

Medicaid Managed Care: Transformation to Accelerate Use of High Performing Medical Homes for Young Children

Working Paper Five

InCK Marks Child Health Care Transformation Series

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Foreword

The InCK Marks Initiative supports leaders in child health care transformation – health experts, practitioners, administrators, advocates, and policy makers. InCK Marks has developed a number of working papers on key aspects of such transformation, seeking to draw upon state-of-the-field research, science, practice knowledge and experience, and policy design. The practice field has advanced substantially over the last decade in child health care, with recognized ideal standards for providing primary and preventive child health services and a growing array of exemplary programs and practice innovators and early adopters showing the value of doing so.

As the field of exemplary and transformative practice has grown, advocates and policy makers and administrators also have sought to support it and redefine health financing structures to advance further diffusion and adoption. On this, there is broad recognition that Medicaid and CHIP, and therefore state structures administering those funding sources, play an absolutely foundational role.

One of the questions that leaders in the field, particularly at the advocacy and policy administration level, have raised and are seeking to address is, “How can states advance such transformation through Medicaid and CHIP, particularly through Medicaid managed care contracts?”

This working paper begins to address this question, first by reviewing the current state-of-the-field efforts by states to incorporate provisions related to child health care transformation into managed care contracts. In effect, through drawing upon the expertise and overall review of Medicaid managed care contracts by the Milliken Center for Public Health at George Washington University (GWU), InCK Marks performed a “due diligence” review of existing state Medicaid contractual language for incorporation of child-specific language related to child health care transformation.

Overall, this review found states at the beginning stages of doing so, with no state having a comprehensive approach to contracting for child health care services distinct from the overall Medicaid population or related to the unique needs of children for primary, promotive, and developmental health services. At the same time, different states, often based upon some specific model or practice effort they have supported in the child health area, have produced different pieces of contractual language that can be used to inform the development of a more comprehensive approach.

As states continue to explore this topic, InCK Marks emphasizes the need for detailed contract language specific to child health care provision, incentives to MCOs and the providers with which MCOs contract to move toward that transformation, and state structures (and staffing) to ensure that MCOs are accountable to meeting those contractual provisions.

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Health at George Washington University, who identified child-specific contractual language from the database they developed of Medicaid contractual language now provided as a searchable database on the Commonwealth Fund website. BrunerChildEquity LLC is the grant administrator for InCK Marks, and Charles Bruner serves as the National Resource Network manager, with Kay Johnson chairing the InCK Marks National Advisory Team. InCK Marks engages over 35 national organizations in providing state-of-the-field assessments of and resources related to child health care transformation. Resources produced by the InCK Marks Initiative can be found at: www.inckmarks.org.

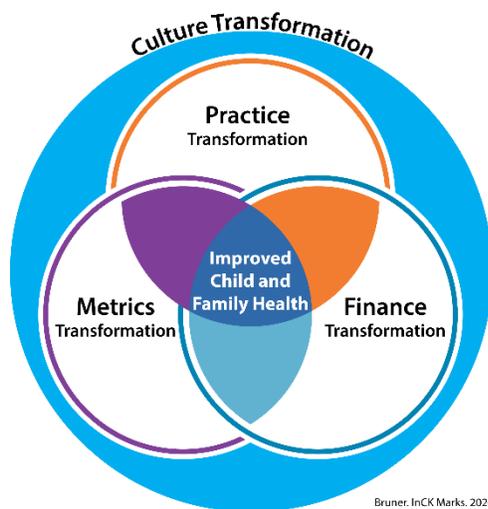
Table of Contents

Foreword.....	2
Acknowledgements and Disclaimer.....	3
Introduction.....	4
The Role of Medicaid Managed Care.....	5
The Importance of Medicaid Managed Care Contract Language.....	6
Using Medicaid to Support High Performing Medical Homes for Young Children.....	7
Medicaid Managed Care Contract Language to Support Child Health Care Transformation...	11
Promotion and Prevention in EPSDT Well Child Visits.....	12
Improved Use of Case Management and Care Coordination.....	14
Interagency Cross System Collaboration and Coordination.....	18
Measurement, Measures, and Metrics.....	25
Conclusion.....	35
Appendices.....	38

Introduction

Transformation of health care for young children will require changes in practice, finance, metrics and the culture of health care. (See Figure 1). In terms of practice transformation, the design for a “high performing medical home” (HPMH) for young children calls for improvements in three core elements of the care process and structure: 1) primary care with comprehensive well-child visits, 2) care coordination and case management that is relational, tiered in intensity, and responsive to families, and 3) other services embedded in primary care (e.g., Healthy Steps, DULCE, integrated behavioral health) or to which the medical home links (e.g., home visiting, Title V, early childhood mental health, Part C early intervention services).¹

Figure 1. Child Health Transformation



States, at best, are in the initial stages of developing a system under Medicaid that provides both coverage and reimbursement for the array of services and activities that comprise a high performing medical home. State Medicaid Plans overall, as well as specific service definitions, billing codes, provider guidance, and payments for services largely do not contain the provisions needed to advance high performing medical home. Similarly, and in parallel, state Medicaid managed care contracts do not yet have strong language to support high performing medical home.

Legal and public health researchers at GWU have studied Medicaid managed care contracts for more than 20 years.^{2 3} Recently, they completed an updated compilation and

examination of contracts from the 39 states and the District of Columbia with Medicaid managed care⁴ to help researchers, state employees, and policy makers see how different states are addressing eight different topic areas (including primary care).. A public, searchable data base providing this compilation is available on the Commonwealth Fund website, but does not distinguish between provisions related to children specifically.⁵

InCK Marks commissioned a scan of managed care contracts from GWU of this database to understand what provisions relate to the high performing medical home for young children in Medicaid. (See Appendix A for details.) That scan identified few specific examples of language that directly support the financing, structure, and operation of high performing medical home. At the same time, existing contract provisions point to mechanisms states are using for other purposes that could support high performing medical home (e.g., medical homes for children with disabilities, management of services for adults with chronic disease, and care coordination). This working paper summarizes these existing contract provisions and uses them as the basis for developing contract language and purchasing specifications which do support development and sustainability for HPMH for children.

The Role of Medicaid Managed Care

Medicaid is the largest source of publicly financed health coverage. States operate Medicaid in a federal-state partnership that requires a State Medicaid Plan. States can manage the operation of the plan directly through a fee-for-service (FFS) reimbursement system or through managed care contracts (MCCs).

Managed care contracting is widely used because it gives states the ability to better control coverage, care, and costs, as well as to introduce changes in care delivery to improve health and health care.

Ten Things to Know about Medicaid Managed Care

1. Managed care is the dominant way states finance services to Medicaid beneficiaries.
2. More than two-thirds of all Medicaid beneficiaries receive care through comprehensive, risk-based MCOs.
3. Children and adults are more likely to be enrolled in MCOs than seniors and persons with disabilities.
4. Expansion of Medicaid managed care has been accompanied by increased attention to measuring quality and outcomes.
5. States are allowing and encouraging MCO contracts to promote strategies to address social determinants of health, particularly to avert high cost medical care.
6. An increasing number of states use MCO contracts to finance behavioral health services, pharmacy benefits, and long-term services and supports (LTSS).
7. Payments to MCOs account for nearly half of total Medicaid spending.
8. Large health insurance companies account for a large share of the Medicaid managed care market.
9. Ensuring an adequate network of providers, particularly recruiting specialty providers, is a challenge.
10. Alternative payment models (rather than fee-for-service) are being more widely used.

Adapted from Kaiser Family Foundation.
<https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicare-managed-care/>

Medicaid managed care also can be a tool for states seeking to improve use of preventive and primary care services.⁶

Since 1997, states have been permitted to require that most beneficiaries enroll in Medicaid managed care, and the use of managed care arrangements has grown dramatically since that time.^{7, 8} More than 80 percent of Medicaid beneficiaries are enrolled in some type of managed care arrangement, and 70 percent of all Medicaid beneficiaries are enrolled in comprehensive plans offered by managed care organizations (MCOs).⁹ Medicaid managed care accounts for an estimated half of all Medicaid spending.¹⁰ As of July 2019, 39 states and the District of Columbia were using managed care arrangements. Of these, 36 states reported covering 75 percent or more of all children through Medicaid managed care. Of the 34 states that had implemented the ACA Medicaid expansion, 29 were using managed care arrangements to cover newly eligible adults. In 32 states using Medicaid managed care, 75 percent or more of low-income adults in pre-ACA expansion groups (e.g., parents, pregnant women) are covered through managed care organizations (MCOs).¹¹ In 2020, reflecting guidance from the Centers for Medicare and Medicaid Services (CMS) and Congressional action, most states are using Medicaid managed care to respond to the COVID-19 pandemic, with action such as changes in MCO contracts, eligibility, benefits covered, and payment methods.¹²

According to the Medicaid and CHIP Payment and Access Commission (MACPAC), Medicaid care may be of three types: (1) comprehensive risk-based managed care, (2) primary care case management (PCCM), or (3) limited-benefit plans. Currently, most states are using comprehensive, risk-based MCOs. Extensive federal regulations guide the structure of these relationships

however, the contracts are an essential element of the legal structure which vary widely across states in their details and level of specificity.

The Importance of Medicaid Managed Care Contract Language

The Medicaid managed care contract has become a central tool used by states management of their Medicaid programs, generally with specific efforts to managed overall health expenditures.¹³ Contracts set out how managed care organizations (MCOs) will be reimbursed, monitored, and held accountable. Contracts are used to design and structure health care delivery and financing, as well as to specify the terms for beneficiary protections and MCO relationships with other public agencies. They set out states' performance expectations related to coverage, access, services, payment, quality improvement, and provider responsibilities. They spell out what MCOs are required to do in terms of provider networks, ensuring the delivery of health services, and adhering to state and federal Medicaid requirements. States' contracts also may describe population health priorities and innovations in care and payment reform. Thus, understanding the Medicaid managed care contract is central to understanding what guides delivery of services for a large majority of Medicaid beneficiaries.

States have the responsibility to establish managed care contracts under Medicaid, which often are documents hundreds of pages in length and with finely detailed specifications. The contracting process is guided not only by federal rules but also by each state's Medicaid policy and the complex procurement rules applicable to these large state purchases. Given their complexity, states' contracts may be updated at 3- to 5-year intervals, or sometimes on an annual basis.

In contracts for MCOs, accountable care organizations (ACOs), and similar arrangements, the agreement generally reflects and builds upon what is in the Medicaid state plan. Therefore, it is important to understand and distinguish between: (1) what states develop within their Medicaid State Plans and administrative regulations, billing codes, service definitions, and provider requirements; and (2) what states incorporate into their managed care contracts.

