



Early Childhood and Medicaid: Opportunities for Partnering

Nemours[®] Children's Health System

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Early Childhood and Medicaid: Opportunities for Partnering

A Vision for Partnership: An ECE and Medicaid Example

Imagine a collaboration between an early care and education (ECE) program and Medicaid around developmental screenings. With parental consent, a pediatrician conducts routine developmental screenings during well-care visits. The results are shared with the child's ECE provider. Medicaid pays for the screening and the ECE program avoids duplicating the screening. Instead, the ECE provider uses the information from the pediatrician to talk with the parent, develop individualized classroom experiences that promote the child's development, link the child to other community resources and provide follow-up activities to address milestones. Concerns regarding the child's development also flow from the ECE program to the child's medical home to allow the pediatrician to make necessary referrals and ensure appropriate services are provided.

Children and families, especially those engaged with safety net programs, must navigate a labyrinth of rules and requirements on top of an already stressful life. The early childhood (EC) sector (*those serving children birth – five and their families including child care, Head Start, home visiting, foster care*) and Medicaid/Children's Health Insurance Program (CHIP) (see Appendix 1 for definitions) serve an overlapping population and have an opportunity to partner and help lessen the administrative burdens while improving health and wellbeing outcomes.

Even recognizing this potential, state and community level efforts to improve outcomes for children under five often fail to include a critical partner in children's health and development—health insurance payers, especially Medicaid and CHIP. Forty-five percent of children under five are enrolled in Medicaid or CHIP.¹ CHIP provides health insurance to children whose families earn too much money to qualify for Medicaid. EC state advocates and policy makers need to better understand why and how to partner with Medicaid/CHIP. Also, as we better understand the social determinants of healthⁱ, we know that non-health factors (e.g. housing, food insecurity, domestic violence) impact families' ability to pursue and follow medical guidance and raise their children in healthy environments. Partnerships between the EC sector and health insurers can lessen the impacts of social determinants of health on child health outcomes.



ⁱ Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

Nemours National Office of Policy & Preventionⁱⁱ (Nemours) works with states to improve coordination between the EC sector and Medicaid/CHIP. Our experience has taught us that state EC advocates and policy makers need additional information to partner successfully with the state agencies that insure millions of low-income children. We have identified strategies for engaging Medicaid/CHIP staff around child outcomes and have gathered examples of successful partnerships. While Medicaid/CHIP programs are focused on their core mission of providing health coverage, partnering and having them at the table can help ensure that scarce resources from both sectors are optimally coordinated in support of children's overall health and well-being.

The goal of this brief is to encourage partnerships between the EC sector and Medicaid/CHIP to improve health and wellbeing outcomes. Partnering with state Medicaid/CHIP agencies around common child health and well-being goals can both improve outcomes for children and target resources to children most likely to experience adversity. Ensuring that children obtain allowable services through their existing Medicaid/CHIP coverage would enable EC programs to better use their limited resources to serve more children or improve quality in other ways. In this brief, we will focus on children ages birth to five, but concepts are applicable as children age and enter school.

Why Should the EC Sector Partner with Medicaid/CHIP?

Medicaid/CHIP covers key health services for almost half of the young children in this country. In addition, the breadth of Medicaid services for children tends to be even more comprehensive than what is covered by private insurance.

Sharing data, screening results, diagnoses of health conditions, treatment and/or referrals for further evaluation across the Medicaid and EC sectors could dramatically improve the care children receive at home, in foster care, in homeless shelters and in early care and education (ECE) environments. For example, if a homeless shelter is aware that a young child is being treated for asthma, they can assign the family a room that limits exposure to airborne particulates.

Medicaid includes a package of early intervention, prevention, and treatment services commonly referred to as Early Periodic Screening, Diagnosis and Treatment (EPSDT). This pediatric benefit in Medicaid explicitly requires (1) a focus on prevention, and (2) that all children in Medicaid receive medically necessary treatment, even if the service is not provided to adults. Each state develops a pediatric preventive care screening schedule (including developmental and social/emotional screening).

Partnering in Action

Minnesota's Interagency Developmental Screening Task Force identified standardized screening instruments used by ECE providers which facilitated the physicians' acceptance of results. The Task Force also serves as a resource for quality improvement projects such as efforts to improve referral links between clinics and the education sector. There is training on how information should flow and of the types of consent required for different scenarios. The Task Force identifies referral options for families needing resources and provides guidance on how follow-up should happen with families, for example, promoting warm referrals. Another focus is making electronic screening tools available online and via mobile platforms.²

In Atlanta, the Healthy Beginnings initiative integrates ECE and health services for children enrolled in ECE programs serving low-income infants and toddlers. Nurse health navigators help families access existing services, provide health literacy coaching, track service provision and coordinate care. These navigators could be reimbursed by Medicaid. Because the RN works as part of the ECE program staff, she helps teachers understand each child's health needs so they can better adapt their teaching to the needs of individual children. The Healthy Beginnings database supports the coordinated approach by providing a unified health history for each child, with information on health needs and service use.³

