

Improving the Lives of Young Children

Meeting Parents' Health and Mental Health Needs through Medicaid and CHIP So Children Can Thrive

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In an early childhood education program, a teacher notices a boy who is aggressive toward other children, and she starts to get to know his mother. Over the next few years, as the mother becomes more comfortable with the teacher and the program's family advocate, she decides to address her long-standing depression and other issues, such as obesity and chronic pain. While her son has a pediatrician, the mother has never gone to the doctor except while pregnant, and she has no Medicaid coverage or money to pay for health care. Eventually, the early childhood program helps her find a clinic that will see her. As she feels better, her son starts to do better; and, as he becomes calmer and less stressful for her to parent, her own depression lifts further.

But as the boy gets ready for kindergarten, it is clear that his tough early childhood years have left their mark. The teachers who know the family wonder whether the mother could have been helped earlier, if she had had a doctor or if her son's pediatrician had gotten to know her well during her son's infancy. And if she had received help earlier, might the child have struggled less with emotional and cognitive delays and now be better prepared for school?

Source: Fictional example, based on interviews and focus groups conducted in three cities as part of the research project Preventing Child Abuse and Neglect by Identifying and Treating Maternal Depression. The focus groups and interviews are described in Golden and Hawkins (2011).

Executive Summary

Many young children have developmental or behavioral problems that could be addressed or even prevented with the right early response but that are not identified or treated before entering kindergarten, compromising children's ability to perform up to their potential in school and leading to more costly health and special education interventions later. Because the quality of parenting is so critical to young children's development, parental or family difficulties—including maternal depression and other parental mental health and medical problems—can endanger children's development. In these situations, treating parents may be crucial to getting children's development back on track. Yet, for many reasons, parents often do not receive needed medical or mental health care or other supportive services.

This brief discusses state Medicaid and CHIP choices that can enhance delivery to parents and families of the medical, mental health, and related services needed to support young children's development. A range of physical and mental health

problems affects parenting (for example, parents' chronic pain and general health), but the evidence for the role of two-generational services is greatest for parental mental health problems. Among these problems, research attention has focused especially on maternal depression, which is widespread among low-income mothers, particularly damaging to young children's development if left untreated, yet very treatable (NRC and IOM 2009). Therefore, after initially identifying possible two-generational issues a state could consider, we focus largely on barriers and solutions to helping parents receive treatment for depression.

Other briefs in this series address children's screening for developmental delays, referral and follow-up treatment, and case management/care coordination for young children (Hanlon 2010; Kenney and Pelletier 2010; Pelletier and Kenney 2010). This brief is more exploratory and less definitive than the other three because a more challenging policy environment has meant less program experience on which to base firm recommendations. Policy and service approaches that

consider parents and children together cut against the grain of most federal and state funding streams and service systems; while there are important exceptions, many health, human services, and early childhood programs are organized to support either services to the child or services to the parent but not both. For Medicaid, the central focus of these briefs, the key distinction is that Medicaid eligibility and benefits are more restrictive for parents than children. However, even with these constraints, there are important policy opportunities for states to explore, and health reform will considerably expand those opportunities.

After addressing the reasons that two-generational services matter, the Medicaid policy framework, and the changes that health reform will bring, the brief focuses on three policy opportunities for states: increasing Medicaid coverage among eligible parents of young children, increasing service receipt among parents, and increasing receipt of family-based services when children are Medicaid-eligible but their parents are not.

Increasing Medicaid Coverage among Eligible Parents

Many strategies cited in earlier briefs to expand coverage among children can also apply to parents. In addition, states should consider adopting the policy options available in Medicaid and CHIP to cover all pregnant women and taking advantage of coverage during pregnancy to ensure screening for potential parent and family needs (for example, maternal depression), case management, and links to ongoing Medicaid coverage and non-Medicaid services.¹

Increasing Receipt of Services Needed to Promote Children's Healthy Development among Medicaid-Eligible Parents

Even when parents are eligible for Medicaid, they face many barriers to treatment, particularly mental health services. As a specific example, this brief concentrates on maternal depression. States should consider the following steps to improve parents' access to treatment:

- assess specific barriers to high-quality treatment for depression;
- target reimbursement, billing, and cost barriers;

- support teamwork among providers serving depressed parents and their young children;
- enhance providers' availability, capacity, and skill; and
- design services to address issues of stigma and trust.

Increasing Receipt of Family-Based Services Needed to Protect Young Children's Development When Parents Are Ineligible for Medicaid but Their Children Are Eligible

Even after states have enhanced services to eligible parents, however, many parents of Medicaid-eligible young children are not eligible. Three Medicaid policy approaches could support family-based approaches that would reduce the risk to children's development:

- provide two-generational services under the child's Medicaid benefit, consistent with Early and Periodic Screening, Treatment, and Diagnosis (EPSDT);
- provide two-generational services under the child's Medicaid benefit using the rehabilitative services option for young children who have mental health diagnoses; and
- use Medicaid funding for eligible families to expand home visiting programs, leveraging other home visiting funds to support parents who are not Medicaid-eligible.

States have opportunities to take these two-generational issues into account as they prepare for health reform. State early childhood and health policy leaders who gain experience working together under today's Medicaid framework can draw on those relationships to make an even greater difference for families as health reform is implemented.

Introduction

The quality of parenting is central to young children’s emotional and cognitive development from the earliest moments of infancy. Parents’ well-being, including physical and mental health, substantially affects the quality of parenting. The most widely studied parental health problem has been maternal depression, which is known to adversely affect a child’s cognitive, socioemotional, and behavioral development early in life with long-term implications for child’s learning abilities and physical and mental well-being (Center on the Developing Child [CDC] 2009; Knitzer, Theberge, and Johnson 2008; McKay et al. 2009; NRC and IOM 2009).² Parents’ general health and parental chronic pain have also been related to parenting and to children’s psychological, social, and physical well-being (Evans, Keenan, and Shipton 2007; Waylen and Stewart-Brown 2010).

Damaging Health and Mental Health Conditions That Affect Parenting

Parental health and mental health challenges are widespread among low-income parents. For example, among parents receiving welfare or Food Stamp benefits, about two in five have at least one disability,³ compared with about one in five among low-income single mothers (those whose income is less than twice the poverty level) and about one in six among all adults. In turn, low-income single mothers are more likely than adults in general to report that they have a physical, mental, or emotional problem that keeps them from working or limits the kind or amount of work they can do; they are almost twice as likely as other adults to report emotional or mental issues (Loprest and Maag 2009).

Depression is also particularly prevalent among women living in poverty and low-income mothers of young children. In a national sample of 9-month-old infants, one in nine of those living in poverty had a mother who was severely depressed, and more than half had a mother experiencing some level of depression. Among infants at all family income levels, 1 in 14 had a severely depressed mother, and about 2 in 5 mothers experienced some level of depression (Vericker, Macomber, and Golden 2010).

The impact of maternal depression on early child development is compounded by other risk factors for

parenting and child development. Infants living in poverty with severely depressed mothers are more likely than other infants in poverty to have mothers who report that their health is only fair (24 percent compared with 11 percent) and who report abusing alcohol and being victims of domestic violence (Vericker et al. 2010). Other risk factors that often occur with depression include poverty, adverse life circumstances (such as parent’s own experience of abuse), father’s absence, teenage parenting, stress, other mental health conditions, and lack of social supports. Depression rates for poor women are high regardless of race and ethnicity (CDC 2009; Knitzer et al. 2008; NRC and IOM 2009).⁴

Interrupting the Cycle

Many of the health problems that plague low-income parents can be treated. This is true of both medical and mental health problems, including depression. Various safe and effective treatments are available for depression in adults, including antidepressants, psychotherapy, behavioral therapy, and alternative medicine (CDC 2009; Knitzer et al. 2008; NRC and IOM 2009). Some evidence suggests that treating parental depression sufficiently to achieve remission improves children’s outcomes, while other evidence suggests that treating maternal depression alone might not be enough to improve child-mother interactions and that family-oriented strategies that focus on child-mother interactions while treating maternal depression offer more promise for improving children’s development (CDC 2009; NRC and IOM 2009).

Yet, most low-income parents with depression, even severe depression, do not get treatment. Among infants living in poverty with severely depressed mothers, only about 30 percent of mothers reported speaking with a psychiatrist, psychologist, doctor, or counselor in the past year about an emotional or psychological problem, leaving more than two-thirds who had not sought any of those types of help (Vericker et al. 2010). Reasons for this lack of treatment include lack of linguistically and culturally appropriate mental health services, stigma and distrust of mental health agencies, lack of trained providers, and lack of health insurance—specifically, insurance for mental health services (Clemans-Cope and Kenney 2007; Golden and Hawkins 2011; Kaiser Commission on Medicaid and the Uninsured 2010a; Knitzer et al. 2008; NRC and IOM 2009).