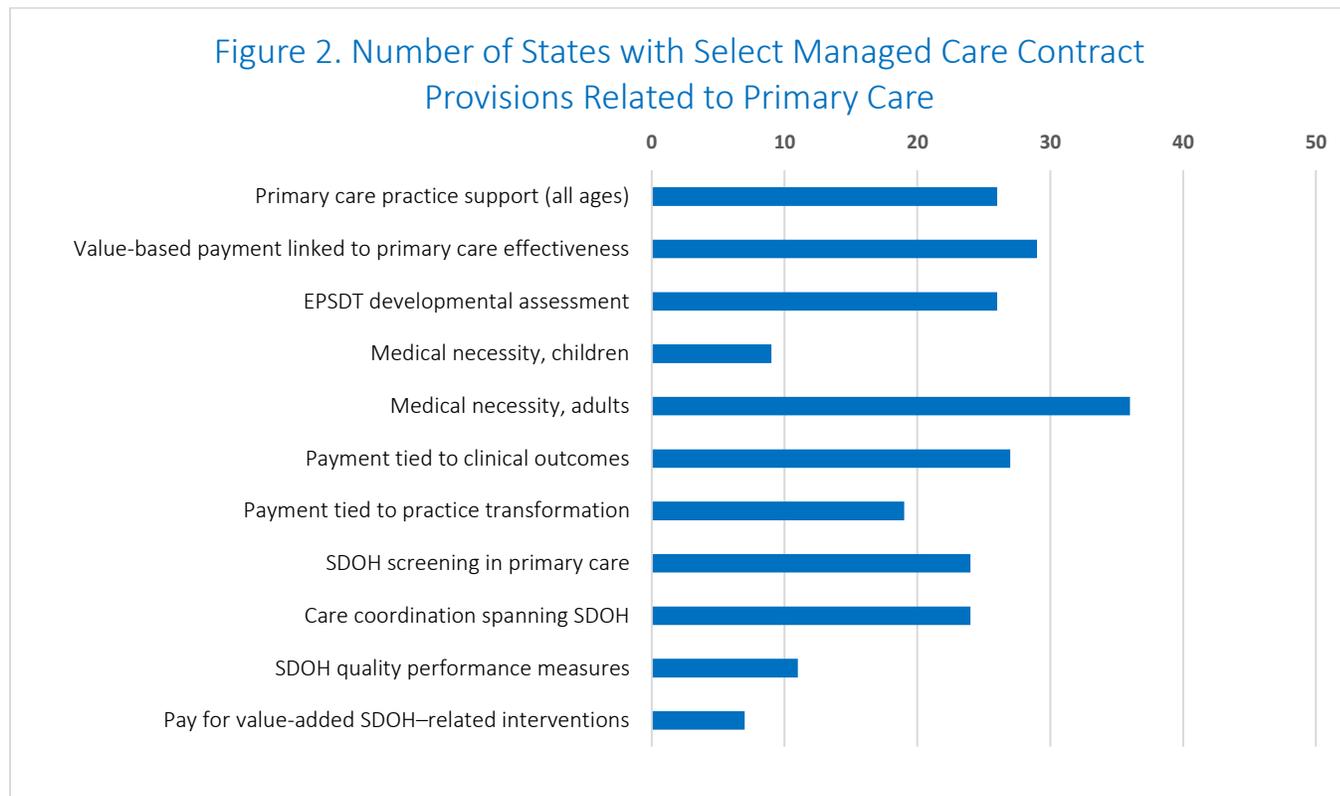
States' Medicaid managed care contracts specify the terms of coverage—typically including the scope of services covered, authorizations required to cover services, the duration and intensity of the services eligible for payment, the documentation required to receive payment, payment rates, and terms for any incentives based on performance or quality. States' Medicaid contract specifications should reflect coverage for the health care needs of children, as distinct from adults. Whether or not specified in the Plans, the state (and through it the MCO) remains responsible for providing Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefits for children.

A recent general analysis by George Washington University (GWU) of contract provisions related to primary care points to the similarities and variations that exist today, as well as key areas for improvement.¹⁴ In particular, GWU found that states vary widely as to when they use a prescriptive approach versus broader purchasing specifications that defer to contractor judgement about how to operationalize a broadly stated aim.

Figure 2 shows key elements across several areas of primary care identified by GWU researchers which are particularly relevant to child health care transformation. For example, while 36 of the 40 states' contracts studied specify an adult medical necessity standard, fewer states (9) describe Medicaid's special

pediatric medical necessity standard, possibly because the EPSDT benefit for children 0-21 years already contains related requirements. A promising finding is that, as permitted under federal rules, 7 states treat social determinant of health (SDOH) activities as value-added services, meaning that the states encourage MCOs to offer such services. At the same time, while 24 states have contract provisions calling for SDOH screening in primary care, some states include highly specific expectations and others give contractors broad discretion.

Figure 2. Number of States with Select Managed Care Contract Provisions Related to Primary Care



Adapted from: Rosenbaum S, et al. How states are using Medicaid managed care to strengthen and improve primary health care. *Commonwealth Fund Issue Brief*. 2020. Data from George Washington University analysis of 40 state Medicaid managed care purchasing documents including requests for proposals, model contracts, and/or executed contracts publicly available as of October 1, 2019.

Using Medicaid to Support High Performing Medical Homes for Young Children

The principles for a medical home¹⁵ and the *Bright Futures Guidelines*¹⁶ for preventive pediatric health care have been developed and endorsed by the American Academy of Pediatrics (AAP)¹⁷ and the federal Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS).¹⁸ Beginning in 2010 and updated in 2018, federal law has used the *Bright Futures Guidelines* as the standard for preventive, well-child visits to be provided without cost-sharing.¹⁹ Yet national data indicate that 20-30 percent of infants, toddlers, and preschoolers

in Medicaid receive less than the recommended number of well-child visits; thus missing opportunities for recommended screenings, immunizations, parent education, and other benefits of well-child visits.

An increasing body of research and professional guidelines define the characteristics of a medical home (also called a patient-centered medical home). The shared principles for a medical home call for delivery of primary care that is: patient and family-centered, comprehensive, team-based, accessible, coordinated and committed to quality, safety, and equity.²⁰ Although not always included in lists of the attributes of the medical home, equity was identified as one of the six core dimensions of a high-quality health care system in the landmark Institute of Medicine (IOM) report *Crossing the Quality Chasm*.²¹

Too many poor children, children with special health care needs, and children of color do not have a health care provider who meets the definition a medical home. National survey data indicate that among young children 0-5 years, about half (51 percent) of those without special health care needs, and 39 percent of those with special needs have a medical home.²² Additionally, too few providers serving children in Medicaid receive payments sufficient to support provision of a medical home or full implementation of the *Bright Futures Guidelines*.

While all children should have access to a medical home, many families with young children in Medicaid need additional support through what has been defined as a “high performing medical home.”²³ Building from the team-based, family-centered, and comprehensive criteria of the basic medical home, the high performing medical home adds quality and value across three components of care that fit within the purposes of the Medicaid EPSDT benefit design.

1. **Provide comprehensive well-child visits, including increased emphasis on promotion and preventive services** based on *Bright Futures Guidelines* and EPSDT standards, including screening, anticipatory guidance, and parent education. This includes engaging and partnering with families to screen for and respond to issues that include the array of physical, mental, developmental, dental, and social factors that affect young child health and development, with a two-generation emphasis.^{24, 25, 26}
2. **Provide care coordination/case management at appropriate levels** (low, moderate, and more intensive levels), depending on child and family needs. At a more intensive level, this would include a relational approach and care coordination staff. Ideally, this would include a warm “handoff” from the primary care provider to the care coordinator (based inside the medical home and/or in the community) to discuss strengths and needs, provide ongoing relational support that builds family agency in maintaining a safe and nurturing home environment, and ensure referral and follow-up that connects families with additional resources and services.
3. **Increase use of other services and supports for optimal child development.** This may include augmented services co-located within the primary care setting, such as family specialists (e.g., in models such as DULCE or HealthySteps) or approaches for integrated behavioral health. Medical home providers also should link to or integrate with other services for families with young children such as home visiting, parent-child dyadic mental health therapy, early intervention for developmental delays and disabilities, or parent support programs.

High performing medical homes could be approved, designated, or certified by Medicaid agencies or managed care plans and would report on specific measures to demonstrate their delivery of these

components. (See below for a list of measures related to high performing medical homes). States and health plans could provide enhanced payments to pediatric primary care providers operating such high performing medical homes for young children, based on a fee-for-service, per capita, prospective payment, value-based, or other payment arrangement.

Figure 3. Design for High Performing Medical Homes for Young Children in Medicaid



Adapted from: Johnson K and Bruner C. *A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health*. Child and Family Policy Center. October, 2018.

Source: Johnson and Bruner. 2018.

Overall, the aim of high performing medical homes is to ensure that all children receive care based on the professional standards contained in the *Bright Futures Guidelines* for well-child visits and preventive care screenings and appropriate responses to identified concerns, risks, and conditions. The design reflects the following goals.

- All children receive well child visits based on *Bright Futures Guidelines* and periodicity schedule, as reflected in the state's EPSDT periodic visit schedule.^{27, 28}
- All children are screened for medical, developmental, and social factors based on *Bright Futures* guidelines and periodicity schedule, using objective and recognized tools.^{29, 30, 31} The state's Medicaid contracts for health plans and guidance for providers reflects this as an EPSDT standard of care.
- Practitioners provide anticipatory guidance for all children that covers both child-specific medical and developmental issues, as well as protective factors³² and social determinants of health that may negatively affect the family (e.g., concerns related to income, housing, food, or parental health, social support).^{33, 34, 35, 36, 37, 38 39}
- The medical home team uses enhanced care coordination/case management for children with identified medical, developmental, and/or social risk factors, at the level of intensity and duration necessary to respond to those needs.^{40, 41, 42, 43} For those with more intensive medical or social needs, this response would ideally be based on a care plan. These services might be routine Medicaid case management (a covered element under Medicaid's EPSDT benefit) or in some instances under a State Medicaid Plan Amendment for targeted case management.
- The medical home links to or integrates evidence-based models demonstrated to improve health and developmental outcomes for young children, such as home visiting, parent-child mental health therapy, family developmental specialists, parenting programs, and group-based assistance programs. Medicaid finances these and other early childhood model programs in many states.⁴⁴
- The team-based approach includes trained staff whose roles are to engage with families, assess family needs, provide linkage to resources or referral sources, and focus on promoting strong families, relationships, and development. In turn, Medicaid provides reimbursement for preventive services delivered by a broad array of health and related staff including family specialists, community health workers, parent educators, developmental specialists, nutrition counselors and lactation consultants.
- Monitoring and measurement systems promote continuous quality improvement and measure the impact at the child and family, as well as population levels.

To advance high performing medical homes children birth to five, a Medicaid State Plan should include related criteria, service definitions, billing codes, and administrative requirements. Generally, these State Plan elements are needed to undergird Medicaid managed care contracts.

Medicaid Managed Care Contract Language to Support Child Health Care Transformation

As states make increasing use of MCOs, policymakers have increasing responsibility to ensure that contracts contain appropriate provisions related to child health. Today, most Medicaid managed care contracts set out requirements for securing an adequate number of providers of care, providing core covered services in the Medicaid plan, and reiterating the requirements under EPSDT for children. Often, however, they do not go much further in setting expectations and requirements for child health, and particularly for primary and preventive health services for young children.

Nearly two decades ago, legal and health policy researchers at GWU developed purchasing specifications to guide Medicaid agencies in developing strong and effective contracts under managed care arrangements to promote child development generally.⁴⁵ Another set of contract purchasing specifications proposed by GWU describe considerations in making coverage and medical necessity determinations about treatment under EPSDT.⁴⁶

Based on a request from InCK Marks, GWU reviewed its 2020 scan of managed care contracts for provisions related specifically to children and to screening, guidance, care-coordination, and provision of health-related services, e.g. to specific guidance or direction from the state to MCOs that would advance health care transformation for young children in Medicaid. GWU's scan revealed few specific examples of contract language that directly supported the financing, structure, and operation of the high performing medical home. At the same time, GWU identified some existing contract provisions point to mechanisms states are using for other purposes that could support high performing medical homes and accelerate transformation (e.g., medical homes for children with disabilities, management of services for adults with chronic disease, care coordination structures, and measurement approaches). The next sections describe the scan and specific opportunities around focus areas of the scan (with examples of existing language on which to build):

- Promotion and prevention in EPSDT well child visits
- Improved use of case management and care coordination
- Interagency and cross-system collaboration and coordination

Aligning with Bright Futures Screening

To align with the Bright Futures Periodicity Schedule and Recommendations for Preventive Pediatric Health Care, states should have definitions, billing codes, recommended tools, and separate payments for the following.

