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Fostering Social and Emotional Health through Pediatric Primary Care: A Blueprint for Leveraging Medicaid and CHIP to Finance Change

Donna Cohen Ross Center for the Study of Social Policy
Jocelyn Guyer **Alice Lam** **Madeleine Toups** Manatt Health

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Dear Colleagues:

Nearly half of children under age three in the United States get their health insurance through Medicaid and the Children's Health Insurance Program (CHIP). With such broad reach, these programs can play a powerful role in steering the course of care delivery by helping to finance effective practices, making it more likely that they become routine, expected components of pediatric well-child visits. Recently, policy discussions are more sharply focused on how best to support and sustain methods that advance optimal child development. This new resource, *Fostering Social and Emotional Health through Pediatric Primary Care: A Blueprint for Leveraging Medicaid and CHIP to Finance Change,* is intended to contribute in a very practical way to this exploration.

With generous funding from the Pediatrics Supporting Parents (PSP) initiative, the Blueprint builds upon earlier PSP work, which examined a range of programs and interventions that have been shown to promote social and emotional development through pediatric primary care. These interventions vary in approach, but they reflect common themes related to how pediatric care providers, in partnership with parents, can support strong parent-child relationships, model language-rich, brain-building interactions and other nurturing behaviors, provide guidance on age-appropriate milestones, and assure that health-related social needs—such as adequate food, stable housing, and income security—are addressed.

Medicaid and CHIP are designed with the specific needs of children in mind, and the programs' inherent flexibility can be used to enhance the care they get through the pediatric medical home. This Blueprint not only suggests what could be done to utilize Medicaid and CHIP financing opportunities, but also shows how such financing strategies can be implemented. Together with our co-creators, Alice Lam and Madeleine Toups, and with critical input from Medicaid leaders both inside and outside government, we drew upon federal statutes and regulations, State Plans and policy documents, managed care contract language, and other resources to provide specific tools for implementation. We also highlight where strategies are already operating across the country.

We are looking forward to sharing the ideas and materials featured in the Blueprint and working with Medicaid agencies, managed care representatives, pediatric care providers, advocates, parents, and others to help improve health and make the system more responsive to the needs of children and families. We are most excited to see where seasoned and emerging leaders may take these opportunities, and how their efforts will further the role Medicaid and CHIP play in advancing kindergarten readiness and a children's future academic, social, and economic success.

Thank you in advance for your dedicated efforts to improving the life prospects for children and families.

Donna Cohen Ross
Center for the Study of Social Policy
Donna@DCRinitiatives.com

Jocelyn Guyer
Manatt Health
jguyer@manatt.com

Introduction

A child's brain is developing at an unparalleled pace during the first three years of life. This is an extremely sensitive period, during which the factors that influence social and emotional health—including a strong parent-child relationship, nurturing interactions between parent and child, and safe and stable living conditions—can have important and enduring consequences.[1] The landmark study by the National Academy of Sciences, *From Neurons to Neighborhoods: The Science of Early Childhood Development,* summarized it nearly two decades ago: "What happens during the first months and years of life matters a lot, not because this period of development provides an indelible blueprint for adult well-being, but because it sets either a sturdy or fragile stage for what follows."[2] A strong foundation can affect whether a child is prepared to begin school, achieve academic success, become a productive member of the workforce and society, and can anticipate physical and mental health and well-being as an adult.[3] With so much to gain, the focus on supporting the social and emotional development of young children by policymakers and health care leaders is imperative.

A Role for Medicaid and the Children's Health insurance Program: Toward a New Standard of Care for Children

The birth of a new baby requires families to make significant adjustments, which may be especially challenging for those whose resources or social networks are limited. Often parents rely on their child's health care provider for guidance and support. Twelve well-child visits are recommended by the American Academy of Pediatrics (AAP) in the first three years of life. The high frequency of these visits and the deep level of trust parents tend to have with their pediatric care provider underscore the importance of the pediatric primary care setting as a place to support children's social and emotional development.[4]

Medicaid and the Children's Health Insurance Program (CHIP) provide health care coverage to close to half (48.5 percent) of America's children under three years of age. Approximately nine in 10 children under age three visited with a primary care provider in the preceding year, and a clear majority attend regularly scheduled well-child visits.[5,6] By definition, Medicaid and CHIP beneficiaries are in families with low or moderate incomes. They also are at higher risk for experiencing other challenges that can adversely affect their healthy social and emotional development, including low birth weight, living with a caregiver who suffers from depression, and food and housing insecurity.[7,8] As the dominant source of coverage, Medicaid and CHIP have a central role in financing efforts to drive a new, more responsive, family-centered standard of pediatric primary care that addresses children's social and emotional development.

Addressing Social and Emotional Development

The Center for Excellence for Infant and Early Childhood Mental Health Consultation (IECHMHC) describes the social and emotional health and development of children as the capacity, within the context of their family, community, and cultural background to:

- Form secure relationships;
- Experience and regulate emotions; and
- Explore and learn.[10]

Many factors affect children's social and emotional development, including their innate temperament and the way in which their parents respond to them, the stability of their family, exposure to violence in their home or community, physical health issues, development delays, and more. By definition, many of these factors are not strictly medical, as the AAP long has recognized.[11] To address children's broader needs, the AAP launched the concept of a medical home in 1992. This model was proposed initially as a way to address the special needs of children with chronic health conditions and has evolved over time to refer more generally to a model for delivering pediatric primary care through "a family-centered partnership within a community-based system that provides uninterrupted care with appropriate payment to support and sustain optimal health outcomes."[12] New research findings, policies, technology, and other insights continue to refine the concept. Today, a priority goal for high-performing pediatric medical homes—and for pediatric practices more broadly—is to foster healthy child development and to support parents as responsive caregivers.

Specifically, a high-performing approach to pediatric care includes:

- **Care for the whole child.** The provider offers services that address the child's physical health, the parent-child relationship, developmental progress, behavioral health, and helps families secure services and supports that help them address social and economic needs.
- **Family-based care.** The provider offers family-based care that focuses on the parent-child relationship and validates the strengths parents bring to that relationship. Pediatric providers model and reinforce positive interactions and provide anticipatory guidance to support parents in addressing their children's social and emotional development. Since a parent's health and behaviors have a direct impact on a child's well-being, the provider screens the adult for conditions such as depression, tobacco or other substance use, and oral health.
- **Attention to social and economic issues.** In light of the critical role stable housing, food, and income security play in the healthy development of children, the provider addresses social and economic issues. As recommended by the AAP, the provider conducts a psychosocial/behavioral health assessment during well-child visits, including

an assessment of social determinants of health.[13] As a trusted source of information for families, the provider can refer families to services and ensure that the "loop is closed" for any referral.

- **Team-based care.** Since no single person will have the expertise and time needed to address all of the relevant needs of children and their families, the provider employs a team approach. Among others, the team may include a community health worker or other similar team member, sometimes called a family support specialist or *promotora*, who may deliver services in the clinic, home or an early childhood setting. The team members are equipped to care for the parent-child by respecting cultural differences, eliminating implicit bias, and incorporating trauma-informed practices.[14]

OPPORTUNITIES TO PURSUE CONSISTENT COVERAGE FOR YOUNG CHILDREN: COULD STATES IMPLEMENT FIVE-YEAR CONTINUOUS ELIGIBILITY FOR MEDICAID?

There is growing interest in exploring whether Medicaid could be used to establish stable, reliable coverage for young children from birth until they enter kindergarten. States have long had the option to provide 12 months of continuous coverage to children under Medicaid and CHIP, allowing them to remain enrolled for a year regardless of changes in income or family size. About half the states have adopted this option, reducing disruptions in children's care which is especially important for children who need medication or other treatment on an ongoing basis. States implementing the option save the administrative costs associated with frequent terminations and re-enrollments, and also avert the costs of treating health conditions that may have become more difficult to address during periods of uninsurance.

The prospect of five-year continuous eligibility is a potentially ground-breaking innovation that could significantly improve the health and well-being of young children with lifelong positive consequences. Since family incomes do not vary much in these early years, this should not pose substantial risk for states and could be highly advantageous for children, families, and state agencies. One study showed that children who are consistently enrolled in Medicaid in the first two years of life are more likely to have the recommended number of well-child visits and have school readiness scores at a higher rate compared to those with fewer visits (71 percent compared to 64.1 percent).

While the current federal 12-month continuous eligibility option is relatively simple for states to adopt, a state would need to request a waiver to implement this practice for a longer period of time. Under Medicaid law, states can negotiate with the federal government for a "Section 1115 waiver" to waive certain provisions of the statute and to cover services not otherwise eligible for Medicaid funding. To secure such a waiver, states must establish that it will be "budget neutral" to the federal government (i.e., it does not cost the federal government more in Medicaid dollars than would have been spent in the absence of the waiver.) The process of negotiating and securing a Medicaid 1115 waiver can be lengthy and time-consuming, and states tend to pursue them only if they are essential to a broader delivery system reform agenda. Some states have used them to cover home visiting programs (Maryland, New Mexico) or to finance interventions aimed at mitigating interpersonal violence and toxic stress (North Carolina).

This Blueprint presents five core strategies and tools that state Medicaid and CHIP agencies, managed care plans, pediatric care providers, and others can use to optimize the social and emotional development of young children through a high-performing approach to pediatric practice. The five strategies are:

1

Cover and support a full range of screening, assessment, and treatment services for children and their parents. Medicaid has a longstanding commitment to the health of young children, providing a comprehensive benefit package designed to meet their unique health and developmental needs. Medicaid's companion program, CHIP, features similar (although sometimes more limited) services. States have broad flexibility to emphasize benefits and policy strategies that support children's social and emotional development.

2

Leverage quality and performance improvement initiatives to spur changes in pediatric practice. States can incorporate a focus on social and emotional development into their statewide quality strategy. They can require reporting on measures related to social and emotional health, require plans to implement performance improvement projects to increase the extent to which providers deliver services designed to help foster children's social and emotional health, and reward plans and providers that embrace these changes through fiscal incentives.

3

Establish payment models that support and incentivize a focus on the social and emotional development of children, ideally as part of a high-performing pediatric medical home. States can offer financial incentives to health plans and providers to focus on children's social and emotional development, including through enhanced reimbursement for high-performing pediatric medical homes. Increasingly, states are looking for ways to address children's needs as part of their value-based payment initiatives, creating an important opportunity to promote high-performing pediatric medical homes.

4

Facilitate investment in team-based care and training on children's social and emotional development. States can support the use of team-based care to make it more feasible for pediatric practices to connect families to public benefits and community resources, and offer support to help strengthen parenting and prevent problems with social and emotional development. They also can use Medicaid administrative funds to cover allowable expenditures associated with practice transformation and training on relevant topics, such as trauma-informed care and the impact of adverse childhood experiences, as they relate to the delivery of services to Medicaid beneficiaries.

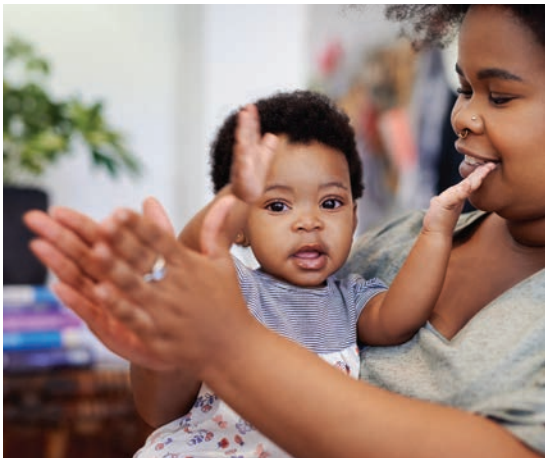
5

Leverage a CHIP Health Services Initiative to finance interventions aimed at supporting children's social and emotional development. Using CHIP administrative funds, states can implement a wide array of interventions to foster children's social and emotional development. These can include interventions to support home visiting, address exposure to violence, promote lead screening and abatement, train providers on practices that strengthen the parent-child relationship, develop early literacy skills, and other efforts, including initiatives that ordinarily cannot be financed with Medicaid funds.

The Blueprint provides:

- A detailed description of each core strategy, along with its statutory and regulatory bases;
- Action steps to implement the strategies;
- Tools for implementation, including relevant federal guidance, contract language, sample state plan amendment language, and other helpful material; and
- Examples of policies in effect and activities underway across the country.