In addition, the lack of two-generational strategies that focus on child and parent together appears to constitute a major barrier to identifying, treating, and preventing maternal depression. Traditional interventions for depression focus on the individual and do not address the need for improving parenting and the child-parent relationship. The divide between children's and parents' eligibility for health coverage among low-income families further impedes treatment (CDC 2009; Knitzer et al. 2008; NRC and IOM 2009). In particular, under Medicaid and CHIP, many children have health coverage while their parents do not.

The Medicaid and CHIP Policy Framework

Medicaid provides acute and long-term care services to many low-income Americans, including children, parents, the disabled, and the elderly.⁵ The program is jointly financed by the federal government and the states, with the federal government funding between 50 and 76 cents of every dollar spent (Centers for Medicare and Medicaid Services 2010). After meeting federally mandated minimum standards on eligibility rules and covered benefits, states have broad latitude over the design of their Medicaid programs. As a result, eligibility rules, application processes, and delivery systems vary widely.

Medicaid covers a large share of low-income children and an even larger share of low-income young children. Among poor infants whose mothers are severely depressed, an important target group for two-generational interventions, more than four in five live in a home where someone (most likely the infant) receives Medicaid (Vericker et al. 2010). Thus, if Medicaid policies supported services to these families, the program could make a major difference.

The Children's Health Insurance Program (CHIP) was established in 1997 to provide health insurance coverage for children in families whose incomes were too high to qualify for Medicaid but who lacked access to affordable private health insurance. Though CHIP is an optional program, all states participate, and it now covers just under 5 million children (V. Smith et al. 2010). While few states cover parents through CHIP, many states cover pregnant women.

Differences between Child and Parent Eligibility

Other briefs in this series focused on Medicaid and CHIP policies affecting children. In this brief, we turn to the possibilities for parents to receive needed treatment. However, the Medicaid framework is far more restrictive for parents than for children, and CHIP in most states does not cover parents after pregnancy.

The Medicaid/CHIP framework for children features broad eligibility, with coverage through Medicaid or CHIP often available up to family incomes of 200 percent of the federal poverty level (FPL) or more, and a mandated federal benefit for Early and Periodic Screening, Treatment, and Diagnosis (EPSDT) under Medicaid (figure 1). This benefit covers any service that is medically necessary to promote a child's healthy physical, behavioral, and emotional development (Kenney and Pelletier 2010).

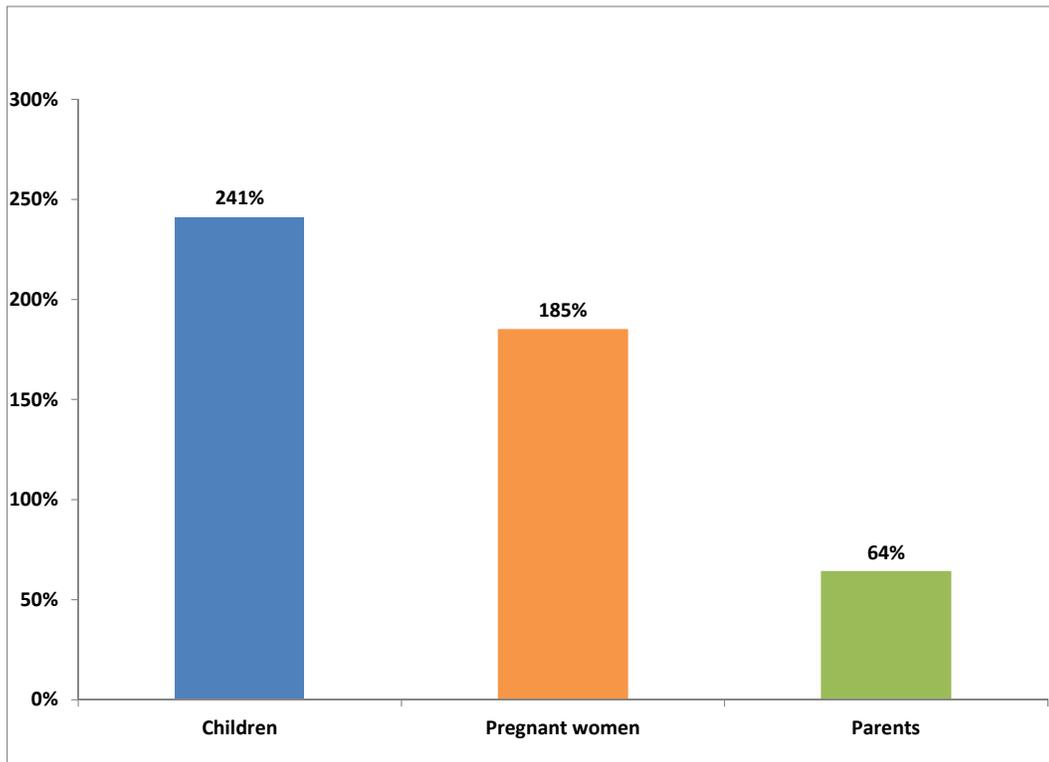
For parents, both eligibility and benefits are more restricted. The eligibility level in most states is sharply lower than for children, with pregnant women (covered until 60 days postpartum) somewhere in between. Benefits for adults are defined by the states, consistent with limited federal requirements.

Parents' Eligibility for Medicaid and CHIP

While children's health insurance coverage under Medicaid and CHIP has expanded dramatically, parents' eligibility remains far more limited, despite significant eligibility expansions in some states. Under Medicaid, pregnant women are generally covered to higher income levels than parents, but their eligibility ends 60 days after the baby is born. After that, eligibility for parents varies widely. States are required to cover pregnant women and parents to federal minimum levels but also have the option to expand eligibility to higher incomes.⁶ States also have the option to expand coverage for parents through waivers or state-funded programs (Kaiser Commission 2010a).

Another complicating factor is that almost 4 million children age 0 to 3 who are themselves U.S.-born citizens (and therefore eligible for Medicaid and CHIP) have parents who are authorized or unauthorized immigrants (Fortuny, Hernandez, and

Figure 1. Median Income Eligibility Threshold Levels as a Percentage of the Federal Poverty Level, January 2011



Sources: Henry J. Kaiser Family Foundation, State Health Facts: Income Eligibility Limits for Pregnant Women as a Percent of Federal Poverty Level, January 2011," <http://www.statehealthfacts.org/comparereport.jsp?rep=77&cat=4>; "State Health Facts: Income Eligibility Limits for Working Adults at Application as a Percent of the Federal Poverty Level by Scope of Benefit Package, January 2011," <http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4>; "State Health Facts: Income Eligibility Limits for Children's Regular Medicaid and Children's CHIP-Funded Medicaid Expansions as a Percent of Federal Poverty Level, January 2011," <http://www.statehealthfacts.org/comparereport.jsp?rep=76&cat=4>; and "State Health Facts: Income Eligibility Limits for Children's Separate CHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, January 2011," <http://www.statehealthfacts.org/comparemtable.jsp?ind=204&cat=4>.

Chaudry 2010).⁷ Therefore, another policy variable that affects two-generational services is whether parents' immigration status makes them ineligible for Medicaid and CHIP.

Noncitizen parents' access to Medicaid and CHIP services is complex. Under Medicaid, undocumented immigrants are only eligible for Emergency Medicaid, including coverage of labor and delivery. Lawfully residing immigrants who are not yet U.S. citizens are ineligible for Medicaid services during their first five years in the United States, with some exceptions (particularly for children and pregnant women) at state option (Fix, Capps, and Kaushal 2009; Fortuny and Chaudry forthcoming). In addition, a number of states provide some health services to lawfully residing immigrants with state-only funding (Fortuny and Chaudry forthcoming; National Immigration Law

Center 2010b). Health reform does not change the restrictions that immigrants face in Medicaid: states still have the option to cover legal immigrant children and pregnant women during the five-year ban, while undocumented immigrants remain ineligible (Fortuny and Chaudry forthcoming; Henry J. Kaiser Family Foundation 2010a).

Eligibility for pregnant women

The federal minimum eligibility for pregnant women is 133 percent of FPL, but many states have expanded coverage to women with higher family incomes. As of January 2011, 44 states and the District of Columbia have higher income thresholds, including up to 300 percent of FPL in the District of Columbia, Iowa, and Wisconsin (table 1, column A). Medicaid coverage for pregnant women, however, is provided only through

a 60-day postpartum period, so many new parents lose insurance coverage at a crucial time in their child's development (Rosenbaum et al. 2001).

Another special feature of Medicaid eligibility during pregnancy is presumptive eligibility. This means that for pregnant women (and children, but not other adults), states are authorized to create a system where women are eligible for Medicaid services (and the state is eligible for federal match for those services) from the time a state-designated provider (such as a maternal and child health clinic or a doctor's office) determines that women are income-eligible until the state agency determines their full eligibility (Broadus 2008).⁸ The purpose is to ensure that pregnant women receive health care as quickly as possible.