In Vermont, physicians help train ECE program staff to conduct screenings, which could be paid for by Medicaid. Coordinated training and agreed upon screening tools enable physicians to trust the quality of screening results so they can be incorporated into the medical record.⁴

ⁱⁱ Part of the Nemours Children's Health System, an internationally recognized children's health system that owns and operates the two free-standing children's hospitals: the Nemours/Alfred I. duPont Hospital for Children in Wilmington, Del., and Nemours Children's Hospital in Orlando, Fla., along with outpatient facilities in six states, delivering pediatric primary, specialty and urgent care. Nemours also powers the world's most-visited website for information on the health of children and teens, KidsHealth.org. www.nemours.org

For example, Medicaid/CHIP providers are required to administer EPSDT screenings according to their state's established schedule and Medicaid/CHIP funds reimburse providers for screenings as well as well-child visits, immunizations and other preventive and clinical services. EC providers perform many of the same screenings. Unfortunately, screening results are not often shared across sectors as we rely on parents to hand carry forms, remember to sign releases, and to verbally pass along information. Partnerships with Medicaid/CHIP can address confidentiality and HIPAA issues across a state or community to facilitate routine sharing of information and improved services for children. In addition, Medicaid/CHIP funds can be used to reimburse qualified providers in different settings including child care settings and the home setting, for screenings.

Sharing screening results with EC programs allows staff to customize family services, assist with case management, and support health literacy and care compliance. In addition to better tailoring service delivery at the individual level, cross-sector collaboration also has the potential to support this at the system or policy level.

Why Should Medicaid/CHIP Partner with the EC Sector?

Most young children spend significantly more time in out-of-home care settings than they do in the health care system. An opportunity exists to leverage the child development expertise of EC providers and relationships they have with families to reach shared goals. For example, Medicaid/CHIP may be paying incentives to health care providers for increasing or improving well care visits for children. To facilitate achieving this goal, Medicaid/CHIP could partner with Head Start agencies to host health fairs and provide well care visits for a large number of their insured children at one time.

Additionally, EC programs employ staff that can support Medicaid agencies. Many have child development specialists who can observe children in a variety of activities (e.g. indoor and outdoor play) and share information with pediatricians that can help inform treatment plans. Head Start agencies employ case managers who help families with address socio-economic barriers (also referred to as social determinants of health) to keep well care visits and follow-up on identified issues. Partnerships between Medicaid/CHIP and Head Start can support families to address barriers in transportation and translation, for example, that may be reimbursable by Medicaid/CHIP. With parent permission, EC staff can share case management plans with Medicaid/CHIP providers so they know how families are being supported. Medicaid/CHIP can then share with EC staff their health care challenges with families to work together to efficiently and effectively support families.

Understanding Medicaid/CHIP

The first step to a solid partnership is learning the basics of Medicaid/CHIP, which is administered by the Center for Medicare and Medicaid Services (CMS) within the U.S. Department of Health & Human Services at the federal level. State Medicaid/CHIP agencies receive funding from the federal government that matches their state funds to run their programs. State Medicaid programs and match requirements vary significantly. In addition to the role of federal funding, another key aspect of Medicaid is its entitlement nature. Anyone who meets a given state's Medicaid eligibility criteria is entitled to receive medically necessary benefits; there is no cap on enrollment.

Knowledge of the [options that a state has in place](#) helps to understand what services are covered for whom and by what type of professional, and how and in what setting those individuals can access services.⁵ Appendix 2 provides an extensive overview of Medicaid/CHIP and resources that describe state Medicaid/CHIP programs including [federal government's State Medicaid and CHIP Overviews](#), and the [Kaiser Family Foundation's Medicaid State Fact Sheets](#). Given this variability, advocates and policy makers working in the EC sector must make an effort to understand how the program operates in their state which is a strategy identified later in this paper.

State Flexibility Under Medicaid/CHIP and Role of Managed Care

Medicaid/CHIP give states a high degree of flexibility in shaping their programs. A key aspect of partnering is understanding this flexibility and helping to identify places where things could be done differently. For example, many state Medicaid/CHIP agencies increasingly rely on managed care organizations (MCOs) to provide services to insured children. Most children in Medicaid/CHIP (approximately 68 percent) are enrolled in comprehensive managed care, where the MCO covers the cost of most of the services a participating child receives, and the state pays them a per child fee. In states with predominantly using managed care, partnerships should engage MCOs as well as the state Medicaid/CHIP agency.



