

**Federal Health Reform and Children's Healthy Development:
Opportunities for State and Community Advocacy
and Foundation Action**

The 111th Congress enacted three pieces of landmark legislation that not only dramatically expand health insurance coverage for children but also offer states and communities the opportunity to strengthen the provision of primary, preventive, and developmental health services to children. The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA), the Patient Protection and Affordable Care Act of 2010 (PPACA), and the Health Care and Education Reconciliation Act of 2010 (HCERA) collectively offer many new opportunities and directives to improve primary, preventive, and developmental health services for children. In most instances, it will be up to states and communities to take advantage of these opportunities.

The following is a very brief summary of the following provisions.

1. Coverage of preventive health services (Sec. 2713 of PPACA).
2. Payment to primary care physicians (Sec. 1202 of HCERA).
3. Child health quality outcomes development and demonstration grants (Sec. 401 of CHIPRA).
4. Childhood obesity demonstration projects (Sec. 401 of CHIPRA and Sec. 4306 of PPACA).
5. Pediatric accountable care organization demonstration project (Sec. 2706 of PPACA).
6. MACPAC assessment of policies affecting all Medicaid beneficiaries (Sec. 2801 of PPACA, especially subparagraphs B through E).
7. Maternal, infant, and early childhood home visitation program (Sec. 2951 of PPACA).
8. Center for Medicare and Medicaid innovation and healthcare innovation zones (Sec. 3021 of PPACA).
9. Community health teams to support the patient-centered medical home (Sec. 3502 of PPACA).
10. Prevention and public health fund (Sec. 4002 of PPACA).
11. Education and outreach campaigns regarding preventive benefits (Sec. 4004 of PPACA).
12. School-based health centers (Sec. 4101 of PPACA).
13. Oral healthcare preventive services (Sec. 4102 of PPACA).
14. Community transformation grants (Sec. 4201 of PPACA).
15. Primary care extension program (Sec. 5405 of PPACA).
16. Spending for federally qualified health centers (Sec. 5601 of PPACA).

Summary of Provisions

1. Coverage of preventive health services (Sec. 2713 of PPACA). For the first time, the federal government has established a group health plan and health insurance issuer mandate, with no cost sharing requirements, for certain preventive services. Included in these requirements are “with respect to infants, children, and adolescents, evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration” [e.g. *Bright Futures*]. This also provides federal recognition of a standard for well-child visits that should apply to children covered under Medicaid and CHIP, particularly through Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. While *Bright Futures* offers guidance regarding the provision of well-child care, it does not enumerate specific minimum standards for that care and this will require more explicit definition.

2. Payment to primary care physicians (Sec. 1202 of HCERA). Beginning in 2014, state payments under Medicaid for primary care physicians shall be equivalent to payments made under Medicare, with the federal government initially covering the full cost of increases in reimbursements. This likely would include billing codes related to well-child care, developmental screenings, and EPSDT visits. Current state reimbursements vary widely in their payment rates to primary care physicians, and there are not necessarily specific reimbursement structures under Medicare for such children’s primary services to reference. Setting the federal rates will be very important to matching expectations with realizable provision of services. Clearly, however, the increases are likely to be large in some states for primary and well-child visits, and such increases should come with accountability to produce greater adherence to providing comprehensive primary services.

- Implications. These first two provisions fit together. States are at varying levels in promoting *Bright Futures* practice within their Medicaid programs. Mining the field for best practices and for reimbursements and billings and for technical assistance to practitioners for continuous improvement could form the basis for providing guidance to states not only on incorporating such practices into Medicaid (which serves over 30% of all children and over half of all children with special health care needs) but also into private health insurance coverage. As states gear toward higher reimbursement rates for primary and well-child visits, they also can benefit from help in establishing appropriate monitoring and accountability provisions for such care to ensure that increased reimbursements result in comprehensive services.
- Advocacy and foundation role. Advocates and foundations can seek to leverage state investments in designing these systems and advocate to the federal government for strong guidance in promoting a comprehensive approach to primary and preventive child health care. Since this will involve both policy changes and practice and culture changes within the pediatric community, it will be important to include stakeholder groups that represent the advocacy

community, including child advocates, parents, and those speaking on behalf of children's special needs.

3. Child health quality outcomes development and demonstration grants (Sec. 401 of CHIPRA). The Institute of Medicine is directed to develop initial measures of child health care quality and continue to refine them, for use in patient practice and electronic data systems. A demonstration grant program, with 20 million in funding annually, is established for fiscal years 2009 through 2013 for not more than 10 grants to states and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of children's health care provided under Medicaid and CHIP. The first round of demonstration grants has been awarded.

