Executive Summary

Organization of Sourcebook

This sourcebook is designed to support advancements in primary child health care for young children that are preventive, developmental, and responsive to the needs of young children and their families. It reflects work on the cutting edge of such practice and financing reform. The health care system and health care finance are complex, and the different parts of this sourcebook go into depth on different important topics. They all are based on a common framework related to the emerging role of the primary care child health practitioner. This starts with — but often goes beyond — what the practitioner does.

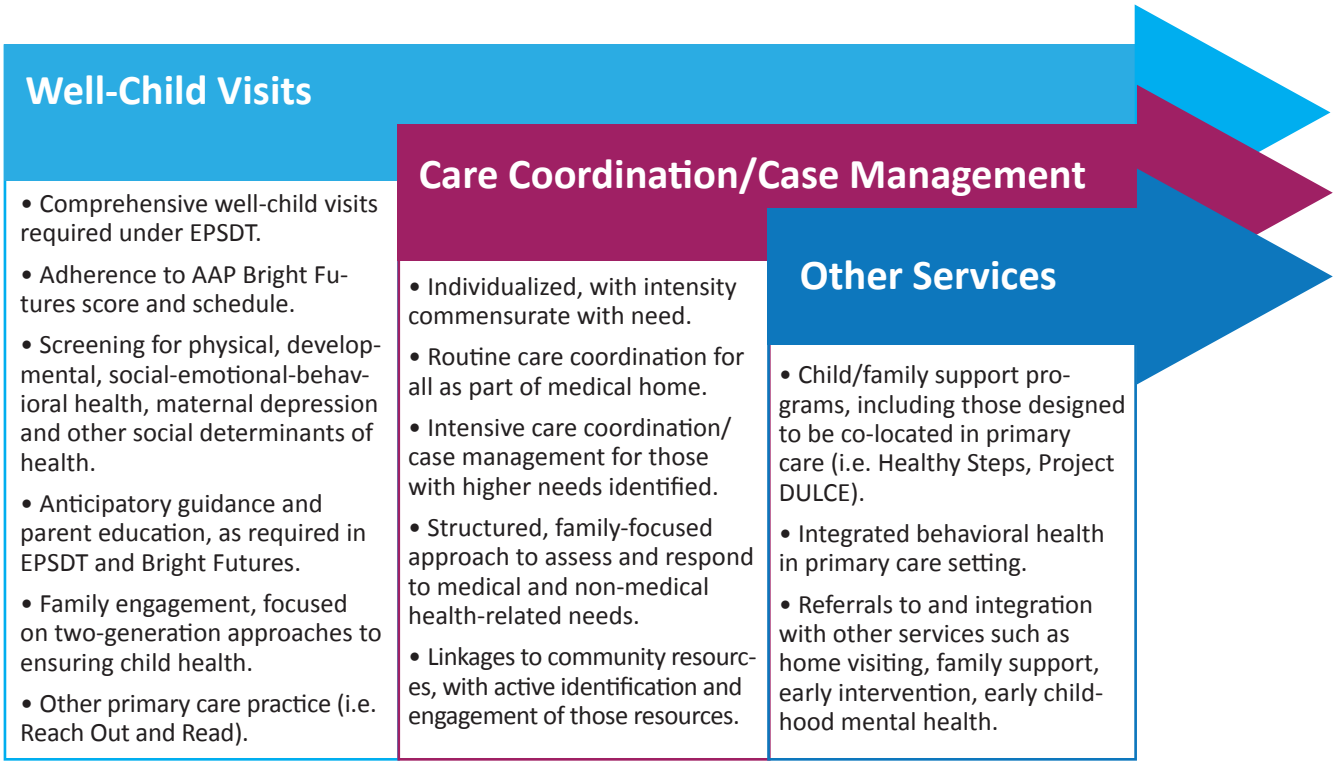
We define this emerging form of practice as a "high performing medical home." The sourcebook goes into detail on the core elements of a high performing medical home, distinguishing it from common practice today, which is much more limited in its scope and impact. This expanded approach is particularly important for the vulnerable, low-income children covered by Medicaid.