PARENT COVERAGE IS CRITICAL TO CHILDREN'S SOCIAL AND EMOTIONAL DEVELOPMENT



When parents have health coverage, they are more likely to be able to address their own physical and behavioral health needs, including conditions that could interfere with strong attachments to their children.[15] Under the Affordable Care Act, states have the opportunity to expand Medicaid coverage to more adults, including parents in families with low incomes. This has increased the chances that parents will have access to appropriate health care and that family-based care delivered in a high-performing pediatric medical home will be more effective. As of February 2019, 37 states including Washington, DC have expanded Medicaid, meaning a larger proportion of low-income parents have access to coverage than in the past.[16] Even so, one in eight parents of children with Medicaid coverage remain uninsured and parents of young children in non-expansion states are nearly twice as likely to be uninsured as parents in expansion states.[17] Additional states are debating expansion, so the likelihood that parents with low income will have health coverage could increase, though some states also are considering work requirements, premiums, and other policies that would work in the opposite direction.

STRATEGY

1

Cover and support a full range of screening, assessment, and treatment services for children and their parents.

Medicaid has a longstanding commitment to provide children access to a set of services designed to meet their unique health and developmental needs. This commitment to children is backed by the program's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit package. It helps to assure that children receive a full array of preventive, developmental, dental, mental health, and specialty services in accordance with the AAP's Bright Futures guidelines for pediatric practice.[18] Medicaid's companion program, CHIP, provides similar (although often more limited) services. A provision of federal opioid legislation signed into law in October 2018 enhances CHIP benefits for children and pregnant women, bringing them a step closer to Medicaid's by requiring access to a range of services to address mental health and substance use disorder services.[19] States can use the Medicaid and CHIP benefit requirements to encourage or require social and emotional screening, assessment, and treatment in pediatric visits.

IMPLEMENTATION STRATEGIES

Incorporate screening for social and emotional concerns within routine developmental and behavioral surveillance and screening conducted during well-child visits. AAP guidelines, which support the services covered under EPSDT, call for psychosocial/behavioral screening at each well-child visit from birth through age 21. This screening should address "social and emotional health, caretaker depression, and social determinants of health."[20] According to a 2018 survey of states by the National Center for Children in Poverty (NCCP), 43 states (including Washington, DC) cover social and emotional screenings for young children while eight states do not. Even in states that cover such screenings, however, pediatric providers do not always use valid and reliable screening tools or conduct screenings on a routine basis. This may be due to inadequate reimbursement, competing demands on their time, and concern that screenings will uncover problems that providers cannot address.[21] States can take specific actions to reduce these barriers. For example, they can provide pediatric practices with a way

to bill for the time spent on such activities and ensure that they are adequately reimbursed. As of 2018, the NCCP survey found that 23 states reported that they provide a separate code to bill for social and emotional developmental screenings, while 28 do not.[22]

Action Steps:

- Review whether the state allows and encourages pediatric providers to bill Medicaid for comprehensive developmental and behavioral screenings that include social and emotional development in accordance with Bright Futures guidelines.
- Assess whether the state has established standards for developmental and behavioral surveillance and screening to ensure that social and emotional domains are included; meet standards for accuracy; include family input; and address any other state priorities.[23,24,25]
- Allow providers to bill for additional specific social and emotional and/or autism screenings on the same days comprehensive developmental and behavioral screenings are conducted.
- Incentivize or require use of team-based care to support developmental promotion, early detection (surveillance and screening), referral and linkage to needed supports and services (Discussed in Strategy 4).
- Reward plans or providers for strong performance on screening rates using validated screening tools, developmental health promotion, referral to needed supports and services, and follow-up.
- Offer providers support in modifying practice workflow to incorporate screening, developmental health promotion, referral to needed supports and services, and follow- up. Invest Medicaid administrative funds to conduct outreach to individual practices and provide practice assessments, redesign guidance, billing advice and other assistance.

Minnesota has a robust initiative to screen children routinely in accordance with Bright Futures guidelines, including screenings for social and emotional development and social determinants of health. The state has developed expansive training materials on how to conduct screenings and report results to families, and also provides resources on identifying appropriate screening tools. To help ensure that pediatric care providers focus attention on social and emotional development, the state allows them to bill separately for screenings that address social and emotional concerns.[26]

Build social and emotional screening, assessment, and interventions into care management requirements. In states with managed care, the state can set standards for "care management" that include a focus on the social and emotional development of children, including requiring some services that are not considered coverable Medicaid benefits. In general, states cannot build into the capitation rates that they pay plans the cost of providing services that are not Medicaid

covered benefits. Care management, however, is considered a core function of Medicaid managed care plans—even though it is not classified as a Medicaid covered benefit—and states are obligated to reimburse plans for the cost of providing it. As such, states can define their care management expectations in their contracts with managed care plans and build the cost of providing care management into their capitation rates.[A]

Under federal requirements for care management, Medicaid managed care plans must provide beneficiaries with a designated person or entity to help navigate the health care system and coordinate care, including in different care settings and with community and social support organizations. States, however, can go beyond these minimum federal requirements. Some now require managed care organizations to routinely screen and assess patients for social and economic needs and to employ local staff to connect beneficiaries to resources. For young children, states can require managed care plans to consider the economic, social, and emotional circumstances of a family when deciding whether a child needs intensive care management services, as well as require that plans connect families to social and economic supports. For example, a state could require plans, as part of their care management obligations, to identify children at high-risk for social and emotional challenges and connect them to care across health, educational, and social domains.

Action Steps:

- In Medicaid managed care states, adopt care management requirements that include social and emotional screening as part of comprehensive developmental and behavioral health screenings.
- Require plans to consider the social and emotional health of young children when establishing criteria for identifying who will receive intensive care management.
- Require that care management encompass active coordination of care and services across the health care, educational, and social service settings. Develop Memoranda of Understanding (MOUs) among appropriate agencies to formalize new collaborative efforts.

North Carolina requires Medicaid managed care plans to screen all beneficiaries (not only children) to identify whether they face interpersonal violence, are subject to toxic stress or have unmet housing, food, or transportation needs. Beneficiaries identified as "high risk" must be provided with enhanced care management services, including help addressing social and economic issues. The assistance is expected to be provided by local care managers in most instances because they have the ability to meet with families in person and have greater first-hand knowledge of community resources.

[A] In general, states cannot build into the capitation rates that they pay plans the cost of providing services that are not a Medicaid covered benefits. Care management, however, is considered a core function of Medicaid managed care plans—even though it is not classified as a Medicaid covered benefit—and states are obligated to reimburse plans for the cost of providing it. As such, states can define their care management expectations in their contracts with managed care plans and build the cost of providing care management into their capitation rates.

Promote investments in the social and emotional development of children as "value-added" services. Medicaid managed care organizations must meet their contractual obligation to provide covered benefits and care management services. In addition, they can use a share of any remaining capitation funds to invest in the social and emotional development of children via "value-added" benefits. These are benefits provided by a plan that do not fit under a Medicaid benefit definition, but that could improve health outcomes and reduce costs for beneficiaries.[B] Some states explicitly consider a Medicaid managed care plan's offer to provide specific value-added services when deciding whether to award the plan a contract. For example, a state could use its procurement process to require Medicaid managed care plans to describe how they will address the social and emotional development of young children, including their willingness to offer related value-added services, such as group parenting programs or the full cost of home visiting for families that otherwise might not be covered.

Action Steps:

- Require Medicaid managed care plans bidding to participate in the state's Medicaid managed care market to describe their strategy for addressing the social and emotional health of young children.
- Encourage plans to provide value-added services aimed at supporting the social and emotional health of children.
- Award extra points in the procurement process to plans that offer value-added benefits to support children's social and emotional development, such as home visiting services (not otherwise covered by Medicaid) for child beneficiaries and their families.

Louisiana is using its Medicaid managed care procurement process to encourage plans to offer adult dental coverage, medical respite care, and a number of other value-added services. Bidders that agree to do so receive additional points in the procurement processes. Similarly, a state could award extra points for plans willing to provide parenting programs or home visiting services (to the extent not otherwise covered) to families of children at high risk for social and emotional challenges.[27]

[B] While the cost of providing value-added services is not considered when a state sets the capitation rate for Medicaid managed care plans, it still can be beneficial to plans to provide value-added benefits. Plans provide value-added benefits to attract additional members (e.g., by offering vision care); to invest in interventions that are not covered by Medicaid, but that could reduce a beneficiary's use of medical services (e.g., short-term housing after a hospitalization to avoid a rapid return to the hospital); or to demonstrate their commitment to an issue of importance to a state.

Maximize coverage of screening, assessment, and treatment services for parents. A strong body of evidence supports the connection between a child's health and social and emotional development and the well-being of parents and caregivers.[28,29] In response, pediatric care initiatives have increasingly emphasized the importance of support for parents and caregivers. This is more feasible now that Medicaid expansion has extended coverage to many more parents with low incomes.

The opportunity to address maternal depression, a serious and widespread condition that affects both parents and their children, provides an example. CMS guidance issued in May 2016, clarified that states have the authority to cover maternal depression screening as part of a well-child visit, a best practice for pediatric primary care providers.[30] The guidance explains that "a maternal depression screening can be considered an integral part of a risk assessment for the child, in light of the evidence that maternal depression can place children at risk of adverse health consequences… and state Medicaid agencies may allow such screenings to be claimed as a service for the child as part of the EPSDT benefit." In addition, needed follow-up interventions that directly involve the parent and child together also can be billed to the child's Medicaid.[31]

While states may cover maternal depression screening through either the mother's or the child's Medicaid, payment policies that allow the latter can increase the chance that this serious condition will be identified and addressed. Conducting such screening during the well-child visit provides an opportunity for new mothers—as many as half of whom do not receive their own postpartum visit—to discuss concerns they may have.[32] The ability to bill on the child's Medicaid is important since pediatric providers generally do not have access to the mother's medical records. This practice also accounts for the reality that in states that have not expanded Medicaid, postpartum coverage under Medicaid typically ends 60 after days, leaving many women with low incomes uninsured. As of 2018, the NCCP survey found that 32 states (including Washington, DC) allow maternal depression screening to be billed under the child's Medicaid; 19 states do not.[33]

COVERING A RANGE OF ADULT PREVENTIVE SERVICES—INCLUDING MATERNAL DEPRESSION SCREENING—CAN BOOST MEDICAID FUNDING FOR STATES

Under Medicaid, states must cover a full range of preventive services for children, but historically, coverage of such services for adult beneficiaries has been optional. The Affordable Care Act promoted a shift in perspective: States that expand Medicaid must cover, without cost-sharing, for *newly enrolled adults,* all preventive services recommended given an A or B rating by the United States Preventive Services Task Force (USPSTF), and all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines. Coverage of these services for the "traditional" Medicaid population remains optional. To provide an incentive for states to make preventive services available to all adults in Medicaid, states that cover all the recommended services can earn a one percentage point increase in their federal reimbursement rate for preventive services expenditures.[34] While the USPSTF has had a long-standing recommendation related to screening adults, including pregnant and postpartum women, for depression, in February 2019 the task force issued a new recommendation on perinatal depression screening and gave it a B rating, making it a required service for adults enrolled under Medicaid expansions and for all adults in states that want to secure or maintain the boost in federal Medicaid matching rates. The USPSTF recommendation also describes examples of effective treatment strategies when perinatal depression is identified.[35]

Action Steps:

- Adjust the state's Medicaid payment policies to support the following practices:
  - Maternal depression screening, billed under either the mother's or the child's Medicaid number;
  - Treatment that includes a mother and child together.
- Increase Medicaid payments to pediatric primary care practices that adopt these polices.
- Offer training and support to pediatric Medicaid providers on maternal depression screening and treatment, including through the following activities, all of which can be treated as a Medicaid administrative expense:
  - Post information about maternal depression screening on provider websites and publish information in provider newsletters;
  - Deliver provider trainings to promote the use of maternal depression screening tools and proper billing codes;
  - Conduct in-person visits to clinics to train providers on how to implement screenings, talk to families about results, help practices modify clinic flow, and discuss referral strategies; and
  - Take steps to assure the privacy of caregivers screened for depression during well-child visits.

Colorado reimburses pediatric and family medicine providers for screening new mothers for depression at well-child visits under either the mother's or child's Medicaid. The state also covers up to six visits of short-term behavioral health services—which includes diagnostic evaluation and family psychotherapy—delivered by behavioral health clinicians such as family therapists, social workers, and psychologists in a primary care setting.[36] This allows for integration of primary and behavioral health care, as well as the opportunity to provide family-centered care.

