California Children's Trust

FIRST 5 CENTER FOR CHILDREN'S POLICY

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PROPOSAL FOR AN EARLY CHILDHOOD HEALTH SERVICES INITIATIVE IN CALIFORNIA:

An Opportunity to Expand Preventive Supports for Young Children

California is home to more than two million children ages 0 to 5, half of whom receive their health care from Medi-Cal. During the first years of life children's brains are developing more rapidly than at any other point. Ensuring access to prevention and early intervention for physical, mental, developmental, or social concerns is essential during this period as it lays the foundation for all future learning, behavior, and health.

Unfortunately, many young children enrolled in Medi-Cal do not receive required preventive services, like developmental screenings and immunizations in their first years of life. Even fewer have access to early childhood mental health services that can prevent the onset of later, more severe mental health concerns. This is despite the evidence that 43% of young children have experienced at least one Adverse Childhood Experience (ACE).[1]

California's persistently poor performance in this area also means missed opportunities for referrals to additional needed care like developmental or mental health supports.[2] Even when concerns are identified in early childhood, support services can be hard to access. Provider scarcity across many areas of early childhood specialty care limits the availability of services, and few providers offer interventions that appropriately address early childhood well-being. For Black, Indigenous, and Latinx children these issues are compounded by a higher incidence of trauma and ACEs, as well as a lack of culturally responsive providers.

Proven early childhood programs and services have been largely funded by county First 5 commissions and a patchwork of other state and federal programs that face declining or inconsistent revenues. New and sustainable funding sources are needed to ensure young children under age 5 have access to age-appropriate, whole-child supports in family-friendly, community-based settings.

California has an immediate path to sustainable funding that can help close the gap in preventive services for children ages 0 to 5. This paper explores California's opportunity to improve the health and development of young children by leveraging the Children's Health Insurance Program (CHIP) Health Services Initiatives (HSIs).

Health Services Initiatives

The federal Children's Health Insurance Program (CHIP)—which operates as part of the Medi-Cal program in California—allows states to use a limited amount of CHIP funding to administer programs focused on improving the health of children in low-income households. Federal rules define these programs, known as Health Services Initiatives (HSIs), as activities that protect the public health, protect the health of individuals, improve or promote a state's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals relating to improving the health of children, including targeted low-income children and other low-income children.

States can use up to 10% of the CHIP funding they spend on direct services for program administration and other non-coverage activities, like outreach or HSIs. Administrative expenses associated with programmatic needs and meeting regulatory requirements must be covered prior to funding HSIs. Once administrative costs are covered, states have wide latitude up to the 10% cap to propose focused initiatives to improve the health and welfare of children in their state. Initiatives are not restricted to children who are CHIP eligible.

To draw down CHIP funds for an HSI, a state must identify state-only (non-federal) match funds. In Federal Fiscal Year 2023, California's CHIP Federal Medical Assistance Percentage (FMAP) is 65%.[3] This means the state portion of a total HSI program budget would account for the remaining portion—equaling 35%.

States seeking to implement HSIs must submit a state plan amendment describing the need for the HSI, the populations to be served, a description of how the HSI will improve children's health, an updated CHIP program budget, and assurances that they will not supplant or match CHIP federal funds with other federal funds. HSIs may be subject to periodic update or renewal, depending on the terms of federal approval and annual reporting requirements, to ensure expenditures remain within the 10% administrative cap.[4, 5, 6, 7]

EXAMPLES FROM OTHER STATES

As of 2019, 24 states have approved HSIs of which 13 states have multiple HSIs. Focus areas vary and include projects on poison control, school health services, lead poisoning, maternal care, child nutrition, reproductive health, and behavioral health. For example, North Carolina has an HSI to expand and improve the delivery of Reach Out and Read, making it part of routine pediatric primary care visits for children birth to age five. Maine had an approved HSI to provide funding to community agencies for home visiting services for first-time families and pregnant and parenting adolescents. Massachusetts, which has 18 HSIs, created an HSI to evaluate and treat infants or children who exhibit childhood malnutrition and growth failure known as failure to thrive. In this HSI, the Department of Public Health contracted with hospitals and community health centers to provide services by multidisciplinary teams. The team also included outreach efforts to help pediatricians with early detection and intervention for nutrition-related illnesses.[8, 9]

HSIs in California: Current Initiatives and a Future Investment Opportunity

California has significant latitude to expand HSI funding. Currently, the state has two HSIs that do not expend total available HSI funds:

1. California Poison Control System (CPCS), started in 2009, funds poison control center services. CPCS provides free, daily, 24-hour emergency telephone treatment advice, referral assistance, and information to manage exposure to poisonous and hazardous substances. CPCS also implements public education programs for at-risk populations. In 2017, 220,000 children were served by CPCS, of which 40% were low-income.

