USING MEDICAID TO SUPPORT YOUNG CHILDREN'S HEALTHY MENTAL DEVELOPMENT

Kay Johnson and Neva Kaye

September 2003

Revised January 2004

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

This report (**#705**) is available online only from The Commonwealth Fund's website at **www.cmwf.org.**

ACKNOWLEDGEMENTS

This document could not have been produced without the support of the Commonwealth Fund which funded the ABCD Initiative and this report. Special thanks go to Melinda Abrams and Ed Schor for their guidance and support.

This report would also not have been possible without the input of a number of experts who reviewed an early draft. Our thanks go to the following:

- Anne Barry, Minnesota Department of Finance;
- Judith Dolins, American Academy of Pediatrics;
- Barbara Edwards, Ohio Department of Job and Family Services;
- MaryAnn Lindeblad, Washington Department of Social & Health Services;
- Christopher Kus, New York State Department of Health;
- Paul Wallace Brodeur, Office of Vermont Health Access; and
- Scott Williams, Utah Department of Health.

Finally, special thanks go to NASHP's own Helen Pelletier for her editing expertise. Any errors, however, are the sole responsibility of the authors.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Recent research documents how and why social-emotional development may be as important as cognitive (intellectual) development. Children who are viewed by others as "sad, mad, or bad" are far less likely to experience school success and may be unable to use preschool intervention. Recent research also documents the important role Medicaid can play in supporting young children's healthy mental development. This report examines both why and how Medicaid can support children's healthy mental development, including a discussion of how states can use Medicaid to better support young children's social/emotional development even in the current economic climate.

Although few would argue the importance of healthy mental development, families with children who need help face a number of barriers to care. One major barrier is that effective interventions usually require more than one provider or system of care, creating the potential for children to fall between the cracks, especially when no one system or agency is clearly responsible for seeing that all needed care is delivered. All too often, families can find themselves navigating multiple, uncoordinated eligibility and delivery systems. Additionally:

- Young children have different needs and different symptoms than adults. They may exhibit signs of risk (such as poor attachment to caregivers) without yet having a clearly defined mental or emotional disturbance. Furthermore, because it may be impossible to distinguish between developmental, emotional, and physical conditions in very young children, determining eligibility for a specific program or treatment may be difficult. In addition, many decision-makers are new to the concept of mental health services for young children and may not see the value of such services.

- Families with children who need only preventive care or low-level intervention may have difficulty obtaining care both because the primary care providers they see most frequently may not know how to identify the need and because many existing systems were developed to serve those with more intense needs.

Medicaid is uniquely able to support young children's social and emotional development. The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) child health component of Medicaid, creates a clear avenue for states to finance services that meet the needs of young children who are at risk for poor mental development, not just those with a diagnosis or mental illness. EPSDT screening (well-child) exams also present an opportunity for providers to identify needs, if providers have the tools and knowledge to do so. Medicaid provider manuals and training provide an opportunity to transfer that knowledge and help providers know what will be covered when a need is identified. Medicaid is also uniquely positioned to promote young children's healthy mental development because it serves many children: Medicaid covers nearly half of U.S. infants and an estimated one in three children under age six. The poor and low-income children it serves are more likely to be in circumstances that put them at risk for delayed social and emotional development.

Strategies Medicaid agencies can use (and have used) to support young children's healthy mental development include the following.

- Crafting Medicaid policy guidance that:
  - clearly defines early childhood mental health services coverage and qualified providers;
  - permits and/or encourages use of age appropriate developmental screening and diagnostic tools appropriate for young children;
  - distinguishes between screening and diagnostic assessment; and
  - recognizes the important role that families play in a child's healthy mental development including clarifying the coverage of family therapy, even when only the child is a Medicaid beneficiary.

- Adopting Medicaid billing codes that can be efficiently used by providers of early mental health services and supports (e.g., pediatricians, public health nurses, social workers, child psychologists);

- Modifying Medicaid managed care contracts to more clearly specify the responsibilities and opportunities of managed care contractors, primary care physicians, and mental health providers in ensuring young children's healthy mental development; and

- Using existing funds more effectively by:
  - Establishing interagency billing systems that combine or can access funds from different federal, state, and local sources;
  - Obtaining state executive agency or legislative approval to use state child care, foster care, public health, maternal and child health, early intervention, mental health, or social services dollars as Medicaid matching funds in programs serving young children; or
  - Appropriating additional general funds to match federal Medicaid dollars.

Specific state and local efforts to finance services to promote the healthy mental development of young children illustrate how innovative leaders have created community and state-based systems and supports. In each case policymakers and professionals worked together to combine strategies and create initiatives that fit within their fiscal and programmatic context. Florida has improved Medicaid guidance to better meet the emotional needs of young children. Indiana has established an electronic system to authorize services based on each child's needs and to pay providers a uniform rate. The system has helped make it possible for the state to expand the financial resources available for services by utilizing all available federal and state dollars. Vermont uses federal/state Medicaid dollars to finance a variety of services for young children with or at-risk for mental health or behavioral health problems. Additional information about the work being done in these three states appears on page 19.

INTRODUCTION

Social and emotional impairments can seriously compromise early child development.[1] As the editors of *From Neurons to Neighborhoods* write: "Young children are capable of deep and lasting sadness, grief, and disorganization in response to trauma, loss, and early personal rejection." The risks that accompany early mental health impairments are substantial in both the short- and long-term and are particularly acute for low-income children.[2] Other studies confirm that children covered by Medicaid may be at heightened risk for poor mental development. Many live in families with below poverty income[3] and studies have shown that poor children are less likely than their peers to be ready for kindergarten, are more likely to fall behind as grade-schoolers, and face a higher prospect of dropping out of high school, becoming teen parents, and being either a victim or a perpetrator of violence.[4] Further, adverse social conditions (e.g., extreme and persistent poverty, family violence, and serious mental illness in parents) can be extremely damaging to children. A combination of biological and environmental risks poses the greatest threat to optimal development and the cumulative impact of multiple risk factors is even more serious.[5] Finally, recent research documents the cost-effectiveness of ensuring young children's social and emotional development needs. Findings from these studies include the following.

- Services which support young children's healthy mental development can reduce the prevalence of serious emotional disorders (SED) and other high-cost, long-term mental health conditions.[6]

---

[1] Note: In this report, *ensuring children's healthy mental development* means identifying and addressing the social, emotional, and developmental needs of children who need preventive care or are at-risk for more intensive care.

