Moving Medicaid Prevention Services Upstream:

An Exploration of How to Embed Medicaid Dietitian Services in Head Start Settings

AcademyHealth
Robert Wood Johnson Foundation
Nemours Children's Health System

Moving Medicaid Prevention Services Upstream:

An Exploration of How to Embed Medicaid Dietitian Services in Head Start Settings

By: Alycia Steinberg, MPH, Burton Policy Consulting

March 2018

TABLE OF CONTENTS

INTRODUCTION

Almost all children enrolled in Head Start are eligible for Medicaid. Obesity and overweight are major health conditions affecting children enrolled in Head Start and their adult family members.[1] Group nutritional counseling by dietitians is one approach for addressing and preventing obesity. Maryland Medicaid has undertaken a childhood obesity prevention strategy to facilitate the delivery of group nutritional counseling in Head Start settings by a licensed dietitian. Collaborative efforts are underway among a Maryland Medicaid managed care organization (MCO), the Maryland Academy of Nutrition and Dietetics and Head Start programs. Under a newly approved Medicaid billing code for group nutritional counseling, Medicaid MCO-participating dietitians can provide the service and be reimbursed by the child's MCO.

Nemours Children's Health System was awarded a one-year grant to help state three state Medicaid programs test approaches to financing upstream prevention and population health through AcademyHealth's Payment Reform for Population Health initiative with funding from the Robert Wood Johnson Foundation. While almost all states have begun Medicaid delivery system reform, initiatives and programs geared toward upstream prevention and population health are in varying stages of development. Nemours provided technical assistance to three states – Maryland, Oregon and Washington – as they developed or implemented upstream prevention strategies using Medicaid funds. This brief is one in a series of six "how to" briefs illustrating how states can use existing Medicaid authority to finance innovative upstream prevention and population health initiatives. The entire series of briefs can be found at **https://movinghealthcareupstream.org/innovations/medicaid-payment-strategies-for-financing-upstream-prevention**. To learn more about AcademyHealth's Payment Reform for Population Health initiative, visit **www. academyhealth.org/p4ph**

This brief profiles how a state Medicaid agency and its partners can explore maximizing the authority that exists under federal Medicaid and Children's Health Insurance Program (CHIP) law to deliver an upstream preventive service in a nonclinical setting. Services for children provide an entry point for states desiring to move prevention upstream, given the robust scope of the federal Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for children. Although the activities described here focus specifically on group nutritional counseling in Head Start settings in Maryland, key lessons and insights highlighted through the issue brief are relevant to other strategies that link traditional clinical preventive care to community-based settings to address chronic disease.

EVOLUTION OF MARYLAND'S INITIATIVE

Local initiatives and private funding provided momentum for the state Medicaid agency's focus on children's nutritional services and obesity prevention within Head Start settings. A community public health policy campaign targeting sugary drink consumption — *Howard County Unsweetened* — was launched in Maryland in 2012, and included Head Start programs as partners.[2] In addition, the Horizon Foundation and the Maryland Chapter of the American Academy of Pediatrics (MDAAP) piloted clinical quality improvement initiatives with local pediatricians, focusing on the prevention, diagnosis and treatment of pediatric obesity. A Maryland collaboration involving some of these same partners was launched as part of the Center for Health Care Strategies' 2015 *Innovations in Childhood Obesity* initiative. Collaborators included the Horizon Foundation, the Maryland Department of Health (Maryland Medicaid and the Center for Chronic Disease Prevention and Control), Baltimore City and Howard County Health Departments, MDAAP, and two Medicaid MCOs.[3]

Key Lesson

Start where momentum already exists.

In 2016, the Horizon Foundation provided grant funds to the Community Action Council of Howard County to support the Healthy Families, Healthy Children program.[4] The program helped three- and four-year-old children at all Howard County Head Start centers and their families develop healthy habits and better manage chronic diseases through the EatPlayGrow[5] curriculum. The program integrated classroom lessons by dietitians into the Head Start curriculum and included multiple opportunities for parental engagement, including monthly family nights that included food and nutritional education. Funding for dietitians providing services through the Healthy Families, Healthy Children program was provided via grants. Group nutritional services were not yet covered by Medicaid. The dietitians were not enrolled as Medicaid and MCO providers and did not bill Medicaid for services.

Also in 2016, Nemours, with funding from the Robert Wood Johnson Foundation, developed a "Roadmap" and other resources (available at http://www.movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention) with a range of examples showing how states and MCOs can implement prevention interventions under Medicaid.

