



Young Child Primary Pediatric Practice Transformation – Medicaid Financing to Improve Child Health Trajectories

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Introduction. Medicaid now finances more than half of all US births and is the source of health coverage for nearly half of the country’s youngest children (birth to three). These young children include: the poorest, a disproportionate share of children of color and the largest share of those young children with health trajectories likely to be compromised due to adverse social determinants of health.

There is a growing array of exemplary primary pediatric practices, largely financed through philanthropic or pilot funding, that have shown the ability, starting with the primary care visit, to strengthen the safety, stability, and nurturing in the home environment (address key social determinants of health) and raise the trajectory of child health – very much consonant with Bright Futures guidelines and often incorporating two-generation interventions that explicitly strengthen parent-child bonding and support.

These exemplary primary pediatric practices deserve further diffusion; but the diffusion and sustainability of the programs themselves requires that Medicaid (and other health insurance systems) cover at least a share of their costs. While practitioner champions and advocates are eager to promote Medicaid as a source of funding, the pathways to doing so often are very technical and geared to clinical models of care and documentation that do not easily align with the most effective ways of providing services. Medicaid administrators may also be leery of audit exceptions if they cover certain services or of lack of controls in limiting services to those for whom they truly are intended. Providing more preventive and developmental services to children also does not necessarily fit well into managed care operations, unless the contracts themselves are explicit in promoting and rewarding such practices.

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The following offers a brief description of where and how Medicaid and its EPSDT provisions can and should provide coverage for much of what is provided within these exemplary primary pediatric practices.

Medicaid and EPSDT Coverage Opportunities. The Early and, Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefits under Medicaid is the child health benefit package, covering prevention, early intervention, and a wide array of interventions. “Early” modifies all three actions (screening, diagnosis, and treatment) in order to assure healthcare intervention as early as possible to prevent lifelong disabling conditions. EPSDT begins with regularly scheduled, comprehensive well-child visits. EPSDT entitles children enrolled in Medicaid to services or treatments that are necessary to “correct or ameliorate” physical, developmental, or mental health conditions, regardless of whether such services are covered for adults and is not limited to a specific set of diagnoses.

EPSDT offers opportunities for states to transform primary child health practice and to respond much more preventively, developmentally, and holistically to improve the trajectory of child health for children at risk. To do so, however, states have to be intentional and proactive in:

1. Expanding well- visit schedules and enhancing reimbursement levels for well-child visits,
2. Using administrative claiming and fulfilling their administrative obligations under EPSDT,
3. Applying EPSDT’s “medical necessity” standard,
4. Supporting, and in many instances providing direct reimbursement for screening for developmental, mental health, and social risks, as well as physical ones, using validated screening tools,
5. Defining how an array of personnel beyond health clinicians (e.g., community health workers, home visitors) can provide services that are reimbursable under Medicaid,
6. Defining and financing a variety of care coordination and case management services that support children and their families, and
7. Developing and using health indicators, metrics, and outcomes consistent with a broader vision of child health and well-being.

These apply both to providing fee-for-service reimbursement and for incorporating primary and specialty care into managed or accountable care structures (where the contracts will have to specify these expectations and develop fiscal incentives for achieving them). All of these are needed to further such practice transformation to meet the standards for “evidenced-informed” primary care as established in the American Academy of Pediatrics *Bright Futures*.²

Actions that States Can Take. Here is a brief enumeration of the different actions states can take within their Medicaid financing systems to foster such transformation.