Tools for Implementation

Strategy	Tools	
	Federal Statute & Regulations	Implementation Resources
Cover and support a full range of screening, assessment, and treatment services for children and their parents.		
Incorporate social and emotional screening within routine developmental and behavioral surveillance and screening, and developmental promotion, conducted during well-child visits.	EPSDT (Social Security Act §§ 1902(a)(43), 1905(r), 1905(a)(4)(B); 42 CFR § 441.50-.62(b))	**Federal** • Birth to 5: Watch me Thrive; A Compendium of Screening Measures for Young Children **Minnesota** • State Guidance **American Academy of Pediatrics** • Developmental Screening for Behavioral and Emotional Problems • Developmental Screening for Infants and Young Children in the Medical Home • Screening Technical Assistance & Resource Center **National Center for Children in Poverty** • 50-State Survey on Early Childhood Mental Health Services
Build social and emotional screening, assessment, and interventions into care management requirements.	Care Coordination & Management Standards (Social Security Act §§ 1905(a)(25), 1905(t); 42 CFR §§ 438.2, 438.208. 400.203, 440.168, 457.1200(c), 457.1230(c))	**North Carolina** • Managed Care Contract (starting on page 121)

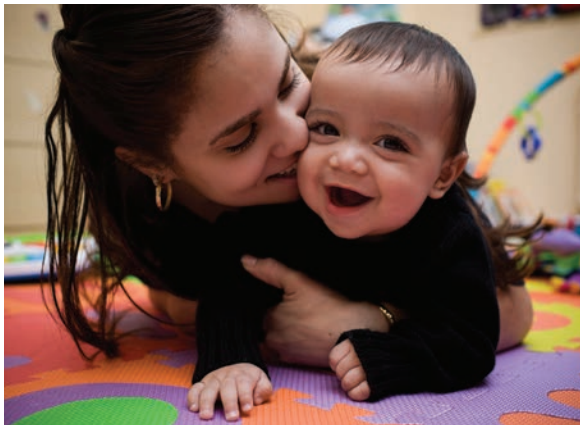
Strategy	Tools	
	Federal Statute & Regulations	**Implementation Resources**
Promote investments in the social and emotional development of children as "value-added" services.	In Lieu of and Value Added Services (42 CFR §§ 438.3(e), 457.1200(c), 457.1201)	**Louisiana** • Managed Care Request for Proposal (starting on page 20)
Maximize coverage of screening, assessment, and treatment services for parents.	EPSDT (Social Security Act §§ 1902(a)(43), 1905(r), 1905(a)(4)(B); 42 CFR § 441.50-.62(b))	**Federal** • CMS Guidance—Information Bulletin on Maternal Depression • CMS Guidance—State Medicaid Director Letter on ACA Section 4106, Preventive Services • USPSTF Recommendation—Perinatal Depression **Colorado** • State Guidance

STRATEGY

2

Leverage quality and performance improvement initiatives to spur changes in pediatric practice.

States continue to look for ways to improve the quality of care provided in Medicaid, reflecting both strong federal requirements to improve quality and their own interest in ensuring that they are buying high-quality care for their substantial investments in Medicaid. Historically, however, little has been done to develop quality measures that address children's social and emotional development. This is beginning to change, in part due to the growing recognition that these issues are critical to the long-term health and well-being of children and because of stronger federal requirements related to child health quality measures.



The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) required the U.S. Department of Health and Human Services (HHS) to identify and publish a core set of children's health quality measures for use by state Medicaid and CHIP programs. This "Child Core Set" provides an important tool for states to track and improve the quality of care provided to children with Medicaid and CHIP coverage. Although reporting has been voluntary, beginning in 2024, all states will be required to report on the full set of measures.[37]

The 2019 Child Core Set comprises 26 measures that span categories such as access to primary and preventive care, maternal and perinatal health, care of acute and chronic conditions, behavioral health, dental and oral health services, and beneficiaries' experience of care.[38] One of the current measures considers the percentage of children with Medicaid and CHIP coverage who received a developmental screening in the first three years of life, including screening related to social and emotional health. In 2017, 27 states reported a median of 40 percent of children were screened for developmental, behavioral, and social delays using a standardized tool preceding or on their first, second, or third birthday.[39] Given that less than half the states are currently reporting on this measure, understanding of the national picture is incomplete at best. The requirement to report on the full set of Child Core Set measures beginning in 2024 is expected to increase states' focus on gathering data and reporting on child health measures. It also could result in the adoption of additional measures related to the social and emotional development of children.

ENSURING THAT METRICS EVOLVE TO ALIGN WITH NEW VISION OF PEDIATRIC CARE

The National Quality Forum (NQF) convenes the multi-stakeholder Measure Applications Partnership (MAP)—specifically a Medicaid Child Workgroup within MAP—that makes recommendations annually for strengthening the Child Core Set.[40] States and other stakeholders could encourage the federal government to incorporate specific measures related to social and emotional development into future versions. States also could develop their own measures that help assess progress on improving social and emotional development. For example, measures related to family experiences and changes in parenting behaviors and social circumstances as a consequence of health care received could be tracked.

IMPLEMENTATION STRATEGIES

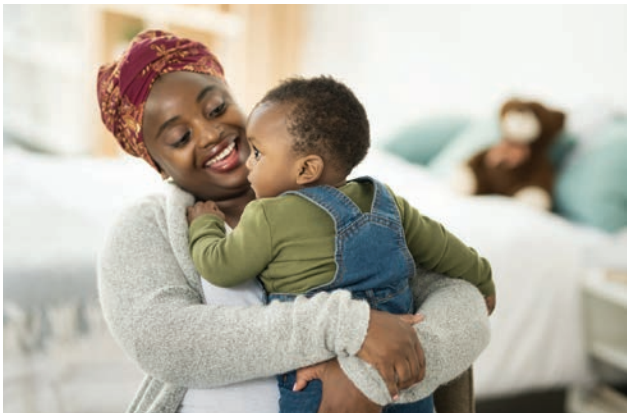
Support the use of Child Core Set measures and explore development of additional measures related to social and emotional development. The Child Core Set provides a valuable starting point for consistent quality measurement across states, and the new reporting requirements should help to improve our understanding of progress and gaps in performance and outcomes In addition to the measures contained in the Child Core Set, states may find it useful to incorporate more specific or additional measures to help advance efforts to promote social and emotional development in the pediatric care setting.

Action Steps:

- Review the state's current use of Child Core Set measures to see whether it is collecting appropriate data and reporting on the developmental screening measure. If not, accelerate plans to begin doing so.
- Consider modifying existing measures to increase their impact. For example, a state could modify the developmental screening measure to require that any screening tool used include a social and emotional component.
- Consider using or testing additional measures designed to promote children's social and emotional health.

Oregon is in the midst of a process to develop metrics that focus on the health sector's role in achieving kindergarten readiness.[41] The resulting metric or metrics are intended to be incorporated into the Oregon Medicaid's Coordinated Care Organizations (CCOs) Incentive Measure Set, a powerful tool for encouraging CCOs to focus on the state's child health and development priorities.

Use performance improvement projects to promote the social and emotional development of children. Medicaid managed care states are required to facilitate a number of quality improvement activities, including developing and maintaining a managed care quality strategy and requiring plans to perform performance improvement projects (PIPs) annually. States can ensure that their quality improvement activities include a focus on pediatric care priorities, including the development of high-performing pediatric medical homes. Notably, states can include the cost of implementing these activities in the capitation rate paid to Medicaid managed care plans, and they can count expenditures on these activities in the numerator of a managed care plans' medical loss ratio (i.e., the percentage of the premium an insurer spends on claims and expenses that improve health care quality). In addition, while most states give Medicaid managed care plans significant discretion to determine how to implement PIPs, some are becoming more directive to increase the focus on top state priorities.



Action Steps:

- Require or encourage plans to implement PIPs that promote the social and emotional development of children.
- Work with plans to monitor such PIPs and identify successful initiatives that could be built into Medicaid managed care contracts on an ongoing basis.

As part of the **New York** State First 1,000 Days on Medicaid initiative, the state is implementing a "Kids' Quality Agenda" which requires the participation and collaboration of all Medicaid managed care plans on a two-year common PIP to improve performance on children's and perinatal health care quality measures.[42] The initial PIPs will address lead testing and follow-up, newborn hearing screening and follow-up, and developmental screening. Data collection and analysis will be underway from March 2019 through December 2020, with final reporting in July 2021.

Reward plans that perform well on children's social and emotional development by auto-assigning them more beneficiaries. In Medicaid managed care states, beneficiaries must have a choice of health plans, however if beneficiaries do not make a selection, the state will auto-assign a plan. Managed care states may use their auto-assignment algorithms to provide additional inducement to plans to focus on state priorities. Currently, only nine states report that they do or will soon include quality performance in their auto-assignment algorithm.[43] In creating their auto-assignment algorithms, states can take into account how well plans are integrating the promotion of social and emotional development into high-performing pediatric medical homes, creating a powerful incentive for plans to strive to perform well in this area.

Action Steps:

- Review the factors used for auto-assignment in the state; if appropriate, incorporate performance on the social and emotional development of children, ideally as part of a high-performing pediatric medical home.

Michigan incorporates performance on quality metrics into its auto-assignment algorithms, with the Michigan Department of Health and Human Services setting quality metrics every year based on clinical performance, administrative performance, and network capacity. To date, these measures have included childhood immunization rates, well-child visits in the first 15 months of life and from three to six years, timeliness of prenatal care, and postpartum care. In future years, Michigan could elect to use measures even more directly related to the social and emotional development of children.[44,45]

Tools for Implementation

Strategy	Tools	
	Federal Statute & Regulations	Implementation Resources
Leverage quality and performance improvement initiatives to spur changes in pediatric practice.		
Support the use of Child Core Set measures and explore development of additional measures related to social and emotional development.	Child Core Set Measures (Social Security Act § 1139A(a)) Quality Strategy (Social Security Act § 1932(c); 42 CFR §§ 438.334, 438.340, 457.1200(c), 457.1240(e))	**Federal** • CMS Guidance—Informational Bulletin • 2019 Child Core Set • 2019 Maternity Core Set • 2017 Child Core Set Reporting **National Quality Forum** • 2018 Measure Applications Partnership Recommendations for Strengthening Child Core Set **Oregon** • State Guidance
Use performance improvement projects to promote the social and emotional development of children.	Performance Improvement Projects (42 CFR §§ 438.240(d), 438.330, 457.1200(c), 457.1240(b))	**New York** • First 1,000 Days Initiative *Current managed care contract not available at time of publication.*
Reward plans that perform well on children's social and emotional development by auto-assigning them more beneficiaries.	Member Auto Assignments (Social Security Act § 1932(a)(4); 42 CFR §§ 438.54, 457.1200(c), 457.1210)	**Michigan** • Managed Care Contract (page 30) **Foundation** • KFF State Health Facts—Medicaid Managed Care Quality Initiatives

STRATEGY

3

Establish payment models that incentivize a focus on the social and emotional development of children, ideally as part of a high-performing pediatric medical home.

