



Medicaid Support for Infant and Early Childhood Mental Health: Lessons from Five States

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Summary

The policy and advocacy experiences related to Medicaid support for infant and early childhood mental health (IECMH) in five states (California, Colorado, Michigan, North Carolina, and Washington State) offer lessons for other states seeking to more effectively prevent, identify, and address mental health conditions among young children in Medicaid. Lessons below speak to the importance of:

1. Leadership
2. Strategic Partnerships
3. Advocacy
4. Incremental Progress
5. Medicaid Policy Levers
6. Addressing the full Continuum of Care from Prevention to Treatment

States seeking to apply the lessons from these and other states can get started in a number of ways depending on state policy context and political will: cultivating leadership, engaging a range of public and private partners, creating a strategic plan with clear priorities, linking IECMH to broader state health reform efforts, identifying state-specific Medicaid opportunities and taking steps toward health equity by engaging with and listening directly to families.

Introduction

Given the outsized role of Medicaid coverage for young children, understanding how to leverage financing for early childhood health, mental health, and developmental services is important to ensure equity and optimal developmental outcomes. Medicaid has the largest reach of any public program providing services to young children, covering more than 40 percent of young children ages birth to six and three-fourths of low-income children under age 6 in 2021.¹ More than 40 percent of infants and more than 6 in 10 Black, Hispanic, and Native American/Indigenous babies are covered by Medicaid. Enrollment [data in 2022](#) shows more than half of the nation's children are covered by Medicaid and CHIP, which likely extends to young children as well. The vast majority of young children (90 percent) receive one or more health care visits in a year, which offer important changes to strengthen promotion, prevention, and early intervention services for children and their families. Medicaid's Early Periodic Screening, Diagnostic, and Treatment (EPSDT) child health benefit is designed to focus on prevention and early intervention by financing an array of services children need to correct or ameliorate identified conditions. At the same time, coverage for health and developmentally-appropriate services to aid healthy early childhood development, particularly early childhood mental

¹ Georgetown University Center for Children and Families analysis of US Census Bureau 2021 American Community Survey (ACS) Public Use Microdata Sample (PUMS).



health services, are [not consistently recognized or broadly understood](#) by the more adult-focused traditional health system. The EPSDT benefit is implemented by states under broad federal guidelines, and wide variations can be seen among state interpretation and implementation impacting access to health care services.

Together, the Georgetown University Center for Children and Families, National Center for Children in Poverty, and Johnson Group Consulting conducted [a 2022 survey](#), which provides up-to-date and point-in-time information about how state Medicaid policy and financing are evolving in relationship to the field of early childhood mental health.

As awareness has grown, a number of states have used Medicaid to finance early childhood mental health services for [several decades](#) or have made recent policy changes with potential for large-scale change. This report summarizes lessons learned based on interviews with Medicaid officials, child advocates, and early childhood mental health leaders in five select states: California, Colorado, Michigan, North Carolina, and Washington State. (See list of individuals interviewed in Appendix A.) The states were selected from a dozen or more who have effectively used Medicaid to finance infant and early childhood mental health services (IECMH) and represent variations in policy development.

While many states use Medicaid to finance specific prevention and intervention services related to infant and early childhood mental health, these five states are among those

widely recognized as leaders in IECMH. Interviews sought to better understand the evolution of state leadership, policy change, and investments. Interviewees were asked their perspectives on 1) the forces and key actions that led to Medicaid policy change, 2) the extent to which Medicaid is being used to finance and support access to a continuum of early childhood mental health services from prevention to early intervention and treatment, 3) the role and impact of Medicaid delivery system structures (i.e. managed care or accountable care), 4) the most important Medicaid policy or process innovation, and 5) next steps in their state's work to improve access to mental health services for young children in Medicaid. (See interview questions in Appendix B.)

This report highlights what we heard and learned, describing key themes and strategies that have been used in these five states. We found that use of inside-outside government leadership, cross sector partnerships, and knowledge of the levers that can lead to change in Medicaid financing were the most important strategies. The role of champions and advocates with vision and determination cannot be overstated. Aiming to strengthen systems of care and close gaps left between fragmented or siloed programs and providers is another key theme. For more details about the current status of Medicaid policy related to mental health services for children from birth to 6 years, see the [2022 survey](#).



Key Findings

1. LEADERSHIP MATTERS

Opportunities for meaningful change increase dramatically when a governor, legislator, Medicaid director, or other state official prioritizes early childhood or early childhood mental health. Policymaker attention can come in many forms, such as executive budget proposals, legislation, revised agency rules, and/or dedicated agency staff. In these five leader states, support from the highest levels of public leadership at key points in time set the trajectory for IECMH policy and program development. Medicaid directors in Colorado, Michigan, and Washington State have championed young children. But policymakers can't successfully advance IECMH in isolation. Private sector leaders from philanthropy, professional organizations (e.g., mental health, pediatrics), child advocacy, and family organizations are key to long term success to sustain knowledge and momentum. As key policy champions change over time, states risk losing institutional knowledge and capacity, making partners outside of state government key to sustaining gains.

Cultivating leadership and subject matter expertise within state agencies also aids strong policy development and implementation. Colorado is considered the first state to have a director of early childhood mental health who helps guide development of a strategic plan, sustain programs,

and foster strong relationships with Medicaid. Michigan also funds a position for an Early Childhood Mental Health Co-ordinator in the Department of Health and Human Services, which began with federal funds from the U.S. Department of Education Race to the Top grant and continued with state resources. State Medicaid agencies may also hire staff with expertise in IECMH who bring practice experience, knowledge of best practice, and relationships with the field. In Washington State, philanthropic funding provided initial resources to create positions within the Medicaid agency to boost internal capacity to advance IECMH and early relational health as part of larger health care transformation efforts. Key to hiring IECMH practitioners in Medicaid is the support of senior agency leadership. Hiring staff with IECMH practitioners expertise provides an important vantage point for Medicaid policy development. But new practice-oriented staff can also face a steep learning curve on the nuances of Medicaid policy and identifying the most effective strategies to leverage Medicaid to finance needed services and scale best practices. Medicaid staff dedicated to IECMH change need consistent support from Medicaid senior leadership to be successful in creating meaningful and sustained change.

