NATIONAL ACADEMY
for STATE HEALTH POLICY

State Approaches to Promoting Young Children's Healthy Mental Development:
A Survey of Medicaid, and Maternal and Child Health, and Mental Health Agencies

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November 2005

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by

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EXECUTIVE SUMMARY

Children's healthy social and emotional development is essential to school readiness, academic success, and overall well-being. Services that support young children's healthy mental development can reduce the prevalence of developmental and behavioral disorders which have high costs and long-term consequences for health, education, child welfare, and juvenile justice systems.

As part of the Assuring Better Child Health and Development (ABCD II) program, NASHP surveyed Medicaid, maternal and child health, and children's mental health agencies in all 50 states and the District of Columbia to gather information on how states are addressing the healthy mental development of children ages birth to three. The objective of the survey was to identify critical issues, common approaches to addressing them, and innovative approaches that might be useful to states participating in the ABCD II Consortium and to other states as well. NASHP received survey results from 101 respondents representing all 50 states and the District of Columbia.

Key Findings

- In just over half of the states (26), at least one agency reported recommending specific screening tools to detect young children who may be delayed, or at risk of delay, for social emotional development. The most frequently recommended screening tools are the Ages and Stages Questionnaire (ASQ), the Ages and Stages Questionnaire: Social and Emotional (ASQ:SE), the Denver Developmental Screening Test, and the Parents' Evaluation of Developmental Status (PEDS).

- The majority of states (32) reported reimbursing for the use of screening tools, usually through Medicaid programs.

- States reported that providers raise a number of concerns regarding screening for social emotional development. A lack of referral resources, insufficient payment, and a lack of expertise are the most commonly cited concerns.

- Half of Medicaid agencies that responded (16 of 32) reimburse for services for children who are at risk of delays in social emotional development but who do not have a diagnosis. However, many respondents (6) did not know whether their states reimburse for these children.

- Various resources are available in the states to assist primary care providers who identify a child in need of further assessment or in-house follow up. Mental health consultation was mentioned most frequently (48 percent), followed by state-funded care coordinators (33 percent), public health nursing consultation (30 percent), and lists of organizations for

physician referrals (27 percent). However, these low percentages suggest that none of these resources are readily available.

- Respondents to the survey noted that children with mild or subtle emotional and behavioral disorders obtain care through a variety of agencies: private primary care providers, local health departments, early intervention, community mental health centers, school systems, or community programs. However, many respondents indicated that these children often do not receive services, either because they do not qualify or the programs lack resources to treat the children.

- Medicaid and mental health agencies reported some collaboration with each other but each reported less collaboration with early intervention agencies. Collaboration tends to be in the form of regularly scheduled meetings to share information and jointly developed policies and projects. Many states are involved in comprehensive strategic planning efforts that may assist state agencies in enhancing collaboration with each other and with private partners.

- Most state agencies do not actively encourage or reimburse for screening for maternal depression by pediatric providers. Medicaid agencies are likely to reimburse for treatment for maternal depression but usually only for women who are Medicaid beneficiaries.

- Most states do not require special infant mental health certification for individuals who work with (45), or bill for working with (42), infants.

- Just over half (26) of all states reported providing education or information to primary care providers to encourage them to focus on young children's early mental health development. Nearly half of respondents (48 percent) indicated that other organizations in their states provide training. They consider on-site training and in-person conferences to be the most effective mechanisms, but they tend to use fairly traditional methods to provide information, most commonly through dissemination of materials. Nevertheless, states are adopting new formats such as learning collaboratives and in-office training.

- Respondents perceive their state's system as most able to serve young children with severe mental health issues and least able to serve young children with mild mental health issues.

- States report that healthy mental development of children ages birth to three might not be the highest priority of state agencies for the following reasons: lack of funding for this particular issue, lack of system capacity to address the issue, higher prioritization of other issues for this age group, or higher prioritization of other populations.

The report illustrates many opportunities for improving the systems of care for young children's social emotional development. Respondents mentioned many areas in which information sharing among states could be useful. Many respondents expressed interest in learning more about specific models and best practices, among them:

- mechanisms for increasing the number of providers qualified to care for infants;
- Medicaid payment, blended funding, and other funding for these services;
- interagency collaboration;
- cost-benefit studies;
- provider education on screening, referral, and treatment;
- the use of DC:0-3™ (the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, used in some states to diagnose very young children and crosswalked to ICD-9 codes);
- comparison of state strategic early childhood plans; and
- Child Find approaches.

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INTRODUCTION

Young Children's Healthy Mental Development

Young children's healthy mental development refers to healthy social and emotional development, or the development of the ability to experience, regulate, and express a range of emotions, to form close and secure relationships, and to explore the environment and learn.[1]

Research demonstrates that children's healthy social and emotional development is essential to school readiness, academic success, and overall well-being. Services that support young children's healthy mental development can reduce the prevalence of developmental and behavioral disorders that have high costs and long-term consequences for health, education, child welfare, and juvenile justice systems.[2] According to the National Academy of Sciences, infants begin to explore their environment and learn to communicate from birth, and soon after they begin to construct ideas about how things work. The Academy urges early childhood programs to:

- balance emphasis on cognition and literacy skills with emotional, regulatory, and social development;
- develop strong linkages among welfare, protective services, early intervention, and mental health policies and programs; and
- make substantial investments in professional development.[3]

Although various state agencies can help promote young children's healthy mental development, state policies and practices vary among states and among states agencies. Information about state initiatives may be useful in terms of identifying opportunities for improvement.

Project Overview

The Assuring Better Child Health and Development (ABCD II) program, sponsored by the Commonwealth Fund, is designed to help states strengthen primary health care services and systems that support the healthy mental development of young children, ages birth to three. The

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[1] http://www.zerotothree.org/imh
[2] 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).
[3] Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development* (Washington, D.C.: National Academy Press, 2000).

program focuses particularly on preventive care of children whose health care is covered by state health care programs, especially Medicaid.

The National Academy for State Health Policy (NASHP) administers the ABCD II program which is focused on helping states create models of service delivery and financing that promote healthy mental development for Medicaid eligible children. Five states—California, Illinois,[4] Iowa, Minnesota, and Utah—were awarded grants for this program in 2004. Although the projects are led by the states' Medicaid agencies, they all entail working in partnership with other key stakeholders to achieve their objectives. Together, these states form the ABCD II Consortium, a laboratory for program development and innovation that shares its findings with all 50 states.

In February 2005, NASHP surveyed Medicaid, maternal and child health (MCH), and children's mental health (MH) agencies in all 50 states and the District of Columbia to gather information on how states are addressing the healthy mental development of children ages birth to three, including the issues and challenges confronted by the ABCD II consortium states. The objective of the survey was to identify critical issues, common approaches to addressing them, and innovative approaches that might be useful to ABCD II states as well as other states. The information gleaned from the survey is summarized in this report.

Methodology

NASHP designed the survey with the input and guidance of the ABCD II states in order to address their interests and needs. ABCD II states helped draft the questions, piloted the survey, and reviewed a draft of this report.

NASHP distributed via e-mail a 75-question survey to state Medicaid, maternal and child health, and children's mental health agencies. NASHP chose these agencies because they each have the potential to set policies that may influence young children's social emotional development, and NASHP believed that surveying all three agencies would result in more comprehensive information than choosing any one agency.

For the purposes of this survey, the following definitions apply:

- **Infant mental health**: the developing capacity of an infant or young child to experience, regulate, and express emotions; form close and secure interpersonal relationships; explore the environment; and learn.

- **Young children**: children ages birth through three (48 months).

[4] Unlike the other four states in the collaborative, Illinois's individual project is not funded by the Commonwealth Fund, but rather by a local funder: the Michael Reese Health Trust.

- **Social emotional development**: development of the capacity to experience, regulate, and express a range of emotions; to form close and secure relationships; and to explore the environment and learn.

- **Maternal depression**: clinical depression that women experience during pregnancy or up to one year following the birth of a child.

- **Screening**: the process by which a large number of asymptomatic individuals are tested for the presence of a particular trait.

- **Assessment**: the process, after screening, of determining with greater certainty the degree of impairment, the nature of the condition, and whether the individual identified in a screen could benefit from an intervention.

- **Tools**: instruments that allow a standardized method for identifying emotional or behavioral problems in young children. There are several kinds of tools, some of which can be completed by the parent. The survey asked about some specific tools by name.

Limitations to survey

This report provides information on responses to the survey. It does not attempt to validate the accuracy of the responses.

Some of the questions may have caused confusion due to different terminologies used by various state agencies. For example, some of the questions inquired about reimbursement for services. This language may be most appropriate to Medicaid agencies, which finance care, than to maternal and child and mental health agencies, which fund services through different mechanisms. Some specific questions that may have caused confusion are noted within the report.

The responses may represent the experience and knowledge of only one person within a particular agency. NASHP sent the survey primarily to agency directors who may have forwarded it to other staff for completion. Although NASHP has the name and contact information of each respondent, it is not possible to determine whether the information was provided by staff with the most complete knowledge or whether several staff may have collaborated on the responses. It is possible that other staff would have responded differently to some of the questions.

Finally, we have chosen to present most responses to the survey in the present tense, assuming that responses provided within the last year remain valid and accurate.

Survey respondents

NASHP received survey results from 101 respondents representing all 50 states and the District of Columbia. Thirty-three Medicaid agencies, 32 maternal and child health agencies (MCH), and 27 children's mental health (MH) agencies responded.

Table 1 Respondents by state and agency

State	MCH	Medicaid	MH	State	MCH	Medicaid	MH
Arizona	●	●		New Hampshire			●
Arkansas		●		New Jersey		●	●
California	●	●	●	New Mexico	●		●
Colorado		●	●	New York	●		
Connecticut			●	North Carolina	●	●	
Delaware		●		North Dakota	2	●	
Florida		●	●	Ohio	●	●	●
Georgia	●	●		Oklahoma	●	●	
Hawaii	●	2	●	Oregon			●
Idaho	●	●		Pennsylvania			●
Illinois		●		Rhode Island	●	●	
Indiana	●		●	South Carolina	●	●	
Iowa	●	●		South Dakota	●		●
Kansas	●	●		Tennessee	●		●
Kentucky	●	●	2	Texas		●	
Louisiana	●	2	2	Utah	●	●	●
Maine			2	Vermont			●
Maryland			●	Virginia		●	
Massachusetts	●	●		Washington	2	●	●
Michigan		2		Washington, DC	●	●	
Minnesota	●		●	West Virginia			●
Mississippi	●		●	Wisconsin	●		
Missouri	●	●	●	Wyoming		●	
Nebraska	●			**Total Agencies**	**32**	**33**	**27**
Nevada	2	●		**Respondents**	**35**	**36**	**30**

In some cases, more than one representative of an agency responded, which explains why the total agency responses do not match the total number of responses. The report provides information on agency responses, total responses, and responses by state where useful. In cases where several agencies within a state disagreed about whether or not a particular service or program existed, NASHP assumed that "yes" answers were likely to be more accurate and coded them in that manner. In cases where several respondents from a single state agency disagreed, NASHP assumed that "yes" answers were likely to be more accurate and coded them in this manner. The appendix includes detailed information on all responses.

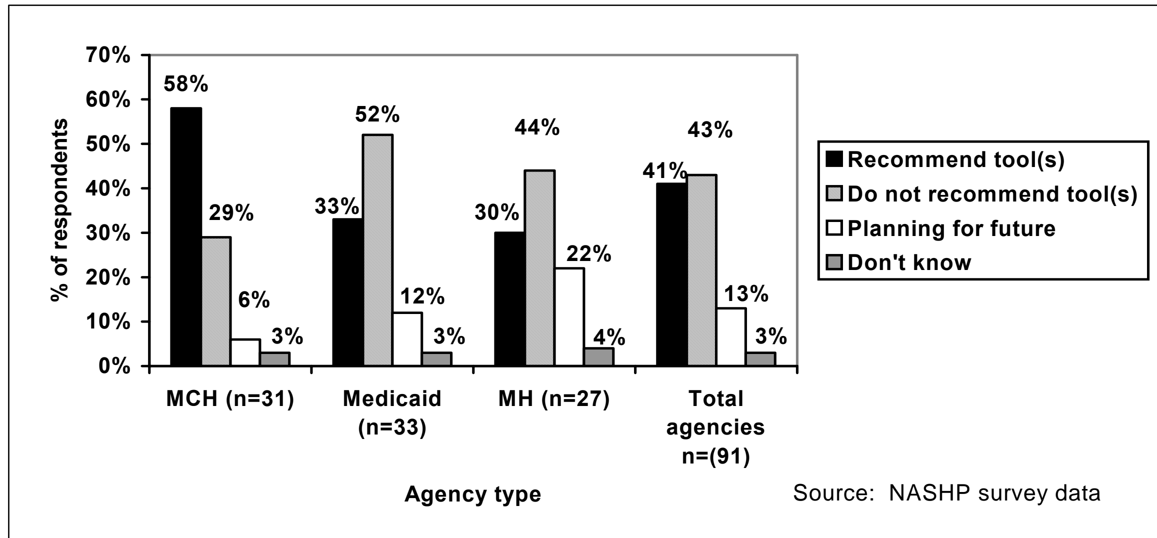
SCREENING

Recommending the Use of Validated Screening Tools

Recognizing that early intervention can have a lasting impact on children, many states are interested in identifying and serving young children at risk for behavioral developmental problems. Screening provides an opportunity to identify these children. For the purposes of this survey, NASHP defined screening as the process by which a large number of asymptomatic individuals are tested for the presence of a particular trait.[5] By recommending specific validated screening tools and encouraging their use, states can facilitate use of tools that can help improve identification of children in need of further assessment.

In just over half of the states (26), at least one agency recommends to providers specific screening tools to detect young children who may be delayed, or at risk of delay, for social emotional development. Maternal and child health agencies are the most likely to recommend screening tools,to providers, and children's mental health agencies are most likely to be planning to do so in the future.

Figure 1 Almost half of agencies surveyed recommend at least one screening tool



[5] The definition comes from David Bergman, *Screening for Behavioral Developmental Problems: Issues, Obstacles, and Opportunities for Change* (Portland, ME: National Academy for State Health Policy, 2004), 5. Many definitions of screening use the term "assessment" in the definition, which may cause confusion. Bergman's definition was reviewed by experts in the field of child development and screening.

State recommendations are unlikely to influence provider behavior in screening children unless states find effective mechanisms to inform providers of their recommendations. As a result, states agencies use a variety of methods to inform providers of their recommendation to use screening tools, most commonly through provider training sessions, language in provider manuals, and language in agency policies. Respondents mentioned Web sites with links or information on good screening practices least often.

Maternal and child health agencies are most likely to use provider training, including training for staff who conduct newborn screening, home visits, and other public health providers. Medicaid agencies are most likely to use language in provider manuals.[6] Several respondents mentioned contractual language for purchased services. Unless states actively disseminate this information, providers may be unlikely to know about the recommendations.

Table 2 State agencies that recommend screening tools do so in various ways

Agency	Language in agency policies		Language in provider manuals		Provider training sessions		Web site with links or information about good screening practices		Other	
	#	%	#	%	#	%	#	%	#	%
MCH (n=18)	12	67%	9	50%	16	89%	5	28%	8	44%
Medicaid (n=11)	6	55%	9	82%	6	55%	2	18%	1	9%
MH (n=8)	4	50%	4	50%	5	63%	2	25%	0	0%
All Agencies (n=37)	22	59%	22	59%	27	72%	9	24%	9	24%

[6] According to a 50-state review of Medicaid fee-for-service provider manuals, 16 state provider manuals recommend specific developmental screening tools. These 16 states do not match the 9 that responded positively to this survey. The discrepancy may be due to the difference in the question, the response rate to this survey, or other factors. For example, this survey focused specifically on social emotional development of children birth through three, while the review of provider manuals focused on developmental screening for a broader age group of children. Anne Markus, et al., *Fulfilling the Promise:How States Invest in Child Development Under Medicaid and SCHIP, A 50-State Comparison and Compendium of Coverage and Payment Policies of Preventive Pediatric Care* (Washington, DC: Center for Health Services Research and Policy, Department of Health Policy, George Washington University School of Public Health and Health Services), forthcoming.

Reimbursement for Screening

The EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) program provides comprehensive health services for infants, children, and adolescents enrolled in Medicaid. These services include both mental and physical developmental assessment.[7] Routine developmental screening and assessment services covered by EPSDT can identify young children with developmental or behavioral problems. Medicaid agencies have opportunities to define and manage screening services. States can adopt separate definitions, billing codes, and payment rates as part of improvements to early childhood developmental and mental health services financing.[8] The following sections address state practice in reimbursing and encouraging the use of valid, structured screening tools to identify mental health problems in young children.

Respondents were asked whether their agency reimburses (either separately or as part of a fee for another service) for the use of standardized screening tools to detect young children who may be delayed, or at risk of delay, for social emotional development. The responses indicate that the majority of states reimburse for the use of standardized screening tools. Although Maternal and Child Health agencies are most likely to recommend specific screening tools, Medicaid agencies are most likely to reimburse for the use of such tools. Several maternal and child health agencies indicated that they fund or finance screening as part of the process of determining eligibility for Part C Early Intervention services.[9] Others indicated it is part of the local public health funding fee structure.

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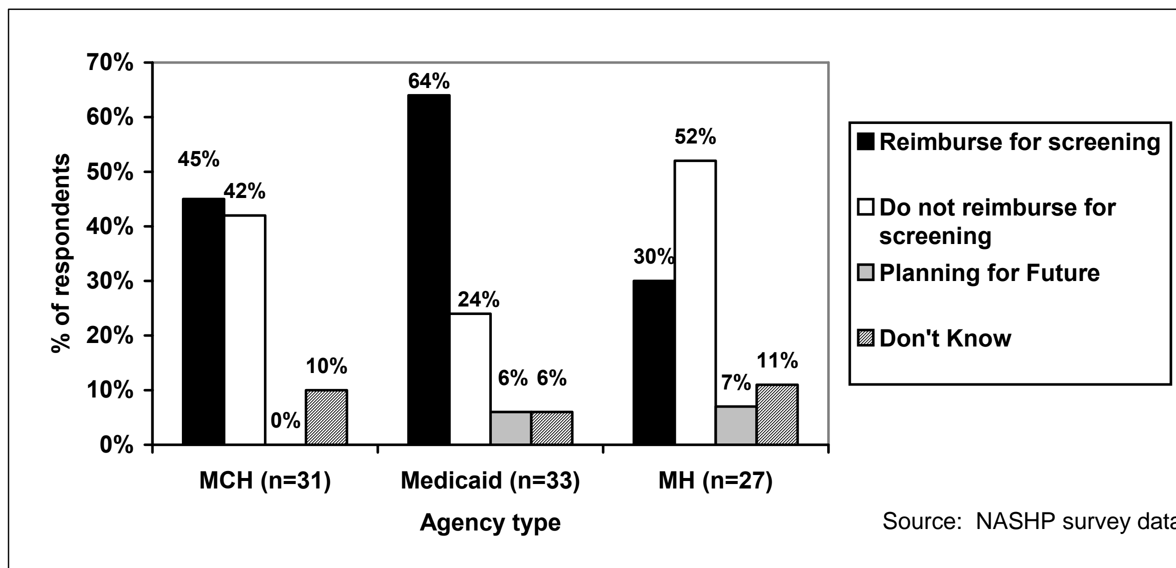
[7] Sara Rosenbaum, Michelle Proser, Andy Schneider, and Colleen Sonosky, *Room to Grow: Promoting Child Development through Medicaid and SCHIP* (Washington, D.C.: The George Washington University Medical Center, School of Public Health and Health Services, Center for Health Services Research and Policy, July 2001), 26.

[8] For more detail on mechanisms that state Medicaid agencies can use to define and manage EPSDT services to better promote young children's healthy mental development, see Kay Johnson and Neva Kaye, *Using Medicaid to Support Young Children's Healthy Mental Development* (National Academy for State Health Policy, Portland, ME: 2003).

[9] The Program for Infants and Toddlers with Disabilities (Part C of IDEA) is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for infants and toddlers with disabilities, ages birth through two, and their families. In order for a state to participate in the program, it must assure that early intervention will be available to every eligible child and its family. Also, the governor must designate a lead agency to receive the grant and administer the program. Currently, all states and eligible territories are participating. Source: http://www.nectas.unc.edu/partc/partc.asp#overview. Retrieved 3 Nov 2005.

Figure 2 Medicaid agencies are most likely to reimburse for screening with validated, structured tool



According to survey respondents, the two most common methods of Medicaid reimbursement for use of standardized screening tools are payment for an EPSDT periodic screen and for procedure-specific rates followed by payment for an EPSDT interperiodic screen. Many states checked multiple responses, indicating that states have created multiple ways for providers to be paid for screening, which may encourage screening in that providers may prefer to bill in different ways or in different ways for different situations.

For those who use an EPSDT screening (essentially a comprehensive well child exam, but defined by federal Medicaid regulations) or bundled rate for well child exams (as defined by the American Academy of Pediatrics), the rate tends to include a comprehensive health and developmental history, assessment and exam, immunizations, laboratory tests, and health education services. Respondents indicated that the maximum fee paid for bundled rates and EPSDT screening ranges from $51 to $95.

Those states that use procedure-specific rates frequently mentioned nationally approved CPT procedure codes.[10] The most commonly mentioned procedure-specific codes are listed below. Most respondents did not list rates for the codes, but for the few that did, the rates are listed below.

[10] Current Procedural Terminology

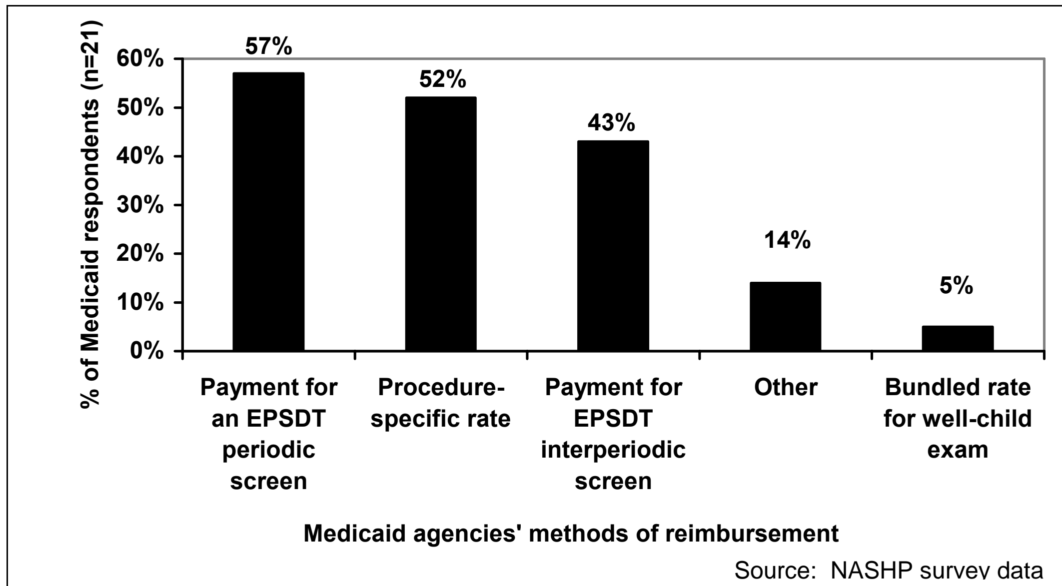
Table 3 Most commonly reported procedure codes and rates

Most commonly listed codes	Code description	Rates	AAP listed Medicaid rates[11]
99381-99385	Initial preventive visits for new children ages birth-4	99381: $52.00 (SC) $99.19 (WY) 99382: $47.00 (SC) $57.61 (OH) $106.79 (WY)	99381: $20-$113.15 99382: $20-$113.15
99391-99395	Periodic preventive visits for established children ages birth-4	99392: $47.00 (SC) $84.35 (WY)	99392: $20-$95
96111	Developmental psychological testing, extended	96111: $16.10 (IL) $59.84 (IA) $95.00 (RI)	96111: $16.10-$143.47

Of all the responses, the highest rate for the codes being used was $150.00 for a 50-minute psychiatric diagnostic interview exam (code 90801). More information on the specific codes and reimbursement rates are provided in the appendix.

[11] American Academy of Pediatrics, *Medicaid Reimbursement for Commonly Used Pediatric Services, 2004/5 Interim Report.* Retrieved 3 Nov 2005. http://www.aap.org/research/medreimPDF0405/Medicaid_Reimbursement_2004-05_Interim_Report.pdf

Figure 3 Medicaid most frequently reimburses for screening through EPSDT periodic screens and procedure-specific rates



According to survey respondents, states are more likely to reimburse EPSDT providers (those clinicians authorized by the state to provide EPSDT services, which might include physicians, public health practitioners, and others) and specialized early intervention providers for screening rather than primary care physicians or all physicians as a whole. The trend is most noticeable among maternal and child health agencies. Other providers most frequently mentioned for reimbursement include public health nurses and community mental health providers. Some states also mentioned Federally Qualified Health Centers (FQHCs), school-based service providers, and dentists.

Recommended Screening Tools

The use of systematic screening tools can help increase the identification of at-risk children who could benefit from an intervention but do not have a diagnosis. Different screening tools may be appropriate depending on time available, reimbursement mechanisms, training, and other factors.[12]

The most frequently recommended screening tools are the Ages and Stages Questionnaire (ASQ); the Ages and Stages Questionnaire: Social and Emotional (ASQ:SE); which focuses exclusively on behavioral development; the Denver Developmental Screening Test, and the Parents' Evaluation of Developmental Status (PEDS). Maternal and Child Health agencies

[12] David Bergman, *Screening for Behavioral Developmental Problems: Issues, Obstacles, and Opportunities for Change* (Portland, ME: National Academy for State Health Policy, 2004).

overwhelmingly reported recommending the use of the ASQ and ASQ:SE. Medicaid and mental health agencies did not as frequently mention any particular tool. Table 2 provides information from agencies that reported recommending screening tools.

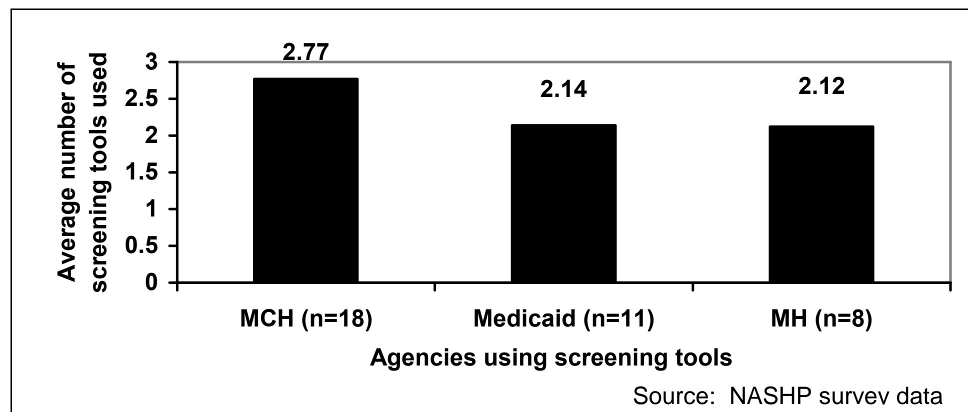
Table 4 ASQ, ASQ:SE, Denver, and PEDS are most commonly recommended tools

Agencies	Ages and Stages Questionnaires (ASQ)	Ages and Stages Questionnaires: Social-Emotional (ASQ:SE)	Batelle Developmental Screener	Bayley Infant Neurodevelopment Screener	Brief Infant-Toddler Social and Emotional Assessment (BITSEA)	Denver DST/Denver II	Infant-Toddler Symptom Checklist	Parent's Evaluation of Development (PEDS)	Prescreening Developmental Questionnaire (PDQ)	Temperamental and Atypical Behavior Scale (TABS) Screener	Other
MCH (n=32)	11	10	0	2	1	4	1	6	2	1	4
Medicaid (n=33)	6	4	4	4	2	6	5	6	3	2	7
MH (n=27)	4	4	1	2	3	2	2	3	0	1	1
Total Agencies (n=92)	21	18	5	8	6	12	8	15	5	4	12

Source: NASHP survey

Several states indicated that they provide a list of tools from which providers can choose. Agencies that recommend screening tools are likely to recommend at least two tools.

Figure 4 Agencies that recommend screening tools are likely to recommend more than one tool

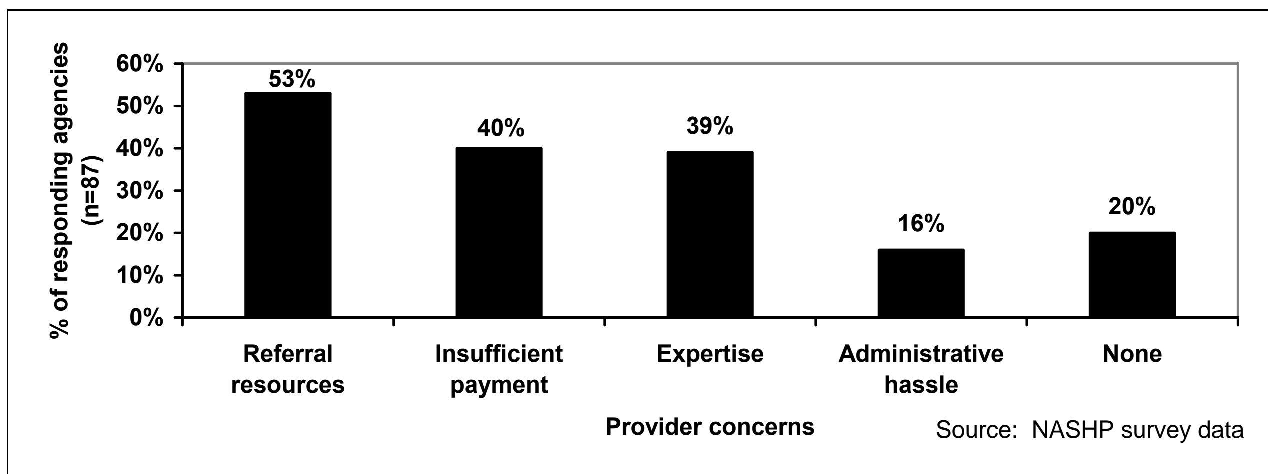


States report that providers raise a number of concerns regarding screening for social emotional development. States mentioned that providers may be hesitant to screen for the following reasons:

- Referral resources: hesitancy to screen may be related to provider belief that there are inadequate resources to treat issues that may be identified.
- Insufficient payment: hesitancy to screen may be related to provider concern about reimbursement for the services.
- Expertise: hesitancy to screen may be related to provider concern that they do not have the expertise to address issues that may be identified.