To reward quality outcomes and cost-efficiency in their Medicaid programs, states have been designing and implementing value-based payment (VBP) initiatives. With VBP, states are seeking to move away from reimbursing providers based on the volume of care they provide and move toward reimbursing them for improving outcomes and reducing costs. Generally, states and Medicaid managed care plans have focused their Medicaid value-based payment initiatives on adults with high-cost or chronic conditions. These efforts have not been aimed at children since, in the absence of special health care needs, most children are relatively healthy, making it unlikely that payment initiatives will generate near-term cost-savings. Moreover, many of the longer-term savings generated by upfront investments in children's care are likely to accrue to the social service and educational sectors, a challenge known as the "wrong pocket" issue. States will need to take these challenges into account when they consider changing their current payment strategies to incentivize activities and outcomes related to children's social and emotional development. Most importantly, they may need to place a greater priority on improved outcomes, rather than cost savings, when evaluating alternative payment strategies.[46]

IMPLEMENTATION STRATEGIES

Provide enhanced payments to providers for pursuing high-performing pediatric medical homes that integrate promotion of social and emotional development. Both managed care and fee-for-service states can increase reimbursement for care delivered in a high-performing pediatric medical home. For example, they can offer an add-on payment for pediatric providers who meet state-established standards for such medical homes either directly (in a fee-for-service state) or via a requirement on Medicaid managed care plans. Along with the "traditional" elements of a pediatric medical home (e.g., robust care coordination, engagement of families, procedures for transitioning youth to adult care, etc.), the enhanced criteria could

include expectations for comprehensive developmental and behavioral screening that includes social and emotional development, parenting and family support activities, use of team-based care that includes a community health worker, integration of physical and behavioral health, linkages to social and economic supports within the community; and provider training on social and emotional development and supporting parent-child relationships.[47,48]

Action Steps:

- Identify the key features of a high-performing pediatric medical home in accordance with state priorities.
- In Medicaid managed care states, modify the managed care contract to require plans to offer higher reimbursement to practices meeting high-performing pediatric medical home standards; require plans to offer training and support to pediatric providers, potentially in collaboration with local provider organizations.
- In fee-for-service states, establish a primary care case management program that offers certified providers an additional per-member, per-month fee to cover the infrastructure and staff training costs associated with the high-performing pediatric medical home.
- If applicable, revise any state limits on same-day billing for physical and behavioral health visits to support integrated care.[49]

Colorado, a fee-for-service state, provides primary care medical providers additional payments for meeting a set of clinical and structural standards, including behavioral health integration, behavioral health screening, and development of patient-centered care plans;[50] and

North Carolina will be deploying an Advanced Medical Home (AMH) model in its forthcoming Medicaid managed care program. The AMH is designed to improve primary care for children and adults alike and, as such, it includes numerous features important to the social and emotional health of children. For example, AMHs are expected to adopt a team-based approach that addresses the whole person, including food, housing, interpersonal violence/toxic stress and transportation. In its Medicaid managed care contract, North Carolina requires its plans to contract with a large majority of AMH practices in each of the regions that they serve.[51]

Leverage quality incentives and/or "withholds" to reward plans with strong performance on promoting social and emotional development. States with Medicaid managed care have the ability to apply incentives and withhold arrangements to encourage plans to focus on state priorities. Specifically, states can challenge plans to earn up to five percent above their

capitation payments by meeting state objectives (incentive arrangement) or withhold a portion of a plan's capitation payment pending achievement of goals (withhold arrangement). A state could ensure focus on children's social and emotional health by tying quality incentives or withholds to performance on measures related to children's social and emotional development. Plans can be encouraged to invest earned incentive payments to enhance services related to fostering children's social and emotional development.[52]

Action Steps:

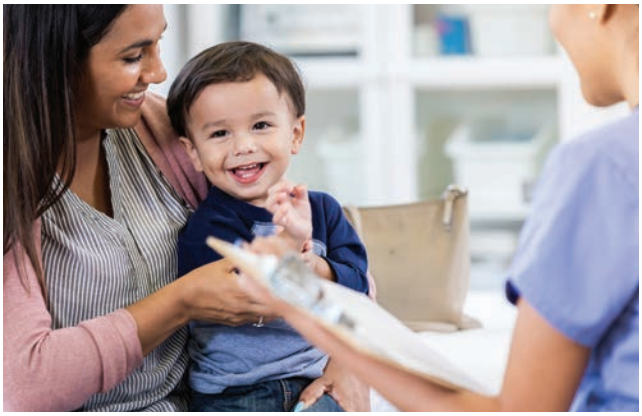
- In Medicaid managed care states, incorporate measures related to children's social and emotional development into the State's required quality strategy.
- Include consideration of a plan's performance on measures related to children's social and emotional development in any incentive or withhold initiative operated by the state.

Since 2011, **Oregon** has implemented an incentive program that allows its managed care plans (referred to as "Coordinated Care Organizations") to earn as much as 4.25 percent above their capitation payments. Each year the state assesses how well the CCOs performed on specific measures and awards incentive funds based on their performance. In recent years, child development screening has been one of the measures, and CCOs have made impressive improvements, tripling screening rates statewide from 2011 to 2017. HealthShare of Oregon, one of the State's largest CCOs, received about $69 million in incentive payments for over 315,000 members. It reinvested these funds into parent coaching strategies, efforts to reduce disparities in developmental screening rates across cultural groups, and other child health initiatives.

North Carolina requires its Medicaid managed care plans to conduct a "care needs screening" that includes questions on housing, food insecurity, domestic violence, and gaps in transportation within 90 days of a beneficiary signing up with a plan. To incentivize plans to focus on these issues, North Carolina intends to link a share of the money it withholds to reward plans that have high rates of screening and referral of beneficiaries to social services.[53]

Develop value-based payment initiatives that prioritize children's social and emotional development. As noted earlier, the use of value-based payment for children's care requires states to take into account the unique circumstances of children, including that any broad-based, value-based payment model for children will likely need to focus more on improving

outcomes rather than on generating significant short-term savings. To support the pathway to value-based payment, new payment models will require fundamental changes to care delivery, investment in infrastructure, and development of additional provider capabilities. As states continue to build their value-based payment initiatives, they have the opportunity to focus on children's social and emotional development.[54]



Action Steps:

- Review the state's current value-based payment strategy and assess the degree to which priorities focus on children and, in particular, their social and emotional development.
- Identify opportunities to emphasize children's social and emotional development in target populations or providers, measures, and activities.

Virginia requires its Medicaid managed care plans to maintain and implement a VBP strategy that follows the alternate payment model (APM) framework developed by the Health Care Payment Learning and Action Network (HCP LAN).[c,55] In addition, Virginia's Medicaid managed care contract stipulates that plans must implement special medical home initiatives—currently called Medallion System Innovation Partnerships (MSIP)—that feature value-based payment arrangements with providers, performance-based incentives, and/or other incentive reforms tied to state-approved quality metrics and financial performance. Virginia's 2017-2018 contract required that the MSIP focus on pediatric services and target pediatric populations, and that services provided through the MSIP be designed to individually coordinate Medicaid primary and acute care and mental health services.[55]

[c] The Health Care Payment Learning & Action Network (HCP LAN) is a public-private partnership created in 2015 by the US Department of Health and Human Services to implement Advanced Payment Models (APM) that drive Triple Aim—enhance quality care, improve patient outcomes, and reduce costs.

Tools for Implementation

Strategy	Tools	
	Federal Statute & Regulations	Implementation Resources
Establish payment models that incentivize a focus on the social and emotional development of children, ideally as part of a high-performing pediatric medical home.		
Provide enhanced payments to providers for pursuing high-performing pediatric medical homes that integrate promotion of social and emotional development.	Enhanced Reimbursement (Social Security Act § 1902(a)(30)) Care Coordination & Management Standards (Social Security Act §§ 1905(a)(25), 1905(t); 42 CFR §§ 438.2, 438.208. 400.203, 440.168, 457.1200(c), 457.1230(c)) Directed Payments (42 CFR §§ 438.6(c), 457.1200(c))	**Colorado** • State Guidance **North Carolina** • Managed Care Contract (starting on page 129)
Leverage quality incentives and/or withholds to reward plans with strong performance on social and emotional development.	Incentive and Withhold Arrangements (42 CFR 438.6)	**Oregon** • Managed Care Contract (starting on page 96) • 2017 Metrics Report **North Carolina** • Managed Care Quality Strategy (starting on page 38)
Develop value-based payment initiatives that prioritize children's social and emotional development.	Enhanced Reimbursement (Social Security Act § 1902(a)(30)) Care Coordination & Management Standards (Social Security Act §§ 1905(a)(25), 1905(t); 42 CFR §§ 438.2, 438.208. 400.203, 440.168, 457.1200(c), 457.1230(c)) Directed Payments (42 CFR §§ 438.6(c), 457.1200(c))	**Federal** • CMS Guidance—Informational Bulletin **Virginia** • Managed Care Contract (starting on page 233)

STRATEGY

4

Facilitate investment in team-based care and training on children's social and emotional development.

States can help pediatric providers overcome some of the constraints they face in adopting practices aimed at fostering children's social and emotional health. These include having insufficient time to spend with each patient and family, as well as needing greater knowledge and resources to identify and address families' health-related social needs. Integrating individuals such as social workers, community health workers, or *promotoras* into the health care team can extend the reach of pediatric care providers and deepen trust with families. States also have the flexibility under Medicaid to allow care to be provided in home or community-based early childhood settings, as well as help finance training and pediatric practice transformation.

IMPLEMENTATION STRATEGIES

Encourage or require use of community health workers and allow for the provision of services in home and early childhood settings. Medicaid reimbursement for preventive services can be used to finance expanded care teams, including community health workers. These care team members can help to conduct screenings, model healthy interactions with young children, offer parenting support and resources, provide care coordination, monitoring and follow-up, and assist families in securing food and housing assistance.[58,59] State Medicaid agencies have the discretion to pay for the delivery of covered services by a Medicaid provider outside of "traditional" medical settings, including in home and early childhood settings.[60]

Action Steps:

- Review whether the state authorizes Medicaid coverage for expanded care team members, and if not, amend the Medicaid State Plan to include expanded care team members.
- Review any state requirements regarding where services can be provided and, if necessary, consider expanding allowable settings to include the home, early care and education programs, family resource centers, WIC clinics and other places where young children receive services.
- Establish qualifications and guidelines for reimbursement of care team members.[61]
- In managed care states, modify the contract to require pediatric practices to use team-based care and provide support for such efforts.
- Require plans to contract with a sufficient number of providers and/or practices with the special skills and training needed to address the social and emotional health of children in more complex situations.

New Mexico's Medicaid managed care contract requires plans to engage community health workers, and has established a goal to ensure that they serve at least three percent of enrolled members.[62] The community health workers are expected to provide interpretation and translation services, offer informal counseling and guidance on health behaviors, and assist people in accessing social services.

Washington State's Medicaid agency and Early Learning Department are working together to explore the use of preventive and developmental screenings covered by Medicaid at Head Start centers, as well as strategies for sharing results with pediatric practices.[63]

Require Medicaid managed care plans to contract with pediatric providers that deploy a team-based approach. States have broad flexibility to require Medicaid managed care organizations to contract with pediatric providers that deploy a team-based approach. Doing so can help to ensure that family support specialists or community health workers are available to connect families to social, economic, and parenting support.

Action Steps:

- In managed care states, require that plans contract with a specified number of practices (or serve a specified share of beneficiaries) that adopt a team-based approach.
- Alternatively, require participation in a state-level care management initiative that relies on a team-based approach.

Missouri requires Medicaid managed care plans to participate in the Local Community Care Coordination Program (LCCP), an evidence-based patient-centered concept that ensures every beneficiary has a primary care physician that leads an integrated team focused on care coordination and social needs and support referrals.[64,65]

Promote training of providers on the social and emotional development of young children and the use of screening tools to identify and address potential concerns. States have broad flexibility to use Medicaid and CHIP administrative funds to improve the delivery

of program services by conducting training and practice support for providers. (One key exception is that training cannot be financed with Medicaid funds if it is part of a continuing education requirement.) Medicaid administrative funds can be used, for example, to support pediatric providers in establishing or strengthening a high-performing pediatric medical home and on training related to evidence-based strategies and interventions to improve the social and emotional health of children. Medicaid administrative funds also can be used to provide outreach and training on implementing new payment policies established to support the use of such methods, such as how to operationalize new coding guidance. In addition, clinical guidelines are required to ensure that Medicaid managed care plans adopt valid and clinically reliable practice guidelines that consider the needs of their members. These provide states with a handle to require Medicaid managed care plans to ensure that providers are trained on issues such as the social and emotional development of children and trauma-informed care.

Action Steps:

- Use Medicaid or CHIP administrative funds to provide pediatric practices with technical assistance and support on practice transformation including methods for integrating social and emotional health into well-child care.
- Update clinical guidelines to reflect best practices with respect to addressing the social and emotional development of young children, including by linking clinical guidelines directly to Bright Futures and expanding on expectations regarding the approach to social and emotional issues.
- In Medicaid managed care states, require plans to furnish providers with training on social and emotional development, trauma-informed care, and related issues.