Building on this momentum, in 2016 Maryland applied for and received federal approval of a Medicaid state plan amendment (SPA)[6] to cover group nutritional counseling for children under the EPSDT benefit. Maryland Medicaid already covered individual nutritional counseling for children under EPSDT, as well as for pregnant women. The SPA language deleted the requirement that counseling be "one-on-one," and reads as follows:

The Nutrition Therapy Program covers medically necessary counseling and education services to nutritionally high-risk children under the age of 21 years and pregnant women of all ages. The services are provided by appropriately qualified staff as described below. Services must be directly related to a written treatment plan developed by the licensed dietitian/nutritionist.

Nutrition services covered by Maryland Medicaid include:

1. Assessment – Making a nutritional assessment of individual food practices and nutritional status using anthropometric, biochemical, clinical, dietary, and demographic data;
2. Developing an individualized plan that establishes priorities, goals, and objectives for meeting nutrient needs for the child; and
3. Nutritional counseling and education to achieve care plan goals and includes strategies to educate client, family, caregivers, or others in carrying out appropriate interventions.

Nutritionists and dietitians shall be licensed by the Maryland State Board of Dietetic Practice, as defined in Health Occupations Article, Title 5, Annotated Code of Maryland, or by the appropriate licensing body in the jurisdiction where the nutritional counseling services are performed.

The Maryland Medicaid Nutrition Services Program does not cover:

1. services for non-pregnant adults ages 21 and over
2. more than one visit per day
3. services provided by a school health-related services provider that are not included on a child's IEP or IFSP

The federal EPSDT program recognizes the importance of delivering care in different settings, such as schools.[7] Likewise, state Medicaid policy does not impose any barriers on setting. It is important to note that Medicaid MCOs may have different coverage policies that take service setting into consideration. In Maryland, Medicaid nutritional counseling services have traditionally been provided in hospital outpatient settings as well as office-based settings. The new group service introduces a funding mechanism via Medicaid that is more sustainable than previously utilized temporary grant funding.

Although the provision of nutritional counseling by licensed dietitians is a relatively traditional clinical preventive service, Maryland's initiative moves prevention upstream because it shifts the provision of a basic preventive health measure—healthy eating—into the community in Head Start settings. Thus, it integrates clinical and community-based approaches to prevention. The American Academy of Pediatrics (AAP) states, "because intervention programs are few, and program costs are high, the most successful intervention for promoting a healthy weight is prevention."[8]

Nutritional services can be an important tool for obesity prevention. The AAP's *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents* notes that healthy weight has special significance not only because of its importance to childhood and future adult health but also because of "its interrelationships with lifestyle, behavior, the environment, and family life."[9] The integration of

eating habits with family and community life means that healthy behaviors motivated by nutritional counseling have the potential to positively affect not just an individual child, but also the parents, family, and even community.

Despite momentum at the local level, Maryland faced practical challenges promoting the provision of Medicaid-reimbursed nutritional counseling services by licensed dietitians to children in Head Start settings. Maryland Medicaid experienced low rates of uptake of group nutritional counseling services subsequent to the reimbursement code first becoming available in 2016.

Key Lesson

Invest in relationship-building and identify a "translator" when establishing new collaborations across systems

Given that federal Head Start funding flows directly to local Head Start program grantees, there is no state-level Head Start counterpart to the Maryland Medicaid agency. This means there is less history of collaboration relative to staff at Medicaid and other state-level child- and family-serving agencies. As an alternative, the state invested resources to have Medicaid staff attend a Maryland Head Start Association conference to facilitate relationship-building. This enabled Medicaid and project staff from one system (Medicaid) to immerse themselves in the issues, priorities and language of the collaborating system (Head Start). This engagement was helpful to bridge different perspectives. In addition, Maryland Medicaid received technical assistance from a former Head Start program director at Nemours, who could serve as a "translator," explaining Head Start policy, operations and reporting. For example, this provided information on how Head Start intake and case management processes function.

CONSIDERATIONS WITHIN A MANAGED CARE DELIVERY SYSTEM

Maryland Medicaid has a robust managed care delivery system, with almost all children and families enrolled in one of nine capitated, at-risk Medicaid MCOs.[10] The MCOs serve overlapping areas of the state, and in high-density areas such as Baltimore City, Medicaid beneficiaries may choose to enroll in any one of the nine MCOs.

