Early Childhood Developmental Health Systems | EVIDENCE TO IMPACT CENTER

Ten Key Payment and Policy Improvements for Early Childhood Pediatric Transformation

Medicaid's comprehensive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for children guarantees a regular schedule of screenings, follow-up diagnostic services, and any medically necessary treatment to address physical, developmental, and behavioral or mental health concerns.[1] Prevention is essential, with care focused on addressing health concerns before they can develop or worsen. While EPSDT establishes a strong foundation for child health, states have considerable flexibility to design, implement, and finance EPSDT services.

This top ten list was originally developed for state- and community-level teams, known as Hubs, funded by the Transforming Pediatrics for Early Childhood (TPEC) program, which is designed to advance the delivery of early childhood development (ECD) services in pediatric practice settings.

TPEC Hubs identified the following policies as the most influential in supporting integrated care in pediatric primary care settings and enhancing developmental services available to young children and their families.

Most of the policies are featured in guidance issued by the Centers for Medicare & Medicaid Services (CMS).[2,3] State government agencies and other stakeholders can determine the steps needed to adopt and implement policies that will advance and sustain their own early childhood pediatric transformation efforts.

Ten Key Payment and Policy Improvements

1. **Age-Appropriate and Nonspecific Diagnosis Codes: Enable Use for Mental Health Services**

State Medicaid payment policies that cover developmentally appropriate and nonspecific codes are better able to support early identification, reduce obstacles to treatment, and align with best practices that emphasize prevention and early intervention. Age-appropriate DC:0-5 diagnosis and nonspecific codes help ensure that young children can access mental health treatment, even when a specific diagnosis has not been established, but the child exhibits behaviors, symptoms, or risk factors that may lead to a diagnosis if untreated.[4] Mental health diagnosis codes and their treatment should include Z and R codes, especially for young children. For example, R 62.50 developmental concern or Z 62.820 parent-child conflict can be supported with mental health treatment or dyadic care to prevent a mental health diagnosis and the need for more extensive treatment in the future.

2. Community Health Workers: Secure Medicaid Coverage

Community health workers (CHWs) have close relationships with the communities they serve and are a trusted link between families and the health care system, delivering a wide range of services, including health promotion, care coordination, patient advocacy, and other services central to families' health and well-being. CHWs are uniquely positioned to help Medicaid enrollees increase the appropriate use of primary and preventive care, contributing to improved health outcomes, cost savings, and patient and provider satisfaction. Medicaid payment may be available through several pathways, including state plan amendments (SPAs), Section 1115 waivers, or Medicaid managed care contracts. A "Preventive Services SPA," which leverages the state's authority to allow non-licensed providers (i.e., CHWs) to deliver preventive services recommended by licensed practitioners, may be particularly useful in the pediatric care context given EPSDT's focus on screening and prevention.[5]

TPEC Hub Examples:

- **Established payment for certified CHWs through an Arkansas house bill**, and a Section 1115 waiver that supports CHW workforce development under its LIFE360 HOME Program, provides intensive care coordination to at-risk families. [6,7]
- **Established reimbursement through a Medicaid SPA in Oregon** includes an extensive program for traditional health workers and requires that coordinated care organizations integrate them within care teams.[8]

3. Community Reinvestment: Outline Commitments in Medicaid Managed Care Contracts

Increasingly, state Medicaid agencies are requiring Medicaid managed care organizations (MCOs) to reinvest saved dollars in the communities they serve to improve health. Such requirements provide an opportunity to boost funding in key priority areas, including strategies that address social needs or enrich primary care services. States generally use one of two approaches to determine the amount of funding MCOs must reinvest: (1) require MCOs to reinvest a percentage of annual profits or (2) require MCOs that do not meet the state-specified Medical Loss Ratio (MLR), which reflects the proportion of total per-member payments the MCO receives in a year, to spend on clinical care and quality improvement.