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Leadership in Colorado

Colorado began the [journey toward IECMH](#) by funding a pilot program for Early Childhood Mental Health consultants in childcare out of the (then) Office of Behavior Health in 1997, which has since expanded and been sustained statewide. Additional IECMH efforts took off in 2001 with the founding of a new Colorado Association for Infant Mental Health, a cross-system Blue Ribbon policy council, and federal pilot projects that helped to evolve IECMH alongside other early childhood initiatives. For more than 20 years, the Colorado Department of Health Care Policy and Financing, Colorado Medicaid, has been an active participant in the design and planning



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of early childhood initiatives, not merely in the role of payer. Medicaid directors' leadership has been an essential component of success in combination with long-time Medicaid EPSDT program administrator, Gina Robinson, who helped ensure a consistent vision for the important role that Medicaid's EPSDT child benefit could play in improving children's mental health and well-being. But, a team of agency staff have been key to strong program implementation. Medicaid staff person Alex Weichselbaum said: "Across the years, a culture of having the will to do what it takes to make things work has evolved."

Colorado Medicaid has [played a vital role](#) in financing services along the continuum of care, including screening for mothers and young children, early interventions to address risks, and more intensive treatment when needed. To operationalize benefits and assure their effective use, Medicaid adopted billing codes, provider qualifications, and service definitions related to early childhood mental health. Innovation in benefit design has been a major contributor to change. In 2016-18, the state reimaged ways to improve access to mental health for beneficiaries through their medical home. New policy provided for Medicaid financing of six visits per member per year, without a diagnosis, for short-term behavioral/mental health services provided by qualified mental health providers in primary care settings. In addition, three maternal depression screenings can be financed at well-child visits during an infant's first year. In Colorado, Medicaid does not mandate use of specific IECMH models, therapies, or screening tools. The state instead relies on the expertise and competencies of the mental health and primary care professionals, combined with measurement and quality improvement systems, to address quality of care.

Recently, behavioral health transformation efforts in the state have broadened focus to include the developmental needs of younger children, not just adolescents and adults. A [Children's Behavioral Health Subcommittee](#) was established within the Colorado Behavioral Health Task Force, with the task of improving outcomes by developing a plan to address delivery and management of children's behavioral health (ages birth to 26 years). They conceptualized a [financial map](#) of the behavioral health system in 2020 and made [recommendations for change](#) in 2021.

Colorado's philanthropic community, including an Early Childhood Mental Health funders group, has a long history of support for IECMH. One year into Colorado's federal HHS SAMHSA-funded Project LAUNCH grant, a collaborative of eight foundations invested \$11.5 million to create the [LAUNCH Together](#) initiative. New funds supported five additional communities to implement the LAUNCH strategies in partnership with the Project LAUNCH local site. All six communities learned together and benefited from the tools, processes, experts, and champions made available through the combined initiatives. Private funders also supported both staff positions inside government and child advocacy. Public-private partnerships helped to make the state a pioneer in IECMH. Colorado was the first state to have a director of early childhood mental health (a position that no longer exists), among the first to have an early childhood mental health strategic plan, and [a leader in continually assessing unmet needs](#) and taking steps to fill remaining service gaps. Angela Rothermel of Early Milestones Colorado emphasized:



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Through public-private partnerships, we've done a remarkable job of embedding and expanding mental health supports at the state and local levels, beyond Medicaid.

Looking ahead, Colorado leaders are hopeful about the positive impact of Medicaid coverage expansions for undocumented residents and the postpartum coverage extensions to support improved maternal and early childhood mental health. These aspirations are parallel to those of advocates for maternal and child health in other states.

Key stakeholders in Colorado [emphasized the importance](#) of partnerships between leaders and champions inside and outside of government. Jordana Ash, former Director of Early Childhood Mental Health in the Colorado Office of Early Childhood, Department of Human Services, reflects:

At the end of the day, what's needed in systems change are champions with longevity.

2. STRATEGIC PARTNERSHIPS CAN SUSTAIN THE WORK THROUGH TRANSITIONS

Interagency partnerships inside state government are foundational components of effective policy and program implementation. No one governmental agency can or is intended to provide all of the resources needed to finance services, develop the workforce, and ensure support for the most vulnerable children and families. Partnerships and shared understanding among Medicaid, public health, mental health, early childhood, and social services agencies can provide a more coordinated system, program, and policy responses to addressing the mental health needs of young children and their families. Further, because low-income families may rely on more than one state system to access services and supports, the lack of strong interagency collaboration can exacerbate gaps in needed care, leaving more families to fall through the cracks.

Having an inside-outside government partnership can further accelerate progress to advance program, provider, and family success. In each of the five states, a balance of partners inside and outside of government helped to drive and sustain Medicaid program and policy change in support of mental health services for children ages birth to 6. Private sector partners bring additional resources, knowledge of how

services work, and lived experience. They can also help hold states accountable for centering the needs and voices of children and their families.

Philanthropy can accelerate progress by funding new initiatives to grow IECMH awareness and engagement. Private foundations support embedded public agency staff, demonstration projects, startup initiatives, and /or support coalitions and work groups that can build consensus and inform policy decision-making in several states. In Colorado, an early childhood mental health funders group played an active role over a period of years in guiding, supporting, and sustaining programs and projects at local and state levels. In Washington State, private dollars from the Perigee Fund spurred IECMH by supporting dedicated Medicaid agency staff, policy advocacy, outreach to families, IECMH workforce development, improved maternal mental health services, and research studies (e.g. unrestricted cash transfer for pregnant people, social media campaigns).