South Carolina works in collaboration with the South Carolina Chapter of the American Academy of Pediatrics to operate the Quality Through Technology and Innovation in Pediatric Practice (QTIP). The initiative provides technical assistance and peer-learning opportunities in support of practice transformation, quality improvement, and integration of mental health services into pediatric practice.[6]

In **Oregon's** procurement for Coordinated Care Organizations (CCO 2.0), the State includes a provision requiring CCOs to ensure providers are trained in trauma-informed care, implementing trauma-informed practices, and screening for adverse childhood experiences (ACEs).[67]

Tools for Implementation

Strategy	Tools	
	Federal Statute & Regulations	**Implementation Resources**
Facilitate investment in team-based care and training on children's social and emotional development.		
Encourage or require use of community health workers and allow for the provision of services in home and early childhood settings.	Expanded Care Teams (Social Security Act § 1905(a)(13)(A); 42 CFR § 440.130(c)) Social Security Act § 1902(a)(30)(A); 42 CFR § 447.200-205; Social Security Act § 1903(a)(7); 42 CFR § 433.15(b)(7)	**Federal** • CMS Guidance—Information Bulletin on Preventative Services **Delaware** • Community Health Workers Program **New Mexico** • Managed Care Contract (starting on page 372)
Require Medicaid managed care plans to contract with pediatric providers that deploy a team-based approach.	Care Team Standards (Social Security Act § 1932(b)(5); 42 CFR §§ 438.68, 438.206(b) 457.1200(c), 457.1218) Funding for Training (Social Security Act § 1902(a)(30)(A); 42 CFR § 447.200-205; Social Security Act § 1903(a)(7); 42 CFR § 433.15(b)(7))	**Federal** • CMS Guidance **Missouri** • Managed Care Contract (starting on page 13)

Strategy	Tools	
	Federal Statute & Regulations	**Implementation Resources**
Promote training of providers on the social and emotional development of young children and the use of screening tools to identify and address potential concerns.	Training Guidelines (42 CFR § 438.236, 457.1200(c), 457.1233(c)) Funding for Training (Social Security Act § 1902(a)(30)(A); 42 CFR § 447.200-205; Social Security Act § 1903(a)(7); 42 CFR § 433.15(b)(7))	**Federal** • CMS Guidance **Oregon** • Managed Care Request for Proposal (starting on page 195) **South Carolina** • Quality through Technology and Innovation in Pediatrics (QTIP)

FOSTER STRONG COLLABORATION ACROSS AGENCIES SERVING YOUNG CHILDREN AND THEIR FAMILIES

Integrating interventions targeted to social and emotional development in a health care setting is by nature cross-cutting, touching on Medicaid, maternal and child health, early intervention, and early care and education. Stakeholders in these sectors work with a common population and generally share the goal of fostering children's healthy development. States could harness this shared focus by organizing state agencies overseeing these areas under a common governance structure and leadership. They also can reinforce a cross-cutting approach to early childhood and healthy development by incorporating relevant agencies into the same Cabinet department, building on existing State Advisory Councils on Early Childhood Care and Education or by appointing a Children's Cabinet or Governor's Initiative focused on a broad set of children's needs.[57]

In addition, states can use strategies such as:

- Using data-sharing agreements between Medicaid and other agencies, including early intervention services (i.e., early childhood intervention program Part C of IDEA), child welfare, etc.
- Moving Part C into Medicaid and adding an inter-agency project manager.
  - For example, South Carolina moved its Part C program into its Medicaid agency to ensure stronger coordination, including through use of Medicaid claims data to identify children who would qualify for a Part C evaluation.
- Leveraging state purchasing power and applying requirements to address the social and emotional health of children across coverage programs for which states are responsible (i.e., Medicaid, State employees, public educators).

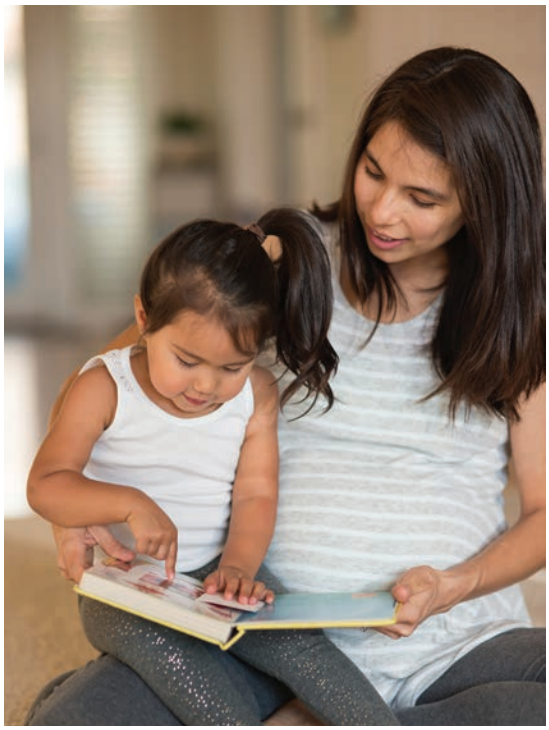
STRATEGY

5

Leverage a CHIP Health Services Initiative to finance interventions aimed at supporting children's social and emotional development.

A CHIP Health Services Initiative (HSI) is an activity designed to improve the health of children with low income and targets children under age 19 who are eligible for Medicaid or CHIP, although a state's HSI may benefit all children within a state regardless of income. States can use HSIs to cover the costs of direct services or to support public health priorities, such as the operation of poison control centers or intensive lead screening promotion and lead abatement.

Under CHIP, states can use up to 10 percent of the amount they spend on health coverage for program administration and other non-coverage activities. States must prioritize administrative funding for necessary programmatic expenditures, including eligibility determinations and renewals, contract negotiations, performance measurement, and other activities to meet regulatory requirements. However, they also can use a portion of administrative funds for outreach activities to identify and enroll eligible children in the program, and for the implementation of an approved HSI. Most states have significant "room" under the 10 percent administrative cap, meaning they have spent only a small portion of the available amount. In FY 2017, for example, state expenditures on non-coverage activities averaged only 4.2 percent (see Appendix C).[68]



HSIs provide states flexibility and a chance to experiment. Since states are not required to execute HSIs on a statewide basis, they can identify communities or populations that might reap particular benefits from the HSI, or they can pilot new ideas and approaches to delivering quality healthcare. The federal matching rates for CHIP-funded activities are also advantageous to states. On average, the federal matching rates for state CHIP programs are 15 percentage points higher than the rates for Medicaid and range from 76.5 to 95.39 percent in FY 2020.[69,70]

In addition, federal matching rates for CHIP have been *temporarily* enhanced even further: through September 2019, each state's reimbursement rate

receives a boost of an additional 23 percentage points, up to a maximum of 100 percent. For this limited period, with an average enhanced federal reimbursement rate of 94 percent, the non-federal share of the cost of an HSI averages just six percent and can be as low as zero. (In 2019, 13 states receive a CHIP matching rate of 100 percent.) After September 30, 2019, the enhanced match ratchets down to an 11.5 percentage point boost through September 30, 2020, and matching rates return to the customary CHIP enhanced levels thereafter.[71]

A critical first step in determining the opportunity for an HSI in a state (also the first step in CMS's review in approving HSIs) is to assess the state's CHIP administrative funds and current spending relative to the 10 percent limit.[72] Appendix B presents an analysis of states' current CHIP allotments and spending relative to the 10 percent limit. Assuming a state has available funding, it could pursue an HSI to finance an intervention that addresses children's social and emotional development.

IMPLEMENTATION STRATEGIES

Leverage a CHIP Health Services Initiative to finance interventions aimed at supporting children's social and emotional development.

Action Steps:

- Assess the state's CHIP administrative funds and current spending relative to the 10 percent limit; Identify appropriate interventions and estimate spending.
- Identify additional sources of funding (private or public) for the non-federal share.
- Prepare CHIP State Plan Amendment (SPA) with a description of the HSI, the number of low-income children the state expects to serve, a statement of the cost and the source of the non-federal share the state expects to dedicate to the initiative, and available research findings and evidence on the efficacy of the initiative for low-income children's health.

Massachusetts' initiative to prevent youth violence through after-school programs is aimed at mitigating the consequences of trauma and promoting healthy development.[73]

Maine's Family Home Visiting Program provides funding for community agencies to deliver home visits to first-time families and pregnant and parenting adolescents.[74]

Oklahoma's HSI provides funds to train pediatric primary care providers to promote early literacy during well-child visits in accordance with the AAP practice recommendations. The HSI is also intended to help increase the percentage of young children attending well-child visits and improve the percentage of children receiving standardized developmental screening.[75]

Tools for Implementation

Strategy	Tools	
	Federal Statute & Regulations	**Implementation Resources**
Leverage a CHIP Health Services Initiative to finance interventions aimed at supporting children's social and emotional development.		
Leverage a CHIP Health Services Initiative to finance interventions aimed at supporting children's social and emotional development.	Health Services Initiatives (Social Security Act § 2105(a)(1)(D)(ii); 42 CFR § 457.10)	**Federal** • CMS Guidance—Frequently Asked Questions **Oklahoma** • State Plan Amendment **Massachusetts** • State Plan Amendment **Appendix B** • States' Current CHIP Allotments and Spending Relative to 10% Limit

Conclusion

The strategies and tools presented in this Blueprint reflect the broad flexibility available in Medicaid to strengthen efforts that foster the social and emotional health of young children. The importance of pursuing such initiatives is clear, given the research on the long-term consequences children face when they start their lives confronting threats to their well-being. Interest in leveraging Medicaid and CHIP to support child development is increasing, and "leading edge" states have already taken steps to launch and begin implementing path-breaking initiatives.

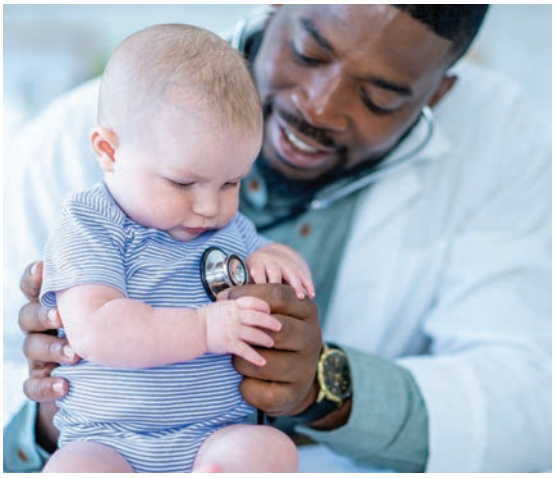


Table 1: Strategies and Tools

Strategy	Tools	
	Federal Statute & Regulations	**Implementation Resources**
1. Cover and support a full range of screening, assessment, and treatment services for children and their parents.		
Incorporate social and emotional screening within routine developmental and behavioral surveillance and screening, and developmental promotion, conducted during well-child visits.	EPSDT (Social Security Act §§ 1902(a)(43), 1905(r), 1905(a)(4)(B); 42 CFR § 441.50-.62(b))	**Federal** • Birth to 5: Watch me Thrive; A Compendium of Screening Measures for Young Children **Minnesota** • State Guidance **American Academy of Pediatrics** • Developmental Screening for Behavioral and Emotional Problems • Developmental Screening for Infants and Young Children in the Medical Home • Screening Technical Assistance & Resource Center • Birth to 5: Watch me Thrive; A Compendium of Screening Measures for Young Children **National Center for Children in Poverty** • 50-State Survey on Early Childhood Mental Health Services
Build social and emotional screening, assessment, and interventions into care management requirements.	Care Coordination & Management Standards (Social Security Act §§ 1905(a)(25), 1905(t); 42 CFR §§ 438.2, 438.208. 400.203, 440.168, 457.1200(c), 457.1230(c))	**North Carolina** • Managed Care Contract (starting on page 121)

Strategy	Tools	
	Federal Statute & Regulations	**Implementation Resources**
Promote investments in the social and emotional development of children as "value-added" services.	In Lieu of and Value Added Services (42 CFR §§ 438.3(e), 457.1200(c), 457.1201)	**Louisiana** • Managed Care Request for Proposal (starting on page 20)
Maximize coverage of screening, assessment, and treatment services for parents.	EPSDT (Social Security Act §§ 1902(a)(43), 1905(r), 1905(a)(4)(B); 42 CFR § 441.50-.62(b))	**Federal** • CMS Guidance—Information Bulletin on Maternal Depression • CMS Guidance—ACA Section 4106, Preventive Services • USPSTF Recommendation—Perinatal Depression **Colorado** • State Guidance
2. Leverage quality and performance improvement initiatives to spur changes in pediatric practice.		
Support the use of Child Core Set measures and explore development of additional measures related to social and emotional development.	Child Core Set Measures (Social Security Act § 1139A(a)) Quality Strategy (Social Security Act § 1932(c); 42 CFR §§ 438.334, 438.340, 457.1200(c), 457.1240(e))	**Federal** • CMS Guidance—Informational Bulletin • 2019 Child Core Set • 2019 Maternity Core Set • 2017 Child Core Set Reporting **National Quality Forum** • 2018 Measure Applications Partnership Recommendations for Strengthening Child Core Set **Oregon** • State Guidance
Use performance improvement projects to promote the social and emotional development of children.	Performance Improvement Projects (42 CFR §§ 438.240(d), 438.330, 457.1200(c), 457.1240(b))	**New York** • First 1,000 Days Initiative • Current managed care contract not available at time of publication.