Respondents also mentioned that providers are concerned about administrative hassle and time constraints for training and screening, but they did not mention these concerns as frequently.

Figure 5 Providers are concerned about referral resources, insufficient payment, and expertise, according to states



ASSESSMENT AND DIAGNOSIS

For the purposes of this survey, NASHP defined assessment as the process, after screening, of determining with greater certainty the degree of impairment, the nature of the condition, and whether the individual identified in a screen could benefit from an intervention. This section reviews state practices in facilitating the assessment and diagnosis process through tools, reimbursement, and guidance.

Use of DC:0-3™

The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3™) was developed in 1986 to provide a common language for researchers, clinicians, and families in diagnosing very young children. DC:0-3™ is focused on developmental issues unique to infancy and toddlerhood. Relationships are of central importance in DC: 0-3™. Clinicians can use the classification framework to create a developmental profile of an infant or toddler that focuses attention on the various factors involved in an infant's strengths, difficulties, and potential areas for intervention.

Although the DC: 0-3™ serves a useful purpose, it may not be appropriate to a primary care setting. The framework requires a clinician or team to conduct a number of sessions to understand how an infant, toddler, or young child is developing in each area of functioning, and it requires well-trained clinicians with sufficient time and resources to conduct comprehensive diagnostic assessments. A primary care provider can appropriately screen for these issues, but a full evaluation usually requires a minimum of three to five sessions of 45 or more minutes each.[13] Nevertheless, state adoption of the DC:0-3™ system has the potential to improve primary care screening by allaying primary care providers' fears that children who are referred outside of the office will not receive a comprehensive assessment or an appropriate diagnosis or that they will not qualify for services.

Although most mental health services are billed according to ICD-9 (International Classification of Diseases, 9th Edition) codes, these codes may not be suitable for infant mental health services because they do not account for developmental issues unique to infancy and toddlerhood. As a result, some states use the DC:0-3™ classification system, but use a crosswalk with the ICD-9 codes in order to meet reimbursement criteria. The crosswalk of codes allows states to bill third party payers (including Medicaid) for infant mental health services and also anticipates the use of a national mental health classification system being developed under the HIPAA federal guidelines.[14] ZERO to THREE, the organization that developed the DC:0-3™, recommends that

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[13] For more on this topic, go to ZERO to THREE, http://www.zerotothree.org/imh/.

[14] The Health Insurance Portability and Accountability Act, or HIPAA (Public Law 104-91), is a federal law enacted by Congress in 1996 to reform the health care system in the United States. One of the

states that are interested in establishing reimbursement mechanisms for infant mental health services and that plan to use DC:0-3™ develop or adopt code crosswalks between DC:0-3™ and ICD-9.[15]

According to the survey, mental health agencies are most likely to have adopted, or have plans to adopt, the DC:0-3™. Maternal and Child Health agencies may be less likely to adopt the framework because the public health practitioners that provide services through these agencies may not be qualified to use it. Some Medicaid agencies that may be using DC:0-3™ crosswalks may have indicated that they have not adopted the DC:0-3™ as a billable code because they require DC:0-3™ codes to be crosswalked to ICD-9 codes for reimbursement in order to be HIPAA compliant. DC:0-3™ codes have not been approved for reimbursement.

Florida is one state in which the Medicaid agency has actively promoted the use of the DC:0-3™ with a crosswalk to ICD-9 codes. The Florida Medicaid Handbook section on mental health services recommends using DC:0-3™ as a guide to developing an ICD-9 diagnosis for birth to three. The Medicaid agency has also disseminated a DC:0-3™ crosswalk to the ICD-9 that was developed in Florida and approved by ZERO TO THREE.[16]

Only states that have adopted the DC:0-3™ for billing purposes, or are planning to do so, were asked whether they have crosswalked the DC:0-3™ or whether they provide tools, guidance, training, or outreach to providers regarding the framework. As a result, the following table describes only these states. No agencies responded that they provide guidance or tools to assist providers with using the DC:0-3™, but many of the mental health agencies in states that use the DC:0-3™ provide training or outreach on it.

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efficiency measures required by HIPAA is that billing transactions be conducted using national, uniform standards. Existing code sets, including the ICD-9 codes and the Current Procedural Terminology, 4th Edition (CPT-4), were adopted. These code sets will be used (by covered entities) to bill for the delivery of all health care services, including mental health services. (Source: ZERO to THREE, http://www.zerotothree.org/imh/).

[15] ZERO to THREE, http://www.zerotothree.org/imh/.

[16] ZERO TO THREE: http://www.zerotothree.org/

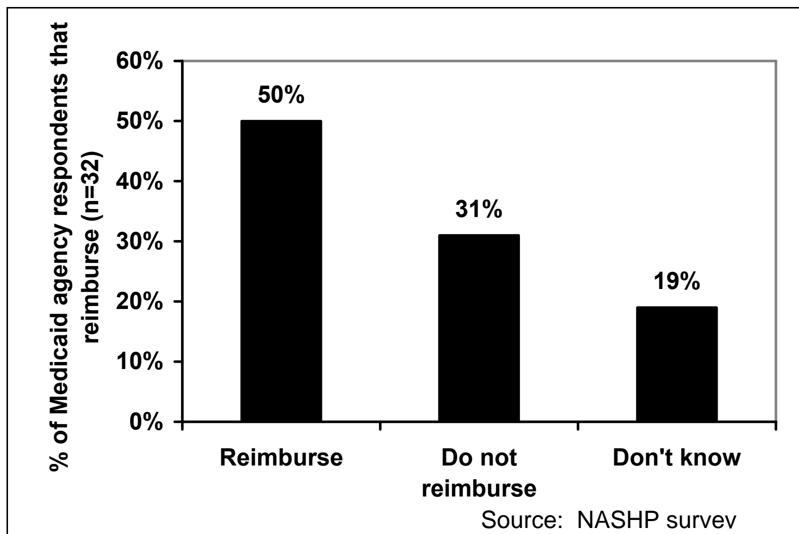
Table 5 State agencies that use or plan to use DC: 0-3, conduct crosswalks, and provide training or outreach

State	Agency	Comments	Use or plan to use DC:0-3™	Use DC:0-3™ Crosswalk	Provide training or outreach on DC:0-3™
CA	MH	California has not adopted DC:0-3™ due to MH specialty carve-out, but uses it informally and bills with DSM-IV.	Planning	Yes	Yes
CO	MH		Planning		Yes
FL	MH	The Florida mental health agency has adopted the DC:0-3™ classification system but not as a billable code. The agency uses a crosswalk to the ICD-9 codes. The state adopted the DC:0-3™ because it is considered a state of the art classification system for the birth to 3 population, it is based on careful observation and understanding of child/parent interactions, and it integrates all of the child's development for a concise understanding and development of treatment plans.	Using	Yes	Yes
MD	MH		No	Yes	
ME	MH	Maine uses the DC:0-3™ to insure eligibility of young children for Medicaid covered services and to allow providers to be reimbursed for services provided to young children in need of service.	Using	Yes	Yes
MN	MH	DC:0-3™ is the most developmentally appropriate classification available.	Using	Yes	Yes
NM	MCH, MH	MCH: DC:0-3™ is the standard of care. MH: DC:0-3™ is the best resource.	Planning	Yes	Yes
OH	Medicaid, MH	Medicaid: DC:0-3™ is an appropriate tool to use for the 0-3 age range. MH: The decision was based on research and recommendations from providers in Ohio and other states.	Planning	Yes	Yes
OK	Medicaid		Planning		
TN	MCH		Using	Yes	
TX	Medicaid		Using		
UT	MH	DC:0-3™ is an excellent assessment tool for consistency.	Planning		Yes
WA	MH	DC:0-3™ makes the most sense and fits with the DSM IV.	Using		

Medicaid Payment and Guidance

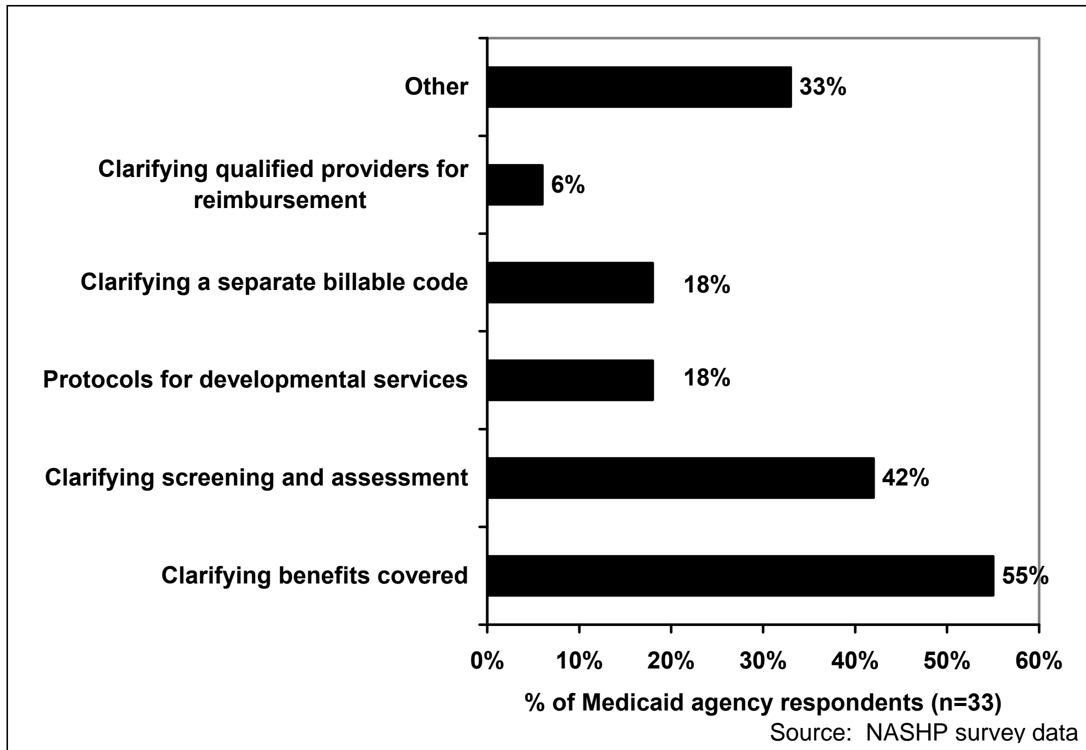
Many respondents were unclear whether their state Medicaid agency would reimburse for treatment of children who are at risk for delay in social emotional development but who do not have a diagnosis. Of all agencies that responded, almost an equal number answered yes (28) as no (29). Mental health agencies were least likely to believe that the Medicaid agency would reimburse for such services. However, the Medicaid agencies themselves were more likely to indicate that they would reimburse for such services. Still, only half of the Medicaid agencies who responded to the question stated that they reimburse for such services. The responses suggest that clarification of Medicaid policy on this issue may be helpful.

Figure 6 Half of Medicaid agencies reimburse for services for children at-risk of delay in social emotional development



Twenty-nine of 33 Medicaid agencies reported providing some guidance on billing, policy, and provider qualifications to providers on screening, referral, and treatment for young children's healthy mental development. Many of the remaining are in the process of doing so. States are most likely to provide guidance in the form of clarification of benefits covered and clarification of screening and assessment. Maternal and child health and mental health agencies are not likely to know about such guidance, indicating another area in which it may be helpful to clarify Medicaid practice.

Figure 7 Medicaid agencies provide guidance to providers on screening, referral, and treatment in a number of ways

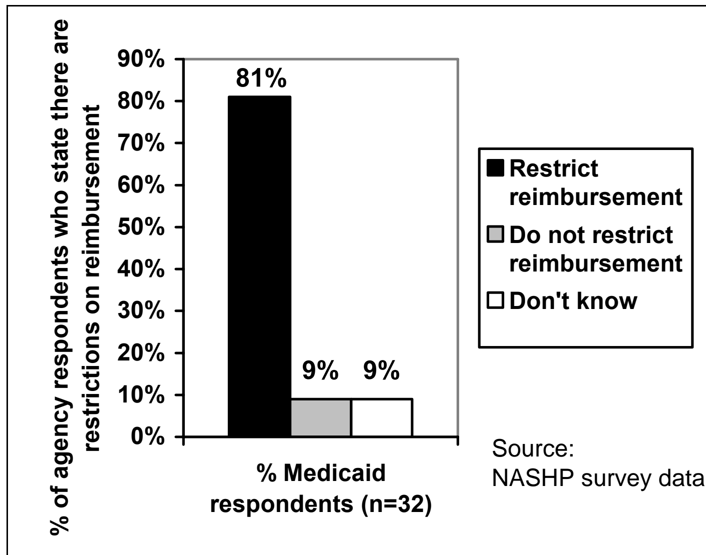


Source: NASHP survey data

Reimbursement for Assessment and Diagnosis

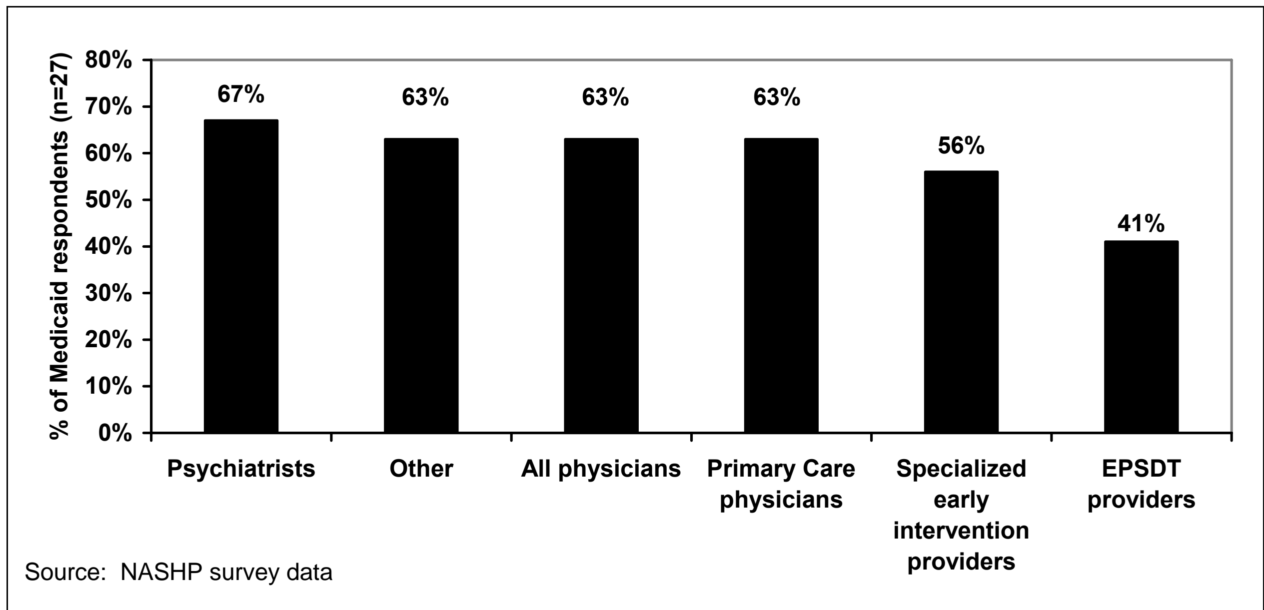
Most agencies place restrictions on the types of providers who can be reimbursed for assessment and diagnosis. Medicaid agencies are most likely to do so. However, they are likely to reimburse for many categories of providers, including primary care physicians, other physicians, psychiatrists, EPSDT providers (those authorized by the state to provide EPSDT services), and other behavioral health specialists, especially licensed social workers, mental health specialists, psychologists, or other mental health specialists employed by licensed centers.

Figure 8 Most Medicaid agencies restrict who can be reimbursed



Source:
NASHP survey data

Figure 9 Medicaid reimburses many types of providers for assessment and diagnosis



Source: NASHP survey data

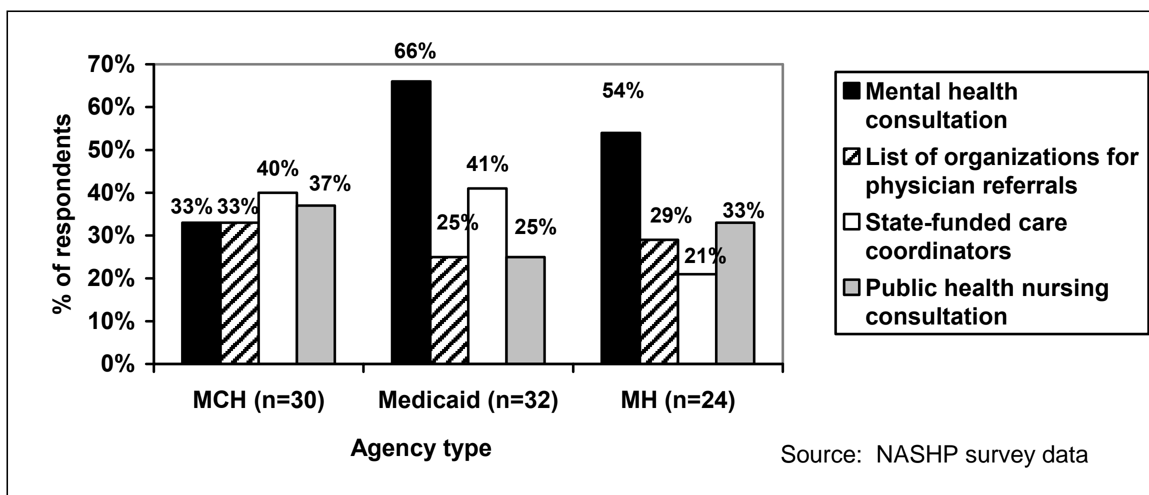
TREATMENT AND REFERRAL

As mentioned previously, states report that providers raise concerns about screening for social emotional development if they do not feel confident that there are referral resources available to treat children who may be identified through the screening process. As a result, identification of treatment and referral resources is critical to state efforts to promote young children's healthy mental development.

Follow-up Support

Survey respondents indicated that a variety of resources are available to assist primary care providers who identify a child in need of further assessment through a referral or follow up within the practice. Respondents mentioned mental health consultation[17] most frequently (48 percent), followed by an approximately equal number who mentioned state-funded care coordinators (33 percent), public health nursing consultation (30 percent), and lists of organizations for physician referrals (27 percent). Other resources that respondents mentioned include early intervention networks, 1-800 referral hotlines, or other locally-developed networks. However, no resource appears to be readily available, as evident by the low percentages.

Figure 10 Mental health consultation is the most frequently reported follow-up support

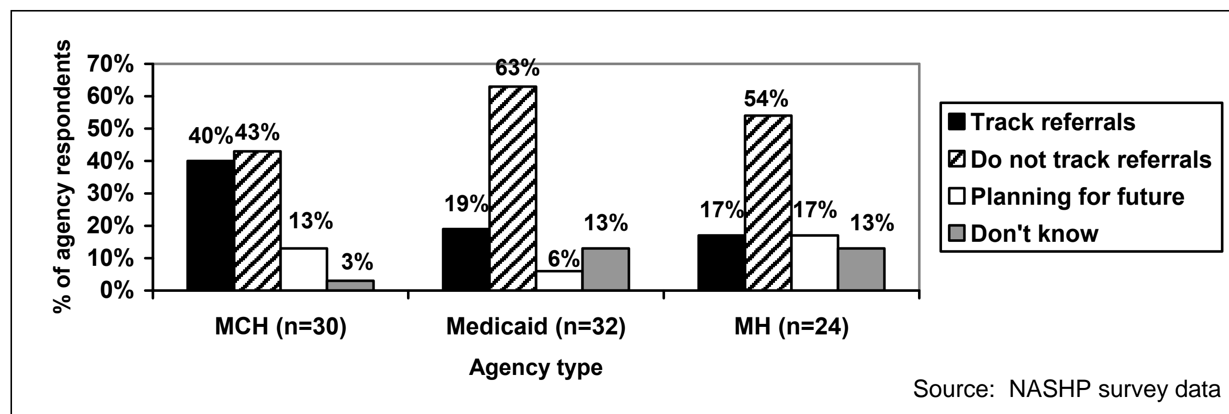


[17] Mental health consultation refers to a process in which a mental health professional assists a primary care provider with a client with the goal of helping the provider and client, adapted from M. Dougherty, *Consultation: Practice and Perspectives*, *3rd ed.* (New York: Guilford, 2000).

Follow-up Tracking

Follow-up tracking can help ensure that children do not fall through the cracks in services by monitoring whether children get the services for which they have been referred. However, less than 20 percent of states indicated in the survey that they track where children are referred for follow-up treatment or services. Tracking is most common among maternal and child health agencies.

Figure 11 Most agencies do not track referrals for follow-up treatment



Source: NASHP survey data

When tracking does occur, respondents indicated that referrals are about equally likely to be made to mental health therapists, early intervention programs, and community-based organizations. Maternal and child health agencies tend to refer more frequently to early intervention programs. Figure 13 provides referral locations for those who indicated that they track referrals.

Table 6 Early intervention is the most frequent referral location for maternal and child health agencies that track referrals

Agency	Mental health therapists		Early intervention program		Community-based organizations	
	#	%	#	%	#	%
MCH respondents (n=12)	7	58%	12	100%	8	67%
Medicaid respondents (n=6)	6	100%	6	100%	4	67%
MH respondents (n=4)	4	100%	4	100%	4	100%
All agencies responding (n=22)	17	77%	22	100%	16	73%

Source: NASHP survey

Eligibility for Follow-up Services

In most states, IDEA Part C Early Intervention services are administered by departments of health and social services or their equivalents (health and human services, health and welfare, health and environment, etc). In some cases the lead agency is a larger umbrella agency such as departments of rehabilitation, developmental services or disabilities, or human or social services. In 13 states, Part C is administered by departments of education (in two of these states, Nebraska, and Vermont, the department of education is a co-lead).[18]

According to Part C, states must provide services to children with developmental delays and those who have a diagnosed mental or physical condition that has a high probability of resulting in developmental delay. However, states must operationalize the definitions to determine eligibility within these categories. A small number of states (8) have more lenient criteria, choosing to serve children who are at risk of developmental delay if early intervention services are not provided. All states have the authority to adopt the at risk definition if they so choose, but, in doing so, they must use the very specific definition of at risk as established in Part C regulations: "an individual under three years of age who would be at risk of experiencing a substantial developmental delay if early intervention services were not provided to the individual." The at risk categories that states frequently describe include conditions of established risk, biological/medical risk, and environmental risk. The latter two categories may be likely to cover risks to social emotional development, including risk such as failure to thrive, low birth weight, family social disorganization, and child abuse or neglect.[19]

As noted in the survey responses, Part C language and definitions may cause confusion for state agencies that are not intimately involved in Part C. In some states, for example, the eligibility criteria mention that children are eligible if they have a developmental delay or a known condition that has a high probability of developing a delay. However, a high probability of delay does not meet the Part C criteria for at risk.

Although high probability does not meet the strict definition of at risk, it can be a critical component to a state's Part C eligibility criteria. For example, in a state with a high probability category, newborns with Down's Syndrome may be eligible for services before they experience significant delays. Technically, newborns with Down's Syndrome do not experience significant delays during their first few months, but due to their known condition, they have a high probability of developing such delays, especially if early intervention services are not provided; thus, they may be eligible for Part C services.

[18] Source: The National Early Childhood TA Center (NECTAC). Retrieved 3 Nov 2005. http://www.nectac.org/partc/ptclead.asp.
[19] Jo Shackelford, *State and Jurisdictional Eligibility Definitions for Infants and Toddlers with Disabilities under IDEA*, (Chapel Hill, NC: National Early Childhood TA Center's NECTAC Notes, Issue No. 18, March 2005), www.ectac.org/~pdfs/pubs/nnotes18.pdf.

A few examples from the survey help clarify the criteria:

- **Iowa** requires a 25 percent delay or a high probability of developing such delay without early intervention services.
- **North Carolina**: Children can be at risk, developmentally delayed, or have problems in social emotional development.
- **Rhode Island**: Children are eligible with a single established condition, developmental delay, or multiple established conditions.

Children with mild or subtle emotional behavioral disorders obtain care through a variety of agencies: private primary care providers, local health departments, early intervention services, community mental health centers, school systems, or community programs. The following examples from the survey describe how some states provide various services for children with varying needs:

- **Florida**: The state of Florida infant mental health strategic plan provides for three levels of infant mental health services:
  - Level I: Strengthening the caregiver child bond;
  - Level II: Strengthening services to families of children with delays, health problems, and with multiple risk factors; and
  - Level III: Infant mental health treatment for families with children diagnosed with emotional disorders.

- **Louisiana**: Currently the Office of Mental Health operates the Early Childhood Supports and Services Program which includes mental health services for children at risk for poor psychosocial, behavioral, and cognitive outcomes in certain geographic locations.

- **Oregon**: Ten counties in Oregon have funded projects to provide early childhood behavioral health services for children ages birth to eight and their families. All of these projects provide mental health consultation in early childhood care and education settings. Other services that are available include specific parent-child therapies, substance abuse treatment, parenting education, and skills training. The projects offer services for children, parents, families, and other service providers.

However, many respondents indicated that children with mild or subtle emotional behavioral disorders often do not receive services, either because they do not qualify or states lack resources to treat them. Several respondents summarized the gap in services:

> *This is not easy to find. Their primary care providers provide most of this. They can be referred to psychiatrists (not easy to find with the low reimbursement) or to community mental health (not easy to access because of more acute needs of severely affected population).*

These children often fall through the cracks... [There are] not enough early childhood resources trained in early childhood screening and assessment tools to provide quality care.

Primary Care and Mental Health Co-Location

Co-location of primary care and mental health providers may present an opportunity to ensure children receive needed services. However, it is not a common practice. About one in four states reported that they encourage pediatricians and other primary care providers to co-locate with mental health specialists to help address mental health issues and coordinate mental health and medical care. Almost as many indicated that do not currently do so but are planning to do so in the future. There were no significant differences among types of agencies, although Medicaid agencies were least likely to respond that they encourage co-location. The survey asked whether agencies encourage co-location; the method of encouragement was not included.

Most states do not have any specific reimbursement procedures for primary care providers who co-locate with a mental health specialist. Some of the responses are provided below:

- **Kansas**: Generally, co-location is primarily happening in Federally Qualified Health Centers (FQHCs) and there is a rate methodology for encounter data and cost settlement.
- **Ohio**: Psychiatrists are paid a rate based on the CPT code billed. Under community mental health, providers are paid on a cost reimbursement basis. Physicians, social workers, and professional clinical counselors are paid a percentage of the rate paid to a physician if the non-physician is employed by or under contract with the physician.
- **South Carolina**: The state reimburses primary care providers and pediatricians for the assessments/screenings. Mental health specialists are reimbursed if they meet medical necessity criteria and provider enrollment criteria. South Carolina co-locates psycho-social providers within medical homes.[20]
- **Utah**: The state Medicaid agency is working with the capitated mental health plans to co-locate staff and/or better coordinate with primary care.

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[20] According to the Health Resource and Service Administration (HRSA)'s Maternal and Child Health Bureau, a medical home is a source of ongoing routine health care in the community where providers and families work as partners to meet the needs of children and families. The medical home assists in the early identification of special health care needs; provides ongoing primary care; and coordinates with a broad range of other specialty, ancillary, and related services. HRSA considers the establishment of medical homes to be a critical indicator of progress toward achieving and measuring success in developing a national agenda for children with special health care needs. HRSA Maternal and Child Health Bureau. "Achieving and Measuring Success: A National Agenda for Children with Special Health Care Needs." Retrieved 7 Nov 2005. http://mchb.hrsa.gov/programs/specialneeds/measuresuccess.htm

Payment for Specialists

States reported using a variety of methods to pay for mental health specialists. The most frequent sources of funding include: state general revenue funds, Part C federal funding, Title V block grant, and Medicaid. Medicaid agencies pay through either fee for service, cost-based reimbursement, or capitated arrangements with community mental health centers. Some mental health providers are enrolled directly with Medicaid and others are reimbursed through their affiliation with mental health centers.

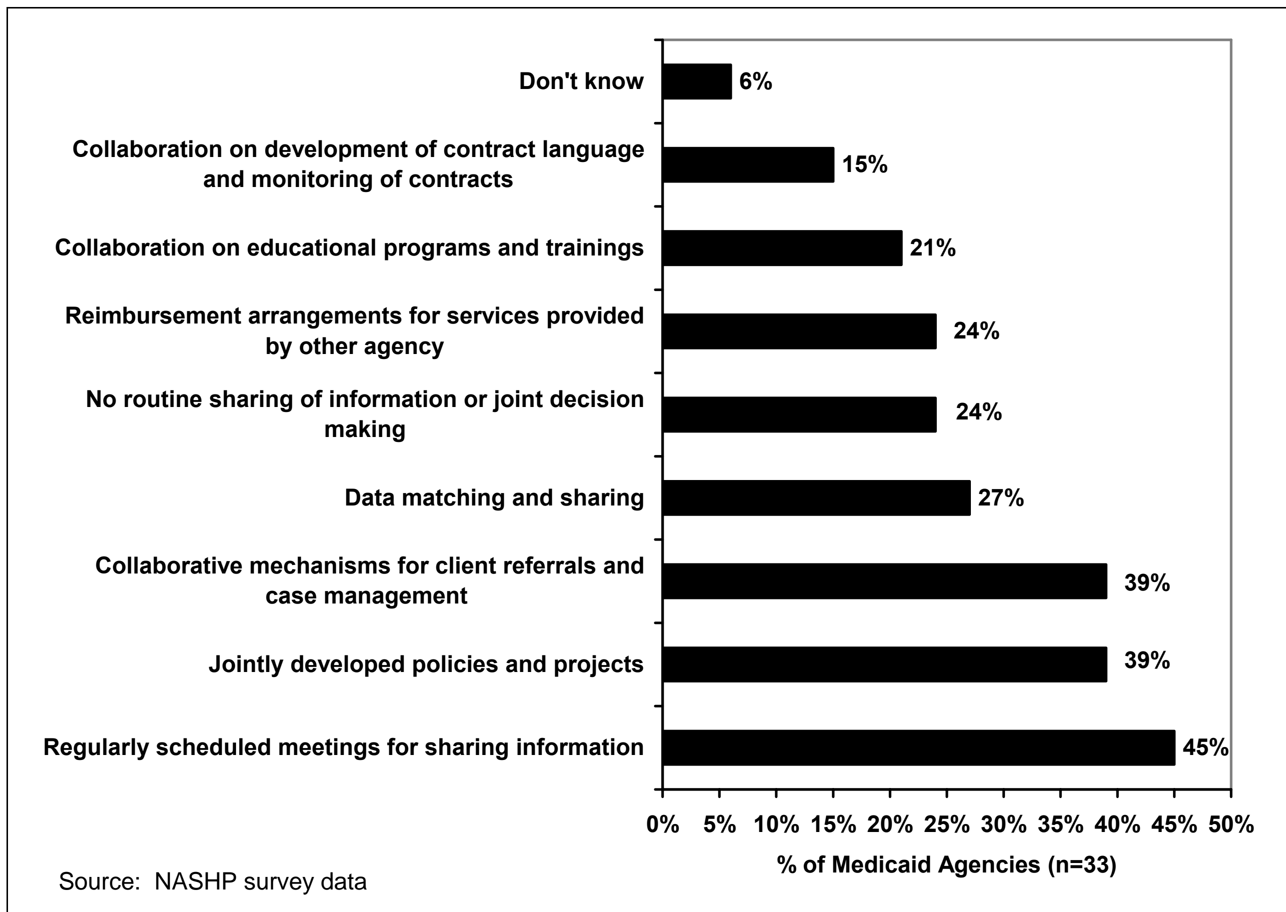
COORDINATION OF SERVICES

Medicaid, early intervention, and mental health agencies, among others state agencies, may have overlapping missions and serve overlapping populations. The social emotional development of young children may be addressed by any number of agencies, or these services can fall through the cracks if no one agency is viewed as responsible. These complex systems and agencies may operate independently of each other unless explicit policies and projects call for integration. Survey respondents were asked to describe the relationships between and among various state agencies to get a perspective on current relationships and opportunities for improvement. For these questions, respondents were allowed to check all categories that applied. They were not asked about relationships with maternal and child health agencies, an oversight of the survey design.