Partnering with professional mental health or other health practitioner organizations can help to strengthen and inform advocacy efforts. In addition, partnering with professional organizations working in children's health and mental health,



care providers can increase understanding of system and practice challenges, the potential impact of proposed changes, and the pace of policy implementation of new policies. The Washington State Chapter of the American Academy of Pediatrics (AAP) has played an active role in recent policy developments related to IECMH and early relational health, as well as in workforce development. Michigan leaders emphasized the importance of simultaneously giving attention to policy and program implementation, along with workforce development, to maximize the impact of Medicaid financing by helping to generate critical buy-in among practitioners early in the advocacy process.

Finally, strong and effective relationships among providers at the community level are central to ensure that young children

receive the services they need for optimal development. For example, creating clear, structured relationships and communication processes between IDEA Part C Early Intervention, IECMH consultation, and primary care providers, among others, are [frequently identified as key to delivery of a continuum of care for young children](#) with social-emotional-mental health needs. Without consistent screening and effective referrals, children with both developmental and mental health needs often fall through the cracks between these service delivery systems. Integration of behavioral/mental health in pediatric primary care also [requires practice redesign and community-level partnerships](#) that require support well beyond Medicaid payment change.



Partnerships in Washington State

The Washington State Medicaid agency (Health Care Authority) has accelerated focus on IECMH in recent years in part thanks to strong agency leadership. Health Care Authority director Sue Birch is passionate about improving maternal and child health and population health. Washington was the [second state](#) in the nation to [provide continuous Medicaid eligibility from birth to age six](#).

Philanthropic funding from the Perigee Fund supported new positions in the agency to create internal capacity to advance IECMH and early relational health in Medicaid. Medicaid agency leadership and dedicated IECMH expertise on staff helped to create an environment that fosters a culture of change and administrative action for smoother implementation. This is seen as a tipping point for Medicaid policy and program development in IECMH. Christine Cole, Infant-Early Childhood Mental Health Program Manager in the Washington State Health Care Authority, believes that:

The magic was in applying the principles of IECMH, grounding Medicaid policy decisions in what had been learned in practice.

In 2021, the Washington State legislature adopted important changes to improve IECMH, requiring Medicaid to allow reimbursement for: up to five sessions for mental health professionals to conduct mental health assessments, mental health assessments in home and community-based settings, and use the DC:0-5 (Diagnostic Classification of Mental Health and Development in Infancy and Early Childhood, a developmentally based diagnostic approach). In response, the agency developed a [DC:0-5](#) “crosswalk” with clinical and community input. In 2022, the legislature approved funding for a Medicaid pilot project designed to co-locate community health workers in primary care settings, including funds dedicated to the role of community health workers in



improving the early relational health and well-being of children birth to 3 and their caregivers. The Medicaid managed care reprocurement process in 2024, where the state will allow private insurance companies to bid for updated contracts with Medicaid, will provide opportunities for further refinements to maternal and infant health prevention and intervention efforts.

Washington is also among the growing number of states that have implemented extension of Medicaid postpartum coverage from 60 days to one year, under a new state option. The Medicaid agency and its partners intend to focus implementation of the extended coverage period on ways to improve maternal-infant health and mental health with coverage and financing under the postpartum coverage expansion.

Partnerships with child advocates, philanthropy, the Washington State Chapter of the AAP, Seattle Children's Hospital, other providers, and families have been essential to creating the conditions for change. Collaboration and partnerships also took the form of the Children and Behavioral Health Workgroup and participation by a cross-agency team that participated in the Zero to Three's Infant-Early Childhood Mental Health Finance and Policy Project. Washington has been fortunate to leverage strong health care sector leaders, notably both pediatricians and child psychiatrists have been active in shaping IECMH Medicaid changes. Kiki Fabian, Infant-Early Childhood Mental Health Analyst, Washington State Health Care Authority, commented:

Partnering with other systems, providers, and parents is essential to ensure a continuum of services.

Washington leaders recognize that getting the child-and family serving workforce ready for change is essential to the success of Medicaid investments. Many workforce development efforts are underway. For example, the Barnard Center for IEMCH at University of Washington has partnered with Seattle Children's Hospital to build the skills of pediatric residents in promoting early relationships and strengths-based approaches in primary care. Sarah Rafton of the Washington State AAP said:

Since COVID, clinics and primary care providers are overwhelmed. Getting the workforce ready for change is critical.

3. ADVOCACY CAN SHAPE THE AGENDA AND MAKE THE CASE

Effective policy advocacy is essential for policy and program change, especially related to Medicaid financing. Advancing IECMH in Medicaid requires both legislative (budget and program) and administrative advocacy. While multi-issue child advocacy organizations were not the leading change agents for IECMH in every state profiled, they were a driving force for change in states where their resources and partnership allowed. For example, the California Children's Trust set out a comprehensive agenda for change in Medicaid to promote,

protect, and intervene for children's mental health. Working in coalition with other child advocates and policy leaders, including Children Now, First 5 Center for Children's Policy, and the AAP, this initiative was able to take advantage of a new gubernatorial administration prioritizing early childhood with the added willingness to consider Medicaid changes.

A clear vision, strategic plan, or agenda for change, reported in all five states, makes a difference by focusing attention. Such a shared agenda, including near- and longer-term



action steps, should include the full continuum of IECMH services and supports, with specific steps to address each agenda priority over time. This may be a formally adopted document or an advocacy agenda used as a roadmap for an organization or coalition.

Policy entrepreneurs — experts on and advocates for an issue who look for opportunities to insert their program and policy priorities into the political process — can be important change agents within state advocacy efforts. Decades of policy research has shown that policy entrepreneurs help to sustain focus and guide change over time, educate policymakers, and frame policy solutions in alignment with policymakers' agendas and interests.