1. **Developmental screening** for overall development with objective and validated tools (recommended in visits at 9 months, 18 months, and 30 months).
2. **Autism Spectrum Disorder** Screening with objective and validated tools (recommended in visits 18 months and 24 months).
3. **Social-emotional development** screening (psychosocial/behavioral assessment) with objective and validated tools (recommended in all 15 visits birth to 5th birthday).
4. Screening young children and families related to **social determinants of health** (psychosocial/behavioral assessment) with objective tools (recommended in all 15 visits birth to 5th birthday).
5. **Maternal depression** screening in pediatric primary care, with billing under the child's number (recommended by 1 month and in visits at 2 months, 4 months, and 6 months).

- Measurement, measures, and metrics.

Promotion and Prevention in EPSDT Well Child Visits

As expected, substantial gaps exist between the Medicaid managed care contract language of today and what would be needed to focus on health promotion and prevention in primary care for young children, particularly for those children experiencing social rather than (or in addition to) medical complexity.⁴⁷ In some ways, states' contract language leans on the preventive purposes and visit structure of Medicaid's EPSDT benefit, but without doing more than, in most instances, references to the general EPSDT benefit. More can be done to modernize EPSDT well-child visits, align with *Bright Futures* 4th edition, and focus on promotion and prevention of child health conditions beyond disease and injury.

- **Opportunity: Build upon examples on developmental screening and the examples of standard EPSDT provisions to write sample contract specifications that focuses on more comprehensive screening** as defined in *Bright Futures* 4th edition (see box) and the design for the high performing medical home. This would include, in addition to general developmental screening, use of objective tools to screen for social-emotional-mental development, screening for social determinants of health, and for maternal depression. Contract provisions should distinguish general developmental screening from other types of screening, as well as from developmental assessment for diagnostic purposes. Many states currently still have contract provisions that do not make this distinction between screening and diagnostic assessment clear. The problem is related to a lack of clarity in the EPDST regulations written long ago (Medicaid Manual Part 5); however, current practice guidelines separate the two and should be reflected in Medicaid managed care contracts.
- **Opportunity: Use examples related to social determinants of health screening and follow up to draft contract specifications that focus on SDOH and children, rather than adults.** Most of the contract examples related to SDOH focus on adults or are so generic as to not be particularly useful for children. For example, many existing provisions focus broadly on housing, food, employment, and education and do not specify how this relates to pediatric primary care, parent guidance, or child health. In addition, many extracted contract provisions describe the partnerships in response to SDOH in adult systems. The GWU legal analysis team defined this category of examples as follows: “*Screening for social determinants of health/social complexity means use by primary care providers/in primary care settings of screening tools such as CMS’ Accountable Health Communities Health-Related Social Needs Screening Tool to systematically detect the health-related social needs of beneficiaries who are minors.*” Examples that may be helpful in drafting more specific child and family focused SDOH contract provisions are identified below.
 - Kentucky clarifies the responsibility of the MCO to conduct SDOH screening and links it to tiered case management, and Virginia language links SDOH to early intervention case management.
 - Louisiana has been using tiered case management and set a priority on SDOH. “2.7.2.1 *The Contractor shall attempt to conduct enrollee health needs assessments (HNA) as part*

of the enrollee welcome call to identify health and functional needs of enrollees, and to identify enrollees who require short-term care coordination or case management for medical, behavioral or social needs. Where an enrollee is a child, the HNA [Health Needs Assessment] shall be completed by the enrollee's parent or legal guardian... 2.7.2.5 The Contractor's HNA shall: ... 2.7.2.5.5 Screen for needs relevant to priority social determinants of health as described in the Population Health and Social Determinants of Health... ” (pp. 89-90).

- The Minnesota contract language also may be useful, although it currently only applies to children with SED. *“(2) The in-reach service coordination will include performing an assessment to address an Enrollee’s mental health, substance use, social, economic, and housing needs, or any other activities targeted at reducing the incidence of emergency room and other non-medically necessary health care utilization and to provide navigation and coordination for accessing the continuum of services to address the Enrollee’s needs. For a Child with SED [Severe Emotional Disturbance], this also includes arranging for these community-based services prior to discharge.” (p. 81).*
- North Carolina is recommending two instruments for early childhood social risks and social determinants of health.
- Rhode Island focuses on groups as higher risk. *“A primary focus of the Health Plan's Care Management program will be: 2.16.04: To identify members with significant health and social needs that are at high risk of poor health outcomes who may require care management services, such as children with special health care needs and individuals with HIV/AIDS, mental illness, addiction issues or those recently discharged from correctional facilities... ” (p. 423, July 2019, Rhode Island UnitedHealth Care Medicaid Managed Care Contract).*
- Colorado has an example more tailored to adults but perhaps helpful. *“10.3: Community and the Social Determinants of Health: 10.3.1: The Contractor shall demonstrate an understanding of the health disparities and inequities in their region and develop plans with Providers, Members, and Community Stakeholders to optimize the physical and behavioral health of its Members. 10.3.2: Recognizing that the conditions in which Members live also impact their health and well-being, the Contractors shall establish relationships and collaborate with economic, social, educational, justice, recreational, and other relevant organizations to promote the health of the local communities and populations.”* Additional and related Colorado contract language below under interagency coordination.
- Further in the Colorado contract: *“12.8.2: The Contractor shall create an information strategy to connect and refer Network Providers to existing resources, and fill in any information gaps for the following topics: ... 12.8.2.5: Community-based resources, such as child care, food assistance, services supporting elders, housing assistance, utility assistance and other non-medical supports.” (p. 74, July 2019, Region 1, Colorado Medicaid Managed Care Contract).*

- **Opportunity: Build upon examples regarding anticipatory guidance and parent education, as well as the EPSDT law, to write contract specifications that broaden and modernize this topic.** Development of sample contract specifications should rely on the current edition of the *Bright Futures Guidelines*. At a minimum, the specifications should use both the terms parent education and anticipatory guidance and specify that guidance be age appropriate. Ideally, the contract language would call for family-centered, strengths-based, and relational approaches that are becoming the new standard of practice. It might describe coverage for group parent education (e.g., CenteringParenting). It should go beyond the narrow focus of many states on lifestyle changes (e.g., smoking and substance use), injury prevention, and other risk-reduction education and counseling. Many states now just say anticipatory guidance, while others mention health promotion and/or health education, which can have a different connotation in today’s pediatric primary care practice. The GWU legal analysis team defined this category of examples as follows: “*Anticipatory guidance is defined as proactive counseling that addresses the significant physical, emotional, psychological, and developmental changes that will occur in children during the interval between health supervision visit.*” Examples that may be helpful in drafting contract provisions that describe anticipatory guidance and parent education are shown below.
 - While most of the extracted contract language on anticipatory guidance is very generic and fits with traditional wording for EPSDT benefit, some states (e.g., Georgia) call for “*parenting skills education to expectant and new parents.*”
 - Rhode Island focuses on coordination and referrals to their teen pregnancy/parenting programs, with some specifics about parent education. “*Health Plans are expected to coordinate with/refer members to other programs offered by the State, such as Comprehensive Emergency Services Program (DCYF), and the Early Start Program... Rhode Island Executive Office of Health and Human Services currently operates an Adolescent Self-Sufficiency Collaborative ("ASSC") service network consisting of community-based Programs located throughout the State. These programs provide targeted case management to women under the age of twenty (20) who are pregnant and parenting. The ASSC provides: (1) case management services, including home visiting, and intensive case management to minor parents focusing on parenting education and life-skills development; (2) pregnancy prevention programs that involve teen parents, their parents and other family members, including "hard-to-serve" families where English is not the primary language; and (3) access to programs where participants learn and practice pre-employment/work maturity skills, where they explore vocational options and where they participate in community work experience settings matching their skills and interests. Contractor is encouraged to make referrals to the ASSC programs as appropriate... ” (pp. 89- 91).*

Improved Use of Case Management and Care Coordination

Medicaid law specifies case management as a benefit, but does not define “care coordination.” Many states and health professionals, however, use the terms interchangeably. Under EPSDT, all Medicaid enrolled children are entitled to case management coverage. In the past, some states’ Medicaid agencies

would not agree to pay for services called care coordination, but this distinction has softened. The terms describe a range of activities that better link children and families to services and supports, promote access, ensure follow up and completed referrals, and address needs beyond what can be done in a well-child or acute care visit. A basic level of care coordination/case management for all patients is defined as part of the medical home for children and adults. Tensions sometimes exist between Medicaid, child welfare, IDEA, and other agencies regarding who pays for what in terms of case management, care coordination, and service coordination roles. Today, as shown in the extracted contract language, some managed care contracts use the term care coordination and others describe case management services.

States also can use the targeted case management (TCM) benefit under Medicaid, with flexibility to offer select services to individuals in defined groups, in targeted geographic areas, and/or delivered by specific providers. Many states use the TCM benefit to finance home visiting, finance case management for individuals with disabilities, or support people with mental health or substance use disorders (SUD). In addition, states can pay for an array of care coordination type activities in primary care settings or in the community apart from the case management or TCM benefit.

Federal regulations define the following four categories of activity: 1) assessment, 2) development, 3) referrals and related activities, and 4) monitoring and follow-up. Minnesota contract language specifies parallels the federal definition:

“CMS definition for targeted case management services, including: i) A comprehensive assessment of the Enrollee to determine the need for any medical, educational, social or other services, ii) The development of a specific care plan that: is based on the information collected through the assessment; specifies the goals and actions to address the medical, social, educational, and other services needed by the Enrollee; includes activities such as ensuring the active participation of the eligible Enrollee, and working with the Enrollee (or the Enrollee’s authorized health care decision maker) and others to develop those goals; and identifies a course of action to respond to the assessed needs of the eligible Enrollee. iii) Referral and related activities to help the Enrollee obtain needed services including activities that help link an Enrollee with medical, behavioral, social, educational Providers; community services; or other programs and services available for providing needed services...” (p. 101).

In the area of case management/care coordination, contract language is more likely to focus on children with special health care needs (CSHCN) than on those with social risks or interventions for developmental concerns (i.e., before a developmental delay or diagnosis occurs). In some cases, contracts specify responsibilities for care coordination to support children in foster care. In addition, contract provisions are more likely to describe case management approaches designed to reduce costs, such as long-term services and supports (LTSS), primarily for adults with disabilities and seniors in Medicaid.

- **Opportunity: Build upon examples of contract language regarding case management /care coordination for CSHCN.** The national CSHCN standards and ongoing work of state Title V CSHCN agencies and family advocates have led to much improved efforts to finance care coordination/case management for children with health care needs. Multiple states have

somewhat standard language, adapted from the Maternal and Child Health Bureau, Health Resources and Services Administration (MCHB-HRSA) definitions of a system of care for CSHCN which can be a useful starting point. Some of the examples in the extracted provisions provide an excellent basis for more relational and/or intensive case management/care coordination and could be applied to children with social risks or complexities as well as children with specific special health needs (medical complexities). States' contract specifications should link to the concept of a high performing medical home for young children.

