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ISSUE BRIEF

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LEVERAGING THE CCBHC MODEL TO ADDRESS INFANT AND EARLY CHILDHOOD MENTAL HEALTH IN KANSAS

Introduction

The years from birth to age five are critical for a child's development, with rapid brain growth and increased neural connections laying the groundwork for cognitive, emotional and social skills that last into adulthood. Often referred to as the "critical window," this period is marked by opportunities to influence a child's future well-being through early and targeted support. During these formative years, the brain is particularly responsive to positive experiences, which can be enhanced by nurturing environments, secure attachments and supportive community networks.

In Kansas, there has been progress in recognizing the importance of infant and early childhood mental health (IECMH) and expanding access to services for young children and their families. A variety of partnerships have played a pivotal role in promoting these advancements, with public agencies, health care practitioners and community organizations working collaboratively to prioritize preventive and holistic approaches. These collective efforts have fostered greater awareness of the need to integrate IECMH practices, leading to policy changes and increased advocacy among practitioners, educators and policymakers.

Infant and Early Childhood Mental Health (IECMH) Definition:

The ability for children to establish strong and secure bonds with peers and adults, navigate and regulate an array of emotions, and engage in exploration and learning in their family, community and cultural setting during the first five years of life.

Source: ZERO TO THREE.

KEY POINTS

- ✓ The Certified Community Behavioral Health Clinic (CCBHC) model offers a comprehensive approach to mental health services that can be leveraged to provide timely and effective support for children and families.
- ✓ The early years, from birth to age five, are critical for a child's development and lay the foundation for cognitive, emotional and social skills that last into adulthood.
- ✓ Addressing policy and practice challenges with providing infant and early childhood mental health services is essential for ensuring equitable and continuous access to early intervention and other mental health services and supports for infants, young children and their families.
- ✓ Strategies to elevate and enhance the delivery of infant and early childhood mental health services include leveraging Medicaid policy and reimbursement options, using age-appropriate diagnostic criteria, strengthening referral networks and expanding workforce capacity.

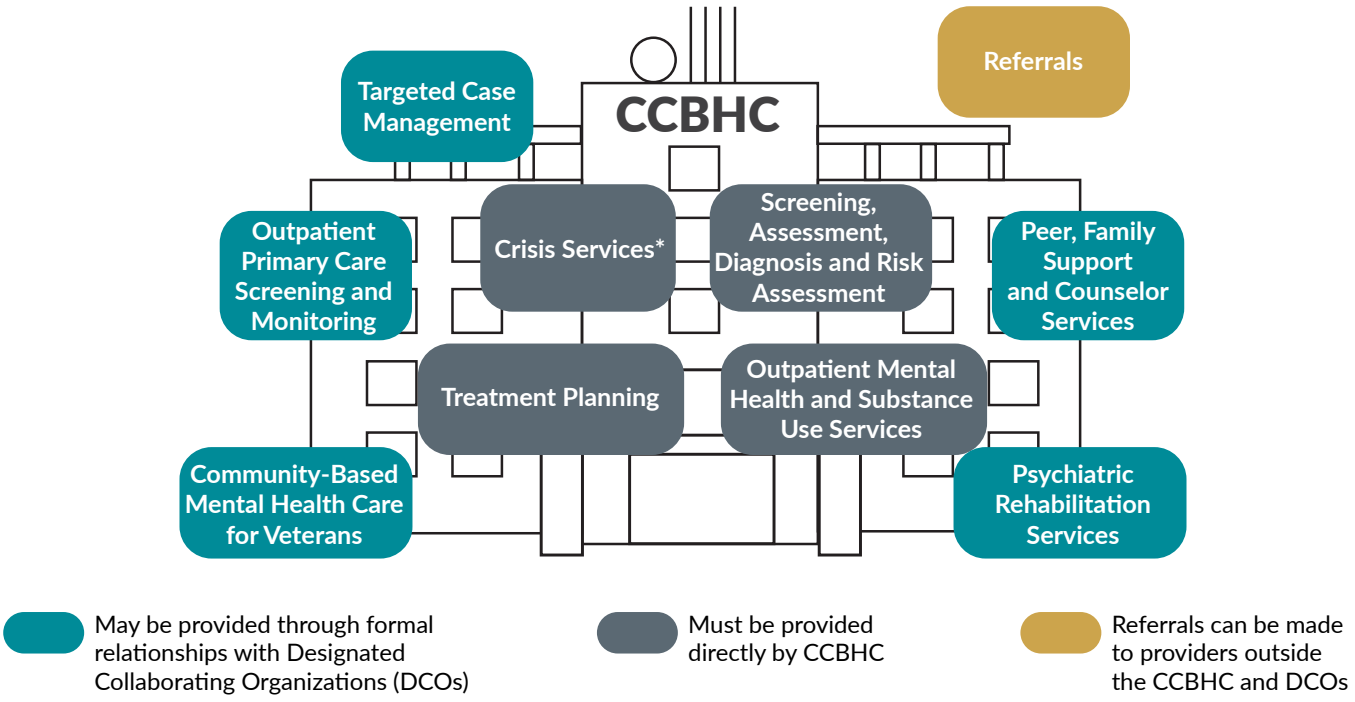
However, challenges remain in ensuring equitable access to mental health services for young children and their families across the state. The Certified Community Behavioral Health Clinic (CCBHC) model presents a framework to address these gaps, emphasizing comprehensive, person-centered care through strategic partnerships, workforce development and targeted interventions. Kansas has an opportunity to strengthen its system for delivering early childhood mental health services, leveraging the model's services and payment structure to ensure that all children and families can benefit from timely and effective support.