States also have two options for covering noncitizen pregnant women using federal matching funds under Medicaid and CHIP. Since 2009, states have been able to provide Medicaid/CHIP coverage with federal funding to lawfully residing immigrant children and pregnant women under the Children's Health Insurance Program Reauthorization Act of 2009, or CHIPRA (National Immigration Law Center 2010a.) Currently, 21 states and the District of Columbia provide Medicaid/CHIP coverage under CHIPRA to lawfully residing children and pregnant women, including during the five-year ban (Fortuny and Chaudry forthcoming). States can also cover immigrant pregnant women regardless of immigration status under a CHIP provision known as the unborn child option. Fourteen states have taken advantage of this option to provide prenatal care to immigrant women using federal funds (Fortuny and Chaudry forthcoming; Kaiser Commission 2009b).

Eligibility for parents

In contrast to coverage during pregnancy, parents' eligibility levels are much lower, with a median income eligibility of 64 percent of FPL for working parents.⁹ In 33 states, Medicaid eligibility is limited to less than 100 percent of FPL; in 16 of these states, eligibility is limited to less than 50 percent of FPL (table 1, column B).

The Benefit Package for Children

For children, Medicaid provides a comprehensive benefit package that covers any service deemed

medically necessary to promote a child's healthy physical, behavioral, and emotional development. This EPSDT benefit mandates as a matter of federal law that all children in Medicaid receive screenings and follow-up services to "correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services," not only to treat existing conditions but to prevent conditions from developing or worsening (Kenney and Pelletier 2010).¹⁰ The screenings must include a "comprehensive health and developmental history (including assessment of both physical and mental health development)." As part of this broad mandate, states are explicitly required to provide parents with "health education and counseling...designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices."¹¹

Just what parent-child or family-oriented services can be covered under this broad EPSDT benefit is not spelled out in HHS guidance or policy. However, one example of currently covered services is screening for family risks as part of the EPSDT comprehensive health and developmental history. In particular, several states are actively promoting parental screening for depression as part of a broad-based strategy to address the mental and socioemotional development of children (Knitzer et al. 2008). As of 2005, just four states—Illinois, Montana, Ohio, and Oklahoma—reimbursed pediatric providers for depression screening of mothers whose children were enrolled in Medicaid (Rosenthal and Kaye 2005).

States can also cover interventions, such as parental education and consultations for ineligible parents, under the child's EPSDT services as long as these services do not constitute treatment; few states, however, exercise this option (Rosenbaum et al. 2001). Although some states screen for parental depression as part of EPSDT, no state to our knowledge has sought to reimburse a broad range of services (such as dyadic therapy for parent and child) to reduce parental depression or to directly improve parenting or parent-child functioning in depressed mothers under the child's EPSDT benefit package. States may offer these services, but only for women who are themselves enrolled in Medicaid (Rosenthal and Kaye 2005).

Table 1. Income Eligibility for Medicaid/CHIP and State-Funded Coverage, Low-Income Pregnant Women and Working Parents, 2009

State	Income threshold (% of FPL)		State	Income threshold (% of FPL)	
	Pregnant women ^a	Working parents ^b		Pregnant women ^a	Working parents ^b
Alabama	133%	24%	Montana	150%	56%
Alaska	175%	81%	Nebraska	185%	58%
Arizona	150%	106%	Nevada	185%	88%
Arkansas	200%	17%	New Hampshire	185%	49%
California ^c	200%	106%	New Jersey	200%	133%
Colorado	250%	106%	New Mexico	235%	67%
Connecticut ^d	250%	191%	New York	200%	150%
Delaware	200%	120%	North Carolina	185%	49%
District of Columbia	300%	207%	North Dakota	133%	59%
Florida	185%	59%	Ohio	200%	90%
Georgia	200%	50%	Oklahoma	185%	53%
Hawaii ^e	185%	100%	Oregon ^k	185%	40%
Idaho	133%	39%	Pennsylvania	185%	46%
Illinois	200%	191%	Rhode Island	250%	181%
Indiana ^f	200%	36%	South Carolina	185%	93%
Iowa ^g	300%	83%	South Dakota	133%	52%
Kansas	150%	32%	Tennessee	185%	127%
Kentucky	185%	62%	Texas	185%	26%
Louisiana	200%	25%	Utah ^l	133%	44%
Maine ^h	200%	200%	Vermont ^m	200%	191%
Maryland	250%	116%	Virginia	133%	31%
Massachusetts ⁱ	200%	133%	Washington	185%	74%
Michigan	185%	64%	West Virginia	150%	33%
Minnesota ^j	275%	215%	Wisconsin	300%	200%
Mississippi	185%	44%	Wyoming	133%	52%
Missouri	185%	25%	United States	133%	

Sources: Henry J. Kaiser Family Foundation, “State Health Facts: Income Eligibility Limits for Pregnant Women as a Percent of Federal Poverty Level (FPL), January 2011,” <http://www.statehealthfacts.org/comparereport.jsp?rep=77&cat=4>; and “State Health Facts: Income Eligibility Limits for Working Adults at Application as a Percent of the Federal Poverty Level by Scope of Benefit Package, January 2011,” <http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4>.

Notes: Eligibility levels are shown as percent of the federal poverty level. The FPL for a family of three in 2010 was \$18,310 for the 48 contiguous states and District of Columbia, \$22,890 for Alaska, and \$21,060 for Hawaii.

a. Income thresholds for pregnant women for Medicaid (Title XIX) or the state’s CHIP-funded Medicaid expansion program (Title XXI). If the state covers pregnant women under Medicaid and CHIP, the higher of the income thresholds is displayed. Data are as of January 2011.

b. Income thresholds for working parents for Medicaid or Medicaid look-alike coverage. Income thresholds take earnings disregards, when applicable, into account. Computations are based on a family of three with one earner. Data are as of January 2011.

c. California provides coverage more limited than Medicaid up to 200% of FPL.

d. Connecticut provides coverage more limited than Medicaid up to 306% of FPL.

e. Hawaii provides coverage more limited than Medicaid up to 200% of FPL.

f. Indiana provides coverage more limited than Medicaid up to 200% of FPL.

g. Iowa provides coverage more limited than Medicaid up to 250% of FPL.

h. Maine provides coverage more limited than Medicaid up to 300% of FPL.

i. Massachusetts provides coverage more limited than Medicaid up to 300% of FPL.

j. Minnesota provides coverage more limited than Medicaid up to 275% of FPL.

k. Oregon provides coverage more limited than Medicaid up to 201% of FPL.

l. Utah provides coverage more limited than Medicaid up to 150% of FPL.

m. Vermont provides coverage more limited than Medicaid up to 300% of FPL.

In some limited circumstances and on a small scale, a few states provide family-oriented behavioral health services to support the child’s developmental needs. For example, Iowa has a small program that provides such services as parent training to parents of young children with specific diagnoses, such as failure to thrive. In addition, a pediatric primary care clinic in Denver has sought to support an integrated mental health program using several funding sources, including Medicaid billing for family visits using the American Medical Association health and behavior codes (Talmi et al. 2009).¹² These relatively new codes provide for assessment and intervention services, including to families, for addressing the child’s physical health and behavior problems and improving overall well-being. Colorado, Vermont, and Wisconsin are the three states we know use the codes under their state Medicaid programs (Wisconsin Department of Health and Family Services 2006).¹³

In addition to EPSDT, states may select Medicaid options that provide additional benefits for certain groups of children. Particularly relevant to family-oriented services, states may provide benefits including “family psychosocial education” to the families of children and youth with serious emotional disturbances (as well as mentally ill adults) under the rehabilitative services option (G. Smith et al. 2005).¹⁴

The Benefit Package for Adults

In contrast to the broad, nationally mandated benefit package for children, the Medicaid benefit package for adults varies by state. Within federally specified parameters, states have latitude in designing their Medicaid plans; as a result, benefits vary across states in optional services covered, duration, amount, and scope of services. States limit various services for adults to ensure appropriateness and, in some cases, to control costs; these limits also vary across states (Kaiser Commission 2010b).

Generally, states are required to cover federally specified services with the option of covering additional services.¹⁵ Mandated services include hospital care, physician services, lab and x-ray services, nursing home care, and family planning services. States can also cover optional services, including dental care and vision care, rehabilitative services, and home- and community-based services, but not all of them do (Henry J. Kaiser Family

Foundation 2010b; Kaiser Commission 2010b). Although optional, states can and all do cover prescription drugs.

Mental health benefits are not explicitly included in the federally specified services, but all states have chosen to cover mental health and most cover behavioral health (that is, substance abuse services). However, the framework for state coverage and the limits on the kinds and amount of services covered vary by state (Robinson et al. 2005).¹⁶ States can choose to cover mental health services either under the mandatory service categories (such as physician services), the optional services, or both. In practice, almost all states provide mental health benefits (except acute inpatient mental health care) under the optional services—in particular, the rehabilitation option—or under the home- and community-based service program waiver (Robinson et al. 2005).

Medicaid is now “the largest payer of mental health services in the United States” (Shirk 2008) and generally provides more comprehensive mental health benefits than private insurance (Rowland, Garfield, and Elias 2003). However, because of the complex ways in which different mental health services are funded within a state—as well as the variation in coverage, reimbursement, and benefit choices across states—it can be difficult even for experts to figure out how well the system is working or to describe how a particular state’s choices support or inhibit the delivery and quality of mental health services.