² However, it is important to note that service need not be evidence based to be covered. States should not use quality measure components to deny coverage due to a lack of evidentiary base

- 1. Schedules and reimbursement for well-child visits.** Under federal law, states must establish a periodic well child visit schedule (known as a “periodicity schedule”), which sets the frequency for medical, dental, vision, and hearing checkups. Each area should have its own periodicity schedule. While states set their own schedules, they are required to consult with professional organizations and reflect current professional standards. However, many states have not updated with visit schedules to reflect recent changes in the American Academy of Pediatrics *Bright Futures* recommended schedule. In particular, many states’ schedules do not include the 9, 18, and 30 month visits recommended as the minimal standard for developmental screening. Appropriate visit schedules help to incentivize providers to deliver appropriate services. Another challenge for primary child health providers aiming to deliver more comprehensive screening as well as anticipatory guidance (parent advice and counseling), and referrals to other needed services, is the time they are allotted for well-child care. Reimbursement rates for EPSDT well-child visits in many states are very low and result in limited participation and acceptance of Medicaid patients, let alone providing the level of well-child care they desire. Despite a temporary increase of reimbursements for such visits to Medicare payment levels through federal funding (part of the ACA), many states have now reverted back to their lower rates. While Medicare provides an enhanced payment for the first, “welcome to Medicare” visit (and additional screening requirements around safety, depression, and social determinants), most state Medicaid programs do not have specific requirements for well-child visits or elevated payments that would make it more financially feasible to extend the time for such visits, particularly for first-time visits. Because payments are often quite low, states have been reluctant to require more comprehensive activities or to set up external quality review, pay for performance incentives, or other structures to enhance the comprehensiveness of such visits.
- 2. Using administrative claiming and fulfilling their administrative obligations under EPSDT.** Ensuring the diffusion of new practices and fidelity to standards of practice requires training and support in educating practitioners and their practices. This is not a direct, billable service to a particular patient, but it can be covered as an administrative cost under administrative claiming. Similarly, as providers seek to provide referrals and connections to a broader array of services than those provided in clinical settings, there is a need for continual outreach to, identification of, and connection with such services within a community. This requires concerted and persistent outreach and staffing and training and support with that community. While this is not a direct service, it also lends itself to administrative claiming (there is an ICD 9 billing code for care coordination, however how its definition is not clearly or consistently defined). In both instances, administrative claiming could come through Title V and public health agencies that provide for or contract for those services. States have several affirmative obligations to

children under EPSDT and their families. They are required to: arrange directly or through referral for treatment of conditions identified in EPSDT well child screening visits, assist in scheduling visits and transportation, and inform families about their benefits under EPSDT. Administrative claiming represents an opportunity for providing important actions that may fall outside of direct billing for a distinct service to a specific client. For example, many families have language barriers. Language services can be covered as a Medicaid service.

3. **“Medical necessity.”** Federal law for EPSDT sets a unique and broad standard for medical necessity decisions for children in Medicaid and therefore what services will be covered. Services are medically necessary to prevent, maintain, improve, ameliorate (to make more tolerable), or cure a health condition. States implement and operationalize this standard, using their unique Medicaid administrative approaches (e.g., some but not all states have a standardized and individualized utilization review process specific to EPSDT). Medical necessity is often defined by insurance companies under managed care models. Decisions about medical necessity are required to be made on an individual basis, not on arbitrary or categorical standards. The key is to assure that intervention for the particular condition not only treats the condition but also promotes healthy development. Particularly for young children, applying a prevention standard necessitates that the state to define “medical necessity” itself to include environmental/social determinants as well as child-specific medical diagnoses. States can clarify the definition for the range of medically necessary treatment to explicitly include family and environmental factors influencing health, which is essential to covering two-generation responses that strengthen the safety, stability, and nurturing in the home environment – recognized as foundational to young children’s health. For example, in the case of prevention and amelioration of asthma, Medicaid might pay not only for physician services and respiratory therapy but also for certified asthma educators, healthy homes specialists, and other community health workers and for actions that reduce allergens/toxins in the home.³ For some young children at risk, Medicaid might pay for home visiting program services to reduce risk for developmental delay, child maltreatment, or behavioral difficulties and future physical health challenges that are the result of the absence of safety, stability, and nurturing in the home environment. Medical necessity needs to be operationalized with specific reference to the developmental nature of children’s health and well-being, and not on an adult base for medical necessity. This includes family support and new treatments such as infant/toddler and parental therapy. States can also encourage their providers to use the ICD 10 poverty code.