[2]Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development.* Jack P.Shonkoff and Deborah A. Phillips (eds). (Washington, DC: National Academy Press, 2000). http://books.nap.edu/books/0309069882/html/index.html

[3] Kaiser Commission on Medicaid and the Uninsured. *Fast Facts: Health Coverage of Low-Income Children* (Washington, DC: Kaiser Family Foundation, 2001).

[4] Among the works cited here: The Kauffman Early Education Exchange, *Set for Success: Building a strong foundation for school readiness based on the social-emotional development of young children* (Kansas City, MO: The Ewing Marion Kauffman Foundation, 2002); Douglas Nelson, *1996 Kids Count Data Book* (Baltimore, MD: Annie E. Casey Foundation, 1996); Karen Scott Collins et al., *Issue Brief* (New York, NY: The Commonwealth Fund, Nov. 1998); Barbara Starfield, "Child and Adolescent Health Status Measures," *Future of Children,* 1992; 2:25-39; Nicholas Zill et al., *Approaching Kindergarten: A Look at Preschoolers in the United States* (U.S. Department of Education, NCES 95-280, 1995); Judith A. Chafel, *Child Poverty and Public Policy* (Urban Institute Press, Washington, DC, 1993); and Arloc Sherman, *Wasting America's Future* (Boston, MA: The Beacon Press, 1994.)

[5] See Note 2.

[6] Sources include: Institute of Medicine*, Reducing Risks for Mental Disorders: Frontiers for preventive intervention research* (Washington, DC: National Academy of Sciences, 1994); Carnegie Task Force on Meeting the Needs of Young Children*. Starting Points: Meeting the Needs of our Youngest Children*" (New York, NY: Carnegie Corporation of New York, 1994).

- Early diagnosis and intervention increase effectiveness and efficacy for both children with social risk factors and those with biologically based conditions.[7]

- Interventions tailored to specific needs have been shown to be more effective in producing optimal outcomes than services that provide generic advice and support. This is not one size fits all or generic health promotion.[8]

Research and experience suggest that different families and children need different amounts and types of care to support their child's social and emotional development. Many need no care, some may simply need to be monitored to see if needs develop, some may need only preventive care or low-level interventions, others may need intensive treatment. Children who do not need intensive treatment have particular difficulty obtaining care. Existing systems, such as the public mental health system and the early intervention system, in many states were not designed to serve these children and may not have the resources to serve them in addition to those with more intensive needs. The types of care that these children with less intense needs could benefit from include:

- **Preventive strategies intended to strengthen child-caregiver relationships for all children**. All families benefit from professional support during their child's early development. The main service categories are: 1) developmental screening and assessment services, and 2) developmentally based health promotion and parent education.[9] Primary care pediatricians, home visitors, mental health consultants in child care settings, child development specialists, and others can provide these services.

- **Early intervention strategies targeted to young children who have elevated risk.** Children with elevated risk are children (and their families) with environmental risks such as domestic violence, substance abuse, or severe parental depression.[10] Young children with biological risk factors such as communication disorders, genetic conditions, or developmental delays also may need support. Interventions typically involve consultation and support to parents and other caregivers. Integrating social-emotional-developmental interventions into ongoing medical treatment, foster care, child care, or other services is one key to success. [11]

---

[7] See note 2.

[8] See note 2.

[9] Michael Regaldo and Neal Halfon, "Primary Care Services Promoting Optimal Child Development from Birth to Age 3 Years: Review of the literature," *Archives of Pediatric and Adolescent Medicine*, 2001; 155:1311-1322.

[10] Infant Health and Development Program, "Enhancing the Outcomes of Low Birthweight Premature Infants," *JAMA* , 1990; 263:3035-3042.

[11] Sources include: The Florida State University Center for Prevention and Early Intervention Policy, *The Florida Strategic Plan for Infant Mental Health* (Tallahassee, FL: The Center, 2000), www.cpeip.fsu.edu; Roxane Kaufmann and Joan Dodge*, Prevention and Early Intervention for Young Children At Risk for Mental Health and Substance Abuse Problems and their Families: A background paper* (Washington, DC: Georgetown University Child Development Center, 1997); Jane Knitzer and Stanley Bernard, *The New Welfare Law and Vulnerable Families: Implications for child welfare/child protection systems*, Children and Welfare Reform, Issue Brief (New York, NY: National Center for Children in Poverty, 1997); and Cynthia Lederman and Sandra Adams. "Innovations in Assessing and Helping Maltreated Infants and Toddlers in a Florida Court," *Zero to Three*, 2001; 21(6):16-20.

State Medicaid programs have an opportunity to promote healthy mental development and to meet the needs of young children at risk. Federal EPSDT rules call for prevention and early intervention to promote both physical and mental development. From screening (well-child) exams, which provide an opportunity for primary care providers to provide guidance to parents and to identify children at risk, to financing for a range of early interventions, Medicaid's EPSDT program is an essential tool for states. Surveys and reports indicate, however, that most state Medicaid agencies have not taken full advantage of this opportunity to identify and meet the needs of children at risk. Only now are state Medicaid agencies considering new prevention and early intervention strategies to reduce both the incidence and high costs of severe emotional and behavioral conditions.

This report examines Medicaid's significant role in financing and delivering services designed to promote young children's healthy mental (social-emotional) development. Recent research and state experience makes clear the importance of such efforts and offers guidance to Medicaid programs in how to develop and sustain early childhood mental health services and supports that can improve outcomes. In brief, this paper addresses:

- Medicaid's role in providing services to promote healthy mental development in young children;
- Barriers to using existing services and authority; and
- Opportunities to respond, even in tight budget times.

CORE CONCEPTS FOR THE WELL-BEING OF YOUNG CHILDREN

The well-being and well-becoming of young children are dependent on two essential conditions:

1. Nurturing, stable, responsive, and consistent relationships are the building blocks to healthy development.

2. Young children need a safe and predictable environment that promotes cognitive, linguistic, social, emotional, and moral development.

