

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

The Pediatrics Supporting Parents (PSP) Initiative is focused on cultivating optimal social-emotional development in our country's youngest, most vulnerable children; valuing the central role parents play in that development; and seizing the opportunity for pediatricians to better support parents in this role.^{1,2} Research tells us that young children's social-emotional development is a key component of school readiness and is a key building block for cognitive development, learning, and future mental health. It is the outcome of positive, stimulating, and nurturing parent-child relationships in the context of safe and well-resourced families and communities.^{3,4,5}

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

As the largest federal-state health programs serving young children, Medicaid and the Title V Maternal and Child Health Services (MCH) Block Grant present particularly important

opportunities to catalyze transformation in pediatric primary care. We cannot achieve health equity for children without strong performance by these programs. Medicaid, together with the Children's Health Insurance Program (CHIP), covers about half of all births and more than 40 percent of infants and toddlers, birth to three.⁶ More than half of all children of color under age 19 are covered by Medicaid and CHIP.⁷ State Title V MCH programs anchor an array of services and supports for children with low income, as well as system structures that affect all pregnant women, children, and families.

Every state has the potential to improve the finance and delivery of pediatric primary care to better support parents and improve social-emotional development in ways that have lifelong impact. The specific policy, program, and practice opportunities described below for state Title V MCH programs, state Medicaid agencies, and for the two in partnership are based on existing state innovations, research on how to promote social-emotional development, and federal law. Change will require action by state agencies, health plans, providers, and family leaders. Family engagement in care and systems is an essential component of the work. These actions should be undertaken as part of intentional efforts to advance equity, reduce provider bias, and eliminate the disparities driven by racism. If more than 40 percent of young children are in Medicaid, then this is the place to start building a future with equity in health and well-being.⁸

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



Using Pediatrics to Support Parents and Improve Social-Emotional Development, Early Relational Health, and Future Well-Being: Opportunities for Primary Care, Title V, and Medicaid

Continuum	Examples of Primary Care/Medical Home Action	Examples of Tools, Models, and Programs	Title V Roles and Opportunities	Medicaid Roles and Opportunities
<p>Align with and Advance Use of Guidelines</p>	<ul style="list-style-type: none"> Deliver well-child visits based on Bright Futures Guidelines⁹ and EPSDT.^{10,11,12} 	<ul style="list-style-type: none"> American Academy of Pediatrics Bright Futures Periodicity Schedule.¹³ 	<ul style="list-style-type: none"> Advance Bright Futures Guidelines, periodicity schedule, screening protocols, and other more specific guidelines for primary care. Partner with Medicaid to develop guidelines, contract provisions, provider manuals, and other documents related to EPSDT and well-child visits. Use Title V funds to support Pediatric Improvement Projects for aligned purpose: i.e., support improvement in the scope, quality, and utilization of well-child visits for young children in Medicaid. Include Title V National Performance Measures (NPM)¹⁴ on medical home (NPM #11) and on developmental screening (NPM #6) as priorities for State Title V plan. Align with Medicaid/CHIP core measures when possible. 	<ul style="list-style-type: none"> Align state's EPSDT rules and periodicity schedule with Bright Futures. Apply Bright Futures Guidelines in Medicaid financing process, including contracts, measurement, incentives, and oversight. Collect and submit data on Child Core Set measure "Well-Child Visits in the First 15 Months of Life" (W15-CH); "Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life" (W34-CH); and "Developmental Screening in the First Three Years of Life" (DEV-CH).¹⁵ Use Medicaid administrative claiming mechanisms¹⁶ to provide training and QI projects that support improvement in the quality, scope, and focus of well-child visits for young children in Medicaid. Include in Medicaid contracts with MCO/ ACO/ ACH a focus on pediatrics, particularly promotion and prevention, two-generation, relational health.