What is the CCBHC Model?

The CCBHC model was developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS) as an outpatient model that integrates care coordination. CCBHCs are required to provide nine services directly or through a formal relationship with a designated collaborating organization (*Figure 1*): crisis services; outpatient mental health and substance use services; person- and family-centered treatment planning; community-based mental health care for veterans; peer family support and counselor services; targeted case management; outpatient primary care screening and monitoring; psychiatric rehabilitation services; and screening, assessment, diagnosis and risk assessment. Of the nine required services, CCBHCs must directly provide at least three — screening, assessment, diagnosis and risk assessment; patient-centered treatment planning; and outpatient mental health and substance use services.

The model uses a prospective payment system (PPS) for Medicaid beneficiaries, which establishes Medicaid payment based on predetermined rates, regardless of the quantity or intensity of services provided. A PPS can be applied daily or monthly, with a monthly PPS resembling value-based payment models — incentivizing efficient care delivery and risk management, with rates adjusted based on patient complexity. States have flexibility in defining CCBHC requirements, setting rates through cost-reporting processes and tailoring services to their populations.

Figure 1. **Required Services for Certified Community Behavioral Health Clinics (CCBHCs)**



*"Unless there is an existing state-sanctioned, certified or licensed system or network for the provision of crisis behavioral health services that dictates otherwise."
Source: CCBHC Information for Providers, Kansas Department for Aging and Disability Services. Accessed on May 16, 2024, from https://www.kdads.ks.gov/services-programs/behavioral-health/certified-community-behavioral-health-clinics/for-providers.

CCBHCs in Kansas

Established in Kansas through the passage of Senate Substitute for House Bill 2208 in 2021, CCBHCs are an opportunity to improve the behavioral health of Kansans through increased access to mental health and substance use disorder services, integrated behavioral and physical health care and consistent use of evidence-based practices. Overseen by the Kansas Department for Aging and Disability Services (KDADS) and the Medicaid program at the Kansas Department of Health and Environment (KDHE), CCBHCs conduct community needs assessments to inform services, emphasizing person-centered, family-centered, trauma-informed and recovery-oriented care. They provide services regardless of ability to pay, insurance status or where someone lives. Kansas utilizes a daily PPS model, meaning only one qualifying encounter will be reimbursed per patient per day, no matter how many services are provided within that day.

A key strength of the CCBHC network is its ability to provide services across the entire state, ensuring that children and families residing in rural or underserved areas have access to needed services. The 26 community mental health centers (CMHCs) covering all 105 Kansas counties have become provisionally certified as CCBHCs, but not all are fully certified to the model criteria yet. Following the passage of House Bill 2784 in the 2024 legislative session, any community mental health center or qualified nonprofit provider that meets the criteria may apply for CCBHC certification beginning Feb. 1, 2027.