Making the case for investment in young children's mental

health is not easy. Educating policy makers and state agency leaders is an ongoing challenge. Helping policy-makers understand opportunities to promote and intervene for early childhood mental health, including parent-child services, can challenge traditional views on what mental health care looks like. Real or perceived competition for limited resources also makes strong and strategic advocacy key. The COVID-exacerbated mental health crisis has rightly elevated concern for the mental health of school aged children and youth. Effective advocacy can help policymakers understand the need for a continuum of services across the age span, and the heightened opportunity to prevent more costly unaddressed mental health challenges by investing in young children before a crisis intervention is necessary.



Advocacy in California

In recent years, two major Medicaid policy initiatives in California — CalAIM (California Advancing Innovation in Medi-Cal, the multi-year initiative to implement broad delivery system, program and payment reforms) and the re-procurement of Medi-Cal managed care contracts — present opportunities for transforming coverage for children. With leadership from then California Surgeon General Dr. Nadine Burke Harris and strong advocacy from the [California Children's Trust](#) and other organizations, [AB133](#), was passed by the legislature and California's Medi-Cal agency (the Department of Health Care Services, DHCS) [adopted new policies](#) that permit children, along with their parents/caregivers, to receive promotion, prevention, and treatment related to social-emotional-mental behavioral health. Alex Briscoe of the California Children's Trust believes:

With the roll out this year of the dyadic behavioral health benefit, we should see a big bump in the ability of Medi-Cal to pay for the right services, to address social drivers of health and ACEs.

Sarah Crow, Managing Director, First 5 Center for Children's Policy, pointed out that the:

DHCS adopted bold goals that resulted in a real shift in focus toward the health and well-being of children and families. The work is moving upstream with greater focus on promotion and prevention, with greater emphasis on social drivers.

Colleague Alexandra Palma, Senior Policy Research Associate at the First 5 Center for Children's Policy, described the advocacy in support of these policy changes as:

a chorus of voices on early childhood mental health that pointed out what has not been working, elevated the issue on the radar, and brought greater visibility to policy solutions.



In January 2023, Medi-Cal began coverage of a range of dyadic (parent-child/family) behavioral health care to promote child and family well-being. The statutory change (*Ca. Welf. and Inst. Code § 14132.755*) calls for dyadic behavioral health care as a covered benefit under Medi-Cal. The dyadic services are family-focused and intended to address developmental and behavioral health conditions of children as soon as they are identified, and that fosters access to preventive care for children, care coordination, child social-emotional health and safety, developmentally appropriate parenting, and parental mental health. As described by [Medi-Cal in a March 2023 letter to managed care plans](#), California's new "Dyadic Services" include Dyadic behavioral health (DHB) well-child visits, Dyadic Comprehensive Community Supports Services, Dyadic Psychoeducational Services, and Dyadic Family Training and Counseling for Child Development.

New [promotive and preventive dyadic services are anchored in DBH well-child visits](#), where the caregiver and child have the chance to experience more positive ways to interact with each other and to learn from providers about child development. This benefit will permit providers to bill for services delivered under [evidence-based models in embedded primary care such as HealthySteps](#) and DULCE, to support the parents in the well-child visit process and to provide care coordination as follow up to referrals to other services. Under EPSDT standards, a diagnosis is not required to qualify for these preventive services. DBH well-child visits are intended to be universal and reflect the Bright Futures periodicity schedule and guidelines for behavioral/social-emotional screening. Such visits do not need a specific recommendation or referral, but rather are part of well-child care. Managed care plans and their pediatric primary care providers may deliver DBH well-child visits as: a) part of the HealthySteps program, b) a different DBH program, or c) in a clinical setting without a certified DBH program as long as the core components are included (e.g., behavioral health history, developmental history, mental health assessment of parents/caregivers, screening for family needs and SDOH, related anticipatory guidance/education and needed referrals/connections via care coordination).

Some services may be provided to a parent/caregiver during a well-child visit for the benefit of the child and may be [billed using the child's beneficiary number](#). Services include: screening for depression and other mental/behavioral health conditions, tobacco and substance misuse, ACEs, and social determinants of health (e.g., food insecurity and housing instability), as well as health behavior interventions (e.g., tobacco cessation), family guidance on child development, care coordination, and referrals for appropriate follow-up care.

[Family therapy](#) is a separately covered Medi-Cal benefit delivered to at least two family members together to improve parent/child or caregiver/child relationships, resolve conflicts, and create a positive home environment. Under federal law governing the Medicaid EPSDT child health benefit requires family therapy services (and other treatments) be provided if needed to correct or ameliorate a child's mental health condition. Children enrolled in Medi-Cal under age 21 may receive family therapy sessions before a mental health diagnosis is required. This benefit is intended to reach children: a) with a diagnosed mental health disorder, b) having symptoms



without a diagnosis, and c) with select social and psychological risk factors (e.g., NICU hospitalization, parent separation or death, foster home placement, food or housing insecurity, maltreatment, bullying, and discrimination). Parental risks include: serious illness or disability, history of incarceration, depression/mood or psychotic disorder, PTSD, substance use disorder, job loss, interpersonal violence, and teen parenthood. Providers approved to deliver the family therapy benefit includes an array of mental health professionals, including but not limited to licensed clinical social workers, licensed psychologists, psychiatric nurse practitioners, and psychiatrists.

Extension of postpartum coverage for pregnant women from 60 days to a full year will ensure uninterrupted coverage for mothers who had a Medicaid financed pregnancy/birth. As in other states, the extended postpartum coverage will enable mothers to receive their own mental health therapy and other health services that are beyond the scope of dyadic preventive or treatment services.

California also has added new provider categories: community health workers, doulas, and behavioral health coaches. Adopting policies that permit Medi-Cal billing by these groups of providers will enhance and diversify the workforce available to serve families with young children in community and clinical settings. This creates an opportunity to embed these workers into primary care and help to implement promotion, prevention, and treatment models that focus on mental health for young children. Nonetheless, Karen Finello of WestEd believes:

We still need more trained early childhood mental health specialists in order to provide consultation in child care and health care settings.