Managed care delivery systems are characterized by a greater degree of flexibility than fee-for-service payment models. For example, MCOs can opt to cover extra preventive services beyond what is required in a state's Medicaid State Plan, or can negotiate provider fee schedules that vary regionally (for example, offering higher provider reimbursement rates in geographic areas with provider shortages), which can help ensure access to services.[11] For a more in-depth exploration of the Medicaid managed care authorities that can be used to cover upstream prevention and examples of how states and managed care plans are using those authorities, see the issue brief *Implementing Social Determinants of Health Interventions in Medicaid Managed Care* (available at https://movinghealthcareupstream.org/innovations/medicaid-payment-strategies-for-financing-upstream-prevention/implementing-social-determinants-of-health-interventions-in-medicaid-managed-care).

Another advantage of managed care delivery systems is the ability of MCOs to innovate in different ways and provide examples of innovation to the state Medicaid agency. One of Maryland's first steps in this initiative was to query MCOs regarding their current level of engagement with Head Start. Two MCOs responded that they were engaged with Head Start centers for purposes of conducting health outreach and education. One of these MCOs had a pre-existing collaboration with Head Start, out-stationing one of its MCO community health advocates at a Head Start center. Maryland Medicaid was able to build on that relationship to move forward this initiative.

While a managed care delivery system offers the advantages of flexibility and innovation, it can also introduce increased levels of administrative complexity. Maryland Medicaid found that, not surprisingly, different MCOs have different nutritional counseling policies, for example with regard to prior authorization requirements and claims approval standards.

Another administrative hurdle is that children at a single Head Start center will likely be enrolled in different MCOs. The health care providers—in this case, dietitians—would need to be credentialed to participate in each of the MCO's provider networks, and they would need to tailor billing processes to each MCO.

Key Lesson

Start small to identify and overcome administrative and operational issues before spreading and scaling up.

To overcome operational and practical challenges to implementation, Maryland Medicaid focused efforts at a pilot level by engaging one MCO, leadership from the Maryland Academy of Nutrition and Dietetics and one to two Head Start programs. Together these partners sought to identify barriers and work through solutions, first in a single geographic region in the state. The project was introduced at a meeting of the Maryland MCO Medical Directors, and this particular MCO remained engaged. The MCO also has a strong existing relationship with Head Start. The small-scale start provides an opportunity to work through a single MCO's credentialing and billing processes. Another approach could be to focus first on the MCO with the highest concentration of enrollment among children at a given Head Start center—this is information known to a Head Start center, so it is a viable option.

IMPLEMENTATION QUESTIONS

Maryland Medicaid sought to explore a number of key questions to facilitate implementation of Medicaid-funded group nutritional counseling in Head Start settings. Gathering qualitative information from stakeholders — MCOs, community-based dietitians, and Head Start centers — was essential to understand challenges of implementation, and potential solutions for overcoming them.

Key Lesson

Invest time at the front-end to gather information from key stakeholders regarding implementation considerations.

Key Question: ***What are the barriers to community-based dietitians' participation in Medicaid?***
Finding: ***Dietitians' perceived administrative challenges presented a barrier.***

Through monitoring of its fee-for-service claims and MCO encounter data, Maryland Medicaid could see that the uptake of group nutritional counseling was low in the first year of the code being available. Maryland Medicaid reached out to the Maryland Association of Nutrition and Dietetics to gain their perspective on this. The dietitian who was consulted identified administrative challenges, namely provider enrollment and credentialing, as the major barrier to participating with Medicaid. It is significant that although the dietitian representative acknowledged that other payors typically have higher nutritional counseling reimbursement rates than Medicaid, reimbursement rates did not present a major barrier to Medicaid participation.

This information gathering process uncovered two key misconceptions regarding provider enrollment and credentialing processes. The first was related to technical issues around the use of group versus individual National Provider Identifiers (NPIs) for dietitian enrollment as a Medicaid provider. Maryland Medicaid enrolls both individual dietitians and group dietitians as providers, however, there was a misconception that only group dietitians could enroll as Maryland Medicaid providers. The second was related to the steps to participation that involved both (1) Medicaid provider enrollment (with the state Medicaid agency) and (2) credentialing by an MCO to participate in its provider network.

Key Lesson

Breaking down administrative barriers can be just as powerful as increasing reimbursement rates for provider participation.

