MISSISSIPPI kids count

CHILDREN'S FOUNDATION OF MISSISSIPPI

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NAVIGATING THE PATH TO HEALTHY DEVELOPMENT: EARLY INVESTMENTS PAY OFF!

The foundations that young children build in the earliest stages of life help determine their future abilities to thrive. Mississippi could improve outcomes for young children—and for our state as a whole—by providing additional state resources to increase families' access to early intervention supports. This brief examines which states are leading the way in providing early intervention supports to children in their state.

The architecture of our brains is built from the bottom up, with intense construction going on from infancy through age five. In the earliest years of life, *one million new neural connections are made each second!* Because experiences in early childhood are the basis for lifelong learning, taking a close look at young children's developmental progress is key. The earlier that concerns around developmental progress are discovered, the easier they typically are to address effectively. For example, the earlier that a language delay is recognized and addressed with speech therapy, the less likely it is that more intensive interventions will be needed in later years. In fact, research shows that when children receive early intervention services before their third birthday, they have better developmental outcomes.[1-3] As a result, states reap substantial cost savings, due to a lower number of children needing special education services at age three.[4-6] In order to provide appropriate supports for Mississippi's families, which benefits our entire state, it is important to sustain an effective, comprehensive statewide system of early intervention services.

Early intervention services are provided under two federal programs: Parts B and C of the Individuals with Disabilities Education Act (IDEA), with implementation by individual states.

Mississippi's Part C services are administered through the Mississippi State Department of Health (MSDH)'s First Steps program, which serves very young children (birth-age two). First Steps services include screenings, evaluations, assessments, Individualized Family Service Plans (IFSPs), and any needed transition plans to Part B services as children approach their third birthday.

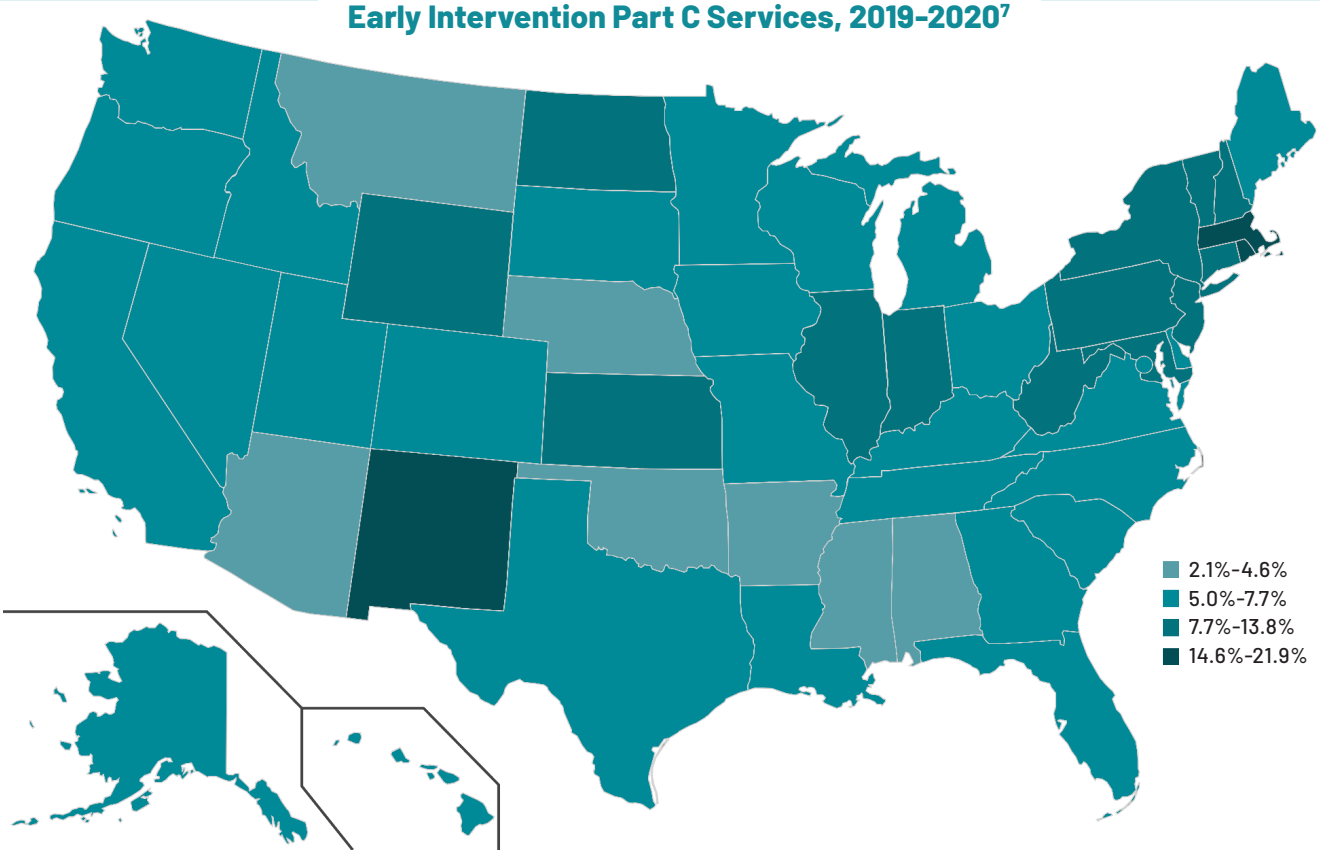
For more information on services provided by Parts B and C, please see our companion brief, *Navigating the Path to Healthy Development: Today's Children Are Tomorrow's Leaders!* (see https://childrensfoundationms.org/research/)