Incorporating these elements into practice involves implementing practice changes and enhancements, establishing a financing system to sustain them, and creating monitoring and measurement systems to ensure their implementation (shown in the table and figure below).

Table: Supporting a High Performing Medical Home for Young Children

	Well-Child Visits and Primary-Care Practice	Care Coordination/Case Management	Other Needed Services
Practice design	Comprehensive EPSDT well-child visits adhering to AAP *Bright Futures* scope and schedule with appropriate screening, response, and family engagement.	Care coordination/case management ranging from basic care coordination in medical home to more intensive care coordination. Family-focused need assessment and responses to connect to practice and community resources that address need and promote family agency.	Effective completed referrals to in-house or linked services that address both social and bio-medical conditions affecting child health trajectories, including physical, mental, oral, developmental, and social risk factors.
Medicaid financing	Reimbursement to cover costs and incentivize performance, including visits, array of screening, and office administration.	Reimbursement to cover costs — ranging from basic care coordination in medical home to more intensive care coordination — to improve access to timely support for families with identified needs.	Financing additional preventive and developmental health-related services (e.g., home visiting, early childhood mental health, and other program models).
Measurement	Measures and methods to monitor performance and promote quality improvement, building on Medicaid/CHIP Child Core Measures set.	Measures and methods (e.g., charting and documentation) to monitor performance and promote quality improvement in various types and levels of care coordination.	Measures and methods to monitor performance, demonstrate adherence to effective practices, document connections to improving child health, and promote shared accountability.

Figure: Design for High Performing Medical Homes in Medicaid



Medicaid provides health coverage for millions of low-income Americans, including children, persons with disabilities, adults 19-64, and seniors >65. It is a primary source of coverage for children. Combined with the Children's Health Insurance Program (CHIP), Medicaid provided coverage for 46 million children, out of a total population of 78 million children, at least some time during federal fiscal year (FFY) 2016. Expansions to Medicaid and the establishment and expansion of CHIP reduced the percentage of uninsured U.S. children from 17 percent in 1990 to less than 5 percent in 2016.

Medicaid is particularly important as a source of coverage for the youngest children. U.S. Census data indicate that Medicaid covered just over 40 percent of young children (0 to 5) in 2016. State-reported data show that 60 percent of children 0 to 3 and 56 percent of children 3 to 5 were enrolled in Medicaid during FFY 2016.

Medicaid is a federal-state partnership in terms of its funding and structure. Federal law establishes certain minimum eligibility, benefit, and other requirements, while states play the central role in implementing Medicaid, including establishing eligibility above federal minimums, provider reimbursement rates, and use of managed care arrangements.

State-level information on Medicaid's coverage and financing for child health services points to areas of need and opportunity. There is wide variation in state implementation, but all states are in a position to improve their Medicaid systems as they relate to providing more preventive, developmental, and family-centered responses for young children. Variations among states include:

- *Eligibility Levels for Children in Medicaid*
  On average nationally, as of January 2018, child eligibility levels were 195 percent of poverty for infants and 164 percent of poverty for children ages 1-5, but eligibility levels vary substantially by state.

- *Proportion of All Children Covered under Medicaid and CHIP*
  While Medicaid and CHIP together cover 59 percent of all U.S. children under age 18, the proportion varies across states, from a low of 32 percent to a high of 80 percent. Such variations reflect different child poverty rates, Medicaid/CHIP eligibility levels, and efforts to enroll children.

- *Proportion of Children with No Health Insurance Coverage*
  Because of Medicaid expansions and CHIP, all states have increased health coverage levels among children, but the gains are uneven. Across the states, the percentage of uninsured children ranges from a low of 0.9 percent in Massachusetts to a high of 9.2 percent in Texas.

- *Proportion of Medicaid Beneficiaries who are Children*
  Nationally, children made up 43 percent of enrollees in Medicaid in FFY 2014. Again, there were wide variations among states, primarily driven by: 1) the percentage of low-income children in the state; 2) the levels of eligibility for children; and 3) the substantial variations in eligibility and coverage levels for adults 19-64 (including whether it has expanded Medicaid under the Affordable Care Act).

