources, and insufficient supply of providers (e.g., waiting lists, no children's mental health providers accepting Medicaid).[236,237,238,239] Project TEACH[240] and similar initiatives[241] have demonstrated how to build capacity and expertise among pediatric primary care providers related to child and adolescent mental health, including screening, assessment, treatment, and ongoing management of mental health conditions.

Prevention and Support

Family Specialists, Developmental Specialists, and Family Navigators

> "We need to demystify mental health screening and assessment. Primary care providers are trained as clinicians and can do this. We have easy to use tools that work in practice. Let's eliminate some barriers through policy action and some through training."
>
> **— Danielle Laraque Arena, MD, FAAP, New York Academy of Medicine (interview)**

High performing medical homes and similar team-based care models are increasingly adding trained staff whose roles are to engage with families, assess family needs, provide linkage to resources or referral sources, and focus on promoting strong families, relationships, and development. Sometimes called community health workers, care coordinators, peer-support providers, or other job titles, they receive training specifically to support children and families in the medical home (e.g., training about child development, community resources, care processes). Often hired from within the community, these specialists have high acceptability by families and greater success with engagement and follow through.[242,243] When relationships begin prenatally, as with many community health workers or doulas, studies have shown the potential for improved birth outcomes.

State Title V MCH programs can fund training for this element of the workforce and support initiatives that assist pediatric medical home providers to embed these roles and trained individuals.

State Medicaid agencies have multiple ways to finance the services of such family specialists. Their role might be funded as part of an enhanced payment for high performing medical homes. In addition, with a state plan amendment, states can use the option 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)). The rule change went into effect January 1, 2014 and is different than prior regulations, which said that services needed to be provided by a physician or other licensed provider or under their direct supervision.[244] Medicaid can now provide reimbursement for preventive services staffed by a broad array of health and related

staff including family specialists, community health workers, parent educators, developmental specialists, and nutrition counselors and lactation consultants. Integrated care models such as accountable care organizations or accountable health communities create multiple opportunities to deliver such preventive services in community-based settings; however, locating these staff in the medical home is also valuable.[245]

Programs to Support Families

A growing number of group parenting programs delivered within the medical home or community have demonstrated benefits for families with young children, including strengthened parent-child relationships, children's social-emotional development, and more relational and responsive parenting skills. Typically delivered in a group format through multiple sessions, these parenting programs may be delivered in primary care or other community settings.

Programs such as Developmental Understanding and Legal Collaboration for Everyone (DULCE) are intentionally designed to be a universal prevention strategy, that is, one that is offered to all parents in a pediatric primary care practice with a new baby during the first six months of an infant's life. DULCE is an evidence-based pediatric care innovation designed to identify and address SDOH.[246,247,248,249] DULCE supports relational health for families with infants in communities that are under-resourced or have been marginalized by racist systems[250] and facilitates a multi-sector collaboration, operating in pediatric primary care settings and connected to early childhood systems and legal partners.

Many approaches also have been developed to support social-emotional development through relationship-based, strengths-based, family-centered methods. For example, the Video Interaction Project (VIP) is designed to be delivered at the time of well-child visits with the support of a child development specialist.[251] Another example is the Play and Learning Strategies (PALS) Infant and Toddler program, a preventive parent education program designed to strengthen the bond between parents and their infants and toddlers (5–18 months) and to stimulate social-emotional, cognitive, and language development. PALS offers a parent education approach that can be used in home, in health care, in early care and education, and other settings.[252,253,254,255] As discussed above, other efforts to support parents use family specialists, family navigators, community health workers, promatoras, and others.[256,257]

Many home visiting models are designed to provide prevention and support to families during the prenatal period and early childhood years. This includes many models identified as evidence-based by the HomVEE (Home Visiting Evidence of Effectiveness) review process which supports the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.[258] Among the approximately 20 models approved, those most frequently used by state MIECHV efforts to provide selective, targeted prevention services are: Healthy Families America (HFA), Nurse-Family Partnership (NFP), and Parents As Teachers (PAT). A growing number of states also are advancing the Family Connects model, which has a universal approach.

Care Coordination/Case Management with Tiered Levels of Intensity

The design of the medical home includes care coordination for all patients/families. The terms "care coordination" and "case management" are both used, often interchangeably, to describe activities that better link children and families to services and supports, help with navigation to improve access, and ensure follow up to address needs. The AAP, MCHB, and other child health leaders generally use the term care coordination,[259,260,261] however, Medicaid traditionally finances this type of service under the case management benefit.[262] Some care coordination/case management is designed to reduce barriers related to geographic access, language, literacy, and related factors. For CSHCN, care coordination provides additional help to families in navigating systems of care.[263,264]

While the medical home includes basic, routine care coordination, some families with young children need more intensive care coordination. This guide points to the value of tiered levels of care coordination/case management. Pediatric primary care providers with a high proportion of families who need more intensive care coordination need dedicated time from care coordination staff (who might be family navigators, family specialists, or others), whether based inside the health care setting or in the community. The design of a high performing medical home in Medicaid calls for care coordination capacity to respond to both SDOH and bio-medical conditions. While a growing number of practices provide care coordination that focuses on both bio-medical and social determinants, many do not have the resources (e.g., financing, personnel) to use this approach and concentrate efforts on CSHCN, particularly those with medically complex conditions.

Medicaid regulations specify a case management benefit, but do not define "care coordination." Two primary Medicaid benefit categories can be used to cover more intensive care coordination. Many states are financing care coordination: (1) case management, or (2) targeted case management. Under EPSDT, children are entitled to general case management coverage; however, targeted case management requires a specific state plan amendment.

States use the Medicaid targeted case management benefit because it gives administrators the flexibility to cover services to individuals in defined groups (such as young children or children in foster care), specific geographic areas, and delivered by qualified providers. Federal regulations define the following four categories of activity for targeted case management: 1) assessment, 2) development of a care plan, 3) referrals and relative activities, and 4) monitoring and follow-up based on the plan. Targeted case management is used in many states to finance home visiting, prenatal care coordination, and/or care coordination for CSHCN.

States can pay for an array of care coordination activities in primary care settings or in the community apart from the case management benefit. Financing for care coordination/case management may be through direct reimbursement on a fee-for-services basis, on a capitated basis (e.g., per member, per month-PMPM payment), or through incentives or bonuses for performance. Whatever the finance mechanisms, the costs of both direct time with the child and family and indirect time—to gather information, develop or update the care plan, follow-up with families, schedule appointments, or meetings with families to monitor the care plan—need to be reflected in the payments.

Early Interventions and Mental Health Treatment

For young children and their families, an array of programs and services designed as early intervention to address identified risks or early childhood mental health treatment exist. EPSDT and *Bright Futures* guidelines call for mental health screening, but data suggest that children are not routinely screened. Moreover, a shortage of pediatric mental and behavioral health providers for young children is a longstanding challenge.[265] Referral to appropriate behavioral health services can be challenging for families and primary care pediatricians. As a result, many children and families do not receive the services they need.

In response, states, communities, and pediatric practices have undertaken an array of initiatives to maximize available provider and financial resources. Some are built upon other programs, some on evidence-based models, and some on innovative strategies to integrate services. This section discusses early intervention and mental health treatment approaches that could be more widely used and advanced through Title V and Medicaid action.

Part C Early Intervention Programs

The Individuals with Disabilities Education Act (IDEA) Part C Early Intervention Program for Infants and Toddlers[266] or Part B Special Education Program when serving preschool aged children play unique roles supporting development for young children. The IDEA regulations state that infants and toddlers with a disability or with diagnosed physical or mental condition that has a high probability of resulting in developmental delay are eligible. While states must comply with the definition contained in federal IDEA regulations (20 U.S.C. 1400-1444), they are permitted to develop their own eligibility criteria for Part C early intervention services.

At their option, states may extend eligibility to infants and toddlers "who would be *at risk* of experiencing a substantial developmental delay if early intervention services were not provided to the individual… because of biological or environmental factors that can be identified (including low birth weight, …a history of abuse or neglect, and being directly affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure)." This ability to serve those at risk of developmental delay opens up opportunities for intervening before a concern becomes a risk or causes developmental delays and disabilities.

Social-emotional development is one of the areas specified for developmental delays or disabilities that can lead to eligibility for Part C services. While every state participating in Part C must provide services in the domain of social-emotional development to children with a delay or disability (or at risk of delay at their option), the criteria and definitions for social-emotional delays vary across states. National surveys and additional state or local studies indicate that a small proportion of children become eligible based on social-emotional delays and few social-emotional and behavioral services are delivered under Part C.

In some states, Medicaid has partnerships with Part C and maternal and child/family health programs to maximize use of Medicaid and improve outcomes.[267] Medicaid financing is used by most states to finance a portion of Part C Early Intervention services, mainly health-related services such as physical, occupational, or speech therapies. Projects across the country have demonstrated ways to streamline administrative practices, achieve cost efficiencies, maximize available providers, and better serve families with young children, including partnerships with pediatric medical homes.[268] State Medicaid agencies can review their Part C related services expenditures to determine the extent to which social-emotional services are being financed.

State Title V MCH programs often administer Part C programs or both programs are located within state Departments of Health. This provides an opportunity to review eligibility criteria, collect and analyze data, and promote collaboration and linkages to pediatric primary care.

Programs Designed to Address Social-Emotional-Behavioral Risks

An increasing number of programs have proven successful in supporting social-emotional development and improving parent-child relationships through coaching and education for parents. Incredible Years is an evidence-based program that aims support the social-emotional development and reduce challenging behaviors among children from birth to age 12. The BASIC parenting program involves weekly two- to three-hour sessions for groups of parents, with design that varies by age group. Positive Parenting Program (Triple P) is an evidence-based program that helps parents learn strategies to promote social competence and self-regulation in children.[269,270] Triple P consists of five tiers, with two universal tiers designed for all parents and three tiers of targeted supports for families with greater needs. Both can be delivered in a variety of settings, including health, early care and education, community, and school settings. The Video Interaction Project (VIP) is an evidence-based approach to promoting positive parenting through reading aloud and play. The VIP program has shown strong success when based in pediatric primary care.[271,272,273] Circle of Security Parenting (COS-P) is a group, video-based parenting program for families with children under six years old designed to help them interact with and understand their children.[274] My Baby and Me[275] is designed to increase mother-infant relationships, building upon the PALS curriculum and offering an intensive series of video-based coaching sessions. These and other evidence-based models are referenced in Table 3 only as examples.