Recent reviews of mental health benefits have identified several key elements of the detailed Medicaid policy framework chosen by individual states that may substantially affect access to and quality of mental health services. Whether the effects in a given state are positive or negative may be difficult to tell without a detailed assessment, since each choice (for example, different approaches to managed care) may have advantages and disadvantages. These key elements of the policy framework include the following four:

State rules regarding the amount, scope, and duration of services. When states choose to provide a benefit, they must allow beneficiaries to receive services under that benefit that are “sufficient in amount, duration, and scope to reasonably achieve its purpose.” Within that framework, states may limit

(for example) the number of visits or prescriptions allowed in a period of time. In the mental health context, observers have identified state limitations that prevent sufficient services to the seriously mentally ill (Shirk 2008) and to people who would benefit from receiving mental health services in a doctor's office or other primary care setting (Mauch, Kautz, and Smith 2008). Providers may also find it difficult to bill for mental health services because of ambiguity about the right codes to use for diagnosis and treatment (Mauch et al. 2008). Lack of appropriate diagnostic codes is a particular problem in early childhood, affecting the ability to serve both children and parents and leading states to develop crosswalks between standard mental health diagnostic coding and pediatric classification systems (Zero to Three 2005).

Co-payments and other restrictions on prescription medication. Prescription medications used to treat mental health problems, including depression, can be expensive and in fact represent one of the fastest-growing portions of Medicaid spending. In response, states may restrict prescription drug benefits in various ways (for example, prior authorization requirements and limits on the number of drugs a beneficiary may receive), including increasing co-payments (Rowland et al. 2003; G. Smith et al. 2005).

Managed care arrangements. For the portion of the Medicaid population served through managed care arrangements, states have taken two approaches to providing mental health services (Shirk 2008). One approach is to “carve out” mental health from the regular managed care provider, so individuals who need mental health care get it either through another managed care provider or on a fee-for-service basis. The other is to have the same managed care provider cover both medical and mental health services.

Rules that affect ease of collaboration among providers. Mental health services are delivered by various providers with different credentials in different organizations. Collaboration among individual practitioners and among organizations may be important to delivering services effectively. As indicated in other briefs in this series, many state policy choices (such as whether to pay for care coordination/case management and whether to pay

for providers with different expertise to work in a team) affect collaboration.

Health Reform and Parents' Medicaid Eligibility

This policy landscape will change dramatically in 2014 as a result of health reform. Under the Affordable Care Act (ACA) of 2010, many low-income uninsured adults will become eligible for Medicaid or for subsidized health coverage through the new health benefit exchanges. As of January 1, 2014, states are required to expand Medicaid to all individuals under age 65 who are citizens or who meet the immigration requirements—children, parents, and adults without dependent children, with gross incomes up to 138 percent of FPL (Henry J. Kaiser Family Foundation 2010a).

Once health reform is implemented, ACA requires states to provide most newly eligible adults with benchmark benefits versus the traditional, full Medicaid benefit package (Henry J. Kaiser Family Foundation 2010b).¹⁷ ACA has also added a requirement that the benchmark package provide all “essential health benefits.” Essential health benefits include mental health services and behavioral health treatment, along with other services, such as transportation and family planning. Moreover, most low-income parents and pregnant women are to receive the full Medicaid benefit package.

State Policy Opportunities to Promote Two-Generational Services

Despite the importance to young children's development of identifying and treating mental health and medical conditions that impede parenting, many families that need these services do not receive them. The potential state policy choices that could enhance families' chances of receiving effective two-generational services are complex and poorly studied. Therefore, rather than try to cover every possible parental need, this brief concentrates as an illustrative example on just one, parental depression.¹⁸

Despite the risk to children and distress to parents, treatment rates for depression are extremely low. As indicated earlier, in one national sample, among babies whose mothers had severe depressive symptoms, fewer than a third of mothers reported talking to any doctor or counselor once in the past

year (Vericker et al. 2010). Access to treatment that meets standards for quality and continuity—treatment that lasts long enough, is consistent with the evidence, and provides support over time in case of relapse in what is often a chronic condition—is likely substantially lower. Even less prevalent is access to an array of services that treat the parent’s depression while also offering support for the parent-child relationship, most likely the most effective way to address the child’s healthy development (NRC and IOM 2009).

To address these problems, states can take a number of steps within today’s Medicaid/CHIP policy environment. According to some research, even if these steps have immediate costs for state Medicaid programs, increasing the number of parents treated for depression may produce offsetting cost savings. For example, mothers whose depression is under control are able to ensure that children receive regular asthma care and avoid expensive hospitalization (Perry 2008). Longer-term benefits, such as avoiding costly and damaging developmental problems for children, would presumably make expanded treatment even more advantageous.

However, little evidence exists about what state approaches to enhancing the Medicaid policy environment for depression treatment might work best. Therefore, the steps identified below are exploratory rather than proven. As states explore promising directions, collecting data to fine-tune the initial ideas is particularly important.

Increase Medicaid and CHIP Coverage among Eligible Parents of Young Children

Although Medicaid eligibility limits affect many parents, many others are eligible yet not enrolled. In 2008, Medicaid covered 13.3 million adults age 19 to 64, or 7 percent of all nonelderly adults (Holahan and Cook 2009). While these numbers represent a steady increase since 2000, as of 2007, an estimated 30 percent of uninsured parents were eligible for Medicaid/CHIP but not enrolled (Kenney, Haley, and Pelletier 2009). Therefore, a key step on the way to effective two-generational strategies is enrolling these eligible parents in Medicaid.

Build on knowledge gained from children’s enrollment to enroll eligible parents

Earlier briefs in this series reviewed the major steps states can take to enroll children who are Medicaid-eligible but not participating, and many of these steps likely apply to parents as well (Kenney and Pelletier 2010; Pelletier and Kenney 2010). These include outreach efforts to ensure that parents understand their eligibility, streamlined enrollment and retention processes, community partnerships, and cross-agency data sharing. For parents, a promising approach may be to direct outreach at the family—enrolling eligible children and parents together. Achieving high retention by reducing the burdens associated with renewal is also important (Kaiser Commission 2010a). In the context of young children’s development, parents’ continued enrollment over time likely matters, since treatment for problems such as depression should continue with a trusted provider rather than be episodic.

While states have taken measures to simplify the procedures for parents, barriers still remain. As of January 2009, 31 states, including the District of Columbia, use a single, simplified application for parents; 41 states, including the District of Columbia, do not require face-to-face interviews for parents; and 46 states do not require such an interview for renewal. In 40 states, including the District of Columbia, coverage is renewed annually versus more often (Ross and Marks 2009). On the other hand, enrollment barriers such as asset limits (which exclude many families with a savings account) and burdensome paperwork remain in place for parents but not children in more than half of states (Ross and Marks 2009).

Take full advantage of Medicaid and CHIP options to enroll pregnant women and link them to postpartum care

States could also explore taking full advantage of the period of Medicaid or CHIP eligibility that women may have during pregnancy to connect them to follow-up care—including mental health care if a review of personal and family history suggests risk—and to ongoing Medicaid eligibility. States could use care coordination and case management during pregnancy to help connect women to follow-up care and Medicaid enrollment. In Camden, New Jersey, a collaboration between Healthy Start (a maternal and child health grant program) and Medicaid uses

Healthy Start grant funds to provide case management for women identified during their pregnancy as at risk for depression and then refers them to behavioral health programs reimbursed by Medicaid (National Association of State Medicaid Directors 2008).¹⁹

Increase Receipt of Services by Medicaid-Eligible Parents

In practice, however, even parents who are Medicaid enrollees may not receive needed treatment for depression. While Medicaid benefits for mental health are generally comprehensive compared with private insurance, researchers have nonetheless identified many barriers to mental health treatment generally, to treatment for depression, and to treatment provided in an easily accessible primary care setting such as a clinic or doctor's office. Among these barriers are limitations on Medicaid reimbursement, which may unintentionally restrict mental health treatment generally and in primary care settings; lack of access to providers and specialists with the needed skills, including language and cultural competence; insufficient support (or even barriers) in Medicaid reimbursement for the teamwork among providers that may be required to serve low-income parents with depression; and the reluctance of parents to engage in mental health treatment for a cluster of reasons including stigma, distrust of counselors or of medication, fear of losing their children to the child protective system, and the many competing crises in their lives (Berman et al. 2002; Cunningham and O'Malley 2009; Kaiser Commission 2010b; Knitzer et al. 2008; Mauch et al. 2008; NRC and IOM 2009; Ross and Marks 2009; Zuckerman et al. 2004).

States have options for addressing all these barriers, at least to some degree. It will likely be necessary to tailor policy solutions for a particular state, since the rules governing Medicaid payment for mental health benefits—not to mention the ways these rules interact with family, community, and provider characteristics—differ from one state to the next.