Medicaid and Early Intervention Agencies

Medicaid respondents generally view their relationships with Part C Early Intervention agencies as active. Almost one-half of respondents indicated that these agencies hold regularly scheduled meetings to share information. Close to 40 percent also noted that they jointly develop policies and projects and have collaborative mechanisms for client referrals and case management. However, almost one in four respondents felt there was not routine sharing of information or joint decision making among these agencies.

Figure 12 Medicaid and early intervention agencies collaborate on reimbursement and other policies



Source: NASHP survey data

Several respondents mentioned that the location of the agencies in the state's organizational structure influences relationships. Agencies under the same umbrella structure may be more likely to collaborate. Other respondents noted that some relationships with early intervention specialists are formed at the local level. Some of the responses are reflected below.

- **Hawaii**: The Medicaid agency informally collaborates with early intervention on special projects.
- **Michigan**: The Medicaid agency collaborates with early intervention on policy manuals.
- **Minnesota**: Local coordination occurs at Interagency Early Intervention Committees (IEICs).
- **Nebraska**: The chief of maternal and child health sits on the review committee for Medicaid managed care contracts and works to ensure coverage of early intervention.

Medicaid and Mental Health Agencies

Survey responses from Medicaid and mental health agencies indicate that these two agencies are more likely to collaborate with one another than are Medicaid and early intervention programs. When asked to define their collaborations, respondents from Medicaid and mental health were most likely to mention jointly developed policies and practices and data matching and sharing. They also frequently mentioned holding regularly scheduled meetings for sharing information.

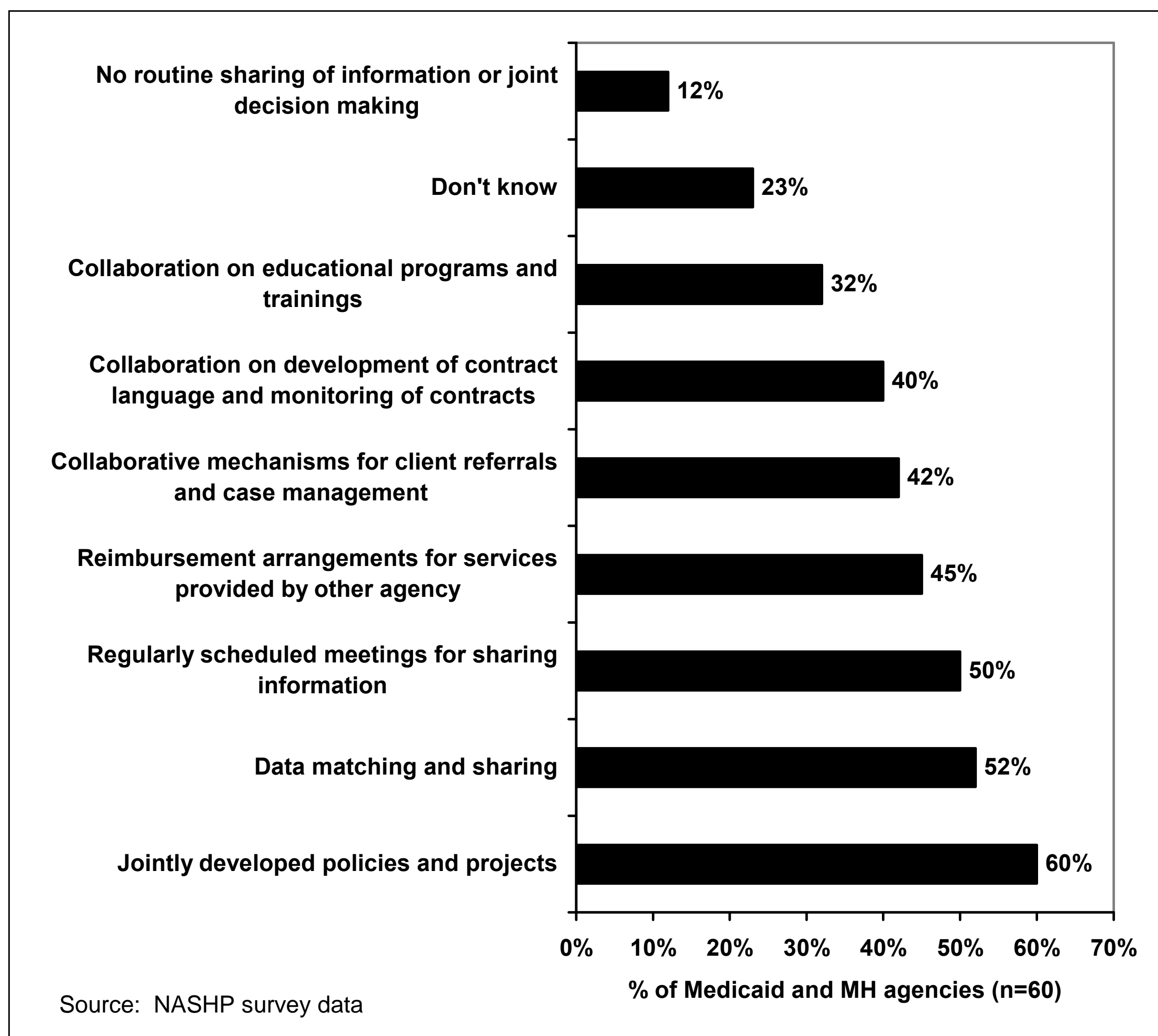
Just as early intervention and Medicaid respondents mentioned organizational structure as a factor in their relationship, so, too, did respondents from Medicaid and mental health agencies. Survey responses to questions about the relationship between Medicaid and mental health included:

- **Arkansas**: The state's Medicaid and mental health divisions are located within the same department. Shortly before the survey was conducted, some Medicaid staff members were placed in the mental health division, resulting in a great deal of interaction between the two divisions. In the process, new systems are being developed.

- **Florida**: The mental health and Medicaid agencies are working together to develop specialized service codes for the 0-5 population.

- **Iowa**: A recent children's mental health partnership has encouraged increased collaboration and joint projects.

Figure 13 Medicaid and Mental Health agencies collaborate most frequently



Early Intervention and Mental Health Agencies

Relationships between early intervention and mental health agencies were not mentioned as frequently by mental health agency respondents as the other relationships. More than 40 percent of respondents mentioned collaboration on educational programs and trainings. However, more than 35 percent indicated that they did not know about the relationship between mental health and early intervention agencies.

Several states mentioned developing memorandums of understanding and efforts to improve relationships. Some of the responses are noted below.

- **Colorado**: At the time of the survey, the early intervention/mental health relationship was just developing. The mental health agency had been invited to serve on an

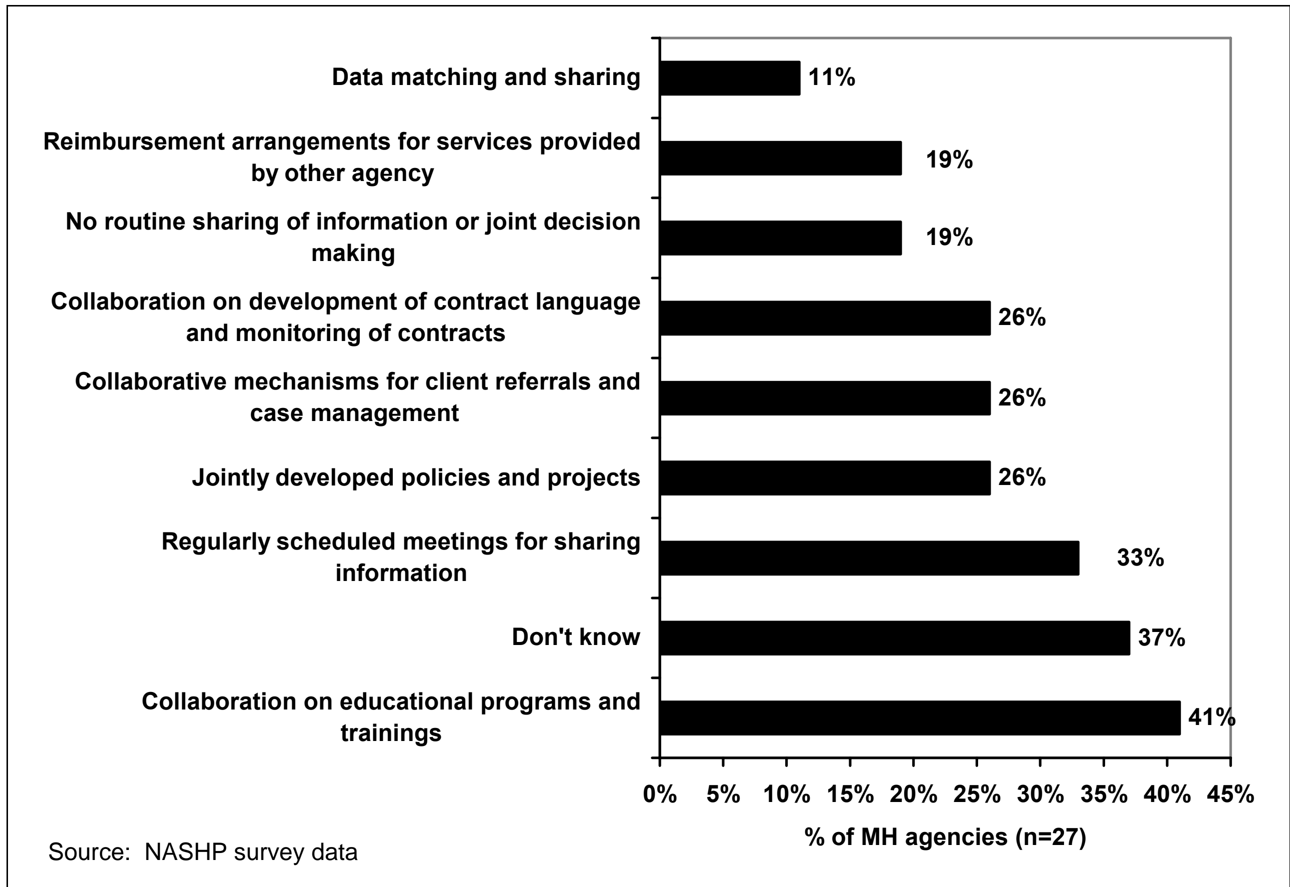
Interagency Coordinating Council. The council was working on a technical assistance document that detailed how social emotional issues are handled in Part C.

- **Montana**: The state's children's mental health bureau had been directed by the legislature to develop a system of care for children's mental health services. This task is being conducted with the oversight of a Children's System of Care Planning Committee established by law. The maternal and child health program is one of a number of agencies and programs serving children and adolescents that is represented on the committee. The committee meets monthly to provide oversight, assist in policy development, and establish standards for community interagency programs.

- **New Hampshire**: The state's mental health, early intervention, Part B Education,[21] maternal and child health, Head Start, developmental services, and family agencies are part of the Children's Care Management Collaborative (CCMC). CCMC is using braided funds to contract for technical assistance to 14 local infant mental health teams that are working to improve supports for young children and their families.

[21] Part B refers to disability categories enumerated in the Education for All Handicapped Children Act, for which states must provide education and related services.

Figure 14 Early intervention and Mental Health agencies collaborate most on training and education



Source: NASHP survey data

MATERNAL DEPRESSION

The mental health of parents influences the well-being of their children. For infants and young children, maternal depression can affect emotional and cognitive development of children and interactions between mothers and their children.

Maternal depression is often unrecognized and untreated. Pediatric providers, as the health professionals who often have the most contact with mothers, have the opportunity to help mothers recognize their symptoms as depression. However, only 50 percent of women with depression are identified during routine clinical care by either adult or pediatric providers. Pediatricians react to maternal concerns but only 8 percent routinely ask mothers about depressive symptoms during the postpartum period or at other times. Screening mothers for depression at well-child visits represents an opportunity to identify mothers and children in need of follow up assessment and care.[22]

Screening for Maternal Depression

About one in four of the Medicaid, maternal and child health, and mental health agencies who responded reported that they encourage pediatric providers to screen for maternal depression, but almost as many plan to do so in the future. When asked how they encourage pediatric providers to screen for maternal depression, agencies were most likely to respond that they do so through provider training sessions followed by language in agency policies.

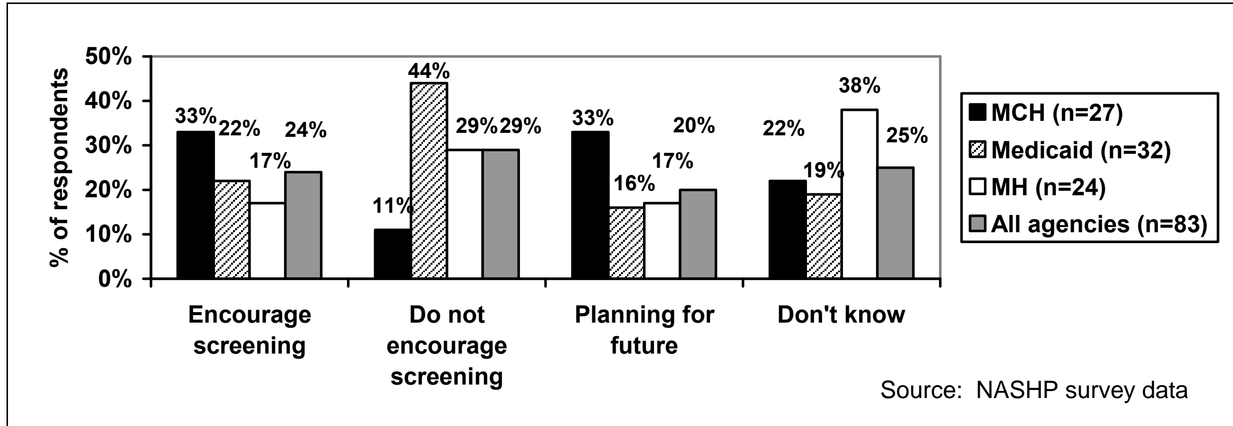
Maternal and child health agencies were most likely to report that they encouraged pediatric providers to screen for maternal depression or are planning to do so in the future. Some examples of state agencies that encourage screening:

- **Iowa** has included training on maternal depression/screening/referral/treatment at all of maternal and child health grantee conferences for the last few years.

- **Louisiana** reported including questions related to maternal depression in the infant risk assessment questionnaire that is used in its six counties that participate in the Early Childhood Support and Services program. The program is providing mental health services for children at risk for poor psychosocial, behavioral, and cognitive outcomes.

[22] A.L. Olson, "Maternal Depression," *About Children: An Authoritative Resource on the State of Childhood Today*, Eds. Cosby AG, Greenberg RE, Southward LH, Weitzman, M (Washington, D.C.: American Academy of Pediatrics, 2005), 142-145.

Figure 15   Most agencies do not encourage screening for maternal depression

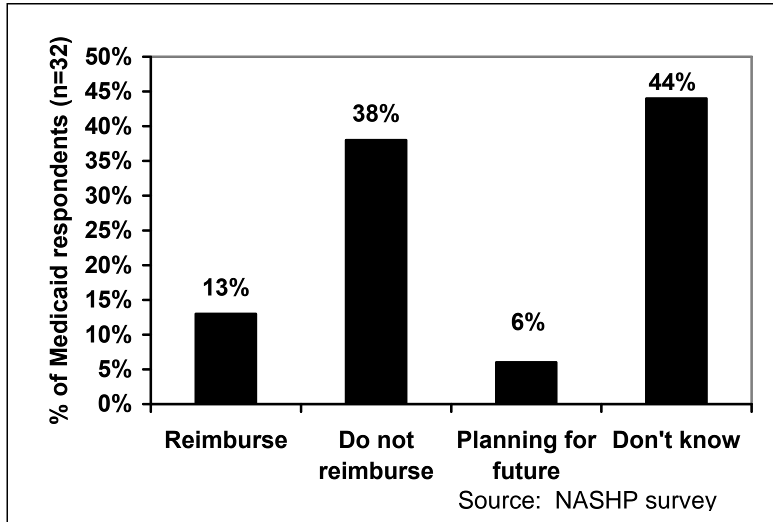


Source: NASHP survey data

Reimbursement for Screening for Maternal Depression

Most states do not reimburse pediatric providers for maternal depression screening, nor do they have plans to do so. Many respondents were not sure. The following chart provides responses for Medicaid agencies, since Medicaid agencies have the greatest potential to reimburse for screening. Illinois, Montana, Ohio, and Oklahoma Medicaid agencies reimburse for screening. It should be noted that Medicaid reimbursement most likely applies only to mothers who are themselves Medicaid beneficiaries (not all mothers of children who are Medicaid beneficiaries).

Figure 16 Most Medicaid agencies do not know whether they reimburse for maternal depression screening by pediatric providers

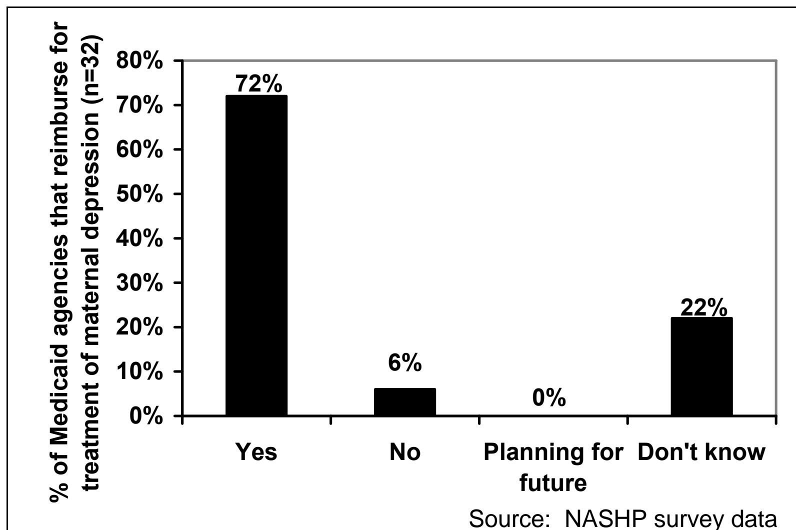


Treatment for Maternal Depression

In contrast to screening practices, most states responded that they encourage treatment for maternal depression or plan to do so. Maternal and child health agencies were most likely to answer positively. However, about one-third of mental health and Medicaid agencies were not aware of their state's practices regarding this issue. The survey did not ask specifically how agencies were encouraging treatment.

Most state agencies that provide health coverage cover treatment for maternal depression. Since Medicaid agencies are the most likely to provide health coverage, they are also the most likely to reimburse for maternal depression (in contrast to MCH and MH agencies, which also fund some services but do not provide health coverage). However, according to survey respondents, Medicaid agencies are likely only to reimburse for mothers who are Medicaid beneficiaries.

Figure 17 Medicaid agencies are likely to reimburse for treatment of maternal depression for mothers who are Medicaid beneficiaries



Some states mentioned that they are promoting screening, referral, and treatment for maternal depression through community mental health centers. Many maternal and child health agencies mentioned provider training and outreach activities. Some examples are listed below.

- **Louisiana**: The state is educating staff about referral of women with maternal depression. Mental health consultation and treatment services are provided for women through the Nurse Family Partnership Program (a prenatal and early childhood intervention program designed to improve the health and social functioning of low-income first time mothers who are found to have maternal depression).

- **New York**: The state is working with the American College of Obstetricians and Gynecologists (ACOG) to provide training for Ob/Gyn providers to identify maternal depression. The state is also planning to work on training with the American Academy of Pediatrics (AAP) and is trying to develop local resources for treatment of maternal depression so that health care providers will know where to refer for services.

- **Wisconsin**: The Wisconsin Association for Perinatal Care is focusing public and medical community attention on maternal depression and is supported by MCH Block Grant statewide initiative funding.

Some Medicaid agencies noted that treatment for maternal depression is a covered service for enrollees. Other Medicaid activities and Medicaid partnerships include:

- **Delaware**: The Medicaid agency works with the External Quality Review Organization (EQRO) to conduct focus studies, cooperate with the Division of Public Health on programs, and supply information on identification to primary care providers.

- **Illinois**: The University of Illinois at Chicago operates a perinatal depression consultation line for providers. Information on the project is available at http://www.psych.uic.edu/clinical/HRSA/.

- **Iowa**: The state Title V agency routinely screens for depression in its clients and identifies treatment resources. If a woman is covered by Medicaid, treatment can be covered through a mental health contractor.

- **Massachusetts**: No referral is required. The Medicaid agency provides information in member-support materials and newsletters and collaborates with the Department of Public Health on a maternal postpartum screening grant project.

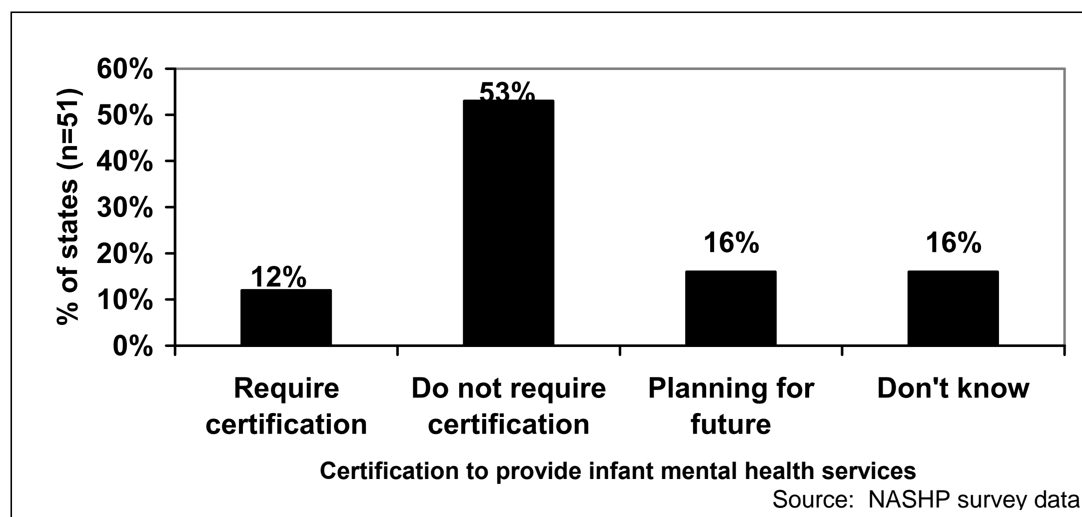
QUALITY ASSURANCE

As large payors of children's services, states undertake a variety of activities to assure quality of care and may link payment to identified and specified outcomes. The following sections describe some opportunities that states may use to measure and monitor quality and consistency of mental health services for young children.

Infant Mental Health Certification

Survey results indicate that most states do not require any type of infant mental health certification in order for professionals to work with infants. Of those that do, five require licensure as a mental health clinician (one of those requires a master's degree with appropriate education and experience) and one required bachelor level training. Other states require professional training but have no specific requirements for infant mental health.

Figure 18 Most states do not require infant mental health certification to provide infant mental health services



Survey findings suggest that most states do not require any specific type of infant mental health certification to bill for certain codes. States have general requirements for qualified providers, but nothing specific to infant mental health. Several states mentioned certification for early intervention or EPSDT providers.

Since infant mental health certification is not generally required, few training programs are available. Some are noted below.

- According to survey respondents, colleges and universities in the **District of Columbia, Kansas, Massachusetts**, and **North Carolina** offer training.

- The states of **Mississippi, North Carolina, and South Carolina** also offer training.

- **Georgia**: Training in social emotional development in young children is provided to various early intervention, public health, mental health, child welfare, education, and other state agency representatives throughout the state.

- **South Carolina** noted that its Department of Health and Human Services offers a child health maintenance course through the Department of Health and Environmental Control (DHEC) to registered nurses employed by physician screeners or screening clinics. Registered nurses performing screenings in schools must have successfully completed this course.

- **Utah** respondents indicated that providers affiliated with the Children's Center in Salt Lake City, which specializes in children with mental health disorders, offer training through a contract with the Division of Mental Health and Substance Abuse in the Department of Human Services.

Most states that do not require infant mental health certification do not have a formal process in place for monitoring quality of infant mental health services. Many states rely on professional licensing and certification processes to assure quality of care. Some states indicated that they monitor providers' internal quality assurance processes and conduct periodic quality reviews for provider groups and managed health plans, but they are not specific to infant health. Some of the monitoring arrangements are described below.

- **Kentucky**: The state has a training contract with a university to provide early childhood mental health training across the state to clinicians. Funds have also been provided to send clinicians to infant and early childhood trainings conducted by child psychiatrist Stanley Greenspan, M.D. The early childhood mental health specialists (ECMH), located in regional mental health centers to provide prevention and intervention services to early care and education programs and the young children and families they serve, receive ongoing training in early childhood mental health issues. ECMH specialists meet quarterly for training, technical assistance, monitoring, and case discussion. Periodic site visits are conducted in the Part C program as well as the ECMH Program.

- **North Carolina**: Providers are monitored through a contract with the local early intervention lead agency.

- **South Carolina**: The state conducts routine chart audits and observes visits.

State Sponsorship of Training

Few state agencies reported sponsoring their staff to get mental health certification, which might be expected given the lack of requirements for certification.

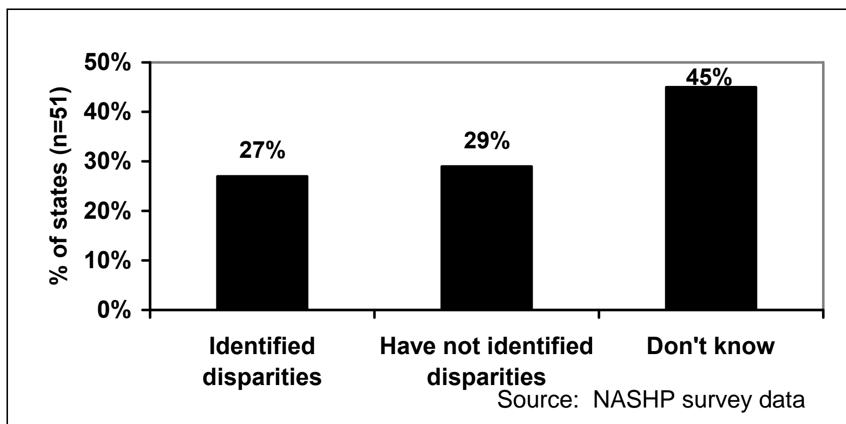
- **M**ental health agencies in **Florida, Louisiana, and Tennessee** and **New Mexico's** maternal and child health agency were the only agencies that reported sponsoring their staff. These states are not the same states as those that require certification for treatment or billing purposes.

- The **Louisiana** Office of Mental Health's Early Childhood Supports and Services program provides screening and treatment by psychiatrists, psychologists, and social workers who have undergone intensive infant mental health (IMH) assessment and intervention training provided through two medical schools in Louisiana. The screening and treatment program is available in limited geographic areas. Services are monitored by IMH-trained registered nurses and ongoing supervision and case consultation are provided by the medical schools. External program evaluation is also conducted.

Disparities

Slightly more than a quarter of states (27 percent) have identified racial or ethnic disparities in screening, assessment, or treatment for young children's healthy mental development.

Figure 19 Most states are not aware of ethnic or racial disparities



Respondents who believe there are disparities mentioned that racial and ethnic minorities tend to be underserved. Some respondents specifically mentioned African-Americans, American Indians, and Latinos, especially those who speak English as their second language or whose parents are undocumented immigrants. Several mentioned that racial and ethnic minorities are overrepresented in intensive treatment settings.

Of those who identified disparities, an approximately equal number are attempting to address them as are planning to do so. Interventions include cultural competency training for staff, hiring bilingual staff, using home based services, identifying and contracting with key community leaders to promote services, and increased Child Find[23] efforts in high concentrations of target populations. Two state responses are provided below.

- **Montana** mentioned that state agencies reviewed issues of disparities as part of state efforts to develop a system of care. The state plans to contract with one Native American reservation to develop a system of care delivery model that is culturally appropriate for the native nation and its reservation. The state expects a three- to six-year effort, ending in 2010.

- **Oregon** is contracting with a cultural competency consultant regarding recommendations for its children's mental health system of care.

Changes to Cost and Utilization

Research suggests that services that support young children's healthy mental development can reduce the prevalence of serious emotional disorders and other high-cost, long-term mental health conditions.[24] NASHP's survey inquired whether states have identified changes to cost or utilization as the result of effectively identifying children's social emotional development needs.