More Intensive Home Visiting Programs focused on Social-Emotional Development

Some more intensive home visiting models are designed to intervene with and support young children with social-emotional-behavioral risks. Two evidence-based models are Child First and Attachment and Biobehavioral Catch-up (ABC). Either of these or other similar programs could be connected to or anchored in pediatric primary care. Models such as Minding the Baby® are designed for first-time young parents in under resourced communities, to bridge primary care and infant mental health services by pairing a nurse with a mental health professional (typically a social worker) to conduct home visits.[276] In the framework of this guide, these are distinguished from home visiting models designed for more general preventive purposes.

Early Childhood Mental Health Consultation

Early childhood mental health consultation (sometimes known as infant and early childhood mental health consultation or IECMHC) is an approach that connects and pairs mental health professionals with other providers who work with young children and their families, with the aim to improve children's social-emotional development and mental health.[277,278,279,280,281,282] One study of mental health consultation found that while approximately half of pediatric primary care providers used some type of consultant or referral arrangements with mental health providers, few (17 percent) reported on-site consultation of mental health provider co-location.[283] Many states have early childhood mental health consultation programs, most often delivered through early care and education settings and sometimes through home visiting programs. The potential is great to better use early childhood mental health consultation within primary care settings. Across the country, initiatives have used a variety of funding sources, including federal and state mental health (e.g., Project LAUNCH), Title V MCH Block Grant, Healthy Futures grants, Medicaid, home visiting, and child care dollars to fund such efforts. Tools for assessment and measures for monitoring program performance are available.[284]

> "In the area of child health, we have an access/navigation model designed to support social-emotional development and to reduce the impact of social determinants of health.... The Department of Health also has responsibility [assigned from Medicaid] for outreach to families to assure they are informed about EPSDT and get to well-child visits."
>
> **— Joan Brandt, Minnesota Title V director (interview)**

Parent-Child Dyadic Therapy

Using parent-child, dyadic therapy for mental health conditions recognizes that for young children, mental and behavioral health 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.[285] Typically, a mental health professional coaches the parent to encourage positive interactions that can help improve the parent-child relationship, parenting and reflection skills, and the child's behavior. Several evidence-based models of parent-child therapy have been developed, highly recognized and in use nationwide.[286] Two widely used and evidence-based therapy models are Child-Parent Psychotherapy (CPP)[287,288] and Parent-Child Interaction Therapy (PCIT).[289,290] These and similar therapy models aim to support and strengthen parent-child relationships for young children who are experiencing behavioral, attachment, and other mental health problems. Such approaches may be used with individual families, in clinical or home-based settings,[291] and with groups.[292] These and other programs and models are referenced in the table below only as examples of approaches widely used. As discussed below, in most states Medicaid pays for parent-child dyadic therapy for families with young children.

Maternal Depression

Research is clear that the mental health of the parents, both mothers and fathers, affects parent-child relationships and can have impact on the mental health and developmental status of the child, particularly in the earliest years of a child's life.[293] The potential role of the pediatric primary care provider in identifying and mitigating the impact of such depression has been described.[294]

A CMS Informational Bulletin for state Medicaid agencies emphasizes the negative impact maternal depression can have on child development and the role Medicaid/EPDST plays in addressing this condition. CMS encourages maternal depression screening during EPSDT well-child visits and informs states have the option to permit pediatric primary health care providers billing for maternal depression screening under the child's Medicaid during well-child visits. The bulletin 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; for example, parent-child dyadic therapy. Notably, within the therapy process the child and the parent may not spend the whole time in the same room, while present for the same visit.

> *"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."*[295]

Beyond parent-child dyadic therapy, additional treatment of the mother's depression may be needed (e.g., therapy visits or prescriptions for medication specifically for the mother), and these can be covered for the mother under Medicaid but only if she is covered under Medicaid. Much can be done, however, under the child's Medicaid coverage to begin to address maternal depression and strengthen the parent-child relationship, which often contributes to the mother's health and well-being.[296]

Diagnoses and Diagnostic Codes

One challenge in financing early childhood mental health services is that young children may not yet have clearly defined or diagnosable mental health conditions. However, a specific diagnosis is not required for a determination of medical necessity under Medicaid/EPSDT. For some young children, a constellation of risks may point to the need for intervention and may support a medical necessity determination via EPSDT, with approval of payment for treatment services or a plan of care. In other words, without a diagnosis, states can and should use the Medicaid EPSDT benefit to finance needed early interventions and treatments for young children in addition to coverage when appropriate through traditional diagnoses.

In particular, the youngest 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). However, some age-appropriate diagnostic codes can be useful in the process of care and financing 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 in order 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 coding and billing purposes.

Integrated Mental/Behavioral Health Services

The trend toward integrating mental health within the medical home has been developed for both children and adults. Despite EPSDT and Bright Futures Guidelines recommendations for mental health screening, there is a shortage of pediatric mental and behavioral health providers for children, particularly for young children.[297] 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.

> "There is tremendous potential for Medicaid to turn on codes and make billing possible for an array of services related to early childhood mental health, particularly for relational, dyadic, and two-generation services for those at-risk."
>
> **— Sheila Smith, PhD, National Center for Children in Poverty (interview)**

Integrating mental/behavioral health services within the medical home is a trend for both children and adults. Use of innovative approaches to integrate mental/behavioral health into pediatric primary care settings is increasing.[298,299,300] Co-location of mental/behavioral health providers in the pediatric medical home is an important opportunity, particularly if the services include those appropriate for young children, not only school aged children and adolescents with readily identifiable conditions. Research indicates that a team-based approach in which primary care providers, care managers, and mental health specialists coordinate care produces better results.[301] Beyond addressing those children and families with already identified behavioral and mental health challenges, co-location services also allow for upstream prevention and early interventions. Medicaid financing can support this type of primary care augmentation, particularly for medical homes serving high concentrations of children enrolled in Medicaid. Clearly defined benefits, coverage rules, billing codes, adequate reimbursement rates, requirements for medical necessity where appropriate, and managed care contract provisions are needed as the practical, operational mechanisms for Medicaid to finance integrated mental/behavioral health.

Cross-continuum Community-Level and Population-Based Efforts

Increasing the effectiveness of relationships between pediatric providers and other child serving entities is one key step toward improving care and services for families. Coordinated and efficient early childhood system structures can help to ensure effective referrals and aligned service responses across clinical care, public health, social services, family support, and early care and education. State Title V MCH programs can assist with development of systems of care, building on approaches used to advance systems of care for CSHCN. The lessons learned from Early Childhood Comprehensive Systems (ECCS) grant activities also point to opportunities for state Title V programs to go farther in developing effective systems at the state and local levels.

Help Me Grow[302] works at the community and population-level rather than a model specific approach. It is like a utility or grid (like the electric power grid) that helps providers and families connect. All children and families benefit from an organized system of community resources and services; however, when the system is not well organized, it can be difficult for families and providers to connect. Help Me Grow provides a centralized access point with outreach to families and child health providers, as well as connections to community partners and data analysis support.[303] Generally, Help Me Grow operates as a comprehensive, statewide, coordinated system of early identification and referral for children at risk for developmental or behavioral problems.[304] It has been shown to strengthen families protective factors through supports and connections.[305] State Title V MCH programs are funding or partnering with Help Me Grow in some states. There are many factors that influence the availability of Help Me Grow in more states, including: the availability of local, state, and federal funding streams; the accessibility and reach of HMG within communities.

Child health improvement partnerships are quality improvement entities that exist in more than 20 states and have a national coordinating network.[306] These child health improvement partnerships use collaboration among public and private organizations that share interests in improving child health to advance the quality of health care delivered to children. Typically, they generate and rely on partnerships between academic medical centers, state Title V programs, Medicaid agencies, parents, and pediatric providers for targeted initiatives. They frequently use quality improvement learning collaborative approaches; many offer credits toward pediatric "maintenance of certification" for pediatric providers who participate. States have opportunities to use child health improvement partnerships to advance medical homes, improve measurement, conduct projects to expand use of approaches to promote social-emotional development, and more.

> "Every state Title V MCH program needs a child health improvement project. The Vermont Child Health Improvement Project (VCHIP) is a partnership between Medicaid, Title V, the university, and pediatric primary care providers who work together, select priorities, and improve care for kids. It is built on the strength of the partnership between Title V and Medicaid EPSDT going back decades."
>
> **— Breena Holmes, MD, FAAP, Former Vermont Title V director (interview)**

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) is a federal grant program administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) to promote the social-emotional, cognitive, physical, and behavioral health of children from birth to eight years of age.[307] Overall a total of 55 Project LAUNCH grants were awarded. An evaluation of 24 grantees across 21 states (that were funded in three cohorts between 2010 and 2018) was conducted and found that there was strong emphasis was on implementing home visiting service strategies. In addition, about half (46 percent) of grantees provided training or other supports designed to integrate mental health more fully into pediatric primary care. Most of the efforts involved support for physical co-locate of LAUNCH-supported mental health staff in primary care settings, with all of these providing related training. These efforts resulted in significant positive changes for parents and children. Only a small number of grantees

used LAUNCH funds to directly support mental health treatment. In addition, about three-quarters (75 percent) of Project LAUNCH sites supported expanded use of family strengthening or parenting programs (e.g., Incredible Years, Triple-P, Centering Parenting), as well as intervention and treatment programs (e.g., Parent Child Interaction Therapy). **Across sites, 80-95 percent of parents reported that these family strengthening programs were helpful in terms of their parenting skills, family functioning, child's health, and child's readiness for school or preschool**.[308] Looking more specifically at the efforts to integrate mental health services and supports into primary care, some key approaches were identified. The essential components in the LAUNCH grantees' approaches were:

1. promotion of social-emotional development as part of the well-child visit;
2. social-emotional-mental-behavioral health screening;
3. inclusion of a family partner/specialist/navigator;
4. embedded mental health consultants;
5. warm hand-off between primary care and mental health consultant or family partner;
6. assessment followed by brief intervention;
7. parenting groups and health promotion activities;
8. cross-system training;
9. shared recordkeeping; and
10. more intensive care coordination.[309]

State Opportunities for Using Title V and Medicaid/EPSDT to Promote Social-Emotional Development and Mental Health

Every state has the potential to improve the financing and delivery of pediatric primary care in ways that better support parents and improve social-emotional development for immediate benefit and lifelong impact. The framework for action across a continuum of services and structures was described above. Table 5 identifies many specific opportunities that exist today for state Title V MCH programs and Medicaid agencies to support, finance, and advance those services, strategies, and structures. States can use coordination and partnerships between Title V and Medicaid to accelerate improvement in child health access and outcomes. Collaboration between state Title V MCH programs and Medicaid agencies can help to ensure access to needed services for children. In most states, ensuring delivery and financing of appropriate, effective, and quality child health services also requires engagement of pediatric providers, families, and other child experts and advocates, as well as managed care organizations (MCOs), accountable care organizations (ACOs), accountable communities of health (ACH), or similar entities.