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<p>Advance Use of High Performing Medical Homes</p>	<ul style="list-style-type: none"> Develop advanced, high performing medical homes for young children in Medicaid.¹⁷ 	<ul style="list-style-type: none"> Apply the design for a high performing medical home to augment primary care, with improvements in well-child visits, care coordination, and other services, in a medical home that is team-based and family-centered, as well as more holistic, strengths-based, relational, and culturally and linguistically competent. Provide comprehensive well-child visits, including recommended screening, exams, and family engagement. Use tiered care coordination, including more intensive, relational care coordination to serve families with identified risks and need for additional support.¹⁸ Improve integration into primary care and linkages in community to evidence-based models, other programs, and a range of services. 	<ul style="list-style-type: none"> Use funds from the 30 percent of Title V MCH Block Grant funding dedicated to preventive and primary care for children to strengthen pediatric medical homes for all young children.¹⁹ Create projects and structures to advance high performing medical homes for young children in Medicaid (e.g., training, technical assistance, QI, certification, measures) that provide team-based primary care, relational care coordination, and other services and supports. Partner with American Academy of Pediatrics chapters, child health improvement partnerships, children’s hospital ambulatory care groups, and primary care providers to transform medical homes, improve well-child visits and augment use of universal preventive screening and interventions Focus on Title V NPM #11: “To increase the percentage of children with and without special health care needs who have a medical home.”²⁰ Apply strategies now used to advance medical homes for CSHCN in order to support high performing medical homes for more young children without diagnosed conditions. Work with federally qualified health centers (FQHC) to introduce components of the high performing medical home for young children in Medicaid. Align and crosswalk performance measures on medical home and well-child visits across Title V, Medicaid/CHIP core measures, and HEDIS. 	<ul style="list-style-type: none"> Define and incentivize high performing medical homes for young children, including use of Medicaid managed care contract language. Increase reimbursement rates/payments for high performing medical home for young children in Medicaid, relying on certification and/or measurement. Permit use of Medicaid administrative claiming to finance related training and quality improvement activities for enrolled pediatric primary care providers. Make adjustments to cover the additional costs and scope of services related to high performing medical home as part of FQHC prospective payment system (PPS) or alternative payments methodologies (APM) under Medicaid, including use of supplemental payments where appropriate.²¹ Compare performance on medical home and well-child visit measures across Title V, Medicaid/CHIP core measures, and HEDIS.

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<p>Promotion <i>Universal promotion</i>²²</p>	<ul style="list-style-type: none"> • Use relational, strengths-based, culturally appropriate approaches.²³ • Provide anticipatory guidance and education for parents on general health, developmental, relational, and mental health.²⁴ • Use tools and approaches for partnering with and coaching parents, encouraging early relational health.^{25,26,27} • Use tools and models for family engagement.^{28,29} • Maximize opportunities for families to connect with other families for peer-to-peer support.³⁰ 	<ul style="list-style-type: none"> • Well-Visit Planner™ and Cycle of Engagement^{31,32,33} • Pre-visit tools in Bright Futures³⁴ • Family Engagement in Systems Toolkit and Assessment Tool (FESAT)³⁵ • Parent-focused Redesign for Encounters, Newborns to Toddlers (PARENT)^{36,37} • Strengthening Families framework • Reach Out and Read (ROR)³⁸ • Play and Learning Strategies (PALS) Infant, Toddler^{39,40,41,42} • Promoting First Relationships in Primary Care • The BASICS⁴³ • Mind in the Making⁴⁴ 	<ul style="list-style-type: none"> • Use Title V funds to provide training to increase use of strengths-based, relational, culturally and linguistically appropriate, and responsive interactions between pediatric primary care providers and parents. • Encourage use of pre-visit tools to support more effective family engagement during well-child visits (e.g., Well-Visit Planner and Cycle of Engagement). • Partner with Medicaid and the private sector to fund Reach Out and Read for all children in medical homes. • Invest in family led organizations and build on existing family-to-family organizations to provide support to families whose children do not have an identified special health care need. • Fund projects designed to increase parent/family engagement in health care at the clinical and systems levels. 	<ul style="list-style-type: none"> • Inform families and providers about the EPSDT benefit and the importance and value of comprehensive well-child visits.⁴⁵ • Provide reimbursement for services delivered by family specialists, community health workers, and other care team members (using flexibility for preventive services by non-licensed staff).⁴⁶ • Permit provider billing for parenting programs and family peer support services conducted within the medical home. • Permit billing for evidence-based enhancements for universal preventive interventions such as Reach Out and Read. • In Medicaid managed care contracts, require that pediatric primary care providers use the CAHPS survey questions for the Patient-Centered Medical Home/Child Version.⁴⁷