More than 80 percent of states did not know whether there were any changes to cost or utilization as the result of effectively identifying children's social emotional development needs. Many indicated that it is too early to tell. Those that identified changes to cost or utilization noted an increase in costs as the result of increased services to children who were previously not identified. However, they listed other benefits, including serving children earlier in order to improve outcomes and anticipating long-term savings of doing so. Some of the responses are described below.

- **California** identified increased caseload and increased draw-down of EPSDT.

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[23] The Individuals with Disabilities Education Act (IDEA) requires all states to have a comprehensive Child Find system to assure that all children who are in need of early intervention or special education services are located, identified, and referred as early as possible to Early Intervention (Part C) or Preschool Special Education (Part B/619) services. http://www.childfindidea.org/overview.htm

[24] Kay Johnson and Neva Kaye, *Using Medicaid to Support Young Children's Healthy Mental Development* (Portland, ME: National Academy for State Health Policy, 2003), 3. Sources cited include: Institute of Medicine, *Reducing Risks for Mental Disorders: Frontiers for preventive intervention research* (Washington, D.C.: 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).

- **Florida** claims it is still early to know the full impact; however, there has been an increase in services to young children, and "the earlier the identification and service provision, the better the outcome."

- **Idaho**: Medicaid utilization and costs have increased annually for the past five years due to increased identification of children with emotional disturbance.

- **Kentucky**: There has been an increase in the number of children aged birth to five served through the community mental health centers since the inception of the state's Early Childhood Mental Health (ECMH) program.

- **Louisiana**: Depending on the nature of the need, identification of social emotional development needs leads to the need for intervention and services that will involve a cost.

- **North Carolina**: More infants and toddlers are accessing early intervention and more providers have been identified.

- **North Dakota**: The EPSDT program has identified children with mental health problems at earlier ages and referred them for treatment. Utilization and cost have increased for young children.

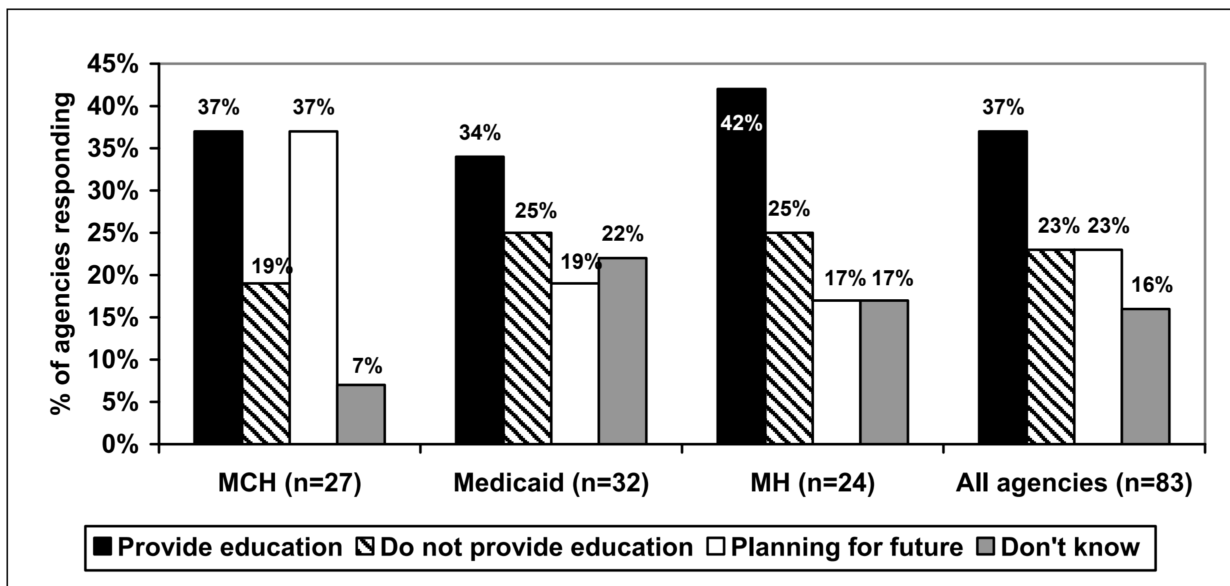
PROVIDER EDUCATION

State Agency Provider Education

State agencies may sponsor provider education programs, either independently or in conjunction with private organizations, with the goal of improving quality and coordination of care. Such activities may help improve care as well as develop collaborative relationships with providers.

Just over half of all states (26) reported providing information or education to primary care providers to encourage them to focus on young children's early mental health development. Many other states (13) are planning to do so. Mental health agencies are most likely to provide education or information.

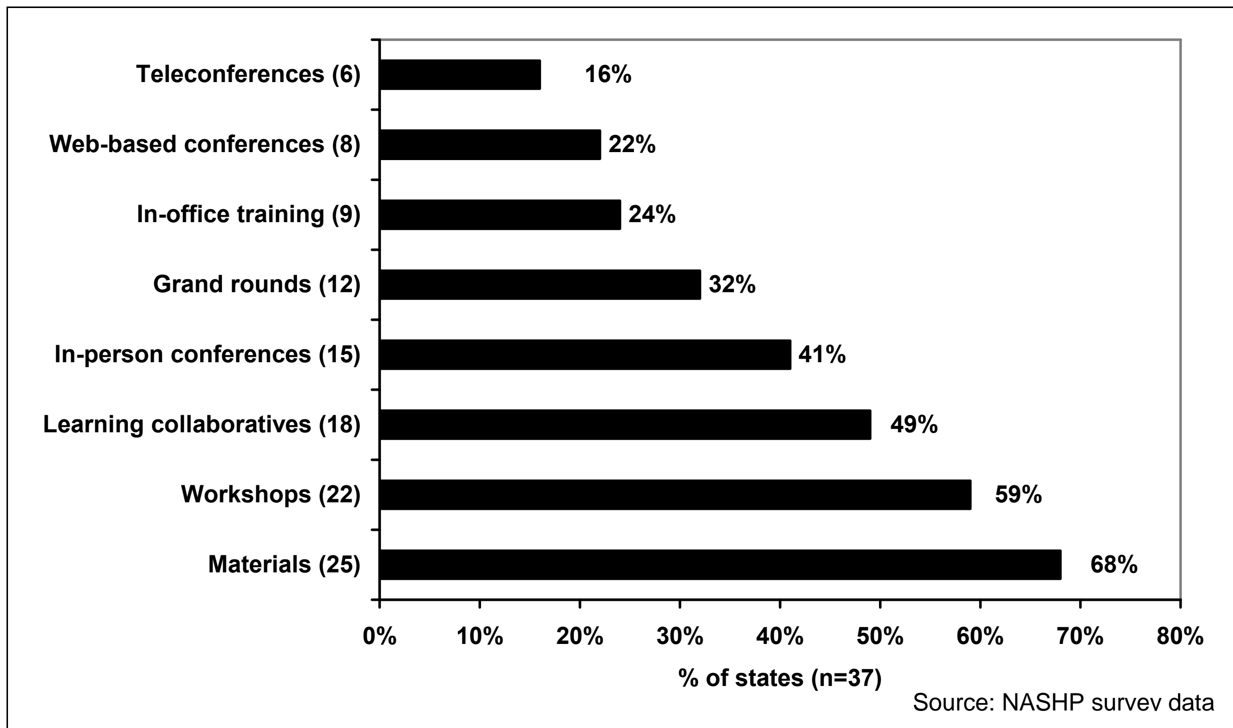
Figure 20 Primary care providers in most states receive some education or information on infant mental health from state agencies



Source: NASHP survey data

Most agencies, especially Medicaid agencies, provide information in the form of materials. Respondents also frequently mentioned the use of learning collaboratives and workshops.

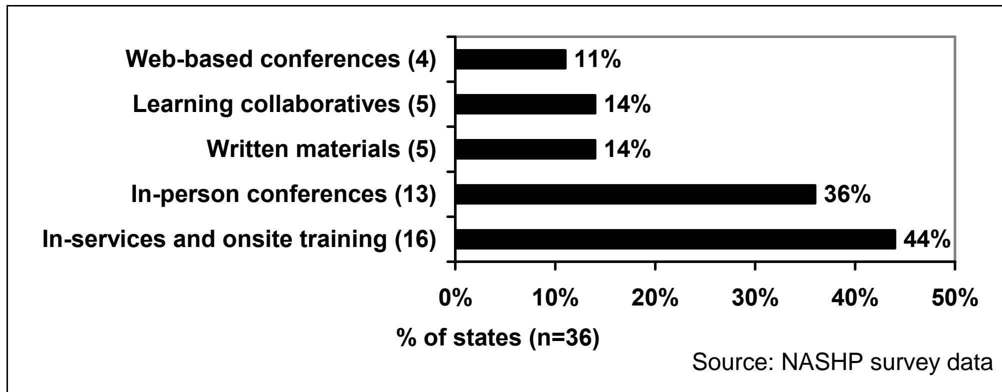
Figure 21 States are most likely to educate providers through materials and workshops



When asked about the type of provider education that states have found to be most effective, respondents most frequently mentioned small groups and onsite training followed by conferences. They did not rate materials as highly effective, even though materials are frequently used to provide information. This feedback conforms with much current thinking on what makes for effective provider education. One review of provider education initiatives suggests that effective programs take into account the complexity of office systems; are learner-centered, self-directed, and relevant to clinical practice; include a combination of approaches; and are interdisciplinary.[25]

[25] Scott G. Allen, *Emerging Models for Pediatric Education Nationally and in Illinois* (Chicago, IL: prepared for the Michael Reese Health Trust Health Care Issues Roundtable, May 6, 2005). See also Helen Pelletier, *Working with Physicians to Improve the Quality of Children's Healthcare,* (Portland, ME: National Academy for State Health Policy, forthcoming).

Figure 22 In-services and onsite education are viewed as most effective



State respondents to the survey offered the following examples of their efforts to educate and inform providers.

- **Arkansas** conducts visits to provider offices, group training sessions by the state's quality improvement organization, and policy manual updates.

- **North Carolina** provides on-site technical assistance in a small-group format provided through professional organizations such as the state pediatric society.

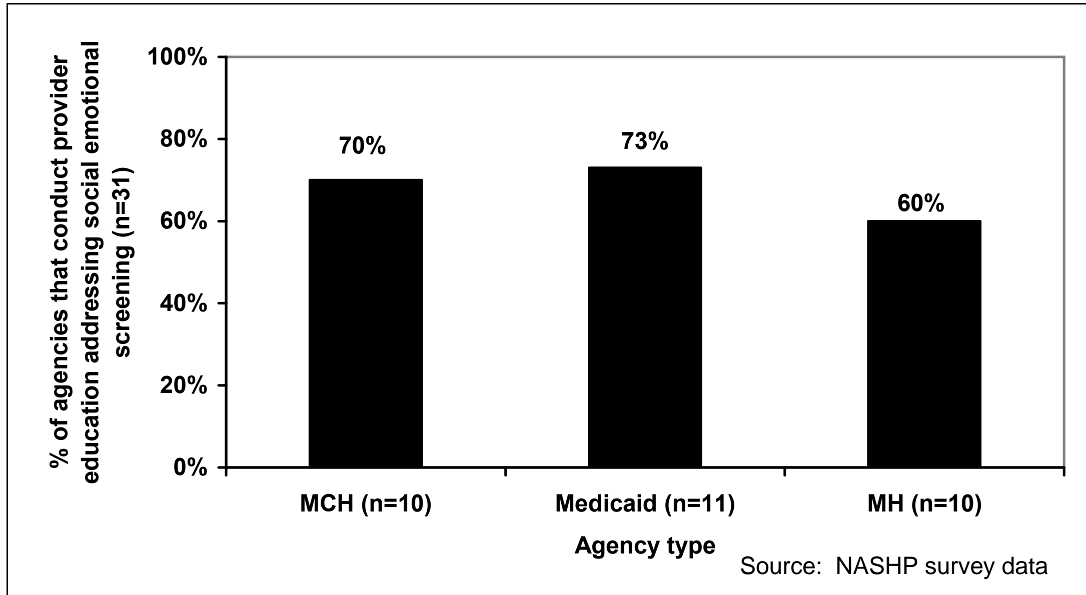
- **Ohio**: Workshops are conducted as part of general conferences that focus on young children. The conferences are followed by more intense training sessions for those who want more in-depth information.

- **Wisconsin**: State staff have discussed workshops for cross-disciplinary early childhood providers jointly developed and sponsored by the Initiative for Infant Mental Health (out of state government project), the Early Childhood Comprehensive System project, the American Academy of Pediatrics Wisconsin chapter, and perhaps the state's medical schools. The state reports growing interest in and acceptance of the Initiative for Infant Mental Health's goal of infusing the principles of healthy social emotional development into all service systems that touch the lives of babies and preschoolers.

Education on Social Emotional Screening

Almost all of the agencies and states that provide, or plan to provide, education to primary care providers on social emotional development are focusing some of their educational efforts on screening. Of 31 agencies that are currently providing training or information, 21 are focusing some of their activities on screening. These agencies represent 17 of the 26 states that are currently providing training or information.

Figure 23 Most agencies that conduct provider education address social emotional screening



In addition to providing training on general developmental screening, assessment, and referral, state respondents to the survey also mentioned focusing their provider education efforts on the following: social emotional development, early intervention, EPSDT, and billing issues. Florida's response is described below.

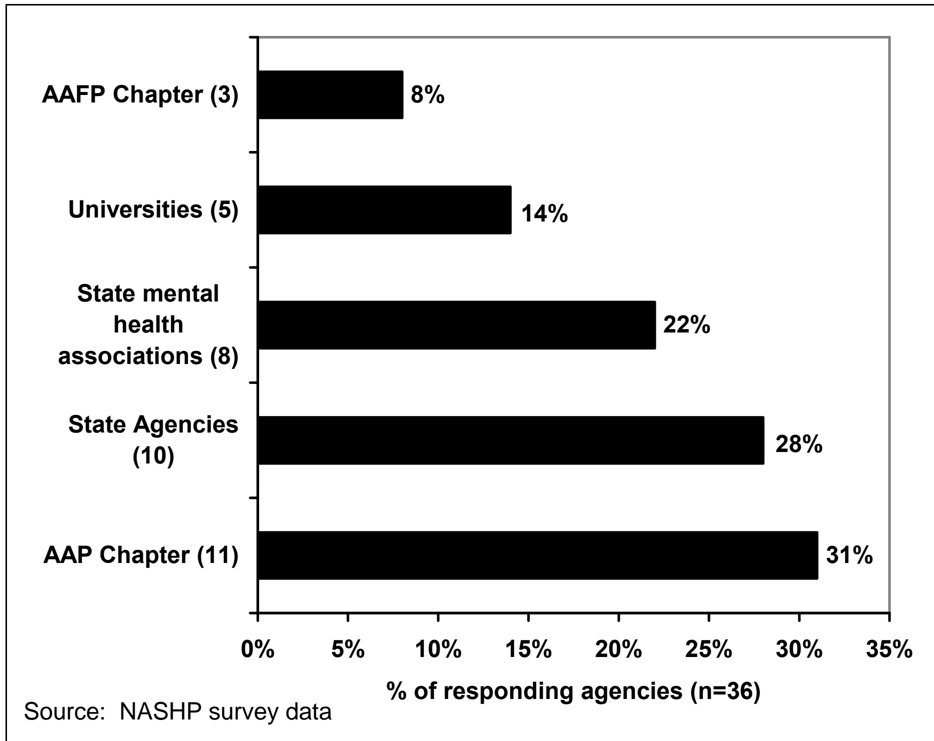
- **Florida** Medicaid has supported funding for training mental health professionals statewide through funding from the Harris Training Institute at Florida State University. The agency has also funded statewide trainings on the use of DC:0-3™ and actively supported and participated in the development of a statewide strategic plan for the development of infant mental health services in Florida.

Education Provided by Other Organizations

Nearly half of respondents (36 of 85) indicated that other organizations in their states are providing some type of training to primary care providers. Ten respondents mentioned state chapters of the American Academy of Pediatrics and three mentioned state chapters of the American Academy of Family Physicians. Other organizations that were frequently mentioned included other state agencies, state infant or child mental health associations (Colorado, Connecticut, Indiana, Minnesota, Montana, New Jersey, New Mexico, Rhode Island), and universities. Some respondents also mentioned HeadStart, advocate groups, and local mental

health authorities. Approximately half of the respondents, especially in Medicaid agencies, did not know whether other organizations were providing this type of training.

Figure 24 Other organizations provide training on infant mental health screening



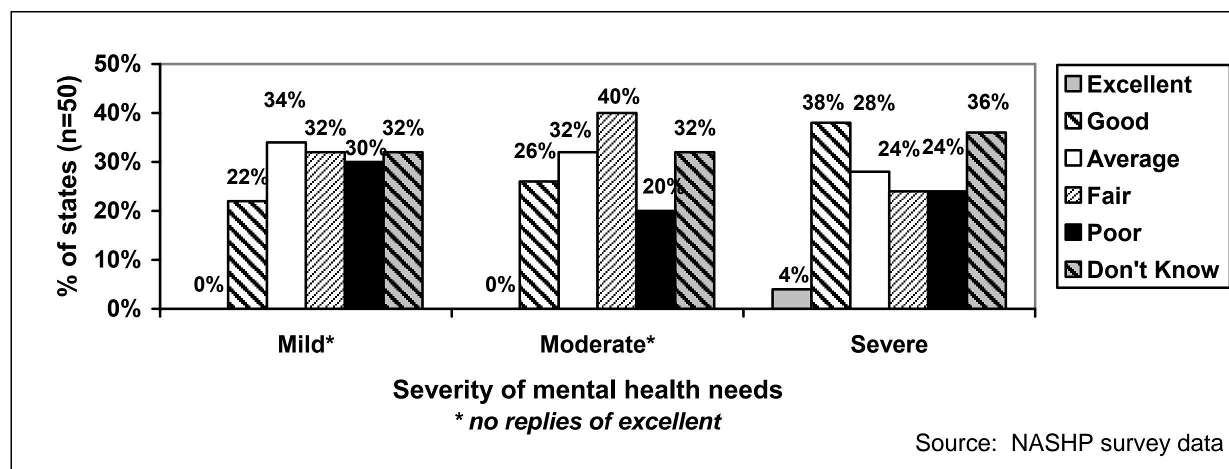
Source: NASHP survey data

SYSTEM CAPACITY

System Rating

Respondents rated their state's system capacity to address mental health as good, average, fair, or poor, but not excellent. State system capacity tended to receive higher ratings as the severity of the infants' needs increased. Thus respondents perceive the system as most able to serve infants with severe mental health issues and least able to serve infants with mild mental health issues. This trend held true for each type of agency. However, mental health agencies tended to rate system capacity as slightly better than did Medicaid and maternal and child health agencies.

Figure 25 States' system capacity improves with severity of needs



Staff Available to Provide Services

Since most states do not have specific certification requirements for infant mental health providers, respondents to the survey mentioned many types of professionals who provide these services, including psychologists, psychiatrists, primary care providers, social workers, those clinicians authorized by the state to provide early intervention services, and child development specialists. Respondents to the survey offered the following information about the types of providers who provide infant mental health services in their states.

- **Colorado**: Colorado has no special requirement at this time. Mental health centers have standards for licensed professionals, but there is no special training required for infant mental health through the public mental health system. However mental health centers are engaged in intensive training on DC:0-3™ and have a fellowship program with the Irving Harris Program in Child Development and Infant Mental Health at the University

of Colorado that recognizes clinicians who have gone through a year of intensive training as specialists.

- **Florida**: Florida Medicaid has different training requirements for the provision of different mental health services for ages birth to 3.

- **Illinois**: Any therapist (speech, occupational, physical, developmental), social worker, psychologist, or service coordinator who is credentialed in the early intervention system and has received the additional social emotional training in relationship-based intervention can provide infant mental health services.

- **Kentucky**: Regional early childhood mental health specialists have a background in children's mental health or child care/early childhood education. All are required to attend Greenspan Infant and Early Childhood (IEC) training and regularly scheduled professional development related to early childhood mental health throughout the year. Additionally, other clinicians within the regions who have received training in early childhood mental health and work closely with the specialists for consultation/case supervision can provide services.

- **Louisiana**: Professionals with additional training through a recognized program in the area of infant mental health are authorized to provide services.

- **Michigan**: Public community mental health agencies provide services and must be trained in infant mental health interventions.

Other State Activities

States are engaged in a number of related activities to promote young children's healthy mental development. Some respondents from MCH agencies (5 of 20) mentioned their involvement in the State Maternal and Child Health Early Childhood Comprehensive Systems (SECCS) strategic plans.[26] These states mentioned many agencies that are involved in strategic planning to develop a seamless coordinated system of care. Other respondents mentioned other collaborative efforts, including many that involve child-serving state agencies, private partners, and families. The following responses represent the range of activities underway, many of which have strong MCH components:

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[26] The purpose of this grant program is to support state efforts to plan, develop, and ultimately implement collaborations to support families and communities in their development of children that are healthy and ready to learn at school entry. Plans are expected to build toward systems that include, but are not limited to, access to medical homes, mental health and social-emotional development, early care and education/child care, parent education and family support. For more information, go to http://www.hrsa.gov/grants/preview/guidancemch/hrsa05115.htm, Attachment 2.

- **Kentucky**: Kentucky's Healthy Start in Childcare Consultants (Public Health Nurses) provides tools to screen for social and emotional development to child care centers. Upon scoring and meeting with partners, the child care centers make appropriate referrals to the state's early childhood mental health specialists. To date, more than 1,100 children ages birth to 5 years have received services through this program.

- **Massachusetts**: The Massachusetts Children's Psychiatry Access Project is attempting to address the critical shortage of child-trained psychiatric clinicians. The project provides pediatricians and family practitioners with immediate access to consultations with child trained psychiatrists; care management to assist families with access to routine family and child counseling services; short-term behavioral therapy as a transitional service through telephonic consultation; or face-to-face care until the child/family can access routine behavioral health services and acute psychopharmacological consultation with a child trained psychiatrist, if needed.

- **Missouri**: At the time of the survey, the state was in the final stages of a SECCS planning grant and planned to seek an implementation grant. The Department of Mental Health is on the Steering Committee of the SECCS project and heads a subcommittee on social emotional development. Legislation in 2004 created a Coordinating Board for Early Childhood that is designed to bring together all the agencies that serve your children in some way.

- **Nebraska**: At the time of the survey, the Nebraska Department of Education was leading a collaborative planning process focusing on early childhood mental health. This collaborative process has been linked to Nebraska's Early Childhood Comprehensive Systems grant efforts. In addition, an early childhood mental health pilot project has been funded in central Nebraska, using a blend of funds. Finally, Nebraska recently received a five-year SAMHSA State Infrastructure Grant (SIG) to address children's mental health infrastructure.

- **New Jersey**: Early intervention was recently determined to be a priority for the Division of Child Behavioral Health Services during a major reform of all services for children and adolescents in New Jersey. In addition, a second new division, the Division of Prevention and Community Partnership, is addressing prevention at the community and neighborhood level. Both of these initiatives will greatly enhance the provision of services for infants and toddlers.

- **New Mexico**: A pre-kindergarten initiative has become a priority for both the governor and lieutenant governor. In addition, the state is developing a behavioral health collaborative with a focus on addressing early childhood, and the statewide Infant Mental Health Collaborative has developed a strategic plan to increase capacity for the state.

- **Oklahoma**: All of the state's child-serving agencies formed a Children's Collaborative that includes Medicaid, the Department of Mental Health and Substance Abuse Services, the Department of Human Services, the Oklahoma Juvenile Authority, the Department of

Health, the Department of Education, and the Oklahoma Commission on Children and Youth.

- **Rhode Island**: Early social emotional development is one of the major focuses of the state's Successful Start (SECCS) initiative.

- **Washington**: One MCH staff person has primary responsibility for mental health of children, youth, and families. The state formed a stakeholder group of state agencies, providers, and other interested persons to begin addressing the need for a full continuum of mental health services (prevention, early intervention and treatment) for children and youth. A public health prevention specialist from the Centers for Disease Control is working on a mental health needs assessment. The state has provided additional training and resources to child care health consultants statewide to help them better address young children's social emotional and mental health. Social emotional/mental health is one of five focus areas in the state's Early Childhood Comprehensive Systems Grant planning effort.

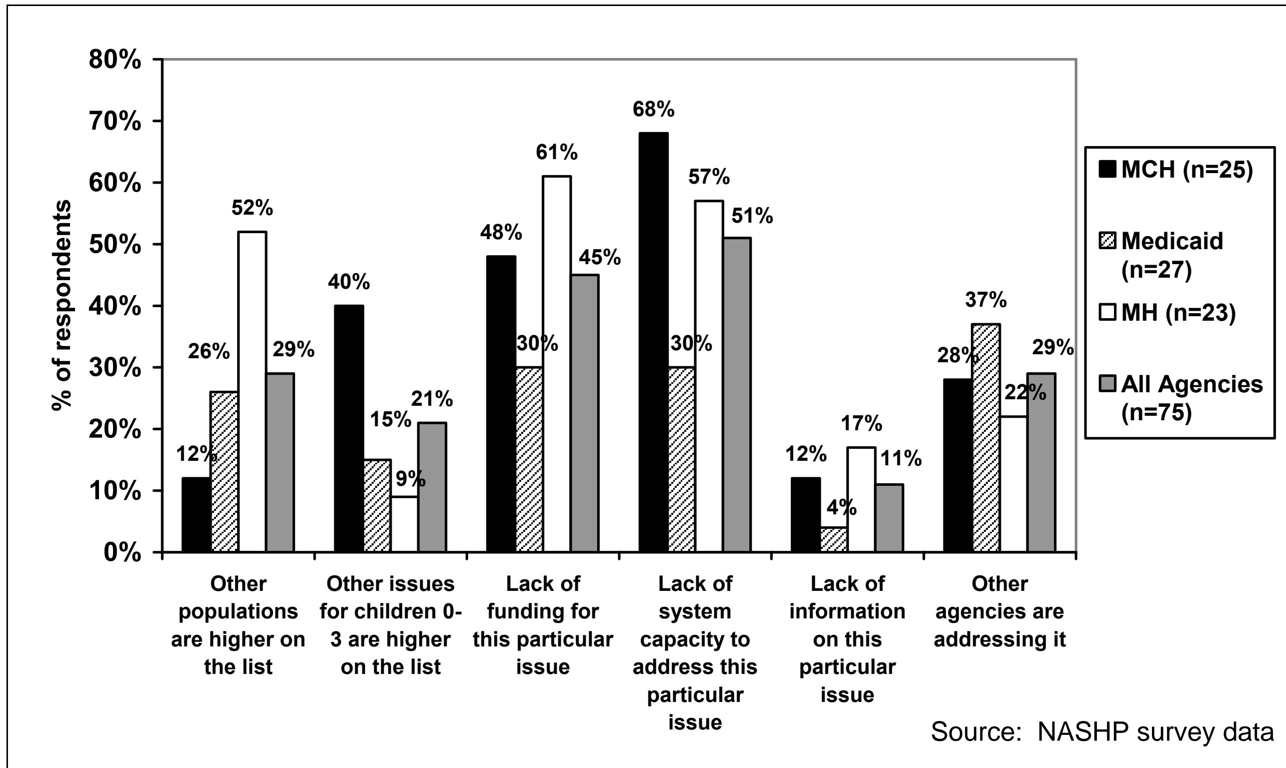
- **Wisconsin**: The Department of Health and Family Services (DFHS) is working closely with the Initiative for Infant Mental Health (IIMH), a broadly representative private agency whose recently-developed implementation plan was endorsed by the governor as part of his Kids First Agenda. A cross-departmental group is meeting to share information on programs of the various bureaus within DHFS to support the IIMH. The IIMH director is closely engaged in SECCS planning and is currently being funded by SECCS to conduct an assessment of the state's existing regional early childhood infrastructure.

PRIORITY ISSUES

Respondents identified reasons why the healthy mental development of children ages birth to three is not the highest priority of their agency. Respondents most frequently identified lack of funding for this particular issue and lack of system capacity to address the issue. These concerns echo the concerns that respondents attributed to providers, namely, concerns about referral resources, insufficient payment, and expertise. Although more than 60 percent of responding Medicaid agencies indicated that they reimburse for social emotional screening using a structured tool, half responded that they reimburse for services for children at-risk of delay, and more than 70 percent responded that they reimburse for maternal depression (likely for Medicaid beneficiaries), funding remains a major concern. This concern may arise—or linger—because a state is paying an insufficient amount for the service, or not paying at all, or because costs are increasing as the result of increased utilization from effective screening and assessment.

Maternal and Child Health agencies also frequently mentioned that other issues for children ages birth to three are higher on their priority list. A number of mental health agencies indicated that other populations are higher on their priority list. Medicaid agencies frequently mentioned that other agencies are addressing the issue. Very few respondents mentioned that they lack information on the topic. The responses point to the gaps in services that may exist when no agency identifies this issue as its primary mission.

Figure 26 Lack of funding and system capacity keep infant mental health from being highest priority



Challenges

The most frequently cited challenges to addressing the healthy mental development of young children included funding, provider availability and expertise, and system coordination. Other responses included lack of public awareness of the critical nature of the issue, lack of flexibility in the use of Medicaid funds, lack of demonstrated connection between early recognition and later cost savings, and stigma associated with mental health issues. Survey responses included the following:

- **California**: "Lack of clarity about who is responsible for children without serious diagnosable conditions [leads to] gaps in services for at-risk children."

- **Florida**: According to one respondent, barriers include inadequate "understanding on the part of doctors of the importance of assessing and addressing the needs of this population. The continued skepticism and lack of acceptance by clinicians regarding the need for infant mental health services."

- **Indiana**: Barriers include a "lack of funding, lack of consistent screening for the problem, lack of providers for assessment and treatment."

- **Oregon**: Barriers include inadequate "funding for conditions without a diagnosis, treatment for family members for issues such as attachment, and parenting education."

- **Rhode Island**: According to one respondent, there is a "need for increased collaboration between state agencies and increased expertise in early intervention"

Information Sharing

Respondents mentioned many areas in which information sharing could be useful. Many respondents expressed interest in models and best practices in other states, particularly in the areas of increasing the number of providers qualified to care for infants; Medicaid payment, blended funding, and other funding for these services; interagency collaboration; cost-benefit studies; provider education on screening, referral, and treatment; the use of DC:0-3™; comparison of state SECCS early childhood plans; Child Find approaches; and increasing awareness of the issue. Survey respondents identified the following needs:

Iowa: "How they use Medicaid to pay for more services in this area, the links between Part C and these issues."