Key facts that the general public should know and understand about early childhood development (as presented by the Institute of Medicine) include:

- Detecting problems early and promptly providing appropriate interventions can improve developmental outcomes for both children living in high-risk environments and those with biologically based disabilities. Yet we know that not all interventions are effective, offer quick fixes, or, like immunizations, offer a lifetime of protection.
- Each individual is shaped by the interaction of risk factors and protective factors, by sources of vulnerability and of resilience.
- Brain development begins before birth, continues throughout life, and is influenced by both genetics and experiences.
- The astonishing developmental achievements of the earliest years occur naturally when parents and other caregivers talk, read, and play with young children and respond sensitively to their cues.
- Efforts to protect early brain development are best embedded in an overall strategy of general health promotion and disease prevention.
- Adverse social conditions (e.g., extreme and persistent poverty, family violence, and serious mental illness in parents), which exist in all cultures, can be extremely damaging to children. A combination of biological and environmental risks poses the greatest threat to optimal development.
- The early years are an important time of development; however there is no scientific reason to believe that negative early experience cannot be ameliorated in later life (i.e., we should not give up on older children).
- Normally developing children exhibit a wide range of individual differences, some of which may present challenges to parents and other caregivers.

Source: Institute of Medicine. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Jack P. Shonkoff and Deborah A. Phillips, (eds), (Washington, DC: National Academy Press, 2000).

MEDICAID COVERED SERVICES THAT PROMOTE YOUNG CHILDREN'S HEALTHY MENTAL DEVELOPMENT

Meeting the full range of young children's mental health needs requires the coordinated efforts of primary care health professionals, mental health professionals, education professionals, families, and community-based organizations providing support services. Medicaid can cover many of the services offered by these providers. Services that are key to identifying and caring for young children at-risk for poor social-emotional developmental outcomes are examined here. They include: EPSDT, physician services, home visiting, and mental health treatment services.

EPSDT

Medicaid's EPSDT rules establish requirements for children's care under Medicaid. They also offer an opportunity for states to use Medicaid for financing services needed to promote healthy mental development among children in low-income families.

Federal EPSDT rules require that states have a schedule for and finance periodic well-child visits (often called EPSDT screening visits) for all Medicaid beneficiary children under age 21. States also are required to pay for "inter-periodic" screening visits, provided outside the schedule whenever a problem is suspected. Screening visits consist of a comprehensive health and developmental history, an unclothed physical exam, appropriate immunizations, laboratory tests, and health education. The purpose of these visits is to identify physical, mental, or developmental problems and risks as early as necessary and to link children to needed diagnostic and treatment services.

The services Medicaid agencies are required to cover for a condition identified in an EPSDT visit include "other necessary health care, diagnostic services, treatment, and other measures"[12] that fall within the federal definition of medical assistance. Further, Medicaid programs must cover services needed to "correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services."[13] In other words, if a service can be covered under federal Medicaid law *and* it is needed to correct or ameliorate a condition identified in an EPSDT screen, the state Medicaid agency must cover that service. The agency must cover the service even if the agency has chosen not to cover that service under other conditions (such as for adults). [14]

State Medicaid agencies are required to cover a wide range of medical and health services for children, including services that traditional insurance might not cover. Services that can be covered under EPSDT and are particularly valuable for promoting early child emotional

[12] Section 1905 of the Social Security Act.

[13] Ibid.

[14] Sara Rosenbaum and Colleen Sonosky, *Federal EPSDT Coverage Policy.* (Prepared by the George Washington University Center for Health Services Research and Policy under contract to the Health Care Finance Administration, 2000.)

development include: routine developmental screening and assessment, health education, home visiting, preventive health counseling for families, case management, developmental therapies, mental health counseling, and other "early intervention" services.

> "Screening for developmental assessment is a part of every routine initial and periodic examination. Developmental assessment is also carried out by professionals to whom children are referred for structured tests and instruments after potential problems have been identified by the screening process....
>
> In younger children, assess at least the following elements:
>
> - Gross motor development, focusing on strength, balance, locomotion;
> - Fine motor development, focusing on eye-hand coordination;
> - Communication skills or language development, focusing on expression, comprehension, and speech articulation;
> - Self-help and self-care skills;
> - Social-emotional development, focusing on the ability to engage in social interaction with other children, adolescents, parents, and other adults; and
> - Cognitive skills, focusing on problem solving or reasoning."
>
> CMS State Medicaid Manual, Part 5, EPSDT § 5123.2

Covering Developmental Services Under EPSDT

Federal Medicaid law specifically defines some categories of service as optional (e.g., targeted case management or prescription drugs) and some as mandatory (e.g., inpatient hospital or physician services). However, the list of named categories does not include services specifically labeled "child development," "early intervention," or "early childhood mental health" services. This lack of a specific federal category does not, however, prevent Medicaid agencies from covering those services. Indeed, federal EPSDT regulations create a clear avenue for identifying and caring for children at-risk for poor social and emotional development outcomes.[15]

As previously discussed, the screening component of EPSDT is meant to, among other things, detect developmental problems and risks and provide health education to the family regarding child development, developmental milestones, and strategies to maximize growth and development.[16] Screening for children's social and emotional development offers providers additional information on which to base parent guidance, education, and counseling, as well as an indication of when further assessment is needed by a child.

State Medicaid agencies have opportunities to define and manage these services. Current federal Medicaid EPSDT legislation and regulation use only one general term "developmental assessment" for what are two discrete functions in routine child health, developmental, and mental health practice (1) screening to identify possible problems and (2) more in-depth assessment to diagnose such problems. States could adopt separate definitions, billing codes, or

[15] Jane Perkins, *Medicaid Early and Periodic Screening, Diagnosis and Treatment as a Source of Funding Early Intervention Services* (Los Angeles: National Health Law Program, 2002).

[16] Sara Rosenbaum, Michelle Proser, and Colleen Sonsoky*, Health Policy and Early Child Development: An overview* and *Room to Grow: Promoting child development through Medicaid and CHIP* (New York: The Commonwealth Fund, 2001).

payment rates as a part of improvements to early childhood developmental and mental health services financing. For example, states could:

- Distinguish a routine developmental screening conducted as part of an EPSDT screen from a developmental examination (with structured professional tests) or diagnostic assessment conducted by a medical social worker, public health nurse, or developmental pediatrician.

- Encourage use of professionally recommended screening tools appropriate for young children. Many EPSDT programs do not now recommend age-specific tools.

- Define a set of services (with billing codes and rates) that encompass early childhood development practices, including screening, assessment, and diagnostic services. Parent guidance, education, and counseling on child development could be included. States may wish to exclude treatment services, including care coordination, from this service group because treatment varies widely in service and provider type.

- Assist families in obtaining referred services and assist pediatricians in making efficient referrals to a network of qualified providers and community resources.