Assess specific barriers to high-quality depression treatment

A first step to overcoming these barriers could be a state assessment that matches the evidence about high-quality treatment for depression with a careful

inventory of services available through the state's Medicaid plan and services actually delivered. Such an approach would describe what services should look like and what Medicaid is now supporting, pinpoint major gaps, and identify potential opportunities to bring actual services closer to desired services. Such a process is very similar to the approach recommended by the HHS handbook for states developing a Medicaid plan for services to the severely mentally ill: figure out the desired services, then design the mental health plan with specific provisions that will achieve that goal (G. Smith et al. 2005).

As part of this assessment, states could consider evidence about high-quality treatment for depression, including specific expert recommendations relating to pregnant women and parents. (So individual states do not have to design their own clinical framework, this would be a very helpful area for federal goal-setting and technical assistance.) Clinical recommendations that might have particular implications for Medicaid choices include the importance of building a strong doctor-patient relationship and coordinating care with other clinicians, the role of education for both the patient and the family, the need for clinicians to pay specific attention to treatment adherence—that is, to the reasons depression itself as well as other factors including “logistical, economic, or cultural barriers to treatment” may hinder a person's compliance with recommended treatment—and the importance of ongoing care and/or the opportunity to return easily to treatment in those cases where depression is chronic (American Psychiatric Association 2010; NRC and IOM 2009).

Target reimbursement, billing, and cost barriers

As states assess barriers to services needed to treat depressed mothers of young children, recent reviews of related mental health issues suggest that one area may be specific features of reimbursement, billing, and cost control policies that hinder effective care. One key area is Medicaid policies that affect the ability and willingness of primary care practices (such as doctors' offices or clinics) to offer mental health services. This is important for individuals with depression and other mental health problems, because offering mental health care in primary care settings has been found to effectively reduce stigma, decrease costs of care, and increase positive patient outcomes (for example, a family practice might

include a licensed clinical social worker or a psychologist as a team member). State policy obstacles related to Medicaid reimbursement practices include limitations on payments for same-day billing for both physical and mental health visits, lack of reimbursement for case management related to mental health services, lack of reimbursement for services provided by non-physicians such as social workers or psychologists, lack of incentives for screening and prevention, and lack of funding for primary care physicians' training (Mauch et al. 2008).

Some states that have attempted to address these barriers have reported progress (NASMD 2008). For example, Michigan revised its rules to allow Medicaid reimbursement for brief therapy visits in order to allow appropriate professionals “to provide behavioral health services as an adjunct to a medical visit when behavioral health issues are identified.” New Jersey has sought to improve collaboration through different initiatives, including Medicaid reimbursement for a range of providers including psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional counselors, nurse practitioners, advanced practice nurses, and psychiatrists. Responding to a study of the behavioral health care provided in primary care settings, Delaware focused on providing information to primary care providers and making improved collaboration a focus of its quality review activities and oversight in managed care. It reports improvements in the delivery of services and increased patient access to mental health providers (NASMD 2008).

Another possible area for states to review is their policies for prescription drug coverage, including prior authorization, co-payments, and other limitations. Because medication for mental health problems is expensive and getting more so, states may have an incentive to impose limitations. However, limitations may have unintended consequences; under some circumstances, they could get in the way of appropriate care or medication and potentially cost money in the long term, if they contribute to psychiatric hospitalizations that could otherwise be avoided (Cy et al. 2010; Goodell and Swartz 2010; Ross and Marks 2009; Rowland et al. 2003).

Support teamwork and collaboration among providers in serving families with depressed parents

Serving low-income adults with depression who are also parents of young children is likely to require collaboration among multiple service providers, such as the parent's doctor and mental health clinician (whether in the same practice or not), the child's pediatrician, and early childhood or family support providers who work with the family (such as a Head Start, Early Head Start, or child care program or a home visitor). While Medicaid likely will not support all the services such a vulnerable family would need, Medicaid benefits can be designed to support clinicians in coordinating their work with each other and can support case managers in building a relationship with the family, organizing and following up referrals, and helping the family with support services needed to access treatment, such as transportation. The brief in this series on care coordination and case management offers ideas about how Medicaid can best support these activities, which are even more crucial in this two-generational context (Hanlon 2010).

Enhance providers' availability, capacity, and skill

To enhance the availability and capacity of mental health providers, states should examine the adequacy of provider payments for mental health services; assess other factors that affect the availability of well-trained mental health specialists to Medicaid and CHIP participants; and design reimbursement, training, and quality improvement strategies targeted to the barriers they identify. Nationally, low provider payment rates and delays in payment contribute to problems with access to specialists, including mental health providers, in Medicaid (Cunningham and O'Malley 2009; Kaiser Commission 2010b). Access problems can be compounded for low-income parents because of the limited availability of providers with the needed skills who are available in a convenient neighborhood and who are culturally and linguistically competent (Clemans-Cope and Kenney 2007; Jacobs et al. 2004; Kaiser Commission 2010a).

We did not identify examples of states that have implemented broad-based reimbursement rate increases to enhance the availability of mental health specialists to Medicaid and CHIP recipients. As noted earlier, states have implemented reimbursement

improvements intended to make sure that mental health treatment can be billed in specific settings, such as primary care.

Beyond reimbursement rates, states may be able to improve provider capacity and skills for targeted services such as depression treatment using focused quality improvement strategies. For example, in practices randomly selected to take part in a quality improvement strategy to improve depression care (including training for nurses and psychotherapists and additional nurse resources, among other improvements), patients' receipt of appropriate care improved substantially within each ethnic group (Latino, African-American, white), and outcomes (reports of depression 6 and 12 months later) significantly improved for Latino and African American patients (Miranda et al. 2003).

Several examples of training have focused on improving the capacity of pediatricians and pediatric clinics that see many Medicaid children to address family mental health issues. One example of a model for training (as well as service delivery) developed in such a clinic is Project CLIMB (Consultation Liaison in Mental Health and Behavior), an integrated mental health program located in a pediatric primary care clinic and residency training center affiliated with a university medical school. Supported by several funding sources, including philanthropic support as well as Medicaid/CHIP (about 90 percent of the children are Medicaid/CHIP eligible), the program screens for maternal depression and then delivers mental health services in the well-child clinic; mental health clinicians provide direct mental health services and train pediatric residents to increase their skill and comfort level in discussing perinatal mental health issues with families (Talmi, Stafford, and Buchholz 2009). At the state level, Utah has provided supports to pediatric practices for screening and serving parents with depression, including conducting a learning collaborative (Kaye and Rosenthal 2008).

Design services to address stigma and trust issues

Even when services are available that could treat problems interfering with children's development, many factors influence parents' use of services. In the case of depression, a particular challenge is that the illness erodes parents' energy and hope for change and thereby hinders their access. In addition, child

care and transportation interact as barriers, since a parent with young children may need to ride several buses with several children in tow to reach appointments, and parents working in low-wage jobs who have appointments during working hours can lose their jobs or lose pay. Language and cultural competence can also hinder parents' ability to get an appointment, develop a relationship with a provider, and receive appropriate care (Clemans-Cope and Kenney 2007; Golden and Hawkins 2011; Kaiser Commission 2010a; Jacobs et al. 2004; NRC and IOM 2009).

Additional barriers, often grouped under a broad heading of "stigma," inhibit parents' willingness to accept mental health services. Parents may believe that they ought to be self-reliant and that only people who have failed or are deeply disturbed should seek treatment. They may fear the consequences of acknowledging a mental health problem, including the removal of a child by child welfare services. They may express concern about the reactions of their families, particularly their spouse or partner or, for young parents living with their own mother, the older generation. They may (based on experiences of their own or others) believe that mental health providers are condescending or judgmental, and they may believe that medication prescribed for depression or other mental health problems is damaging (Knitzer et al. 2008; NRC and IOM 2009).²⁰

Not a lot is known about the best Medicaid policy choices for addressing these barriers. Most likely, a successful approach will include reimbursement for activities by the clinical team that build the patient's trust and explain the treatment and medication to the patient at each step. For example, states may choose to cover medication education and management as part of a mental health plan under the rehabilitation services option, and they may choose to cover care coordination and case management in several ways (Hanlon, 2011; G. Smith et al. 2005). Removing the barriers to mental health treatment in primary care settings is another strategy, since it makes it possible for a parent to receive care in a convenient and trusted location. Building a partnership between home visitors who have a relationship with a family and in-home mental health services offers a variant on this approach worth considering for mothers with very young children (Ammerman et al. 2010; Golden and Hawkins 2011).

Another potential strategy builds on parents' commitment to their children's health to encourage them to take care of their own health. The ABCD maternal depression screening initiative, which seeks to create incentives and/or requirements for pediatricians' offices to screen mothers for depression when they see the baby for well-child visits, seeks to take advantage of this opportunity. Several ABCD states have chosen to reimburse the screening as part of the child's EPSDT benefit; other Medicaid adaptations that could help support this model include tailoring Medicaid reimbursement to support a team that includes mental health counseling for the parent and the child (such as a licensed clinical social worker) in the pediatrician's office.