- New Hampshire gives practical examples of clinical topics: “*4.13.4.1.1 The MCO shall develop and make available Provider support services which include, at a minimum: ... 4.13.4.1.1.5. Training curriculum, to be developed, in coordination with DHHS, that addresses clinical components necessary to meet the needs of Children with Special Health Care Needs. Examples of clinical topics shall include: federal requirements for EPSDT; unique needs of Children with Special Health Care Needs; family driven, youth-guided, person-centered treatment planning and service provisions; impact of adverse childhood experiences; utilization of evidence-based practices; trauma-informed care; Recovery and resilience principles; and the value of person-centered Care Management that includes meaningful engagement of families/caregivers...*” (p. 237-38).
- As discussed elsewhere, Virginia has a “Connection for Children Program” which is a classic CSHCN design based on MCHB-HRSA definitions and is often used as an example of how managed care contracts and services could function better for CSCHN. It has a strong care coordination element. (Virginia also has provisions related to foster care, neonatal abstinence syndrome, Part C early intervention, infant care, and other special needs.)
- Washington State has language that can help guide efforts in other states to require contractors to provide care coordination. “*Children’s Health Care Coordination 14.15.1 The contractor shall ensure coordination for all Enrollees under age 21 in accordance with EPSDT requirements. The Contractor shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services needed to treat health problems and conditions when the Contractor becomes aware of an unmet need. This requirement does not preclude Enrollees under the age of 21 from receiving any other care coordination activity described in this Contract. 14.15.2 In accordance with chapter 74.09.337 RCW, when the Contractor receives notification or identifies children requiring mental health treatment, including behavioral intervention to treat autism, the Contractor will, as necessary: 14.15.2.1 Coordinate mental health treatment and care based on the child’s assessed needs, regardless of referral source, whether the referral occurred through primary care, school based services, or another provider; 14.15.2.2 Follow-up to ensure an appointment has been secured; and 14.15.2.3 Coordinate with the PCP regarding development of a treatment plan, including medication management.*”
- West Virginia states that MCOs must: “*Make all reasonable efforts to assure that all enrolled enrollees with special health care needs, ages zero (0) to twenty-one (21), have*

access to a medical home and receive comprehensive, coordinated services and supports pursuant to national standards for systems of care” for CSHCN.

- Some states contract language relates to subsets of CSHCN. For example, Minnesota describes TCM for children with mental health needs, and Georgia uses the children’s mental health system of care language. In Massachusetts, care coordination is mentioned for children in a behavioral health initiative, and Minnesota has a similar provision related to children’s mental health collaboratives and describes children’s mental health TCM. Delaware mentions case management processes for children who receive nursing services in home or community-based settings. A couple of states have case management language in the contract related to blood lead poisoning. South Carolina’s contract discusses TCM for children in foster care, the juvenile justice system, with disabilities, who are “emotionally disturbed” and some groups of adults.
- **Opportunity: Build upon examples of language describing tiered case management or levels of intensity.** The design for the high performing medical home calls for care coordination with varied levels of intensity based on family need. The first level would be the basic required for a standard medical home. Additional levels should be defined and financed for individuals/families with higher medical or social risks and conditions. Some states already are using this approach. States’ contract specifications should describe responsibilities for case management/care coordination specifically for children and their families, not just adult focused risks and needs. Louisiana contract provisions provide two examples.
 - In Louisiana, the contract includes a requirement to have a multi-disciplinary care team and someone with expertise in early childhood if it is a child under 6. *“The Contractor shall identify a multi-disciplinary care team to serve each enrollee based on individual need for all enrollees in case management Tiers 2 and 3 and transitional case management. Contractor shall assign lead case managers based on an enrollee’s priority care needs, as identified through the individual care plan. Where behavioral health is an enrollee’s primary health issue, the case manager shall be a behavioral health case manager. As needed, case managers with expertise in physical or behavioral health care will support lead case managers where there are secondary diagnoses. If the enrollee is under the age of six (6), the lead case manager shall have expertise in early childhood mental health or access to a consultant with expertise in infant and early childhood mental health.”* (p. 96, Louisiana Medicaid Managed Care Model Contract).
 - A second example from Louisiana is shown here and also in the SDOH section. *“2.7.6 Tiered Case Management Based on Need 2.7.6.1 Intensive Case Management for High Risk Enrollees (High) (Tier 3) Enrollees engaged in intensive case management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. A plan of care shall be completed in person within thirty (30) calendar days of identification and shall include assessment of the home environment and priority SDOH... 2.7.6.2 Case Management (Medium) (Tier 2) Enrollees engaged in the medium level of case management are typically of rising risk*

and need focused attention to support their clinical care needs and to address SDOH. A plan of care shall be completed in person within thirty (30) calendar days of identification and include assessment of the home environment and priority SDOH...

2.7.6.3 Case Management (Low) (Tier 1) Enrollees engaged in this level of case management are of the lowest level of risk within the case management program and typically require support in care coordination and in addressing SDOH. A plan of care shall be completed in person within ninety (90) calendar days of identification and include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section). (pp. 91-92).

- **Opportunity: Use language that describes the relational aspects of care coordination for families with young children.** As documented by InCK Marks, a growing number of exemplary practices and evidence-based models point to the value of using family-centered, strengths-based, two-generation, and relational care coordination and support services. In order to improve outcomes, care coordination for families with young children must build on what has been learned in evaluations of effective programs. This includes assessment, referral, and follow-up to ensure receipt of other needed services, but it also includes establishing a relationship and partnership with families in identifying goals and building family agency to provide a nurturing home environment. States' contract language should define and offer examples of approaches appropriate for children and their families, including family-centered, strengths-based, two-generation, and relational care coordination. The language also should discuss the role of and financing for the work of community health workers, family specialists, navigators, peer-to-peer support staff, and others who can provide outreach, care coordination, and preventive services financed under Medicaid. State Medicaid agencies have multiple ways to finance the services of such members of the care team (with such "team-based" care recognized as part of a medical home). Their role might be funded as part of an enhanced payment for high performing medical homes. In addition, with a state plan amendment, states can use the option to reimburse preventive services "recommended by a physician or other licensed practitioner...within the scope of their practice under State law" (42 CFR §440.130(c)), and such relational care coordination can meet this definition and can be provided, under supervision, by a community provider. The rule change went into effect January 1, 2014 and is different than prior regulations, which said that services needed to be provided by a physician or other licensed provider or under their direct supervision.⁴⁸

Interagency and Cross System Collaboration and Coordination

There also are provisions related to coordination across systems and interagency collaboration that can be incorporated into managed care contracts. The GWU legal analysis team defined this area as follows: *"Social service provider relationships means interactions-- including care coordination, care integration, data sharing, referrals and communication-- between primary care providers and local, state or federal agencies or other entities tasked with providing social services to the beneficiary. Social services deal with economic stability, housing, education, relationships, neighborhood, and other environmental influences. Examples of agencies include IDEA Part B & IEP or Part C & IFSDP; child care or early*

learning centers; maternal and child health departments; child welfare agencies; Help Me Grow, home visiting programs, etc.” Interagency collaboration with food and nutrition programs such as the Supplemental Nutrition Program for Women, Infants, and Children (WIC) is also mentioned by some states. Examples that may be helpful in drafting contract provisions that describe responsibilities for interagency and cross system collaboration are shown below.

- **Opportunity: Build upon examples used to describe collaboration with IDEA Part C Early Intervention.** The Individuals with Disabilities Education Act (IDEA) Part C Early Intervention for Infants and Toddlers with Disabilities program provides grants to state for implementing a system of services for children birth to three experiencing a developmental delay or with a condition that has high probability of leading to delay. (20 U.S.C. 1431 (b)(1), P.L. 108-446).⁴⁹ With parental consent, states can use Medicaid to finance services to which the child is entitled under both Medicaid and Part C, typically health-related services such as physical therapy, hearing aids, or mental health.⁵⁰ This is an important area of early childhood system underperformance, and some states have contract language about collaboration that was advanced under an Assuring Better Child Health and Development (ABCD) initiative and other early childhood initiatives under Medicaid.⁵¹ In some states, IDEA services are carved out of managed care arrangements in order to enable Medicaid payments directly to education or health departments that operate the programs. Managed care arrangements can have an impact on receipt of Part C services.⁵² Contract specifications should reflect what Medicaid pays for, as well as the nature of the collaboration expected between Medicaid MCOs and Part C agencies and providers. These provisions also should: a) indicate coverage of evidence-based practices on IDEA Part C early intervention (e.g., include direct therapy and parent coaching models of service), b) specify the responsibilities of the MCO for financing and delivery of services to which the child is entitled, c) specify the responsibilities of the MCO for including appropriate therapists and other providers of services under Part C, d) specify the responsibilities of the child’s medical home provider with regard to the IFSP, and e) clarify responsibilities with regard to payment for Part C-related coordination services for families.
 - Virginia has some unique language, regarding a “blended” role for service coordination. *“Early Intervention Targeted Case Management/Service Coordination: The Contractor shall provide coverage for EI [Early Intervention] Targeted Case Management (also referred to as EI Service Coordination). EI service coordination is a service that will assist the child and family in gaining access to needed and appropriate medical, social, educational, and other services. EI Service Coordination is designed to ensure that families are receiving the supports and services that will help them achieve their goals on their child’s Individual Family Service Plan (IFSP), through monthly monitoring, quarterly family contacts, and on-going supportive communication with the family. The Service Coordinator can serve in a “blended” role; in other words, a single practitioner can provide both Early Intervention Targeted Case Management/Service Coordination and an IFSP service, such as physical therapy, developmental services, etc. to a child and his or her family. The Contractor shall submit an annual report outlining its efforts in the four social determinants of health areas listed above.”* (p. 380).

- **Opportunity: Specify the expectations for coordination and Medicaid financing related to services and programs operated through the state’s Title V Maternal and Child Health Services (MCH) Block Grant program.** It is key for Medicaid contracts to ensure that MCO’s coordinate with and support services provided through the Title V MCH Block Grant and public health systems.⁵³ Title V and Medicaid are required under federal law to engage in coordination and partnerships in order to improve access to health services for children, including interagency agreements, reimbursement of Title V providers for Medicaid-covered services rendered, and coordination of EPSDT.⁵⁴ While federal funding under Title V cannot serve as a match for Medicaid, every state uses some Medicaid funding for services delivered by public health agencies and their MCH programs. Often this is a substantial portion of MCH program funding, accounting for more than one third of the total for the nation overall.⁵⁵

 - Louisiana specifically references the Title V MCH and other programs in the Louisiana Department of Health: *“The Contractor shall comply with all state and regulatory laws where applicable, including screening and follow up. LDH programs and initiatives include, but are not limited to, the following: ...; 2.6.3.3.2 Programs, services, and initiatives administered through the State’s Title V, Maternal and Child Health Block Grant Program”* (Appendix B: Model Contract, pp. 86-87).
 - Additional provisions from West Virginia reinforce this contract obligation. *“5.3.4.1 Care Coordination with the Title V State Agency - The MCO, through BMS, will coordinate with the Bureau for Public Health (BPH), Office of Maternal, Child and Family Health, to: 1. Make all reasonable efforts to assure that all enrolled enrollees with special health care needs, ages zero (0) to twenty-one (21), have access to a medical home and receive comprehensive, coordinated services and supports pursuant to national standards for systems of care for children and youth with special health care needs; 2. Make all reasonable efforts to assure better access to and receipt of the full range of screening, diagnostic, and treatment services covered under EPSDT; 3. Improve the rates and content of well child visits; 4. Improve care coordination for children with special health care needs, particularly those with multiple systems of care in place; 5. Make all reasonable efforts to assure Medicaid children and their established plans of care are being met.”* (p. 114, 2020, West Virginia Medicaid Managed Care Contract).
- **Opportunity: Use the examples related to collaboration between Medicaid MCOs and other public health agencies and other local community-based service providers.** In addition to Medicaid itself and IDEA, the federal government supports an array of services that are important to child health and development, including WIC and SNAP benefits, community health programs and services, and child welfare services ranging from more preventive services under Title IV-b to services to children in foster care. It is important that state contracts recognize the need for collaboration and coordination across these programs and be clear in providing direction to ensure that children do not fall through the gaps or fail to receive coverage because of disputes over who is responsible for providing the payment and coverage.