In addition to changes in Medi-Cal, on July 2023, [California announced \\$30.5 million](#) in grants to [63 groups](#) to support youth mental health through community and evidence-based practices, supporting parents, grandparents, and other family caregivers. The funded evidence-based practices and community-defined evidence practice models include: Positive Parenting Practices (Triple P), Incredible Years, HealthySteps, Parent Child Interaction Therapy, Effective Black Parenting Program, Positive Indian Parenting, and a variety of other community-defined parenting support programs. Community based organizations receiving awards include: First 5 county sites, community health centers, mental health programs, schools, tribal organizations, and others. These grants are grounded in broad partner engagement and are part of the multi-year [Children and Youth Behavioral Health Initiative](#), which seeks to reimagine the systems that support behavioral health for California's children, youth, and their families, especially for those most at risk. As part of the announcement, DHCS Director Michelle Bass, said:

DHCS is awarding grants to organizations seeking to strengthen families and improve youth behavioral health based on robust evidence for effectiveness for children and families, impact on racial equity, and sustainability.



4. INCREMENTAL ACTIONS SIGNAL PROGRESS, HELP BUILD MOMENTUM OVER TIME

Advancing IECMH requires patience and persistence to create shared knowledge across systems and consider the full constellation of supports needed to create meaningful changes for families. State leaders pointed to the importance of identifying incremental steps that will help to progress the long-range vision set out in a strategic plan or policy agenda. Long-time leaders in states such as Colorado and Michigan have been working to improve Medicaid financing for IECMH for two decades or more. While major policy change can take years, incremental advances help maintain momentum among partners and create a shared sense of progress. Change does not necessarily occur in a natural sequence or as a reflection of need. Some changes occur because of political traction offering policy windows in state legislatures or agencies. For example, initial policy change might have been stimulated by a focus on social-emotional screening, maternal mental health, or family (dyadic) therapy, as was true in California. Champions of IECMH seized those opportunities and then returned to seek funding for other services along the continuum of care.

Many states' efforts in early childhood mental health were building upon related federal policy initiatives or grant funds, including: 1) early childhood initiatives (e.g., Race to the Top, Early Childhood Comprehensive Systems), 2) early childhood mental health grants in Project LAUNCH, or 3) Medicaid innovations (e.g., State Innovation Models – SIM Initiative grants, Medicaid Section 1115 waivers, [Integrated Care for Kids-InCK](#)). Such initiatives may help to accelerate change; the terms and structures of these initiatives may define or influence what is possible. For example, a time-limited federal grant might be best used to develop the

workforce or start up new models of care, while Medicaid or multi-year formula funds may be deployed to scale or sustain services and supports where possible.

Building from national policy recommendations, federal Medicaid guidance, and successful initial policy change in California, state agency leaders and advocates are seeking to better use Medicaid to finance services that promote and protect early childhood mental health and early relational health before a more serious, diagnosed condition emerges. While delivery of screening, diagnostic, and early intervention services in advance of a confirmed mental health diagnosis for young children are widely supported by research, it has long been a challenge to secure health system recognition, including Medicaid financing, for mental health services without a diagnosed condition. Accelerated progress could result in more support for evidence-based models of care, evidence-informed best practices, and effective interventions for generalized developmental and mental health concerns among the youngest children.

Seizing the moment, advocates also described the potential they see for advancing maternal-infant-early childhood mental health and well-being through Medicaid postpartum coverage extensions. With more than half of states having adopted the Medicaid postpartum extension option for coverage to one year following the end of pregnancy, the potential is great. In those states, mothers and infants have automatic and continuous Medicaid coverage for 12 full months. Many states, providers, and family advocates are exploring the best ways to do this, which might include dyadic services for promotion, prevention, and intervention related to mental health and well-being.



Action in Michigan

Medicaid financing for maternal, infant, and early childhood mental health services has a long history in Michigan. In the 1980s, Michigan child behavioral health leaders began to focus on IECMH with prevention dollars. When mental health spending was expanding in the 1990s, they envisioned broadening access to an existing infant mental health services program developed by IECMH pioneer Selma Fraiberg. Funding for direct prevention services (behavioral health) under Medicaid evolved between 2005 and 2007. By 2010, the state's Infant Mental Health Home Visiting (IMH-HV) model was [added to Medicaid home-based services](#) as a Medicaid-covered prevention model to be delivered to at-risk parents and their young children by community mental health service providers across the state. In addition, while IECMH consultation is primarily funded by child care dollars (Child Care Development Fund quality set aside, Race to the Top, 2015-2019; and Preschool Development Grant, 2020-2023), a subset of eligible consultation services, considered to be prevention and early intervention, are [financed in part by Medicaid and Community Mental Health Block Grant funds](#).

Over the past decade, Medicaid's role has expanded to cover parent-child therapies up to age five and other evidence-based practices in IECMH. Michigan also has incorporated an infant mental health specialist into the teams delivering the Maternal Infant Health Program (MIHP), an evidence-based home visiting program for families in Medicaid. In 2018, the [Medicaid provider manual](#) was updated to include maternal depression screening as part of its guidance related to EPSDT well-child visits. Medicaid leader Mary Ludtke emphasized the importance of:

being able to write specific Medicaid language and guidance to fund the right services to be included in the Michigan Medicaid specific provider manual.

The commitment of leadership coupled with grants, partnerships, and system development efforts, has made Michigan a leader,

said Kim Batsche-McKenzie of the Department of Health and Human Services. For example, with funds initially from a Race to the Top grant in partnership with the Michigan Department of Education and continuing with other state dollars, Michigan funds a position for a state-level early childhood mental health coordinator. Assuring that the IMH-HV would become designated as an evidence-based program has also been a priority. In addition, support and infrastructure for other parent-child interventions (e.g., Child-Parent Psychotherapy, Triple P, Incredible Years, Circle of Security) have grown. Thinking about the system of care, child health advocate Amy Zaagman, executive director of the Michigan Council on Maternal and Child Health, sees the potential to:

better integrate and connect pediatric primary care and mental health services for children in Medicaid.