CCBHCs act as central hubs, coordinating care and linking families to a wide range of services that extend beyond behavioral health, including early intervention programs, pediatric care, home visiting services, IECMH consultation and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). This comprehensive, community-centered approach is particularly beneficial for children birth to age 5 who may need multidisciplinary support. By offering a single point of entry, CCBHCs streamline access to multiple services, fostering smoother hand-offs and reducing barriers for families.

Medicaid Considerations

Medicaid, as the largest payer for mental health services in the United States, plays a pivotal role in facilitating access to care within the CCBHC model. Kansas' recent selection as a Medicaid demonstration state for the CCBHC model further strengthens this role, providing an opportunity to expand and innovate. The current available Medicaid billing codes and adequacy of Medicaid reimbursement rates under this demonstration will impact the capacity of a CCBHC to provide comprehensive mental health care to young children.

Recommendations to address behavioral health challenges through Medicaid

The Centers for Medicare and Medicaid Services (CMS) released guidance in 2022 on how to address several challenges and leverage Medicaid, the Children's Health Insurance Program (CHIP) and other federal programs to deliver behavioral health services.

Select recommendations from this guidance are highlighted in the following sections of this brief.

Early and Periodic Screening, Diagnostic, and Treatment

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive preventive and therapeutic services, including mental health screenings and treatment, for all children, birth to age 21, who have Medicaid coverage. EPSDT is a federally mandated benefit. In Kansas, EPSDT services for Medicaid-eligible children include regular health screenings, diagnostics and treatments to address any identified conditions, such as vision, dental and hearing care through the program KanBeHealthy.

KanBeHealthy also allows for reimbursement for maternal depression screenings within certain

guidelines under an infant's Medicaid ID, which can play a crucial role in supporting the mental health of both the child and the mother. While EPSDT services are typically provided by primary care practitioners or local health departments, CCBHCs are uniquely positioned to leverage this benefit to deliver a wide range of services tailored to the developmental and mental health needs of young children and families, such as early intervention programs, trauma-informed care, dyadic therapy and school-based mental health services. EPSDT services are not covered under the daily PPS rate for CCBHCs, so these services can be billed separately.

If a child's health care provider determines a service is medically necessary, the state is required to arrange for its delivery under the EPSDT benefit, even if the service is not listed in the state plan. However, the unique developmental and mental health needs of young children may not always be fully addressed under standard medical necessity criteria. For example, the KanCare EPSDT Medical Necessity Form for non-covered services requires a diagnosis related to the request, as do many mental health services offered by CCBHCs. This can create challenges, as traditional criteria may not fully account for the complexities of IECMH. KanCare Managed Care Organizations (MCOs) are required to cover EPSDT services; however, MCOs make determinations on whether medical necessity is met based on individual circumstances. Kansas has an opportunity to make this process less subjective by including specific language in MCO contracts or within KanBeHealthy policies to expand medical necessity criteria, such as not requiring a diagnosis to access EPSDT services. Current state contracts and federal law require that at least 80 percent of Medicaid beneficiaries under age 21 have EPSDT screenings. CMS has provided additional guidance regarding best practices for providing EPSDT services.

CMS Recommendation to States: *Avoid requiring a behavioral health diagnosis for the provision of EPSDT services. States can determine that some services are medically necessary for children and youth without a diagnosed behavioral health condition.*

Developmental Screenings

Developmental screenings are a key component of the EPSDT benefit package and are also part of the Child Core Set Quality Measures. States are now required to collect data and report to CMS on the full range of these measures. By utilizing the EPSDT benefit to provide screenings such as the Ages and Stages Questionnaires, Pediatric Symptom Checklist and Batelle Developmental Inventory Screening Tool, CCBHCs not only ensure early interventions but also support state efforts in meeting federal quality reporting requirements.

CMS Recommendation to States: *Increase access to behavioral health screenings by incorporating age-appropriate, evidence-based behavioral health and developmental screenings into well-child examinations.*

Medical necessity in Kansas refers to a health intervention that:

- Is recommended by the treating physician and is determined to be necessary by the secretary or secretary's designee.
- Has the purpose of treating a medical condition.
- Provides the most appropriate supply or level of service, considering benefits and harms to the patient.
- Is known to be effective in improving health outcomes.
- Is cost-effective for the condition compared to alternative interventions.