- Coordinate developmental services by clarifying guidance and rules on Medicaid payment for IDEA Part C Early Intervention Services, Preschool Special Education, children's mental health services, medical services for children in the child welfare system, Head Start, and other early care and education.[17]

Medicaid-covered Developmental Services and IDEA Part C

Under the federal Individuals with Disabilities Education Act (IDEA) Part C program, states provide early intervention services for infants and toddlers (birth to age 3) who have or have a high risk for experiencing developmental delays. Each state sets its own eligibility criteria within broad federal guidelines. Eligibility based on risk varies greatly among states, with states such as Indiana, Maryland, and North Carolina offering extensive coverage for at-risk children. Typical services include physical, occupational, and speech-language-hearing therapies, but some families receive parent-child developmental therapy under Part C. Medicaid covers many of these services, and most states use Medicaid financing for Part C services furnished to children eligible for both programs.

Both Medicaid and IDEA federal laws clearly permit Medicaid financing for certain services provided to a child and family under Part C. IDEA federal rules make it clear that Part C is the "payer of last resort" and Part C funds "may be used only for early intervention services that an eligible child needs but is not currently entitled to under any other federal, state, local or private source."[18] In other words, under IDEA, Medicaid funds would be used before Part C funds to finance Medicaid-covered services for dually eligible children.

---

[17] Jack P. Shonkoff and Samuel J. Meisles, "Early Childhood Intervention: The evolution of a concept," In S.J. Meisels and J.P. Shonkoff (Eds.), *Handbook of Early Childhood Intervention* (2nd ed.). (New York: Cambridge University Press, 1997).

[18] 34 CFR § 303.

Physician Services

Medicaid covers physician services. As the physicians most likely to care for children, pediatricians have a major role to play in prevention and early intervention for early childhood mental health and development. *Bright Futures in Practice: Mental Health*[19] offers suggestions for primary care pediatric practice and for collaborative practice between primary care pediatricians and a range of professionals (e.g., developmental specialists, child psychiatrists, psychologists, social workers).

Four major categories of developmental services have been defined for primary pediatric practice: 1) screening and assessment, 2) health promotion and education, 3) interventions, and 4) care coordination.[20]

A chief role for pediatricians to play in promoting optimal emotional development is to provide developmental screening for all children in their care. Clinical screening tools for use in the primary care setting can identify social, emotional, and developmental concerns. The three general categories of tools are: 1) broad tools to screen for overall health, developmental, and mental health risks, 2) tools to screen for social-emotional risks and problems, and 3) tools to screen for specific symptoms and problems (e.g., depression, poor attachment to caregivers, Attention Deficit Hyperactivity Disorder, Fetal Alcohol Syndrome). As previously discussed, mental health screening should be part of an EPSDT screening visit. However, states often do not recommend use of specific and appropriate tools for such screening nor have they established billing systems that encourage providers to use such tools.

Another important role for pediatricians is parent education. The parent/child relationship is key to a child's healthy development. Parents also are likely be the first to notice any potential mental development issues, and pediatricians interact both with the young child and his or her parents during office visits. During these visits primary care providers can and should provide health education (referred to in EPSDT rules as anticipatory guidance) to the family regarding child development, developmental milestones, and strategies to maximize growth and development.

Other important roles for pediatricians are referral and coordination. Primary care pediatric providers are the essential link for making referrals and maintaining linkages with other providers and systems of care.

New models for service integration have been tested with the combined support and encouragement of professional associations, state agencies, and The Commonwealth Fund.[21] In

---

[19] Michael Jellinek, *Bright Futures in Practice: Mental Health—Volume I. Practice Guide*, (Washington, DC: National Center for Education in Maternal and Child Health and Georgetown University, 2002). http://www.brightfutures.org/mentalhealth/

[20] See Note 9.

[21] See, for example, information on the Assuring Better Child Health and Development (ABCD) Initiative, funded by The Commonwealth Fund and administered by the National Academy for State Health Policy. NASHP's website

some of these models, professionals—such as child development specialists, psychologists, and social workers—are joining or co-locating with pediatric primary care practices. Having such mental and developmental professionals on-site increases the capacity for screening, diagnosis, and referral of children with special needs

Home Visiting Services

In Illinois, Michigan, Vermont, Wisconsin, and more than a dozen other states, Medicaid covers services provided in the child's home.[22] Services pertinent to ensuring young children's healthy mental development might include: assessment of a family's home environment for health risks, screening and assessment of a child's development, assessment of the parent-child relationship, or parent education. Medicaid also can cover intensive home-based interventions for families with higher-level social and medical risks. For high-risk families, services might include parent-child therapy or care coordination. Some of these services, such as assessment of the home environment, can only be delivered in the home, while others are simply more effective if delivered there. An additional benefit of incorporating home visiting into Medicaid's covered services is that home visitors may have training in screening for social-emotional risks or in delivering social-emotional interventions.

Mental Health Services

All Medicaid programs cover mental health services for children. Most mental health services financed today by Medicaid focus on treatment for older children and adults or those with identified (typically severe) conditions. Services to support the social and emotional development of young children are less likely to be provided by the public or the private mental health providers. Nonetheless, Medicaid covers a number of services that would enhance early childhood mental health prevention and treatment. For example, Medicaid mental health coverage could include:

- Screening to detect problems with mental, socio-emotional, and behavioral development;
- Diagnostic assessment for socio-emotional, behavioral, and developmental conditions;
- Enhanced screening and assessment through placement of social workers and child development specialists in primary pediatric care settings;
- Family education, training and support;
- Home visits and home-based professional services;

(www.nashp.org) contains detailed information about the initiative as well as a toolbox of resources on state efforts to strengthen early childhood development services.

[22] Kay Johnson, *No Place Like Home: State Home Visiting Programs* (New York, NY: The Commonwealth Fund, 2001).

- Case management and care coordination, particularly for children entering the child welfare system and foster care;
- Child care consultation for individual children;
- Individual behavioral health aides to help a child remain in early childhood education or school; [23]
- Relationship-based, parent-child therapy for families at risk, as well as families who have entered the child welfare system;
- Therapeutic (specialized) day treatment in a variety of early childhood care and education settings;
- Wraparound and community support services; [24]
- Other traditional mental health inpatient and outpatient treatment.[25]

Although Medicaid covers a number of services that can enhance young children's healthy mental development, the structure of a state's delivery system may create a barrier to obtaining that care. Specifically, many Medicaid agencies separate the mental and physical health sides of the program by:

- assigning responsibility for mental health services to the state mental health agency;
- developing special rules and procedures;
- limiting Medicaid payments to a network of clinics; or
- creating separate managed care systems for physical and behavioral health.