Idaho: "Best practices in provider education."

Kansas: "Mental health and physical health in this state are housed in separate agencies. How are other states configured and how do they work best together?"

Louisiana: "Cost benefit studies for provision of infant mental health services. Successful programs."

Wisconsin: "Statewide collaborative models of early childhood systems that incorporate infant mental health with other early childhood systems. Alone the issues related to infant mental health will not become front and center because of all the barriers associated with mental health initiatives being a priority."

CONCLUSION

Survey respondents from Medicaid, maternal and child health, and children's mental health agencies indicate that states are involved in promoting young children's healthy mental development in many ways.

Many types of providers are involved in mental health screening, assessment, and treatment for young children, including private providers, local health departments, community mental heath centers, federally qualified health centers, schools, and community organizations. Although reimbursement issues and concerns restrict who can provide these services in many states, most states reimburse a wide range of clinicians.

Survey responses illustrate gaps and opportunities for improving services that address young children's social emotional development. For example, only 26 states recommend screening for social emotional development with a structured tool. Most state agencies do not track referrals for follow-up treatment nor do they encourage screening for maternal depression by pediatric providers.

Survey responses suggest that state agencies could benefit from clarification of policies and coordination of services. Confusion exists among various agencies regarding eligibility for Part C Early Intervention services and Medicaid reimbursement for children at risk of delays but without diagnosis. Most Medicaid agencies provide guidance to providers on screening, referral, and treatment, but other state agencies are not aware of this practice. Some state agencies are not aware of collaboration with other agencies or indicate that collaboration is not occurring.

States also have an opportunity to improve provider education on social emotional development. Only half of states are educating providers about this issue. States tend to use traditional formats including dissemination of materials, which may not be effective in changing provider behavior. As states explore new educational interventions, they will benefit from the experiences of states that are trying new techniques and evaluating the effectiveness of their programs.

The survey identified many opportunities to improve screening, assessment, and treatment for both young children and their mothers. Funding concerns, provider availability and expertise, competing priorities, and system fragmentation all serve as barriers to addressing the healthy mental development of young children

Despite the challenges, many state agencies recognize the needs in this area and are actively working to improve services, as evident in the number of respondents who indicated that their agencies are planning to undertake certain initiatives. Many state agencies have formed partnerships with universities, private providers, mental health associations, and advocates to identify opportunities to collaborate and improve services. State collaboratives, planning

councils, and steering committees are focusing on infant mental health, and it is likely that improvements to existing systems will result from these efforts.

Appendix: Survey Data

Limitations to survey

This report provides information on responses to the survey. It does not attempt to validate the accuracy of the responses.

Some of the questions may have caused confusion due to different terminologies used by various state agencies. For example, some of the questions inquired about reimbursement for services. This language may be most appropriate to Medicaid agencies, which finance care, than to maternal and child and mental health agencies, which fund services through different mechanisms. Some specific questions that may have caused confusion are noted within the report.

Table 1 Respondents by state and agency

State	MCH	Medicaid	MH	State	MCH	Medicaid	MH
Arizona	•	•		New Hampshire			•
Arkansas		•		New Jersey		•	•
California	•	•	•	New Mexico	•		•
Colorado		•	•	New York	•		
Connecticut			•	North Carolina	•	•	
Delaware		•		North Dakota	2	•	
Florida		•	•	Ohio	•	•	•
Georgia	•	•		Oklahoma	•	•	
Hawaii	•	2	•	Oregon			•
Idaho	•	•		Pennsylvania			•
Illinois		•		Rhode Island	•	•	
Indiana	•		•	South Carolina	•	•	
Iowa	•	•		South Dakota	•		•
Kansas	•	•		Tennessee	•		•
Kentucky	•	•	2	Texas		•	
Louisiana	•	2	2	Utah	•	•	•
Maine			2	Vermont			•
Maryland			•	Virginia		•	
Massachusetts	•	•		Washington	2	•	•
Michigan		2		Washington, DC	•	•	
Minnesota	•		•	West Virginia			•
Mississippi	•		•	Wisconsin	•		
Missouri	•	•	•	Wyoming		•	
Nebraska	•			**Total Agencies**	**32**	**33**	**27**
Nevada	2	•		**Respondents**	**35**	**36**	**30**

NASHP received survey results from 101 respondents representing all 50 states and the District of Columbia. Thirty-three Medicaid agencies, 32 maternal and child health agencies (MCH), and 27 children's mental health (MH) agencies responded.

In some cases, more than one representative of an agency responded, which explains why the total agency responses do not match the total number of responses. The report provides information on agency responses, total responses, and responses by state where useful. In cases where several agencies within a state disagreed about whether or not a particular service or program existed, NASHP assumed that "yes" answers were likely to be more accurate and coded them in that manner. In cases where several respondents from a single state agency disagreed, NASHP assumed that "yes" answers were likely to be more accurate and coded them in this manner.

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Method to recommend screening tools

State	AGENCY	AGENCY recommends screening tools	Method to recommend screening tools (1 - Language in AGENCY polices; 2 - Language in Provider manuals; 3 - Provider training sessions; 4 - Website with links or information about good screening practices)				
			1-Policies	2-Provider Manuals	3-Provider Training	4-Website	Other
AK	MH	no					
AL	MCH	yes					The Denver II Assessment tool
	Medicaid	no					
AR	Medicaid	no					
AZ	MCH	no					
	Medicaid	yes		•			Through contracts with health plans
CA	MCH	no					
	Medicaid	no					
	MH	no					
CO	Medicaid	planning					
	MH	planning					
CT	MH	planning					
DC	MCH	yes	•	•	•	•	
	Medicaid	no					
DE	Medicaid	planning					
FL	Medicaid	yes		•			
	MH	no					
GA	MCH	yes	•		•		
	Medicaid	Don't Know					
HI	MCH	yes	•	•	•		Through contractual language for purchased services
	Medicaid	no					
	MH	no					
IA	MCH	no					
	Medicaid	planning					
ID	MCH	no					
	Medicaid	yes	•	•	•	•	
IL	Medicaid	yes	•	•	•	•	
IN	MCH	planning					
	MH	yes					
KS	MCH	yes		•	•		
	Medicaid	no					
KY	MCH	yes	•	•	•		
	Medicaid	no					
	MH	yes	•	•	•	•	

Method to recommend screening tools

State	AGENCY	AGENCY recommends screening tools	Method to recommend screening tools (1 - Language in AGENCY polices; 2 - Language in Provider manuals; 3 - Provider training sessions; 4 - Website with links or information about good screening practices)				
			1-Policies	2-Provider Manuals	3-Provider Training	4-Website	Other
LA	MCH	yes	•	•	•		
	Medicaid	yes	•	•	•		Provider site certification visits by Regional Nurse Monitors
	MH	yes		•	•		
MA	MCH	yes	•		•	•	
	Medicaid	yes	•	•			
MD	MH	no					
ME	MH	yes	•	•	•	•	
MI	Medicaid	planning					
MN	MCH	yes	•		•		
	MH	yes	•	•	•		
MO	Medicaid	no					
	MCH						
	MH	planning					
MS	MCH	Don't Know					
	MH	yes	•				
MT	MCH	planning					
	Medicaid	no					
	MH	no					
NC	MCH	yes			•		Memos
	Medicaid	no					
ND	MCH	yes	•	•	•		We have a nurse consultant that is a Master Denver II Developmental Trainer that provides training to local public health.
	Medicaid	yes	•	•	•		
NE	MCH	no					
NH	MH	no					
NJ	Medicaid	no					
	MH	no					
NM	MCH	yes	•		•	•	Use of screening tools such as Ages and Stage Social Emotional. New Mexico has an at risk for developmental delay due to social/emotional issues which can qualify a child for Part C Services.
	MH	planning					
NV	MCH	yes			•		
	Medicaid	yes	•				
NY	MCH	no					

Method to recommend screening tools

State	AGENCY	AGENCY recommends screening tools	Method to recommend screening tools (1 - Language in AGENCY polices; 2 - Language in Provider manuals; 3 - Provider training sessions; 4 - Website with links or information about good screening practices)				
			1-Policies	2-Provider Manuals	3-Provider Training	4-Website	Other
OH	MCH	yes					
	Medicaid	no					
	MH	yes			●		Through cross-agency meetings
OK	MCH	yes	●	●	●		
	Medicaid	no					
OR	MH	no					
PA	MH	no					
RI	MCH	yes		●	●		Developmental screening has long been part of our newborn assessment and home visiting followups. We're working on complementary tools for early care and medical home use.
	Medicaid	yes			●		
SC	MCH	yes	●		●	●	Training sessions for other targeted providers
	Medicaid	yes		●			
SD	MCH	no					
	MH	no					
TN	MCH	no					
	MH	yes					
TX	Medicaid	no					
UT	MCH	yes	●	●	●	●	CQI processes with providers
	Medicaid	yes		●	●		
	MH	planning					
VA	Medicaid	no					
VT	MH	no					
WA	MCH	no					
	Medicaid	no					
	MH	Don't Know					
WI	MCH	no					
WV	MH	planning					
WY	Medicaid	no					
	Total MCH agencies		12	9	16	5	
	Total Medicaid agencies		6	9	6	2	
	Total MH agencies		4	4	5	2	
	Total all agencies		22	22	27	9	

Reimbursement for screening

State	AGENCY	Reimbursement method for screening (1-Procedure-specific rate; 2-Bundled rate for well-child exam; 3-Payment for an EPSDT periodic screen; 4-Payment for EPSDT interperiodic screen)				
		1-Procedure	2-Bundled	3-EPSDT Periodic	4-EPSDT interperiodic	Other
AR	Medicaid	•				
AZ	MCH					We contract for a general evaluation which includes: 1)Review of history, 2)comprehensive assessment of each of the five developmental domains, 3)A narrative summary. Core tools for evaluation include: Infant Neurological Battery (INFANIB) if under 18 months of age, Revised Developmental Inventory (RDI) (Gessell), Early Learning Milestone Scale (ELM), Anthropometric measures, Vision Screen, Hearing Screen.
	Medicaid					
CA	MH			•		
CO	Medicaid	•				FQHCs, RHCs and IHCs are reimbursed a flat encounter rate regardless of the procedure (and is then subsequently adjusted based on costs).
DE	Medicaid					
FL	Medicaid	•				
GA	MCH		•			Early Intervention, Part C
HI	MCH	•				
	Medicaid			•	•	
IA	Medicaid	•				
ID	Medicaid			•		
IL	Medicaid	•				
KS	MCH					From State office and based on formula, Infant-Toddler networks receive lump sum funds. They use these funds to screen, evaluate, assess, provide services for eligible infants and toddlers
	Medicaid	•		•		
KY	MCH	•				Bundled in program rate
	MH					
LA	Medicaid		•	•	•	
	MH			•		Through contract with MH professionals
MA	MCH					As part of EI
	Medicaid			•	•	
MD	MH			•		
MN	MH					
MO	MH	•			•	
MT	MCH			•	•	
	Medicaid	•		•	•	
NC	MCH	•				

Reimbursement for screening

State	AGENCY	Reimbursement method for screening (1-Procedure-specific rate; 2-Bundled rate for well-child exam; 3-Payment for an EPSDT periodic screen; 4-Payment for EPSDT interperiodic screen)				
		1-Procedure	2-Bundled	3-EPSDT Periodic	4-EPSDT interperiodic	Other
ND	MCH			•		
	Medicaid			•	•	Public Health provider specific nursing service.
NE	MCH					
NJ	Medicaid	•		•		
NM	MCH	•				As part of the evaluation process to determine eligiblity for Part C.
	MH	•		•		
NV	Medicaid					
OH	MCH					OH Dept. of Health currently provides funding to all counties to provide screening for developmental delays and vision and hearing deficits. We will be implementing a screening tool for social/emotional development in late 2006 and the reimbursement to the counties will continue at the rate allocated to them beginning July 2005.
	Medicaid			•		
OK	Medicaid	•			•	
RI	MCH		•			Part of screening contract and home visiting fee structure.
	Medicaid	•				
SC	MCH	•		•		
	Medicaid	•		•		
SD	MH	•				
TN	MH					
TX	Medicaid				•	Case Management Services for ECI and payment for an EPSDT periodic screen.
UT	MCH			•		
VT	MH	•		•		
WA	MCH					
	Medicaid			•	•	
WY	Medicaid			•	•	
MCH agencies		5	2	4	1	
Medicaid Agencies		11	1	12	9	3
responding		4	0	5	1	
All agencies		20	3	21	11	

Recommended screening tools

		Recommended screening tools (1- Ages and Stages Questionnaires (ASQ); 2 - Ages and Stages Questionnaires: Social-Emotional (ASQ:SE); 3 - Batelle Developmental Screener; 4 - Bayley Infant Neurodevelopment Screener; 5 - Brief Infant-Toddler Social and Emotional Assessment (BITSEA); 6 - Denver DST/Denver II; 7 - Infant-Toddler Symptom Checklist; 8 - Parent's Evaluation of Development (PEDS); 9 - PDQ; 10 - Temperamental and Atypical Behavior Scale (TABS) Screener; 11 - None)											
State	AGENCY	1- ASQ	2- ASQ:SE	3- Batelle	4- Bayley	5- BITSEA	6- Denver	7-ITSC	8-PEDS	9- PDQ	10- TABS	11- none	Other
AR	Medicaid											•	
AZ	MCH	•	•				•						
CA	MH	•	•		•	•		•	•		•		
CO	Medicaid	•							•				
FL	Medicaid												CANS 0 - 3. Child and Adolescent Needs and Strengths Manual for 0 to 3 developed by John S. Lyons, Northwestern University
GA	MCH	•	•				•		•				
HI	MCH	•	•		•								Acenbauck
	Medicaid	•	•	•	•	•	•	•	•	•	•	•	All of the above are acceptable
IA	Medicaid												No official recommendation for any at this time. We are moving towards a recommendation
ID	Medicaid							•					As determined by providers
IL	Medicaid	•	•	•	•	•	•	•	•	•	•		Provider choice among accepted tools; others include: Brigance Early Preschool, Chicago Early Developmental Screening Inventory, Child Behavior Checklist 2-3 and Caregiver-Teacher Report Form Ages 2-5, Child Development Inventory, Conners' Rating System, Developmental Profile II, Dial-R Developmental Assessment, Early Coping Inventory, Early Language Milestone Scales Screen, Early Screening Inventory, Early Screening Profiles, Erhardt Development Prehension Assessment, Infant Toddler Developmental Assessment, Infant-Toddler Social and Emotional Assessment, Infant-Toddler Symptom Checklist, Minneapolis Preschool Screening Instrument, Project Memphis Developmental Screening Tool, Revised Development Screening Inventory, Revised Parent Developmental Questionnaire

Recommended screening tools

State	AGENCY	Recommended screening tools (1- Ages and Stages Questionnaires (ASQ); 2 - Ages and Stages Questionnaires: Social-Emotional (ASQ:SE); 3 - Batelle Developmental Screener; 4 - Bayley Infant Neurodevelopment Screener; 5 - Brief Infant-Toddler Social and Emotional Assessment (BITSEA); 6 - Denver DST/Denver II; 7 - Infant-Toddler Symptom Checklist; 8 - Parent's Evaluation of Development (PEDS); 9 - PDQ; 10 - Temperamental and Atypical Behavior Scale (TABS) Screener; 11 - None)											
		1- ASQ	2- ASQ:SE	3- Batelle	4- Bayley	5- BITSEA	6- Denver	7-ITSC	8-PEDS	9- PDQ	10- TABS	11- none	Other
KS	MCH												Infant-Toddler networks are made aware of all available screening and/or assessment tools. They determine which they will use; it could be one or a combination.
	Medicaid											•	
KY	MCH		•										Devereux Early Childhood Assessment
LA	Medicaid	•					•		•				Brigance Screens, Child Development Chart, PDQ II (Prescreening Developmental Questionnaire),
	MH	•	•				•		•				KROLL
MA	MCH												Michigan EIDP starting 7/2005! Battelle Developmental Inventory 2
	Medicaid	•					•		•				Tools are suggested but providers are not required to use any particular tool, although the Pediatric Symptom Checklist is encouraged and discussed with providers and offered in the both the adult and youth administered versions through the PCC Plan Catalog. Other suggested tools include; BRIGANCE and Child Development Inventories
MD	MH					•							
MO	MH												No specific screening tool is endorsed for payment at this time
MT	MCH	•											
	Medicaid											•	
	MH												
NC	MCH	•	•						•	•			
	Medicaid												
ND	MCH	•	•										Pediatric Symptom Checklist
	Medicaid						•	•		•			We also allow providers to use any of the above, but recommend the checked items.
NJ	Medicaid				•								Follow best practice for standards of care.

Recommended screening tools

State	AGENCY	Recommended screening tools (1- Ages and Stages Questionnaires (ASQ); 2 - Ages and Stages Questionnaires: Social-Emotional (ASQ:SE); 3 - Batelle Developmental Screener; 4 - Bayley Infant Neurodevelopment Screener; 5 - Brief Infant-Toddler Social and Emotional Assessment (BITSEA); 6 - Denver DST/Denver II; 7 - Infant-Toddler Symptom Checklist; 8 - Parent's Evaluation of Development (PEDS); 9 - PDQ; 10 - Temperamental and Atypical Behavior Scale (TABS) Screener; 11 - None)											
		1- ASQ	2- ASQ:SE	3- Batelle	4- Bayley	5- BITSEA	6- Denver	7-ITSC	8-PEDS	9- PDQ	10- TABS	11- none	Other
NM	MCH	•	•		•	•		•	•	•	•		
	MH	•	•										
OH	MCH	•	•				•						
	Medicaid												We let the physician decide the appropriate tool.
OK	Medicaid	•	•	•			•						
RI	MCH	•							•				
	Medicaid		•	•	•			•	•				HOME, Hawaii Early Learning Profile(HELP), Child Behavior Checklist, Carolina Curriculum
SC	MCH	•	•				•		•				
	Medicaid											•	
SD	MH											•	
TX	Medicaid												Provider's choice of standardized tool, Texas Health Steps (THSteps) also provides as an option, age-specific mental health screening tools and parent questionnaires.
UT	MCH	•	•						•				
VT	MH	•	•	•	•	•	•	•	•				
WA	Medicaid												When we had a Commonwealth grant, we identified strengths and limitations of each tool but we don't recommend a specific tool.
WV	Medicaid											•	The tools used are per the provider's professional judgment.
MCH agencies		11	10	0	2	1	4	1	6	2	1	0	
Medicaid agencies		6	4	4	4	2	6	5	6	3	2	6	
MH agencies		4	4	1	2	3	2	2	3	0	1	1	
Total		21	18	5	8	6	12	8	15	5	4	7	

Provider concerns about screening

State	AGENCY	Provider concerns about screening						
		Referral resources	Insufficient payment	Administrative hassle	Expertise	None	Other	Comments
AK	MH		•		•			
AL	MCH					•		
	Medicaid					•		
AR	Medicaid					•		
AZ	MCH	•	•					
	Medicaid	•	•					
CA	MCH	•		•	•			
	Medicaid	•	•		•			
	MH	•	•	•	•			
CO	Medicaid	•	•	•	•			
	MH	•	•	•	•		•	We are training on the DC:0-3™ but as of yet our Medicaid billing system does not recognize this.
CT	MH	•	•	•	•		•	Child Welfare has assigned a minimal amount of time, energy or funding for the 0-3 population.
DC	MCH	•	•	•				
	Medicaid					•		
DE	Medicaid	•	•	•				
FL	Medicaid				•			
	MH		•		•			
GA	MCH	•	•	•	•		•	Time commitment to complete screen.
	Medicaid					•		
HI	MCH					•		
	Medicaid					•		
	MH							Screening for children 0-3 rests with a different division within Department of Health. I've asked Early Intervention Section (0-3 Program) to respond to this survey.
IA	MCH	•	•		•			
	Medicaid						•	Need for provider education
ID	MCH					•		
	Medicaid	•	•		•			
IL	Medicaid							Unknown at this time - just beginning in office training through ABCD II

Provider concerns about screening

State	AGENCY	Provider concerns about screening						
		Referral resources	Insufficient payment	Administrative hassle	Expertise	None	Other	Comments
IN	MCH	•	•		•			
	MH				•			
KS	MCH	•	•			•	•	The screening tools have been added to the EPSDT and SCHIP funded assessments. No extra payment added at this time.
	Medicaid	•	•	•				
KY	MCH				•			
	Medicaid					•		
	MH	•	•		•		•	Hesitancy to 'label' infants as needing further MH assessment or intervention
LA	MCH	•		•			•	Time constraints
	Medicaid	•				•		
	MH					•		To be addressed by Medicaid Office
MA	MCH	•	•		•			
	Medicaid	•	•		•			
MD	MH					•		
ME	MH					•	•	Training time for agency staff who will use the tool is not reimbursed
MI	Medicaid							
MN	MCH					•		
	MH	•	•					
MO	Medicaid					•		
	MCH							
	MH		•		•			
MS	MCH				•			
	MH				•			
MT	MCH		•					
	Medicaid	•			•			
	MH						•	Because social-emotional development screens are not a specific mental illness service we do not cover them under our program. However developmental screen is part of the EPSDT service. At present EPSDT does not include a mental health screen. This is under review for change in the near future.

Provider concerns about screening

State	AGENCY	Provider concerns about screening						
		Referral resources	Insufficient payment	Administrative hassle	Expertise	None	Other	Comments
NC	MCH				•			
NC	Medicaid					•	•	This may not be the place but we want you to know that while we do not have a standardized tool in our EPDST screenings we do include mental health
ND	MCH	•	•		•			
ND	Medicaid	•	•		•			
NE	MCH	•			•			
NH	MH					•		
NJ	Medicaid	•	•					
NJ	MH	•	•	•				
NM	MCH	•	•		•			
NM	MH				•		•	Availability of trained screeners, evaluators, providers.
NV	MCH						•	We do not work directly with providers of young children unless they are CSHCN, and none of them have.
NV	Medicaid							
NY	MCH	•	•		•			
OH	MCH	•	•	•				
OH	Medicaid						•	Insufficient payment
OH	MH	•						
OK	MCH	•			•		•	Lack of adequate screening tools
OK	Medicaid	•						
OR	MH		•	•				
PA	MH	•	•		•			
RI	MCH	•			•			
RI	Medicaid				•			
SC	MCH	•	•	•	•		•	Plans are to alleviate the administrative hassle by bringing screening activity back to Dept. of Health and Environmental Control
SC	Medicaid					•		
SD	MCH	•						
SD	MH					•		
TN	MCH	•	•	•	•			
TN	MH							

Provider concerns about screening

State	AGENCY	Provider concerns about screening						
		Referral resources	Insufficient payment	Administrative hassle	Expertise	None	Other	Comments
TX	Medicaid	•	•					
UT	MCH	•	•		•		•	Time constraints
	Medicaid	•	•					
	MH	•	•	•	•			
VA	Medicaid							don't know
VT	MH	•			•			
WA	MCH	•						
	Medicaid	•	•	•	•		•	Expertise/referral issues are particularly acute with mental health issues
	MH	•	•					
WI	MCH	•	•	•	•		•	Children grow out of most things so not priority to spend time and money.
WV	MH	•	•				•	Medical Provider - takes too much time
WY	Medicaid					•		
MCH agencies		22	16	8	18	5	8	
Medicaid Agencies		15	12	4	9	11	4	
MH agencies		12	14	6	13	5	7	
All agencies		49	42	18	40	21	19	

Agency adoption of the DC:0-3™ diagnostic classification

State	AGENCY	Why did your AGENCY choose to adopt the DC:0-3™ diagnostic classification?	Has your AGENCY crosswalked the DC:0-3™ to IDC-9 codes?				Does your AGENCY use a crosswalk between DC:0-3™ and IDC-9 codes that was developed by another STATE?				Has your AGENCY developed any guidelines or tools to assist providers with using the DC:0-3™?				Has your AGENCY provided any training or outreach to educate providers about the use of DC:0-3™?		
			Yes	Plan	No	Don't Know	Yes	Plan	No	Don't Know	Yes	Plan	No	Don't Know	Yes	Plan	No
CA	MH	Have not adopted due to MH specialty carve-out; we use it informally and bill with DSM-IV	•					•				•			•		
CO	MH	The Division of Mental Health Services does not do the billing for Medicaid Mental Health Services. That is handled by our Medicaid Office.		•				•				•			•		
FL	MH	We have adopted the DC:0-3™ classification system but not as a billable code directly; we utilize a crosswalk to the ICD-9 codes. 1.State of the art classification system for 0-3 2.Based on careful observation and understanding of the child/parent interactions. 3.Integrates all of child's development for a concise understanding and development of treatment plans.	•						•				•		•		
ME	MH	To insure eligibility of young children for Medicaid covered services; to allow for providers to be reimbursed for services provided to young children in need of service.	•				•			•				•	•	•	
MD	MH		•														
MN	MH	It was the most developmentally appropriate classification available.	•				•					•			•		
	MCH	Standard of care		•				•				•			•		
NM	MH	It is the best resource.		•			•						•		•		

Agency adoption of the DC:0-3™ diagnostic classification

State	AGENCY	Why did your AGENCY choose to adopt the DC:0-3™ diagnostic classification?	Has your AGENCY crosswalked the DC:0-3™ to IDC-9 codes?				Does your AGENCY use a crosswalk between DC:0-3™ and IDC-9 codes that was developed by another STATE?				Has your AGENCY developed any guidelines or tools to assist providers with using the DC:0-3™?				Has your AGENCY provided any training or outreach to educate providers about the use of DC:0-3™?		
			Yes	Plan	No	Don't Know	Yes	Plan	No	Don't Know	Yes	Plan	No	Don't Know	Yes	Plan	No
	MH	Based on research and recommendations from providers in Ohio and other states.		•			•					•			•		
OH	Medicaid	It was an appropriate tool to utilize for the 0-3 age range.			•				•				•				•
OK	Medicaid				•				•				•				•
SC	MCH	Other		•				•				•				•	
TN	MCH		•				•						•				•
TX	Medicaid					•				•				•		•	
UT	MH	Excellent assessment tool: consistency		•						•		•			•		
WA	MH	It makes the most sense and fits with the DSM IV				•				•			•				•

Reasons for not adopting DC:0-3™ diagnostic classification

State	Agency	Why did your AGENCY choose to not adopt the DC:0-3™ diagnostic classification as a billable code?
AK	MH	This is currently not provided for in our state plan. May be at some time in future.
AZ	MCH	Not applicable to the services we offer.
	Medicaid	Medicaid requires the use of ICD-9 codes. DC:0-3™ is not allowed by CMS.
CA	Medicaid	To my knowledge, this has not been discussed. We pay our managed care plans on a fully capitated basis for primary care services. Many of our plans pay their primary care providers on a fully capitated basis for primary care services; so many of our primary care providers are not billing for specific codes.
CO	Medicaid	This is not a Healthcare Common Procedure Coding System (HCPCS) code. Medicare does not use it
CT	MH	The focus is on older children not younger children. EPSDT is underutilized in Connecticut
DE	Medicaid	Our programs are all HIPAA compliant. When we developed our HIPAA compliant coding this was not a set of codes that were approved. We may relook at this in the future.
FL	MH	Medicaid and our Department encourage the use of the DC:0-3™ in determining diagnosis for children 0-3, and a crosswalk has been established to ICD-9 for billing purposes.
	Medicaid	Our Agency is required to use ICD-9 billing codes. Our Medicaid Handbook, in the section on mental health services to children ages 0 to 5, recommends using DC:0-3™ as a guide to developing an ICD-9 diagnosis for 0 to 3 year olds. We have also disseminated a DC:0-3™ code cross walk to the ICD-9, that was developed here in Florida by Kathryn Shea and that was approved by DC:0-3™ in DC.
GA	MCH	We couldn't.
HI	MCH	Have own internal billing system
IL	Medicaid	HIPAA compliance with billing codes. DC:03™ is not recognized by AMA. Crosswalks from other states not (yet) recognized by mental health or early intervention in Illinois.
IA	MCH	We did not make this choice. Our state Medicaid office made this choice.
IA	Medicaid	HIPAA standards. We are going to investigate publicizing one of the 0-3 crosswalk to ICD 9 codes so that it is not seen as a billing barrier.
KS	MCH	Payment is set by another state agency. It is being requested.
	MCH	Through our Medicaid program in Kansas, the Infant-Toddler networks have their own Provider 18 numbers and billing is set up differently for them. Thus, they are billing for assessment, but not sure if it is this specific code; this is something I need to investigate.
	Medicaid	We are generally not adding reimbursable codes.
KY	MCH	This billing would occur through Dept. of Mental Health and Mental Retardation Services
	Medicaid	Our state has chosen to use all of the ICD-9 diagnostic codes.
	MH	Not currently billable under our state Medicaid system.
LA	MCH	Our agency does not reimburse providers; staff paid by Title V Block Grant conduct screening. Our agency does bill Medicaid for screening as a part of the EPSDT billable code.
	Medicaid	We use ICD-9-CM diagnosis codes.
MA	MCH	EI is bundled service in Massachusetts
MI	Medicaid	CMS does not accept it.
MN	MCH	We don't reimburse from our agency. This would fall under our Minnesota Department of Human Services.