Strategy	Tools	
	Federal Statute & Regulations	**Implementation Resources**
Reward plans that perform well on children's social and emotional development by auto-assigning them more beneficiaries.	Member Auto Assignments (Social Security Act § 1932(a)(4); 42 CFR §§ 438.54, 457.1200(c), 457.1210)	**Michigan** • Managed Care Contract (page 30) **Foundation** • KFF State Health Facts—Medicaid Managed Care Quality Initiatives

3. Establish payment models that incentivize a focus on the social and emotional development of children, ideally as part of a high-performing pediatric medical home.

Provide enhanced payments to providers for pursuing high-performing pediatric medical homes that integrate promotion of social and emotional development.	Enhanced Reimbursement (Social Security Act § 1902(a)(30)) Care Coordination & Management Standards (Social Security Act §§ 1905(a)(25), 1905(t); 42 CFR §§ 438.2, 438.208. 400.203, 440.168, 457.1200(c), 457.1230(c)) Directed Payments (42 CFR §§ 438.6(c), 457.1200(c))	**Colorado** • State Guidance **North Carolina** • Managed Care Contract (starting on page 129)
Leverage quality incentives and/or withholds to reward plans with strong performance on social and emotional development.	Incentive and Withhold Arrangements (42 CFR 438.6)	**Oregon** • Managed Care Contract (starting on page 96) • 2017 Metrics Report **North Carolina** • Managed Care Quality Strategy (starting on page 38)

Strategy	Tools	
	Federal Statute & Regulations	**Implementation Resources**
Develop value-based payment initiatives that prioritize children's social and emotional development.	Enhanced Reimbursement (Social Security Act § 1902(a)(30)) Care Coordination & Management Standards (Social Security Act §§ 1905(a)(25), 1905(t); 42 CFR §§ 438.2, 438.208. 400.203, 440.168, 457.1200(c), 457.1230(c)) Directed Payments (42 CFR §§ 438.6(c), 457.1200(c))	**Federal** • CMS Guidance—Informational Bulletin **Virginia** • Managed Care Contract (starting on page 233)

4. Facilitate investment in team-based care and training on children's social and emotional development.

Encourage or require use of community health workers and allow for the provision of services in home and early childhood settings.	Expanded Care Teams (Social Security Act § 1905(a)(13)(A); 42 CFR § 440.130(c)) Social Security Act § 1902(a)(30)(A); 42 CFR § 447.200-205; Social Security Act § 1903(a)(7); 42 CFR § 433.15(b)(7)	**Federal** • CMS Guidance—Information Bulletin on Preventative Services **Delaware** • Community Health Workers Program **New Mexico** • Managed Care Contract (starting on page 372)
Require Medicaid managed care plans to contract with pediatric providers that deploy a team-based approach.	Care Team Standards (Social Security Act § 1932(b)(5); 42 CFR §§ 438.68, 438.206(b) 457.1200(c), 457.1218) Funding for Training (Social Security Act § 1902(a)(30)(A); 42 CFR § 447.200-205; Social Security Act § 1903(a)(7); 42 CFR § 433.15(b)(7))	**Federal** • CMS Guidance **Missouri** • Managed Care Contract (starting on page 13)

Strategy	Tools	
	Federal Statute & Regulations	**Implementation Resources**
Promote training of providers on the social and emotional development of young children and the use of screening tools to identify and address potential concerns.	Training Guidelines (42 CFR § 438.236, 457.1200(c), 457.1233(c)) Funding for Training (Social Security Act § 1902(a)(30)(A); 42 CFR § 447.200-205; Social Security Act § 1903(a)(7); 42 CFR § 433.15(b)(7))	**Federal** • CMS Guidance **Oregon** • Managed Care Request for Proposal (starting on page 195) **South Carolina** • Quality through Technology and Innovation in Pediatrics (QTIP)

5. Leverage a CHIP Health Services Initiative to finance interventions aimed at supporting children's social and emotional development.

Leverage a CHIP Health Services Initiative to finance interventions aimed at supporting children's social and emotional development.	Health Services Initiatives (Social Security Act § 2105(a)(1)(D)(ii); 42 CFR § 457.10)	**Federal** • CMS Guidance—Frequently Asked Questions **Oklahoma** • State Plan Amendment **Massachusetts** • State Plan Amendment **Appendix B** • States' Current CHIP Allotments and Spending Relative to 10% Limit

Appendix A: Pediatrics Supporting Parents Background Information

In 2017, the Silicon Valley Community Foundation launched Pediatrics Supporting Parents, a 3-year initiative supported by five early childhood funders (Einhorn Family Charitable Trust, J.B. and M.K. Pritzker Family Foundation, The David and Lucile Packard Foundation, W.K. Kellogg Foundation, Overdeck Family Foundation, and an anonymous individual contributor). The initiative seeks to learn what strategies can be implemented in the pediatric primary care setting to improve social emotional development (SED) of children with a focus on nurturing the primary caregiver-child relationship.

To accomplish this, the Center for the Study of Social Policy (CSSP) is conducting an analysis of leading programs and interventions in and adjacent to the pediatric primary care channel that promote positive outcomes around SED and the primary caregiver-child relationship. During site visits to primary care practices where these leading programs and interventions are occurring, CSSP will learn more about which successful program characteristics may be effectively integrated into the primary care setting. The results of CSSP's program analysis will be tested and refined through a learning community, led by the National Institute for Children's Health Quality (NICHQ) with guidance from experts in the field, including CSSP, Family Voices, and a pediatric primary care expert advisory group.

The sites participating in the learning community will test strategies that can be implemented in the pediatric medical home setting that promote the SED of young children and strengthen the primary caregiver-child relationship. The strategies include opportunities along the full continuum of preventive care for every member of the pediatric care team to provide families with anticipatory guidance, link families to early learning resources, and connect families with community-based systems that help them promote their child's SED. The learning community will be organized using the Institute for Healthcare Improvement's Breakthrough Series (BTS) Learning Collaborative model. Sites will be selected in December 2018 and the 18-month learning community will launch in January 2019.

While the learning community is underway, the Silicon Valley Community Foundation is also funding CSSP, along with their partners at Manatt Health, to demonstrate how Medicaid can help finance effective strategies to foster SED, making it more likely that such strategies become routine, expected components of pediatric primary care. The results of the different components of this initiative will build confidence in effective and scalable implementation strategies and identify the community characteristics that strengthen families to improve the SED of children and ultimately, make progress towards changing the standard of care.

Our combined work acknowledges that well-child visits offer the opportunity to enhance a family's ability to promote their child's SED and that a child's SED is determined by contexts beyond the pediatric medical home, including their home environment, medical system, community network, access to specialty medical care and early educational opportunities. Keeping the pediatric medical home and the larger community context in mind presents the greatest chance to impact kindergarten readiness.

Appendix B: Statutory and Regulatory Authorities

The statutory and regulatory bases for the strategies featured in this Blueprint are summarized here.

Provision	Description	Statutory / Regulatory Citation[D]
Coverage		
Early Periodic Screening Diagnostic & Treatment (EPSDT)	States must provide all Medicaid-enrolled children a comprehensive array of services designed to meet health and developmental needs.	Social Security Act §§ 1902(a)(43), 1905(r), 1905(a)(4)(B); 42 CFR § 441.50-.62(b)
Access to Mental Health and Substance Use Disorder Services for Children and Pregnant Women	States must provide all CHIP-enrolled children and pregnant women access to all mental health services (including behavioral health treatment) necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders, including substance use disorder.	Social Security Act § 2103(c)
In Lieu of and Value Added Services	States may determine medically appropriate and cost-effective substitutes for Medicaid and CHIP services ("in lieu of" services) and authorize managed care plans to provide these services under certain conditions. Managed care plans also may choose additional services not covered under Medicaid or CHIP but aimed at improving health outcomes and reducing costs ("value added" services). Both of these authorities provide MCOs additional flexibility to offer services which could be tailored or targeted to interventions for children's social and emotional development.	42 CFR §§ 438.3(e), 457.1200(c), 457.1201
Preventive Services Enhanced Match	States that cover, without cost-sharing, all United States Preventive Services Task Force (USPSTF) A and B preventive services and Advisory Committee on Immunization Practices (ACIP) recommended vaccines and their administration may receive a one-percentage-point increase in their federal Medicaid matching rate for spending on those services. Such services include depression screening for adults, including pregnant and postpartum women, and adolescents.	Social Security Act §§ 1905(a)(13), (b)(5)

[D] Social Security Act 2103(f)(3) extends Medicaid managed care requirements relating to enrollment, beneficiary information, beneficiary protections, quality assurance, and program integrity to CHIP managed care plans. Further, for any CHIP operated as a Medicaid expansion program, 42 CFR 457.1200(c) applies all Medicaid managed care regulatory provisions.

Provision	Description	Statutory / Regulatory Citation[D]
Coverage		
Early Periodic Screening Diagnostic & Treatment (EPSDT)	States must provide all Medicaid-enrolled children a comprehensive array of services designed to meet health and developmental needs.	Social Security Act §§ 1902(a)(43), 1905(r), 1905(a)(4)(B); 42 CFR § 441.50-.62(b)
Access to Mental Health and Substance Use Disorder Services for Children and Pregnant Women	States must provide all CHIP-enrolled children and pregnant women access to all mental health services (including behavioral health treatment) necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders, including substance use disorder.	Social Security Act § 2103(c)
In Lieu of and Value Added Services	States may determine medically appropriate and cost-effective substitutes for Medicaid and CHIP services ("in lieu of" services) and authorize managed care plans to provide these services under certain conditions. Managed care plans may choose also additional services not covered under Medicaid or CHIP but aimed at improving health outcomes and reducing costs ("value added" services). Both of these authorities provide additional flexibility to offer services which could be tailored or targeted to interventions for children's social and emotional development.	42 CFR §§ 438.3(e), 457.1200(c), 457.1201
Preventive Services Enhanced Match	States that cover, without cost-sharing, all United States Preventive Services Task Force (USPSTF) A and B preventive services and Advisory Committee on Immunization Practices (ACIP) recommended vaccines and their administration may receive a one-percentage-point increase in their Federal Medicaid matching rate for spending on those services. Such services include depression screening for adults and adolescents.	Social Security Act §§ 1905(a)(13), (b)(5)
Incentives for Providers and Plans		
Enhanced Reimbursement	States may establish a "rate add-on" to payments to pediatric care providers if they meet state-defined standards for addressing the social and emotional health of children, such as including a family support specialist on their care team and connecting families to social and economic supports. States with fee-for-service systems can directly establish the add-on, while those with Medicaid managed care can require, through their contracts, that managed care organizations to make such payments.	Social Security Act § 1902(a)(30)

Provision	Description	Statutory / Regulatory Citation[D]
Incentives for Providers and Plans		
Member Auto-Assignment	States must provide Medicaid and CHIP beneficiaries an opportunity to make an active and informed decision in selecting their managed care plan. In the absence of a beneficiary decision, they determine the algorithm used to assign beneficiaries automatically to managed care plans. When designing the algorithm, a state could include criteria such as managed care plan quality and performance with respect to children's social and emotional health to reward plans that excel on these issues.	Social Security Act § 1932(a)(4); 42 CFR §§ 438.54, 457.1200(c), 457.1210
Incentive and Withhold Arrangements	To incentivize managed care plans to focus on a state's priorities, states may provide additional payments for meeting certain performance levels (incentive arrangement), or withhold a portion of a plan's capitation payment pending achievement of a certain performance level (withhold arrangement). These performance goals must be linked to the quality goals and measures defined in a state's managed care plan quality strategy, which could include a focus on children's social and emotional health. These arrangements apply to Medicaid managed care and CHIP managed care to the extent that CHIP is operated as a Medicaid expansion program.	42 CFR §§ 438.6(c), 457.1200(c)
Directed Payments	If it is part of a delivery system reform agenda, states may direct managed care plans to reimburse providers meeting certain standards using specified payment methodologies. The provider payment methodologies could be payments linked to a high-performing pediatric medical home or pay-for-performance on metrics related to children's social and emotional health. This authority applies to Medicaid managed care and CHIP managed care to the extent that CHIP is operated as a Medicaid expansion program.	42 CFR §§ 438.6(c), 457.1200(c)
Quality Measurement and Improvement		
Child Core Set Measures	Since 2010, states have been voluntarily reporting on a national standard Core Set of Children's Health Quality Measures (Child Core Set). Starting in 2024, states will be required to report on these measures for Medicaid and CHIP. Measures address primary care, behavioral health, and maternal and perinatal health. The Child Core Set establishes an important expectation of consistent and ongoing measurement and begins to develop comparative data across states. State may leverage the Child Core Set and could also develop additional measures that emphasize social and emotional development.	Social Security Act § 1139A(a)