- Several states have examples of generic collaboration with local health departments. Georgia has a broad requirement to coordinate and work collaboratively with all divisions and other state agencies. Rhode Island mentions WIC, IDEA, child welfare, and an adolescent initiative. Mississippi has a similar list, adding school health and Health Start. Delaware includes school-based services (primarily IDEA). Many include WIC. New Jersey and some other states have lists that focus primarily on adults.
- Louisiana has broad provisions and also identifies a particular set of activities, including WIC, HIV, STI, and behavioral health. They also specify relationships with other community-based organizations: “2.6.3.2 *Services Provided by Community-Based Organizations or the Office of Public Health* 2.6.3.2.1 *The Contractor shall identify and coordinate with community-based organizations and/or OPH on population health improvement strategies. 2.6.3.2.2 The Contractor shall identify and, to the extent applicable, enter into agreement with community-based organizations and/or OPH [Office of Public Health] to coordinate population health improvement strategies which address socioeconomic, environmental, and/or policy domains; as well as provide services such as care coordination and intensive case management as needed and supported by evidence-based best practices. Agreements shall address the following topics: 2.6.3.2.2.1 Data sharing; 2.6.3.2.2.2 Roles/responsibilities and communication on development of care coordination plans; 2.6.3.2.2.3 Reporting requirements; 2.6.3.2.2.4 Quality assurance and quality improvement coordination; 2.6.3.2.2.5 Plans for coordinating service delivery with primary care providers; and 2.6.3.2.2.6 Payment arrangements.*” (p. 83).
- In Michigan, contract language focuses on collaboration with social services agencies: “.3 *A method for coordinating the medical needs of an Enrollee with his or her social service needs. This may involve working with Local Agency social service staff or with the various community resources in the county. Coordination with the Local Agency social service staff will be required when the Enrollee is in need of the following services.*”
- Kentucky has an example of a Performance Improvement Project (PIP). “*Performance Improvement Projects (PIPs) ... The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies, community based health/social agencies and health care delivery systems to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives. The Contractor shall be committed to ongoing collaboration in the area of service and clinical care improvements by the development of best practices, use of encounter data–driven performance measures and establishment of relationship with existing organizations engaged in provider performance improvement through education and training in best practices and data collection. Evidence of adequate partnerships should include formal documentation of meetings, input from stakeholders and shared responsibility in the design and*

implementation of PIP activities.” (p. 52, July 2019, Kentucky Medicaid Managed Care Contract).

- Oregon has a similar contract provision, which is strongly linked to their local structures. *“2. Community Health Assessment (CHA) and Community Health Improvement Plan (CHP) a. The Contractor, through its [Community Advisory Council], shall adopt a CHA and a CHP... b. To the extent practicable, Contractor shall include in the CHA and CHP a strategy and plan for: (1) Working with the Early Learning Council, Early Learning Hubs, the Youth Development Council, Local Mental Health Authority, oral health care Providers, the local public health authority, Community-based organizations, hospital systems and the school health Providers in the Service Area/region; and (2) Coordinating the effective and efficient delivery of health care to children and adolescents in the Community.”* (pp. 215-216, January 2020, Oregon Medicaid Managed Care RFA).
- Oregon also says: *“State and Local Government Agencies and Community Social and Support Services Organizations: Contractor shall promote communication and coordination with State and local government agencies and culturally diverse Community social and support services organizations, including early child education, special education, Behavioral Health and public health, as critical for the development and operation of an effective delivery system. Contractor shall consult and collaborate with its Providers to maximize Provider awareness of available resources to ensure diverse Members’ health, and to assist Providers in referring Members to the appropriate Providers or organizations. Contractor shall ensure that the assistance provided regarding Referrals to State and local governments and Community social and support services organizations takes into account the Referral and service delivery factors identified in the Community Health Assessment and Community Improvement Plan.”* (p. 62)
- **Opportunity: Build upon examples used to describe collaboration more broadly with an array of community-based entities.** These provisions are often related to SDOH efforts. Some states have projects such as health homes or SDOH initiatives which require collaboration between MCOs and other community-based entities. Contract specifications should offer approaches appropriate for children and their families, not just adult focused risks and needs for care coordination. Where integrated service plans are used, the language should reflect the contractors’ responsibility for participating in the process. This may be applicable to states with Integrated Care for Kids (InCK) model projects, as well as other states with integrated service systems at the community level (e.g., Oregon, Vermont, Washington State).
 - Mentioned above but shown here at greater length, Colorado contract language is helpful.
 - *“Contractors shall establish relationships and collaborate with economic, social, educational, justice, recreational, and other relevant organizations to promote the health of the local communities and populations.*

- *10.3.3 The Contractors shall know, understand and implement initiatives to build local communities to optimize Member health and well-being, particularly for those Members with complex needs that receive services from a variety of agencies.*
 - *10.3.4: The Contractors shall establish relationships and communications channels with Community organizations that provide resources such as food, housing, energy assistance, childcare, education, and job training in the region.*
 - *10.3.4.1: The Contractor shall collaborate with school districts and schools to coordinate care and develop programs to optimize the growth and well-being of Medicaid children and youth.*
 - *10.3.7: The Contractor shall work with Community organizations to remove roadblocks to Member access to programs and initiatives, particularly evidence-based/promising practice programs in the region.*
 - *10.3.8: The Contractor shall share information with Community organizations in the region about identified Community social service gaps and needs.*
 - *10.3.9: The Contractor shall engage with hospitals and local public health agencies regarding their community health needs assessments to develop and implement collaborative strategies to reduce health inequities and disparities in the Community.*
 - *10.3.10: The Contractor shall collaborate with the Department, other state agencies, and regional and local efforts in order to expand the Community resources available to Members.” (p.65-6, July 2019, Region 1, Colorado Medicaid Managed Care Contract).*
- Washington State has a complex set of providers that call for an “allied system coordination plan” for each regional service area in which the contractor participates. It is reminiscent of the CMS InCK model, including: “*Clearly defined roles and responsibilities of the allied systems in helping Enrollees served by more than one system. For children this includes EPSDT coordination for any child serving agency and a process for participation by the agency in the development of a cross-system ISP [Individual Service Plan] when indicated under EPSDT; Identification of needed local resources, including initiatives to address those needs; A process for facilitation of community reintegration from out-of-home placements... for Enrollees of all ages; A process for working with ACH [Accountable Community of Health],...*” and more.
- Illinois says: “*5.12.2.2 Contractor shall coordinate services with the services the Enrollee receives from community and social support providers. (p. 84). 2.1.3.12.2 Contractor shall have ... a provider network for social services support ...*” (p. 321, January 2018, Illinois Medicaid Managed Care Model Contract Draft).
- Similarly, Kentucky says: “*21.2 National Standards for Medical Necessity Review ...E. The Contractor shall have written policies to ensure the coordination of services: ... 4*

With the services the Enrollee receives from community and social support providers...”
(p. 55, July 2019, Kentucky Medicaid Managed Care Contract).

- **Opportunity: Build upon examples of medical home initiatives and systems of care for children.** The GWU legal analysis team defined this category of examples as follows: *“Pediatric medical homes means contract language regarding medical home or health home programs that is specific to pediatric patients.”* As discussed above, the AAP, HRSA-MCHB, and CMS all recommend that each child have a patient/family centered medical home. The AAP and HRSA-MCHB long-standing definition calls for a pediatric medical home provides health care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. In 2007 the AAP, American Academy of Family Practice, American College of Physicians and American Osteopathic Association developed the *“Joint Principles of the Patient-Centered Medical Home (PCMH)”* and adopted the National Center for Quality Assurance (NCQA) criteria as standards for practice.⁵⁶ This broad definition has been applied by NCQA and many states now certify medical homes. At the same time, this broad definition does not include specificity on how it needs to be constructed to respond to young children’s unique health and developmental needs and the particular role that parents and caregivers play in that response. Still, the extracted contract language provides some useful examples. Notably, most apply to CSHCN. State contract specifications should seek to capture and describe key elements of the design for a high performing medical home for children.
 - Rhode Island has a child health transformation initiative that is one of InCK Marks examples of exemplary practice. The contract makes reference to it. *“2.07.08 Care Transformation Collaborative of Rhode Island: Contractor is required to participate both financially and operationally in the Care Transformation Collaborative of Rhode Island (CTC-RI), including **Patient-Centered Medical Home for Kids (PCMH-Kids)**, according to the requirements for participation as set forth by EOHHS and consistent with parameters established by the CTC-RI Executive Committee. This participation shall include, but not be limited to provision of high utilizer reports to participating practice sites, provider PMPM payments, CTC-RI administrative payments, and referrals to community health teams.”* (p. 71, July 2018, Rhode Island Medicaid Managed Care Contract)... *“Care management is to be performed by Health Plan staff or agents located in the State of Rhode Island. Rhode Island staff will be key for their ability to work closely with local resources. Face-to-face meetings shall be conducted where appropriate; to best coordinate the services and supports needed to meet the needs of members, including behavioral health needs, social supports and services and out-of-plan services. The Program Coordinator (and/or Care Manager) and all their needed support staff shall be located in Rhode Island.”* (p. 88).
 - The Rhode Island health home initiative, which was created post- ACA from a longstanding program for developmental services to children in Medicaid which did not qualify for Part C Early Intervention, is also described in the contract. *“Integrated Health Home (IHH) is built upon the evidence-based practices of the patient-centered medical*

home model. IHH builds linkages to other community and social supports, and enhances coordination of primary medical, specialty and behavioral healthcare, (including Addiction care) in keeping with the needs of persons with multiple chronic illnesses. IHH is a service provided to community-based clients by professional behavioral health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure. IHH teams monitor and provide medically necessary interventions to assist in the enhancement of health, management of symptoms of illness, as well as overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. IHH uses a team-based approach for care coordination, mental health and physical health chronic condition management, health promotion and peer/family support.” (pp. 389).

- As noted above, West Virginia contract language parallels the MCHB-HRSA definition of a medical home for CSHCN. “2.4.8 Children with Special Health Care Needs Program (CSHCN) Providers - The Children with Special Health Care Needs (CSHCN) Program provides care coordination and access to specialty services through a system of community-based Care Coordinators¹¹ and specialty clinics, thus enabling children and youth with special health care needs to receive a patient/family-centered medical home approach to comprehensive, coordinated services and supports. The MCO is encouraged, but not required, to contract with CSHCN providers. However, if the MCO does not contract with CSHCN providers, the MCO must provide the same level and types of services as those currently available through the CSHCN program. This includes access to multidisciplinary care. The CSHCN eligibility criteria and services are available from BMS. BMS will monitor compliance with this requirement; if the MCO fails to satisfy these requirements, it will be required to reimburse the traditional CSHCN providers at the Medicaid fee rate.” (p. 74).

Measurement, Measures, and Metrics

The InCK Marks framework for child health transformation focuses on practice, finance, and metrics/measurement transformation. In states using Medicaid managed care, contract language to support the high performing medical home and encourage practice transformation should include appropriate requirements related to measurement and measures. As discussed below, the provisions extracted by GWU legal research team indicate that contract language gives insufficient attention to the child health measures, including those related to young children.

The *Sourcebook on Medicaid's Role in Early Childhood* included an entire section on measurement and set out a recommended set of measures related to the high performing medical home. As shown in Table 2, this includes six topics from the CMS core child set, as well as additional topics for measurement. InCK Marks has produced several working papers related to health metrics and measurement that stress the need to screen for social and medical (and relational) complexity, incorporate measures of attachment and early self-regulation and resiliency for young children, and measure the extent to which practices engage children and their parents and partner with them.⁵⁷ These additional areas are important for monitoring quality in the context of a high performing medical home, including: referral processes,

screening beyond general development, family engagement, and practice augmentations. If states were to certify and make differential payments for the preventive primary care of high performing medical homes, then measurement would be essential and such measures should be specified in related contracts language.

