

Early Identification and Intervention for California's Infants and Toddlers: 6 Key Takeaways

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California's early identification and intervention system for low-income infants and toddlers is complex. The pathways by which families enrolled in Medi-Cal find services to detect and ameliorate developmental and mental health concerns are hard to navigate. For years, families have voiced their frustration with seeking these services for their children, and reported that the process is inefficient, confusing, and taxing on the family's well-being. The limited data available on service utilization align with the stories families tell, and make a strong case that change is needed.

The First 5 Center for Children's Policy developed a [flowchart of these pathways](#) to describe what families and providers face, and the role of different entities in delivering services. The background research conducted to produce this map, as well as interviews with families, system leaders, and advocates suggest that the following areas are most in need of attention to create a system that is family-centered and effective. Here are our key takeaways:

1. Children with developmental delays or mental health concerns do not have access to the full array of EPSDT screening and treatment services they are entitled to.

Federal law and regulations that govern the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit require Medi-Cal to provide services to children that are medically necessary, including those to "correct or ameliorate defects and physical and mental illnesses or conditions."¹ This means children should be able to receive services to maintain or improve their health, not just to correct a problem.

The first step in navigating the early identification and intervention system is screening, and California has one of the lowest developmental screening rates in the country, at 26%.² Children of color and those living in households with low income are less likely to be screened than white children and those living in higher-income households.³

Before 2019, California state law used the more limited adult benefit to define medical necessity for children. Senate Bill 1287, passed in 2019, brought state law into compliance with the federal EPSDT benefit, and specified a broader definition of medical necessity for children.^{4, 5} Providers and families may not know about the change to a broader benefit, however, which may continue to limit their access to services.

Also, the way California administers Specialty Mental Health Services (SMHS) still conflicts with federal law in two important ways:

1. State law requires that children have a mental health diagnosis to receive SMHS. Yet EPSDT is meant to *prevent* the development or worsening of conditions, so requiring a diagnosis is not aligned with prevention.⁶
2. A portion of counties' financing for SMHS is capped, limiting local resources. Since EPSDT is a federal entitlement, any child who needs a medically necessary service should be able to receive it regardless of how much county budget is available.⁷

2. There is widespread confusion about the delivery of children's mental health benefits.

It is not always clear whether Specialty Mental Health Services or the Medi-Cal mental health benefit (sometimes called non-specialty mental health services) should provide mental health supports.⁸ Current law and policy are somewhat ambiguous on which entity is responsible, and there is overlap in the services covered by each system.⁹ Although the law is clear that services should be provided in accordance with EPSDT, the rules that govern mental health services have been shaped by a federal waiver and state law, which are partially in conflict with one another.^{10, 11}

First, in 1995, California received 1915(b) waiver authority from the federal government to provide specialty mental health services in a managed care structure through local Mental Health Plans. This waiver has been renewed since 1995 and continues to include some outdated language on diagnostic criteria.¹²

Second, California realigned responsibility and authority for a number of public services in 1991 and 2011. Through this realignment, the nonfederal share of Medi-Cal funding and responsibility for public mental health services was transferred to the counties, including children's EPSDT mental health. Although state law regarding realignment does not change California's federal obligations, it does include language that is contradictory to the prevention and entitlement aspects of EPSDT.¹³ For example, the Bronzan-McCorquodale Act (Realignment Act) states that the mission of California's mental health system is to enable children with "serious emotional disturbances" and provide services "to the extent resources are available," rather than as needed.¹⁴

Finally, mental health service delivery for children was constructed atop an adult-centric model, and adult eligibility criteria are sometimes applied to children inappropriately and without regard for EPSDT. For example, children are routed to the Medi-Cal mental health benefit for mild-to-moderate concerns, and to Mental Health Plans for more severe concerns. This routing is appropriate for adults, but under EPSDT, children are entitled to non-specialty and specialty mental health services regardless of the severity of their condition.¹⁵

These differing rules and complicated history has led to widespread confusion about children's mental health benefits.¹⁶ As a result, how and if a child ends up getting services for mental health concerns is not consistent across the state and depends on referring providers' knowledge of the system, local provider networks, and the relationship between local health plans and Mental Health Plans.¹⁷

3. Eligibility for mental health services does not align with how young children develop.

Young children rarely come to the doctor with mental health concerns significant enough to warrant a diagnosis. Instead, the most important way to monitor infant and toddler mental health is to check on family well-being.¹⁸ By focusing eligibility criteria on symptoms the child is experiencing, California misses the opportunity to provide early relational health supports like dyadic care to children experiencing risk factors that impact long-term mental health.¹⁹