³ It should be noted that, outside of waivers, all services must be directed to address the condition of the child

4. **Support of screening for developmental, mental health, and social risks.** For more than 30 years, federal law has recognized coverage of developmental screening and assessment as a core function of EPSDT. In recent years, progress has been made on operationalizing this coverage. In particular, more states have explicitly identified the billing codes providers should use for child developmental screening, as well as valid and preapproved tools for conducting such screening. Another advance that states have made and CMS has recognized is that Medicaid can cover maternal depression screening as part of a child’s screening visit (and secure administrative claiming for educational, outreach, and training efforts to promote that use). In addition, the American Academy of Pediatrics has recognized that screening for social determinants of health can include broader measures of family stress and functioning and safety in the home environment. Providers also can engage in additional developmental/behavioral screening and surveillance of children that can improve early identification and response. Such screening does not have to occur within the practitioner’s time during the well-child visit, but can be conducted in the waiting room, through web-based tools, or by someone other than the primary practitioner. The infrastructure for providing such screening (e.g. space and equipment such as touch pads for use in the office) can be built into the reimbursement. Clear and consistent guidance must be provided by states regarding how to bill for these types of screening tools. The level of reimbursement must provide sufficient financial incentives to ensure that practices provide that screening and integrate the results into their subsequent actions. Appropriate referrals or direct interventions for risks identified through such screening for children are required under federal Medicaid/EPSDT law.

5. **Defining how an array of personnel, beyond health clinicians, can provide Medicaid services.** Health coverage tends to be restricted to what is directly provided by a licensed medical practitioner or specialist. The emphasis in EPSDT is to move coverage to a broader array of preventive and ameliorative services to improve child health. In fact, federal regulations allow states to cover “medically necessary” services that are provided by someone (e.g., nutritionists, home visitors, community health workers) operating under the supervision of a licensed practitioner of the healing arts (which states themselves can define to include social workers, registered nurses, and other non-medical personnel), even when such services otherwise are not eligible for reimbursement under Medicaid. Such services as home visiting, parenting education, and group counseling and support sessions can be defined and covered under Medicaid as long as they meet definitions of medical necessity, have an appropriate scope of practice, and provide documentation that they are being used to address identified health issues (e.g. based upon early and periodic screening and diagnosis).

6. **Case management.** Most child health providers discuss the importance of care coordination as part of the medical home. Under federal law, Medicaid covers two main types—administrative case management and targeted (medical assistance) case management. Case management services assist in gaining access to needed medical, social, education and other services. Targeted case management requires a state to get federal approval (through a state Medicaid plan amendment or waiver) for serving a specific group or geographic area (e.g., pregnant women, young children, persons with disabilities) and is matched as a medical assistance service under Medicaid. (Some other rules permit case management programs as a component of managed care, primary care case management, health homes, or integrated care.) Either case management or targeted case management might be part of effective care coordination in practice, to support referrals from primary to specialty medical care or from health to education or other related services. Care coordination also can help families navigate among health and other services or use available services more effectively. To do the latter, in particular, these care coordinators need to establish some relationship of trust with families and to start where families are, serving at times as counselor, navigator, advocate, and support system to increase the family’s agency in meeting their child’s needs. Ongoing support of this nature may be provided through community health workers, home visitors, family development specialists, social or behavior health staff in the practitioner’s office or referred by the office, or other family advocates (potentially funded as an ongoing service under targeted case management or as a bundled service) – but the initial connections and bridges are likely to be through a direct referral/warm handoff from the child practitioner or office to someone whose responsibility is for initial response and that care coordination. Many states are demonstrating the effectiveness of care coordination teams, although these often focus upon patients who already have identified health conditions that require costly and often complex health conditions. Defining and then commensurately reimbursing care coordination is essential – and likely is best achieved through some form of bundled payment that reflects the overall work and not the time segment units of service specifically designated and documented as meeting some identified clinical need.
7. **Relevant health indicators, metrics, and outcomes.** Federal law calls for creation of a core set of child health measures. Currently about half of states have adopted one or more of the child core set, which includes 15 measures of perinatal and infant care, well child care, and/or adolescent well child care. These inform the nation’s effort to improve child health under Medicaid and the Children’s Health Insurance Program (CHIP). For example, regarding utilization, in federal fiscal year 2014, on average, 61 % of children received 6 or more well-child visits in the first 15 months of life (n=40 states reporting) and 87% of children 25 months to 6 years had a primary care visit in the prior year (n=43 states). Measuring health care utilization is important, but, more information