- Implications. The initial list of child health outcomes developed by the Institute of Medicine under this provision includes a reference to developmental screenings based upon the ABCD Initiative, but there is no uniform definition for what constitutes developmental screenings. The demonstration funding provides options for changing and strengthening provider practice as well as developing records. As states and providers work to develop electronic medical records and health information systems, they will need to examine what information should be part of electronic records from well-child visits and what should be expected within charts. States also could be in a position to review such records for payment determinations under Medicaid and CHIP. Compared with many other provisions in health reform, the actual funding is fairly small, but there is a need to develop more comprehensive systems for recording and accessing child health quality, including primary, preventive, and developmental care.
- Advocacy and foundation role. Advocates and foundations could seek to work with state Medicaid and CHIP divisions and the pediatric community in developing strategies to build health quality measures into pediatric care, examining potentials for securing funding support under this and other provisions in the health reform legislation. This could even extend to creating an office or commission of child health quality within state government, potentially financed through a public and private partnership (see the Model Act in SECPTAN's publication, Health Care and School Readiness for an illustration). It also could include developing a Child Health Improvement Partnership similar to that established in Vermont (VCHIP).

4. Childhood obesity demonstration projects (Sec. 401 of CHIPRA and Sec. 4306 of PPACA). A childhood obesity demonstration project is established to develop comprehensive and systemic models for reducing childhood obesity by awarding grants to a variety of local and community entities (CHIPRA), with \$25 million provided for the period of fiscal years 2010 through 2014 (PPACA).

- Implications. In addition to federal health reform, First Lady Michelle Obama is heading an administrative task force to reduce child obesity, with a broad-based strategy. The increase in child obesity threatens the long-term health of

American society and social costs in health, education, and employment. These grants afford an opportunity for state actions that involve both clinical and community health approaches. Secretary of Agriculture Tom Vilsack has stated that “hunger and obesity” are twins and there also are opportunities within federal food and nutrition programs to address the issue of obesity from a comprehensive perspective.

- Advocacy and foundation role. There are multiple opportunities to impact childhood obesity, and some require attention to issues of poverty and neighborhood disadvantage as well as personal health practices. Children develop their nutrition and exercise patterns early in life, and a focus on obesity prevention efforts during the preschool years (0-5) is as important as a focus on school settings. Advocates and foundations can play a role in directing significant attention to the early years (birth to three or five) in combating obesity (and other chronic early childhood conditions) and to focusing upon economic and neighborhood as well as individual responses.

5. Pediatric accountable care organization demonstration project (Sec. 2706 of PPACA).

The pediatric accountable care organization demonstration project, to begin January, 2012 and end December 2016, allows participating states to allow pediatric medical providers that meet specified requirements to be recognized as accountable care organizations and be eligible to receive incentive payments for savings in care they are able to realize under Title XIX and CHIP.

- Implications. Accountable care organizations (ACOs) have been posed as a way to contain health care costs by restructuring financial incentives to providers in order to reduce over utilization of services. This section establishes a specific demonstration project for pediatric medical providers. Achieving savings through ACOs could occur from reducing hospitalization and emergency room use by providing care coordination services and support services for children with special conditions such as asthma, allergies, or other special health care needs, which might be achieved through payment changes that provide incentives for such care coordination and response services through capitated or global payment systems or other reforms.
- Advocacy and foundation role. The Concord Group has promoted accountable care organizations as a way to control health care costs through revising the financing incentive structure for groups of providers. The arguments for ACOs are similar to those made for health maintenance organizations, when they were developed two decades ago. A great deal of the attention in developing such organizations has been for the high-cost users of health services, the chronic care and senior populations. There may be different opportunities and challenges in developing ACOs for children and adolescents. Some have suggested building ACOs around the base provided by children’s hospitals. These could also include participation of states’ Title V CSHCN program resources. Pediatric ACOs might also facilitate coordination with early child

education and other education systems, as well as child welfare agencies. Advocates and foundations might play a role in supporting efforts in developing demonstration pediatric ACOs that stress patient-centered medical homes and involve consumers in the development of strategies promoting whole child approaches.