Table 2. Measuring High Performing Pediatric Medical Homes for Young Children in Medicaid

High rates of access to care
High percentage of children receiving well-child visits*
High rates of children who are up-to-date on immunizations*
High performance on developmental screening measure*
Satisfaction with the experience of care as measured with the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H*
Use of the validated CSHCN screening tool
Use of SDOH screening tool, including maternal depression
Low rates of unnecessary emergency department visits*
Family engagement demonstrated through use of recommended Bright Futures pre-visit tools and/or the electronic Well-Visit Planner
Documentation on rates of referrals, follow up and completed referrals
Documentation of augmented resources and supports provided in practice (e.g., integrated mental health, Healthy Steps, Project DULCE, Reach Out and Read)

* Measures are part of CMS Medicaid-CHIP Core Child Set. See below Appendix B for full list.

The CMS has defined a core child set of measures for Medicaid and CHIP that are focused primarily on monitoring quality using key indicators of the care process. (See core child measure set in Appendix B). In 2019, 11 of the 26 core child set measures related to young children (prenatal to age 5). While all states will be required to report quality measures in the child core set beginning in FFY 2024, many states do not yet report on all of the measures. Moreover, contract language does not consistently reflect the core child set measures. Many states continue reference the HEDIS [Healthcare Effectiveness Data and Information Set] measures in their contracts. While HEDIS has overlap with the CMS child core set, they are not the same. In addition, EPSDT (CMS Form 416) performance data are important, although the responsibility to collect and report EPSDT data is not consistently described in managed care contracts.

- **Opportunity: Build upon examples that use measures from the child core set.** Many states do not currently include the full set of child core measures, but some extracted provisions point to what might be stated. As mentioned above, many states reference the HEDIS measures, while listing some of the CMS child core set measures that overlap. States’ contract specifications should include at least the six CMS child core set measures identified in the table above. (The six topics are: access, well-child visits, developmental screening, immunizations, CAHPS child version, and emergency visits). In addition, states should require collection and reporting of EPSDT 416 data and consider adding the NCQA access measure. The following examples offer language that other states might consider.
 - Arizona specifies the obligation for reporting on the CMS core set: “*Quality Improvement Performance Requirements: The Contractor shall monitor and report all CMS Children’s Core Set measures, as applicable, and may be required to monitor and report select*

NCQA HEDIS® or other AHCCCS-required measures, as mandated by AHCCCS, for the applicable Contract Year. The Contractor shall utilize the appropriate measure specifications, to include the appropriate measure steward and version/year, as directed by AHCCCS. The Contractor shall perform in accordance with established standards, as outlined in this section. Contractor performance that does not meet established standards may be subject to regulatory action.... The Contractor must meet and sustain, as well as ensure that each subcontractor meets and sustains, the AHCCCS stated Minimum Performance Standards (MPS) for each applicable population/eligibility category (i.e. Title XIX and/or Title XXI – KidsCare Program) for each required performance measure...” (p. 94).

- *Nebraska has broad language and references multiple measurement sets. “M. QUALITY MANAGEMENT.... 6. Quality Performance Measurement and Evaluation. A. The MCO must report specific performance measures, as listed in Attachment 7 – Performance Measures. MLTC [Division of Medicaid and Long-Term Care] may update performance targets, including choosing additional performance measures or removing performance measures from the list of requirements, at any time during the contract period. Performance measures include, but are not limited to, Health Care Effectiveness Data and Information Set (HEDIS®) measures, CHIPRA [Children’s Health Insurance Program Reauthorization Act] Quality Measures required by CMS [Centers for Medicare and Medicaid Services], Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures, ACA [Affordable Care Act] Adult Quality Measures as defined by CMS (Section 2701 of the ACA), and any other measures as determined by MLTC.” (pp. 121-122, December 2015, Nebraska Medicaid Managed Care RFP).*
- *District of Columbia has broad and inclusive language: “C.5.32. Quality Assessment and Performance Improvement (QAPI).... C.5.32.1.2. In accordance with 42 C.F.R. § 438.330, the D.C. HMO Act, D.C. Code § 31-3406, Contractor shall develop, maintain and operate a QAPI program consistent with this Contract, which shall be reviewed and/or revised annually and submitted to DHCF for approval.... C.5.32.1.7. The QAPI program shall be consistent with the following requirements, but not limited to: ... C.5.32.1.7.2. Contractor shall use performance measures including, but not limited to, HEDIS®, CAHPS®, Provider surveys, satisfaction surveys, CMS [Centers for Medicare and Medicaid Services]-specified Core Measures, EPSDT, Clinical and Non-Clinical Initiatives, Practice Guidelines, Focused Studies, Adverse Events, and all External Quality Review Organization (EQRO) activities as part of its QAPI program.” (pp. 148-149).*
- *Hawaii has broad expectations in its contract language, as illustrated in the small section here: “The following include types of performance measures that the Health Plan shall be required to track and provide to DHS: a) Clinical and Utilization Quality measures - a set of clinical and utilization measures are required from the Health Plan each year. DHS shall provide a list of the performance measures each calendar year for the next year’s required measures. The measures may be HEDIS measures. b) HEDIS-Like*

measures – a set of measures (both clinical and utilization measures) that are based on HEDIS measure definitions, but modified as needed to achieve such goals as alignment with the CMS Medicaid Core Set, or alignment with DHS prioritiesf) EPSDT data - the Health Plan shall report EPSDT information utilizing the CMS 416 format. This report includes information on EPSDT participation, percentage of children identified for referral, percentage of children receiving follow-up services in a timely manner, etc.” (pp. 305-307, August 2019, Hawaii Medicaid Managed Care RFP).

- **Opportunity: Encourage states to use the CAHPS child measure.** The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Child Survey is part of the CMS core child set of measures and HEDIS (<https://www.medicaid.gov/medicaid/quality-of-care/downloads/cahpsbrief.pdf>). It includes six additional questions about health promotion and education, shared decision making, and coordination of care. There is a set for the general population (with commercial and Medicaid questionnaires) and a special needs version. The general population version has five composite measures that include: 1) access to specialized services, 2) family-centered care: personal doctor who knows the child, 3) coordination of care for children with chronic conditions, 4) access to prescription medication, and 5) family-centered care: getting needed information. The CAHPS for Children with Chronic Conditions (i.e., CSHCN) is an extensive set of items that assess the experiences of this population with health plans and health care services. It allows for comparison of the experiences of CSHCN with those of similar children in other health plans and/or the general population of children in the same plan. (This set of supplemental items consists of two types of questions: a) the five-item CSHCN screener that classifies children with chronic conditions during the analysis stage after the survey has been administered; and b) a set of supplemental questions regarding the health care experiences of children with chronic conditions. <https://www.ahrq.gov/cahps/surveys-guidance/item-sets/children-chronic/index.html>)

 - The District of Columbia, Nebraska, North Dakota, Pennsylvania, and Utah contract language calls for use of CAHPS; however, not all specify use of both the CAHPS for children and the CAHPS for children with chronic conditions (CSHCN).
 - Louisiana specifies use of the child version. “*Quality Performance Measures (DRAFT) ... 1. Well-Child Visits in the First 15 Months of Life; 2. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life; 3. Adolescent Well-Care Visits; ... 12. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version (Medicaid); ...*” (Attachment G: Quality Performance Measures (Draft), Appendix B: Model Contract, pp. 1-11, February 2019, Louisiana Medicaid Managed Care RFP).
 - Ohio specifies use of the general child rating. “[*MEASURES INDICATED FOR MINIMUM PERFORMANCE STANDARDS*] ... *General Child Rating of Health Plan (CAHPS Health Plan Survey); General Child – Customer Service Composite (CAHPS Health Plan Survey);...*” (Appendix M, pp. 171-173).
- **Opportunity: Build upon examples of linking metrics/performance measures to payments and incentives.** Some states are using quality measures to set minimum performance standards and/or create incentives for performance (e.g., pay for performance, payment withholds). Many

variations exist, with a few examples of distinct approaches shown below. Some of these illustrate approaches that could be used incentivizing the high performing medical home for young children, that is states could offer performance bonuses such as these to those who meet the criteria for a high performing medical home and/or show results under related performance metrics.

- New Jersey ties NCQA accreditation, HEDIS, and CAPHS measures together as criteria for getting into a high performance bonus pool: “8.5.7. *Performance-Based Contracting Program. B. Eligibility – MCOs must earn “Commendable” NCQA [National Committee Quality Assurance] Accreditation status based on their performance against NCQA’s rigorous requirements and their performance on HEDIS and CAPHS 2019 measures ... and perform under this contract for the full twelve months of calendar year 2018 to be eligible for the Performance-Based Incentive Program. C. Performance payment pool – Criteria for earning the performance pool payment is achieving the benchmark on the following five metrics: Pre-term birth rate... ; Pre-natal care timeliness... ; Post-partum care timeliness... ; HbA1C < 8... ; Body mass index documentation for children and adolescents.... D. High Performance Bonus - Each eligible contractor who successfully meets three of the five benchmarks will qualify for incentive payments from the High Performance Bonus Pool. The \$3,000,000 high performance bonus pool will be divided equally amongst the qualifying contractors. In the event that none of the participating Contractors qualify for the High Performance Bonus, no payments will be made. This amount will not be redistributed to participating Contractors in the current year or succeeding years.” (Article 8, pp. 8-9, January 2019, New Jersey Medicaid Managed Care Model Contract).*
- Florida describes penalties: “3. For performance measures where the Managed Care Plan’s rate falls below the 50th percentile, liquidated damages may be assessed at \$100 per eligible member not receiving the service being measured up to the 50th percentile rate for the measure. 4. The Agency may assess liquidated damages for each of the following measures: (a) Antidepressant Medication Management (acute); (b) Follow-up Care for Children Prescribed ADHD Medication (initiation); (c) Follow-up after Hospitalization for Mental Illness (7 day); (d) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (initiation – total); (e) Adolescent Well Care Visits; (f) Childhood Immunization Status – Combo 3; (g) Immunizations for Adolescents – Combo 1; (h) Well-Child Visits in the First 15 Months of Life (6 or more); (i) Well-Child Visits in the First 15 Months of Life (0 visits); (j) Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life; (k) Lead Screening in Children; (l) Adults’ Access to Preventive/Ambulatory Health Services (total); (m) Annual Dental Visits (total); (n) Adult BMI Assessment; (o) Breast Cancer Screening; (p) Cervical Cancer Screening; (q) Children and Adolescents’ Access to Primary Care (includes 4 age group rates); (r) Chlamydia Screening for Women (total); (s) Prenatal and Postpartum Care (includes two (2) measures); (t) Comprehensive Diabetes Care - HbA1c Testing; (u) Comprehensive Diabetes Care - HbA1c Control (< 8%); (v) Comprehensive Diabetes Care - Eye Exam; (w) Comprehensive Diabetes Care - Medical Attention for Nephropathy; (x) Controlling

High Blood Pressure; (y) Medication Management for People with Asthma (75% - total); and (z) Annual Monitoring for Patients on Persistent Medications (total).” (pp. 98-99, February 2019, Attachment II, February 2020, Florida Medicaid Managed Care Model Contract).