Separating these two types of care may increase the barriers to prevention and early intervention services for young children.

---

[23] Terry Whitney, Scott Groginsky, and Julie Poppe, "Funding Inclusive Child Care," *State Legislative Report*, (National Conference of State Legislatures, 1999); 24(1)1-5.

[24] Robert F. Cole, and Susan Poe, *Partnerships for Care: Systems of care for children with serious emotional disturbances and their families* (Washington, DC: Washington Business Group on Health, 1993).

[25] Sources include: Bazelon Center for Mental Health Law, *Making Sense of Medicaid for Children with Serious Emotional Disturbance* (Washington DC: Bazelon Center for Mental Health Law, 1999); Bazelon Center for Mental Health Law, *Managing Managed Care for Publicly Financed Mental Health Services* (Series of Issue Papers on Contracting for Managed Behavioral Health Care): Paper #1: "Defining Medically Necessary Services to Protect Plan Members" (1995); Paper #3: "An Evaluation of State EPSDT Screening Tools" (1997); and Paper #5: "Defining Medically Necessary Services to Protect Children" (1997); Bazelon Center for Mental Health Law, *Making Medicaid Work: An advocacy guide to financing key components of a comprehensive State system of care*. (Washington DC: Bazelon Center for Mental Health Law, 1994); and Chris Koyanagi, *Making Medicaid Work: To fund intensive community services for children with serious emotional disturbance*. (Washington DC: Bazelon Center for Mental Health Law, 1994).

MEDICAID MANAGED CARE AND PROMOTING HEALTHY MENTAL DEVELOPMENT

No current discussion of Medicaid coverage for children would be complete without mention of managed care arrangements. Overall, more than half of all Medicaid beneficiaries are enrolled in some form of managed care. Families and children are more likely than other groups of Medicaid beneficiaries to be required to enroll in managed care. In 2000, 33 Medicaid agencies reported that they covered some or all mental health services through a comprehensive managed care organization (MCO) that also delivered physical healthcare and/or through a prepaid health plan (PHP)[26] that delivered only behavioral health services. Specifically:

- Seventeen Medicaid agencies delivered mental health care through comprehensive MCOs;
- Eight delivered mental health services through a PHP; and
- Eight did so through both comprehensive MCOs and PHPs.[27]

In those eight agencies that used both types of managed care contractor, one of two situations is likely to exist.

1. The Medicaid agency may require MCOs to deliver a limited mental health benefit, while the PHP serves those who need more extensive care.
2. Both the comprehensive MCO and the PHP may provide a full mental health benefit but serve different groups of Medicaid beneficiaries. These groups are often defined either by geography (the two contractors serve different parts of the state) or by the beneficiary's MCO enrollment status (those enrolled in MCOs receive all mental health care from the MCO, those not enrolled into an MCO receive all mental health care from the PHP).

Providing mental health services through managed care presents states with both opportunities and challenges. Managed care contracts offer states an opportunity to define how services should be delivered and ensures that there is an entity responsible for seeing that those contract requirements are fulfilled.

At the same time, however, splitting the delivery of physical and mental health care among contractors or between managed care and fee-for-service can create an extra barrier for those seeking services and make care coordination difficult. And a 1999 Surgeon General's Report on Mental Health argued that Medicaid managed care arrangements involving children with behavioral health needs warrant careful consideration:

> "…administrators of state Medicaid programs have recently implemented managed care approaches and structures to reduce health care costs. However, Medicaid populations

[26] Like an HMO, a PHP is a managed care organization that usually receives a capitation payment in exchange for delivering a specified set of services. However, unlike an HMO, a PHP does not contract to offer a comprehensive set of services. Instead a PHP accepts risk for a limited set of services, usually just mental health or just dental services.

[27] Neva Kaye, *Medicaid Managed Care: A Guide for States, 5th Edition* (Portland, ME: National Academy for State Health Policy, 2001).

tend to have a higher prevalence of children with serious emotional disturbance than that seen in privately insured populations…."

In *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*,[28] the George Washington University Center for Health Services Research and Policy published analyses of state Medicaid managed care contract provisions. One analysis of child health provisions found that state Medicaid agencies' contracts generally have added specific details about services for children. *A Special Report: Mental Illness and Addiction Disorder Treatment and Prevention*[29] found that for children:

- More than one third of states specify treatment plan coordination between managed care organizations and court-ordered or child welfare agency plans. However, fewer states' Medicaid managed care contracts define or require a specific linkage to Individualized Family Service Plans (IFSPs) for infants and toddlers or Individualized Education Plans (IEPs)[30] for children age 3 to 21 years.

- Since Medicaid covers many services excluded by traditional private insurance, Medicaid managed care contracts may "carve out" or exclude certain services. Few contracts enumerate the exclusions.

The George Washington University team also has prepared purchasing specifications related to pediatric care, child development services, and behavioral health (www.gwhealthpolicy.org).

[28] Sara Rosenbaum et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (Washington, DC: The George Washington University, 1st ed., 1997; 2nd ed., 1999; 3rd ed. 2000).

[29] Rosenbaum et al, *Special Report: Mental Illness and Addiction Disorder Treatment and Prevention* (Washington, DC: The George Washington University, 1999).

[30] IFSPs and ISPs are care plans that are agreed to by parents that define the services to be publicly financed.

BARRIERS TO SUPPORTING YOUNG CHILDREN'S HEALTHY MENTAL DEVELOPMENT

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

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

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

- **The concept of "mental health services" to infants, toddlers, and preschool age children is new for many decision-makers**, but researchers have identified interventions and therapies that can prevent or ameliorate social, emotional, behavioral, and mental health conditions among young children.[31] Many such interventions and therapies are now being covered by some Medicaid agencies under EPSDT or mental health.[32] Recent research findings and states' experiences in applying those findings can aid replication in other states.

---

[31] Jane Knitzer. *Building Services and Systems to Support the Healthy Emotional Development of Young Children* (New York, NY: National Center for Children in Poverty, 2002). Also see Jane Knitzer. "Early Childhood Mental Health Services Through a Policy and Systems Development Perspective." In S.J. Meisels and J.P. Shonkoff (Eds.), *Handbook of Early Childhood Intervention* (2nd ed.) (New York: Cambridge University Press, 1997).