Building on Collaboration Requirements and Interagency Agreements

Looking beyond and building upon the reciprocal Title V and Medicaid collaboration requirements described earlier, every state has opportunities to maximize and leverage such partnerships. An analysis of state Title V-Medicaid Interagency agreements conducted as part of preparation of this guide found that while all states have some version of this required agreement, most are focused on payment arrangements or administrative communication, and less on programmatic opportunities. Most follow the elements of the legal obligations for coordination and relationships, and many quote, paraphrase, or make citation to the sections of federal law. For example, the agreements typically contain the terms regarding how: (1) Medicaid is expected to pay when a public health entity delivers services to Medicaid beneficiaries, (2) data will be shared, (3) duplication of efforts will be avoided, and (4) communication will be structured. A few contain provisions related to interagency advisory groups, annual meetings, task forces, and other mechanisms for collaboration. A few identify populations or specific areas of service—well-child visits, immunizations, home visiting, oral health, nutrition, CSHCN, or pregnant women—where coordination and collaboration are expected. Few agreements have details related to projects or initiatives.

New York state's 2019 agreement is a notable exception, including provisions that specify Title V will assist in Medicaid Redesign, Delivery System Reform Incentive Payment Program, and efforts to provide enhanced care coordination for CSHCN. Oregon includes a range of more specific provisions related coordination, programs, data, reimbursement, and outreach and referral, as well as support to the state's Medicaid waivers and coordinated care organizations. Vermont's agreement specifies the interagency liaisons, roles of the Title V agency under the state's Medicaid "global" waiver, and roles in establishing guidelines, periodicity schedules, and activities in partnership with the Vermont Child Health Improvement Program.

Augmenting Initiatives in State Title V MCH Programs

A similar scan and analysis of state Title V MCH program reports and plans conducted in March-April 2020 identified some trends. (See Appendix C for examples and Appendix D for a summary of findings from this scan.) Virtually all states have efforts underway to increase the rate of developmental screenings, aiming at National Performance Measure (NPM) #6, with most focused primarily on screening for general development. A very small number of states mentioned screening initiatives focused on maternal depression, social-emotional development, or social determinants of health. Most state MCH agencies are using dollars, strategies, and momentum from Help Me Grow, Project LAUNCH, home visiting, and early care and education initiatives. In line with a nationwide movement to expand infant and early childhood mental health (IECMH) services, a few state Title V MCH programs reported partnerships and/or leadership of such efforts. Notably, many of the IECMH efforts were related to consultation for home visiting or early care and education, with few related to pediatric primary care.

> "There are three anchors for Title V going forward: focus on equity, community inclusion and upstream intervention. Our state's high-level health impact areas for the coming years are: behavioral health, access to care, and nutrition security."
>
> **— Rachel Hutson, Colorado Title V Director (interview)**

Strikingly, state Title V programs reported only a few initiatives focused on or connected to pediatric primary care/medical homes beyond those for CSHCN. A small number of states (e.g., Connecticut, Idaho, Oregon, Rhode Island) have initiatives focused on increasing access to medical homes generally, and some of these are done in partnership with Medicaid. States use Title V "Partnership" dollars (i.e., combined federal, state, and other funding) to invest in early childhood system activities. Most infuse dollars from multiple funding streams (e.g., federal ECCS, Project LAUNCH, Essentials for Childhood, Preschool Development Grants, Race to The Top, or private Pritzker Children's Initiative grants); however, few mention collaborations with Medicaid on such efforts. While more than a dozen states have child health improvement projects, these were not reported as Title V-funded activities or priorities in most states.

All states are meeting the requirement to use 30 percent of their Title V MCH Block Grant award for preventive and primary care for children; however, few described efforts underway that are connected to pediatric primary care and medical homes. Most of these expenditures are reported for activities such as school health (e.g., school nurses, school-based health centers), adolescent health, immunization services, newborn screening, lead poisoning, oral health, and child health services in local health departments. Most states have opportunities to increase their investments in direct, enabling, population-based, and infrastructure services to improve access to and the quality of medical homes for children. As states prepare their new five-year needs assessments and state plans, they should consider the opportunities identified in this guide.

TABLE 5

Opportunities for Title V and Medicaid to Promote Social-Emotional Development and Mental Health

Continuum of Services and Supports	Title V Roles and Opportunities	Medicaid Roles and Opportunities
Align with and Advance Use of Guidelines	• Advance Bright Futures Guidelines, periodicity schedule, screening protocols, and other more specific guidelines for primary care. • Partner with Medicaid to develop guidelines, contract provisions, provider manuals, and other documents related to EPSDT and well-child visits. • Use Title V funds to support Pediatric Improvement Projects for aligned purpose: i.e., support improvement in the scope, quality, and utilization of well-child visits for young children in Medicaid. • Include Title V National Performance Measures (NPM)[310] on medical home (NPM #11) and on developmental screening (NPM #6) as priorities for State Title V plan. Align with Medicaid/CHIP core measures when possible.	• Align state's EPSDT rules and periodicity schedule with Bright Futures. • Apply Bright Futures Guidelines in Medicaid financing process, including contracts, measurement, incentives, and oversight. • Collect and submit data on Child Core Set measure "Well-Child Visits in the First 15 Months of Life" (W15-CH); "Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life" (W34-CH); and "Developmental Screening in the First Three Years of Life" (DEV-CH).[311] • Use Medicaid administrative claiming mechanisms[312] to provide training and QI projects that support improvement in the quality, scope, and focus of well-child visits for young children in Medicaid. • Include in Medicaid contracts with MCO/ ACO/ ACH a focus on pediatrics, particularly promotion and prevention, two-generation, relational health.

Continuum of Services and Supports	Title V Roles and Opportunities	Medicaid Roles and Opportunities
Advance Use of High Performing Medical Homes	• Use funds from the 30 percent of Title V MCH Block Grant funding dedicated to preventive and primary care for children to strengthen pediatric medical homes for all young children.[313] • Create projects and structures to advance high performing medical homes for young children in Medicaid (e.g., training, technical assistance, QI, certification, measures) that provide team-based primary care, relational care coordination, and other services and supports. • Partner with American Academy of Pediatrics chapters, child health improvement partnerships, children's hospital ambulatory care groups, and primary care providers to transform medical homes, improve well-child visits and augment use of universal preventive screening and interventions • Focus on Title V NPM #11: "To increase the percentage of children with and without special health care needs who have a medical home." • Apply strategies now used to advance medical homes for CSHCN in order to support high performing medical homes for more young children without diagnosed conditions. • Work with federally qualified health centers (FQHC) to introduce components of the high performing medical home for young children in Medicaid. • Align and crosswalk performance measures on medical home and well-child visits across Title V, Medicaid/CHIP core measures, and HEDIS.	• Define and incentivize high performing medical homes for young children, including use of Medicaid managed care contract language. • Increase reimbursement rates/payments for high performing medical home for young children in Medicaid, relying on certification and/or measurement. • Permit use of Medicaid administrative claiming to finance related training and quality improvement activities for enrolled pediatric primary care providers. • Make adjustments to cover the additional costs and scope of services related to high performing medical home as part of FQHC prospective payment system (PPS) or alternative payments methodologies (APM) under Medicaid, including use of supplemental payments where appropriate.[315] • Compare performance on medical home and well-child visit measures across Title V, Medicaid/CHIP core measures, and HEDIS.

Continuum of Services and Supports	Title V Roles and Opportunities	Medicaid Roles and Opportunities
Promotion *Universal promotion*	• Use Title V funds to provide training to increase use of strengths-based, relational, culturally and linguistically appropriate, and responsive interactions between pediatric primary care providers and parents. • Encourage use of pre-visit tools to support more effective family engagement during well-child visits (e.g., Well-Visit Planner and Cycle of Engagement). • Partner with Medicaid and the private sector to fund Reach Out and Read for all children in medical homes. • Invest in family led organizations and build on existing family-to-family organizations to provide support to families whose children do not have an identified special health care need. • Fund projects designed to increase parent/family engagement in health care at the clinical and systems levels.	• Inform families and providers about the EPSDT benefit and the importance and value of comprehensive well-child visits.[316] • Provide reimbursement for services delivered by family specialists, community health workers, and other care team members (using flexibility for preventive services by non-licensed staff).[317] • Permit provider billing for parenting programs and family peer support services conducted within the medical home. • Permit billing for evidence-based enhancements for universal preventive interventions such as Reach Out and Read. • In Medicaid managed care contracts, require that pediatric primary care providers use the CAHPS survey questions for the Patient-Centered Medical Home/Child Version. [318]

Continuum of Services and Supports	Title V Roles and Opportunities	Medicaid Roles and Opportunities
Screening for strengths and risks	• Use Title V funds to support training and QI projects related to screening for general development, social-emotional development, maternal depression, and SDOH. • Partner with Medicaid to develop more specific guidelines and contract provisions related to screening (i.e., screening, response, and measurement). • Measure developmental screening in pediatric medical home as part of work on NPM #6 "Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year." • Measure response to developmental screening in medical home. • Measure social-emotional developmental screening in pediatric medical home as part of work toward and reporting on NPM #6. • Measure response to social-emotional developmental screening in medical home. • Conduct QI and pilot projects with health plans related to screening for social-emotional development and young children. • Encourage and measure response to maternal depression screening in pediatric medical home. • Encourage and measure screening for social determinants of health (SDOH) in pediatric medical home. • Fund expansion of Help Me Grow or similar systems "utilities" to support referrals and follow up to positive screen results, including concerns about early childhood social emotional development.	• Measure and report on developmental screening in pediatric medical home, based on CMS Child Core Set measure "Developmental Screening in the First Three Years of Life" (DEV-CH).[320] • Through managed care contracts and provider guidelines, require screening for general and social-emotional development, based on Bright Futures periodicity schedule recommendations. • Finance and measure maternal depression screening in pediatric medical home. • Finance and measure screening for social determinants of health (SDOH) in pediatric medical home. • Use electronic health records (EHR) or other care process tools to record positive screens and follow up. • Use Medicaid administrative claiming dollars to support training and supporting practitioners in their use, and for establishing the infrastructure necessary for implementation of Help Me Grow or similar systems "utilities" to support referrals and follow up to positive screen results.