Postpartum Coverage Extension

Kansas extended Medicaid coverage for enrolled pregnant women from 60 days to 12 months postpartum in 2022, impacting an estimated 7,000 postpartum women annually. The extension, made possible by a new state plan opportunity through the American Rescue Plan Act, supports screening, enhanced use of case management and treatment of behavioral health issues. CMS offers technical assistance to help states improve the quality, access and equity of postpartum care. Separate billing and policy guidance are available for CCBHCs and non-CCBHC settings such as clinics, mental health providers and physicians. For CCBHCs, this extension means an increased demand for services tailored to pregnant and postpartum individuals, including caregiver depression screenings, counseling and support services. Extending this coverage benefits children by increasing the likelihood their mothers receive consistent care during the critical first year of development, contributing to the crucial development of secure attachment between child and caregiver. A mother receiving services also may bring their child with them to appointments, offering another opportunity for providers to identify developmental delays or issues within the family system. However, families may face challenges if the mother does not qualify for Medicaid after the 12-month extension or at any future point. In such cases, CCBHCs can play a pivotal role in continuation of care, as they are required to provide services regardless of ability to pay — the same as when they operated as CMHCs.

Dyadic Treatment and Reimbursement

Dyadic treatment is a therapeutic approach where the infant or young child and their caregiver are treated together. This method includes coaching caregivers to encourage positive interactions that can help improve parenting, strengthen the dyadic relationship and positively influence the child's behavior. In Kansas, several organizations, including KidsTLC, TFI and the University of Kansas Health System, provide dyadic therapy through a parent-child interaction therapy model. Kansas Medicaid offers family psychotherapy codes that allow for billing treatment with or without the patient, which may enable CCBHCs to address similar dyadic treatment methods. For example, under EPSDT, dyadic treatment may be covered if the child is eligible, even if the caregiver is not.

Evidence-based home-visiting models, such as Attachment and Biobehavioral Catch-Up, could also be considered dyadic care models. These programs provide support directly in the home environment, helping caregivers foster secure attachments and promote healthy child development.

Integrating such models into IECMH services could further strengthen family-focused interventions. Group-based parenting programs also can play a role in addressing IECMH by educating and supporting parents in nurturing healthy parent-child relationships within a peer environment. However, these programs that foster social and emotional development are not currently included in the Kansas Medicaid fee schedule, representing an area for potential expansion for instances where services are not covered under medical necessity criteria.

Strategies for Enhancing IECMH in CCBHCs

Referral Networks

While CCBHCs are required to provide certain services directly — crisis services; outpatient mental health and substance use services; treatment planning; and screening, assessment, diagnosis and risk assessment — other services can be provided via referrals. A key strategy for enhancing IECMH services through the CCBHC model is to build and strengthen community partnerships and referral networks. Kansas faces challenges in ensuring that services are accessible across the state, particularly in rural areas. To address these gaps, CCBHCs can leverage their role as central hubs to establish robust referral networks. This involves collaborating with community organizations, early childhood education centers, home visiting programs, primary care practitioners and other stakeholders to create a seamless system of care. Establishing a "referral champion" within the CCBHC can help advocate and provide outreach services for IECMH, ensuring practitioners are aware of the available resources. By fostering partnerships with organizations such as IDEA Part C agencies, Kansas Association for Infant and Early Childhood Mental Health (KAIMH) and early childhood educators, CCBHCs can enhance their capacity to identify and address behavioral health needs in young children and families.

Examples of CCBHC Referral Partners:

- Education and human service agencies that provide the Individuals With Disabilities Education Act (IDEA) Part C program.
- Home Visiting Programs (Parents as Teachers; Maternal, Infant and Early Childhood Home Visiting Program).
- Primary Care Practitioners, Pediatricians and Family Practice Physicians.
- Behavioral health providers (e.g., play therapists, private practice).
- Local Health Departments.
- Federally Qualified Health Centers (FQHCs).
- Kansas Association for Infant and Early Childhood Mental Health.
- Early Childhood Educators.
- Court System (foster care and juvenile justice).
- KSKidsMAP at the University of Kansas Medical Center.
- Kansas Connecting Communities.
- ZERO TO THREE.