- Georgia has measures related to value-based purchasing: “*ATTACHMENT U. Georgia Families. Value Based Purchasing Measures. Figure Z: Value Based Purchasing Performance Measures and Targets - Georgia Families Core Measures. Performance Measures: Preventive Care for Children: 1) Well-child visits in the First 15 Months of Life – 6 or more visits; 2) Preventive Care for Children: Childhood Immunization Status – Combo 10; 3) Developmental Screening: Developmental Screening in the first three years of life; 4) Preventive Care for Adolescents: Adolescents Well-Care Visits; 5) Preventive Dental Services: Total Eligibles Receiving Preventive Dental Services; 6) Obesity Prevention: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile – Total; 7) Behavioral Health: Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase; ... 9) Birth Outcomes: Rate of Infants with Low Birth Weight.*” (Attachment U, pp. 8693-8695, 2016, Georgia CareSource Medicaid Managed Care Contract).
- Indiana uses a withhold: “*EXHIBIT 3.B. CONTRACT COMPLIANCE AND PAY FOR OUTCOMES – HOOSIER HEALTHWISE.... B. Pay for Outcomes Program.... 4. Performance Measures and Incentive Payment Structure.... a. Incentive Payments – Withholds – Hoosier Healthwise. The following incentives are payable in the form of release of funds withheld.... ii. Well child visits (0-15 months); iii. Well child visits (3-6 years); iv. Adolescent well child visits (12-21 years); ... vii. Lead Screening in Children; viii. Medication Management for People with Asthma.*” (Amendment #4, pp. 321-326, February 2018, Indiana Medicaid Managed Care Contract).
- Michigan says remedial action may be needed if plans fail to meet minimum performance standards: “*Minimum performance monitoring standards for FY 2018 are included in this document. Failure to meet the minimum performance monitoring standards may result in the implementation of remedial actions and/or improvement plans as outlined in the Contract. Performance Area[s]: Blood Lead Testing; Developmental Screening; ... Childhood Immunization; Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Fourth, Fifth and Sixth Years of Life; Adolescent Well Care Visits; Appropriate Testing for Children with Pharyngitis; Child Access to Care 12 to 24 months; Child Access to Care 7 to 11 years;*” (pp. 147-154, January 2016, Michigan Medicaid Managed Care Model Contract).
- New Mexico says: “*4.12.8. Performance Measures. 4.12.8.1.... The CONTRACTOR shall meet performance targets specified by HSD [New Mexico Human Services Department]. The Performance Measures will require either: 1) a two (2) percentage point improvement above the MCO’s prior year audited Health Effectiveness Data and Information Set (HEDIS) reported rates; or 2) achievement of the prior year Health and Human Services (HHS) Regional Average as determined by the National Committee for*

Quality Assurance (NCQA) Quality Compass data. Failure to meet the two (2) percentage point improvement or the target for the performance measure during the Calendar Year will result in a monetary penalty as stated in Section 7.3.3.6.7 of this contract.... 4.12.8.2 The performance measures (PMs) shall be evaluated using the following criteria: 4.12.8.2.1. PM #1 (1 point) — Well Child Visits in the First fifteen (15) Months of Life (W15); ... 4.12.8.2.2. PM #2 (4 total points) — Children and Adolescents' Access to Primary Care Practitioners (CAP); ... 4.12.8.2.3. PM #3 (1 point) — Adult BMI Assessment (ABA); ... 4.12.8.2.4. PM #4 (3 total points) — Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC); ...” (pp. 184-186).

- *New Jersey states that: “8.5.7. Performance-Based Contracting Program. B. Eligibility – MCOs must earn “Commendable” NCQA [National Committee Quality Assurance] Accreditation status based on their performance against NCQA’s rigorous requirements and their performance on HEDIS and CAPHS 2019 measures ... and perform under this contract for the full twelve months of calendar year 2018 to be eligible for the Performance-Based Incentive Program. C. Performance payment pool – Criteria for earning the performance pool payment is achieving the benchmark on the following five metrics: Pre-term birth rate... ; Pre-natal care timeliness... ; Post-partum care timeliness... ; HbA1C < 8... ; Body mass index documentation for children and adolescents.... D. High Performance Bonus - Each eligible contractor who successfully meets three of the five benchmarks will qualify for incentive payments from the High Performance Bonus Pool. The \$3,000,000 high performance bonus pool will be divided equally amongst the qualifying contractors. In the event that none of the participating Contractors qualify for the High Performance Bonus, no payments will be made. This amount will not be redistributed to participating Contractors in the current year or succeeding years.” (Article 8, pp. 8-9, January 2019, New Jersey Medicaid Managed Care Model Contract).*
- *Nevada says: “.... 4. 7.2.2. Comprehensive Well Child Periodic and Inter-periodic Health Assessments/Early Periodic Screening Diagnosis and Treatment (EPSDT)/Healthy Kids. A. Standard: The Vendor shall take affirmative steps to achieve at least a participation rate greater than or equal to the national average for EPSDT screenings. Well Child Care promotes healthy development and disease prevention in addition to possible early discovery of disease and appropriate treatment. B. Required Measures: The following HEDIS measures will be reported: 1. Children's Access to Primary Care Providers; 2. Well-Child Visits in the First 15 Months of Life; 3. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life; 4. Adolescent Well-Care Visits.... 4.7.2.3. Immunizations. A. Standard: Immunization Age appropriate immunizations (according to current Advisory Committee on Immunization Practices (ACIP) schedule. B. Required Measures: The following HEDIS measures will be reported: ...” [includes immunization, dental, and lead testing.] (pp. 101-107, September 2012, Nevada Medicaid Managed Care RFP*

- Ohio formerly used a pay-for-performance approach and quality indices; however, the contract suggests a switch to quality withhold approach: *“Appendix O. Pay-For-Performance (P4P) and Quality Withhold. The Ohio Department of Medicaid (ODM) established a Pay for Performance (P4P) Incentive System and a Quality Withhold Program to provide financial rewards and quality payments to MCPs that achieve specific levels of performance in program priority areas. Standardized clinical quality measures derived from a national measurement set (i.e., HEDIS [Healthcare Effectiveness Data and Information Set]) are used to determine incentive payments. The P4P Incentive System will be phased out after State Fiscal Year (SFY) 2018 (measurement year 2017) and replaced with the Quality Withhold Program in SFY 2019 (measurement year 2018).... 2. Quality Withhold Program: Starting with capitation and delivery payments made in April 2018, ODM will withhold 2.0% for use in the Quality Withhold Program. ODM will use Quality Indices to calculate the amount of the withhold payout. Quality Indices will be comprised of multiple performance measures related to the index topic. Quality Indices measure the effectiveness of the MCP’s [Managed Care Plan’s] population health management strategy and quality improvement programs to impact population health outcomes. Determination of the Quality Withhold payout is specified in this appendix. A bonus pool for high performing MCPs will be established annually based on unreturned quality withhold dollars as specified in this appendix. a. SY 2019 Quality Withhold Payout Determination. The Department will use the MCPs’ self-reported audited HEDIS data submission for the purpose of evaluating performance related to the Quality Withhold Program.... ii. Quality Indices & Measures. Performance will be assessed on four equally weighted Quality Indices. The Quality Indices used in the Quality Withhold program for SFY 2019 (measurement year 2018) are: (1) Chronic Condition: Cardiovascular Disease; (2) Chronic Condition: Diabetes; (3) Behavioral Health; and (4) Healthy Children. Each index is composed of multiple quality measures which are assigned different weights. The index measures and weights are described in ODM’s Quality Indices and Scoring Methodology.... b. SFY 2020 Quality Withhold Payout Determination. The Department will use the MCPs’ self-reported audited HEDIS data submission for the purpose of evaluating performance related to the Quality Withhold Program.... ii. Quality Indices & Measures. Performance will be assessed on four equally weighted Quality Indices. The Quality Indices used in the Quality Withhold program for SFY 2020 (measurement year 2019) are: (1) Chronic Condition: Cardiovascular Disease; (2) Chronic Condition: Diabetes; (3) Behavioral Health; and (4) Healthy Children.... c. SFY 2021 Quality Withhold Payout Determination. The Department will use the MCPs’ self-reported audited HEDIS data submission for the purpose of evaluating performance related to the Quality Withhold Program.... ii. Quality Indices & Measures. Performance will be assessed on four equally weighted Quality Indices. The Quality Indices used in the Quality Withhold program for SFY 2021 (measurement year 2020) are: (1) Chronic Condition: Cardiovascular Disease; (2) Chronic Condition: Diabetes; (3) Behavioral Health; and (4) Healthy Children. Each index is composed of multiple quality measures which are assigned different weights. The*

index measures and weights are described in ODM's Quality Indices and Scoring Methodology." (Appendix O, pp. 198-203, January 2020, Ohio Medicaid Managed Care Model Contract).

- West Virginia has required levels of performance and standards, which are linked to select performance improvement projects (PIPs): “6. *QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) PROGRAM.... 6.1. Required Levels of Performance. The MCO must meet certain required standards of performance when providing health care and related services to Medicaid managed care enrollees. The MCO must meet all goals for performance improvement on specific measures that may be established by BMS [Bureau for Medical Services]. These minimum performance standards will be established by examining historical performance standards as well as benchmarks (best practices) of other health plans and delivery systems. Performance standards for each quality review period will be provided to the MCOs by BMS. 6.2. Performance Improvement Projects (PIPs).... Clinical focus areas include: Primary, secondary, and/or tertiary prevention of acute conditions; Primary, secondary, and/or tertiary prevention of chronic conditions...*” (pp. 130-131, July 2019, West Virginia Medicaid Managed Care Contract).
- **Opportunity: Translate the accountability provisions related to CSHCN into contract specifications that focus on young children’s health and development in a high performing medical home.** As discussed above, many states have contract provisions related to services for CSHCN that really define elements of a high performing medical home and could be applied for any child, particularly those birth to five.
 - New Hampshire has a useful example: “4.13.4.1.1 *The MCO shall develop and make available Provider support services which include, at a minimum: ... 4.13.4.1.1.5. Training curriculum, to be developed, in coordination with DHHS, that addresses clinical components necessary to meet the needs of Children with Special Health Care Needs. Examples of clinical topics shall include: federal requirements for EPSDT; unique needs of Children with Special Health Care Needs; family driven, youth-guided, person-centered treatment planning and service provisions; impact of adverse childhood experiences; utilization of evidence-based practices; trauma-informed care; Recovery and resilience principles; and the value of person-centered Care Management that includes meaningful engagement of families/caregivers...*” (p. 237-38).
 - Virginia specifies that: “*The Contractor shall develop a comprehensive system of care for the provision of services as medically necessary, to children ages 13-18 years in the Medallion 4.0 program. The Contractor must ensure that in the provision of services to this population any strategies and innovations implemented align with and advances the following goals: ... Focuses on teens and adolescent health, including trauma-informed care, ACES and resilience...*” (p. 163).

- **Opportunity: Encourage states to specify EPSDT 416 measurement in the contract.** While most states specify MCO obligations to deliver the EPSDT benefit, including preventive, diagnostic, and treatment services, most do not specify under performance measurement that states are required to submit data on EPSDT participation and related data. Even fewer states set a performance measure at 80 percent, as in federal EPSDT law. A few examples of state contract language related to EPSDT measurement are shown below.