Increase Receipt of Family-Based Services Needed to Protect Children's Development When Parents Are Ineligible for Medicaid

Even if states are effectively providing services to parents who qualify for Medicaid, however, many parents of Medicaid-eligible young children are not themselves eligible for Medicaid. For children who experience developmental risks as a result of a parent's depression or other family mental health issue, supporting healthy development requires identifying how families can get targeted services relevant to the specific risk. Three ways of enhancing Medicaid appear to have promise, though, again, none has extensive evidence at this point.

Provide two-generational services under the child's Medicaid, consistent with EPSDT

State Medicaid programs have some options to use the flexibility in EPSDT and other optional benefits to cover services that are necessary for an eligible child's development yet involve ineligible parents. However, few states are using such flexibility, and those that do are primarily covering maternal screening for depression, not parental, family, or dyadic interventions. This is the case even though states can cover interventions such as parental education and consultations for ineligible parents under the child's EPSDT services as long as those services do not constitute treatment (Rosenbaum et al. 2001). However, states may be uncertain about what activities would be viewed by the federal government as appropriate, in the absence of detailed guidance.

Illinois has mounted an active effort to enhance Medicaid's role in ensuring that parental issues hindering young children's development are addressed even when parents are ineligible. In the last few years, Illinois has developed a broad-based strategy and expanded efforts to address children's mental health and socioemotional development, stressing the importance of parental health and well-being, including passing legislation on perinatal mental health. In the state, Medicaid covers depression screening by primary care providers for mothers of all infants enrolled in Medicaid during the infant's well-child visit with the option of billing the child's Medicaid ID number if the mother is ineligible. Infants whose mothers are diagnosed with post-partum depression are eligible for Part C Early Intervention services (Rosenthal, Hanlon, and Hess 2008).

Iowa has also sought to take a broad approach to the needs of young children whose development is at risk for reasons related to family mental health. While there are many components to this approach and many funding sources, one component relates specifically to EPSDT. For young children who do not have a mental health diagnosis but have another diagnosed problem under EPSDT that could be influenced by family mental health issues (such as failure to thrive), Iowa offers a small parent program funded by the child's EPSDT benefit. The program offers parent training and is intended to provide support to the families and reduce stress and risk to the child.

Colorado and a few other states have started to reimburse for certain family-oriented services under Medicaid using the American Medical Association health and behavior codes (Wisconsin Department of Health and Family Services 2006).²¹ The health and behavior codes cover assessment and intervention services, including those provided to families, for addressing the child's physical health and behavior problems and improving overall well-being, and do not require a mental health diagnosis. Services billable under these codes cover a wide range of cognitive, behavioral, social and/or psychophysiological interventions to improve the child's health.²² Project CLIMB, described earlier, has used the health and behavior codes to provide family-oriented services in a pediatric primary care setting (Talmi et al. 2009).

Provide two-generational services under the child's Medicaid benefit using the rehabilitative services option for young children who have mental health diagnoses

For children with diagnosed mental health problems, states may also cover family-oriented services under the rehabilitative services option. Because many providers do not feel comfortable in their capacity to diagnose mental health problems in very young children, adopting this approach requires extensive provider training. As part of Iowa's plan to get services to young children whose development is endangered by family mental health issues, the state trained 200 providers—psychologists, nurse practitioners, licensed clinical social workers, and others who see these children and families—so they would be comfortable diagnosing young children. Once young children with significant problems are identified and receive a mental health diagnosis, the next step has been to ensure a trained pool of providers can provide effective treatment, including a family intervention. The treatment is intended to help the parent address the issues the child has been identified with, and it is reimbursable under the rehabilitated services option for children with severe emotional disturbance.

Use Medicaid funding for eligible families to expand home visiting programs, leveraging other home visiting funds to support parents who are not Medicaid-eligible

Home visiting offers considerable appeal as a way of getting comprehensive, family-oriented services to vulnerable families with young children, and there has been growing attention to its potential role in helping mothers with depression and other mental health needs (Ammerman et al. 2010; Boris et al. 2006; Golden and Hawkins 2011). Several states have used or plan to use Medicaid resources along with other funds to expand home visiting capacity. For example, Louisiana, Vermont, Pennsylvania, and Kentucky use Medicaid funding along with other funding sources (such as other state funds, Title V Maternal and Child Health funding, and federal human services funding such as TANF) to support nurse home visiting programs. In these states, Medicaid resources expand the reach of these programs to Medicaid-eligible families, allowing the other dollars to go further in reaching parents who are themselves ineligible. However, Medicaid's extensive data requirements and the restrictions of its fee-for-service model mean that

this approach does not work for every state or every program.²³

Conclusion

While clinicians and child development experts have demonstrated that certain parental and family problems, when untreated, pose great risks to a child's development, Medicaid/CHIP policy and reimbursement systems do not always facilitate service delivery to avert those risks. This brief has offered an overview of the barriers and three broad categories of solutions: enrolling more eligible parents in Medicaid, ensuring that eligible parents gain access to the treatment (particularly mental health treatment) they need, and increasing receipt of needed family services when parents of eligible children are ineligible for Medicaid.

Even if progress under today's framework is modest, however, developing a plan for the future could pay off when the Medicaid provisions of health reform are implemented in 2014. These provisions will dramatically change the policy landscape because expanded eligibility for low-income parents in 2014 greatly expands the ability of states to offer two-generational treatments. Specifically, under the 2014 Medicaid expansion to all U.S. citizens under age 65—children, pregnant women, parents, and adults without dependent children—with incomes up to 133 percent of FPL, millions of parents will likely gain Medicaid coverage. Between now and 2014, therefore, whatever early childhood leaders can do to support state Medicaid agencies in preparing for the effective implementation of the health care reform, increasing their administrative capacity, and improving efficiency will be helpful in enrolling as many newly eligible parents as possible.

ACA also includes immediate investments in home visiting programs and requires or authorizes other steps that could support high-quality care for depression. The home visiting initiative in the ACA, jointly administered by the Health Resources and Services Administration and the Administration for Children and Families, includes \$1.5 billion over the next five years to expand evidence-based home visiting services provided by states to pregnant women and mothers with young children. Home visiting, which as noted earlier can be supported by

Medicaid, can be used as part of a comprehensive strategy for addressing maternal depression (Ammerman et al. 2010; Golden and Hawkins 2011).

ACA also requires that core measures be developed to assess health care quality for children and adults. These measures might offer important opportunities to enhance depression treatment—for example, the adult measures include depression screening and effective management of medication to treat depression. However, the measures as currently proposed do not appear to link children’s and their mothers’ experiences—for example, depression screening is not tracked as part of postpartum care -- which may be an area for improvement (Agency for Healthcare Research and Quality 2010). Finally, other provisions authorized (but not necessarily funded) in the ACA include a network of national centers of excellence for depression care and a program of grants for research and services relating to postpartum depression.

Seizing the opportunity offered by ACA to leverage major improvement in young children’s development through two-generational strategies (such as treatment of parents’ depression) will not be automatic. As the evidence presented in this brief suggests, fully realizing the benefits for children and families will likely require state health and early childhood leaders to plan together toward a family-centered vision of health care. Without a shared vision and strategy, good intentions can unintentionally be sabotaged by the extraordinary complexities of the issue and the many different policy decisions and trade-offs—decisions about health and mental health benefits, reimbursement and billing, training and capacity of the workforce, collaboration among different providers, and others.

Yet the strong evidence that two-generational strategies can make an important difference to young children’s development suggests that state policymakers should seize the opportunity and work to overcome the challenges. Even if states feel unable to invest today, as they struggle with deep budget gaps and economic slowdowns, a strategy for family-focused services offers the opportunity to redirect resources more effectively in the future. State early childhood and health policy leaders who gain experience working together under today’s Medicaid

framework can draw on those relationships to make an even greater difference for families as health reform is implemented.

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About the Project

The four briefs in this series provide a common core of knowledge about how state Medicaid/CHIP policy choices affect young children's development, knowledge that can be shared among state Medicaid/CHIP policymakers and state early childhood policymakers and advocates. State Medicaid and CHIP decisions have a large impact on young children's healthy development, both because those programs serve so many young children and because the policy framework for Medicaid and CHIP offers the potential to address children's physical, social, emotional, and developmental health. Above all, the briefs intend to inform early childhood leaders and advocates so they can be at the table for these high-stakes policy decisions.

Young children's healthy development depends on far more than medical treatments for physical conditions, illnesses, and injuries. Health and early childhood fields understand that healthy development requires early identification of a variety of developmental issues, effective referrals to professional treatment services, ongoing involvement in navigating different services and supports, and responses to parents' health and behavioral health challenges and family stress. Each brief concentrates on one of these four areas: screening, professional referrals, care coordination, and two-generation approaches.¹

In each area, the federal-state policy framework for Medicaid and CHIP offers major opportunities to support effective child health systems that in turn can help communities, child health practitioners, and early childhood providers promote young children's healthy development. In these briefs, the Urban Institute seeks to identify the major opportunities and barriers, provide a summary of available research about promising approaches, and set the stage for more detailed state-by-state discussions.