Reasons for not adopting DC:0-3™ diagnostic classification

State	Agency	Why did your AGENCY choose to not adopt the DC:0-3™ diagnostic classification as a billable code?
MO	MH	All codes must be through ICD system, we do not bill under DSM-IV either
	Medicaid	Missouri Medicaid has used ICD-9 diagnosis as a standard
MT	MH	DC:0-3™ has not been reviewed for mental health services as focus is primarily on youth of school age. As we continue our development of a fully implemented system of care for youth with serious emotional disturbance, we will include a review of how early identification tools may be of assistance to us.
NH	MH	Currently do not use any standardized assessment tool. A study group recommended use of DC:0-3™ in 2002 but our agency has been unable to move forward on this due to budget constraints.
NJ	Medicaid	Not aware of DC:0-3™ as billable codes.
	MH	Under the Medicaid Management Information System (MMIS) we are required to use ICD 9CM. As a result of newly placed emphasis on the needs of infants and toddlers we are in the beginning phases of planning. We are aware of the DC:0-3™, will be reviewed for use in the planning we will engage in in the coming months
NV	MCH	We do not provide direct services.
NY	MCH	The issue has not been raised relative to our Medicaid and SCHIP Programs.
NC	MCH	Medicaid Requirements- we have recommended that it be considered
ND	MCH	We are a State Health Department - we do not bill for services. We provide TA and education. Medicaid and Children's Special Health Services (CSHS) are located in Human Services.
OH	MCH	We do not reimburse local providers on a billable basis.
OR	MH	We are currently in the process of evaluating two options: DC:0-3™ and the Revised Diagnostic Criteria-Pre-School Age.
RI	MCH	We're not really in the code/reimbursement business
SC	MCH	Lack of resources for training of providers.
UT	Medicaid	We have just started research on DC:0-3™. We are hoping for support from our partners in the Division of Substance Abuse and Mental Health as well as the community mental health centers. We appreciated the ABCD II technical assistance call and used it as an opportunity to share information with these folks.
VT	MH	We use z code for Parent/child interaction.
WA	Medicaid	We don't know much about this code. Possibly mental health centers use this.
	MCH	We do not provide direct services.
	MCH	We are a State Health Department and do not provide mental health services. Medicaid funded mental health services are provided through different state agency.

Medicaid pays for children at-risk for social/emotional delay without a diagnosis

State	AGENCY	Medicaid payment for children at-risk for S/E delay without diagnosis		
		Yes	No	Don't know
AK	MH		●	
AL	MCH			●
	Medicaid			●
AR	Medicaid		●	
AZ	MCH		●	
	Medicaid	●		
CA	MCH			●
	Medicaid			●
	MH			●
CO	Medicaid	●		
	MH		●	
CT	MH		●	
DC	MCH		●	
	Medicaid			●
DE	Medicaid		●	
FL	Medicaid		●	
	MH		●	
GA	MCH	●		
	Medicaid	●		
HI	MCH	●		
	Medicaid	●		
	MH			●
IA	MCH	●		
	Medicaid	●		
ID	MCH			●
	Medicaid			●
IL	Medicaid	●		
IN	MCH		●	
KS	MCH			●
	Medicaid		●	
KY	MCH			●
	Medicaid	●		
	MH		●	
LA	MCH			●
	Medicaid	●		
	MH	●		
MA	MCH	●		
	Medicaid	●		
MD	MH		●	
ME	MH	●		
MI	Medicaid		●	
MN	MCH			●
	MH		●	
MO	Medicaid		●	
	MH		●	
MS	MCH			●
	MH		●	
MT	MCH			●
	Medicaid	●		
	MH			●
NC	MCH		●	
	Medicaid	●		
ND	MCH	●		
	Medicaid			●
NE	MCH			●
NH	MH			●
NJ	Medicaid		●	
	MH			●
NM	MCH	●		
	MH		●	
NV	MCH			●

Medicaid pays for children at-risk for social/emotional delay without a diagnosis

State	Agency	Medicaid payment for children at-risk		
		Yes	No	Don't know
NY	MCH			●
OH	MCH		●	
	Medicaid	●		
	MH			●
OK	MCH	●		
	Medicaid		●	
OR	MH		●	
PA	MH		●	
RI	MCH	●		
	Medicaid		●	
SC	MCH	●		
	Medicaid	●		
SD	MCH			●
	MH		●	
TN	MCH		●	
	MH			●
TX	Medicaid			●
UT	MCH			●
	Medicaid	●		
	MH			●
VA	Medicaid	●		
VT	MH	●		
WA	MCH			●
	Medicaid	●		
	MH		●	
WI	MCH			●
WY	Medicaid		●	
MCH		9	6	16
Medicaid		16	10	6
MH		3	14	8
All Agencies		28	29	30

Guidance on screening, referral and treatment of young children's healthy mental development

State	AGENCY	Has the STATE Medicaid AGENCY offered guidance to providers on screening, referral, and treatment for young children's healthy mental development in the form of: 1-Clarification of benefits covered; 2-Clarification of screening and assessment; 3-Protocols for developmental services; 4-Clarifying providers who are qualified to receive reimbursement; 5-Clarifying a separate billable code					
		1	2	3	4	5	Other
AK	MH						Have had some workshops on early childhood mental health, but nothing else yet.
AL	MCH			•			
	Medicaid		•				EPSDT screen
AR	Medicaid	•					
AZ	MCH						Not sure
	Medicaid	•	•		•		
CA	MCH						I don't know
	Medicaid						We have policies that require identification of children in need of referrals to developmental and mental health services, and coordination with those services
	MH						Overall, no. Regarding Mental Health, this is a carve-out. In California, individual (of 58) counties have adopted various procedures.
CO	Medicaid	•	•		•		
	MH						We are currently working on an EPSDT pilot with the Medicaid agency to test screening tools and identify administrative barriers
CT	MH						No - the Connecticut Medicaid AGENCY(Department of Social Services) does not focus on young children and reimbursement of the above service types.
DC	MCH						I don't know
	Medicaid	•	•		•		
DE	Medicaid	•			•		
FL	Medicaid	•	•		•		A separate section in our Community Behavioral Health Coverage and Limitations Handbook that specifies requirements for delivering mental health services to this age group.
	MH	•	•		•	•	
GA	MCH		•				
	Medicaid						Guidance is offered but not directly from Medicaid. Medicaid partners with The Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases for definitions, protocols and tools for screening and assessment.
HI	MCH	•			•		
	Medicaid		•				
	MH						Refer to EIS Section Coordinator.
IA	MCH						All of these things are being worked on through our ABCDII project.
	Medicaid						1,2,&3 being worked on
ID	Medicaid	•	•	•	•	•	

Guidance on screening, referral and treatment of young children's healthy mental development

State	AGENCY	Has the STATE Medicaid AGENCY offered guidance to providers on screening, referral, and treatment for young children's healthy mental development in the form of: 1-Clarification of benefits covered; 2-Clarification of screening and assessment; 3-Protocols for developmental services; 4-Clarifying providers who are qualified to receive reimbursement; 5-Clarifying a separate billable code					
		1	2	3	4	5	Other
IL	Medicaid	•	•		•	•	Notification of Early Intervention Services
IN	MCH		•				Not sure of all these issues
KS	MCH	•	•	•	•	•	
	Medicaid	•					
KY	MCH						Not that I'm aware
	Medicaid				•		Our EPSDT screening services manual which defines covered services and suggests screening criteria. This manual can be viewed on the web.
LA	MCH						The only guidance is related to screening for developmental delays, not overall healthy mental development.
	Medicaid	•	•	•	•		
	MH	•	•	•	•		
MA	MCH	•	•		•		
	Medicaid	•	•	•	•		
MD	MH						Don't know
ME	MH					•	Periodically has training for providers; mailings to inform providers of information relevant to young children.
MI	Medicaid						Adding language to web based guidance to Medicaid Health Plans on well child EPSDT visits
MN	MCH	•					
	MH				•		In process of developing training.
MO	Medicaid	•	•		•	•	
	MH						The Department of Mental Health and Division of Medical Services (DMS) have been working collaboratively in some areas of early childhood including piloting added screening for social/emotional development at all ages.
MS	MCH						None that we are aware of
	MH						No answer provided
MT	MCH			•			
	Medicaid						We are currently in the process of redesigning our EPSDT services. Part of this redesign will include increased guidance to providers.
	MH						This is a question best answered by the Medicaid Managed Care Bureau and not the mental health program.

Guidance on screening, referral and treatment of young children's healthy mental development

State	AGENCY	Has the STATE Medicaid AGENCY offered guidance to providers on screening, referral, and treatment for young children's healthy mental development in the form of: 1-Clarification of benefits covered; 2-Clarification of screening and assessment; 3-Protocols for developmental services; 4-Clarifying providers who are qualified to receive reimbursement; 5-Clarifying a separate billable code					
		1	2	3	4	5	Other
	MCH	•	•	•	•	•	
NC	Medicaid						This is part of our HealthCheck (EPDST) screening
	MCH		•		•		Don't know
ND	Medicaid		•	•	•		
NE	MCH						Don't know
NH	MH						Don't know
	Medicaid	•			•	•	
NJ	MH	•	•			•	Division of Child Behavioral Health is in the early planning stages with the Division of Medicaid to expand in all of the areas above.
NM	MCH	•	•	•		•	
NV	MCH						Don't know
NY	MCH						We are working on a Provider Handbook which will address some of these issues.
	MCH						Don't know.
	Medicaid	•	•		•		
OH	MH	•					
	MCH						
OK	Medicaid	•			•	•	We are in the process of developing a checklist for Behavioral Health and Medical providers.
OR	MH						Oregon has a Medicaid waiver. Payment decisions are based on ranked, paired diagnoses and treatments. Based on the state budget, certain conditions are covered if they fall above the line.
PA	MH				•		
	MCH		•				
RI	Medicaid						We are in the process of collaborating with the Department of Children, Youth, and Families as they organize to meet the Child Abuse Prevention and Treatment Act (CAPTA) mandate.
	MCH	•			•	•	
SC	Medicaid			•			
	MCH	•					
SD	MH						I can't answer this question as I'm not with the State Medicaid Office.
	MCH	•					
TN	MH						N/A
TX	Medicaid	•					

Guidance on screening, referral and treatment of young children's healthy mental development

State	AGENCY	Has the STATE Medicaid AGENCY offered guidance to providers on screening, referral, and treatment for young children's healthy mental development in the form of: 1-Clarification of benefits covered; 2-Clarification of screening and assessment; 3-Protocols for developmental services; 4-Clarifying providers who are qualified to receive reimbursement; 5-Clarifying a separate billable code					
		1	2	3	4	5	Other
UT	MCH		•	•			
	Medicaid						Learning collaboratives and guidance in our EPSDT provider manual.
	MH	•	•	•	•	•	
VA	Medicaid	•	•	•			
VT	MH	•	•	•	•		
WA	MCH						I don't know. I cannot answer on behalf of the State Medicaid Agency.
	Medicaid						We have carried out a children's preventive health care initiative and worked directly with clinics/providers. In addition, Seattle-King County Public Health are implementing Kids Get Care, an initiative which also focuses on preventive care (improving developmental screening) and referral--so essentially all of the above.
	MH	•	•	•	•	•	
WY	Medicaid	•				•	
Total of MCH agencies		9	9	6	0	4	
Total of Medicaid		18	14	6	2	6	
Total of MH Agencies		7	6	4	0	5	
Total all agencies		34	29	16	2	15	

State restricts provider reimbursement

State	AGENCY	State has restrictions on providers who can be reimbursed		
		Yes	No	Don't know
AK	MH			●
AL	MCH	●		
	Medicaid			●
AR	Medicaid	●		
AZ	MCH	●		
	Medicaid	●		
CA	MCH			●
	Medicaid		●	
	MH	●		
CO	Medicaid	●		
	MH			●
CT	MH	●		
DC	MCH			●
	Medicaid	●		
DE	Medicaid	●		
FL	Medicaid	●		
	MH	●		
GA	MCH	●		
	Medicaid	●		
HI	MCH	●		
	Medicaid		●	
	MH			●
IA	MCH		●	
	Medicaid	●		
ID	MCH			●
	Medicaid	●		
IL	Medicaid	●		
IN	MCH		●	
KS	MCH	●		
	Medicaid	●		

State	AGENCY	State has restrictions on providers who can be reimbursed		
		Yes	No	Don't know
KY	MCH	●		
	Medicaid	●		
	MH	●		
LA	MCH	●		
	Medicaid	●		
	MH	●		
MA	MCH	●		
	Medicaid			●
MD	MH	●		
ME	MH	●		
MI	Medicaid	●		
MN	MCH		●	
	MH	●		
MO	Medicaid	●		
	MH	●		
MS	MCH			●
	MH	●		
MT	MCH			●
	Medicaid	●		
	MH	●		
NC	MCH	●		
	Medicaid	●		
ND	MCH	●		
	Medicaid			●
NE	MCH			●
NH	MH		●	
NJ	Medicaid	●		
	MH	●		
NM	MCH	●		
	MH	●		

State restricts provider reimbursement

State	AGENCY	State has restrictions on providers		
		Yes	No	Don't know
NV	MCH		●	
NY	MCH	●		
OH	MCH	●		
	Medicaid		●	
	MH	●		
OK	Medicaid	●		
OR	MH	●		
PA	MH	●		
RI	MCH	●		
	Medicaid	●		
SC	MCH	●		
	Medicaid	●		
SD	MCH			●
	MH	●		
TN	MCH	●		
TX	Medicaid	●		
UT	MCH			●
	Medicaid	●		
	MH	●		
VA	Medicaid	●		
VT	MH		●	
WA	MCH		●	
	Medicaid	●		
	MH	●		
WI	MCH	●		
WY	Medicaid	●		
MCH agencies		17	5	8
Medicaid agencies		26	3	3
MH agencies		19	3	2
All agencies		62	10	14

Reimbursement for assessment and diagnosis

State	AGENCY	Reimbursement for assessment and diagnosis (1-All physicians; 2-Primary Care physicians; 3-Psychiatrists; 4-EPSDT providers; 5-Specialized early intervention providers)					
		1-All	2-PCP	3-Psychiatrists	4-EPSDT	5-EI	Other Behavioral health specialists
AL	MCH	●	●	●	●	●	
AR	Medicaid			●		●	Psychologists, Licensed Certified Social Workers, Licensed Marriage and Family Therapists, Licensed Professional Counselors and other mental health professionals
AZ	MCH					●	
	Medicaid		●			●	
CA	MH				●		
CO	Medicaid		●	●	●	●	
CT	MH	●	●	●			
DC	Medicaid	●	●	●	●		Psychologists
DE	Medicaid	●		●			Psychologists and Licensed Clinical Social Workers, in our managed care programs
FL	Medicaid	●					Licensed mental health professionals who work for a Medicaid enrolled community behavioral health provider.
	MH			●			Licensed mental health providers enrolled as Medicaid providers and under contract with our Department.
GA	MCH	●			●	●	
	Medicaid						Providers are Community Service Boards and/or Agencies that meet the enrollment criteria outlined in the Utilization Guidelines set forth by The Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases.
HI	MCH	●		●		●	
IA	Medicaid	●	●	●	●	●	Community mental health centers and psychologists. We do not have social workers independently enrolled.
ID	Medicaid	●	●	●	●	●	
IL	Medicaid	●				●	Certified mental health providers, FQHC behavioral health, outpatient clinics. (All physicians includes primary care providers, psychiatrists, EPSDT providers).
KS	MCH	●	●	●			
	MCH					●	If under contract with the I-T network to provide this services -- all of the above.
	Medicaid	●	●	●	●		
KY	MCH					●	Early Childhood Mental Health Specialists
	Medicaid	●	●	●	●	●	First Steps providers, Commission for Children with Special Health Care Needs, School Based Health Services, Health Depts.
	MH						Must be employed by a licensed community mental health center

Reimbursement for assessment and diagnosis

State	AGENCY	Reimbursement for assessment and diagnosis (1-All physicians; 2-Primary Care physicians; 3-Psychiatrists; 4-EPSDT providers; 5-Specialized early intervention providers)					
		1-All	2-PCP	3-Psychiatrists	4-EPSDT	5-EI	Other Behavioral health specialists
LA	MCH				●		
	Medicaid	●	●	●	●	●	
	MH		●				
MA	MCH					●	
MD	MH	●	●	●	●		Licensed mental health professionals
ME	MH	●	●	●	●	●	Independently licensed clinicians, social workers
MI	Medicaid						Michigan has both health care and mental health care in managed, capitated B waivers. There is no reimbursement fee for services.
MN	MH	●		●			Those defined in statute as mental health professionals; includes psychologists, social workers, and advanced practice nurses licensed for independent practice.
MO	Medicaid			●			Psychologists
	MH						We only reimburse DMH providers through community mental health centers or Regional Centers for those with developmental disabilities
MS	MH	●			●		Not specified
MT	Medicaid	●	●	●		●	It must be in their scope of practice
	MH						Our Medicaid program for persons under 18 years of age provides for Mental Health Professionals to bill for assessment and diagnosis. Mental Health Professionals are: licensed physicians (includes psychiatrists), social workers, certified professional counselors, and psychologist (Ph.D.).
NC	MCH	●	●	●	●	●	
	Medicaid	●	●	●	●	●	Other licensed mental health practitioners i.e. PhDs, LCSWs, Nurse Practitioners
ND	MCH	●	●	●	●		
NJ	Medicaid		●	●			
	MH	●	●	●	●	●	Psychologists and Nurse Practitioners
NM	MCH	●		●		●	Social workers, licensed counselors, psychologists
	MH					●	
NY	MCH	●		●	●	●	Social workers and clinical psychologists
OH	MCH					●	Again, we provide funding to counties to provide developmental evaluations on children birth to three. Our agency does not reimburse for screening.
	Medicaid						
	MH	●	●	●	●		Nurses, licensed social workers, licensed counselors

Reimbursement for assessment and diagnosis

State	AGENCY	Reimbursement for assessment and diagnosis (1-All physicians; 2-Primary Care physicians; 3-Psychiatrists; 4-EPSDT providers; 5-Specialized early intervention providers)					
		1-All	2-PCP	3-Psychiatrists	4-EPSDT	5-EI	Other Behavioral health specialists
OK	MCH						
	Medicaid	●	●	●			Contracted Psychologists and outpatient behavioral health agencies.
OR	MH	●	●	●	●		Qualified Mental Health Providers who have a graduate degree in psychology, social work, behavioral science field, recreational, music, or art therapy, or a bachelor's degree in nursing or occupational therapy and licensed by the State of Oregon, and with relevant education and experience.
PA	MH	●	●	●			Licensed Psychologists
RI	MCH	●					
	Medicaid	●	●	●		●	Psychologists and licensed social workers
SC	MCH	●			●	●	
	Medicaid	●	●		●	●	
SD	MH						Within community mental health centers, anyone who meets the criteria to provide SED services can bill for assessment and diagnosis. Minimum staff qualifications are: possess a master's degree in a human services field or a bachelor's degree in a human services field and at least two years of experience in family and children's services. There are supervision requirements for particular staff.
TN	MCH	●			●		
TX	Medicaid					●	
UT	Medicaid						Part of the capitation paid to pre-paid mental health plans. We are investigating for other, non-mental health providers.
	MH		●	●		●	We are looking at codes for community mental health centers using and being reimbursed for licensed mental health therapists.
VA	Medicaid	●	●	●	●		
WA	Medicaid	●	●	●		●	Community mental health centers
	MH		●	●	●		
WI	MCH						Contact previously named staff. Do not know who is most appropriate but they can lead you to that person.
WY	Medicaid	●	●	●	●	●	Psychologists
Total MCH agencies		11	4	7	8	12	
Total Medicaid agencies		17	18	19	12	16	
Total MH agencies		9	10	11	8	4	
Total all agencies		37	32	37	28	32	

Follow-up support

State	AGENCY	Follow-up support (1-Mental health consultation; 2-List of organizations for physician referrals; 3-State-funded care coordinators; 4-Public health nursing consultation)				
		1	2	3	4	Other
AK	MH	•			•	Most services for this population are through EPSDT and the Maternal Child Family Health Section, not through Mental Health.
AL	MCH				•	
	Medicaid	•				
AR	Medicaid	•	•			
AZ	MCH			•	•	
	Medicaid	•	•			
CA	MCH				•	
	Medicaid					Referrals to other state mental health agency and Developmental Disability (DD) agency services
	MH	•	•		•	Mental Health services available only if child has a DSM-IV Diagnosis
CO	Medicaid	•		•	•	
	MH	•	•			This is not yet systematic. These things are available some places.
CT	MH	•	•			Connecticut has a statewide Child Development Infoline - Help Me Grow - that works with a statewide Early Childhood Consultation Program. Resources and early childhood expertise are limited.
DC	MCH	•	•	•	•	
	Medicaid					None. Medical Assistance Administration (MAA), Office of Children and Families provides program oversight only.
DE	Medicaid	•			•	
FL	Medicaid					I do not know. I am answering on behalf of Medicaid Behavioral Health Services. I am not aware of what is available for primary care providers.
	MH		•	•		
GA	MCH		•			
	Medicaid					Children with a mental health diagnosis and/or emotional disturbance issues are eligible for on-going services under two Medicaid Programs: Therapeutic Residential Intervention Services, and Outpatient Community Mental Health Services.
HI	MCH		•	•	•	
	Medicaid	•		•	•	Hawaii Keiki Information Service (HKISS) which is a hotline for referrals
	MH					Early Intervention Services (EIS) Section
IA	MCH		•	•		
	Medicaid	•		•		
ID	MCH					I don't know
	Medicaid	•		•	•	Other specialists as indicated
IL	Medicaid					Early intervention
IN	MCH	•				
KS	MCH	•				I-T networks collaborate with physicians within their communities; work on referrals, etc.
	Medicaid	•				

Follow-up support

State	AGENCY	Follow-up support (1-Mental health consultation; 2-List of organizations for physician referrals; 3-State-funded care coordinators; 4-Public health nursing consultation)				
		1	2	3	4	Other
KY	MCH		●	●	●	The University of Kentucky Pediatric Clinic
	Medicaid	●				
	MH	●		●	●	
LA	MCH	●	●	●	●	In select counties, a program entitled Early Childhood Supports and Services, is a referral source for further assessment/follow up including infant mental health services.
	Medicaid	●	●			Part C Services
	MH					To be addressed by Medicaid Office
MA	MCH	●	●	●		Referral to Early Intervention
	Medicaid	●	●	●		
MD	MH	●			●	
ME	MH	●				Other
MI	Medicaid					Varies
MN	MCH					1-800 Referral and Assistance number of the Title V CSHN (Children with Special Health Needs) program has some limited capacity to assist callers with this type of question.
	MH	●	●			
MO	Medicaid		●			
	MH					Physicians through managed care can request follow up or can refer the family to the community mental health center or Regional Center
MS	MCH	●				
MT	MCH		●			
	Medicaid	●				
	MH					Primary care providers have the ability to refer to any mental health professional or mental health clinic for follow up. These resources are funded under Medicaid, private insurance, and local tax revenues.
NC	MCH					If the child meets eligibility requirements for early intervention, a multidisciplinary evaluation and other Early Intervention services indicated on the Individual Family Service Plan (IFSP)
	Medicaid	●				
ND	MCH	●	●	●	●	
	Medicaid	●		●		There are only two areas of the state with state funded care coordinators. These programs deal mainly with children with special healthcare needs, who may also have a developmental problem.
NE	MCH					Likely to occur through early intervention, but I am not involved in details of this program. Early Childhood Mental Health through the Division of Child and Family Services
NH	MH			●	●	
NJ	Medicaid			●		
	MH			●	●	
NM	MCH			●		Early intervention
	MH	●				

Follow-up support

State	AGENCY	Follow-up support (1-Mental health consultation; 2-List of organizations for physician referrals; 3-State-funded care coordinators; 4-Public health nursing consultation)				
		1	2	3	4	Other
NV	MCH					Early Childhood Mental Health through the Division of Child and Family Services
NY	MCH					Specific follow-up support is not given. Systems for follow-up are developed locally.
OH	MCH					Some mental health professional services may be available locally.
	Medicaid	•				Other mental health services are available in JFS MH (Journaled File System Mental Health) rule 5101:3-4-29.
	MH					It varies by location in the state
OK	Medicaid		•	•		
OR	MH	•				
PA	MH	•				
RI	MCH	•		•	•	
	Medicaid	•	•	•	•	
SC	MCH	•	•	•	•	Public Health Social Work
	Medicaid	•	•	•		
SD	MCH			•		
	MH					The Division of Mental Health doesn't track referrals, as community mental health centers would do the screening and provide services if eligibility criteria were met.
TN	MCH	•				
	MH	•				
TX	Medicaid					Early Childhood Intervention (ECI), pediatric developmental specialists, parent education programs, Mental Health and Mental Retardation (MHMR), substance abuse program, child protective services (not all available state-wide).
UT	MCH				•	Early intervention agencies
	Medicaid	•			•	
	MH		•		•	Referrals to mental health providers for consultation
VA	Medicaid	•		•		
VT	MH	•	•	•	•	
WA	MCH					This varies across the state.
	Medicaid	•		•	•	If child is Title V eligible, yes. Also, some health plans have care coordinators.
WY	Medicaid			•	•	
MCH agencies		16	11	10	12	
Medicaid agencies		15	8	10	6	
MH agencies		13	6	10	9	
All agencies		44	25	30	27	

Agencies tracking referrals

State	AGENCY	Track Referrals				Referral locations (1-Mental health therapists; 2-Early Intervention program; 3-Community-based organizations)			
State	AGENCY	Yes	Plan for future	No	Don't know	1-MH	2-EI	3-Community	Other
AK	MH			●					
	MCH	●					●		
AL	Medicaid			●					
AR	Medicaid			●					
	MCH			●					
AZ	Medicaid			●					
	MCH			●					
	Medicaid				●				
CA	MH			●					
	Medicaid		●						
CO	MH		●						
CT	MH			●					
	MCH	●				●	●	●	
DC	Medicaid			●					
DE	Medicaid		●						
	Medicaid				●				
FL	MH			●					
	MCH			●					
GA	Medicaid			●					
	MCH	●					●		
	Medicaid			●					
HI	MH				●				
	MCH		●						
IA	Medicaid			●					
	MCH				●				
ID	Medicaid	●				●	●		Other specialists as appropriate
IL	Medicaid			●					
	MCH		●						
IN	MH								
	MCH	●				●	●	●	
KS	Medicaid			●					

Agencies tracking referrals

State	AGENCY	Track Referrals				Referral locations (1-Mental health therapists; 2-Early Intervention program; 3-Community-based organizations)			
		Yes	Plan for future	No	Don't know	1-MH	2-EI	3-Community	Other
KY	MCH	●				●	●	●	Various other entities, including medical universities
	Medicaid			●					
	MH	●				●	●	●	
LA	MCH	●					●	●	
	Medicaid	●				●	●	●	
	MH				●				
MA	MCH	●				●	●	●	
	Medicaid				●				
MD	MH			●					
ME	MH	●				●	●	●	
MI	Medicaid			●					
MN	MCH			●					
	MH		●						
MO	Medicaid			●					
	MH			●					
MS	MCH	●					●		
	MH	●				●	●	●	
MT	MCH		●						
	Medicaid			●					
	MH			●					
NC	MCH	●				●	●		
	Medicaid			●					
ND	MCH		●						
	Medicaid	●				●	●		
NE	MCH			●					
NH	MH			●					
NJ	Medicaid			●					
	MH		●						
NM	MCH	●					●	●	
	MH			●					
NV	MCH			●					
NY	MCH			●					

Agencies tracking referrals

State	AGENCY	Track Referrals: Yes	Plan for future	No	Don't know	Referral locations (1-Mental health therapists; 2-Early Intervention program; 3-Community-based organizations): 1-MH	2-EI	3-Community	Other
OH	MCH			•					
	Medicaid			•					
	MH			•					
OK	Medicaid	•				•	•	•	
OR	MH			•					
PA	MH			•					
RI	MCH			•					
	Medicaid	•				•	•	•	
SC	MCH	•				•	•	•	Public Health Social Work.
	Medicaid				•				
SD	MCH	•				•	•	•	
	MH			•					
TN	MCH			•					
	MH				•				
TX	Medicaid			•					
UT	MCH			•					
	Medicaid			•					
	MH	•				•	•	•	
VA	Medicaid			•					
VT	MH		•						
WA	MCH			•					
	Medicaid			•					
WI	MCH			•					
WY	Medicaid	•				•	•	•	
MCH agencies		12	4	13	1	7	12	8	
Medicaid agencies		6	2	20	4	6	6	4	
MH agencies		4	4	13	3	4	4	4	
All Agencies		22	10	46	8	17	22	16	

Medicaid and early intervention relationship

State	AGENCY	Medicaid and Early Intervention relationship (1-No routine sharing of information or joint decision making; 2-Regularly scheduled meetings for sharing information; 3-Jointly developed policies and projects; 4-Data matching and sharing; 5-Reimbursement arrangements for services provided by other agency; 6-Collaboration on educational programs and trainings; 7-Collaborative mechanisms for client referrals and case management; 8 Collaboration on development of contract language and monitoring of contracts)									
		1	2	3	4	5	6	7	8	Don't know	Other
AK	MH										Our division has a Prevention and Early Intervention section, but very young children are served more through Maternal and Child Health which is not in our Division. Within the Division of Behavioral Health, we have little specifically focused on very young children.
AL	MCH		•								
AR	Medicaid	•									
AZ	Medicaid		•	•			•	•			
	Medicaid	•									Much of this happens at the county level with individual managed care plans
CA	MH	•									
	Medicaid		•	•			•				
CO	MH										Medicaid serves on the Memorandum of Understanding (MOU) committee of the state Interagency Coordinating Council
CT	MH	•									Connecticut's Medicaid agency does not sit at the same table with other state agency early childhood representatives.
	MCH							•			
DC	Medicaid	•									
DE	Medicaid					•		•			
	Medicaid	•									
FL	MH		•	•	•	•	•		•		
	MCH		•	•		•	•				
GA	Medicaid									•	
	MCH			•		•		•			
	Medicaid		•								Informal collaboration on special projects
HI	MH									•	
	MCH		•	•	•	•					
IA	Medicaid		•	•		•					
	MCH									•	
ID	Medicaid			•		•		•			
IL	Medicaid				•	•		•			

Medicaid and early intervention relationship

State	AGENCY	Medicaid and Early Intervention relationship (1-No routine sharing of information or joint decision making; 2-Regularly scheduled meetings for sharing information; 3-Jointly developed policies and projects; 4-Data matching and sharing; 5-Reimbursement arrangements for services provided by other agency; 6-Collaboration on educational programs and trainings; 7-Collaborative mechanisms for client referrals and case management; 8 Collaboration on development of contract language and monitoring of contracts)									
		1	2	3	4	5	6	7	8	Don't know	Other
	MCH	•		•	•	•	•	•	•		Some minimal collaboration on policy development.
KS	Medicaid			•			•				
	MCH		•	•	•	•	•	•	•		
	Medicaid		•	•	•	•			•		
KY	MH		•	•	•		•	•	•		
	MCH									•	
	Medicaid		•	•	•	•	•				
LA	MH									•	
	MCH	•				•					
MA	Medicaid			•			•				I may not have been totally inclusive here, please refer to response from Department of Public Health.
MD	MH	•									There is regular collaboration between Medicaid and the State Department of Education
ME	MH									•	
MI	Medicaid					•					Collaboration on policy manuals
	MCH		•	•			•				
MN	MH		•								Local coordination at Interagency Early Intervention Committees (IEICs)
	Medicaid	•									
MO	MH										Little up to this point, but due to federal grant for planning an early childhood system we are developing a plan which involves much more collaboration across all child-serving agencies.
	MCH				•	•		•			
MS	MH				•	•					
	Medicaid									•	
MT	MH		•				•				
	MCH		•	•	•	•	•	•	•		
NC	Medicaid		•	•							
	MCH		•	•	•		•	•	•		Mental Health, Medicaid and Disability Services are part of the Department of Human Services.
ND	Medicaid				•	•			•		
NE	MCH									•	