It is important to acknowledge that each community has unique needs and available resources that inform the local IECMH landscape. When all stakeholders are working together, it is easier to identify gaps in service, areas that lack funding, areas where policies can be improved and workforce development needs.

CMS Recommendation to States: *Develop referral networks of mental health and substance use disorder providers, including through improved connections and data-sharing capabilities linking non-specialty health care providers and community organizations with mental health and substance use disorder providers.*

Expanding Workforce Capacities

The IECMH workforce consists of various professions, including mental health clinicians, child and family advocates, public health professionals, prenatal/perinatal health care providers, home visitors, early childhood educators, primary care practitioners and early childhood and parent educators. In Kansas, like many states, there are shortages in several of these fields, including mental health clinicians, early childhood educators and primary care physicians. This shortage is especially pronounced for mental health professionals with specialized training in early childhood development. Few educational programs offer specific training in infant and early childhood mental health, resulting in a limited number of qualified practitioners. For instance, a survey of IECMH clinicians in Washington found that 42 percent lacked specialized training in IECMH foundations, and 75 percent reported no training in evidence-based practices for working with young children and families. Even in areas where trained professionals are available, timely access can be restricted. In Kansas, 96 out of 105 counties are designated by the Health Resources and Services Administration as mental health professional shortage areas, leaving primary care providers to fill gaps.

Expanding Capacity in Other Care Professions

Addressing the workforce shortage requires innovative strategies that extend beyond traditional mental health roles. By expanding training opportunities for professionals, such as early childhood educators, home visitors and community health workers, Kansas can enhance the capacities of these professionals to identify early signs of mental health concerns and connect families with services. Providing specialized training in IECMH frameworks, assessment tools and intervention strategies to these frontline professionals, who already have established relationships with families, will not only fill the gaps but also foster more integrated and collaborative care models. This approach strengthens partnerships with CCBHCs, ensuring seamless referral pathways and coordinating care, enabling all providers to work effectively with young children and their families.

CMS Recommendation to States: *Recognize an array of providers who together can maximize beneficiary access to needed behavioral health services, including school-based providers.*

Rethinking Training and Licensure Requirements

To further address workforce shortages, CCBHCs can explore alternative training and licensure

models that maintain high standards while broadening the pool of qualified professionals. For example, offering on-the-job training for new hires in certain roles could reduce the need for advanced degrees, while increasing the use of non-clinical roles to handle administrative duties can free up clinical staff to practice at the top of their license. Coordinating with regulatory agencies to adjust educational and vocational requirements, where appropriate, also can help ensure that qualifications align with the real-world demands of the workforce.

Integrating Infant and Early Childhood Mental Health Consultation

Another strategy is to integrate mental health consultation services into early childhood settings, such as child care centers and home visiting programs. Licensed therapists or psychologists working within CCBHCs could serve as IECMH consultants, providing guidance, training and case consultations to those working with young children and families. This indirect service model builds the capacity of caregivers to support children's mental health, encourage positive parent-child interactions, and help create environments that promote healthy development. CCBHCs could explore partnerships with entities such as KSKidsMAP and Kansas Connecting Communities (KCC), as they offer free case consultations for practitioners in certain settings.

Expanding Access Through Telehealth

Utilizing telehealth and innovative delivery models can extend the reach of services to underserved and remote communities. CCBHCs can connect with families and other providers virtually, offering assessment, consultation and therapeutic intervention without geographical constraints, allowing for increased access to care and collaboration within interdisciplinary care teams. While technology can be used to address barriers, there also are some disadvantages to its use. Studies have shown that telehealth can make it harder for providers to observe non-verbal feedback and visual cues, impacting the ability to build a therapeutic relationship and accurately assess and diagnose. It also is important to acknowledge that telehealth is not a sustainable solution to address an overall workforce shortage.