[32] Kay Johnson, Jane Knitzer, and Roxane Kaufmann. *Making Dollars Follow Sense: Financing early childhood mental health services to promote healthy social and emotional development in young children* (New York, NY: National Center for Children in Poverty, 2002).

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

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

- **The diagnostic codes used for older children, youth, and adults may not fit the conditions identified for infants and young children**. Young children may not yet have full-blown or clearly defined mental or emotional disturbances. Instead, the youngest children may exhibit abnormal development, poor attachment to caregivers, or other early signs of serious risk. A new set of diagnostic codes for children under age three (DC:0-3) has been developed by the national organization Zero to Three, but the set is not yet widely used.[33] Florida has adopted the DC:0-3 for developmental services, and other states, such as Washington and Ohio, are piloting their use. Vermont and other states are using Medicaid "V" codes for certain early childhood mental health services. Such alternative diagnostic codes fit better with the conditions most often seen in early childhood. They also offer a diagnostic code that providers can use to bill for services without mislabeling a young child.

- **Among the youngest children, distinguishing between developmental, emotional, and physical conditions may be difficult.** Thus, it may not be clear when a child qualifies for more than one program or source of funding.[34] In most federal/state programs, however, the state has a responsibility to determine eligibility for multiple programs, and federal rules govern who pays for which services. In states such as Indiana, Maryland, North Carolina, Oregon, and Vermont, interagency planning has led to more systematic and collaborative approaches.

---

[33] Zero to Three: National Center for Infants, and Toddlers and Families, *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3)* (1994) and *DC;0-3 Casebook* (Washington, DC: Zero to Three Publications, 1997). See also http://zerotothree.org/ztt_professionals.html.

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

- **While Medicaid finances services under both required Individualized Family Support Plan (IFSP) as part of the IDEA Part C and the individual services plan (ISP)[35] under mental health programs, these two plans generally are not coordinated or consistent.** State interagency agreements between Medicaid, Part C (typically operated by health or education departments), and mental health agencies can be used to structure coordination between the IFSP and ISP. Some states, such as Louisiana and Rhode Island, have piloted projects that require the primary care physician's signature on an IFSP in order for Medicaid financing to be approved.

[35] IFSPs and ISPs are care plans that are agreed to by parents that define the services to be publicly financed.

ADDRESSING THE BARRIERS

Clearly, young children and their families face a number of barriers when seeking care, as do policymakers when seeking to improve the provision of services related to children's healthy mental development. It is particularly difficult to address these barriers during tough economic times. Nonetheless, policymakers can move (and have moved) forward. Many states have adopted or are considering policies and practices to enhance Medicaid coverage for early childhood mental health development services that include.

- Crafting Medicaid policy guidance that:
  - clearly defines early childhood mental health services coverage and qualified providers;
  - permits and/or encourages use of age appropriate developmental screening and diagnostic tools appropriate for young children;
  - distinguishes between screening and diagnostic assessment; and
  - recognizes the important role that families play in a child's healthy mental development including clarifying the coverage of family therapy, even when only the child is a Medicaid beneficiary.

- Adopting Medicaid billing codes that can be efficiently used by providers of early mental health services and supports (e.g., pediatricians, public health nurses, social workers, child psychologists);

- Modifying Medicaid managed care contracts to more clearly specify the responsibilities and opportunities of managed care contractors, primary care physicians, and mental health providers in ensuring young children's healthy mental development;

- Using existing funds more effectively by:
  - Establishing interagency billing systems that combine or can access funds from different federal, state, and local sources;
  - Obtaining state executive agency or legislative approval to use state child care, foster care, public health, maternal and child health, early intervention, mental health, or social services dollars as Medicaid matching funds in programs serving young children; or
  - Securing state appropriation of additional general funds to match with federal Medicaid dollars.

Many of these strategies can be woven together for greater effectiveness and some can be implemented at little or no cost. This final section of the report provides examples of how innovative policymakers have used these strategies and discusses which strategies might be most promising in poor economic times.

Case Studies: Examples of Combining Innovative Strategies

State and local efforts to finance services to promote the healthy mental development of young children illustrate how innovative leaders have created community and state-based systems and supports.[36] In each case policymakers and professionals worked together to combine strategies and create initiatives that fit within their fiscal and programmatic context.

Florida has improved Medicaid guidance to better meet the emotional needs of young children. Through joint leadership of the state Medicaid and Mental Health Agencies, Florida updated its policies in June/July 2001, including changes to address the unmet needs of young children. Among other things, the new guidance: (1) clarifies the process for assessing children under age five to determine which services an individual should receive and recommends use of the DC: 0-3 and other child-oriented diagnostic codes; (2) clarifies that individual or *family* (e.g., parent-child) therapy can be covered by Medicaid; and (3) permits a broader array of mental health service providers (including, for instance, psychologists) to be paid for providing Medicaid mental health services to children. The new guidance was piloted in local sites prior to statewide implementation.

In 1996, the **Indiana** Family and Social Services Administration established an electronic system to (1) authorize services based on each eligible child's IFSP and (2) pay Medicaid and non-Medicaid providers a uniform rate. The state pays the providers and then allocates the cost of the care among an array of state and federal programs based on a funding hierarchy individualized to each child. The array of funding sources that have been combined to pay for Part C services includes: state appropriations for early intervention services, federal Part C allocations, Title V Maternal and Child Health Services Block Grant Program for Children's Special Health Care Services, the Social Services Block Grant, Medicaid, and TANF. As described in the SFY 2000 annual report, "Indiana has been able to expand the financial resources to support services by creatively accessing all available federal and state resources."

Vermont uses federal/state Medicaid dollars to finance a variety of services for young children with or at-risk for mental health or behavioral health problems. These services include: early childhood mental health consultations in child care settings, nurse home visits for at-risk families with young children, public health nurse case management for children entering the foster care system, individual aides for children with behavioral problems, and therapeutic play groups. These efforts required collaboration within the Human Services Agency, including efforts by Medicaid, the Department of Health, the Division of Mental Health, and the Child Care Services Division. The Child Care Services Division, for example, allocated a portion of state child care funding to child care centers. These centers then used this money to obtain federal Medicaid matching funds for provision of early childhood mental health consultation, which provides early intervention and therapy for children in child care settings.

[36] See Note 32.