Continuum of Services and Supports	Title V Roles and Opportunities	Medicaid Roles and Opportunities
Prevention and Support *Universal preventive interventions*	• Fund structures for training, diversification, and workforce development of family specialists within or linked to pediatric primary care (e.g., DULCE, Healthy Steps, other models, and community health workers). This includes a career pathway opportunity for family leaders. • Strengthen partnerships and increase engagement with family led organizations and family-to-family centers. • Fund parent education and peer support services within the medical home or community settings.	• Permit reimbursement of services delivered by family specialists and other care team members (using flexibility for preventive services by non-licensed staff). • Permit billing for parent education and peer support services within the medical home. • Include in contracts for MCO/ ACO/ ACH a focus on pediatrics, particularly promotion and prevention, two-generation, relational health.
Prevention and Support *Selective preventive interventions*	• Encourage use of more intensive and relational care coordination, building parallels to and using lessons from efforts for CSHCN. • Support spread and scale of models that augment pediatric primary care/ medical home either within health care settings or through linkages to services elsewhere in the community. • Fund cross-system training for home visitors, family specialists, community health workers, and child care workers on the basic components and competencies of the early childhood workforce.	• Finance tiered care coordination in managed care or fee-for-service arrangements, including more intensive care coordination/case management for families with young children who have medical complexity, social complexity, or both.[326] • Provide enhanced reimbursement for high performing medical homes that use team-based care and integrate evidence-based models such as Healthy Steps, and DULCE. • Use Medicaid financing to fund some home visiting services. • Use Medicaid financing to fund two-generation, dyadic, relational health interventions that are family focused and advance parent-child bonding, attachment, nurturing, and security.

Continuum of Services and Supports	Title V Roles and Opportunities	Medicaid Roles and Opportunities
Early Interventions and Mental Health Treatment	• Use Title V funds to provide training and QI projects that improve provider knowledge, attitudes, and practices related to early childhood mental health. • Use parent-to-parent and other organizations to inform families about the role of EPSDT and Medicaid in financing treatment and interventions. • Fund training projects and QI processes to support providers. • Partner with Medicaid to develop more specific guidelines and contract provisions related to coverage for early childhood mental health services. • Build on lessons learned from Project LAUNCH to sustain early childhood mental health initiatives using Title V dollars. • Support development of social-emotional and mental health responses in Part C Early Intervention programs. • Increase capacity for IECMH consultation to pediatric primary care providers/medical homes (e.g., through training, standards, certification, co-location, etc.). • Increase workforce capacity for delivery of parent-child, dyadic, mental health therapy using an array of models and practices, working in partnership with primary care providers, mental health providers, and other state agencies. • Fund training, diversification, and development of workforce capacity for evidence-based home visiting focused on social-emotional development and behavioral risks (e.g., Child First, ABC).	• Use EPSDT authority to structure benefits, billing codes, and prior authorization protocols to ensure coverage and financing of early interventions for young children without diagnoses. • Use guidance, provider manuals, and contract language to clarify Medicaid/EPSDT coverage for mental health interventions and treatment among young children, including billing for parent-child, dyadic service models. • Permit Medicaid billing for mental health and other health-related services in Part C Early Intervention program, Individualized Family Service Plans.[327] • Reimburse for IECMH consultation (virtual and in person) to pediatric primary care providers/medical homes. • Reimburse for parent-child, dyadic, mental health therapy under the child's Medicaid number, using expedited medical necessity determinations and/or expedited prior authorizations. • Reimburse for services delivered through integrated behavioral health in pediatric primary care providers/medical homes, including when co-located, on-site referrals, and same day services. • Clarify child/family rights under EPSDT, such as the range of treatment coverage, processes for appeals, and so forth.

Learning from Current State Action

State Policy and Program Examples

Across the country, over the past two decades, an increasing number of projects, initiatives, and partnerships have been formed to change policy, redesign programs, and improve clinical practice with the aim of improving social-emotional development and early childhood mental health. This section highlights examples of what has and can be done by states. At the same time, too many efforts are short-term pilots, limited in capacity by the number of providers or sites, or not sustained due to funding shortfalls. So, while there is nothing in Table 4 that is not done in some state today (even if only for CSHCN), most states do not have a well-rounded approach, using strategies across the continuum and assuring sustainable financing. **Virtually every state has an opportunity to improve using its Title V MCH and Medicaid programs**.

Scans of the Field by National Organizations

A study conducted by the National Center for Children in Poverty in 2000 found that state and federal dollars were already being used to finance early childhood mental health services to promote social-emotional development in young children.[328] These included:

1. screening and assessment for social-emotional concerns;
2. enhanced screening and assessment through placement of early childhood specialists in pediatric care settings;
3. early childhood mental health consultation for individual children;
4. early childhood mental health consultation and training for early childhood program staff;
5. relationship-based, parent-child dyadic therapy for families at risk;
6. specialized treatment in a variety of home and community settings;
7. care coordination and case management for children, particularly for those at highest risk (e.g., entering child welfare system); and
8. treatment for young children with serious emotional disturbances.

Looking at financing, this study found that several federal funding sources were being used, including: Medicaid, Title V MCH Block Grant, Children's Mental Health Services Program, Child Care and Development Fund, Temporary Assistance to Needy Families (TANF), and Part C Early Intervention Program. Many of these early childhood mental health policy and finance innovations have been adopted by other states over the past two decades.

As discussed earlier in this brief, many states are currently using Medicaid in some way to support social-emotional development and early childhood mental health interventions; however, the opportunities inherent in the EPSDT benefit to support the full continuum have not been fully implemented in most states. Surveys conducted by the National Center for Children in Poverty have documented how many states are using Medicaid to finance screening, diagnostic, treatment, as well as navigators and parenting programs related to social-emotional development and mental health needs.[329,330,331] For example, in 2018, state Medicaid agencies covered the following services along the continuum from promotion to treatment used in this guide.

- Parenting programs designed to promote children's social-emotional development or mental health needs (16 states). Some states require that the child or family have risk factors or diagnoses to be approved for coverage of these programs.
- Screening for social-emotional development using a specific tool (43 states), often having a separate code for this service (23 states). Only 20 states required use of a validated social-emotional developmental screening tool.
- Screening for maternal depression during well-child visits billed under the child's Medicaid (32 states), with most requiring use of a validated depression screening tools (20 states).
- Use of the DC:0-5 (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, or the previous version DC:0–3R) to better identify and code mental health conditions among young children (13 states permit providers to use).
- Early childhood mental health services provided by a mental health clinician when delivered in primary care (47), although the extent of specific benefits and amount, scope, and duration of coverage varied substantially. For example, 45 states covered screening and diagnostic assessment, and 44 covered treatment by a mental health clinician integrated into the primary care setting.
- Requirements for a determination of medical necessity for early childhood mental health treatment (40 states). Most states did 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.
- Interventions covered for young children with or without diagnoses. While most states required 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. Coverage for mental health services in the primary care setting may be triggered by different factors, such as when: a parent or provider had a concern (14 states), a child had a positive social-emotional development screen (22 states), or a DC:0-5 diagnosis (9 states). Notably, some states permitted treatment without a diagnosis for the child when there are family factors (e.g., maternal depression) that make it likely the child's development will be affected (24 states).

- Parent-child dyadic therapy covered (42 states). States varied regarding coverage by settings, type of providers, and/or therapy models, with a majority permitting billing by mental health clinics (41) and primary care practices (35). Some states (11) used specific billing codes for these services. States generally required a determination of medical necessity for parent-child dyadic therapy, and some specify evidence-based practices covered.

Looking at the field, ZERO TO THREE and the Georgetown Center for Children and Families worked together to identify examples of how policy, program, and practice is being advanced through state leadership.[332,333] For the efforts described, building an infant/early childhood mental health (IECMH) system is often the focus, and many states have accelerated workforce development. States successful in expanding use of Medicaid financing had clear and active engagement of Medicaid leaders, in addition to engagement from the state children's mental health leadership, state Title V MCH programs, providers, and family advocates. States have advanced development and financing for IECMH consultation services to early care and education settings or home visiting programs; however, few have focused on consultation to pediatric primary care providers. Leadership mattered in every successful effort. Some of these leaders are long time visible actors and advocates in successful early childhood system efforts.

Some examples from one cohort of IECMH state initiatives focused on strategies for financing IECMH assessment, diagnosis, and treatment include the following:[334]

- Coverage of a continuum of IECMH services (e.g., Minnesota).
- Coverage and incentives for maternal depression screening in well-child visits (e.g., Colorado, District of Columbia, Illinois).
- Crosswalks to or adoption of DC:0-5, with billing codes and other processes (e.g., Nevada, Minnesota, and Oregon).
- Adopting codes for parent-child relational problems (e.g., Oregon).
- Language in Medicaid contracts with managed care organizations and accountable care organizations.
- Reimbursement for multiple visits for extended diagnostic assessment of complex needs (e.g., Minnesota, New Mexico, and North Carolina).
- Coverage for IECMH visits in primary care or mental health settings without a qualifying mental health diagnosis (e.g., Colorado).
- IEMCH included in a Medicaid 1115 waiver application (e.g., Alaska).

Most recently, results from the ***Improving Screening Connections with Families and Referral Networks (I-SCRN)*** project show the potential for using a QI collaborative approach (i.e., using the Institute for Healthcare Improvement Breakthrough Series learning collaborative design and its Model for Improvement)[335] to make significant progress in just one year. All 19 participating practices reached and sometimes exceeded the collaborative aims. Large and statistically significant improvements were demonstrated in screening for general development (60 percent to 93 percent), Autism Spectrum Disorders (74 percent to 95 percent), maternal depression (27 percent to 87 percent), and SDOH (26 percent to 76 percent). Practices that implemented social-emotional development screening also demonstrated large improvements (50 percent to 83 percent), and discussion with parents and caregivers of screening results related to social-emotional development also increased substantially (63 percent to 92 percent). Referrals for positive screening results improved in all areas; however, as in many prior studies, referral follow-up did not improve consistently.[336] Parents or caregivers reported screening more frequently after the collaborative efforts. The compelling and positive results of this strong, cross-site study point the way for state agencies, MCOs, child health improvement projects, and state AAP chapters to develop and use QI collaboratives to improve screening and responses.

Selected State Examples

Groundbreaking shifts in policy. Some longstanding efforts and emerging strategies are notable for representing shifts in the field. For example, back in the early 2000s, **Florida's** Medicaid agency changed the service description for children's mental health "individual therapy," renaming it "individual and family therapy" to extend coverage to parent-child dyadic therapy, including therapy with the parent and child together, the parent alone without the child present, or the child alone as appropriate. 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 the state. After Florida secured federal approval from CMS for this approach to using Medicaid to appropriately finance parent-child dyadic therapy, Colorado, Minnesota, and dozens of other states followed their lead.

In California, the UCSF/Zuckerberg San Francisco General Hospital and Trauma Center Children's Health Center, in collaboration with The California Children's Trust, have launched a pilot program to pay for dyadic, family therapy services under the Mild to Moderate Mental Health Benefit administered by California's Medi-Cal Managed Care Organizations. This created the potential for using Medicaid financing for appropriate and recommended dyadic services for millions of families with young children.