is needed to understand child health and well-being. The Centers for Disease Control and Prevention and Healthy People 2020 both stress that ensuring healthy young child trajectories requires improving the safety, stability, and nurturing in the home environment. This represents a foundational outcome for young child health and needs to be part of the overall metrics used to assess child health, both to focus attention on addressing those issues and to track progress and assess effectiveness in doing so. Further, the research is sufficient to show that, if efforts succeed in improving the safety, stability, and nurturing in the home environment, there are improvements in child health, although many of these are likely to manifest themselves or be discernable in child-specific health and development measures in the future and, in fact, the life course through adulthood.

Other Opportunities and Considerations for Implementing Change. Every state has an opportunity to make changes to improve their Medicaid/EPSTDT approaches to serving young children and maximizing prevention. The items listed above should be seen as a priority list for review and action. All seek to better implement federal law, improve the utilization of appropriate services, maximize use of existing health personnel, and improve child health outcomes.

While any or all of these changes to Medicaid financing and accountability could be achieved through state plan amendments and applied at the state level, they also potentially could be implemented under a Medicaid waiver in a specific locality as a place-based strategy, provided that the definition of “revenue neutrality” would take a long-term perspective or incorporate significant shared savings from other efforts to make the upfront investments in this approach.

For states with managed care for primary child health services or developing accountable care organizations, it is essential that contracts recognize the life-course impacts of improving child health trajectories and the importance of addressing social determinants that can strengthen the safety, stability, and nurturing in the home environment. During the earliest years, it is less about child-specific diagnoses for many vulnerable children than it is about family- and community-centered ones. Moreover, incentives and requirements should be included in contracts with MCOs/ACOs that recognize the value of making gains in children’s home environments and health trajectories which do not immediately translate into reduced medical costs. On the one hand, the flexibility afforded under MCOs and ACOs make it easier to provide non-clinical services that promote health and do so on more flexible financing arrangements (such a per member per month and bundled reimbursements for presenting concerns). On the other hand, focusing upon the overall cost bottom line or reducing specific treatment expenditures can be counterproductive to effective strategies that produce health benefits over the long term. Incentives and expectations need to be built into contracts that move MCOs/ACOs toward the actions described above, including value-based incentives not related to health costs, payment structures that allow flexibility in response, quality improvement

initiatives, and an emphasis upon reinvesting at least some of any shared savings accrued with high cost patients into more preventive and developmental services.

Finally, there is the potential, particularly when all family members are covered under Medicaid, to begin to look at “family primary care” and the overall care provided to all members of the family to support health, recognizing the interplay across family members. In fact, this may be an avenue for further innovation and development within a Medicaid demonstration waiver or the private health financing world, which does offer family coverage. Often, particularly in instances where one family member faces a major physical, social, emotional, or behavioral disability, other family members are critical to serving as caregivers, coordinators, and advocates and their own health is impacted by the degree to which they are supported in such roles. This extends the concept included in federal law guiding the “health homes for persons with chronic conditions” provisions of Medicaid.

Conclusion. This discussion paper is just that – setting out different issues related to state opportunities to revise the way they provide Medicaid coverage to improve child health. It is not a definitive statement of what states can do, or how they can do it, to promote broader and more effective services to young children under Medicaid. It does not provide the explicit language that states might use in their Title XIX plans, under different Medicaid billing codes, in their contracts with MCOs or ACOs, or in their regulatory provisions on who can provide services and how they need to be provided and documented.