While the need for workforce development remains high, the focus on professional guidelines (e.g., integrating infant mental health endorsement and reflective supervision/consultation), training in IECMH, and growing provider capacity statewide has yielded results. Tina Jones, Infant and Early



Childhood Development / Early Childhood Mental Health Coordinator in the Department of Health and Human Services reported that Michigan has developed a:

cadre of services and aimed to improve diversity and equity, supported by experts dedicated to delivering a continuum of IECMH services to promote equity.

The success of these efforts is grounded in partnerships among state Medicaid agency staff, mental health agency staff, child advocates, Michigan Association for Infant Mental Health, early care and education, and early childhood systems leadership (e.g., Office of Great Start). Meghan Schmelzer of Zero to Three, who has worked on IECMH in Michigan for years, believes it was important:

to not just create a program but to infuse IECMH into every part of the early childhood system.

5. LEARN ABOUT APPLYING MEDICAID LEVERS

In every state, understanding the primary Medicaid levers for health care change and transformation is essential. Change in policy is the first step; however, successful implementation of policy into practice changes requires further action. When it comes to Medicaid recognition of IECMH services, states often need to: adopt or clarify service definitions, establish billing codes, publish provider guidance, write clear and specific Medicaid managed care contract language, and use measurement to assure quality and monitor progress. In some states, alternative payment mechanisms or broader payment reform initiatives offer an additional lever, such as pay-for-performance, incentive payments for screening, bundled payments, and so forth. In most every case, Medicaid levers to advance IECMH require attention to administrative policy and process changes, not just legislative action. For example, leaders in California took advantage of state health reform efforts through a Medicaid waiver renewal engagement process to elevate IECMH priorities.

Building upon the federal requirements, guarantees, and opportunities in Medicaid's comprehensive EPSDT benefit for children can help states anchor financing for a continuum of mental health services for children birth to age six. As reflected in its name, Medicaid financing for early screening, diagnosis, and treatment is required of every

state Medicaid program. Generally, this begins by having a periodic well-child visit schedule that includes [recommended screening](#) for general development, social-emotional development, and maternal depression. When screening identifies risks or needs, the process should continue with permitting more than one visit for mental health diagnostic assessment and paying for multiple intervention visits for young children without requiring a diagnosis, prior authorization, or medical necessity determination. Among these five states, all have used the strength and breadth of EPSDT to improve early childhood mental health services. For example, Colorado has used EPSDT as the anchor for such work for more than 20 years, and California recently seized the opportunity to improve EPSDT by adding coverage for certain services without a diagnosis.

In these five states and elsewhere across the country, child health champions and decision makers often feel pressure to show short-term cost savings. This is true despite the fact that the return on investments for IECMH and developmental services, when limited to health system investments, primarily accrues over many years rather than in one-to-three years or a legislative budget cycle. While savings from Medicaid investments in health and mental health services for young children may accrue in the state



budget for education or other agencies, such cross-systems savings are rarely acknowledged or easily accounted for in cost estimates or projections. Helping policymakers consider a longer-range view on the benefit and return for prevention and early intervention investments is important.

State and community-level structures responsible for behavioral/mental health in each state may also influence the pace of change. This includes the structure of behavioral/mental health in state government overall (e.g., where does mental health agency sit and does it include IECMH), as well as the existence and role of publicly funded community mental health entities. Linkages between mental health and Medicaid agencies are similarly important, as Medicaid pays for a large proportion of behavioral/mental care in states.

The role of Medicaid managed care organizations (MCOs), accountable care organizations (ACOs), and/or community

care organizations (CCOs) in delivering mental health and IECMH services varies widely across states. These managed care or managed care-like entities are the primary health care delivery system for most Medicaid beneficiaries in most states, and the wide state variation in such arrangements is hard to understate. For example, in some states separate MCO-like entities may provide Medicaid mental health services. Some interviewees in these five states raised concerns that separate Medicaid contracts with behavioral/mental health organizations can leave the youngest children excluded from mental health care or otherwise falling through into cracks in the healthcare delivery system that is not designed to address early risk factors that may prevent or mitigate later mental health conditions.



Medicaid Levers in North Carolina

North Carolina has adopted a series of improvements designed to promote optimal child development and IECMH over the past two decades. Champions for IECMH and optimal child development have engaged in a long series of administrative and advocacy efforts. At the same time, the continuing redesign and evolution of the state's Medicaid program meant that IECMH efforts have been challenged to evolve evenly amidst large-scale delivery systems change. Most recently, North Carolina, by direction of the state legislature, has begun transitioning its entire Medicaid program to managed care.

Based on the success of the Assuring Better Child Health and Development (ABCD) initiative, including Medicaid policy changes to require and incentivize developmental screening, North Carolina attained a developmental screening rate of 94 percent (including general development, maternal depression, and autism screening) by 2014 for infants and toddlers—far and away a top performer nationwide in Medicaid. The state also created a standardized referral system for IDEA Part C Early Intervention and Part B Exceptional Preschool, and used Title V Maternal and Child Health Services Block Grant dollars to fund public health nurses to conduct screenings and make community referrals. Provider acceptance of the policy was high. Unfortunately, the quarterly screening data have not been collected and reported after 2019, so no up-to-date progress report is available.

Since 2001, thanks to the [leadership of pediatricians](#) and other advocates, North Carolina Medicaid policy has permitted Medicaid payment for up to 6 mental health visits without a diagnosis.



Originally as high as 26, now 16 “unmanaged” mental health intervention visits also are permitted. These changes allow young children and their families to be supported with needed services when developmental and mental health risks are identified. The state also provides a small payment incentive for completion of perinatal depression screens as part of infant well-child visits, a [universally recommended screening](#) for a major risk factor in a child’s development.