Progress and expansion through sustained, strategic effort and leadership. Colorado has been a leader in early childhood over the past 15 years. Since 2006, ***Colorado's Assuring Better Child Health & Development (ABCD) initiative*** has been a leader working to remove barriers for children related to developmental services. In 2011, ABCD encouraged Colorado Medicaid to change the Medicaid reimbursements for developmental screenings. (Many states in the ABCD project initiated or increased

separate payments to stimulate use of developmental screening.) Prior to that time, primary care practices were being reimbursed for screening but there were no standards or generally agreed upon tools. In 2012, ABCD became the state coordinator to scale and spread the HealthySteps model. ABCD supports primary care providers in implementing QI projects (e.g., related to child development and maternal depression). ABCD also was positioned in recent years to share best practices with the state's Medicaid agency's Accountable Care Collaborative and build upon coordinated early childhood systems in ABCD communities. Colorado also is a national leader in early childhood mental health. These successes include the 2015 Early Childhood Mental Health Strategic plan the state's implementation of Project LAUNCH, inclusion of pediatrics in the Medicaid State Innovation Model (SIM), and creation of an early childhood mental health system. The result by 2017-18 was a $62 million investment in 12 programs focused on early childhood social-emotional development and mental health, including $37 million for targeted supports and services (e.g., home visiting, early childhood mental health specialists, HealthySteps, Incredible Years), $21 million for intervention and treatment, and more than $3 million in systems development. Through the State Innovation Model (SIM) project, Medicaid has played a strong role in these efforts, particularly by providing capitated payments for core behavioral health services that permit more flexibility and more focus on prevention and early intervention. The project also provides technical assistance to pediatric primary care providers and community mental health centers to improve service quality and move the focus toward upstream prevention. The MCH program leveraged funds from the State Innovation Model Grant to fund a Children and Families Behavioral Health Integration Specialist, who served as the MCH Implementation Team lead. Title V MCH Block Grant dollars funds ABCD to provide technical assistance to local public health agencies early childhood development efforts, as well as training for pediatric primary care providers, home visiting programs, and others. MCH led the formation of an Early Childhood Screening and Referral Policy Council, which advances systems change to improve service coordination and promote optimal child development for children (birth through five) to receive developmental screening and referral to appropriate services.

> "We need to move upstream with structures and financing. Oregon's state health improvement priorities for 2020-2024 are focused on: (1) equitable access to preventive health care,(2) institutional bias, (3) ACES, trauma and toxic stress, (4) economic drivers of health [i.e., social determinants of health], and (5) behavioral/mental health."
>
> **— Cate Wilcox, Oregon Title V director (interview)**

Building on an equity initiative. In ***Rhode Island, Health Equity Zones (HEZ)*** are partially funded through the Title V MCH block grant and funding is categorized across population domains. The HEZ initiative supports local communities that have documented health disparities, poor health outcomes, and poor social and environmental conditions. HEZ's are funded to identify and prioritize health issues, develop and implement plans of action, and monitor and assess success. A braided funding approach to supporting the HEZs is used with the Rhode Island Department of Health allocating the amount to be charged within the infrastructure budget to each funding stream, using both state and federal dollars. This funding can be used

to support multiple MCH projects including but not limited to: breastfeeding support groups; community health workers; parent engagement/education (e.g., Parents As Teacher, Incredible Years, Familias Unidas); mental health; infant health (e.g., Project LAUNCH, collaboration with Family Home Visiting Programs); and social determinants of health (e.g., food, housing, stress, built environment).

Connecting early childhood systems and Medicaid through policy, finance, and practice structures. Over the last decade, Oregon has developed an innovative coordinated care and early childhood system model that brings unique opportunities for early childhood and health care transformation: Coordinated Care Organizations (CCOs) and the regional Early Learning Hubs. With the state's continued Oregon Health Plan (Medicaid) innovation, the latest contracts with the state's 15 CCO's prioritize work in four key areas: improve the behavioral health system; increase value and pay for performance; focus on SDOH; and maintain sustainable cost growth. The state's 16 Early Learning Hubs are also focused on organizing and reporting on aligned local early learning activities. These two policy structures are charged with coordinating their efforts to improve the outcomes for children and families, and are increasingly data driven with the rich data on Child Health Complexity from the Oregon Pediatric Improvement Partnership (OPIP). Using this public data, the CCO's are now charged with developing innovative value-based purchasing models of investment and incentives, in partnership with community leaders and medical homes. Planning is underway to make progress toward improved social-emotional health and kindergarten readiness, by managing upstream SDOH, stratified population risks, and effective use of measurement. The CCO's are required to spend a portion of their net income or reserves on SDOH and health equity, directed to community efforts and partnerships to achieve improved outcomes. To do so, the CCO's have active child health advisory teams focused on generating the financing and accountability models of child health care coordinated with the local hub/ communities. In addition, Title V and local public health agencies are simultaneously developing the integration and implementation of the Family Connects Oregon, a universal home visiting model, within the CCO 2.0 and Early Learning Hub structures. This will contribute to greater engagement of and support for families who have infants. The Governor's commitment to the value and use of the public Oregon Child Integrated Dataset (OCID) to inform policy and decisionmaking to improve the well-being of Oregon's children is a unique and groundbreaking next step.

> "It is past time for us to address the systemic and operational barriers that prevent individuals and their families from getting the right support at the right time."
>
> **— Oregon Governor Kate Brown, 2018**

Innovations driven by partnerships. Since the mid-1980s, the Vermont Medicaid agency and the Title V MCH program have been a national example of collaboration, including innovative use of Medicaid administrative claiming dollars and a role for Title V in administration of EPSDT. The Vermont Child Health Improvement Project (VCHIP) was started in 1998 based on ongoing collaboration between the state Title V program, the Medicaid agencies, the Vermont Chapter of the American Academy of Pediatrics, the Vermont Academy of Family Physicians, and the University of Vermont Department of Pediatrics. Through this and expanded partnerships, VCHIP

has become an anchor and a driver for a long series of initiatives related to preventive services, child health quality improvement, and implementation of the Bright Futures Guidelines. VCHIP is supported in part by Medicaid administrative claiming. Vermont also has implemented Help Me Grow to advance systems level efforts to increase collaboration and communication between medical homes and other early childhood providers. The Building Bright Futures partnership keeps results-based accountability and early childhood systems development going across 12 regions of the states. The Early Childhood Learning Innovation Network for Communities (EC-LINC) team in Lamoille and Central Vermont Regions is a strong, coordinated, and innovative rural early childhood system, including a Parent Child Center, a Help Me Grow network, and a DULCE site. Recently, Vermont's Accountable Care Organization (ACO) has undertaken efforts to expand community sites for DULCE, promote developmental screening, and connect with VCHIP. The goal of Vermont's Medicaid Next Generation Model ACO program is to improve the quality of care and curb health care cost growth. Under Vermont's model, the ACO must meet minimum quality performance targets for a selected measure set in order to qualify for payment from the ACO's Quality Incentive Pool. Notably, Vermont has aligned measure sets across payers under an all-payer model agreement. The pediatric measures include the developmental screening measure from the CMS Core Child Measures, with reporting based on claims data.[339] This effort dovetails with Vermont's early childhood scorecard and the comprehensive developmental screening data collection and communication system (aka Universal Developmental Screening registry). Through these efforts, pediatric primary care providers, Parent Child Centers, DULCE family specialists, mental health agencies, and others are coming together at the community level across Vermont to promote health and development. The state Title V program and Medicaid are involved in every component of these efforts, with guidance, funding, encouragement for service integration, and focus on high-quality services for families with young children.

Opportunities to Use Medicaid Managed Care Contracts to Promote Social-Emotional Development

The InCK Marks project has worked with George Washington University legal and health policy researchers to identify examples of Medicaid managed care contract language related to the transformation of health care for young children. InCK Marks is completing an analysis and working paper regarding Medicaid contract language, with a focus on advancing child health care transformation and high performing medical homes. For purposes of this guide, the following examples illustrate 10 areas related to the framework and continuum for promoting social-emotional development. State Medicaid agencies—in partnership with state Title V MCH programs, health plans, providers, and families—have the opportunity build upon and modify existing Medicaid managed care contract language in order to address the following:

1. **Medical homes and systems of care for children, modifying language for children with special health care needs to include all children.**

   - **Rhode Island:** "2.07.08 Care Transformation Collaborative of Rhode Island: Contractor is required to participate both financially and operationally in the Care Transformation Collaborative of Rhode Island (CTC-RI), including Patient-Centered Medical Home for Kids (PCMH-Kids)…"

- **West Virginia:** "Make all reasonable efforts to assure that all enrolled enrollees with special health care needs, ages zero (0) to twenty-one (21), have access to a medical home and receive comprehensive, coordinated services and supports pursuant to national standards for systems of care."

- **Virginia:** "The Contractor shall develop a comprehensive Infant Care program for the provision of services to infants ages 0-3 years... The Contractor must ensure that in the provision of services the Infant Care program any strategies and innovations implemented align with and advances the following goals: ... Infant and early childhood mental health, including trauma-informed care, ACES and resilience."

2. **Title V and Medicaid collaboration to improve implementation of EPSDT, modifying language to include children with and without special health care needs.**

   - **West Virginia:** "Coordination with the Title V State Agency - The MCO, through BMS, will coordinate with the Bureau for Public Health (BPH), Office of Maternal, Child and Family Health, to: 1. Make all reasonable efforts to assure that all enrolled enrollees with special health care needs, ages zero (0) to twenty-one (21), have access to a medical home and receive comprehensive, coordinated services and supports pursuant to national standards for systems of care for children and youth with special health care needs; 2. Make all reasonable efforts to assure better access to and receipt of the full range of screening, diagnostic, and treatment services covered under EPSDT; 3. Improve the rates and content of well-child visits; 4. Improve care coordination for children with special health care needs, particularly those with multiple systems of care in place; 5. Make all reasonable efforts to assure Medicaid children and their established plans of care are being met."

3. **Developmental screening, modifying language to include the range of screening defined in Bright Futures Guidelines 4th edition.**

   - **Iowa:** "In covering well-child visits, the Contractor shall follow the latest guidance from the American Academy of Pediatrics (AAP)."

   - **Minnesota:** "The MCO must: ... services include up to three (3) maternal depression screenings that occur during a pediatric visit for a child under age one (1). The STATE recommends the initial maternal screening within the first month after delivery, with a subsequent screen suggested at the four-month visit."

   - **New Hampshire:** "The MCO shall require that PCPs that are Participating Providers include all the following components in each medical screening [EPSDT well-child visit]: Comprehensive health and developmental history that assesses for both physical and mental health,...; Screening for developmental delay at each visit through the fifth (5th) year using a validated screening tool;..."