6. MACPAC assessment of policies affecting all Medicaid beneficiaries (In CHIPRA and Sec. 2801 of PPACA, especially subparagraphs E). A Medicaid and CHIP Payment and Access Commission (MACPAC) is established, similar to the MEDPAC, in order to review Medicaid and CHIPRA payment and quality of care provisions. The provisions in PPACA delineate additional responsibilities of the MACPAC established in CHIPRA to review Medicaid and CHIP policies as they relate to quality of care. The MACPAC has a purview over all Medicaid and CHIP payment and access issues (while the majority of Medicaid and CHIP recipients are children, Medicaid and CHIP costs disproportionately are for chronic care services for persons with disabilities, including nursing home care for seniors, so the degree to which MACPAC focuses upon children may be limited).

- Implications. MACPAC provides a federal locus for focusing upon payment and quality of care issues under Medicaid and CHIP, but the extent of its focus upon child health, and healthy child development in particular, is not yet clear. The more that innovative work is being conducted and can be brought to the MACPAC and a “feedback” loop established with the MACPAC from such efforts, the more MACPAC can meet its goals.
- Advocacy and foundation role. Advocates and foundations can emphasize the importance of including pediatric voices and experts on the MACPAC and focusing some attention on well-child care and healthy child development. The more that funding is available to organize and provide information to the federal government in implementation of all these child health-related actions, the more the MACPAC and other federal offices can focus upon them.

7. Maternal, infant, and early childhood home visitation program (Sec. 2951 of PPACA). The provisions establish a grant program to be administered through state maternal and child health agencies to provide evidenced-based home visiting to pregnant and parenting families, with \$100 million available for fiscal year 2010 increasing to \$400 million for fiscal year 2014.

- Implications. The administration has called this home visiting provision and the as-yet-to-be-enacted Early Childhood Challenge grants as the “bookends” of an early childhood system for ensuring children start school healthy and equipped for success. Of all the provisions within federal health reform, this may be the one with the most explicit connection to other child-serving systems, including Parts B and C of IDEA, ESEA, Head Start, TANF, and CCDBG. The location within the MCH Bureau, which has administered the Early Childhood Comprehensive Services grant program, provides a connection with broader school readiness and early childhood systems building work in many states.

- Advocacy and foundation role. While home visiting can be an effective way to reach isolated families about to become parents or with young children and support them in providing consistent and competent parenting as well as linking their children to a medical home, research indicates that its quality, intensity, and duration are critical components to produce long-term gains. Further, home visiting in and of itself can only address some of the needs of young children and their families in maintaining protective factors and fostering resiliency. As states expand their home visiting efforts, it will be important to press for continuous improvement in home visiting approaches and, in particular, seek to expand the body of knowledge for fully closing gaps in healthy child development that exist among some populations. Advocates and foundations can play a key role in pressing for continued action research in strengthening home visiting and other complementary services and supports families need to ensure the healthy development of their children. They can help to place home visiting in the context of comprehensive early childhood systems building efforts.

8. Center for Medicare and Medicaid innovation and healthcare innovation zones (Sec. 3021 of PPACA). A Center for Medicare and Medicaid Innovation is established within the Centers for Medicare and Medicaid Services (CMS) and charged with promoting payment and service innovations that can improve health and reduce costs. Also authorized are healthcare innovation zones, which are defined as zones including a teaching hospital and other providers that come together to provide integrated health services. There is \$50 million authorized in 2010 to set up the Center and \$10 billion over the next eight years to implement innovations.

- Implications. The Center for Medicare and Medicaid Innovation is designed to foster innovation and continuous improvement around the delivery and financing of health services under Medicare and Medicaid. The healthcare innovation zones may be the place where innovation is financed and supported. While there is a strong emphasis upon payment reforms and there will likely be a strong focus upon the Medicare and chronic care Medicaid populations, where the vast majority of health costs reside, there may be some carve out of focus and funding for primary, preventive, and developmental pediatric care, particularly around populations of children that have vulnerabilities that relate to social and economic as well as medical conditions.
- Advocate and foundation role. Advocates and foundations may have a role to play in securing some attention and federal funding resources to developing healthcare innovation zones that focus upon children's healthy development. This could include specific emphasis upon reducing health disparities and addressing social and economic determinants of health within the context of providing clinical care. Advocates and foundations could offer themselves as a needed voice and perspective in the development of innovation zones and the Center's focus itself, as having particular expertise in cross-system approaches

and incorporating strategies that address social and economic determinants of health.

9. Community health teams to support the patient-centered medical homes (Sec. 3502 of PPACA). A grant program is authorized to establish community-based interdisciplinary, interprofessional health teams to support primary care practices within hospital service areas served by the teams, which incorporates capitated payments to primary care providers. States or a state-designated entity are eligible. This authorization does not have a specific appropriation attached to it.