Continuum	Examples of Primary Care/ Medical Home Action	Examples of Tools, Models, and Programs	Title V Roles and Opportunities	Medicaid Roles and Opportunities
<p>Screening for strengths and risks</p>	<ul style="list-style-type: none"> • Screen for general development. (Bright Futures schedule calls for screens at 9, 18, 24, and 30-month well-child visits).^{48,49,50,51} • Screen for social-emotional (SE) development with objective and validated tools (recommended in all 15 visits birth to 5th birthday).^{52,53,54,55,56,57,58,59} • Screen for maternal depression in pediatric visits (Bright Futures schedule calls for four screens in the first year of infant life).^{60,61,62} • Screening for Autism Spectrum Disorder (ASD) with objective and validated tools (recommended in visits 18 months and 24 months). • Screen for social determinants of health (SDOH) (Bright Futures schedule calls for screens at all 15 visits birth to 5th birthday).^{63,64,65,66,67,68,69} 	<ul style="list-style-type: none"> • Ages & Stages Questionnaire (ASQ)^{73,74} • Ages & Stages Questionnaire: Social Emotional (ASQ:SE) • Pediatric Symptom Checklist (PSC)^{75,76} • Maternal depression screening tools (e.g., Edinburgh,⁷⁷ PHQ⁷⁸) • SDOH tools (e.g., CAHMI,⁷⁹ PRAPARE,⁸⁰ AHC^{81,82}) • Promoting Healthy Child Development Survey (PHDS)^{83,84,85} • ACE/PCE screening^{86,87} (e.g., PEARLS⁸⁸) • Survey of Well-being of Young Children (SWYC)^{89,90} • Safe Environment for Every Kid Parent Questionnaire (SEEK-PQ)^{91,92,93} 	<ul style="list-style-type: none"> • Use Title V funds to support training and QI projects related to screening for general development, social-emotional development, maternal depression, and SDOH.⁹⁵ • Partner with Medicaid to develop more specific guidelines and contract provisions related to screening (i.e., screening, response, and measurement). • Measure developmental screening in pediatric medical home as part of work on NPM #6 “Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.”⁹⁶ • Measure response to developmental screening in medical home. • Measure social-emotional developmental screening in pediatric medical home as part of work toward and reporting on NPM #6. 	<ul style="list-style-type: none"> • Measure and report on developmental screening in pediatric medical home, based on CMS Child Core Set measure “Developmental Screening in the First Three Years of Life” (DEV-CH).⁹⁷ • Through managed care contracts and provider guidelines, require screening for general and social-emotional development, based on Bright Futures periodicity schedule recommendations. • Finance and measure maternal depression screening in pediatric medical home. • Finance and measure screening for social determinants of health (SDOH) in pediatric medical home.

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<p>Screening for strengths and risks (continued)</p>	<ul style="list-style-type: none"> Standardize workflow to provide developmental, behavioral, and SDOH screenings, health promotion, support, and resources.^{70,71} Use 6R response to concerns identified through screening = Respect, Reinforce, Resource, Return, Refer, and Resolve.⁷² 	<ul style="list-style-type: none"> Help Me Grow⁹⁴ system for responding to parental needs, positive developmental screening results, and provider concerns related to early childhood development. 	<ul style="list-style-type: none"> Measure response to social-emotional developmental screening in medical home. Conduct QI and pilot projects with health plans related to screening for social-emotional development and young children. Encourage and measure response to maternal depression screening in pediatric medical home. Encourage and measure screening for social determinants of health (SDOH) in pediatric medical home. Fund expansion of Help Me Grow or similar systems “utilities” to support referrals and follow up to positive screen results, including concerns about early childhood social emotional development. 	<ul style="list-style-type: none"> Use electronic health records (EHR) or other care process tools to record positive screens and follow up. Use Medicaid administrative claiming dollars to support for training and supporting practitioners in their use, and for establishing the infrastructure necessary for implementation of Help Me Grow or similar systems “utilities” to support referrals and follow up to positive screen results.

Continuum	Examples of Primary Care/Medical Home Action	Examples of Tools, Models, and Programs	Title V Roles and Opportunities	Medicaid Roles and Opportunities
<p>Prevention and Support <i>Universal preventive interventions</i>^{99,100}</p>	<ul style="list-style-type: none"> • Basic level care coordination/case management for all served in medical home. • Integrate family specialists trained in child-family development and relational care coordination as part of the medical home team. • Integrate strategies to support parents' well-being and mental health. 	<ul style="list-style-type: none"> • DULCE¹⁰¹ • WE CARE (Well Child Care, Evaluation, Community resources, Advocacy, Referral, Education)¹⁰² • CenteringParenting^{103,104} 	<ul style="list-style-type: none"> • Fund structures for training, diversification, and workforce development of family specialists within or linked to pediatric primary care (e.g., DULCE, Healthy Steps, other models, and community health workers). This includes a career pathway opportunity for family leaders. • Strengthen partnerships and increase engagement with family led organizations and family-to-family centers. • Fund parent education and peer support services within the medical home or community settings. 	<ul style="list-style-type: none"> • Permit reimbursement of services delivered by family specialists and other care team members (using flexibility for preventive services by non-licensed staff). • Permit billing for parent education and peer support services within the medical home. • Include in contracts for MCO/ ACO/ ACH a focus on pediatrics, particularly promotion and prevention, two-generation, relational health.