   - **North Carolina:** "Require that participating primary care providers include all of the following components in each medical screening [EPSDT well-child visit]. a) Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP)... described in Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents. 1. Screening for developmental delay at each visit through the 5th year;..."

4. **Social determinants of health (SDOH) screening, including a specific focus on children.**

   - **Louisiana:** "Where an enrollee is a child, the HNA [Health Needs Assessment] shall be completed by the enrollee's parent or legal guardian… The Contractor's HNA shall: … Screen for needs relevant to priority social determinants of health as described in the Population Health and Social Determinants of Health…"

5. **Anticipatory guidance and parent education, including response to screening results.**

   - **Tennessee:** "Health education which includes anticipatory guidance based on the findings of all screening. Health education should include counseling to both members and members' parents or to the legally appointed representative to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention."

6. **Medical necessity definition, including prevention, maintenance, and improvement of health.**

   - **New Hampshire:** "For Members under twenty-one (21) years of age, per EPSDT, the following definition of medical necessity shall be used: "Medically Necessary" means any service that is included within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act, regardless of whether such service is covered under the Medicaid State Plan, if that service is necessary to collect or ameliorate the defects and physical and behavioral illnesses or conditions."

   - **New Jersey:** "Medically Necessary Services--…In the case of pediatric enrollees, this definition shall apply with the additional criteria that the services, including those found to be needed by a child as a result of a comprehensive screening visit [EPSDT well-child visit] or an interperiodic encounter whether or not they are ordinarily covered services for all other Medicaid enrollees, are appropriate for the age and health status of the individual and that the service will aid the overall physical and mental growth and development of the individual and the service will assist in achieving or maintaining functional capacity."

7. **Case management /care coordination with tiered approaches, modifying existing language used for CSHCN, high-risk pregnant women, and others with complex medical and social needs.**

   - **Delaware:** "Care coordination provided to link children and their families to needed medically-related services, and coordination with relevant agencies that provide those services; consultation with the child, family members, and family social network in the development of the child's integrated health and behavioral health treatment plan."

- **Louisiana:** "Intensive Case Management for High Risk Enrollees (High) (Tier 3) Enrollees engaged in intensive case management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. A plan of care shall be completed in person within thirty (30) calendar days of identification…"

- **Washington State:** "…when the Contractor receives notification or identifies children requiring mental health treatment, including behavioral intervention to treat autism, the Contractor will, as necessary:… 14.15.2.1 Coordinate mental health treatment and care based on the child's assessed needs, regardless of referral source, whether the referral occurred through primary care, school based services, or another provider; 14.15.2.2 Follow-up to ensure an appointment has been secured; and 14.15.2.3 Coordinate with the PCP regarding development of a treatment plan, including medication management. 14.15.3 The Contractor will submit a report to HCA of Children who have been identified as needing mental health care and appointment status."

8. **Collaboration with Part C Early Intervention programs.**

   - **California:** "…Contractor shall develop and implement systems to identify children under 3 years of age who may be eligible to receive services from the Early Start [Part C] Program and refer them… These include children who have a developmental delay in either cognitive, communication, social, emotional, adaptive, physical, motor development, including vision and hearing, or a condition known to lead to developmental delay, or those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. Contractor shall collaborate with the local [Part C] Program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start [Part C] Program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed… with Primary Care Provider participation."

9. **Collaboration with an array of community-based entities.**

   - **Kentucky:** "The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies, community-based health/social agencies and health care delivery systems to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives."

   - **Washington State:** "Clearly defined roles and responsibilities of the allied systems in helping Enrollees served by more than one system. For children this includes EPSDT coordination for any child serving agency and a process for participation by the agency in the development of a cross-system ISP [Individual Service Plan] when indicated under EPSDT…"

10. **Encourage use of child health measures and measurement approaches, including the CMS Child Core Measures and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Child Survey**

- **Arizona:** "Quality Improvement Performance Requirements: The Contractor shall monitor and report all CMS Children's Core Set measures, as applicable, and may be required to monitor and report select NCQA HEDIS® or other AHCCCS-required measures, as mandated by AHCCCS, for the applicable Contract Year."
- **District of Columbia:** "Contractor shall use performance measures including, but not limited to, HEDIS®, CAHPS®, Provider surveys, satisfaction surveys, CMS [Centers for Medicare and Medicaid Services]-specified Core Measures, EPSDT, Clinical and Non-Clinical Initiatives, Practice Guidelines, Focused Studies, Adverse Events, and all External Quality Review Organization (EQRO) activities as part of its QAPI program."
- **Georgia:** "Value Based Purchasing Performance Measures and Targets - Georgia Families Core Measures. Performance Measures: Preventive Care for Children: 1) Well-child visits in the First 15 Months of Life – 6 or more visits; 2) Preventive Care for Children: Childhood Immunization Status – Combo 10; 3) Developmental Screening: Developmental Screening in the first three years of life;..."
- **Louisiana:** "Quality Performance Measures.... 1. Well-Child Visits in the First 15 Months of Life; 2. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life; 3. Adolescent Well-Care Visits; ... 12. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version (Medicaid); ..."

Pediatrics Supporting Parents Requires Family Engagement

To achieve optimal child health and development, pediatric primary care providers must engage, listen to, and respect families.[340,341] Authentic and effective engagement of families has been shown to positively influence the care process and its outcomes.[342] Families should be involved in decisions in the care process, related to the design of services, and at the systems level.[343,344]

Through CSSP's years of work in developing and using the Strengthening Families Protective Factors framework, in defining the importance of foundational relationships,[345,346] and in working with Robert Sege on the Health Outcomes from Positive Experiences (HOPE) initiative,[347,348] we know the importance of shifting to primary care approaches that promote well-being through positive relationships, interactions, and environments. These approaches are fundamentally grounded in being engaged with families and focused on co-creating supporting, culturally sensitive and anti-racist solutions that assist them in caring for their children and helping their families to thrive. This work is grounded in science that tells us about the importance of parental well-being to children's health and development.[349]

> "Not every child is getting the right care. Screening and systems don't always work well for Black, Indigenous, and People of Color (BIPOC). Some problems are overidentified, some things go under the radar due to lack of cultural competence and racism. Behavioral problems in preschool and 1st grade begin the school to prison pipeline. Maximizing family engagement in the medical home is a great unfulfilled opportunity, including engagement of fathers."
>
> **— Kenn Harris, National Institute for Children's Health Quality (interview)**

Listening to Parents

Through the PSP Initiative, CSSP has partnered with Family Voices—a national family-led organization that advocates for children's health care—to ensure that the experiences and perspective of families inform this guide and related work. Despite the COVID-19 pandemic and the increased stress on families, hundreds of parents participating across eight states were willing to participate in focus groups and interviews to share opinions and feedback.

Family Voices facilitated eight focus groups with parents who children receive Medicaid health benefits. Within these focus groups, parents shared experiences, recommendations, resources, and emotional support with one another, demonstrating the power of parent-to-parent connections and advocacy for children. Across diverse geographies and backgrounds, parents in the focus groups expressed remarkably similar concerns about services they received that are designed to promote and support the social and emotional health of young children through the pediatric medical home. While some families had positive experiences to report, most of the focus group participants expressed dissatisfaction with the process. Key concerns included the following:

- Primary care teams were inattentive to and/or did not listen to families' concerns.
- Families felt rushed during primary care visits, with little time for relationship building with providers.
- Communication between families and providers was ineffective, with confusing messages, medical jargon, and attitudes affecting communication. There was also poor communication within the practice among front office staff, nurses, and physicians.
- Interactions with providers reflected a lack of respect, including parents' feeling ridiculed when expressing concerns, being looked down upon for having low income, or experiencing bias due to race or ethnicity.
- Developmental screenings were considered just a checklist "to get through" with no discussion of results or interventions for helping a child improve in areas of concern.
- Parents/caregivers had to advocate for needed developmental and behavioral care for their children, often facing pushback or lack of attention by the provider.
- The "wait and see" culture in the medical community, which leads to a lack of action even when risks and concerns are identified among young children.
- An absence of trust between providers and families, including pediatric primary care providers, home visitors, and others.
- A lack of effective referrals and follow-ups on developmental screenings (when they did occur).
- Primary care providers seemed reluctant to provide diagnoses, but also did not to provide referrals to specialist who might be able to diagnose and provide a treatment plan
- Limited connections or linkages between primary care providers and other community supports or resources, as well as referrals to services not covered by Medicaid. Parent often felt responsible for finding supports and services on their own.

Most participating parents felt that generally pediatric primary care providers are not responsive and not using developmental and other screening in useful and appropriate ways. One parent captured this well, saying: providers "*are checking off things on a paper, but not personalizing it to my child, and does not take environmental factors into account. [The provider] just asks if [child is] doing or not doing stuff. My baby is a little behind with talking, but the doctor does not offer suggestions for helping and doesn't take my concerns seriously or say anything to less my concerns.*" Another parent expressed frustration with the process for screening and follow up: "*I get the same paperwork at visits and fill it out, but if my child is lacking in an area, [the doctor] do not address. I want to know what I can do to address, but no follow up for what I want from the doctor.*" And another parent described how the services were not strength-based or responsive, saying: "*Developmental screenings seem like checking off of a list, and if [my child] didn't meet some milestone, I ask if my daughter is okay. [Staff] is quick to point out stuff my daughter isn't doing, but don't say anything positive about what she is doing.*"

Barriers related to receiving services covered by Medicaid was another theme. Parents report that it is difficult to navigate the Medicaid system and the health care system. The focus groups pointed to a lack of information such as coverage for health-related transportation, as well as what diagnostic and treatment services are covered. Many reported problems with finding a provider who accepted Medicaid, particularly for special tests or services. National studies show this is a pervasive issue.[350]

In addition, specifically to inform this guide, Family Voices conducted four key informant interviews with parent leaders who have years of experience in systems development and advocating for policy change on behalf of young children. Key informant interviews echoed many of these concerns at a policy level. They called for:

- Removing administrative and other barriers to eligibility, benefits, and access to services for children (e.g., eligibility paperwork, waiting lists for providers, lack of information sheets for families);
- Training for providers to address implicit bias, ensure cultural humility, and develop authentic partnerships with parents;
- Scaling of services without duplication across agencies; and
- Sustainable financing for family specialists, peer support, community health workers, and other staff that are focused on supporting young children and their families within the medical home.