Each state is responsible for setting specific eligibility criteria for its Part C program, as well as identifying and providing appropriate services to eligible children. In 2019, approximately 3% of Mississippi's infants and toddlers received services through Mississippi's Part C program.[7] It is estimated, however, that a higher rate of Mississippi's infants and toddlers could benefit from receiving early intervention services. An estimate, based on the state population of children younger than age three and Mississippi's Part C eligibility requirements, suggests that at least 12% of Mississippi's children could benefit from receiving Part C services.[8] Another estimate, based on parent reports from the Mississippi Child Health and Development Survey, suggests that 7.2% of Mississippi's children younger than age three have been diagnosed with one or more developmental delays or disorders.[9]

Each state is provided federal funding for Part C programs, with the amount of federal funds depending on the population of age-eligible children for each program. States can supplement this funding with state and local resources to bolster their early intervention programs. In a survey of state Part C coordinators, Mississippi was one of only 13 states indicating that Part C primarily relies upon federal funding to operate its program.[10] Insufficient state funding is a significant barrier to providing services to all eligible children. In fiscal year 2020, Mississippi received $4,226,412 from the federal government and $1,277,875 from the state to fund the Part C program, with no funding from local entities. Based on conservative estimates provided by the Mississippi State Department of Health, a minimum of $6,000,000 to $11,000,000 in additional funding would be required to increase the rate of service provision to 7% and 12%, respectively. These funds would be used to increase the number of Part C staff (e.g., service coordinators and coaches) and contracted service providers, as well as to increase salaries in order to improve staff recruitment and retention. These funds would also be used to increase infrastructure to support higher numbers of staff and contracted providers, such as training and professional development, additional buildings, technology, materials, and other supplies.

As shown in the map below, Mississippi's current rate of age-eligible children enrolled in Part C services is among the lowest in the nation, at 3.2%.[7] These low levels of enrollment may indicate that some vulnerable populations at higher risk of developmental delays are being overlooked in referrals to Part C. For example, research shows that children involved in the child welfare system are at increased risk of developmental delays. While nine states refer 100% of eligible children who have experienced substantiated maltreatment to Part C agencies, in 2019, 45.2% of Mississippi's children who experienced substantiated maltreatment were referred to Part C.[11]

Percentage of Infants and Toddlers Receiving Early Intervention Part C Services, 2019-2020[7]



Source: United States Department of Education

As shown in the table below, Mississippi has the fourth lowest rate of Part C enrollment in the nation. All ten states with the highest Part C enrollment receive more than half of their funding from the state, while several of the ten states with the lowest Part C enrollment rates, including Mississippi, receive less than half of their funds from the state. In fact, in Mississippi, less than a quarter of the program's funding comes from the state, a far lower share than most other states, even those with lower percentages of children enrolled in Part C. In order to increase the rate of Mississippi's infants and toddlers who receive early intervention services, additional state funding must be invested in the early intervention program.