Quality Strategy	States must develop and implement a quality strategy for assessing and improving the quality of care and services delivered by Medicaid and CHIP managed care plans. The quality strategy serves as an articulation of a State's policy goals and an important anchor for a variety of other tools such as performance improvement projects, withhold and incentive payments, and directed payments. States may leverage the quality strategy to consider children's social and emotional health in their process and outcome measures and performance priorities.	Social Security Act § 1932(c); 42 CFR §§ 438.334, 438.340, 457.1200(c), 457.1240(e)
Performance Improvement Projects	States must require Medicaid and CHIP managed care plans to conduct performance improvement projects, which are designed to achieve significant improvement in health outcomes and enrollee satisfaction. States may leverage this authority and direct specific project focus areas, such as those focused on children's mental health.	42 CFR §§ 438.240(d), 438.330, 457.1200(c), 457.1240(b)
Provider Training and Practice Re-configuration		
Expanded Care Teams	States may provide Medicaid reimbursement for preventive services recommended by, rather than provided directly by, a physician or other licensed practitioner. States must define practitioner qualifications, including any required education, training, experience, credentialing or registration. States may leverage this flexibility in scope of providers to expand care team capacity for integrating and addressing children's social and emotional health, such as for inclusion of community health workers.	Social Security Act § 1905(a)(13)(A); 42 CFR § 440.130(c)
Care Coordination & Management Standards	States must ensure that Medicaid and CHIP managed care plans meet specific coordination and continuity of care standards and may establish additional standards. States may also leverage primary care case management (PCCM) programs for Medicaid and CHIP and designate primary care providers with certain care management and coordination requirements.	Social Security Act §§ 1905(a)(25), 1905(t); 42 CFR §§ 438.2, 438.208. 400.203, 440.168, 457.1200(c), 457.1230(c)
Care Team Standards & Network Adequacy	States must enforce care team standards and network adequacy for Medicaid and CHIP managed care.	Social Security Act § 1932(b)(5); 42 CFR §§ 438.68, 438.206(b) 457.1200(c), 457.1218
Training Guidelines	States must ensure that each managed care plan adopts practice guidelines that, among other requirements, consider needs of enrollees and are based on valid and reliable clinical evidence or expertise.	42 CFR § 438.236, 457.1200(c), 457.1233(c)

Funding for Training	States may recognize and fund provider training in several ways. States may build the costs for training on state-required skills and knowledge into provider reimbursement for services. For provider training aimed at improving the delivery of Medicaid services, states may reimburse this training as a Medicaid administrative expense.	Social Security Act § 1902(a)(30)(A); 42 CFR § 447.200-205; Social Security Act § 1903(a)(7); 42 CFR § 433.15(b)(7)
Health Services Initiatives		
Health Services Initiatives	Leveraging a share of CHIP administrative funds, states may design and deploy interventions focused on direct services and public health goals for low income children, including initiatives that focus on the social and emotional health of children.	Social Security Act § 2105(a)(1)(D)(ii); 42 CFR § 457.10

Appendix C: Table C-1

States' CHIP Spending Relative to the 10 Percent Limit on Non-Coverage Expenditures Federal Fiscal Year 2017

State	Total CHIP Expenditures[1, 3]			Amount of 10% Cap Funds Used[2, 3]			Available Room Under 10% Cap	Available Funds Under 10% Cap
	Total	FY 2019	Federal	State	FY 2020	Federal	Federal	State
Alabama	$367.4	$367.4	$0.0	$7.4	$7.4	$0.0	8%	$29.3
Alaska	$33.9	$29.7	$4.2	$3.0	$2.6	$0.4	1%	$0.4
Arizona	$215.1	$215.1	$0.0	$8.4	$8.4	$0.0	6%	$13.1
Arkansas	$169.9	$169.9	$0.0	$0.8	$0.8	$0.0	10%	$16.2
California	$4,118.0	$3,413.8	$704.2	$78.7	$69.2	$9.4	8%	$333.1
Colorado	$282.0	$248.5	$33.5	$4.5	$4.0	$0.5	8%	$23.7
Connecticut	$42.5	$37.5	$5.1	$4.2	$3.7	$0.5	0%	$0.0
Delaware	$38.4	$34.9	$3.5	$1.7	$1.6	$0.2	6%	$2.1
District of Columbia	$36.6	$36.6	$0.0	$1.9	$1.9	$0.0	5%	$1.7
Florida	$722.3	$691.2	$31.2	$42.0	$40.2	$1.8	4%	$30.2
Georgia	$408.4	$408.6	-$0.2	$23.5	$23.5	$0.0	4%	$17.3
Hawaii	$67.2	$61.5	$5.7	$2.5	$2.3	$0.2	6%	$4.2
Idaho	$81.7	$81.7	$0.1	$3.4	$3.4	$0.0	6%	$4.8
Illinois	$270.5	$243.8	$26.7	$22.9	$20.2	$2.7	2%	$4.2
Indiana	$226.3	$225.8	$0.5	$11.0	$10.9	$0.0	5%	$11.7
Iowa	$134.9	$125.1	$9.8	$10.5	$9.8	$0.8	2%	$3.0
Kansas	$113.3	$103.9	$9.4	$9.8	$9.1	$0.8	1%	$1.5
Kentucky	$214.2	$213.8	$0.4	$5.3	$5.3	$0.0	8%	$16.1
Louisiana	$370.3	$357.2	$13.1	$14.4	$13.8	$0.5	6%	$22.7
Maine	$34.9	$34.2	$0.7	$1.0	$1.0	$0.0	7%	$2.5
Maryland	$363.2	$319.6	$43.6	$17.8	$15.6	$2.1	5%	$18.6
Massachusetts	$778.4	$685.8	$92.6	$22.2	$19.5	$2.7	7%	$55.6
Michigan	$263.8	$259.6	$4.2	$2.7	$2.7	$0.0	9%	$23.6
Minnesota	$13.8	$13.6	$0.2	$1.2	$1.1	$0.2	1%	$0.2
Mississippi	$262.1	$262.1	$0.0	$3.0	$3.0	$0.0	9%	$23.2
Missouri	$236.0	$229.7	$6.3	$4.8	$4.7	$0.1	8%	$18.8
Montana	$101.4	$100.2	$1.2	$5.3	$5.2	$0.1	5%	$4.8
Nebraska	$90.1	$81.9	$8.2	$2.0	$1.8	$0.2	8%	$7.0
Nevada	$69.5	$68.2	$1.2	$2.1	$2.0	$0.0	7%	$4.9
New Hampshire	$35.0	$30.8	$4.2	$0.0	$0.0	$0.0	10%	$3.5
New Jersey	$530.0	$466.6	$63.4	$14.0	$12.7	$1.3	7%	$39.0
New Mexico	$107.3	$107.4	-$0.1	$1.8	$1.8	$0.0	8%	$8.9
New York	$1,445.7	$1,272.2	$173.5	$40.2	$35.2	$5.0	7%	$104.3
North Carolina	$479.3	$478.4	$0.9	$12.6	$12.5	$0.0	7%	$35.4
North Dakota	$27.2	$24.2	$3.1	$2.7	$2.6	$0.1	0%	$0.0
Ohio	$573.4	$546.1	$27.3	$34.2	$32.9	$1.3	4%	$23.2
Oklahoma	$265.4	$252.1	$13.3	$9.0	$8.6	$0.4	7%	$17.5
Oregon	$296.5	$290.7	$5.9	$11.3	$11.0	$0.3	6%	$18.4
Pennsylvania	$682.5	$609.2	$73.4	$11.9	$10.6	$1.3	8%	$56.3
Rhode Island	$36.0	$32.7	$3.3	$0.9	$0.8	$0.1	7%	$2.7
South Carolina	$169.1	$169.1	$0.0	$8.4	$8.4	$0.0	5%	$8.5
South Dakota	$33.6	$30.7	$2.9	$0.5	$0.5	$0.0	9%	$2.9
Tennessee	$215.4	$212.1	$3.4	$19.9	$19.6	$0.3	1%	$1.6
Texas	$1,833.6	$1,692.9	$140.7	$60.8	$56.1	$4.7	7%	$122.6
Utah	$143.6	$142.9	$0.7	$5.7	$5.7	$0.0	6%	$8.7
Vermont	$13.6	$12.4	$1.2	$1.2	$1.1	$0.1	1%	$0.2
Virginia	$339.5	$298.2	$41.3	$21.2	$18.7	$2.5	4%	$12.7
Washington	$154.2	$135.6	$18.6	$2.8	$2.4	$0.5	8%	$12.6
West Virginia	$66.6	$66.6	$0.0	$3.9	$3.9	$0.0	4%	$2.8
Wisconsin	$234.9	$220.8	$14.2	$10.7	$10.1	$0.7	5%	$12.8
Wyoming	$13.6	$12.0	$1.6	$0.4	$0.4	$0.0	7%	$1.0
Total	**$17,822.6**	**$16,224.4**	**$1,598.2**	**$592.1**	**$550.2**	**$41.9**	**$0.1**	**$1,190.1**

SOURCE: CSSP/Manatt analysis of CMS of FY 2017 Financial Management Reports available https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/collection-systems/fmr-chip-expend2017.pdf

1 Net CHIP Expenditures excluding expenditures related to drug rebates. Also does not include Social Security Act Section 2105(g) expenditures in which certain states receive 100% FMAP CHIP funds for certain Medicaid children.

2 CHIP Expenditures for Administration, Translation and Interpretation, and Outreach

3 Certain states show negative expenditures due to prior period adjustments

Appendix C: Table C-2
Available Federal Funds and Contributions
Federal Fiscal Year 2017