> "We can engage families by using better communication, appropriate tools, and parents as true advisors to practice and policy level decisions."
>
> **— Marian Earls, MD, FAAP (interview)**

Pediatric Primary Care Provider Action to Engage Families

The *Common Threads* report emphasizes that parental well-being and family engagement can be advanced in multiple ways through the process of pediatric primary care. Some examples include the following:

- Co-create goals with the family.
- Incorporate questions about parents' well-being in the well-visit and screening process.
- Observe and recognize parents' well-being as a strength.
- Provide services along the continuum, including promotion, screening, referrals, and linkages for services needed to address parental risks and parent-child outcomes.
- Offer verbal and written guidance about social-emotional development and parent-child relationships, including strengths-based observations and positive feedback.
- Use family specialists trained in child development and early relational health.
- Connect families to community resources and supports such as parenting support and education groups that can help to reduce stress and improve parental mental health.
- Develop or refer to opportunities for families to connect with other families for peer support.

Roles of Title V and Medicaid in Advancing Family Engagement

Federal and state Title V leaders have a long history and commitment to family engagement and leadership. This is a strength that can be expanded to ensure that diverse families are engaged in policy and program decisions at all levels across Medicaid as well. Partnering and leveraging the family-led organizations in each state is a place to start. States can invest in family led organizations and build on existing family-to-family organizations to provide support to families whose children do not have an identified special health care need. This will allow for maximizing opportunities for families to connect with other families for peer-to-peer support and inform families about the role of EPSDT and Medicaid in financing treatment and interventions. As states expand the community health worker workforce, family- led organizations can play a critical role in recruitment, training, and mentorship of diverse parents who have navigated systems and are trusted community members. At the policy level, family-led organizations can partner to train and mentor family leaders to participate in policy planning, implementation and evaluation. The Family Engagement in Systems Tool, developed by Family Voices, provides a framework to support agencies in facilitating authentic, meaningful, and productive partnership with family leaders. As one parent leader shared: "*I don't want to be a seat filler. I want to be prepared for the seats I fill. I can remember sitting at Board of Directors' meetings hearing how to spend $1M when families don't even have $100. [We] have to prepare people to be in their role.*"

Conclusion

Our analysis of federal law, state policy, agency action, and research points to the untapped potential to use Title V and Medicaid to promote the social-emotional well-being of children. This guide shows how every state has opportunities to improve the finance and delivery of pediatric primary care in order to better support parents and improve social-emotional development in ways that have lifelong impact. The specific policy, program, and practice opportunities described here point the way for action by state Title V MCH programs, by state Medicaid agencies, and by the two in partnership.

Many existing efforts contain the seeds for moving beyond where things stand today. Major opportunities for change point in three directions. First, every state can expand efforts to support pediatric primary care providers role in promoting social-emotional development and relational health through use of Medicaid and Title V. More promotion and prevention activities in the context of well-child visits is one key step. Second, encouraging the use of strategies that support medical homes for CHSCN in ways that will advance high performing medical homes for young children in Medicaid. Many states have care coordination programs, Medicaid managed care contract provisions, provider training, and other efforts that advance use of the medical home. These should be extended. Third, states can enhance IECMH efforts to include more promotion and prevention efforts linked to primary care, in addition to treatment and consultation for those with identified conditions. In some cases, existing early childhood mental health providers or consultants can be embedded or linked to pediatric primary care/ medical homes. These changes proposed in this guide will require action by state and local agencies, health plans, providers, and family leaders.

These should be intentional efforts, designed to advance equity, reduce provider bias, and eliminate the disparities driven by racism. If more than 40 percent of young children are covered by Medicaid and CHIP, then this is the place to start building a future with equity in health and well-being.

Appendix A: Project Methods

This guide is based on information gathered in several phases and from an array of sources. These were adjusted to fit with the state of the field during the COVID-19 emergency.

First, in March 2020, a detailed review of the literature was conducted for four topics: 1) strategies to promote social-emotional development in pediatric primary care; 2) evidence-based programs, models, and tools related to promoting social-emotional development; 3) EPSDT/Medicaid; and 4) early childhood mental health. This review included five reports on social-emotional-mental health published by the National Academy of Sciences, as well as many national organization reports and online compilations of evidence-based and best practices. This resulted in identification of the many elements in Table 3 and 5, as well as the extensive references throughout this document.

Second, in June 2020, we conducted a scan of state programmatic documents using the Title V Information System (TVIS), including searches for text related to Medicaid, child health, pediatric primary care, medical home, development, and early childhood mental health. The scan focused on each states' Title V annual reports and applications for 2020, specifically the overview, section on child health, and budget narratives. Another search looked at state Title V priorities using similar search terms.

Third, using the Medicaid managed care contract provisions extracted by George Washington University for the InCK Marks project, we conducted an analysis to identify relevant sections. These were separately summarized.

Fourth, throughout the summer, interviews were conducted with state Title V MCH leaders, family leaders, and subject matter experts. One standard interview guide was developed for professional interviews, with a separate but related guide for family leaders. In terms of subject matter experts, individuals were recruited are recognized for their leadership in pediatric primary care, early childhood mental health, and/or Medicaid's role in early childhood. State Title V MCH leaders were identified on the basis of the TVIS scan and knowledge of their states' efforts to promote social-emotional development and early childhood health and well-being. Family leaders interviewed were identified from a pool of individuals with experience in review of Title V programs and policies, as well as health care systems knowledge. The individuals who participated in these interviews are identified by name in the acknowledgements.

Other data (e.g., well-child visit data for maps, Title V expenditure data) were gathered specifically for this guide from federal program websites. They are the most recent available data at the time of publication of this guide.

Finally, for framing this guide and its principles, we relied on previous reports prepared for the PSP initiative, as well as prior projects of CSSP and Johnson Group Consulting.

Appendix B. Examples from a Review of Title V Information System Content Related to Title V-Medicaid Partnerships to Improve Access to Pediatric Primary Care and Promote Social-Emotional Development and Early Childhood Mental Health

Below are quotes extracted from the Title V Information System (TVIS) that offer examples of how state Title V MCH programs are partnering with Medicaid in efforts to increase access to medical homes, expand use and response to an array of developmental screening, and strengthen early childhood systems. A few examples focus specifically on promoting social-emotional development, while others are related to early childhood mental health efforts. These examples were selected to illustrate particular opportunities and do not represent all that these or other state Title V MCH programs are doing. Most are extracted from state plans or state reports.

Colorado: "The state Medicaid program, located within the Department of Health Care Policy and Financing, implemented the Accountable Care Collaborative (ACC) program in 2011 to build a comprehensive statewide network to support a medical home infrastructure for all enrolled members. This program originally included seven Regional Care Collaborative Organizations (RCCOs) to support community-based solutions to care. The responsibility of each RCCO was to develop a comprehensive network of primary care medical providers, build relationships with specialists, collect, and analyze data to support population health, and provide care coordination for members. ...The MCH program collaborates with the state's Medicaid program and is specifically included in the interagency agreement between CDPHE and the state's Medicaid agency."

An illustration of the federal-state Title V partnership in action is through the medical home priority. To implement the strategies in the medical home action plan, Colorado's MCH program braids MCH block grant funds with state general funds to support the policy and system change strategies focused on the following three areas: Improved communication and collaboration across statewide programs that deliver care coordination for children and youth; Increased access to pediatric specialty care, including behavioral health; Improved access to information and resources for children and youth.

Connecticut: Title V and their partners were engaged in the emerging State Innovation Model and plan to advance a role in the design of Accountable Care Communities. The model encompasses a strategy to promote shared accountability among key stakeholders and includes the following approaches to improve community health.... A cornerstone of the innovation plan is supporting the transformation of primary care to the Advanced Medical Home (AMH), a care delivery model comprising five core elements: 1) Whole-person-centered care—care that

addresses the full array of medical, social, behavioral health, oral health, cultural, environmental, and socioeconomic factors that contribute to a consumer's ongoing health; 2) Enhanced access—an array of improvements in access including expanded provider hours and same-day appointments; e-consult access to specialists; non-visit methods for accessing the primary care team; clear, easily accessible information; and care that is convenient, timely, and linguistically and culturally appropriate; 3) Population health management—use of population-based data to understand practice sub-populations (e.g., race/ethnicity), panel and individual patient risk, and to inform care coordination and continuous quality improvement, and to determine which AMHs are impacting health disparities, for which conditions and for which populations; 4) Team-based coordinated care: multi-disciplinary teams offering integrated care from primary care providers, specialists, and other health professionals. An essential element in what makes this work is the combination of behavioral healthcare with medical care, whether through co-location, referral linkages, or as part of a virtual team; 5) Evidence-informed clinical decisionmaking: applying clinical evidence to healthcare decisions using electronic health record (EHR) decision support, shared decisionmaking tools, and provider quality and cost data at the point-of-care to enable consumer directed care decisions. A key enabler of transformation will be the shift from purely fee-for-service payment, which rewards providers for delivering a greater volume of services, to value-based payment, which rewards providers for delivering high-quality care and a positive consumer experience, while reducing waste and inefficiency.

District of Columbia: "DC Health collaborates with Department of Health Care Finance (DHCF), the District's Medicaid agency, in a variety of ways with the goal of improving maternal and child health outcomes....Other examples of collaborations with DHCF include: Help Me Grow, the comprehensive and integrated system designed to address the need for early identification of children at risk for developmental and/or behavioral problems, is funded primarily by DHCF through an inter-agency MOU.... Title V continued to provide staff oversight of the Help Me Grow (HMG) program in FY18. HMG provides services to District residents through a comprehensive and integrated system designed to address the need for early identification of children at risk for developmental and/or behavioral problems."

Florida: "To increase the percentage of parents who read to their young children, Title V funding was provided to county health departments..., with an option to create a reading rich environment in waiting room areas such as a child's reading table and chairs, a bookshelf, children's books, etc. Funds were also available to establish a Reach Out and Read (ROR) program. ROR is an evidence-based early intervention model that encourages literacy and school readiness. ROR gives young children a foundation for success by incorporating books into pediatric care and encourages families to read aloud together. ROR medical providers encourage families to read aloud and engage with their infants, toddlers, and preschoolers every day. Additionally, medical providers give books to children at more than 10 well-child visits from infancy until they start school."

Hawaii: "As part of the Department of Human Services (DHS) health transformation efforts Ohana Nui (ON), the state Medicaid program ('QUEST') released a new waiver application/plan for public review and input: the Hawaii Ohana Nui Project Expansion (HOPE) program. The HOPE plan is a five-year initiative to develop and implement a roadmap to achieve the vision of healthy families and healthy communities. To accomplish this overall goal, it was necessary to align government agencies and funding around a common framework: a multigenerational, culturally appropriate approach that invests in children and families over the life-cycle to nurture well-being, and improve individual and population health outcomes.... [The state] is aligning Title V goals and objectives with the Medicaid program around this groundbreaking initiative."