Strategies for Tight Budget Times

States have an essential role in defining the services, the providers, and the mechanisms to be used to finance child development services for vulnerable low-income children. Some program and policy changes would be costly, but low- and no-cost strategies exist and are identified here. Even in these times of budget constraints, state Medicaid agencies have opportunities to promote healthy mental development of young children by improving administrative practices, maximizing available dollars, and encouraging more effective service delivery.

Improve Administrative Practices

- **Develop protocols and guidelines for more effective screening and referral of mothers and young children**. Families affected by depression, domestic violence, substance abuse, and related conditions can benefit from early intervention. State and local projects could test new approaches to identifying those at risk and linking them to available providers.

- **Clarify state Medicaid guidance on screening, assessment, and treatment related to early childhood mental health development**. Specifically, a state might clarify benefits covered, better define developmental screening and assessment, put protocols into place for developmental services, and define a set of providers qualified to receive reimbursement for such early mental health interventions.

- **Clarify and adopt billing codes appropriate to early childhood development**. Without appropriate billing codes and defined payment rates, providers are less likely to deliver developmental services to young children. Some states found that billing codes specifically tailored to young children's conditions helped to reduce unnecessary spending, minimize fraud, and maximize cost-effective early prevention and interventions.

Use Available Dollars More Effectively

- **Combine funds or create a single point of access to multiple sources of funds**, to enable use of each dollar for the best purpose. The Indiana IDEA Part C Early Intervention central billing system based on a blended pool of state and federal dollars from multiple sources is an excellent example. San Francisco implemented a similar pooling strategy for early childhood mental health.

- **Match state general revenues already being spent**. Interagency transfers and agreements are in widespread use. Medicaid agencies have used state general revenues from child care, public health, education, early intervention, mental health, and child welfare services as the state share of the cost of providing some Medicaid services, thus augmenting funding for early childhood mental health development services.

- **Encourage local matching**. In Ohio, some counties have used local mental health tax levy dollars as Medicaid match and others have used alternative local county funding. San

Francisco used local tax dollars set-aside for children's services as part of blended funding for an early childhood mental health initiative.

Encourage More Effective Service Delivery

- **Bridge the gap between medical and non-medical services.** States might provide assistance in establishing community referral networks to assist physicians in referring patients to community resources. Permitting payment for mental health consultation (i.e., services by a qualified provider) to individual children in child care, Head Start, and similar early care and education settings is another promising approach.

- **Encourage pediatric provider sites to promote healthy mental development.** State Medicaid agencies could reimburse primary pediatric practitioners for providing preventive mental health care and development services as defined under the Bright Futures Mental Health Guidelines. Alternatively, Medicaid might create specific payment rates for social workers and child psychologists co-located in pediatric practices and clinics to promote healthy emotional development through assessment, referrals, and treatment.

- **Eliminate treatment barriers created by requiring providers to diagnose young children as having a mental or behavioral health condition in order to obtain intervention and treatment**. Such requirements are established at the state level. States might review state mental health or Medicaid mental health rules that require a diagnosis prior to Medicaid mental health financing and identify opportunities to finance early interventions that promote healthy mental development. One strategy is to define a set of risk conditions that might trigger intervention (e.g., family substance abuse, maternal depression, domestic violence, or child abuse and neglect).

- **Target at-risk populations already eligible for Medicaid benefits.** This includes groups such as children in protective services/foster care or in IDEA Part C Early Intervention Programs. Specific efforts might involve activities such as more uniform and appropriate early childhood assessment for children entering foster care based on protocols developed by professionals, as well as approved for financing by Medicaid. Some Medicaid agencies require the signature of a primary care provider, as prior approval on each child's IFSP under the IDEA Part C program. Since these populations already use services, this is an opportunity to reduce long-term costs and improve children's mental health outcomes.

SUMMARY

Recent research documents the fundamental importance of social-emotional development for future success in school and in life. Although few would argue the importance of healthy mental development, families with children who need help in this area face a number of barriers to care. One major barrier is that effective interventions usually require more than one provider or system of care, creating the potential for children to fall between the cracks, especially when no one system or agency is clearly responsible for seeing that all needed care is delivered. Families can find themselves navigating multiple, uncoordinated eligibility and delivery systems.
Young children who need only preventive or early intervention care may face additional barriers. They may not yet have a clearly defined mental or emotional disturbance, the primary care providers they see most frequently may not have the tools to identify their needs, or the existing systems of care may not be designed to serve those with less intense needs.

Medicaid is uniquely able to finance services to support young children's social and emotional development. For example, federal EPSDT laws give states an opportunity to finance prevention and early intervention services that meet the needs of young children who are at risk for poor mental development, and EPSDT screening presents an opportunity for providers to identify needs. There are indications, however, that Medicaid has not yet reached its full potential for supporting young children's healthy mental development. This report points to how states can address (and have addressed) barriers to care using strategies that can be implemented at little additional cost.

APPENDIX A: REFERENCES AND RESOURCES

Arst, J. *Working Toward a Good Start in Life: Mental health approaches in early childhood settings*. (San Francisco, CA: Miriam and Peter Haas Fund, 1996.)

Bazelon Center for Mental Health Law. *Making Sense of Medicaid for Children with Serious Emotional Disturbance*. (Washington DC: Bazelon Center for Mental Health Law, 1999.)

Bazelon Center for Mental Health Law. *Managing Managed Care for Publicly Financed Mental Health Services* (Series of issue papers on contracting for managed behavioral health care). Paper #1: "Defining Medically Necessary Services to Protect Plan Members" (1995); Paper #3: "An Evaluation of State EPSDT Screening Tools" (1997); and Paper #5: "Defining Medically Necessary Services to Protect Children" (1997). (Washington DC: Bazelon Center for Mental Health Law.)

Bazelon Center for Mental Health Law. *Making Medicaid Work: An advocacy guide to financing key components of a comprehensive State system of care*. (Washington DC: Bazelon Center for Mental Health Law, 1994.)

Carnegie Task Force on Meeting the Needs of Young Children. *Starting Points: Meeting the Needs of our Youngest Children*. (New York, NY: Carnegie Corporation of New York, 1994.)

Cole, Robert F. and Poe, S. *Partnerships for Care: Systems of care for children with serious emotional disturbances and their families*. (Washington, DC: Washington Business Group on Health, 1993.)

Hanson, Loi, et al. *Key Principles in Providing Integrated Behavioral Health Services for Young Children and their Families: The Starting Early, Starting Smart Experience*. (Washington, DC: US-DHHS, Substance Abuse and Mental Health Services Administration and Casey Family Programs, 2001.)