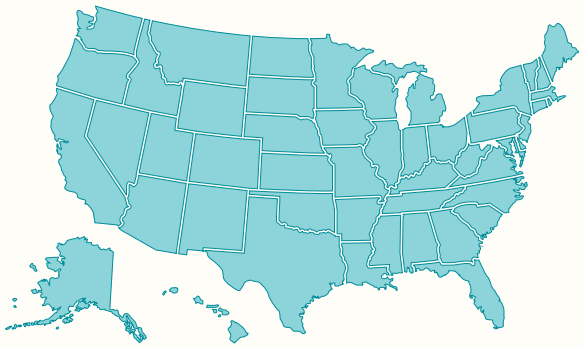
CMS Recommendation to States: *Consider telehealth options to increase access to care, including in school settings. It is important to note that states retain extensive flexibility in the utilization of telehealth within Medicaid outside of the COVID-19 public health emergency; states are encouraged to consult with provider and stakeholder communities in making longer-term decisions about the role of telehealth in behavioral health service delivery.*

Age-Appropriate Diagnosis

Current diagnostic practices for mental health disorders in young children are not able to capture the complexity of early developmental stages. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, is used in various clinical settings to classify mental health disorders. However, it is primarily suited for older children, adolescents and adults, as it often lacks the developmental sensitivity required to accurately assess mental health and developmental disorders in early childhood. The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC: 0-5) addresses this gap by offering developmentally appropriate diagnostic criteria and insights for children up to age 5. By incorporating DC: 0-5, CCBHCs can enhance diagnostic precision, tailor interventions to individual needs and facilitate better communication among providers. A DC: 0-5 diagnosis also may indicate medical necessity and serve to authorize treatment and reimbursement. States have pursued a range of strategies to include DC: 0-5 within state systems and policy, including legislating use, embedding into electronic health records (EHR), and encouraging workforce training. As of now, Kansas does not recognize the DC: 0-5 for diagnosis or reimbursement for services but is evaluating the benefits and determining if it could be recommended or required in the future.

CMS Recommendation to States: *Utilize age-appropriate diagnostic criteria to help aid practitioners in accurately diagnosing conditions in children, especially for those who may lack language skills or exhibit symptoms distinct from older individuals. Effective assessment improves access to suitable care, potentially reducing behavioral issues and improving school and family dynamics.*

Strategies States Use to Elevate DC:0-5:



Legislating DC:0-5 — Washington state passed House Bill 1325 that mandates Medicaid providers to utilize DC: 0-5 for assessing and diagnosing children from birth to age 5. It permits reimbursement for up to five sessions for intake and assessment, along with covering provider travel costs for assessments conducted in home or community settings.

Embedding DC:0-5 into Electronic Health Records (EHR) — Nevada has embedded the DC: 0-5 into an EHR system that allows clinicians to search for the ICD-10 code that correlates to each DC: 0-5 diagnosis. This has allowed the Nevada Health and Human Services Division of Child and Family Services to develop reports that track diagnoses and treatment of young children.

Workforce Training — Many states are dealing with shortages of qualified clinicians and are exploring training in DC: 0-5 as a mechanism to ensure appropriate diagnoses and treatment is offered. Minnesota has invested in statewide training paid for by its federal mental health block grant while MassHealth in Massachusetts uses a "train the trainer" model with funding assistance from the Boston Public Health Commission. DC: 0-5 training also can be helpful for non-diagnosing professions to recognize signs that a child or family needs additional support or assessment.

Conclusion

The integration of the Certified Community Behavioral Health Clinic (CCBHC) model into Kansas' behavioral health framework offers an opportunity to enhance infant and early childhood mental health (IECMH) services across the state. Medicaid plays a key role in facilitating access to these services for low-income families, and while current reimbursement structures exist, there is potential for further improvements. CCBHCs can explore or encourage policy changes that expand reimbursement options for services like dyadic therapy, developmental screenings and home visiting programs.

In addition, evaluating the impact of the current Prospective Payment System (PPS) method and same-day billing policies may help identify alternative reimbursement pathways. Aligning CCBHC payment models with other professional payment models and adjusting medical necessity criteria could further enhance access to Medicaid services.

As Kansas capitalizes on its designation as a federal CCBHC Medicaid Demonstration state, efforts to strengthen referral networks, expand workforce capacities and address the developmental needs of young children will be needed. Ongoing collaboration among stakeholders will be essential to ensure a coordinated, responsive system that supports preventive services, early interventions and comprehensive care for children and families statewide.

ABOUT THE ISSUE BRIEF

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