The briefs are particularly timely because federal actions have provided new opportunities to states.

The recent CHIP reauthorization legislation and the new health reform legislation include important provisions that will affect children's health care access as well as the quality and coordination of health care. States' responsibilities to implement these laws also mean that many states are engaged in a range of major health policy decisions that could affect children and their families. For all these reasons, this is an important time for early childhood experts, policymakers, and advocates to engage in these discussions.

These briefs are one component of a project aimed at engaging early childhood leaders in state health policy decisionmaking. Because the health policy and financing issues that affect young children are so complex, data are so scarce, and states are so diverse, no series of short briefs can convey the full range of information. In addition, the Medicaid/CHIP and early childhood policy worlds have different frames of reference that are hard to bring together: different federal statutes and funding streams, professional backgrounds, even sometimes different languages. Therefore, the project includes three other components to enhance the potential partnerships and improve decisions:

- a federal memo, intended to identify for federal officials who oversee Medicaid and the HHS early childhood programs some of the issues and opportunities to promote more effective connections;
- webinars convened by the BUILD initiative to discuss the briefs with early childhood leaders; and
- targeted state discussions, led by the BUILD initiative, to bring state early childhood and Medicaid/CHIP leaders together in a small number of states.

¹ The National Academy of State Health Policy (NASHP) is the author of the care coordination brief, and experts from NASHP, the BUILD Initiative, and other experts in the field represented on the Institute's advisory board have provided invaluable comments on all the briefs.

References

- Agency for Healthcare Research and Quality. 2010. *National Advisory Council Subcommittee: Identifying Quality Measures for Medicaid-Eligible Adults—Background Report*. Rockville, MD: Agency for Healthcare Research and Quality.
- American Psychiatric Association. 2010. “Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition.” Washington, DC: American Psychiatric Association.
- Ammerman, R. T., F. W. Putnam, N. B. Bosse, A. R. Teeters, and J. B. Van Ginkel. 2010. “Maternal Depression in Home Visitation: A Systematic Review.” *Aggression and Violent Behavior* 15:191–200.
- Berman, Steve, Judith Dolins, Suk-fong Tang, and Beth Yudkowsky. 2002. “Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients.” *Pediatrics* 110(2): 239–48.
- Boris, N. W., J. A. Larrieu, P. D. Zeanah, G. A. Nagle, A. Steier, and P. McNeill. 2006. “The Process and Promise of Mental Health Augmentation of Nurse Home-Visiting Programs: Data from the Louisiana Nurse-Family Partnership.” *Infant Mental Health Journal* 27:26–40.
- Broadbudd, Elena Tyler. 2008. “Presumptive Eligibility for Pregnant Women.” Washington, DC: National Academy for State Health Policy.
- Center on the Developing Child at Harvard University. 2009. “Maternal Depression Can Undermine the Development of Young Children.” Working Paper 8. Cambridge, MA: Center on the Developing Child at Harvard University.
- Centers for Medicare and Medicaid Services. 2010. “CMS Financial Report: Fiscal Year 2010.” Baltimore, MD: U.S. Department of Health and Human Services.
- Clemans-Cope, Lisa, and Genevieve Kenney. 2007. “Low-Income Parent’s Reports of Communication Problems with Health Care Providers: Effects of Language and Insurance.” *Public Health Reports* 122:206–16.
- Cunningham, P. J., and A. S. O’Malley. 2009. “Do Reimbursement Delays Discourage Medicaid Participation by Physicians?” *Health Affairs* 28(1): w17–28.
- Cy, Lu, S. B. Soumerai, D. Ross-Degnan, F. Zhang, and A. S. Adams. 2010. “Unintended Impacts of a Medicaid Prior Authorization Policy on Access to Medications for Bipolar Illness.” *Med Care* 48(1): 1–3.
- Evans, Subhadra, Thomas R. Keenan, and Edward A. Shipton. 2007. “Psychosocial Adjustment and Physical Health of Children Living with Maternal Chronic Pain.” *Journal of Pediatrics and Child Health* 43:262–70.
- Fix, Michael, Randy Capps, and Neeraj Kaushal. 2009. “Immigrants and Welfare: Overview.” In *Immigrants and Welfare: The Impact of Welfare Reform on America’s Newcomers*, edited by Michael Fix (1–36). New York: Russell Sage Foundation.
- Fortuny, Karina, and Ajay Chaudry. Forthcoming. “Immigrant Access to Health and Human Services: Comprehensive Review of Existing Information.” Washington, DC: U.S. Department of Health and Human Services.
- Fortuny, Karina, Donald J. Hernandez, and Ajay Chaudry. 2010. “Young Children of Immigrants: The Leading Edge of America’s Future.” Washington, DC: The Urban Institute.
- Golden, Olivia, and Amelia Hawkins. 2011. “Home Visiting and Maternal Depression: Seizing the Opportunities to Help Mothers and Young Children.” Washington, DC: The Urban Institute.
- Goodell, Sarah, and Katherine Swartz. 2010. “Cost-Sharing: Effects on Spending and Outcomes.” Policy Brief 20. Princeton, NJ: Robert Wood Johnson Foundation.
- Hanlon, Carrie. 2010. “Improving the Lives of Young Children: Opportunities for Care Coordination and Case Management for Children Receiving Services for Developmental Delay.” Washington, DC: The Urban Institute.
- Henry J. Kaiser Family Foundation, The. 2010a. “Focus on Health Reform: Summary of New Health Reform Law.” Publication #8061. Menlo Park, CA: Henry J. Kaiser Family Foundation.
- . 2010b. “Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries.” Publication #8092. Menlo Park, CA: Henry J. Kaiser Family Foundation.
- Holahan, John, and Allison Cook. 2009. “Changes in Health Insurance Coverage, 2007–2008: Early Impact of the Recession” Publication #8004. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
- Jacobs, E., D. Shepard, J. Suaya, and E.-L. Stone. 2004. “Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services.” *American Journal of Public Health* 94(5): 866–69.
- Kaiser Commission on Medicaid and the Uninsured, The. 2009a. “Where Are States Today? Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults.” Publication #7993. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
- . 2009b. “New Federal Funding Available to Cover Immigrant Children and Pregnant Women.” Publication #7915. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
- . 2010a. “Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experiences.” Publication # 8087. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
- . 2010b. *Medicaid: A Primer. 2010. Key Information on Our Nation’s Health Coverage Program for Low-Income People*. Menlo Park, CA: Henry J. Kaiser Family Foundation.
- Kaye, Neva, and Jill Rosenthal. 2008. “Improving the Delivery of Health Care That Supports Young Children’s Healthy Mental Development: Update on Accomplishments and