Maryland Medicaid was able to address misconceptions with the representative of the Maryland Association of Nutrition and Dietetics. One approach is to support dietitians in the provider enrollment and credentialing processes by developing a step-by-step guide that incorporates information already available from the Maryland Medicaid provider enrollment website.

Key Lesson

Head Start center-level information is available to inform projections regarding target population size and engagement. This can help engage MCO and provider participation.

Key Question: ***How can the budget impact of delivering services in Head Start centers be projected?***
Finding: ***Head Start center-level information on enrollment and family engagement can help project service volume.***

Maryland Medicaid wanted to be able to project the budget impact that could be anticipated from implementing the delivery of Medicaid nutritional counseling in Head Start centers. Maryland based assumptions for the size of the target population and rate of engagement of families using Head Start center-level data from Program Information Reports from the federal Office of Head Start.[12] Supplementing this with input from the Howard County experience, MCO coverage policy for nutritional services, and information from dietitians, Maryland Medicaid was able to sketch out projections for the budget impact of providing both individual and group counseling at an individual Head Start center. These projections can be useful when exploring whether an initiative would be a viable undertaking for providers. As noted above, feedback from the dietitian representing the Maryland Academy of Nutrition and Dietetics was that low participation was due more to administrative barriers than reimbursement rates. The projections can also help MCOs understand the potential scope of the pilot.

Key Question: ***Could the nutritional assessments performed by Head Start programs fulfill a component of EPSDT well-child visits?***
Finding: ***The nutritional assessments performed by Head Start programs would not fulfill a component of EPSDT well-child visits. However, dietitians can bill for nutritional counseling services.***

Federal Health Start Program Performance Standards require Head Start programs to provide a range of health, oral health, mental health and nutritional services to support students' growth and school readiness.[13] Maryland was interested in exploring whether the nutritional assessments performed by Head Start staff could fulfill the nutritional assessment element of standard EPSDT well-child visits provided in the pediatric setting.

Maryland Medicaid provides a range of guidance to dietitians regarding EPSDT nutritional services.[14] Maryland Medicaid compared the State's EPSDT requirements for nutritional assessments to federal Head Start requirements related to nutritional assessments. The comparison identified several main take-away points:

- Head Start programs are responsible for making sure children are up-to-date on preventive care, which would include the nutritional assessments that are required by Maryland Medicaid as part of comprehensive physical exams.
- Head Start programs are responsible for identifying children's nutritional health needs.
- Head Start staff provide nutritional education to families, addressing similar topics to what pediatricians cover in anticipatory guidance.
- It is unlikely that Head Start staff are licensed health care providers and, therefore, would not be able to be reimbursed by Medicaid for any element of the EPSDT well-child visit.
- The Medicaid reimbursement structure of EPSDT well-child visits does not break out the separate components (such as nutritional assessment versus other elements of a comprehensive physical exam) to facilitate billing for the assessment individually. As such, even if a licensed health care provider such as a dietitian conducts the nutritional assessment, it could not be billed as part of the EPSDT well-child visit.
- While licensed dietitians could not bill for the nutritional assessment component of the EPSDT well-child visit, they are able to bill for individual and group nutritional counseling services,[15] which are now covered by Maryland Medicaid as EPSDT services. There is no policy prohibition for providing nutritional counseling services on site at Head Start centers.

Key Lesson

EPSDT well-child and Head Start nutritional assessments and education overlap with regard to topics covered. However, Medicaid well-child services must be delivered by licensed health care providers, and reimbursement of the well-child visit does not separate individual elements such as the nutritional assessment.

Key Question: ***Can group services support individuals who are not eligible for Medicaid?***
Finding: ***There are no policy barriers to this; the size and composition of the group receiving services is at the discretion of the provider. However, dietitians may bill Medicaid only for those participating children who are enrolled in Medicaid.***

Project funders were interested in the potential of group services to extend the reach of Medicaid-funded nutritional counseling to meet the needs of non-covered family members or other children without insurance. One key question was whether a dietitian could run a group session that included both Medicaid-enrolled and uninsured participants. There are no policy barriers to allowing children without health coverage to participate in group services. However, dietitians may bill Medicaid only for those participating children who are enrolled in Medicaid. The extent to which this is feasible is a function of the group reimbursement rate as well as the provider's discretion regarding the size of the group. Feedback from the dietitian representing the Maryland Academy of Nutrition and Dietetics is that group sizes typically range from eight to 15 participants. Reimbursement for covered children may accommodate inclusion of uninsured children. In Maryland's case, group nutritional counseling is a covered service for children under EPSDT, and virtually all children in Maryland Head Start programs have covered EPSDT benefits under Medicaid.