- *Medicaid Expenditures for Children as Proportion of All Medicaid Expenditures*
  Due to lower health care costs and Medicaid expenditures, children account for a disproportionately smaller share of spending than other Medicaid enrollees. Nationally, children counted for only 19 percent of Medicaid expenditures in FFY 2014, with children's share of expenditures below the national average in many states. Similar to the variations in children as a proportion of enrollees, the eligibility levels for adults and the number of poor children both affect the percent of spending by eligibility group.

- *Medicaid Expenditures per Enrolled Child*
  States may finance more or fewer services for children in Medicaid and provide greater or lesser reimbursements. Nationally, the average expenditure per enrolled child overall was $2,527 in FFY 2014. Six states had per-child expenditures below $2,000 and five states had expenditures more than twice that amount. These differences cannot be explained by variations across states in child health status; they relate to state Medicaid program decisions.

- *Utilization of Preventive Well-Child EPSDT Visits*
  Medicaid data submitted by states provide information on preventive well-child visits by age. There is a national performance standard that 80 percent of 1- and 2-year-olds have at least one well-child visit, but only 20 states met this minimum standard in FFY 2016. The Medicaid/CHIP primary core measure for well-child visits in this age group is the percentage of children receiving six or more visits by 15 months; states' performances ranged from 29 percent to 83 percent in FFY 2016.

Highlights from Part One

The Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit for Children

- EPSDT is the child health benefit in Medicaid. It sets federal requirements and expectations for using Medicaid to promote and improve child health. Required in every state Medicaid program, EPSDT finances a wide array of appropriate and necessary pediatric services. The EPSDT benefit provides a legal entitlement to children covered under Medicaid and is intended to guarantee children coverage for all services allowed under Medicaid in federal law, even if the state does not cover them for other populations.

- EPSDT requires states to finance a wide array of prevention and treatment services. This includes comprehensive well-child visits to screen for, identify, and respond early to conditions that affect the child's health. EPSDT required benefits also include informing families about their benefits, providing assistance in scheduling appointments, arranging for treatment, and financing transportation to keep appointments.

- Despite federal requirements, states vary in how they implement the EPSDT benefit, both in terms of preventive and primary care and services for children with special health care needs (CSHCN), disabilities, and other conditions necessitating treatment.

- Medicaid and its EPSDT benefit not only enable but set expectations for states to provide high-quality primary and preventive health care. Federal law sets a strong framework and expectation for states to provide comprehensive preventive services for young children, starting with the office visit. EPSDT forms a legal basis for financing high performing medical homes for young children and other prevention and early intervention services.

Highlights from Part Two

High Performing Medical Homes for Young Children: Covering Well-Child Care to Meet *Bright Futures* Guidelines

- Child health practice is undergoing a transformation, broadening its focus from treating disease and managing existing health conditions to promoting healthy development. Children's primary care providers are expanding their role in responding to social as well as bio-medical determinants of health. Science and expert recommendations guide such shifts, which are particularly important in the earliest years of life. *Bright Futures* guidelines describe this role and a patient/family-centered medical home, defining expanded relationships with children, their families, and other community services.

- A growing base of exemplary primary care practices demonstrate the feasibility and value of providing such care for young children, called here "high performing medical homes" to distinguish them from the current general standard of care. While current general primary child health practice provides value in identifying medical concerns, providing immunizations, and treating illnesses and injuries, this practice falls short for the one-quarter to one-third of young children for whom social determinants jeopardize healthy development and who are at very early stages of compromised development. High performing medical homes move beyond this current general practice and have much more value in promoting healthy development, but require more time and resources to achieve optimal outcomes.

- Moving from isolated exemplary practices to widespread diffusion requires Medicaid financing that supports and sustains best practices, including comprehensive well-child visits and the additional care coordination, practice enhancements, and linkages to community services needed to address children's healthy development.

- To do so, states need to differentiate between general pediatric practice and that provided by high performing medical homes. Medicaid reimbursement rates and incentives (either directly or through managed care contracts) should be set accordingly. This includes reimbursements for the well-child visit itself and other office practices (including screening, discussed in part four). States need to use quality measures to monitor high performing medical homes to assure they provide the expected level of care.