- Implications. The community health teams approach is very consistent with providing comprehensive well-child care and, in particular, linking children and their families with community services and supports that are needed to address social and economic determinants of health. While the emphasis may be upon patients with chronic health conditions, the approach also is applicable to those with social and economic needs that otherwise can affect the trajectory of health and subsequent health needs.
- Advocacy and foundation roles. Advocates and foundations can play a role in helping to develop grant applications within states for interdisciplinary health teams that focus specifically upon children and adolescents and address social and economic determinants of health. Advocates and foundations also can play a role in securing an appropriation attached to the authorization.

10. Prevention and public health fund (Sec. 4002 of PPACA). The prevention fund is established with funding of \$500 million in fiscal year 2010 increasing to \$2 billion in fiscal years 2015, for transfer to increase funding for programs authorized by the Public Health Services Act, for prevention, wellness and public health activities including prevention research and health screenings.

- Implications. The prevention fund dramatically increases the amount available for both clinical and population-based prevention approaches. Many of the specific services currently part of programs authorized by the Public Health Services Act are secondary prevention efforts focused upon older populations and arresting or slowing the progress of debilitating conditions requiring chronic care. At the same time, there is the opportunity to focus upon both clinical and population-based prevention efforts starting at birth and even prenatally. The prevention and public health fund language itself, however, does not have strong, explicit connections with Title V Maternal and Child Health.
- Advocacy and foundation roles. The advocacy and foundation community could explore with AMCHIP, CDC, and state Title V programs how to use the funding and support under the prevention fund to build upon the work done through state maternal and child health programs. Child advocates can play a particular role in supporting stronger linkages at the federal level and involving families with children in prevention efforts.

11. Education and outreach campaigns regarding preventive benefits (Sec. 4004 of PPACA). A national prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the lifespan is established. The Secretary of Health and Human Services is directed to provide guidance to states and health care providers regarding preventive and obesity related services and each state is directed to design a public awareness campaign to educate Medicaid enrollees with the goal of reducing the incidence of obesity.

12. Oral healthcare preventive services (Sec. 4102 of PPACA). A five-year national public education on oral healthcare program is established within the Public Health Services Act.

- Implications. Both these provisions call for national public education on issues that are critical to children's healthy development. The emphasis upon obesity and on oral health represents two areas where child prevention efforts are most needed.
- Advocacy and foundation roles. Again, the advocacy and foundation communities can offer to support both state and federal planning and the involvement of child health experts and consumers in the development of strategies. Advocates and foundations also can support a "feedback loop" that ensures that experiences and lessons learned from efforts within states and communities are brought to the attention of federal administrators and policy makers.

13. School-based health centers (Sec. 4101 of PPACA). A school-based health center grant program is established under the Public Health Services Act, with \$50 million appropriated for each of the fiscal years 2010 through 2013 to award grants to school-based health centers.

- Implications. The school-based health center grant program offers additional funding to link schools into prevention and health promotion activities, particularly around supporting exercise and nutrition within school systems.
- Advocacy and foundation roles. In addition to supporting communities in securing federal funding, advocates and foundations can play a role in supporting state efforts that complement federal funding and also broaden the school's role into the early learning and development years.

14. Community transformation grants (Sec. 4201 of PPACA). This provision authorizes competitive grants to be awarded to state and local government agencies and community-based organizations for the implementation, evaluation, and dissemination of evidenced-based community preventive health activities to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming. Included in the

list of possible activities are “prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health,” and “addressing special populations needs, including all age groups.” The authorization of appropriations is for fiscal years 2010 through 2014, but no appropriation figure is provided.

- Implications. Like community health teams and healthcare innovation zones, community transformation grants provide the opportunity for holistic, multi-sector responses that could focus upon children’s healthy development. State and local public health agencies, school districts and safety net health care providers are natural recipients of these grants. They could have particular relevance to working with disinvested neighborhoods, where health (and educational and other societal) disparities are greatest, through taking both a clinical and community-building approach to supporting healthy child development.
- Advocacy and foundation roles. Representatives from both the child advocacy and foundation worlds have been working to collectively define strategies for improving child health within this context. Voices for America’s Children has been working with the California Endowment/Nemours “Brain Trust” on this issue and is participating in their “Communities of Practice” effort to support communities in developing responses that are very aligned with the goals of community transformation grants. These also could be aligned with efforts to develop Promise Neighborhoods, as children and families need both health and education supports to succeed. Again, child advocates and foundations could offer to be part of a learning community that supports the effective roll-out of federal strategies such as community transformation grants, healthcare innovation zones, and Promise Neighborhoods to provide for comprehensive approaches to meeting health, education, social, and economic needs.