Getting to this level of detail involves reviewing what states on the forefront of this work are doing today and how they are integrating broader approaches to primary care child health services, in particular, into their Medicaid financing systems. It involves further delineation of the legal basis for covering and financing specific services that states may now be providing or would like to provide but are not drawing down Medicaid funding (or drawing down funding for only a small share of the service or doing so in ways that entail types of charting and documentation that works against its use). Hopefully, this discussion paper will produce discussion – within the Medicaid and EPSDT financing community, within the child health practitioner community, and across the two – that will produce greater detail on the “how” of implementation within an across each of the areas for Medicaid financing discussed here.

Appendix 1: *Eight Barriers to Billing for Family Focused Interventions in Medicaid—How to Address Them*

1. Reimbursement for screening a parent. For infants and toddlers, “defects” under ESPDT are difficult to detect by screening the child, but can be approximated by screening a parent. Providers of family-focused interventions for infants and toddlers often screen a parent to determine need for the intervention, but can only be reimbursed for this in pediatric primary care in select states.

2. Reimbursement for services without a diagnosis. Generally, to be reimbursed for a service, the provider must specify a diagnosis. Family-focused interventions are provided as early intervention when a child is demonstrating challenging behaviors, but before the child develops a diagnosable mental disorder. EPSDT does not require a diagnosis – it offers diagnostic services, but only requires a need to be identified by the screening instrument for necessary treatment to be covered. In spite of this, many providers struggle to get reimbursed for these interventions without a diagnosis.

3. Determination that these services are “necessary.” The State Medicaid Manual specifies that states have discretion in determining whether a service is necessary when it is not otherwise included in the state plan. Over a dozen family-focused interventions have been found in rigorous controlled trials to be effective in ameliorating children’s needs in social and emotional development,⁴ but many states have not made coverage determinations for most of these services, so they are often difficult to have reimbursed.

4. Reimbursement for group sessions. Some states make it difficult to get reimbursed for providing services to groups, which is a crucial component of these interventions. In addition, the reimbursement rates available for group sessions may be insufficient to incentivize provision of family-focused interventions.

5. Reimbursement for services to the parent without the child present. Some states make it challenging to get reimbursed for services that are provided to the parent for the benefit of the child when the child is not present.

6. Clarity about who can bill. While the pediatrician may recommend the family-focused intervention, they are more efficiently delivered by nurse practitioners, social workers, or clinical psychologists. In addition, some of these interventions are most effectively provided by two providers running the group sessions together. Although there is no requirement under EPSDT that the physician ultimately provide the services, lack of clarity can be a barrier to sustainable reimbursement.

⁴ See <http://www.blueprintsprograms.com/programs>. These programs include: Family Foundations, Nurse-Family Partnership, Family Check-Up - Toddler, Triple P System, Incredible Years – Parent, Parent Management Training, Parent-Child Interaction Therapy, New Beginnings, Strong African American Families Program, Strengthening Families 10-14, EFFEKT, Familias Unidas, Guiding Good Choices, Positive Family Support – Family Check-up, Functional Family Therapy, Multisystemic Therapy.

7. Reimbursement for adequate sessions. Each of the family-focused interventions lasts a set number of sessions that allows it to meet and reinforce all of its treatment goals. Providers need to know that they will be reimbursed for all of the sessions in the intervention in order to adequately incentivize implementation.

8. Proper valuation of administrative costs. Arranging and providing family-focused interventions requires administrative costs that are different from other services that pediatricians and family practice physicians often provide, so the practice expense for the associated relative value units will not be appropriately calculated. Most notably, the costs do not take into account some essential aspects of making family-focused interventions accessible to indigent families, such as providing child care at group sessions.

Source: Nathaniel Counts, Mental Health America

Appendix 2: Value-Based Care for Primary Pediatric Services: Excerpts from [Value-Based Payment Models for Medicaid Child Health Services: Report to the Schuler Center for Analysis and Advocacy and the United Hospital Fund](#)

Bailit Health (2016). Value-Based Payment Models for Medicaid Child Health Services: Report to the Schuler Center for Analysis and Advocacy and the United Hospital Fund. New York.