The NC Medicaid Transformation process to adopt Medicaid managed care has been rolled out across different regions of North Carolina and launched July 1, 2021 with changes to the system of care. If implemented, the next phase of so-called “tailored plans” will be aimed at providing whole-person care for people with serious developmental disabilities and mental health conditions. Child health advocates remain concerned that creation of new structures for managed care plans and contracts holds the potential to disrupt children’s connection to the medical home and create arbitrary barriers in care for children with social-emotional risks and needs but without diagnoses.

While some states’ early childhood system efforts did not initially include health or health care providers, pediatrician Marian Earls has been a force within North Carolina and across the nation driving change in pediatric practice, particularly screening and prompt interventions to improve young children’s development, mental health, and well-being. She is part of a wider group of pediatricians, child psychiatrists, IECMH consultants, and other mental health providers focused on improving policy and practice. Together these champions paved the way for the North Carolina’s Institute of Medicine’s Task Force on the Mental Health, Social, and Emotional Needs of Young Children and Their Families, created at the request of the North Carolina General Assembly in 2010. The panel made strong recommendations based on research and best practices for the unique health practitioner audience. Dr. Earls sees the potential to continue progress toward implementing the [AAP recommendations](#).

In addition, the [EarlyWell Initiative](#) (formerly known as the North Carolina Initiative for Young Children’s Social-Emotional Health) is designed to strengthen and enhance the IECMH system across North Carolina. With input from NC families and other stakeholders, EarlyWell is developing a comprehensive action plan and policy agenda aimed at having family-driven, equitable systems that serve children in the context of their families and communities and offer access to high-quality primary care and mental health services to support social-emotional development. EarlyWell Initiative Director Morgan Forrester Ray affirmed:

We have developed a consensus on recommendations and are rowing in the same direction to support family voice and equity.

Chameka Jackson, Child and Adolescent Services Coordinator for Medicaid, sees the potential to do more. In particular, she envisions:

the opportunity to improve outcomes for children through active listening and partnership with families, providers, and advocates. Together we will be able to identify and fill gaps in the continuum of care – in short, to modernize care and enhance the narrative about children’s health and well-being.



6. WORK ACROSS THE FULL CONTINUUM OF CARE: PROMOTION AND PREVENTION TO INTERVENTIONS AND TREATMENT

The leaders interviewed in five states all pointed to the importance of working to assure a continuum of services to promote social-emotional development, screen for risks, use appropriate diagnostic methods, and intervene for mental health conditions. The diagram below offers a group of successful state strategies for state Medicaid programs to finance care across the continuum of mental health services for children 0 – 6 years to ensure that children and families receive support they need to achieve optimal mental health and well-being. As states identify IECMH service gaps, inequities in services across the continuum may become more apparent. For example, while most states pay for maternal depression screenings in well child visits, a smaller set of states reimburse for family therapy, one key intervention for a child whose parent is experiencing depression. While Medicaid only finances care for a share of children, the program's reach can help to drive toward greater access to a continuum of high quality and age-appropriate mental health services for all young children.

State leaders also described the importance of working within the larger child health care system, beginning with the primary care medical home, as well as in the context of early

childhood systems design, particularly because these services and the providers who deliver them occur across multiple systems of care. Closing gaps among systems was a consistent theme, especially gaps between primary care and other delivery systems such as mental health services, IDEA Part C Early Intervention, and early care and education. Engaging a wide array of diverse stakeholders—including families with varied experience, providers with different qualifications, and public sector decision makers — to guide system design and implementation was seen as a high priority.

For decades states have received small grants related to early childhood comprehensive system development. Recent federal investments include a new round of grants for state and community action to advance early childhood comprehensive systems. In addition, [more federal grants](#) are focused on child health transformation, which might include promotion and prevention for IECMH (e.g., Health Care Resources and Services Administration funding opportunities for Transforming Pediatrics for Early Childhood; Early Childhood Developmental Health Systems-Evidence to Impact; Early Childhood Comprehensive Systems; and Early Childhood Development for Community Health Centers).

FINANCING SERVICES ACROSS THE CONTINUUM OF NEED AND RISK





Conclusion and Key Takeaways

States seeking to make progress on Medicaid financing for IECMH services can learn from states highlighted throughout as they start or continue their journeys. Takeaways from state successes to advance policies, program structures, and systems include the following.

- **Cultivate leadership at all levels.** Seize the moment when the governor, another elected official, or agency director sees early childhood health and/or IECMH as a priority. In some cases, educating leadership is the path to change; however, it may equally be an unexpected change due to an appointment or election. Be a policy entrepreneur who is ready to make proposals and take action when the time is ripe.
- **Engage a wide array of partners.** Effective advocacy requires a strong partnership among those working inside and outside of government. Even if advocates are successful in getting legislation passed or increasing funding, policy and program implementation will rely on the knowledge and support of state agency staff. These five states also exemplify how partnerships with philanthropy, families, professional organizations, and others created the basis for moving IECMH ahead.
- **Create a strategic plan and priorities for action.** In each of these states, a long-range plan for action was set out. Sometimes this was a formally adopted, statewide plan. In other states, the priorities for action were set by an advocacy organization in partnership with key stakeholders. Moreover, advocates recognized that adopting services across the continuum of IECMH risk and need would be an incremental process, taking years not months.
- **Understand state Medicaid policy levers.** In most states, the most powerful lever is the Medicaid managed care contract, which should set specific, concrete, and actionable expectations for health plans and their network providers. Whether or not the state uses managed care or similar arrangements, measurement for quality and performance improvement is key. Also, operationalizing benefits by adopting billing codes, provider qualifications, and service definitions related to early childhood mental health. Each state also has an opportunity to recommend screening tools, use age-appropriate diagnostic codes, and avoid requirements for diagnoses or determinations of medical necessity for diagnostic and early intervention services related to IECMH.
- **Infuse IECMH into broader early childhood reforms.** An early childhood system includes health, early care and education, family support, and other providers that serve young children and their families. IECMH services and the providers who deliver them are working across multiple systems of care. They may work in primary care, mental health, IDEA Part C Early Intervention, early care and education, child welfare, nutrition, or other sectors. Closing the gaps in the system of systems is critical for supporting families in reaching their goals for optimal health and well-being. [System level data](#) can help monitor progress.
- **Advance equity by engaging families.** A focus on equity in access and outcomes should drive efforts to improve system connections for families who have been historically marginalized or underrepresented. As affirmed by the AAP, [racism is a determinant of health for children](#). Authentic engagement of families who use the services and have experience in the systems of care is essential, including not only those whose children have special health or mental health needs, but also those from historically marginalized and minoritized groups. Families should be [engaged](#) and directly involved not only in the health care system but also in co-design of early childhood systems.