 - Florida has language that appears describes the obligation to report on 416 data: “2. *Well-Child Visit Performance Measures. a. Pursuant to s. 409.975(5), F.S., the Managed Care Plan shall achieve a well-child visit rate of at least eighty percent (80%) for those enrollees who are continuously enrolled for at least eight (8) months during the federal fiscal year (October 1 – September 30). This screening compliance rate shall be based on the well-child visit data reported by the Managed Care Plan in its Child Health Check-Up (CMS-416) and FL 80% Screening Report and/or supporting encounter data, and due to the Agency as specified in Section XVI., Reporting Requirements. The data shall be monitored by the Agency for accuracy. Any data reported by the Managed Care Plan that is found to be inaccurate shall be disallowed by the Agency, and such findings shall be considered in violation of the Contract. Failure to meet the eighty percent (80%) screening rate may result in a corrective action plan in addition to the liquidated damages and sanctions provided in this Exhibit. b. The Managed Care Plan shall adopt annual participation goals to achieve at least an eighty percent (80%) well-child visit participation rate, as required by the Centers for Medicare & Medicaid Services.” (p. 66, February 2019, Attachment II, Exhibit II-A, February 2020, Florida Medicaid Managed Care Model Contract).*
 - Hawaii specifies EPSDT data collection and reporting. “...f) *EPSDT data - the Health Plan shall report EPSDT information utilizing the CMS 416 format. This report includes information on EPSDT participation, percentage of children identified for referral, percentage of children receiving follow-up services in a timely manner, etc.*” (pp. 305-307, August 2019, Hawaii Medicaid Managed Care RFP).
 - Missouri contract language says: “f. *Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT): ... The health plan shall provide the full scope of HCY [Healthy Children and Youth]/EPSDT services in accordance with the following: ... 9) The health plan shall report HCY/EPSDT well child visits through encounter data submissions in accordance with the requirements regarding encounter data as specified elsewhere herein. The state agency shall use such encounter data submissions and other data sources to determine health plan compliance with CMS requirements that eighty percent (80%) of eligible members under the age of twenty-one (21) are receiving HCY/EPSDT well child visits in accordance with the periodicity schedule. The state agency shall use the participant ratio as calculated using the CMS [Centers for Medicare and Medicaid Services] 416 methodology for measuring the health plan’s performance.*” (pp. 47-49).

- Nevada has a broad set of expectations, which includes EPSDT and mentions the national performance standard. “4.7.2. *Quality Measurements...* *The Vendor must use audited data, and is responsible for ensuring all updates to the measure are reflected in the final, reported rates. The DHCFP reserves the right to require the Vendor to report on additional quality measures not listed here....* 4. 7.2.2. *Comprehensive Well Child Periodic and Inter-periodic Health Assessments/Early Periodic Screening Diagnosis and Treatment (EPSDT)/Healthy Kids. A. Standard: The Vendor shall take affirmative steps to achieve at least a participation rate greater than or equal to the national average for EPSDT screenings. Well Child Care promotes healthy development and disease prevention in addition to possible early discovery of disease and appropriate treatment.*” (pp. 101-107, September 2012, Nevada Medicaid Managed Care RFP).
- While New Jersey mentions EPSDT performance criteria, it describes measures from the CMS child core set: “C. *EPSDT [Early and Periodic Screening, Diagnostic and Treatment] AND LEAD SCREENING PERFORMANCE CRITERIA. DMAHS [Division of Medical Assistance and Health Services] data specifications for EPSDT and lead screening performance measurement will follow the current HEDIS Technical Specifications for the following measures: 1. Well-Child Visits in the First 15 months of Life; 2. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life; 3. Adolescent Well-Child Visits; 4. Childhood Immunization Status (Combination 9); 5. Annual Dental Visit (Total); 6. Lead Screening in Children. D. The Contractor must demonstrate continuous quality improvement in achieving the performance standards for EPSDT and lead screenings as stated in Article 4. The Division shall, in its sole discretion, determine the appropriateness of Contractor proposed corrective action and the imposition of any other financial or administrative sanctions in addition to those set out above.*” (Article 7, p. 34, January 2019, New Jersey Medicaid Managed Care Model Contract).
- As mentioned above, District of Columbia mentions EPSDT among other things: “*The QAPI program shall be consistent with the following requirements, but not limited to: ... C.5.32.1.7.2. Contractor shall use performance measures including, but not limited to, HEDIS®, CAHPS®, Provider surveys, satisfaction surveys, CMS [Centers for Medicare and Medicaid Services]-specified Core Measures, EPSDT, Clinical and Non-Clinical Initiatives, Practice Guidelines, Focused Studies, Adverse Events, and all External Quality Review Organization (EQRO) activities as part of its QAPI program.*” (pp. 148-149).

Conclusion

As the review of Medicaid managed care contracts shows, states are only beginning to incorporate specific provisions related to children and their unique health care needs into their managed care contracts and only beginning to draw upon the emerging movement toward child health care transformation. Although children represent half of all Medicaid recipients, children account for only one-fifth of

Medicaid costs and expenditures, so the attention of states and MCOs, particularly when it focuses upon cost-containment, has largely been directed to other populations.

At the same time, from a long-term perspective— related to improving population health and address health and health-related costs—advancing child health care transformation must play a key role.

This requires more concerted attention by states to defining and operationalizing Medicaid’s role in financing child health care services, particularly related to high performing medical homes— whether in their own fee-for-service systems or through MCOs or ACOs.

While no state has taken on this full task in developing its managed care contracts, the examples from states presented here offer some guidance in taking on such a task. States must design Medicaid managed care contracts that support the financing and structure of appropriate primary and developmental services for young children; they cannot expect MCOs to do so without such direction and accountability from the state. Key elements to address in MCO contracts include specific provisions about the MCO/contractor’s responsibilities related to:

- Maintaining a sufficient provider network to provide appropriate primary care and medical homes for children.
- Fulfilling obligations under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) child health benefit.
- Providing performance goals and incentives for increasing the proportion of well-child visits which meet the *Bright Futures Guidelines* and EPSDT requirements in terms of content, scope, and timing.
- Conducting the range of recommended screenings for general development, social-emotional-mental development, maternal depression, and social determinants of health (SDOH) at age appropriate intervals and with systems to increase rates of screening with objective tools, counseling, and completed referrals and follow up.
- Providing case management/care coordination, including definitions and terms for tiered and more intensive, relational care coordination, that responds to both medical complexities and social (and relational) complexities which need to be addressed.
- Promoting, through differential payments or incentives, high performing medical homes for young children, with performance expectations and measures, as well as the structure of payments and incentives to cover the cost of augmented well-child visits, additional screening, practice staff focused on development, and/or intensive care coordination. This may be built into the managed care contract as part of or beyond the capitated payment for other services (e.g., performance bonus, incentive payments).
- Establishing language specifying that “medical necessity” is defined for young children to include preventing, ameliorating, and addressing risks and conditions related to child development. Based on individual determinations of medical necessity, this might include services such as developmental interventions, parent support programs, parent-child dyadic mental health therapy, and other early childhood mental health interventions.

- Requiring measures and quality improvement/performance improvement projects designed to increase the quality of well-child visits, screening and responses, and the availability of high performing medical homes.
- Providing overall monitoring and population performance-based measurement and reporting, including disaggregation by medical/social complexities, race/ethnicity, geographic location, etc.)
- Establishing opportunities or requirements for MCOs to use a portion of savings from other efforts that reduce Medicaid costs to make further investments in primary practices engaged in providing enhanced well-child care and to advance other strategies to improve healthy development for the young child population.
- Establishing intentional efforts in practice, financing, and measurement to advance equity, reduce provider bias, and eliminate disparities.

In addition to establishing these elements, states also must develop effective structures for holding MCOs accountable to achieving them. This not only involves sufficient detail in the contractual provisions themselves to enable states to determine that the provisions have been met, but also the effective oversight and staffing to ensure adherence and performance.

Nearly half of births, more than 40 percent of young children, and more than half of children of Black, Hispanic, and Native American children ages 0-17 are covered by Medicaid.^{58 59} Medicaid is key to building a future of health and well-being for all children and youth and society as a whole. Our nation cannot achieve equity for the next generation without strong performance and quality in Medicaid in serving children and their families.

APPENDIX A: GWU Contract Provision Search Terms

Search Terms/Table 1

1. Coverage
 - a. Developmental
 - b. Anticipatory guidance
 - c. As needed assessments (EPSDT/developmental assessments)
 - d. Care coordination
 - e. Bright Futures coverage standards
 - f. Early childhood mental health
 - g. Pediatric medical necessity standards
 - h. Specific forms of therapy – ABA/habilitation
 - i. Preventive services to elevate healthy development
 - j. Screening for social determinants of health/social complexity
 - k. Reach Out and Read provisions

Search Terms/Table 2

2. Access, Care and Performance
 - a. Pediatric medical homes (Expressed or general – leave out the terms for adult population)
 - Particular emphasis upon enhanced reimbursement for medical homes that meet certain standards as high performing medical homes
 - Any enhanced reimbursement to provide services to children at social risk/complexity – (not just medical risk/complexity)
 - Additional reimbursement for persons who are part of the medical home team who are community health workers, family advocates, community navigators, etc.
 - b. Pediatric networks
 - c. Other social service agencies (i.e., relationships with schools)
 - d. ACEs
 - e. Quality performance measures/metrics – related to pediatric development (core performance measures and anything on development)
 - f. Quality performance measures/metrics that speak to secure attachment, bonding or nurturing for young children and/or family stability and nurturing)
 - g. Care coordination, especially with special needs children
 - Particularly care coordination that is relational and more comprehensive in nature and that is triggered by family circumstances and risks (e.g. social determinants) and not just specific conditions in child
 - Care coordination provided by community health workers, family advocates, or other community and paraprofessional staff

Also, contract language that speaks to the MCO giving specific attention to the pediatric population

- a. Requirements related to MCO staffing and expertise
- b. Directions related to use of shared savings or any resources for demonstration programs or improvement partnerships directed to child health and outcomes

APPENDIX B. 2020 /CHIP Child Core Measures Set

Steward	Measure Topic (<i>bold Italics indicate measure related to health of young children prenatal to 5</i>)
Domain 1: Primary Care Access and Preventive Care	
NCQA	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)</i>
NCQA	Chlamydia Screening in Women Ages 16-20 (CHL-CH)
NCQA	<i>Childhood Immunization Status (CIS-CH)</i>
CMS	Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)*
NCQA	<i>Well-Child Visits in the First 15 Months of Life (W15-CH)</i>
NCQA	Immunizations for Adolescents (IMA-CH)
OHSU	<i>Developmental Screening in the First Three Years of Life (DEV-CH)</i>
NCQA	<i>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH)</i>
NCQA	Adolescent Well-Care Visits (AWC-CH)
NCQA	<i>Children and Adolescents' Access to Primary Care Practitioners (CAP-CH)**</i>
Domain 2: Maternal and Perinatal Health	
TJC	PC-02: Cesarean Birth (PC02-CH)
CDC	<i>Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)</i>
CDC	<i>Live Births Weighing Less Than 2,500 Grams (LBW-CH)</i>
NCQA	<i>Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)</i>
OPA	Contraceptive Care — Postpartum Women Ages 15-20 (CCP-CH)
OPA	Contraceptive Care — All Women Ages 15-20 (CCW-CH)
Domain 3: Care of Acute and Chronic Conditions	
NCQA	Asthma Medication Ratio: Ages 5-18 (AMR-CH)
NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)
Domain 4: Behavioral Health Care	
NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6-20 (FUH-CH)
NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
NCQA	Metabolic Monitoring Antipsychotics in Children and Adolescents on Antipsychotics (APC-CH)
Domain 5: Dental and Oral Health Services	
DQA	Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk (SEAL-CH)
CMS	<i>Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)</i>
Domain: 6 Experience of Care	
NCQA	<i>Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H — Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)</i>

AHRQ = Agency for Healthcare Research & Quality; CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; DQA = Dental Quality Alliance (American Dental Association); NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs; TJC = The Joint Commission.

** CMS reported that the CAP-CH measure was retired for the 2020 child core set because it was determined to be more a measure of utilization than of quality, with high rates for most age ranges resulting in a limited ability for states to take action on the results. This makes the EPSDT CMS 416 data on children's EPSDT well child visits important to ensure measurement of utilization.

The 2020 Child Core Health Care Quality Measurement Set is available at: <https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/index.html>

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