2. 12-month postpartum Medi-Cal coverage, launched in 2021, extends postpartum Medi-Cal coverage from 60 days to a full 12-months for birthing people regardless of citizenship or immigration status.

These two HSIs do not fully expend total funding currently available to California. The CHIP State Plan Amendment approving 12-month postpartum Medi-Cal coverage expansion indicated that $327 million was available as of 2021, the year this new HSI launched.[10, 11]

To fully draw down the remaining funding available under the cap, the state would need to identify $176 million of non-federal expenditures to claim against, for a total budget of $503 million (65% federal share = $327 million; 35% state share = $176 million). However, the state can propose an HSI of any budget amount under $503 million and receive 65% federal match.

$503 million TOTAL Potential HSI Budget	
STATE SHARE	**FEDERAL SHARE**
35% of $503 million = $176 million	**65% of $503 million = $327 million**

California has struggled to secure substantial federal Medi-Cal matching funds for whole-child supports in community-based settings in the past. Many of the mechanisms available rely on local jurisdictions, like counties and First 5s, to execute complex and administratively burdensome fiscal practices. However, HSIs are more flexible and could allow California to capture significant new and ongoing revenue.

California could consider using the HSI opportunity to bolster early childhood mental services. These services have been historically underinvested in and under-accessed. In addition, California's children and families are under significant and escalating toxic stress, from both the COVID-19 pandemic and longstanding historical and systemic issues such as poverty, racism, and other forms of community and individual trauma. Although the Children and Youth Behavioral Health Initiative (CYBHI) provides historic investment to address the growing crisis of mental health for children, most funding sunsets in 2026.

Opportunity: Expand Infant and Early Childhood Mental Health Consultation by Leveraging Existing State Investments in a New HSI

An HSI focused on early childhood mental health could increase access to important, community-based prevention services for California's children. One potential initiative could focus on Infant and Early Childhood Mental Health Consultation (IECMHC), a model with proven outcomes in child and caregiver social-emotional well-being that could be scaled through HSI by claiming federal matching funds on existing non-federal expenditures.[12]

IECMHC is a nationally recognized, evidence-based prevention model that pairs a mental health consultant with adults who work with infants and young children in the different settings where they learn and grow, such as child care, preschool, home visiting, early intervention, and their home. Funding for IECMHC comes from a few sources in California, but in general, the intervention has limited availability across the state.

California is spending millions of non-federal dollars on early childhood mental health via various sources, including through contracts from the California Department of Education and California Department of Social Services, as well as First 5s and other county and local early care and education sources. These expenditures are estimated at $30 million or more per year.[13] The largest single source of non-federal IECMH expenditure is CDE. In 2019, California demonstrated its recognition of IECMHC as an important early childhood strategy, by creating a new adjustment factor for state-contracted child care providers who implement IECMHC in their practice. The adjustment factor allows child care providers to use up to .05 of their contract on IECMHC.

In 2022, the adjustment factor will increase to .10. In the years since implementation, CDE has seen the number of providers and the total expenditure on IECHMC grow significantly, and with the higher adjustment factor, non-federal expenditures may be in the tens of millions.[14] **These non-federal funds could account for all or part of the state match for a HSI.**

Next Steps and Critical Considerations

State and early childhood leaders should come together to analyze this opportunity. Essential discussion topics include:

1. EQUITY

Currently large, center-based early child care providers have been most able to use the IECMHC adjustment factor available through state contracts. However, the majority of infants and toddlers in child care are served in non-center, home-based settings.[15] Would an HSI allow for more expanded access to consultation for multiple setting types? Would small child care providers and those without contracts with CDE be able to benefit? How would rural counties and those with limited workforce benefit, or would this HSI be focused on certain selected geographies?[16] One potential way to expand access through additional child care settings is to leverage Resource and Referral organizations or county First 5s and their centralized connection to varied local child care providers.