While Medicaid is one of the primary sources of funding for early intervention services, states implement various approaches in utilizing Medicaid funding to support their Part C programs. Three of the states with the top ten highest Part C enrollment (MA, RI, and CT) also have close partnerships between their Medicaid and Part C programs, which have resulted in increased Part C enrollment.[4]

On average, states with the highest Part C enrollment rates have higher rates of developmental screening and lower rates of young children living in poverty. These states also have more policies in place that support positive family outcomes, such as state Earned Income Tax Credits and Medicaid expansion. There are examples of states with the highest Part C enrollment rates with similar challenges to Mississippi, such as the percentage of young children living in poverty, like New Mexico and West Virginia; each of these states, however, has a much larger state funding contribution than Mississippi. New Mexico's 2020 state contribution was approximately $26 million (90% of total allocation), compared to Mississippi's $1.2 million (23% of total allocation).

States with 10 Lowest and Highest Percentages of Children Receiving Part C Services

	Percentage of Children Receiving Part C Services[7]	Percentage of Program Funds from State, FY2020[10]	Serves Children at Risk of Delay[7]	Developmental Screening Rate (9-35 Mos)[12]	Young Children in Poverty[13]	State Earned Income Tax Credit[14]	State Medicaid Expansion[15]
Lowest 10							
Arkansas	2.1%	*	No	25.9%	26%	No	Yes
Oklahoma	3.0%	70.9%	No	26.2%	22%	No	Yes
Montana	3.1%	52.1%	No	34.4%	15%	No	Yes
Mississippi	3.2%	23.2%	No	31.5%	31%	No	No
Alabama	4.4%	65.9%	No	33.3%	24%	No	No
Nebraska	4.6%	0.0%	No	30.2%	15%	Yes	No
Arizona	4.6%	59.8%	No	24.9%	21%	No	Yes
Georgia	5.0%	40.8%	No	26.4%	20%	No	No
Texas	5.3%	49.8%	No	47.5%	21%	No	No
Florida	5.3%	66.2%	Yes	27.8%	20%	No	No
Highest 10							
New Mexico	21.9%	90.2%	Yes	45.6%	28%	Yes	Yes
Massachusetts	20.1%	80.4%	Yes	52.3%	12%	Yes	Yes
Rhode Island	14.6%	76.0%	No	50.8%	16%	Yes	Yes
West Virginia	13.8%	78.2%	Yes	42.0%	22%	No	Yes
New Hampshire	12.9%	74.1%	Yes	33.0%	7%	No	Yes
Vermont	12.5%	*	No	51.8%	11%	Yes	Yes
Pennsylvania	10.9%	92.0%	No	35.3%	17%	No	Yes
Connecticut	10.7%	85.0%	No	49.0%	15%	Yes	Yes
Indiana	10.7%	66.0%	No	26.1%	17%	No	Yes
Wyoming	10.2%	77.4%	No	39.4%	15%	No	No

*Data not available

Where do we go from here?

The roadblocks to providing more of Mississippi's infants and toddlers with early intervention services are not insurmountable; there are key strategies that have demonstrated success in other states. Recommendations include:

- Increasing Part C's state and local funding streams, directing funding to parts of the system that could be expanded in order to serve more children in need of early intervention services.
- Examining Part C enrollment data in order to determine any inequities regarding race, income, family structure, or geographic location, and providing additional supports to increase access to enrollment for families who could benefit most from early intervention.
- Expanding Part C eligibility criteria to include a variety of risk factors in order to serve more children in need of early intervention services.
- Examining professional development opportunities and other benefits for early intervention providers and staff to ensure that providers have the supports they need to provide timely, quality services.
- Strengthening data sharing between Part C and other agencies in order to identify more eligible children and provide them with needed services. For example, data sharing between Part C and Medicaid would increase the efficiency of identifying Part C eligible children who are also eligible for Medicaid, maximizing third-party payments,[4] while data sharing between Parts B and C would enhance the identification of children with special needs as well as the transition process between these programs.

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