15. Primary care extension program (Sec. 5405 of PPACA). A primary care extension program is established to provide competitive grants to states for establishing state or multistate Primary Care Extension Program State Hubs that can provide grants to county or local level primary care extension agencies that assist providers implement patient-centered medical homes and develop primary care learning communities. Both two-year Hub planning and six-year Hub implementation grants are authorized. There is \$120 million authorized for fiscal years 2011 and 2012 (presumably for planning grants) and such sums as a necessary authorized for fiscal year 2013 and 2014.

- Implication. These Hubs are designed to provide technical assistance and support to providers in primary care practice, including but not limited to children. In fact, the emphasis could be on adults and children with chronic health care conditions, where patient-centered medical homes have had the most growth, but the emphasis still will be on primary care.
- Advocacy and foundation roles. Advocates and foundations can contribute to the planning work within states, particularly if they can put some planning resources

on the table to do so and provide some overall structure for supporting planning. Ideally, planning these hubs would include multi-sector representatives and consumer interests, and advocacy groups and foundations are well-suited to providing the support to ensure they are at the table.

16. Spending for community health centers (Sec. 10503 of PPACA amended by Sec. 2303 of HCERA). Spending on federally qualified health centers (FQHCs) is expanded by \$1 billion in fiscal year 2011, going to \$3.6 billion in fiscal year 2015.

- Implication. FQHCs serve neighborhoods with major health needs and where disparities in health, education, social, and economic outcomes are greatest. There are opportunities to work with FQHCs in broadening their community reach to include primary, preventive, and developmental services and supports for children and their families and to link them to other sources of community support.
- Advocacy and foundation roles. While FQHCs will be in the lead on this funding, there are models of community health centers that provide both clinical and community building services in order to improve child health (see NCSI paper on this subject). Advocates and foundations can offer to participate in expansion of FQHCs, with particular emphases upon supporting their potential in community-building roles.

Supporting Documents and Referenced Documents

Child and Family Policy Center and Voices for America's Children. (2010). *The Healthy Child Story Book: State Implementation Edition*. Des Moines, IA.

Designed for non-health policy staff, this story book first provides the rationale for a comprehensive and preventive approach to well-child care and then briefly outlines a number of exemplary, research-based programs that have improved children's health. It concludes with a set of policy options for states to consider in strengthening Medicaid and SCHIP, in particular, to provide developmental screenings and strengthen the delivery of primary, preventive care.

Bruner, C. et. al. (2003). *Health Care and School Readiness: The Health Community's Role in Supporting Child Development – New Approaches and Model Legislation*. State Early Childhood Policy Center Technical Assistance Network: Des Moines, IA.

Included in this collection of articles is an appendix providing a "Healthy Child Development Office" Model State Act to create a state office or division for improving pediatric practice to provide more comprehensive, developmental child health services and build upon best practices in the field.

Bruner, C. & Schor, E. (2009). *Clinical Practice and Community Building: Addressing Racial Disparities in Healthy Child Development*. National Center for Service Integration: Des Moines, IA.

This article describes current racial disparities in child health in the context of income, education, and justice disparities and also describes the concentration of children of color in very poor and disinvested neighborhoods. It then describes the roles that health care can play in those neighborhoods, both in providing health services and in supporting community building activities. It describes the Help Me Grow program in Hartford, Connecticut as an illustration of the first approach and the East End Community Partnership in Richmond, Virginia as an example of the second approach. It presents a particular case for a broad role that safety net providers like Community Health Centers can play in improving child health at a population level.

Nemours Health and Prevention Services & The California Endowment. (2008). Helping Parents Raise Healthy, Happy, Productive Children. *Big Ideas for Children: Investing in Our Nation's Future*. Washington, DC: First Focus.

This paper describes a transformed child health system that better coordinates health care, education, child care and wellness in a way that makes sense for families today. It suggests how to build on what works, and to transform what does not. It outlines central policy elements that would: (1) establish meaningful health coverage with benefits that support healthy growth and development; (2) make systemic changes to improve the quality, effectiveness and efficiency of care for children; and (3) make children a top priority at all levels of government.

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