TPEC Hub Example:

- **Community reinvestment funds in Oregon** must use savings to support activities that fall within the following child development domains: economic stability, neighborhood and built environment, education, and social and community health. A portion of community reinvestment funds must also be used on housing-related services and support. Oregon's coordinated care organizations must contribute a percentage of average adjusted net income, 10% of dividends recorded or similar payments, or both to shareholders. The final amount is determined by a formula established by the state.[9]

4. Family Intervention: Cover Dyadic Care for Young Children

Unlike older children who can receive individual behavioral health interventions, young children require dyadic care with their adult caregivers. Infants and toddlers develop through relationships with their caregivers and begin developing self-regulation skills from 3 to 6 years old. State health plans should ensure that dyadic care billing codes are accepted by updating policies to create an SPA. States that are developing these policies should specify who can deliver this care and provide a clause that allows for dyadic care, without the child in some instances.

TPEC Hub Examples:

- **California** was among the first to create and use new dyadic care codes.[10]
- The Medicaid offices in **Massachusetts** allowed group and family therapy codes for Medicaid members under 21.[11]

5. Integrated Care: Expand Value-Based Payment Strategies

Value-based payment (VBP) is a financing model that rewards providers for delivering high-quality coordinated care that achieves desired results, rather than for the volume of services delivered. It supports holistic, family-centered approaches by positioning payments with health and developmental outcomes. Integrated care models are likely to be more effective under a VBP model, since traditional fee-for-service systems generally do not adequately support the collaboration and flexibility required by integrated care.

TPEC Hub Examples:

- Arkansas,[12] Maryland,[13] and New Jersey[14] have made greater progress toward financial sustainability with enhanced payment rates for early childhood integrated care. Others have used Medicaid 1115 waivers to restructure their payment systems to expand VBP.
- In Massachusetts, providers are paid through shared savings for meeting standards for access and team-based, integrated care.[15]

6. Payment Parity: Set Standard Rates for Integrated Mental Health Providers

Payment parity is required by law, but some states still have different payment rates by provider type and not by the services provided. This creates complications when staffing and maintaining an integrated care workforce, because integrated mental health care can be provided by many provider types (e.g., counselors, social workers, therapists, psychologists).

TPEC Hub Example:

- New Jersey passed legislation for payment parity by provider type to reduce coverage gaps. Under this law, health insurers must offer coverage for mental health and substance use disorder treatments under the same terms and conditions as they do for other illnesses.

7. Pediatric Prenatal Visit: Increase Coverage and Access

Bright Futures recommends a pediatric prenatal visit for health supervision, and the American Academy of Pediatrics (AAP) provides guidance for the visit in a clinical report.[16] While Medicaid covers the adult caregiver payment for the child's benefit, coverage of this visit is challenging when states do not intentionally outline it in their Medicaid policies, yet it is covered by law as part of their EPSDT benefit in the 37+ states that align EPSDT to Bright Futures. This is an opportunity to increase awareness, education, and clarity among providers about billing and

improve Medicaid billing guidance on how to bill for this visit to increase access and use of this important health visit.

8. Primary Care Consultation: Increase Use of Mental Health and Child Care Health Consultants

States should align with EPSDT and CMS guidance by allowing Medicaid to cover interprofessional consultation between pediatric primary care clinicians and other specialists (e.g., mental health, obstetrics and gynecology).[17] With this approach, practices can finance integrated behavioral health within their setting. Many states pay for this as a distinct service, starting at 5 minutes of consultation and allowing for brief interventions with behavioral health practitioners.

9. Primary Care Autism Diagnosis: Authorize Clinical Diagnosis and Treatment

Some, but not all, states offer payment coverage that allows general pediatricians and specialists to diagnose autism spectrum disorder clinically, providing timely access to services, such as applied behavior analysis (ABA), speech and language, and occupational therapy. Many states also cover the cost of training primary care clinicians to receive appropriate knowledge and skills needed to make diagnoses in the clinic (e.g., CARS, RITA-T). This was recommended by AAP in a 2020 clinical report as it can improve access to early diagnosis and treatment, and in a corresponding 2024 letter issued by AAP to private payers to cover primary care diagnosis.[18]

10. Same-Day Billing: Remove Prohibition for Primary Care and Mental Health

Despite CMS authorizing states to remove same-day billing exclusions, some states experience challenges in which providers can only bill Medicaid once per day per patient. This prevents payment for integrated care when a mental health provider participates in the well-child visit or has an additional health assessment or psychotherapy visit on the same day. Same-day exclusions should be eliminated from state Medicaid policies as detailed in a policy brief developed by the California Children's Trust.[19]

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