As the federal Medicaid agency [describes](#) it:

The goal of the EPSDT benefit is to ensure that individual children get the health care they need in the right place when they need it.

Many states are taking action and most could do more to finance high-performing systems and services that promote the social-emotional-mental health and well-being of children, starting in the earliest years.



Appendix A. Individuals Interviewed

CALIFORNIA

Alex Briscoe, Principal, California Children's Trust
Sarah Crow, Managing Director, First 5 Center for Children's Policy
Karen Moran Finello, Project Director, WestEd
Alexandra Parma, Senior Policy Research Associate, First 5 Center for Children's Policy
Pamela Riley, MD, MPH, Chief Equity Officer & Assistant Deputy Director, Quality and Population Health Management, California Department of Health Care Services

COLORADO

Jordana Ash, Senior Clinical Instructor, Department of Psychiatry; and Co-Director Harris Community Fellowship in Child Development & Infant Mental Health, University of Colorado School of Medicine
John Laukkanen, Behavioral Health Policy and Benefit Operations Unit Supervisor, Behavioral Health Initiatives and Coverage Office, Colorado Department of Health Care Policy and Financing
Erin Miller, Vice President of Health Initiatives, Colorado Children's Campaign
Gina Robinson, Senior Policy Advisor/EPSDT Program Administrator, Health Policy Office, Colorado Department of Health Care Policy and Financing
Angela Rothermel, Deputy Director, Early Milestones Colorado
Alex Weichselbaum, Primary / Rehabilitative Care and Analytics Section Manager, Colorado Department of Health Care Policy and Financing
Tanya Weinberg, Portfolio Director for Health & Well-Being, Early Milestones Colorado

MICHIGAN

Kim Batsche-McKenzie, Division Director, Division of Program and Grant Development and Quality Monitoring, Bureau of Children's Coordinated Health Policy and Supports, Michigan Department of Health and Human Services
Mary Ludtke, Evidence Based Practice and Grant Development Section Manager, Division of Program and Grant Development and Quality Monitoring, Michigan Department of Health and Human Services
Tina Jones, Infant and Early Childhood Development / Early Childhood Mental Health Coordinator, Bureau of Children's Coordinated Health Policy and Supports, Division of Program and Grant Development and Quality Monitoring, Evidence Based Practice and Grant Development Section, Michigan Department of Health and Human Services
Meghan Schmelzer, Senior Manager, Infant Early Childhood Mental Health Policy Center, Zero to Three
Amy Zaagman, Executive Director, Michigan Council for Maternal and Child Health

NORTH CAROLINA

Marian Earls, Independent Consultant; and Clinical Professor of Pediatrics for UNC Medical School
Morgan Forrester Ray, Director, EarlyWell Initiative, NC Child
Chameka Jackson, Child and Adolescent Services Coordinator, North Carolina Medicaid, Department of Health and Human Services
Kaylan Szafranski, Health Program Director, NC Child

WASHINGTON STATE

Christine Cole, Infant-Early Childhood Mental Health Program Manager, Washington State Health Care Authority
Kimberly "Kiki" Fabian, Infant-Early Childhood Mental Health Analyst, Washington State Health Care Authority
Monica Oxford, Executive Director, Barnard Center for Infant Mental Health and Development, University of Washington
Sarah Rafton, Executive Director, Washington Chapter of the American Academy of Pediatrics
Beth Tinker, Maternal and Child Health Consultant, Washington State Health Care Authority



Appendix B. Questions for Interviews

1. Your state has gained attention as one using Medicaid to finance mental services for children 0-6, tell me more about the forces that led to policy change?
 - a. To what extent the Medicaid agency play a key leadership role?
 - b. To what extent did the mental health agency play a key leadership role?
 - c. To what extent did providers and advocates play a role in driving change in Medicaid policy?
2. Your state is reported to have Medicaid policies that finance and support access to a continuum of early childhood mental health services. We'd like to learn more about support for various components along the continuum of care.
 - a. How would you describe your state's Medicaid financing and support for mental health promotion and prevention services for children 0-6?
 - i. We are particularly interested in examples of an array of child or parent screening for social-emotional-mental health
 - ii. This might also include promotion and preventions models such as HealthySteps or DULCE.
 - b. How would you describe your state's Medicaid financing and supports for mental health interventions and treatments for children 0-6?
 - i. This might include therapy models such as Parent-Child Interaction Therapy (PCIT) or Child-Parent Psychotherapy (CPP).
 - ii. We are particularly interested in examples of financing parent-child dyadic or family treatment, in which a clinician treats a parent and infant/young child together to reduce mental health and behavior difficulties.
3. If your state is using Medicaid managed care to serve a large majority of children in Medicaid, what role to do MCOs play in delivery of mental health services for children 0-6?
4. What do you see as the most important Medicaid policy or process innovation you state has put into place in order to finance and ensure access to a continuum of mental health services for children 0-6?
5. What do you see as the key next steps in your state's work to improve access to mental health services for young children in Medicaid?

Prior to the interview, we will confirm whether or not your state has returned the survey. If possible, in addition to this interview, we would like to have your state's survey information to complement this interview and be part of the baseline for our national report.



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