Highlights from Part Three

High Performing Medical Homes: Care Coordination and Case Management

- The terms "care coordination" and "case management" are both used, often interchangeably, to describe a range of activities that better link children and families to services and supports, promote access, ensure follow up and address needs. A basic level of care coordination/case management for all patients is a defined part of the medical home.

- While the definition of a medical home includes basic, routine care coordination, some children and their families need more intensive care coordination. When a child has an identified physical, developmental, mental, or other condition, more than basic care coordination/case management may be needed. Similarly, when the child is in a family experiencing social risks and conditions (e.g. social determinants of health) that threaten the child's health and development, more intensive care coordination may be essential. A high performing medical home in Medicaid must provide care coordination capable of responding to both bio-medical and social risks and conditions.

- Under EPSDT, children are entitled to case management coverage. Medicaid regulations specify a case management benefit, but do not define "care coordination." States also can use the targeted case management (TCM) benefit under Medicaid, with flexibility to offer certain services to individuals in defined groups (such as young children), specific geographic areas, and delivered by qualified providers. Federal regulations define the following four categories of activity: 1) assessment, 2) development, 3) referrals and relative activities, and 4) monitoring and follow-up. In addition, states can pay for an array of care coordination activities in primary care settings or in the community apart from the case management benefit.

- Medicaid case management benefit categories can be used to cover this more intensive care coordination. Many states are financing care coordination under the case management or targeted case management benefit categories. Operationally, financing may be through direct reimbursement on a fee-for-services basis, on a capitated basis (e.g., per member, per month-PMPM payment), or through incentives or bonuses for performance. Whatever the finance mechanisms, the costs of both direct time with the child and family and indirect time — to gather information, develop or update the care plan, follow up with families, schedule appointments for referrals, check in with families and monitor the care plan — need to be reflected in the payments.

Highlights from Part Four

Screening in High Performing Medical Homes: Development, Health, and Well-being

- Practice in the high performing medical home should include but go beyond traditional screening for general development in young children to include separate screening for social determinants of health. This is essential for identifying and responding to social determinants of health and related early childhood risks, with emphasis on affecting health trajectories over the life course, not just immediate health conditions.

- Medicaid's EPSDT benefit requires developmental screening. *Bright Futures* guidelines recommend that developmental screening tests for young children be administered during the well-child visits at 9, 18, and 30 months. These visits are reflected in the American Academy of Pediatrics (AAP) periodicity schedule for preventive well-child visits and in some, but not all, state EPSDT schedules. States have opportunities to improve the financing of these services, as well as the use of validated screening tools and measurement of practice, health plan, and state-level performance.

- One measure in the Medicaid/CHIP Child Core Measurement Set is "Developmental Screening in the First Three Years of Life." This measure can be used to monitor how Medicaid providers, managed care plans, and state programs are performing in terms of developmental screening of young children. Not all states have yet adopted this measure.

- Screening for social-emotional development is increasingly used in pediatric primary care for young children. Screening for social-emotional, behavioral, and mental health is part of the EPSDT benefit. Increasingly, providers are offering and Medicaid is financing social-emotional-behavioral screening designed specifically for young children, and some also are conducting maternal depression screening (one core social determinant of health for young children) as part of well-child visits.

- Screening for social-determinants of health is an emerging area, with new tools, practice approaches, and financing opportunities. Responding to SDOH risks and needs identified through screening requires discussions between health providers and families, as well as referrals and follow up.

- As with the reimbursement for well-child visits and care coordination, the level of reimbursement for screenings should reflect the costs of that screening and its use in the practice.

Highlights from Part Five

Medicaid Financing for Other Needed Services

- Many pediatric primary care practices are augmenting their services or increasing linkages with other community providers to better address risks and concerns related to child development, emotional-behavioral factors, or social determinants of health. Evidence-based models to augment primary care — such as Healthy Steps and Project DULCE — are being used in practices across the nation.

- Promoting social-emotional health and well-being, beginning in early childhood, is a nationwide priority. Medicaid is financing an array of preventive and therapeutic services for young children, including ones where the services are directed to ameliorating parent risks that affect child health.