CONCLUSION

Establishing new collaborative efforts that cross the health care and early childhood education systems, and state- and local-levels, takes time. Maryland is still implementing its pilot initiative to facilitate the delivery of Medicaid nutritional counseling by a licensed dietitian in Head Start settings. By starting on a small scale, the state hopes to test whether this model works effectively in Head Start settings, and if it can be replicated by additional dietitians, MCOs, and Head Start centers. Further, other states could apply this model to other types of licensed health care providers; doing so could support the delivery of a broader range of health care services in Head Start settings.

The new partnerships being developed between Medicaid and Head Start to deliver an obesity prevention initiative lay the groundwork for other potential types of collaboration. Stronger connections among child- and family-serving systems create the potential for other efforts to promote prevention and address the social determinants of health and ultimately improve child health and well-being outcomes. Given that EPSDT has the explicit goal of health promotion, services for children provide an entry point for states desiring to address child health holistically.

REFERENCES

1. Martin, Laurie T., and Lynn A. Karoly. (2016). *Addressing Overweight and Obesity in Head Start: Insights from the Head Start Health Manager Descriptive Study*, OPRE Report 2016-85, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Available at: https://www.acf.hhs.gov/sites/default/files/opre/2016_85_hshm_obesity_161012_b508.pdf
2. Schwartz MB, Schneider GE, et al. Association of a Community Campaign for Better Beverage Choices With Beverage Purchases From Supermarkets. *JAMA Intern Med*. 2017;177(5):666-674.
3. CHCS. Medicaid and Public Health Collaboration to Reduce Obesity in Low-Income Children: Maryland. November 2017.
4. Horizon Foundation. *Horizon Foundation Awards Nearly $1 Million in Grants in 2016*. December 14, 2016. Available at: http://www.thehorizonfoundation.org/horizon-foundation-awards-nearly-1-million-in-grants-in-2016/
5. National Heart, Lung, and Blood Institute. EatPlayGrow: Creative Activities for a Healthy Start. April 2013 Washington, DC: U.S. Department of Health & Human Services. Available at: https://www.nhlbi.nih.gov/health/educational/wecan/tools-resources/eatplaygrow.htm
6. Centers for Medicare & Medicaid Services. *Approved Maryland State Plan Amendment*. December 1, 2016. Washington, DC: U.S. Department of Health & Human Services. Available at: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MD/MD-16-0007.pdf
7. Centers for Medicare & Medicaid Services. EPSDT – *A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*. June 2014. Washington, DC: U.S. Department of Health and Human Services. Available at: www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf
8. Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition. Promoting Healthy Weight. Available at: https://brightfutures.aap.org/Bright%20Futures%20Documents/5-Promoting_Healthy_Weight.pdf
9. Ibid.
10. Select services such as mental health and substance abuse treatment are carved out of the managed care benefit and covered on a fee-for-service basis.
11. COMAR 10.09.65.02(N.) The requirements of Regulation .17A(2) of this chapter, or §M(1) of this regulation, may not be construed to:…(2) Preclude an MCO from using different reimbursement amounts: (a) For different specialties; or (b) For different practitioners in the same specialty; http://www.dsd.state.md.us/comar/comarhtml/10/10.09.65.02.htm
12. Early Childhood Learning & Knowledge Center. *Grantee Service Profiles*. November 2017. Washington, DC: Administration for Children & Families, U.S. Department of Health & Human Services. Available at: https://eclkc.ohs.acf.hhs.gov/federal-monitoring/report/program-service-reports
13. Early Childhood Learning & Knowledge Center. Part 1302-Program Operations. November 2017. Washington, DC: Administration for Children & Families, U.S. Department of Health & Human Services. Available at: https://eclkc.ohs.acf.hhs.gov/policy/45-cfr-chap-xiii/part-1302-program-operations
14. Maryland Medicaid Assistance Program. *Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) Provider Manual*. January 1, 2017. Available at: https://mmcp.health.maryland.gov/epsdt/EPSDT%20Resources/EPSD-NEW-MANUAL-FINAL-01-12-17.pdf
15. Individual and group nutritional counseling procedure codes are 97802, 97803, 97804

AcademyHealth

Robert Wood Johnson Foundation

Nemours®

Children's Health System

Your child. Our promise.