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<p>Prevention and Support <i>Selective preventive interventions</i>^{109,110}</p>	<ul style="list-style-type: none"> • Provide case management/relational care coordination, with tiered levels of intensity.^{111,112,113,114} • Co-locate prevention and early intervention services and models related to social-emotional-mental health in pediatric practice. • Link to prevention and early intervention services and models related to social-emotional-mental health. • Link to family supports and services for intervening early (including community-based parenting education programs and play groups, parent support groups). 	<ul style="list-style-type: none"> • Healthy Steps^{115,116,117,118} • Help Me Grow¹¹⁹ • Peer support, including parents, community health workers, promotoras, and others^{120,121} • Family developmental specialists/family service workers as part of models or otherwise^{122,123} • Medical-Legal Partnerships^{124,125} • Family Check-Up • Home visiting programs providing general prevention and support (e.g., NFP, HFA, PAT, Family Connects)¹²⁶ 	<ul style="list-style-type: none"> • Encourage use of more intensive and relational care coordination, building parallels to and using lessons from efforts for CSHCN. • Support spread and scale of models that augment pediatric primary care/medical home either within health care settings or through linkages to services elsewhere in the community. • Fund cross-system training for home visitors, family specialists, community health workers, and childcare workers on the basic components and competencies of the early childhood workforce. 	<ul style="list-style-type: none"> • Finance tiered care coordination in managed care or fee-for-service arrangements, including more intensive care coordination/case management for families with young children who have medical complexity, social complexity, or both.¹²⁷ • Provide enhanced reimbursement for high performing medical homes that use team-based care and integrate evidence-based models such as Healthy Steps, and DULCE. • Use Medicaid financing to fund some home visiting services. • Use Medicaid financing to fund two-generation, dyadic, relational health interventions that are family focused and advance parent-child bonding, attachment, nurturing, and security.

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<p>Early Interventions and Mental Health Treatment^{128,129}</p>	<ul style="list-style-type: none"> • Co-locate intervention services and models related to social-emotional-mental health in pediatric practice.¹³⁰ • Provide infant and early childhood mental health (IECMH) consultation to primary care providers.¹³¹ • Use virtual mental health interventions. • Use DC:0-5 assessment and diagnostic system. • Make effective and efficient referrals to link families to parent-child relational interventions. • Link to parent-child dyadic mental health therapy. 	<ul style="list-style-type: none"> • Part C Early Intervention^{133,134} • Incredible Years (infant and toddler)^{135,136} • Video Interaction Project (VIP)¹³⁷ • Positive Parenting Program (Triple P)¹³⁸ • Child First^{139,140} • Circle of Security-Parenting (COS-P)¹⁴¹ • My Baby and Me¹⁴² • Parent-Child Interaction Therapy (PCIT)^{143,144,145} • Child-Parent Psychotherapy (CPP for infants and toddlers)¹⁴⁶ • Attachment and Biobehavioral Catch-up (ABC)^{147,148,149} 	<ul style="list-style-type: none"> • Use Title V funds to provide training and QI projects that improve provider knowledge, attitudes, and practices related to early childhood mental health. • Use parent-to-parent and other organizations to inform families about the role of EPSDT and Medicaid in financing treatment and interventions. • Fund training projects and QI processes to support providers.¹⁵⁷ • Partner with Medicaid to develop more specific guidelines and contract provisions related to coverage for early childhood mental health services. • Build on lessons learned from Project LAUNCH to sustain early childhood mental health initiatives using Title V dollars. 	<ul style="list-style-type: none"> • Use EPSDT authority to structure benefits, billing codes, and prior authorization protocols to ensure coverage and financing of early interventions for young children without diagnoses. • Use guidance, provider manuals, and contract language to clarify Medicaid/EPSDT coverage for mental health interventions and treatment among young children, including billing for parent-child, dyadic service models. • Permit Medicaid billing for mental health and other health-related services in Part C Early Intervention program, Individualized Family Service Plans.¹⁵⁸ • Reimburse for IECMH consultation (virtual and in person) to pediatric primary care providers/medical homes.

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<p>Early Interventions and Mental Health Treatment^{128,129} (continued)</p>	<ul style="list-style-type: none"> Implement integrated behavioral health, including appropriate services for young children.¹³² 	<ul style="list-style-type: none"> Project LAUNCH (various local designs)^{150,151,152,153,154,155,156} 	<ul style="list-style-type: none"> Support development of social-emotional and mental health responses in Part C Early Intervention programs. Increase capacity for IECMH consultation to pediatric primary care providers/ medical homes (e.g., through training, standards, certification, co-location, etc.). Increase workforce capacity for delivery of parent-child, dyadic, mental health therapy using an array of models and practices, working in partnership with primary care providers, mental health providers, and other state agencies. Fund training, diversification, and development of workforce capacity for evidence-based home visiting focused on social-emotional development and behavioral risks (e.g., Child First, ABC). 	<ul style="list-style-type: none"> Reimburse for parent-child, dyadic, mental health therapy under the child's Medicaid number, using expedited medical necessity determinations and/or expedited prior authorizations. Reimburse for services delivered through integrated behavioral health in pediatric primary care providers/medical homes, including when co-located, on-site referrals, and same day services. Clarify child/family rights under EPSDT, such as the range of treatment coverage, processes for appeals, and so forth.

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