This report represents one of the first efforts to spell out a “value-based” payment system for primary pediatric care – recognizing the need for a payment system that takes a long-term view to improving health and reducing health costs and a broad developmental perspective that responds to social as well a biomedical determinants of health. While incorporating features associated with “value-based” payment systems for adults (capitation, care coordination, and incentive payments), it recognizes that such “value-based” primary care will require increased overall expenditures on primary care to current expenditures, particularly for children on Medicaid.

Excerpts:

[Primary care practice expectations] Because of the impact of socioeconomic determinants, including ACEs, on the long-term health and well-being of children covered by Medicaid, a pediatric payment model should anticipate the need for pediatric practices to address these factors by 1) screening for them; 2) providing interventions, such as parental education and support and behavioral health services, when appropriate services are available within the practice, 3) establishing robust linkages to community-based behavioral health, educational, and social service organizations that can address more directly the social determinants that are beyond the scope of a pediatric practice, and 4) making and closing referrals to such community-based organizations. (17)

[Implications for immediate cost savings] Because pediatric care is predominantly focused on developmental screening, preventive care and anticipatory guidance, opportunities for short-term cost savings to fund and sustain a value-based pediatric payment model do not exist to the same level as they do for adults. ... For the vast majority of children covered by Medicaid, infrequent inpatient service use means that adult-driven value-based payment models cannot be expected to generate substantial annual savings. (18)

[Value sought for primary care through payment model] In order to define appropriate value-based payment models for children’s health care, it is necessary to first define the value sought through the purchase of health services for children. ... We recommend the following construct as the basis for defining value-based payment models:

1. Process: regular access to a primary care team
2. Process: regular developmental screens and preventive care
3. Process: regular screens for social determinants of health, with resource referral when needed
4. Process: access to coordinated specialty care, when needed
5. Process: family involvement in care
6. Process: seamless integration of behavioral health and primary care
7. Outcome: health is well-managed and the child is emotionally well

8. Outcome: the child is able to appropriately and effectively function – e.g. at developmental milestones, performing activities of daily living, attending school, and achieving academically. (22-23)

[Elements of a value-based primary care pediatric model] We recommend a primary care payment model with three primary elements: capitation, care coordination, and performance bonus. **Capitated payment** for most services delivered to children by pediatric and family medicine practices is our preferred model. ... The [capitated] rate should be based on historical costs that are adjusted upwards, if necessary, to assume: i.) delivery of care consistent with Bright Futures guidelines, ii.) screening for social determinants of health and other risk factors, including parental screening, and iii.) physician time for telephone calls. ... Primary care capitation should be complemented with a **care coordination payment**, probably paid on a per-patient-per-month basis. The payment would cover care coordination activities such as coordinating specialist referrals, tracking tests, and doing patient follow-ups, as well as care coordination services associated with connecting families to a robust network of community-based agencies that can help with addressing social determinants of health. ... The final pediatric primary care payment component is a **performance incentive bonus**. ... The goal of this model is not to place financial risk on the clinician, but to adequately fund traditional and non-traditional services, provide delivery service flexibility, and provide incentives to continually improve the quality of care provided. (26-28)

[Performance measure development] Certain measures capture social determinants that are subject to health care provider influence; we believe that it is time to begin to incorporate these measures into performance incentive and shared savings distribution methodologies. For example, we specifically suggest considering the following as a non-exclusive list of opportunities:

- parental depression and stress,
- kindergarten readiness (e.g. pre-reading skills),
- environmental triggers of asthma, and
- parental education and support regarding Adverse Childhood Experiences (ACEs). (29)

[Financing the model] The most important consideration for implementing the proposed models is how to finance the primary care model. Our recommendations envision capitation rates that would be built to assume funding of some activities that are not always provided today, as well as care coordination payments and incentive bonus opportunities. [We believe] that cross-subsidization will be necessary to maintain an adequate investment in primary care services. ... This cross-subsidized investment will be most necessary for Medicaid. Children served by Medicaid are subject to many more adverse social determinants of health and have worse health status than higher-income children, and yet are funded at lower levels than commercially insured children. (30-31)