Medicaid and early intervention relationship

State	AGENCY	Medicaid and Early Intervention relationship (1-No routine sharing of information or joint decision making; 2-Regularly scheduled meetings for sharing information; 3-Jointly developed policies and projects; 4-Data matching and sharing; 5-Reimbursement arrangements for services provided by other agency; 6-Collaboration on educational programs and trainings; 7-Collaborative mechanisms for client referrals and case management; 8 Collaboration on development of contract language and monitoring of contracts)									
		1	2	3	4	5	6	7	8	Don't know	Other
NH	MH									•	
NJ	Medicaid	•									
	MCH		•	•	•		•	•	•		
NM	MH		•								
NV	MCh	•				•		•			Maternal and Child Health Chief sat on the review committee for Medicaid Managed Care Contracts and worked to ensure coverage of Early Intervention.
NY	MCH			•	•	•	•		•		
	MCH	•									
	Medicaid	•				•					Currently pay for specialized services through state plan and Community Alternative Funding System (CAFS) but the CAFS program will be discontinued 6/30/05.
OH	MH									•	
OK	Medicaid		•	•	•	•	•	•	•		
OR	MH									•	
PA	MH	•									
	MCH		•	•		•			•		Early Intervention has recently been transferred from Health to the Medicaid agency. We assume it will continue good connections to Medicaid
RI	Medicaid										State Medicaid agency and Early Intervention lead agency are the same.
	MCH		•	•		•			•		
SC	Medicaid		•	•				•	•		
	MCH	•				•					
SD	MH									•	
TN	MCH		•								
TX	Medicaid		•	•	•	•					
	MCH									•	
	Medicaid			•		•	•		•		The relationship with the state entity is different than that with the local providers. We continue to work with the state agency but have greater success in working directly with the providers.
UT	MH			•	•	•	•		•		

Medicaid and early intervention relationship

State	AGENCY	Medicaid and Early Intervention relationship (1-No routine sharing of information or joint decision making; 2-Regularly scheduled meetings for sharing information; 3-Jointly developed policies and projects; 4-Data matching and sharing; 5-Reimbursement arrangements for services provided by other agency; 6-Collaboration on educational programs and trainings; 7-Collaborative mechanisms for client referrals and case management; 8 Collaboration on development of contract language and monitoring of contracts)									
		1	2	3	4	5	6	7	8	Don't know	Other
VA	Medicaid		●	●			●	●			
VT	MH			●		●		●			
WA	Medicaid	●	●								Regularly scheduled meetings have just started. So collaboration is in the early stages.
WY	Medicaid		●	●	●	●	●	●			
MCH Agencies		7	9	11	5	10	7	8	3	3	
Medicaid Agencies		5	11	10	10	10	9	6	7	6	
MH Agencies		5	9	10	4	10	5	5	6	4	
All Agencies		17	29	31	19	30	21	19	16	13	

Medicaid and mental health relationship

State	AGENCY	Medicaid and mental health relationship (1-No routine sharing of information or joint decision making; 2-Regularly scheduled meetings for sharing information; 3-Jointly developed policies and projects; 4-Data matching and sharing; 5-Reimbursement arrangements for services provided by other agency; 6-Collaboration on educational programs and trainings; 7- Collaborative mechanisms for client referrals and case management; 8-Collaboration on development of contract language and monitoring of contracts)									
		1	2	3	4	5	6	7	8	Don't Know	Other
AK	MH		•	•	•	•	•	•	•		Different Divisions located w/in the same Department. Recently some Medicaid staff were placed into Divisions. There is a great deal of interaction now, but has not traditionally been as much. New systems are being developed.
	MCH									•	
AL	Medicaid										We feel we have a good relationship with all enrolled providers
AR	Medicaid			•	•				•		
AZ	Medicaid		•	•	•	•	•	•	•		
	MCH										
	Medicaid										Occasional meetings for discussion and sharing
CA	MH	•									
	Medicaid		•	•	•						
CO	MH										Our Medicaid Mental Health just went over to our Medicaid agency so this relationship is just developing and being worked out.
CT	MH	•									
	MCH							•			
DC	Medicaid							•			
DE	Medicaid					•		•	•		
	Medicaid		•	•	•		•		•		
FL	MH		•	•	•	•	•		•		Excellent on-going relationship.
	MCH									•	
GA	Medicaid		•	•	•		•		•		
	MCH									•	
	Medicaid					•					Informal collaboration on special projects; technical assistance by Medicaid given to other government agencies concerning Medicaid coverage
HI	MH		•	•	•	•	•	•	•		For Child and Adolescent Mental Health Division (CAMHD) and the Medicaid agency
	MCH		•	•							
IA	Medicaid					•					
	MCH									•	
ID	Medicaid		•	•	•	•	•	•	•		

Medicaid and mental health relationship

State	AGENCY	Medicaid and mental health relationship (1-No routine sharing of information or joint decision making; 2-Regularly scheduled meetings for sharing information; 3-Jointly developed policies and projects; 4-Data matching and sharing; 5-Reimbursement arrangements for services provided by other agency; 6-Collaboration on educational programs and trainings; 7- Collaborative mechanisms for client referrals and case management; 8-Collaboration on development of contract language and monitoring of contracts)									
		1	2	3	4	5	6	7	8	Don't Know	Other
IL	Medicaid			•				•	•		Recent Children's Mental Health Partnership has encouraged increased collaborations and joint projects.
	MCH			•							They are housed in the same agency but MCH is in another agency! Some sharing of limited data.
	MCH									•	
KS	Medicaid			•	•		•				
	MCH									•	
	Medicaid				•	•		•	•		
KY	MH			•			•	•	•		
	MCH									•	
	Medicaid		•	•	•		•	•		•	
LA	MH		•	•		•					
	MCH		•								
MA	Medicaid		•	•	•	•	•	•	•		
MD	MH		•	•	•	•	•	•	•		
ME	MH		•	•		•	•		•		Overall very close collaboration on the design or re-design of Medicaid policy that defines needed services.
	MCH										These are within the same agency.
MN	MH		•	•	•	•	•		•		
	Medicaid		•	•	•	•		•	•		
MO	MH			•							
	MCH	•									
MS	MH		•	•		•		•			
	Medicaid	•									
MT	MH		•	•	•		•	•			Children's Mental Health Bureau is located within the Health Resource Division which is comprised of the Medicaid programs for hospitals, primary care services, and other Medicaid services for other health related care, includes CHIP. As part of the same Division, collaboration occurs daily at different levels and on different issues to enhance coordination of a Medicaid system of care for children.
	MCH		•	•	•		•	•	•		
NC	Medicaid		•	•	•		•	•	•		We work very closely together

Medicaid and mental health relationship

State	AGENCY	Medicaid and mental health relationship (1-No routine sharing of information or joint decision making; 2-Regularly scheduled meetings for sharing information; 3-Jointly developed policies and projects; 4-Data matching and sharing; 5-Reimbursement arrangements for services provided by other agency; 6-Collaboration on educational programs and trainings; 7- Collaborative mechanisms for client referrals and case management; 8-Collaboration on development of contract language and monitoring of contracts)									
		1	2	3	4	5	6	7	8	Don't Know	Other
	MCH		•	•	•		•	•	•	•	Medicaid and the mental health agencies are located in Human Services.
ND	Medicaid		•	•	•	•	•	•			
	MCH									•	
NE	MCH									•	
NH	MH		•	•	•				•		
	Medicaid	•									Division of Child Behavioral Health Services and Division of Mental Health Services
NJ	MH	•		•	•	•		•	•		In the early planning stages in broad based collaboration
	MCH									•	
NM	MH							•	•		
NY	MCH					•	•				
	MCH									•	
	Medicaid		•	•	•	•		•			
OH	MH									•	
OK	Medicaid		•	•	•	•		•			
OR	MH		•	•	•						
PA	MH	•				•					
	MCH		•	•		•		•		•	Children's mental health is based at our child welfare agency, with some real Title XIX collaboration. Adult mental health is at Mental Health, Retardation, and Hospitals
RI	Medicaid	•									
	MCH									•	
SC	Medicaid		•	•	•				•		
	MCH									•	
SD	MH										The Division of Mental Health (DMH) and the State Medicaid Office have a good relationship. Community mental health centers typically work with Medicaid through the DMH.
TN	MCH			•	•						
TX	Medicaid		•	•	•	•					
	MCH					•					
	Medicaid		•	•	•		•		•		
UT	MH		•	•	•	•	•		•		

Medicaid and mental health relationship

State	AGENCY	Medicaid and mental health relationship (1-No routine sharing of information or joint decision making; 2-Regularly scheduled meetings for sharing information; 3-Jointly developed policies and projects; 4-Data matching and sharing; 5-Reimbursement arrangements for services provided by other agency; 6-Collaboration on educational programs and trainings; 7- Collaborative mechanisms for client referrals and case management; 8-Collaboration on development of contract language and monitoring of contracts)									
		1	2	3	4	5	6	7	8	Don't Know	Other
VA	Medicaid		●	●	●		●	●	●		
VT	MH		●	●	●	●		●	●		
WA	Medicaid		●	●	●	●		●			The Medicaid Integration Project specifically targets multi-need clients (many with mental health issues) to manage their care. The intent is to review results of this pilot and consider expansion or/and other ways to coordinate the care of high needs clients. The regional mental health agencies are capitated by number of Medicaid clients in their regions.
WI	MCH										
WY	Medicaid		●	●	●	●		●			
Medicaid and MH Agencies		6	27	29	24	20	14	19	16	10	
MCH Agencies		1	5	6	3	3	3	4	2	15	
Medicaid Agencies		3	18	21	21	14	11	16	14	1	
MH Agencies		4	13	16	11	12	9	9	12	1	
all Agencies		8	36	43	35	29	23	29	28	17	

Early intervention and mental health relationship

State	AGENCY	Early Intervention and mental health relationship (1-No routine sharing of information or joint decision making; 2-Regularly scheduled meetings for sharing information; 3-Jointly developed policies and projects; 4-Data matching and sharing; 5-Reimbursement arrangements for services provided by other agency; 6-Collaboration on educational programs and trainings; 7- Collaborative mechanisms for client referrals and case management; 8-Collaboration on development of contract language and monitoring of contracts)									
		1	2	3	4	5	6	7	8	Don't know	Other
AK	MH										There is little direct interaction between Maternal, Child and Family Health (MC&FH) and the Division of Behavioral Health (DBH). There is little funding available for proactive and/or early care through the Mental health system in Alaska. The Office of Children's services has an early childhood grant and probably has more involvement with MC&FH.
	MCH									•	
AL	Medicaid										It is my understanding that when you mention State Early Intervention are you speaking of the EPSDT program?
AR	Medicaid									•	
AZ	Medicaid		•	•			•	•			
	Medicaid									•	
CA	MH	•									
	Medicaid									•	
CO	MH										This is also just developing. We have been invited to serve on the Interagency Coordinating Council and I am filling that position. We are currently working together on a Technical Assistance document about how social/emotional issues are handled in Part C.
CT	MH										Division of Child Welfare (DCF)'s Child Welfare Bureau Chief has met with our Early Intervention State Agency but has not included DCF's Early Childhood Intervention Specialist in these meetings. This has undermined the effectiveness of two agencies partnering to improve the quality of early childhood services in Connecticut.
	MCH							•			
DC	Medicaid	•									
DE	Medicaid									•	
	Medicaid									•	
FL	MH			•			•	•			Currently working on Agreement of Understanding between agencies. The Chief of Children's Mental Health is on the state Early Intervention Program (EIP) coordinating council. (FICCIT)
	MCH						•	•			
GA	Medicaid									•	

Early intervention and mental health relationship

State	AGENCY	Early Intervention and mental health relationship (1-No routine sharing of information or joint decision making; 2-Regularly scheduled meetings for sharing information; 3-Jointly developed policies and projects; 4-Data matching and sharing; 5-Reimbursement arrangements for services provided by other agency; 6-Collaboration on educational programs and trainings; 7- Collaborative mechanisms for client referrals and case management; 8-Collaboration on development of contract language and monitoring of contracts)									
		1	2	3	4	5	6	7	8	Don't know	Other
	MCH			•			•	•			
	Medicaid									•	These agencies are not in the same State Department as Medicaid. These agencies are in the Department of Health. Thus, Medicaid is unable to describe the relationship
HI	MH				•			•			
	MCH		•	•		•		•	•		
IA	Medicaid		•	•							
	MCH									•	
ID	Medicaid			•	•	•	•	•			
IL	Medicaid						•				With social/emotional component in Early Intervention (recent addition); more interaction and referrals are expected/encouraged.
	MCH									•	
IN	MH										
	MCH		•	•			•	•	•		Currently working on some of the above.
KS	Medicaid									•	
	MCH		•	•	•	•	•	•	•		
	Medicaid									•	
KY	MH		•	•	•	•	•	•			
	MCH									•	
	Medicaid									•	
LA	MH			•			•	•			
	MCH		•	•			•				
MA	Medicaid									•	
MD	MH		•	•		•	•	•	•		
ME	MH									•	Developing a Memorandum of Agreement that will improve knowledge and future collaborative efforts.
MI	Medicaid		•	•	•	•	•	•			
	MCH		•				•				
MN	MH										We are just beginning to have joint meetings. These agencies have been quite separated from one another.

Early intervention and mental health relationship

State	AGENCY	Early Intervention and mental health relationship (1-No routine sharing of information or joint decision making; 2-Regularly scheduled meetings for sharing information; 3-Jointly developed policies and projects; 4-Data matching and sharing; 5-Reimbursement arrangements for services provided by other agency; 6-Collaboration on educational programs and trainings; 7- Collaborative mechanisms for client referrals and case management; 8-Collaboration on development of contract language and monitoring of contracts)									
		1	2	3	4	5	6	7	8	Don't know	Other
MO	Medicaid									•	
MO	MH										There is no STATE early intervention agency. Several state agencies provide services to the early childhood population including Education and Health.
MS	MCH		•	•			•	•	•		
MS	MH						•	•			
MT	Medicaid	•									
MT	MH		•								The development of the system of care for Children's Mental Health Services is a legislatively directed task of the Children's Mental Health Bureau. This task is conducted with the oversight of a Children's System of Care Planning Committee established by law. Among other child and adolescent serving agencies/program represented on this committee is the Maternal and Child Health program. This committee meets monthly to provide oversight, assist in policy development, establish standards for community interagency programs, etc.
NC	MCH		•	•	•		•	•	•		
NC	Medicaid									•	
ND	MCH		•	•	•		•	•	•		Regular meetings and work groups addressing mental health and early intervention now taking place to complete the Early Childhood Comprehensive System (ECCS) state plan.
ND	Medicaid									•	
NE	MCH									•	
NH	MH		•	•			•		•		Mental Health, Early Intervention, Part B Education, Maternal and Child Health, Head Start, Developmental Services and family agencies are part of the Children's Care Management Collaborative(CCMC). CCMC uses braided funds to contract for technical assistance to 14 local Infant Mental Health Teams that work to improve supports for young children and their families.
NJ	Medicaid									•	
NJ	MH	•					•				We are in the early planning stages of the collaborative relationships with the agencies providing services for this population

Early intervention and mental health relationship

State	AGENCY	Early Intervention and mental health relationship (1-No routine sharing of information or joint decision making; 2-Regularly scheduled meetings for sharing information; 3-Jointly developed policies and projects; 4-Data matching and sharing; 5-Reimbursement arrangements for services provided by other agency; 6-Collaboration on educational programs and trainings; 7- Collaborative mechanisms for client referrals and case management; 8-Collaboration on development of contract language and monitoring of contracts)									
		1	2	3	4	5	6	7	8	Don't know	Other
	MCH					•	•	•			
NM	MH		•	•		•	•	•	•		
NV	MCH		•	•			•	•			Do screenings together and are co-located in Las Vegas.
NY	MCH						•				
	MCH	•									
	Medicaid									•	
OH	MH	•									
OK	Medicaid		•	•	•		•				
OR	MH		•								
PA	MH	•									
	MCH					•			•		
RI	Medicaid	•									
	MCH		•	•		•	•	•	•		
SC	Medicaid									•	
	MCH					•					
SD	MH									•	
TN	MCH		•								
TX	Medicaid									•	
	MCH									•	
	Medicaid	•									We are doing our best to get these folks to work together.
UT	MH	•					•	•			
VA	Medicaid									•	
VT	MH		•	•	•	•	•	•	•		
WA	Medicaid									•	
WY	Medicaid						•	•	•		
MCH agencies		1	12	10	3	6	13	12	8	6	
Medicaid agencies		4	4	5	3	2	6	4	1	21	
MH agencies		5	7	7	3	4	10	9	4	2	
All agencies		10	23	22	9	12	29	25	13	29	

Agency encouragement and reimbursement for screening for maternal depression

State	AGENCY	Does Agency encourage screening				Is Agency reimbursing for Screening			
		Yes	Plan for future	No	Don't know	Yes	Plan for future	No	Don't know
AK	MH			•				•	
	MCH			•				•	
AL	Medicaid			•					•
AR	Medicaid			•				•	
AZ	Medicaid			•				•	
	Medicaid			•					•
CA	MH		•					•	
	Medicaid			•					•
CO	MH			•				•	
CT	MH			•				•	
	MCH	•					•		
DC	Medicaid			•				•	
DE	Medicaid			•				•	
	Medicaid		•						•
FL	MH			•				•	
	MCH	•							•
GA	Medicaid				•				•
	MCH				•			•	
	Medicaid			•				•	
HI	MH				•				•
	MCH		•					•	
IA	Medicaid		•					•	
	MCH			•				•	
ID	Medicaid	•							•
IL	Medicaid	•				•			
IN	MCH		•				•		
	MCH		•					•	
KS	Medicaid				•				•
	MCH	•					•		
	Medicaid				•		•		
KY	MH		•					•	

Agency encouragement and reimbursement for screening for maternal depression

State	AGENCY	Does Agency encourage screening				Is Agency reimbursing for Screening			
		Yes	Plan for future	No	Don't know	Yes	Plan for future	No	Don't know
LA	MCH	•						•	
	Medicaid		•						•
	MH	•							•
MA	MCH	•						•	
	Medicaid	•							•
MD	MH				•				•
ME	MH				•				•
MI	Medicaid		•					•	
MN	MCH		•					•	
	MH		•						•
MO	Medicaid			•				•	
	MH		•					•	
MS	MCH				•				•
	MH				•			•	
MT	Medicaid				•	•			
	MH				•				•
NC	MCH	•				•			
	Medicaid				•				•
ND	MCH	•						•	
	Medicaid			•					•
NE	MCH		•					•	
NH	MH			•				•	
NJ	Medicaid			•				•	
	MH			•				•	
NM	MCH				•				•
	MH				•			•	
NV	MCH		•					•	
NY	MCH		•					•	
OH	MCH		•					•	
	Medicaid	•				•			
	MH	•						•	
OK	Medicaid	•				•			
OR	MH				•			•	

Agency encouragement and reimbursement for screening for maternal depression

State	AGENCY	Does Agency encourage screening				Is Agency reimbursing for Screening			
		Yes	Plan for future	No	Don't know	Yes	Plan for future	No	Don't know
PA	MH				•			•	
	MCH	•						•	
RI	Medicaid			•					•
	MCH	•					•		
SC	Medicaid			•					•
	MCH				•				•
SD	MH			•				•	
	MCH			•		•			
TN	MH				•				•
TX	Medicaid			•				•	
	MCH		•						•
	Medicaid		•				•		
UT	MH	•						•	
VA	Medicaid	•						•	
VT	MH	•						•	
	MCH				•				•
WA	Medicaid	•						•	
WI	MCH				•				•
WY	Medicaid				•				•
MCH agencies		9	9	3	6	2	4	14	7
Medicaid agencies		7	5	14	6	4	2	12	14
MH agencies		4	4	7	9	0	0	17	7
All agencies		20	18	24	21	6	6	43	28

Agencies encourage and reimburse treatment for maternal depression

State	AGENCY	Is agency ecouraging treatment for maternal depression				How is agency encouraging treatment for maternal depression	Is Agency reimbursing for treatment for maternal depression			
		Yes	Plan for future	No	Don't know		Yes	Plan for future	No	Don't know
AK	MH			•						•
	MCH			•					•	
AL	Medicaid				•					•
AR	Medicaid			•			•			
AZ	Medicaid	•				Arizona Health Care Cost Containment System encourages outreach to pregnant members regarding maternal depression.				•
	Medicaid			•						•
CA	MH			•					•	
	Medicaid			•			•			
CO	MH				•				•	
CT	MH			•					•	
	MCH	•				Provider training and education		•		
DC	Medicaid			•			•			
DE	Medicaid	•				External Quality Review Organization (EQRO) Focus Studies; Cooperation with Division of Public Health on programs; Supply of information to Primary Care provides on identification.	•			
	Medicaid				•		•			
FL	MH		•						•	
	MCH	•				Unsure			•	
GA	Medicaid				•					•
	MCH	•				Support and promote screening of prenatal women through contract with community health centers			•	
	Medicaid			•			•			
HI	MH				•					•

Agencies encourage and reimburse treatment for maternal depression

State	AGENCY	Is agency ecouraging treatment for maternal depression				How is agency encouraging treatment for maternal depression	Is Agency reimbursing for treatment for maternal depression			
		Yes	Plan for future	No	Don't know		Yes	Plan for future	No	Don't know
	MCH	•				For the last few years we have included training on maternal depression/screening/referral/treatment at all of our Maternal and Child Health grantee conferences.			•	
IA	Medicaid	•				The state Title V agency is routinely screening for depression in their clients and identifying treatment resources. If the woman is on Medicaid we can cover the treatment through our mental health contractor.	•			
	MCH			•					•	
ID	Medicaid	•				Treatment for maternal depression is a covered Medicaid benefit.	•			
IL	Medicaid	•				Universal screening and referral as needed; University of Illinois at Chicago (UIC) Perinatal Depression Consultation Line; Website referral resources	•			
IN	MCH	•				We are supporting a statewide project to increase screening for maternal depression. Encouraging treatment follows.			•	
	MCH	•				Screening and referral providing outreach and family support to complete community referrals. Via Part C Infant-Toddler networks; part of program to assist families with problems that are/can affect child's development.			•	
KS	Medicaid	•				Referral to Mental Health Provider.	•			
	MCH	•				Referrals to mental health providers as needed and appropriate			•	
	Medicaid		•				•			
KY	MH		•				•			
	MCH	•				Education of staff for referral of women with maternal depression. Mental Health consultation and treatment services are provided for women in the Nurse Family Partnership Program who are found to have maternal depression.	•			
	Medicaid		•				•			
LA	MH	•				Directly provide treatment for those who meet priority population criteria; Referral for those who do not.	•			

Agencies encourage and reimburse treatment for maternal depression

State	AGENCY	Is agency ecouraging treatment for maternal depression				How is agency encouraging treatment for maternal depression	Is Agency reimbursing for treatment for maternal depression			
		Yes	Plan for future	No	Don't know		Yes	Plan for future	No	Don't know
	MCH	●				Public awareness materials through public health, substance abuse, etc.			●	
MA	Medicaid	●				No referral is required, information in member support materials, newsletters and collaboration with DPH on a maternal postpartum screening grant project.	●			
MD	MH	●				Interagency community awareness campaign	●			
ME	MH				●				●	
MI	Medicaid		●						●	
	MCH	●				As part of training and information to providers it is recommended that this be taken seriously and that some follow-up or treatment be included for anyone with a positive diagnosis.			●	
MN	MH	●				Incorporation of material on maternal depression into training of Child & Teen Check Up (EPSDT) providers	●			
	Medicaid			●			●			
MO	MH		●					●		
	MCH				●					●
MS	MH				●					●
	Medicaid				●		●			
MT	MH				●					●
	MCH	●				Training, interagency agreements	●			
NC	Medicaid				●		●			
	MCH	●				Through the Title V five year needs assessment, 'improving early intervention of mental health and substance abuse disorders in women' was identified as a priority need statement. Also through the Women and Depression Provider's Partnership Team.	●			
ND	Medicaid				●		●			
NE	MCH		●			We have an information campaign that is in process.				●
NH	MH				●		●			
	Medicaid				●		●			
NJ	MH			●					●	

Agencies encourage and reimburse treatment for maternal depression

State	AGENCY	Is agency ecouraging treatment for maternal depression				How is agency encouraging treatment for maternal depression	Is Agency reimbursing for treatment for maternal depression			
		Yes	Plan for future	No	Don't know		Yes	Plan for future	No	Don't know
	MCH	•				Home visiting programs; public health screening; Pregnancy Risk Assessment Monitoring System (PRAMS) education to providers				•
NM	MH				•					•
NV	MCH	•							•	
NY	MCH	•				Working with American College of Obstetricians and Gynecologists (ACOG) to provide training for OB/GYN Providers to identify maternal depression. Planning to work with American Association of Pediatricians (AAP) on training. Trying to develop local resources for treatment of maternal depression so that health care providers will know where to refer for services.			•	
	MCH		•						•	
	Medicaid	•				Through reimbursement of Certified Provider Training (CPT) codes for mental health treatment.	•			
OH	MH	•				Through training of early care and mental health providers	•			
OK	Medicaid	•				Public Teleconference provider trainings to the State's Children First program on Post Partum Depression, diagnosis and treatment.	•			
OR	MH			•			•			
PA	MH	•				Informational material to physicians	•			
	MCH	•				Working to make it part of standard of care			•	
RI	Medicaid				•					•
	MCH	•				Including prompts on screening/assessment instrument across disciplines.	•			
SC	Medicaid				•					•
	MCH				•					•
SD	MH			•					•	
TN	MCH	•				Medications	•			
TN	MH	•				Mental health centers will treat any type of depression. Some focus because of Evidence Based Practice on maternal depression and the impact of children.	•			

Agencies encourage and reimburse treatment for maternal depression

State	AGENCY	Is agency ecouraging treatment for maternal depression: Yes	Plan for future	No	Don't know	How is agency encouraging treatment for maternal depression	Is Agency reimbursing for treatment for maternal depression: Yes	Plan for future	No	Don't know
TX	Medicaid			•					•	
UT	MCH	•				Making providers aware of the problem, providing resources for tools to assess, web site information, presentations.	•			
	Medicaid		•				•			
	MH	•				Education of providers, public and part of early childhood assessments.			•	
VA	Medicaid	•				Working with other state agency for grant	•			
VT	MH	•				By colocating with mental health case managers	•			
WA	MCH				•					•
	Medicaid				•		•			
WI	MCH	•				The most visible statewide agency focusing public and medical community attention on maternal depression is supported by MCH Block Grant 'statewide' initiative funding. This is the Wisconsin Association for Perinatal Care.				•
WY	Medicaid				•					•
MCH agencies		13	1	10	5		10	1	12	6
Medicaid agencies		12	6	2	10		15	1	9	6
MH Agencies		13	1	3	6		13	0	4	6
All agencies		38	9	15	21		39	2	25	18

State infant mental health certification requirement

State	AGENCY	STATE certification requirement			
		Yes	Plan for future	No	Don't know
AK	MH			●	
	MCH				●
AL	Medicaid				●
AR	Medicaid			●	
AZ	Medicaid				●
	Medicaid				●
CA	MH		●		
	Medicaid			●	
CO	MH		●		
CT	MH			●	
	MCH	●			
DC	Medicaid			●	
DE	Medicaid			●	
	Medicaid			●	
FL	MH			●	
	MCH			●	
GA	Medicaid				●
	MCH				●
	Medicaid			●	
HI	MH				●
	MCH			●	
IA	Medicaid			●	
	MCH				●
ID	Medicaid	●			
IL	Medicaid			●	
IN	MCH		●		
	MCH	●			
KS	Medicaid				●
	MCH			●	
	Medicaid	●			
KY	MH			●	

State	AGENCY	STATE certification requirement			
		Yes	Plan for future	No	Don't know
	MCH				●
	Medicaid			●	
LA	MH			●	
	MCH		●		
MA	Medicaid				●
MD	MH			●	
ME	MH			●	
MI	Medicaid			●	
	MCH				●
MN	MH		●		
	Medicaid			●	
MO	MH			●	
	MCH	●			
MS	MH	●			
MT	Medicaid				●
MT	MH				●
	MCH	●			
NC	Medicaid			●	
	MCH			●	
ND	Medicaid			●	
NE	MCH				●
NH	MH			●	
	Medicaid				●
NJ	MH				●
	MCH		●		
NM	MH		●		
NV	MCH			●	
NY	MCH			●	
	MCH				●
	Medicaid			●	
OH	MH			●	

State infant mental health certification requirement

State	AGENCY	STATE certification requirement			
		Yes	Plan for future	No	Don't know
OK	Medicaid		●		
OR	MH			●	
PA	MH			●	
RI	MCH			●	
	Medicaid			●	
SC	MCH			●	
	Medicaid				●
SD	MCH				●
	MH				●
TN	MCH			●	
	MH				●
TX	Medicaid				●
UT	MCH				●
	Medicaid			●	
	MH		●		
VA	Medicaid				●
VT	MH			●	
WA	MCH			●	
	Medicaid			●	
WI	MCH			●	
WY	Medicaid				●
MCH agencies		4	3	11	11
Medicaid agencies		2	1	17	13
MH Agencies		1	5	13	6
All agencies		7	9	41	30