Infant Health and Development Program. "Enhancing the Outcomes of Low Birthweight Premature Infants." *JAMA* 1990; 263:3035-3042.

Institute of Medicine. *Reducing Risks for Mental Disorders: Frontiers for preventive intervention research.* (Washington, DC: National Academy of Sciences, 1994.)

Institute of Medicine and National Research Council. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. (Washington, DC: National Academy Press, 2000.)

Jellinek, Michael. *Bright Futures in Practice: Mental Health—Volume I. Practice Guide*. (Washington, DC: National Center for Education in Maternal and Child Health and Georgetown University, 2002.) http://www.brightfutures.org/mentalhealth/

Johnson, Kay. *No Place Like Home: State Home Visiting Programs*. (New York, NY: The Commonwealth Fund, 2000.)

Johnson, Kay, Knitzer, Jane, and Kaufmann, Roxanne. *Making Dollars Follow Sense: Financing early childhood mental health services to promote healthy social and emotional development in young children.* (New York, NY: National Center for Children in Poverty, 2002.)

Kaufmann, Roxane and Dodge, Joan. *Prevention and Early Intervention for Young Children at Risk for Mental Health and Substance Abuse Problems and their Families: A background paper*. (Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, 1997.)

Knitzer, Jane. "Early Childhood Mental Health Services Through a Policy and Systems Development Perspective." In S.J. Meisels and J.P. Shonkoff (Eds.), *Handbook of Early Childhood Intervention* (2nd ed.). (New York: Cambridge University Press, 1997.)

Knitzer, Jane. *Building Services and Systems to Support the Healthy Emotional Development of Young Children*. (New York, NY: National Center for Children in Poverty, 2002.)

Knitzer, Jane and Bernard, Stanley. *The New Welfare Law and Vulnerable Families: Implications for child welfare/child protection systems*. Children and Welfare Reform, Issue Brief 3. (New York, NY: National Center for Children in Poverty, 1997.)

Koyanagi, Chris and Brodie JR. *Making Medicaid Work: To fund intensive community services for children with serious emotional disturbance*. (Washington DC: Bazelon Center for Mental Health Law. 1994.)

Lederman, Cindy and Adams, Sandra. *Innovations in Assessing and Helping Maltreated Infants and Toddlers in a Florida Court*. (Zero to Three, 2001; 21(6):16-20.)

Perkins, Jane. *Medicaid Early and Periodic Screening, Diagnosis and Treatment as a Source of Funding Early Intervention Services*. (Los Angeles: National Health Law Program, 2002.)

Regaldo M and Halfon N. "Primary Care Services Promoting Optimal Child Development from Birth to Age 3 Years: Review of the literature." *Archives of Pediatric and Adolescent Medicine*, 2001; 155:1311-1322.

Rosenbaum S and Sonosky C. *Federal EPSDT Coverage Policy*. Prepared by the George Washington University Center for Health Services Research and Policy under contract to the Health Care Finance Administration, 2000.

Rosenbaum, Sara et al. Room to Grow: *Promoting child development through Medicaid and CHIP*. (New York, NY: The Commonwealth Fund, 2001.)

Rosenbaum, Sara, Proser, Michelle, and Sonsoky, Colleen. *Health Policy and Early Child Development: An overview* (New York, NY: The Commonwealth Fund, 2001.)

Rosenbaum, Sara et al. *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*. (Washington, DC: The George Washington University. 1st ed., 1997; 2nd ed., 1999; 3rd ed., 2000.)

Schorr, Lizbeth, with Daniel Schorr. *Within Our Reach: Breaking the cycle of disadvantage*. (New York, NY: Anchor Books, 1988.)

Shonkoff, Jack P and Meisles, Samuel J. Early. "Childhood Intervention: The evolution of a concept." In S.J. Meisels and J.P. Shonkoff (Eds.), *Handbook of Early Childhood Intervention* (2nd ed.). (New York: Cambridge University Press, 1997.)

U.S. Department of Health and Human Services. *Mental Health: A report of the Surgeon General*. (Rockville, MD: US-DHHS, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services and National Institutes of Health, National Institute of Mental Health, 1999.)

VanLandeghem K, Curtis D, and Abrams M. *Reasons and Strategies for Strengthening Childhood Development Services in the Healthcare System*. (Portland, ME: National Academy for State Health Policy, October 2002.)

Whitney, Terry, Groginsky, Scott, and Poppe, Julie. *Funding Inclusive Child Care. State Legislative Report*. (Washington, DC: National Conference of State Legislatures,1999); 24(1)1-5.

Wishmann, Amy, Kates, Donald, and Kaufmann, Roxane. *Funding Early Childhood Mental Health Services and Supports*. (Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, 2001.)

Zero to Three: National Center for Infants, and Toddlers and Families. *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3)* (1994) and *DC;0-3 Casebook* (1997). (Washington, DC: Zero to Three Publications.)

APPENDIX B: STATE CONTACTS

Florida

Sandra Adams
Director of Special Projects
Florida State University
Center for Prevention and Early Intervention Policy
1339 East Lafayette Street
Tallahassee, FL 32301
Phone: 850-922-1300
Fax: 850-922-1352
E-mail: sanadams@aol.com

Celeste Putnam
Director of Mental Health
Department of Children and Families
1317 Winewood Boulevard, Bldg. 6, Rm 275
Tallahassee, FL 32399-0700
Phone: 850-488-8304
Fax: 850-487-2239
E-mail: celeste_putnam@dcf.state.fl.us

Indiana

Maureen Greer
Emerald Consulting
40 North Ridgeview Drive
Indianapolis, IN 46219-6119
Phone: 317-353-8075
Fax: 317-353-8737
E-mail: mhmgreer@aol.com

Lanier DeGrella
Part C Coordinator, First Steps
Family and Social Services Administration
P.O. Box 7083
402 W. Washington Street
Indianapolis, IN 46207-7083
Phone: 317-233-9229

Vermont

Brenda Bean, Program Director
Children's UPstream Services
Children's Mental Health Services
Department of Mental Health
103 South Main Street, Weeks Building
Waterbury, VT 05671
Phone: 802-241-2650
E-mail: bbean@ddmhs.state.vt.us

Charles Biss, Director
Children's Mental Health Services
Vermont Department of Mental Health
103 South Main Street, Weeks Building
Waterbury, VT 05671
Phone: 802-241-2650
E-mail: cbiss@ddmhs.state.vt.us