One exception is Medi-Cal's new family therapy policy, which covers family therapy for children without a mental health diagnosis but at risk for later concerns, in addition to those with a mental health diagnosis. Risk factors outlined in the policy are broad and include both child-oriented variables, such as trauma exposure and food insecurity, and caregiver-oriented variables, such as substance use disorder and history of incarceration.²⁰ Economic disadvantage is the most significant risk for mental health concerns in children due to increased exposure to environmental, familial, and psychosocial risks.²¹

4. System complexity and narrow eligibility criteria constrain timely access to developmental supports.

In addition to California's low developmental screening rate, access to developmental supports is hindered in two other important ways. First, Regional Centers are "payors of last resort" and must review all other public sources of payment for a child's needs. This means families may need to wait for both Early Start eligibility determination and Medi-Cal authorization before receiving services.²² The Department of Developmental Services (DDS) requires that Regional Centers support families in working with their insurance and begin services for any child with an Individualized Family Service Plan (IFSP) while they explore eligibility determination from other payors. However, this does not always happen.²³ Many critical months in a young child's life can go by as families work out the appropriate payor and navigate between the two systems.

Second, California’s criteria for Early Start is narrower than other states, so many children with less severe delays are not being served who could benefit. The federal Individuals with Disabilities Education Act (IDEA) program allows states some flexibility in establishing their own threshold of developmental delay.²⁴ California’s threshold is higher than other states, and therefore it serves a smaller proportion of the infant and toddler population.²⁵ While approximately 18% of the state’s children have a developmental delay or disability, only 3% of the infant and toddler population receive early intervention in California, compared to almost 10% in Massachusetts.²⁶ California could broaden the eligibility for Early Start, serving kids earlier before delays become more pronounced.

5. Service delivery is inconsistent across the state.

The practices of Mental Health Plans, health plans, Regional Centers, local California Children’s Services programs, as well as the availability of informal developmental and mental health supports, vary across the state. For example, California Children’s Services (CCS) operates in 37 counties as a carve-out of managed care, while in the remaining 21 counties, CCS services are incorporated into managed care plans. In the counties where CCS has not been incorporated into managed care, operations vary and the program is administered by either the local county health department or by state CCS regional offices.²⁷ It is challenging to make many generalizations about how services operate at the state level with so much variation. Other factors that contribute to local variation include:

Pediatric provider network adequacy: There are provider shortages in many areas of pediatrics including developmental pediatrics, mental health, occupational therapy, and speech and language pathology.^{28, 29, 30} This impacts the provider networks for Regional Centers, health plans, and Mental Health Plans. California managed care plans have submitted tens of thousands of requests to exempt them from standards that specify the maximum time and distance families should travel for care because of limited pediatric workforce constraints.³¹ This prevents local systems from adequately meeting the needs of children and families.

Managed care vs. fee-for-service: The Medi-Cal program is offered to children through two provider payment and delivery systems, managed care and fee-for-service (FFS).³² Under the FFS system, children can see any provider who accepts Medi-Cal, and providers are reimbursed for each service or visit. Under managed care, the state contracts with health plans to deliver services in exchange for a monthly payment, or “capitation” for each child. Children access services slightly differently in these two systems. One important distinction is where the responsibility for EPSDT coordination lies; county Departments of Public Health administer Child Health and Disability Prevention Programs (CHDP), which are responsible for coordinating EPSDT in FFS; the plans are responsible for children in managed care.³³

California has moved much of the Medi-Cal population into a managed care plan, including 90% of children with Medi-Cal insurance.³⁴ Practices and policies differ across managed care plans, especially regarding attention to EPSDT care coordination requirements and interpretation of “medical necessity.” Furthermore, managed care plans often use a delegated model where financial risk is transferred from the plan to health care providers through a physician group or independent physician association (IPA). Similarly, for mental health services, many managed care plans subcontract with a managed behavioral health care organization (MBHO) to support the administration of mental health coverage responsibilities.³⁵ This can cause confusion for referring providers and families alike in determining what provider is in-network.

Because the early identification and intervention system is so complicated and variable, referring providers need to know a lot of about the local service delivery system to make an appropriate referral. Given the complexity of these systems it is unclear how successfully families can access services without robust care coordination.

6. Data quality is poor and fragmented.

California does not collect data on how many children are screened for developmental delays and mental health concerns; we can only estimate from national survey data. In addition, California does not collect consistent data on how many children with concerns end up receiving services.

There are utilization data available for Early Start and Specialty Mental Health Services. However, these data are not linked in any systemic way with information about the child from other systems like Medi-Cal. DHCS does report on Medi-Cal performance standards, but there are limited early childhood performance standards currently in place.³⁶

Additionally, as we move more responsibility and children into managed care, data become scarcer. Both the capitated payment structure and the use of delegation make it more challenging for DHCS to know the discrete services children with Medi-Cal insurance are receiving.

NOTES

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