Racial or ethnic disparities

State	AGENCY	Racial or ethnic disparities			
		Yes	No	Don't know	Other
AK	MH			•	
	MCH			•	
AL	Medicaid			•	
AR	Medicaid		•		
AZ	Medicaid		•		
	Medicaid			•	
CA	MH			•	
	Medicaid			•	
CO	MH			•	
CT	MH	•			Two Connecticut Foundations have issued data on identified ethnic or racial disparities.
	MCH	•			Access to care, availabilty of services, quality of care
DC	Medicaid			•	
DE	Medicaid		•		
	Medicaid			•	
FL	MH			•	
	MCH		•		
GA	Medicaid		•		
	MCH			•	
	Medicaid		•		
HI	MH			•	
	MCH		•		
IA	Medicaid			•	
	MCH			•	
ID	Medicaid	•			Hispanic/Latino population appears to access services less frequently.
IL	Medicaid			•	
IN	MCH			•	
	MCH	•			Identified blacks are less likely to receive treatment.
KS	Medicaid			•	
	MCH		•		
	Medicaid			•	
KY	MH		•		
	MCH			•	
	Medicaid			•	
LA	MH			•	
	MCH		•		
MA	Medicaid			•	

Racial or ethnic disparities

State	AGENCY	Racial or ethnic disparities			
		Yes	No	Don't know	Other
MD	MH			•	
ME	MH			•	
MI	Medicaid			•	
	MCH		•		
MN	MH	•			Young African-American children are relatively overrepresented in more intensive treatment settings, e.g. day treatment.
MO	MH	•			Lack of access to minorities and lack of access in rural areas.
	MCH			•	
MS	MH	•			The newly arrived Hispanic chidren are not being served
	Medicaid		•		
MT	MH	•			We have identified that the number of Native American youth in out-of-home treatment environments represents a higher percentage than the Native American youth population represents in the general public. This suggests an over representation of Native Americans in these higher end and cost services.
	MCH		•		
NC	Medicaid		•		
	MCH	•			American Indian disparity
ND	Medicaid	•			Native American and children who have English as a second language have a higher rate of referral in these areas.
NE	MCH			•	
NH	MH			•	
	Medicaid		•		
NJ	MH		•		
	MCH	•			Cultural issues, language, access to care and treatment
NM	MH			•	
NY	MCH			•	
	MCH			•	
	Medicaid			•	
OH	MH		•		
	MCH				
OK	Medicaid		•		
OR	MH	•			Under served children from non-english speaking families.
PA	MH			•	
	MCH			•	
RI	Medicaid		•		
	MCH	•			In Early Intervention services, ethnic and racial minorities are underserved.
SC	Medicaid			•	

Racial or ethnic disparities

State	AGENCY	Racial or ethnic disparities: Yes	No	Don't know	Other
SD	MCH			●	
	MH			●	
TN	MCH	●			Minorities at higher risk
TN	MH	●			Early Intervention Program needed some development to encourage parents of children of color to take advantage of resources
TX	Medicaid			●	
UT	MCH			●	
	Medicaid		●		
	MH	●			We have a large undocumented Hispanic population that has a high birth rate. Most of the women in this group do not receive prenatal care. If the child was born outside of the USA then they do not qualify for any financial assistance. Therefore they are often behind in health care, education and mental health services, or even not getting them.
VA	Medicaid			●	
VT	MH		●		
WA	MCH		●		
	Medicaid			●	
WI	MCH			●	
WY	Medicaid			●	
MCH agencies		6	8	15	
Medicaid agencies		8	4	17	
MH agencies		8	4	13	
All agencies		16	23	47	

Primary care provider education available on infant mental health

State	AGENCY	Primary care provider education available on infant mental health				Education format (1-In-person conferences; 2-Learning collaboratives; 3-Workshops; 4-In-office meetings; 5-Materials; 6-Web-based conferences; 7-Teleconference; 8-Grand Rounds)								
		Yes	Plan for future	No	Don't know	1-Conference	2-Collaborative	3-Workshops	4-In-office	5-Materials	6-Web	7-Teleconference	8-Grand rounds	Other
AK	MH			•										
	MCH			•										
AL	Medicaid			•										
AR	Medicaid				•									
AZ	Medicaid		•											Unknown at this time.
	Medicaid	•					•		•	•				
CA	MH		•				•	•		•	•			
	Medicaid			•										
CO	MH	•												Just developing through our EPSDT pilot
CT	MH			•										
	MCH	•				•	•	•	•	•	•	•	•	
DC	Medicaid			•										
DE	Medicaid		•							•				
	Medicaid				•									
FL	MH			•										
	MCH	•				•	•	•		•	•	•		
GA	Medicaid				•									
	MCH			•										
	Medicaid			•										
HI	MH				•									
	MCH		•											Yet to be determined through ABCD II. All of the above may apply. Some are done already, such as grand rounds, at the University of Iowa.
IA	Medicaid		•			•				•	•			We have not developed a plan but I expect these mechanisms at a minimum.
	MCH			•										
ID	Medicaid	•								•				
IL	Medicaid	•							•	•			•	Web-based materials and training planned
IN	MCH		•					•						Still in the planning phase

Primary care provider education available on infant mental health

State	AGENCY	Primary care provider education available on infant mental health				Education format (1-In-person conferences; 2-Learning collaboratives; 3-Workshops; 4-In-office meetings; 5-Materials; 6-Web-based conferences; 7-Teleconference; 8-Grand Rounds)								
		Yes	Plan for future	No	Don't know	1-Conference	2-Collaborative	3-Workshops	4-In-office	5-Materials	6-Web	7-Teleconference	8-Grand rounds	Other
KS	MCH	•				•		•		•				
	Medicaid	•												
KY	MCH		•										•	
	Medicaid			•										
	MH	•				•		•	•	•	•		•	
LA	MCH			•										
	Medicaid	•							•	•				
	MH	•					•	•		•	•	•	•	
MA	MCH		•											no answer
	Medicaid	•				•	•	•	•	•	•	•		
MD	MH	•				•	•	•					•	
ME	MH	•					•	•					•	
MI	Medicaid	•												Web-based tool kit for EPSDT includes guidance for social emotional development.
MN	MCH	•					•	•		•				
	MH	•				•	•	•		•			•	
MO	Medicaid			•										
	MH	•					•			•				
MS	MCH			•										
	MH		•											don't know
MT	Medicaid		•							•				
	MH				•									
NC	MCH	•				•	•	•						
	Medicaid				•									
ND	MCH	•						•						In the planning process through the ECCS State Plan.
	Medicaid		•					•		•		•		
NE	MCH		•											Not directly involved in planning/development activities
NH	MH				•									
NJ	Medicaid			•										
	MH		•											In early planning and collaborative stages

Primary care provider education available on infant mental health

State	AGENCY	Primary care provider education available on infant mental health				Education format (1-In-person conferences; 2-Learning collaboratives; 3-Workshops; 4-In-office meetings; 5-Materials; 6-Web-based conferences; 7-Teleconference; 8-Grand Rounds)								
		Yes	Plan for future	No	Don't know	1-Conference	2-Collaborative	3-Workshops	4-In-office	5-Materials	6-Web	7-Teleconference	8-Grand rounds	Other
	MCH	•				•		•		•				
NM	MH			•										
NV	MCH		•											
NY	MCH		•			•	•			•			•	
	MCH		•											Types of education and venues to be determined.
	Medicaid				•									
OH	MH	•				•	•	•					•	
OK	Medicaid		•											n/a
OR	MH			•										
PA	MH		•				•	•	•	•	•			
	MCH	•				•	•	•		•			•	
RI	Medicaid			•										
	MCH		•				•	•		•			•	
SC	Medicaid				•									
	MCH				•									
SD	MH			•										
	MCH	•						•						
TN	MH				•									
TX	Medicaid				•									
	MCH	•					•	•		•				
	Medicaid	•					•							
UT	MH	•				•	•	•		•		•		
VA	Medicaid	•								•				
VT	MH	•				•	•	•	•	•			•	
	MCH				•									
WA	Medicaid	•					•	•	•	•				

Primary care provider education available on infant mental health

State	AGENCY	Primary care provider education available on infant mental health				Education format (1-In-person conferences; 2-Learning collaboratives; 3-Workshops; 4-In-office meetings; 5-Materials; 6-Web-based conferences; 7-Teleconference; 8-Grand Rounds)								
		Yes	Plan for future	No	Don't know	1-Conference	2-Collaborative	3-Workshops	4-In-office	5-Materials	6-Web	7-Teleconference	8-Grand rounds	Other
WI	MCH		•											We have discussed - for the future - collaboratively sponsored workshops for cross-disciplinary early childhood providers jointly developed by the Initiative for Infant Mental Health (out of state government project), the Early Childhood Comprehensive System project, the American Academy of Pediatrics Wisconsin chapter, and perhaps the medical schools. There is growing interest in and acceptance of the Initiative for Infant Mental Health's goal of infusing the principles of healthy social emotional development into all service systems that touch the lives of babies and preschoolers. See contact information on the Director for Wisconsin Infant Mental Health Initiative.
WY	Medicaid	•								•				
MCH agencies		10	10	5	2	7	8	12	1	9	2	2	5	
Medicaid agencies		11	6	8	7	2	4	3	5	12	2	2	1	
MH agencies		10	4	6	4	6	10	10	3	8	4	2	7	
All agencies		31	20	19	13	15	22	25	9	29	8	6	13	

Most effective types of provider education

State	AGENCY	Most Effective Type of Provider education (1-In-person conferences; 2- Web-based conferences; 3-In-services and onsite training; 4-Written materials; 5-Learning collaboratives; 6-Consultation; 7-Interdisciplinary training; 8-other)								
		1-In-person	2-Web	3-Onsite	4-Written	5-Collaboratives	6-Consultation	7-Interdisciplinary	8-Other	Most effective type of provider education
AK	MH	●		●					●	In former years, there were conferences and training on infant mental health which State staff participated in, along with private and non-profit providers. This seemed to be effective in raising awareness and introducing skills. However, with budget restrictions, emphasis on priority populations targets children and youth with Severe Emotional Disturbance (SED).
	MCH									Master of Arts education (MA)
AL	Medicaid	●			●					Town Hall meetings, education materials
AR	Medicaid			●					●	Visits to provider offices and group training sessions by the state's Quality Improvement Organization (QIO) and policy manual updates
	Medicaid									Varies by region/managed care plan
CA	MH	●					●			University-based centers of excellence and a range of educational approaches ranging from small to large group
	Medicaid									Provider profiling
CO	MH									We have found DC:0-3™ to be well received. We are using a training of trainers approach.
CT	MH									Individuals who have mental health backgrounds and a passion for infant mental health issues.
DC	MCH	●								Face to face, workshops, academics, classroom
	Medicaid	●								Training sessions designed for this age group.
FL	MH									We have found that we need to evaluate the needs of the providers and develop trainings that meet the needs of the specific audience.
	MCH		●						●	Teleconferences, web-based conferences
GA	Medicaid	●								Billing workshops, provider training and advocacy groups.
	MCH	●		●						Conferences and specific in-service
HI	Medicaid	●								This is not specific to infant mental health, but face to face meetings with discussion of specific topics.
IA	MCH				●	●			●	Grand rounds, through their Academies, learning collaboratives, and written materials.
IL	Medicaid		●	●					●	Uncertain. Provider notices are not the most effective, so we are trying new methods (web-based, in-office training by provider associations, grand rounds).

Most effective types of provider education

State	AGENCY	Most Effective Type of Provider education (1-In-person conferences; 2- Web-based conferences; 3-In-services and onsite training; 4-Written materials; 5-Learning collaboratives; 6-Consultation; 7-Interdisciplinary training; 8-other)								
		1-In-person	2-Web	3-Onsite	4-Written	5-Collaboratives	6-Consultation	7-Interdisciplinary	8-Other	Most effective type of provider education
KS	MCH	•								Presentations at their already scheduled professional organization conferences, i.e., Kansas Chapter of AAP, etc.
	MCH						•			Providers/clinicians have benefited greatly from case method consultation from the University training contract. Face-to-Face education and Phone Consultation.
KY	MH		•						•	Web or CD ROM based
	MCH	•		•						Group training. Educational conferences.
	Medicaid			•						In-office conversations by nurses
LA	MH	•								Workshops
MA	Medicaid			•	•	•				Use of multiple approaches including collaboratives, office specific training, provision materials for provider and member education etc.
MD	MH	•		•						Focus groups and Full day conferences
ME	MH			•						Direct encounter
	MCH			•						Workshops - skill training on using screening tools
MN	MH									Too soon to tell.
MO	Medicaid									DMS only does training for the purpose of requesting prior authorization and billing for services.
NC	MCH			•						On-site technical assistance, small-group format provided through the involved professional organization such as the state pediatric society.
	MCH		•	•						Webcast, in person in-services, Beginning the initiative to explore and provide services for Early Childhood Services.
ND	Medicaid			•						One on one training.
NM	MCH			•	•				•	Written material, web sites, provider specific training
NV	MCH	•								Education that is short and has food. Face to face.
NY	MCH					•				We have limited experience with learning collaboratives. However, learning collaboratives look to be a promising way of increasing provider education and skills regarding infant mental health.
OH	MH	•		•						Workshops that are part of general conferences that focus on young children to get basic information out followed by more intense training sessions for those who want more in-depth.
OR	MH							•		Cross training of providers in our Early Childhood System.
PA	MH								•	Peer education and support

Most effective types of provider education

State	AGENCY	Most Effective Type of Provider education (1-In-person conferences; 2- Web-based conferences; 3-In-services and onsite training; 4-Written materials; 5-Learning collaboratives; 6-Consultation; 7-Interdisciplinary training; 8-other)								
		1-In-person	2-Web	3-Onsite	4-Written	5-Collaboratives	6-Consultation	7-Interdisciplinary	8-Other	Most effective type of provider education
	MCH									Needs to be a variety
RI	Medicaid			•						Target specific, hands on small group trainings
	MCH							•		Opportunity for interdisciplinary, networked learning experience.
SC	Medicaid									Not a provider or direct services
	MCH					•				Learning Collaboratives
	Medicaid					•				We are happy with the learning collaborative model and plan to continue with the model.
UT	MH	•				•	•			Spring and Fall Statewide Conferences sponsored by the Mental Health Division. Conferences. Learning Collaboratives. Resource support and on going monitoring.
VA	Medicaid			•						Trainings and contact with case managers
WA	Medicaid			•		•				Collaborative type in-office training
WI	MCH							•		I do not know but what we have talked the most about is cross-disciplinary provider education. Our major focus is to build a comprehensive and collaborative service system for young children and families that educates all providers and infuses mental health principles into the health systems, the child care system, the pre-school education system, the parent education system, and the family support system. In other words, we aim to cross-train all health and human service providers so that they learn from and become referral resources for each other.
WY	Medicaid				•					Written materials. What gets emphasized gets accomplished.
Medicaid agencies		4	1	8	3	3	0	0	0	
MCH agencies		5	2	6	2	3	1	2	0	
MH agencies		6	1	4	0	1	2	1	2	
All agencies		15	4	18	5	7	3	3	8	

Provider education on screening for social-emotional development

State	AGENCY	Education on screening for social emotional development delays		
		Yes	Plan for future	No
AZ	Medicaid		●	
	Medicaid	●		
CA	MH		●	
CO	MH		●	
DC	MCH	●		
DE	Medicaid			●
GA	MCH		●	
	MCH		●	
IA	Medicaid		●	
ID	Medicaid	●		
IL	Medicaid	●		
IN	MCH		●	
KS	MCH	●		
	MCH		●	
KY	MH		●	
	Medicaid	●		
LA	MH	●		
	MCH			●
MA	Medicaid	●		
MD	MH		●	
ME	MH		●	
MI	Medicaid		●	
	MCH	●		
MN	MH	●		
MO	MH	●		
MS	MH			●
MT	Medicaid		●	
NC	MCH	●		

State	AGENCY	Education on screening for social emotional development delays		
		Yes	Plan for future	No
	MCH		●	
ND	Medicaid		●	
NE	MCH		●	
NJ	MH		●	
NM	MCH	●		
NV	MCH		●	
NY	MCH		●	
	MCH		●	
OH	MH	●		
OK	Medicaid		●	
PA	MH		●	
RI	MCH		●	
SC	MCH		●	
TN	MCH	●		
	MCH	●		
	Medicaid	●		
UT	MH	●		
VA	Medicaid			●
VT	MH	●		
WA	Medicaid	●		
WI	MCH		●	
WY	Medicaid	●		
MCH agencies		7	12	1
Medicaid agencies		8	6	2
MH agencies		6	7	1
All agencies		21	25	4

Other organizations providing training

State	AGENCY	Other ORGANIZATIONS providing training (1-AAP chapter; 2-AAFP chapter; 3-Universities; 4-State agencies; 5-Advocacy groups; 6-Hospitals; 7-State mental health associations; 8-Screening; 9-Public clinics; 10-Child abuse prevention; 11-Private organizations)											
		1-AAP	2-AAFP	3-Universities	4-State	5-Advocates	6-Hospitals	7-State MH	8-Screening	9-Clinics	10-Child-abuse prevention	11-Private	Other Organizations
AK	MH				●								INdividual Learning Plan (ILP) programs, Maternal, Child and Family Health (MC&FH) (possibly), Head Start and other private programs (possibly).
AZ	Medicaid	●											
CA	Medicaid												Local Children and Families Commissions in various counties
	MH									●			Various child guidance clinics
CO	Medicaid				●								Department of Human Services
CT	MH							●					Regional Educational Service Centers, Early Childhood Consultants, Connecticut Association for Infant Mental Health.
DC	Medicaid											●	Contracted Medicaid Managed Care Organizations within the District of Columbia.
FL	MH				●								Department of Health
IA	MCH	●	●										
IL	Medicaid	●	●		●								Title V
IN	MCH							●					Indiana Association for Infant and Toddler Mental Health
KY	MCH			●									Universities
	MH	●				●							Kentucky Child NOW! (children's advocacy group)
LA	MH					●							Families Helping Families (a developmental disabilities advocacy group)
MA	Medicaid	●											
MD	MH												Local Mental Health authorities
MN	MCH							●					Minnesota Association of Children's Mental Health
	MH						●						Hospital and clinic systems, with sponsorship of health plans
MO	MH				●								Health, HeadStart
NC	MCH	●							●		●		Training focuses on screening best practices. Another organization involved is the child-abuse prevention advocacy agency.
	Medicaid	●			●								The Division of Mental Health/Developmental Disability/Substance Abuse is working collaboratively with the Medical Society and the Pediatrics Society to arrange for consultation when needed.

Other organizations providing training

State	AGENCY	Other ORGANIZATIONS providing training (1-AAP chapter; 2-AAFP chapter; 3-Universities; 4-State agencies; 5-Advocacy groups; 6-Hospitals; 7-State mental health associations; 8-Screening; 9-Public clinics; 10-Child abuse prevention; 11-Private organizations)											
		1-AAP	2-AAFP	3-Universities	4-State	5-Advocates	6-Hospitals	7-State MH	8-Screening	9-Clinics	10-Child-abuse prevention	11-Private	Other Organizations
NE	MCH												Early Childhood mental health pilot project in central Nebraska is one example.
NH	MH												Some of the 14 local Infant Mental Health Teams work with providers in their area. Also, I think that Family Centered Early Supports and Services is working on this.
NJ	MH				•			•					New Jersey Association of Mental Health Agencies, Maternal and Child Health, Education, Division of Family Development Division of Child and Family Service, (Child Welfare in New Jersey)
NM	MCH	•						•					New Mexico Infant Mental Health Collaborative Committee
OK	Medicaid			•	•								Health Department - Guidance, University of Oklahoma Health Sciences Center, SoonerStart
OR	MH			•									Portland State University
PA	MH				•								Department of Health
RI	MCH	•											
	Medicaid							•					Rhode Island Association for Infant Mental Health
SC	MCH	•	•										
TN	MCH	•											
UT	MH				•								I do not know about the above. The Department of Health sponsors trainings, Utah has a consortium of pediatric parishioners called UPIC
WA	MCH			•									Kids Get Care (Seattle - King County Public Health) Infant Mental Health Program (University of Washington)
	Medicaid												Seattle King County Health Department sponsors Kids Get Care and a Pediatric Preventive Care collaborative
WI	MCH			•									Dr. Rose Anne Clark is a child psychologist at the University of Wisconsin Medical School who provides training to medical students and pediatric and psychiatric residents.
MCH agencies		6	2	3	0	0	0	3	1	0	1	0	
Medicaid agencies		4	1	1	4	0	0	1	0	0	0	1	
MH agencies		1	0	1	6	2	1	2	0	1	0	0	
All agencies		11	3	5	10	2	1	6	1	1	1	1	

State's system capacity

State	AGENCY	STATE's system capacity																	
		Mild mental health issues						Moderate mental health issues						Severe mental health issues - Excellent					
State	AGENCY	Excellent	Good	Average	Fair	Poor	Don't Know	Excellent	Good	Average	Fair	Poor	Don't Know	Excellent	Good	Average	Fair	Poor	Don't Know
AK	MH					●						●					●		
	MCH			●						●						●			
AL	Medicaid			●						●						●			
AR	Medicaid						●			●						●			
AZ	Medicaid						●						●						●
	Medicaid					●					●				●				
CA	MH					●					●					●			
	Medicaid					●						●				●			
CO	MH			●							●					●			
CT	MH					●						●						●	
	MCH					●						●						●	
DC	Medicaid						●						●						●
DE	Medicaid				●						●				●				
	Medicaid					●					●						●		
FL	MH			●					●						●				
	MCH			●							●						●		
GA	Medicaid						●						●						●
	MCH				●						●						●		
	Medicaid			●						●						●			
HI	MH		●						●					●					
	MCH			●						●					●				
IA	Medicaid				●					●					●				
	MCH						●						●						●
ID	Medicaid					●				●						●			
IL	Medicaid						●						●						●
IN	MCH					●					●					●			
	MCH			●	●					●					●				
KS	Medicaid						●						●						●
	MCH		●						●						●				
	Medicaid		●						●						●				
KY	MH		●						●						●				

State's system capacity

State	AGENCY	STATE's system capacity																	
		Mild mental health issues						Moderate mental health issues						Severe mental health issues - Excellent					
		Excellent	Good	Average	Fair	Poor	Don't Know	Excellent	Good	Average	Fair	Poor	Don't Know	Excellent	Good	Average	Fair	Poor	Don't Know
LA	MCH				•						•						•		
	Medicaid				•						•						•		
	MH					•						•						•	
MA	MCH			•							•							•	
	Medicaid						•						•						•
MD	MH				•					•						•			
ME	MH		•				•		•						•				
MI	Medicaid				•				•						•				
MN	MCH			•							•							•	
	MH				•					•					•				
MO	Medicaid		•						•						•				•
	MH			•							•						•		
MS	MCH				•					•					•				
	MH				•							•							•
MT	Medicaid						•						•						•
	MH						•						•						•
NC	MCH		•							•							•		
	Medicaid			•						•						•			
ND	MCH				•	•					•	•				•		•	
	Medicaid					•					•					•			
NE	MCH						•						•						•
NH	MH			•					•						•				
NJ	Medicaid						•						•						•
	MH				•						•						•		
NM	MCH					•						•						•	
	MH			•						•						•			
NV	MCH						•						•						•
NY	MCH				•					•							•		
OH	MCH			•									•						•
	Medicaid			•						•					•				
	MH		•						•						•				

State's system capacity

State	AGENCY	STATE's system capacity																	
		Mild mental health issues						Moderate mental health issues						Severe mental health issues - Excellent					
		Excellent	Good	Average	Fair	Poor	Don't Know	Excellent	Good	Average	Fair	Poor	Don't Know	Excellent	Good	Average	Fair	Poor	Don't Know
OK	MCH																		
	Medicaid			•							•							•	
OR	MH		•							•						•			
PA	MH					•					•				•				
RI	MCH			•						•					•				
	Medicaid		•						•							•			
SC	MCH			•							•							•	
	Medicaid			•					•						•				
SD	MCH					•					•					•			
	MH				•						•						•		
TN	MCH				•						•							•	
	MH						•						•						•
TX	Medicaid						•						•						•
UT	MCH					•						•						•	
	Medicaid				•						•						•		
	MH				•							•						•	
VA	Medicaid		•						•						•				
VT	MH		•						•						•				
WA	MCH				•						•							•	
	Medicaid				•					•				•					
WI	MCH					•						•					•		
WY	Medicaid		•						•						•				
MCH agencies		0	2	9	8	7	3	0	1	7	11	5	4	0	5	4	6	9	4
Medicaid agencies		0	5	6	6	5	10	0	7	8	7	1	9	1	10	8	3	1	10
MH agencies		0	6	5	6	5	3	0	7	4	6	5	2	1	8	5	4	3	3
All agencies		0	13	20	20	17	16	0	15	19	24	11	15	2	23	17	13	13	17

Reasons infant mental health is not highest priority

State	AGENCY	Reasons for not being highest priority (1-Other populations are higher on the list; 2-Other issues for children 0-3 are higher on the list; 3-Lack of funding for this particular issue; 4-Lack of system capacity to address this particular issue; 5-Lack of information on this particular issue; 6-Other agencies are addressing it)						
		1	2	3	4	5	6	Other
AK	MH	●		●	●		●	
AL	MCH		●				●	
	Medicaid							The Agency is concerned with promoting healthy mental development however, the Department of Mental Health is responsible for these activities
AR	Medicaid			●			●	
AZ	Medicaid				●			
CA	Medicaid							Because of carve-out, perception in agency that mental health issues are not our primary domain
CO	Medicaid		●	●	●		●	No Healthcare Common Procedure Coding System (HCPCS) codes to identify and pay for services.
	MH			●	●			
CT	MH	●		●	●	●		A lack of awareness of the importance of early intervention in a child's life that would prevent high end behaviors at a later age.
DC	MCH						●	We are a part of these efforts and it is a priority but not the highest ranked priority
	Medicaid							Our Agency does not provide direct care or MCO type services.
DE	Medicaid	●		●	●		●	
FL	Medicaid	●			●	●		
	MH		●					Serving the infants and toddlers that are served by our child welfare agency is a high priority.
GA	MCH		●	●	●			Lack of resources to provide treatment for this population.
	Medicaid							I will forward this survey to staff in child and maternal health for better clarification.
HI	MCH			●	●			
	Medicaid	●						
	MH						●	
IA	MCH			●	●			
	Medicaid							As we are primarily a child welfare agency all of the child welfare issues are competing for attention/funding
ID	MCH						●	
	Medicaid						●	
IN	MCH		●	●	●	●	●	
KS	MCH				●			

Reasons infant mental health is not highest priority

State	AGENCY	Reasons for not being highest priority (1-Other populations are higher on the list; 2-Other issues for children 0-3 are higher on the list; 3-Lack of funding for this particular issue; 4-Lack of system capacity to address this particular issue; 5-Lack of information on this particular issue; 6-Other agencies are addressing it)						
		1	2	3	4	5	6	Other
KY	MCH		•		•			
	Medicaid	•						
	MH	•						The DMHMRS serves mental health, mental retardation, substance abuse, brain injury, and developmentally disabled populations, children 0-3 are just a very small part of that
LA	MCH		•		•			
	Medicaid	•	•	•				
	MH	•		•	•			
MA	MCH				•			
	Medicaid							It is a very high priority
MD	MH	•		•				
ME	MH			•			•	
MI	Medicaid	•	•	•	•			
MN	MCH			•	•	•		
	MH				•			
MO	Medicaid						•	
	MH	•		•	•			
MS	MCH		•		•			
	MH	•		•	•	•		
MT	MH							I am not the best person to answer this as this issue is not the repsonsibility of the Children's Mental Health Bureau whose focus is on mental illness, a more restricted focus than 'children's mental health'.
NC	MCH			•	•			
	Medicaid							We are interested in children of all ages. The Early Intervention Branch at DPH is primarily focused on this age group
ND	MCH	•	•	•	•		•	
	Medicaid	•		•	•			
NE	MCH						•	I represent the Office of Family Health, the Title V/MCH unit for Nebraska HHS. The Title V/CSHCN unit is with Aging and Disability Services, which is one of the co-leads for early intervention. This separation gives us a different focus. Family Health/Title V/MCH is somewhat involved in broad systems planning for early childhood mental health, but not involved in the short term details. So my answers to this survey reflect a different perspective than one might get from Early intervention staff.
NH	MH			•	•			

Reasons infant mental health is not highest priority

State	AGENCY	Reasons for not being highest priority (1-Other populations are higher on the list; 2-Other issues for children 0-3 are higher on the list; 3-Lack of funding for this particular issue; 4-Lack of system capacity to address this particular issue; 5-Lack of information on this particular issue; 6-Other agencies are addressing it)						
		1	2	3	4	5	6	Other
	Medicaid		•					
NJ	MH	•	•	•	•		•	Planning to address more comprehensively in the future
	MCH			•	•			
NM	MH				•			
NV	MCh						•	
NY	MCH		•	•				
	MCH	•		•	•			Again, it is not that healthy mental development of young children is not important, it is that much of what is promoted is very comprehensive and includes social and emotional development of young children in the context of their families.
	Medicaid						•	
OH	MH	•		•	•			
OK	Medicaid						•	We are in the processing through the Children's Collaborative between the State Agencies to develop Zero to Five projects related to children's mental health.
OR	MH							This is a clear priority for the Office of Mental Health and Addiciton Services. A staff position is dedicated to this work.
PA	MH			•	•	•		
	MCH							Healthy human development is one of our big eight objectives, but it has to compete with terrorism, pandemic flu, budget eruptions, etc
RI	Medicaid							All developmental areas of children birth to three are our highest priority
	MCH		•		•			
SC	Medicaid						•	
SD	MH							As stated, this is one of the priorities.
TN	MH	•						
	MCH			•	•			Since the Division of Mental Health and Substance Abuse is in another state agency, working on this issue from the Department of Health becomes very difficult
	Medicaid			•	•			There are many priorities - just keeping healthy mental development on the radar will be a critical issue - especially in light of changes to the Medicaid program we are hearing proposed by Washington.
UT	MH	•		•	•	•		
VA	Medicaid						•	
VT	MH	•		•			•	

Reasons infant mental health is not highest priority

State	AGENCY	Reasons for not being highest priority (1-Other populations are higher on the list; 2-Other issues for children 0-3 are higher on the list; 3-Lack of funding for this particular issue; 4-Lack of system capacity to address this particular issue; 5-Lack of information on this particular issue; 6-Other agencies are addressing it)						
		1	2	3	4	5	6	Other
WA	MCH							As the State MCH agency, we are responsible for a broader population and range of health issues.
WA	Medicaid			•	•			Need to coordinate better with other agencies.
WI	MCH	•	•	•	•	•		
WY	Medicaid						•	
MCH agencies		3	10	12	17	3	7	
Medicaid agencies		7	4	8	8	1	10	
MH agencies		12	2	14	13	4	5	
All agencies		22	16	34	38	8	22	