"Hawaii has many engaged partners willing to promote developmental screening, who recognize the importance of timely access to services and supports if a delay is identified. Both the Department of Health Strategic Plan and the Executive Office on Early Learning's Early Childhood State Plan have identified developmental screening as a key priority. By working together to address this issue, providers and partners are now more aware of the importance of developmental screenings using a validated screening tool and ensuring that referrals are timely and communicated with the medical home. More work can be done to promote a more seamless system of screening and referral.... Partnerships with the American Academy of Pediatrics—Hawaii Chapter and Medicaid also help to share consistent information about the screenings and referrals including the availability of the online ASQ through the Hi`ilei program."

Idaho: "The Idaho Divisions of Public Health and Medicaid are both located within the Idaho Department of Health and Welfare, which enhances shared opportunities for systems-building and policy development. The current Memorandum of Understanding between the Divisions of Public Health, Medicaid, and Welfare... seeks to improve public health service delivery and public health outcomes for low-income populations. Specifically, the divisions share available data; coordinate administration of programs designed to improve the health of women of child-bearing age, infants, children and children and youth with special health care needs (CYSHCN); and coordinate implementation of policies that affect shared populations. In addition, the Title V MCH Program coordinates with Medicaid to promote awareness of programs, promote healthy behaviors, and facilitate referrals to appropriate benefit programs, with an emphasis on CYSHCN.... The MCH Program contracts with two public health districts to pilot the Idaho Medical Home Project, which seeks to build capacity for patient-centered medical home and care coordination by introducing the concepts to pediatric and family practice clinics.... Through the Title V Idaho Medical Home Project, two public health districts work with up to three pediatric or primary care clinics in their regions to support transformation to adoption of patient-centered medical home principles through intensive quality improvement and guided practice change. One incentive the health districts use to recruit clinics is the ability to receive increased reimbursement from Medicaid once NCQA levels are met. The Medical Home Project staff guide clinics through this process and offer technical assistance on meeting the NCQA requirements."

Indiana: The purpose of Indiana's Early Childhood Comprehensive Systems Impact (IN ECCS Impact) is to enhance early childhood systems building and demonstrate improved outcomes in population-based children's developmental health and family well-being using a Collaborative Innovation and Improvement Network (CoIIN) approach. Through the ECCS grant, we hope to connect Indy East Promise Zone children ages 0-8 and their families to care coordination, child developmental screening and screening for maternal depression in order to support early detection, referral and intervention.... The ISDH [health agency] established an MOU with Medicaid to receive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) data in the PBC [place-based community] zip codes. This data will assist in evaluating the impact of local ECCS activities around early screening and diagnosis in the PBC.... Indiana will be piloting the HMG system within the ECCS PBC.... The ECCS physician champion,... is also the HMG champion and has been working closely with the HMG team to ensure that other physicians in the ECCS catchment area understand HMG and how to refer to families.

Iowa: The Title V Maternal and Child & Adolescent Health (MCAH) program and the Iowa Medicaid program have a close, mutually beneficial working relationship for approximately three decades. The foundation for this relationship is the contract established each year between the Iowa Department of Public Health (IDPH) and the Iowa Department of Human Services (DHS)—Iowa Medicaid Enterprise (IME). Typically, this agreement is established for a period of six years and renewed annually through an amendment that addresses language and budget updates. This contract - known as the Omnibus Agreement—does not include services for children with special health care needs.... The Cooperative Agreement is established for the purpose of mutual cooperation, developing and sustaining a collaborative relationship to promote the availability of comprehensive, cost effective, and quality health services for its beneficiaries. The development of a strong working relationship at the state level helps to prevent duplication of services and assists local human services offices and health agencies to develop cooperative relationships. This core component addresses cooperation between Title V, Title X, WIC, Title XIX, and Title XXI programs. Roles of DHS and IDPH are identified, and program descriptions are included. There is no funding attached to the Cooperative Agreement section.... Over the years, the Bureau Chief of Family Health has experienced many opportunities to meet with Iowa's Medicaid Director on joint policy issues and problem resolution."

"The 1st Five program, funded by the Iowa Legislature, works with over 300 primary care practices across 88 counties in Iowa. Parents and caregivers of children who visit these engaged practices in Iowa for well-child exams, are more likely to receive developmental screening information and coordination of referral based off of a screen when a developmental or social need is indicated.... 1st Five Children's Healthy Mental Development: Provides IDPH staff support for quality monitoring of 1st Five sites located within Title V contract agencies in 88 of Iowa's 99 counties. Education, consultation, and technical assistance is provided to 1st Five contract agencies to work with local primary care practices to ensure that recommended guidelines for developmental screening, referral processes, and identification of local resources are implemented for Medicaid enrolled children. Funding for 1st Five program evaluation is also included. Funding to support the above is a blend of IDPH, Iowa DHS, and Medicaid matching funds."

Kansas: KanBeHealthy & Bright Futures as Standard of Care for Child Well Visits/ Screening: The Child & Adolescent Health Consultant will continue to represent the Title V program on a team working to review and update the KanBeHealthy (KBH) training. KBH is the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. Kansas Medicaid utilizes Bright Futures as the EPSDT/KBH standard of care, so all services must be provided in accordance..... Over the next year, regional, in-person trainings will be held for MCH grantees and other public health partners providing KBH visits (following Bright Futures guidelines), and online training modules will be available through KS-TRAIN as well as other online early childhood training platforms."

Maine: "The Maine CDC [health agency] and MaineCare [Medicaid agency] continue to partner on the Medicaid Innovation Accelerator Program for the Maternal and Infant Health Initiative. This project links MCH to value-based purchasing. Maine's project is to incentivize providers caring for pregnant women with substance use disorders to use the SnuggleME Guidelines (http://www.maine.gov/dhhs/SnuggleME/) to screen and refer them to treatment. The project requires Title V and the state Medicaid provider to work collaboratively and is now in its implementation phase. The team is assessing the number and those MaineCare providers using the screening billing code. The team will develop a plan to ensure provider notification of the opportunity and provide ongoing guidance on screening, referral and treatment of pregnant women with opioid use disorders."

Maryland: "Medicaid is a key Title V partner. The current MOU outlines agreements and guidelines on administration and policy, systems coordination, outreach and referral activities, and data sharing. Local Title V supported staff work with Medicaid ACCU staff in local health departments to identify and enroll eligible children in the Medicaid Program. Medicaid and Title V staff work collaboratively on nationally led projects such as AMCHP's Policy Leadership Initiative."

APPENDIX C. Themes and Conclusions from Title V Information System (TVIS) Scan

1. State Title V program action on child health is not focused much on preventive and primary care outside of a few areas such as school health, adolescent health, oral health, and immunization.

2. In terms of early childhood activities in State Title V programs, NPM#6 on developmental screening has been a primary driver.

    a. Activities related to NPM#6 and developmental screening include an array of strategies linked to programs and initiatives. Most state Title V programs are using dollars, strategies, and momentum from Help Me Grow, Project LAUNCH, MIECHV, and early care and education (ECE). A few states are using partnerships and strategies that use HealthySteps, CDC Essentials for Childhood, and Preschool Development Grants (PDG) Program or Race to the Top (RTT) education funding.

    b. Related to developmental screening, only a few states described specific strategies within primary care/medical home, even fewer discussed Medicaid. A Title V focus on developmental screening in home visiting was frequently mentioned, as was a focus on developmental screening in early care and education.

    c. Many states were spending considerable time and money to work on integrated reporting and data systems for developmental screening.

3. Title V led developmental screening initiatives in most states were focused on getting data for NPM#6, with screening for general development using ASQ. States rarely mentioned ASQ:SE. A few states mentioned maternal depression screening related to other priorities or performance measures. In a very small number of states, screening for social determinants of health (SDOH) was mentioned.

4. In terms of promoting social-emotional well-being, many State Title V programs report having Infant and Early Childhood Mental Health (IECMH) initiatives underway. A few states reported integrated behavioral health efforts, typically for older children and adolescents. IECMH initiative often stand alone or are linked to early care and education consultation. In some cases, training and focus was on improving the skills of home visitors. These efforts were occasionally linked to Part C Early Intervention programs. State Title V programs rarely described IECMH efforts related to primary care. For example, only a few mentioned working on or financing IECMH consultation services to primary care.

5. States have used Title V "Partnership" dollars (i.e., combined federal, state, and other funding) to invest in early childhood system activities. Most such effort are operated through local departments of health, local coalitions, or local early childhood comprehensive system (ECCS) structures. Few mention Medicaid. These early childhood system efforts vary widely. Most have a hub, anchor, network, or backbone organizations at the local level. Many are building upon existing or prior HRSA-MCHB ECCS grant supported work. Most infuse dollars from multiple funding streams (e.g., ECCS, Project LAUNCH, Essentials for Childhood, PDG, RTT, etc.); however, few mention collaborations with Medicaid on such efforts. State examples to look at include but are not limited to: Colorado, Georgia, Indiana, Iowa, Kansas, and Oregon.

6. State Title V programs reported few connections to pediatric primary care/ medical homes beyond those for Children with Special Health Care Needs (CSHCN). The potential is great for State Title V programs to do more to improve primary care for young children and to promote social emotional development.

7. Few states discussed an active role in implementation of Bright Futures.

8. The potential for states to use "child health improvement projects" is underutilized. Nearly half of states have some version of a child health improvement project. Few partnerships between Title V and improvement projects are mentioned in State Title V reports or applications. Child health improvement projects tend to work on specific topics, often related to a few priorities each year. While some have conducted projects related to development screening, most have not focused on using primary care/ medical home to improve social-emotional development or to promote optimal development. Title V and/or Medicaid funding could be used to accelerate work and focus of child health improvement projects. Vermont is the best example, using Medicaid/EPSDT administrative claiming funds via State Title V program to support Vermont Child Health Improvement Partnership (VCHIP) activities. In addition, the Oregon Pediatric Improvement Partnerships (OPIP) has a long-standing and productive working relationship with the state Medicaid agency.

Appendix D. Suggested Areas for Measurement in High Performing Medical Homes for Young Children in Medicaid

High rates of access to care*
High percentage of children receiving well-child visits*
High rates of children who are up-to-date on immunizations*
High performance on developmental screening measure*
Satisfaction with the experience of care as measured with the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H*
Use of validated CSCHN screening tool
Use of SDOH screening tool, including maternal depression
Low rates of unnecessary emergency department visits*
Family engagement demonstrated through use of recommended Bright Futures pre-visit tools and/or the electronic Well-Visit Planner
Documentation on rates of referrals, follow up, and completed referrals
Documentation of augmented resources and supports provided in practice (e.g., integrated mental health, Healthy Steps, Project DULCE, Reach Out and Read)

* Measures are part of CMS Medicaid-CHIP Core Child Set.

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