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Recommendations for the Inclusion of Early Childhood Mental Health Benefits in New York State's Medicaid Plan

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New York State's Medicaid redesign offers an unprecedented opportunity to ensure that the state's youngest children and their parents have access to mental health services that are key to children's overall health and development and to the reduction of serious, long-term mental health conditions in the state's school-age population. This memo outlines important considerations in developing the package of benefits for young children, 0 to 6, in New York's state plan amendment.

New York's state Medicaid plan should include developmentally appropriate, evidence-based mental health services that are tailored to the unique needs of children birth to age 6 years. Young children receive their primary health and developmental supports from parents and caregivers in home and community settings, and are also regularly seen in pediatric care for well-child visits. Infants, toddlers, and preschoolers are highly vulnerable to family risk factors, conditions of instability, and trauma which include parent depression, family homelessness, and the experience of abuse or neglect, placement in foster care, and separations from the parent. Therefore, mental health services for this population should aim to strengthen key adult-child relationships, ensure the well-being of parents and other caregivers and their ability to provide critical supports for young children's social-emotional well-being and growth, and provide mental health supports in home, community, and pediatric settings.

We recommend that the plan specify the following as covered services and note particular features of coverage that should be considered:

1. Screening for social-emotional problems with a standardized tool.
    - A special code should be used to distinguish an S-E screen from a developmental screen. Minnesota uses a modifier on their code for a developmental screen; using this distinct code will allow the state to track the use of S-E screens with a standardized tool;
    - Allow the provider to be reimbursed for administering both a developmental and social-emotional screen in the same visit.
2. Screening for parent/caregiver depression during a pediatric care visit using a standardized tool.
    - Allow this screening under the child's Medicaid benefit; in a 2013 policy change, Connecticut recently identified a code, "risk assessment," that can be used for a maternal depression screen during a pediatric visit.

3. Home-visits by a clinician for relationship-based treatment.
    - Permit treatment duration to be based on child needs; Michigan covers home visits by a clinician for children under age 6 and places no limits on the number of visits.
4. Medicaid should allow a crosswalk of the DC:0-3R (Diagnostic and Classification of Mental Health and Developmental Disorders of Infancy) to the DSM-V for reimbursement of services for children birth to age 5.
5. Dyadic treatment with evidence-based or research informed models.
    - Establish a CPT code for dyadic treatment for young children. Florida has a flexible individual and family treatment code that is used for this service.
    - Coverage should require clinicians' use of an evidence-based or research-informed dyadic treatment model.
6. Evidence-based parenting programs that promote parenting skills needed to strengthen the parent-child relationship and the child's social-emotional functioning.
    - This may be an especially cost effective service since it allows multiple parents to receive the service at the same time and when used as an adjunct to or follow-on treatment for parents involved in dyadic therapy, it is likely to accelerate and help sustain treatment benefits. Michigan requires evidence-based parenting programs to be offered by its managed care providers. Oregon bills for Incredible Years Parent Groups as multiple family group psychotherapy and negotiated an enhanced rate based on fidelity to an evidence-based model.
7. Evaluation, brief treatment and care management in primary care settings. Clinicians in pediatric settings should be covered for further evaluation of children in pediatric settings when screening suggests conditions of the child, parent, or parent-child dyad in need of treatment.
    - Additional services that should be covered are brief treatment and care management (e.g., facilitated referrals to community providers and follow-up)
    - Inclusion of this covered service allows the integration of health and mental health in pediatric care settings which is well-suited to the needs of young children and their parents, and likely to increase the positive impacts of screening by ensuring that children and their parents receive appropriate follow-up evaluation and treatment.

The following are additional points about age-appropriate mental health services for young children:

- Eligibility for services (excepting screening) should be determined by a developmentally appropriate definition of medical necessity and consideration of the presence of significant risk factors for deviation from a course of typical development, such as maternal depression. According to Minnesota's definition, for example, the expectation that a child will deviate from a course of typical development constitutes medical necessity for treatment. This expectation would occur, for example, in the case of maternal depression or the infant's or toddler's experience of trauma related to child welfare involvement.
- Coverage of services in the widest range of settings (home, pediatric offices, child care settings, family resource centers) will ensure that services are delivered where young children and their parents and caregivers are found, with the provision that appropriate clinical credentials and qualifications of providers will be specified for each service.