2. STIGMA

Consultation in early care settings through the adjustment factor is currently an "opt-in" program enhancement. Due to the stigma associated with receiving mental health support, some providers may be hesitant to explore consultation in their child care settings.

3. INFRASTRUCTURE

IECMHC is an important intervention that requires trained staff who have access to reflective supervision and other workforce supports. How would the workforce be supported to ensure it is available to meet the large unmet need for IECMHC? Could HSI funding be used to expand the pipeline of IECMH providers?

4. QUALITY ASSURANCE AND IMPROVEMENT

IECMHC quality standards and reporting would need to be standardized across participating providers, and critical referral, access, and coordination standards clarified including primary care provider and Medi-Cal managed care plan information sharing and exchange.

Even in the current environment of unprecedented commitment and investment to support the expansion of mental health services for children and youth, California could be more comprehensively wrapping services around our youngest and most vulnerable children, using evidence-based approaches that yield important long-term outcomes. HSI presents a unique and immediately implementable strategy to expand preventative supports for California's children ages 0 to 5, and has the potential to identify and support behavioral and mental health needs within a broader continuum of mental health care—before more significant interventions are needed.

Endnotes

1 https://childrenspartnership.org/wp-content/uploads/2022/03/IECMH-Budget-Proposal-2022-V4.pdf

2 https://www.auditor.ca.gov/pdfs/reports/2018-111.pdf

3 https://www.kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

4 https://www.macpac.gov/wp-content/uploads/2019/07/CHIP-Health-Services-Initiatives.pdf

5 https://www.manatt.com/getmedia/4e26309d-1cc7-4289-92a6-c8f67b27e217/CSSP-Medicaid-Blueprint

6 https://www.shvs.org/wp-content/uploads/2017/01/SHVS-Manatt-Leveraging-CHIP-to-Protect-Low-Income-Children-from-Lead-January-2017.pdf

7 https://www.medicaid.gov/federal-policy-guidance/downloads/faq11217.pdf

8 https://www.nashp.org/leveraging-chip-to-improve-childrens-health-an-overview-of-state-health-services-initiatives/

9 https://www.macpac.gov/wp-content/uploads/2019/07/CHIP-Health-Services-Initiatives.pdf

10 https://www.dhcs.ca.gov/formsandpubs/laws/Documents/CHIP-SPA-21-0032-Approval.pdf

11 According to a 2019 report published by Manatt, California had $333 million of available funds under the 10% cap in 2017, before the 12-month postpartum HSI. https://www.manatt.com/getmedia/4e26309d-1cc7-4289-92a6-c8f67b27e217/CSSP-Medicaid-Blueprint

12 https://www.iecmhc.org/wp-content/uploads/2020/12/CoE-Evidence-Synthesis.pdf

13 Estimates based on current and projected California Department of Education expenditures, as well as First 5 and county MHSA funds.

14 According to data provided by the California Department of Education, the rate adjustment expenditure on IECMHC was $4 million in the year it was created (fiscal year 2018-19) and $13 million in 2020-21.

15 https://strongnation.s3.amazonaws.com/documents/1248/47bbb39b-3578-424d-9193-06911cd6f777.pdf

16 States are not required to execute HSIs on a statewide basis.

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California Children's Trust

The California Children's Trust (The Trust) is a statewide initiative to reimagine our state's approach to children's social, emotional, and developmental health. We work to transform the administration, delivery, and financing of child-serving systems to ensure that they are equity driven and accountable for improved outcomes. The Trust regularly presents its Framework for Solutions and policy recommendations in statewide and national forums. For more information, visit www.cachildrenstrust.org.

FIRST 5 CENTER FOR CHILDREN'S POLICY

First 5 Center for Children's Policy develops research and policy thinking in order to improve early childhood systems in California. Grounded in the experience of First 5s, the Center studies and disseminates best practices and solutions in early childhood development; convenes experts inside and outside the early childhood space to inform policy; and evaluates solutions within and outside California that can be adapted for the state. For more information, visit www.first5center.org.