- Lessons from a Five-State Consortium.” Washington, DC: National Academy for State Health Policy and The Commonwealth Fund.
- Kenney, Genevieve M., and Jennifer E. Pelletier. 2010. “Improving the Lives of Young Children: The Role of Developmental Screenings in Medicaid and CHIP.” Washington, DC: The Urban Institute.
- Kenney, Genevieve M., Jennifer M. Haley, and Jennifer E. Pelletier. 2009. “Covering Kids & Families® Evaluation. Health Care for the Uninsured: Low Income Parents’ Perceptions of Access and Quality.” Princeton, NJ: Robert Wood Johnson Foundation.
- Knitzer, J., S. Theberge, and K. Johnson. 2008. “Reducing Maternal Depression and Its Impact on Young Children: Toward a Responsive Early Childhood Policy Framework.” Project Thrive Issue Brief 2. New York: National Center for Children in Poverty.
- Loprest, Pamela, and Elaine Maag. 2009. “Disabilities among TANF Recipients: Evidence from the NHIS.” Washington, DC: The Urban Institute.
- Mauch, Danna, Cori Kautz, and Shelagh Smith. 2008. *Reimbursement of Mental Health Services in Primary Care Settings*. SMA-08-4324. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- McKay, Judy, Laura Shaver-Hast, Wendy Sharnoff, Mary Ellen Warren, and Harry Wright. 2009. “A Family Approach to Treatment of Postpartum Depression.” *Zero to Three* 29(5).
- Miranda, Jeanne, Joyce Y. Chung, Bonnie L. Green, Janice Krupnick, Juned Siddique, Dennis A. Revicki, and Tom Belin. 2003. “Treating Depression in Predominantly Low-Income Young Minority Women.” *Journal of the American Medical Association* 290(1): 57–65.
- National Association of State Medicaid Directors (NASMD). 2008. “Serving the Needs of Medicaid Enrollees with Integrated Behavioral Health Services in Safety Net Primary Care Settings.” Washington, DC: U.S. Department of Health and Human Services, Health Resources and Services Administration.
- National Immigration Law Center. 2010a. “Facts about Federal Funding for States to Provide Health Coverage to Immigrant Children and Pregnant Women.” Los Angeles: National Immigration Law Center.
- . 2010b. “Medical Assistance Programs for Immigrants in Various States.” Los Angeles: National Immigration Law Center. <http://www.nilc.org/pubs/guideupdates/med-services-for-imms-in-states-2010-07-28.pdf>.
- National Research Council and Institute of Medicine (NRC and IOM). Committee on Depression, Parenting Practices, and the Healthy Development of Children. 2009. *Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention*. Washington, DC: National Academies Press.
- Pelletier, Jennifer E., and Genevieve M. Kenney. 2010. “Improving the Lives of Young Children: Increasing Referrals and Follow-Up Treatment in Medicaid and CHIP.” Washington, DC: The Urban Institute.
- Perry, Cynthia D. 2008. “Does Treating Maternal Depression Improve Child Health Management? The Case of Pediatric Asthma.” *Journal of Health Economics* 27(1): 157–73.
- Robinson, Gail, Neva Kaye, David Bergman, Mirabelle Moreaux, and Caitly Baxter. 2005. “State Profiles of Mental Health and Substance Abuse Services in Medicaid.” Washington, DC: U.S. Department of Health and Human Services.
- Rosenbaum, Sara, Michelle Proser, Andy Schneider, and Colleen Sonosky. 2001. “Room to Grow: Promoting Child Development through Medicaid and CHIP.” New York: Commonwealth Fund.
- Rosenthal, Jill, and Neva Kaye. 2005. “State Approaches to Promoting Young Children’s Healthy Mental Development: A Survey of Medicaid, and Maternal and Child Health, and Mental Health Agencies.” Portland, ME: National Academy for State Health Policy.
- Rosenthal, Jill, Carrie Hanlon, and Catherine Hess. 2008. “The Role of State Health Policy in Multi-Sector System and Service Linkages for Young Children.” Portland, ME: National Academy for State Health Policy.
- Ross, Donna Cohen, and Caryn Marks. 2009. “Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009.” Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
- Rowland, Diane, Rachel Garfield, and Risa Elias. 2003. “Accomplishments and Challenges in Medicaid Mental Health.” *Health Affairs* 22(5): 73–83.
- Shirk, Cynthia. 2008. “Medicaid and Mental Health Services.” Background Paper 66. Washington, DC: National Health Policy Forum.
- Smith, Gary, Cille Kennedy, Sarah Knipper, and John O’Brien. 2005. “Using Medicaid to Support Working-Age Adults with Serious Mental Illnesses in the Community: A Handbook.” Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.
- Smith, Vernon, Dennis Roberts, David Rousseau, and Tanya Schwartz. 2010. “CHIP Enrollment June 2009: An Update on Current Enrollment and Policy Directions.” Washington, DC: Henry J. Kaiser Family Foundation.
- Talmi, Ayelet, Stafford, Brian, and Melissa Buchholz. 2009. “Providing Perinatal Mental Health Services in Pediatric Primary Care.” *Zero to Three* 29(5).
- Vericker, Tracy, Jennifer Ehrle Macomber, and Olivia Golden. 2010. “Infants of Depressed Mothers Living in Poverty: Opportunities to Identify and Serve.” Washington, DC: The Urban Institute.

Waylen, Andrea, and S. Stewart-Brown. 2010. "Factors Influencing Parenting in Early Childhood: A Prospective Longitudinal Study Focusing on Change." *Child: Care, Health, and Development* 36(2): 198–207.

Wisconsin Department of Health and Family Services. 2006. "Wisconsin Medicaid and BadgerCare Update: Wisconsin Medicaid Covers Health and Behavior Assessment and Intervention Services." Madison: Wisconsin Department of Health and Family Services. <http://www.integratedprimarycare.com/medicaid%20update%20about%20health%20and%20beh%20codes.pdf>.

Zero to Three. 2005. *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–3R)*. Revised ed. Washington, DC: Zero to Three Press.

Zuckerman, Stephen, Joshua McFeeters, Peter Cunningham, and Len Nichols. 2004. "Changes in Medicaid Physician Fees, 1998–2003: Implications for Physician Participation." *Health Affairs* W4-374–84.

Notes

¹ Coverage under Medicaid options specific to pregnancy ends 60 days after the birth, which is not enough time to treat some of the ongoing issues mothers may experience. However, the period of pregnancy can be used to begin treatment and identify follow-up options, funded by Medicaid when the mother is eligible and by other sources when not.

² Most studies on parental mental health have focused on depression, a common and universal public health problem that accounts for more disability worldwide than any other condition during the middle years of adulthood (NRC and IOM 2009).

³ This estimate uses a broad measure that includes activity limitations, work limitations, severe hearing or vision limitations with aids, emotional or mental limitations, cognitive or memory problems, and excessive alcohol use (Loprest and Maag 2009).

⁴ Prevalence rates are measured as clinical depression rates or depressive symptoms in different studies; research suggests that multiple depressive symptoms are equivalent to a major depressive disorder (Knutzer et al. 2008).

⁵ Other briefs in this series have also considered CHIP policy as a point of intervention for states (Hanlon 2010; Kenney and Pelletier 2010; Pelletier and Kenney 2010). Because CHIP does not generally cover parents, we do not cover CHIP policy levers as part of this brief. However, some approaches suggested for Medicaid in families where the child is eligible and the parent is ineligible could apply to CHIP as well. In addition, we mention CHIP policy choices that affect pregnant women.

⁶ States cannot cover childless adults under Medicaid under current federal rules. States can cover these adults if they obtain a waiver or create a fully state-funded program. As of 2009, less than half of states provide coverage to childless adults (Kaiser Commission 2009a).

⁷ Authors' tabulations of the 2007 and 2008 American Community Survey.

⁸ Also see the Henry J. Kaiser Family Foundation, "State Health Facts: Has Presumptive Eligibility for Medicaid and CHIP,

January 2011," <http://www.statehealthfacts.org/compare/table.jsp?cat=4&ind=229>; and Donna Cohen Ross, "Presumptive Eligibility for Children: A Promising New Strategy for Enrolling Uninsured Children in Medicaid," <http://www.cbpp.org/cms/index.cfm?fa=archivePage&id=presum.htm>.

⁹ See Kaiser Family Foundation, "State Health Facts: Income Eligibility Limits for Pregnant Women as a Percent of Federal Poverty Level, January 2011," <http://www.statehealthfacts.org/comparereport.jsp?rep=77&cat=4>; and "State Health Facts: Income Eligibility Limits for Working Adults at Application as a Percent of the Federal Poverty Level by Scope of Benefit Package, January 2011," <http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4>.

¹⁰ U.S. Department of Health and Human Services, Health Resources and Services Administration, "EPSDT Overview," <http://www.hrsa.gov/epsdt/overview.htm>.

¹¹ Centers for Medicare and Medicaid Services, "EPSDT Benefits," https://www.cms.gov/MedicaidEarlyPeriodicScrn/02_benefits.asp.

¹² Also see APA Practice Organization, "Update on the Health and Behavior Assessment and Intervention CPT® Codes," <http://www.apapracticecentral.org/reimbursement/billing/update.aspx>.

¹³ Also see APA Practice Organization, "Update on the Health and Behavior Assessment."

¹⁴ Gary Smith and colleagues focus on the use of the rehabilitative services option for working-age adults with mental illness, but they include a state example where the range of rehabilitative services is also available for seriously emotionally disturbed children. We have not been able to determine whether the range of services available for children under the rehabilitation option differs in any way from that available to adults.

¹⁵ With the Deficit Reduction Act of 2005, states were given the option to provide certain Medicaid beneficiaries with an alternative and limited benefit package (e.g., "benchmark" or "benchmark-equivalent coverage"). Only 10 states have used the benchmark coverage for some beneficiaries—for example, providing additional services to adults with special needs, such as heart disease and diabetes (Kaiser Family Foundation 2010b).

¹⁶ Also see Kaiser Family Foundation, "Medicaid Benefits: Online Database," <http://medicaidbenefits.kff.org/index.jsp>.

¹⁷ A recent HHS rule on benchmark coverage suggests that states will be able to provide newly eligible adults with the traditional, full Medicaid benefit package (Kaiser Family Foundation 2010b).

¹⁸ In addition, one author of this paper and other Urban Institute colleagues have been conducting interviews with service providers and focus groups with parents regarding service delivery for depressed parents of very young children, under a related project supported by the Doris Duke Charitable Foundation (see Golden and Hawkins 2011).

¹⁹ Also see Hanlon (2010) for additional suggestions about supporting care coordination and case management through Medicaid.

²⁰ Also see Golden and Hawkins (2011) for a summary of these and other themes as they emerged from six focus groups about depression among mothers of young children.

²¹ Also see APA Practice Organization, “Update on the Health and Behavior Assessment.”

²² See APA Practice Organization, “Update on the Health and Behavior Assessment”; and Jim Georgoulakis, “Proper Utilization of Health and Behavior Assessment Intervention Codes for Psychologists,” http://www.centerforhealthyaging.com/proper_utilization_of_health_and.htm.

²³ Analysis dated August 19, 2008, compiled by Karen Yarbrough of the Ounce of Prevention Fund and provided via e-mail on April 27, 2010.