State	Available Funds Under 10% Cap	Federal Matching Rate [1]	Federal Funds Available	State Contribution Needed	Federal Matching Rate (2)	Federal Funds Available	State Contribution Needed
	Total	FY 2019	Federal	State	FY 2020	Federal	State
Alabama	$29.3	100%	$29.3	$0.0	92%	$26.9	$2.4
Alaska	$0.4	88%	$0.4	$0.1	77%	$0.3	$0.1
Arizona	$13.1	100%	$13.1	$0.0	91%	$11.9	$1.2
Arkansas	$16.2	100%	$16.2	$0.0	91%	$14.9	$1.4
California	$333.1	88%	$293.2	$40.0	77%	$254.9	$78.3
Colorado	$23.7	88%	$20.8	$2.8	77%	$18.1	$5.6
Connecticut	$0.0	88%	$0.0	$0.0	77%	$0.0	$0.0
Delaware	$2.1	93%	$2.0	$0.1	82%	$1.7	$0.4
District of Columbia	$1.7	100%	$1.7	$0.0	91%	$1.6	$0.2
Florida	$30.2	96%	$28.9	$1.3	85%	$25.6	$4.7
Georgia	$17.3	100%	$17.3	$0.0	89%	$15.4	$2.0
Hawaii	$4.2	91%	$3.8	$0.4	79%	$3.3	$0.9
Idaho	$4.8	100%	$4.8	$0.0	91%	$4.4	$0.4
Illinois	$4.2	88%	$3.7	$0.5	77%	$3.2	$1.0
Indiana	$11.7	99%	$11.6	$0.1	88%	$10.2	$1.4
Iowa	$3.0	95%	$2.8	$0.1	84%	$2.5	$0.5
Kansas	$1.5	93%	$1.4	$0.1	83%	$1.3	$0.3
Kentucky	$16.1	100%	$16.1	$0.0	92%	$14.8	$1.3
Louisiana	$22.7	99%	$22.3	$0.3	88%	$20.0	$2.7
Maine	$2.5	98%	$2.5	$0.0	86%	$2.2	$0.3
Maryland	$18.6	88%	$16.3	$2.2	77%	$14.2	$4.4
Massachusetts	$55.6	88%	$49.0	$6.7	77%	$42.6	$13.1
Michigan	$23.6	98%	$23.2	$0.4	86%	$20.4	$3.2
Minnesota	$0.2	88%	$0.1	$0.0	77%	$0.1	$0.0
Mississippi	$23.2	100%	$23.2	$0.0	95%	$22.1	$1.1
Missouri	$18.8	99%	$18.5	$0.2	87%	$16.4	$2.4
Montana	$4.8	99%	$4.8	$0.1	87%	$4.2	$0.6
Nebraska	$7.0	90%	$6.3	$0.7	80%	$5.6	$1.4
Nevada	$4.9	98%	$4.8	$0.1	86%	$4.2	$0.7
New Hampshire	$3.5	88%	$3.1	$0.4	77%	$2.7	$0.8
New Jersey	$39.0	88%	$34.3	$4.7	77%	$29.9	$9.2
New Mexico	$8.9	100%	$8.9	$0.0	92%	$8.2	$0.7
New York	$104.3	88%	$91.8	$12.5	77%	$79.8	$24.5
North Carolina	$35.4	100%	$35.4	$0.0	88%	$31.3	$4.1
North Dakota	$0.0	88%	$0.0	$0.0	77%	$0.0	$0.0
Ohio	$23.2	97%	$22.5	$0.7	86%	$19.8	$3.3
Oklahoma	$17.5	97%	$16.9	$0.6	88%	$15.4	$2.2
Oregon	$18.4	97%	$17.8	$0.6	84%	$15.5	$2.9
Pennsylvania	$56.3	90%	$50.5	$5.9	78%	$44.0	$12.4
Rhode Island	$2.7	90%	$2.4	$0.3	79%	$2.1	$0.6
South Carolina	$8.5	100%	$8.5	$0.0	91%	$7.7	$0.8
South Dakota	$2.9	93%	$2.7	$0.2	82%	$2.3	$0.5
Tennessee	$1.6	99%	$1.6	$0.0	87%	$1.4	$0.2
Texas	$122.6	94%	$114.9	$7.7	84%	$103.1	$19.5
Utah	$8.7	100%	$8.7	$0.0	89%	$7.8	$0.9
Vermont	$0.2	91%	$0.1	$0.0	79%	$0.1	$0.0
Virginia	$12.7	88%	$11.2	$1.5	77%	$9.7	$3.0
Washington	$12.6	88%	$11.1	$1.5	77%	$9.6	$3.0
West Virginia	$2.8	100%	$2.8	$0.0	94%	$2.6	$0.2
Wisconsin	$12.8	95%	$12.1	$0.7	83%	$10.6	$2.2
Wyoming	$1.0	88%	$0.8	$0.1	77%	$0.7	$0.2
Total	**$1,190.1**		**$1,096.4**	**$93.8**		**$967.3**	**$222.8**

SOURCE: CSSP/Manatt analysis of CMS of FY 2017 Financial Management Reports available https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/collection-systems/fmr-chip-expend2017.pdf

1 FY 2019 Enhanced FMAP, as published in 82 Fed Reg 55383 published in https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/collection-systems/fmr-chip-expend2017.pdf

2 FY 2020 Enhanced FMAP as published in 83 Fed Reg 61157, available at: https://www.govinfo.gov/content/pkg/FR-2018-11-28/pdf/2018-25944.pdf

Appendix D: Methodology

State-specific review. CSSP and Manatt identified and assessed states' Medicaid policy environments and adult and pediatric care delivery initiatives focused on social and emotional development. Four states– California, North Carolina, New York and Oregon – were identified as "deep dive" states based on their Medicaid leadership, high rates of children's enrollment in Medicaid, and leading edge practices. To obtain a deeper understanding of these states' policies and practices, CSSP and Manatt reviewed policy documents in these states, including Medicaid managed care contracts, Medicaid 1115 waivers, and state legislation, and conducted interviews with key state Medicaid policymakers and stakeholders. A handful of other states, including Colorado, Oklahoma and South Carolina, were also selected to highlight targeted, leading initiatives focused on Medicaid and children's social and emotional development.

Key informant interviews. Manatt and CSSP interviewed 35 key informants in Medicaid policy and pediatric care, including current and former State Medicaid program officials; leaders at health plans and healthcare-related associations; and experts in pediatric care delivery. The priority state and national expert interviews directly informed the strategies and tools included in the Blueprint. They shared their experiences with various pediatric care initiatives, discussed challenges and key lessons learned and highlighted implementation considerations. Interview guides were shared in advance and interviews entailed 30-60 minute phone calls or in-person discussions focused on the interviewees' insights on leveraging Medicaid to impact young children's social and emotional development.

Interviewees: Priority States	
California	
Mari Cantwell	California Medicaid Director
Brenda Grealish	Acting Deputy Director, Mental Health & Substance Use Disorder Services, California Department of Health Care Services
Rene Mollow	Deputy Director, Health Care Benefits & Eligibility, California Department of Health Care Services
Sarah Brooks	Deputy Director, Health Care Delivery Systems, California Department of Health Care Services
Jacey Cooper	Assistant Deputy Director, Health Care Delivery Systems, California Department of Health Care Services
New York	
Kalin Scott	Director, New York Medicaid Redesign Team, New York State Department of Health
Dr. Douglas Fish	Medical Director, New York State Department of Health
North Carolina	
Dr. Mandy Cohen	Secretary of North Carolina Department of Health & Human Services
Susan Perry-Manning	Principal Deputy Secretary, Office of the Secretary, North Carolina Department of Health & Human Services

Becki Planchard	Senior Early Childhood Policy Advisor, Office of the Secretary, North Carolina Department of Health & Human Services
Dr. Elizabeth Erickson	Pediatrician, Duke Children's Primary Care Roxboro Street
Carolyn Merrifield	Carolinas Programs Director, Reach Out & Read
Ginger Young	Founder and Executive Director, Book Harvest
Isabel Geffner	Advancement Director, Book Harvest
Oregon	
Dr. Helen Bellanca	Family Physician, Kaiser Permanente; Former Medical Director, Health Share of Oregon
Christine Bernsten	Director of Strategic Initiatives, Health Share of Oregon
Tina Edlund	Senior Health Policy Advisor, Office of the Governor
Dr. Dana Hargunani	Chief Medical Officer, Oregon Health Authority
Peg King	Kindergarten Readiness Project Manager, Strategic Initiatives, Health Share of Oregon
Rosa Klein	Human Services Policy Advisor, Office of Governor
Bobby Martin	Foster Care Systems Manager, Strategic Initiatives, Health Share of Oregon
Interviewees: National & State Experts	
Melody Anthony	Deputy State Medicaid Director, Oklahoma Health Care Authority
Kate Breslin	President & Chief Executive Officer, Schuyler Center for Analysis & Advocacy
Suzanne Brundage	Director, Children's Health Initiative, United Health Fund
Dr. Stephen Cha	Chief Medical Officer, UnitedHealthcare
Toby Douglas	Senior Vice President of National Medicaid, Kaiser Permanente
Dr. Paul Dworkin	Executive Vice President for Community Child Health at Connecticut Children's Medical Center and Founding Director of the Help Me Grow National Center
Gretchen Hammer	Founder, Public Leadership Consulting Group; Former Colorado Medicaid Director
Dr. Mike Herndon	Chief Medical Officer, Oklahoma Health Care Authority
Colleen Meiman	Senior Policy Advisor, National Association of Community Health Centers
Becky Pasternik-Ikard	Chief Executive Officer, Oklahoma Health Care Authority
Sara Rosenbaum	Professor, Department of Health Policy, George Washington University
Chad Shearer	Vice President of Policy & Director of Medicaid Institute, United Health Fund
Christian Soura	Vice President of Policy & Finance, South Carolina Hospital Association
Melinda Thomason	Director of Health Care Systems Innovations, Oklahoma Health Care Authority
Bridget Walsh	Senior Policy Analyst for Health and Public Health, Schuyler Center for Analysis & Advocacy

Medicaid Leader Insights. On February 8, 2019, CSSP and Manatt convened 14 national, state and sector-specific experts in young children's development and Medicaid. A working draft of the Blueprint was shared prior to the meeting, where Medicaid leaders shared feedback and engaged in a robust discussion on the priorities, strategies and tools outlined. Some participants had been identified based on their valuable insights during key informant interview phase, while others were recommended by various experts in their common fields.

Medicaid Leaders Convening Participants	
Medicaid Leaders	
Kate Breslin	President & Chief Executive Officer, Schuyler Center for Analysis & Advocacy
Dr. Rahil Briggs	National Director, HealthySteps
Suzanne Brundage	Director, Children's Health Initiative, United Health Fund
Elisabeth Burak	Senior Fellow, Center for Children and Families, Georgetown University
Dr. Stephen Cha	Chief Medical Officer, UnitedHealthcare
Dr. Linda Elam	District of Columbia Medicaid Director & Deputy Director, District of Columbia Department of Health Care Finance
Gretchen Hammer	Founder, Public Leadership Consulting Group; Former Colorado Medicaid Director
Dr. Dana Hargunani	Chief Medical Officer, Oregon Health Authority
Dr. Dipesh Navsaria	Associate Professor of Pediatrics, University of Wisconsin School of Medicine and Public Health
Dr. James Perrin	Professor of Pediatrics, Harvard Medical School
Christian Soura	Vice President of Policy & Finance, South Carolina Hospital Association
Dr. Kimá Joy Taylor	Founder, Anka Consulting; Board Member, Community Catalyst
Melinda Thomason	Director of Health Care Systems Innovations, Oklahoma Health Care Authority
Jennifer Tracey	Senior Director of Growth & Sustainability, HealthySteps
Project Leads & Facilitators	
Dr. Katie Beckmann	Program Officer, Children, Families, and Communities Program, David and Lucile Packard Foundation
Donna Cohen Ross	Senior Advisor, Medicaid and Early Childhood, Center for the Study of Social Policy
Stephanie Doyle	Senior Associate, Young Children and their Families Team, Center for the Study of Social Policy
Jocelyn Guyer	Managing Director, Manatt Health
Alice Lam	Director, Manatt Health
Ngozi Lawal	Project Director, Prenatal to 3 Initiative, Center for the Study of Social Policy
Erin Robinson	Policy Analyst, Center for the Study of Social Policy
Madeleine Toups	Consultant, Manatt Health

4. Glossary of Relevant Terms

Term	Definition
Assessment	Process for monitoring, observing, and evaluating a child's development and developing specific recommendations for addressing a diagnosis.
Bright Futures	Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics and supported, in part, by the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). The Bright Futures Guidelines provide theory-based and evidence-driven guidance for all preventive care screenings and well-child visits
Community Health Worker	Part of the health team who serves as a frontline liaison, guiding individuals and families through the health, social, and community services systems to foster health and well-being.
Dyadic Treatment	Therapeutic treatment that is provided to the caregiver-child dyad together.
Developmental Screening	Indicating whether a child's development is on track through a quick snapshot of a child's health, based on age appropriate metrics and validated tools.
Managed Care Organization	Private health plans that contract with a state under a capitated rate for a comprehensive risk contract.
Medical Home	Patient- and family-centered model of care, typically in primary care offices, that incorporates a team-based approach to provide high-quality, coordinated, compassionate, and culturally effective care for children, adults, and families.
Medical Loss Ratio (MLR)	Measures generally how much a plan spends on the provision of covered services compared to the total revenue it receives in capitation payments from the state. CMS now requires that both Medicaid and CHIP managed care plans calculate and report their MLR according to standards that are similar to Medicare Advantage and the private market.
Providers (pediatric care providers)	Practitioners who work regularly with children and their families (i.e., pediatricians, obstetrician/gynecologists, primary care physician, etc.), as well as nurse practitioners, psychiatrists, psychologists, social workers, medical assistants, and community health workers.
Social and Emotional Development	A child's ability to form secure relationships, experience and regulate emotions, and explore and learn.
Team-based Care	Services delivered by providers working collaboratively with children and their families/caregivers to provide coordinated care across physical, behavioral, social and emotional, and socio-economic domains.
Value-Based Payments	An approach to reimbursement based on paying for health outcomes rather than the volume of care that is provided.

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