- The social-emotional, mental, and behavioral health of young children is a core foundation for healthy growth and development and is strongly associated with school readiness, achievement, and lifelong health and well-being. EPSDT includes preventive, diagnostic, and treatment services related to mental health and physical health equally. Integrating mental/behavioral health services into primary care is another trend, for both children and adults. Early childhood mental health clinicians offer the opportunity to intervene more effectively in the earliest years of life; effective approaches recognize social and emotional concerns at much younger ages than those for traditional mental health diagnoses.

- Medicaid plays a role in financing home visiting and early intervention services. Dedicated federal funding through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program and the IDEA Part C Early Intervention Program provides a foundation and infrastructure for needed services but themselves have insufficient funding to cover all children in need. Many states are using Medicaid to finance some of the cost for delivery of these services, particularly when related to improving child health outcomes, which falls within the scope of Medicaid and its EPSDT benefit. Although federal funds cannot be used as a match for Medicaid, state or local funds directed to these programs can.

- Medicaid also provides opportunities for financing other services related to parenting training, education, and group interventions that respond to developmental, social, and emotional risks. This generally requires that primary child health practitioners or other medical clinicians provide authorization for such services, that staff are appropriately credentialed to provide the services, and that the goals for and documentation of the services are clearly enumerated and are based on the child's identified health needs.

Highlights from Part Six

Optimizing Payment Approaches to Support and Sustain High Performing Medical Homes

- Medicaid can and should play a lead role in advancing high performing medical homes for young children. Payment approaches should cover the costs of needed services, incentivize high performance, ensure that services meet standards of care, and result in improving outcomes for the low-income young children served. This can be done under both direct, fee-for-service payment systems or under managed care arrangements.

- In fee-for-service environments, a key step is to establish Medicaid reimbursement levels sufficient to finance and incentivize high performing pediatric medical homes. Appropriate billing codes, service definitions, provider qualifications, and measurement are needed.

- For Medicaid provided through managed care arrangements, states must incorporate into contracts with managed care organizations (MCOs) and accountable care organizations (ACOs) specific expectations and requirements for the finance and delivery of high performing medical homes for young children and other services in line with the EPSDT benefit. This requires distinguishing services for young children from other populations and services in the Medicaid contract and establishing payment structures and distinct performance incentives. In particular, contracts and payment mechanisms should emphasize the preventive and developmental services needed to improve the health and well-being of young children in Medicaid in both the short and long term.

- Three specific payment approaches common to managed care contracts — per member per month payments, pay-for-performance, and use of "shared savings" — also can be used to advance the development of high performing pediatric homes, but they are not a substitute for the other actions described above.

- Medicaid administrative claiming can be used to cover administrative activities needed to maximize the effectiveness and efficiency of high performing medical homes. State Title V Maternal and Child Health Block Grant programs often are in the position to provide or contract for administrative services related to Medicaid (e.g., related provider training, system coordination, measurement) and bill for administrative costs.

Highlights from Part Seven

Measuring Performance and Progress toward High Performing Medical Homes and Better Outcomes

States are responsible for reporting on EPSDT program performance, particularly for medical and dental preventive visits. Most states have not reached the 80 percent performance goal for all children or for young children. States have opportunities to improve EPSDT performance and the quality of data used to monitor performance.

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. Many states do not yet report on all of the measures. In 2018, 11 of the 26 measures relate to young children (prenatal to age 5). Individual state performance ranges from 29 to 83 percent in terms of well-child visits in the first 15 months of life.

This sourcebook suggests a set of measures specifically designed to monitor high performing medical homes for young children. These can be used under fee-for-service, managed care, or other financing arrangements for identifying and incentivizing such performance. The measures build on the CMS child core set, with additional measures that relate specifically to the performance of medical homes for children in Medicaid and CHIP.

States have an opportunity to advance measure alignment and shared accountability across health and related programs. For example, creating a common, shared set of early childhood measures across Medicaid, Medicaid managed care, Title V MCH Block Grant, and federal home visiting programs might help drive program performance and practice quality improvement, as well as improved outcomes, for young children and their families.

States also need to have monitoring approaches that go beyond examining a core set of measures collected for all enrollees and encounters to more detailed reviews of a representative sample of cases (e.g. chart reviews) that determine, in particular, that services receiving reimbursement are meeting the standards set for them as high performing medical homes.