One of the advantages of a managed care system is that it has greater flexibility and financial incentive to cover services which may not otherwise be mandated, such as case management, or to pay for services provided by personnel other than doctors. Additional information on how this works can be found in a recent Nemours [issue brief](#), which explores how an MCO can cover the coordination of community-based social services with medical services, as long as the community-based social services help meet a patient's health needs. MCOs have a financial incentive to keep their members healthy. If the costs of delivering services to enrolled children is less than the fixed payment received from the state, the MCO gets to keep the difference. For example, by providing supports or services to help a family better manage a child's asthma, the child may have fewer acute asthma attacks and need fewer emergency department visits, resulting in savings to the MCO.

Another example is that a Medicaid MCO could reimburse a health practitioner who talks to a family about socio-economic needs and social determinants of health at the child's pediatric checkup, identifies the family's need for child care, and refers the family to ECE programs that provide support for the socio-economic needs. With parental permission, information on the family's needs and child health issues being impacted by socio-economic needs/social determinants of health could be shared with the ECE program to provide referrals to community resources. At the ECE program, staff could provide support with housing, mental health services, food access and other needs that impact the parent's ability to manage their child's health. EC advocates can help promote these types of approaches.

It should be noted that Medicaid/CHIP programs are considering how to work with community partners to address various social determinants of health and that this is new terrain for them. While there is flexibility to cover supportive non-medical benefits such as housing support and case management, and to allow different professionals to provide benefits such as family support workers or community health workers, many states are just learning about these options, some of which were highlighted relatively recently, via the 2016 Medicaid managed care regulations. In addition, because Medicaid has traditionally focused on care provided in the clinic or doctor's office and not the social determinants of health, EC settings such as child care, are overlooked as settings to provide necessary screenings or services or collaborate with on an initiative.

Many different factors have led to the high degree of variability in state Medicaid/CHIP programs which include, but are not limited to, the following factors highlighted below.

State Budgets

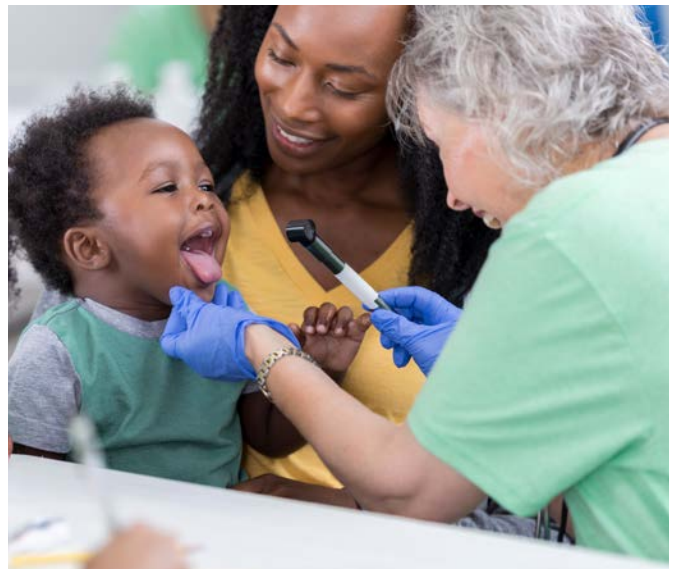
Federal Medicaid funding is structured as an open-ended match, as opposed to a limited block grant. Even with federal funding, Medicaid/CHIP looms large in state budgets.⁶ Medicaid/CHIP accounts for approximately 20 percent of spending from state general funds, second only to education in state budgets. The availability of state revenue to pay for the programs is a major factor in determining the expansiveness of a state's Medicaid/CHIP program. The potential budgetary effect is exacerbated by the federal requirement that, in general, once a population or service is added to the Medicaid/CHIP program it cannot be capped to limit the state's future financial liability. In a 2012 paper on variability in state Medicaid/CHIP funding, the Kaiser Family Foundation noted that “[b]udgets manifest an endless number of policy choices and trade-offs. Revenue and spending patterns are also largely affected by previous decisions because new budgets largely build on current budgets.”⁷

Potential Medicaid/CHIP investments to promote health and prevent disease, particularly among children, are often recognized as cost saving to the health care system; however, cost savings may not be seen until many years past a state's budget cycle and a current governor's term of office. An example of this was states choosing NOT to expand their Medicaid/CHIP program, even though federal dollars were available through the Affordable Care Act (ACA). These states decided their budgets could not cover the state share even with the federal government providing 80 percent of funding. State advocates and policy makers need to be savvy about state budgets and Medicaid/CHIP expenditures when developing a partnership.

State Priority Setting Coupled with Supply and Demand

The variation in state Medicaid/CHIP programs stems from how states have identified their priority health needs over time. States often prioritize populations such as children (children as a whole are the biggest single Medicaid/CHIP population) even though, compared to adults and individuals with disabilities, they comprise a small part of the Medicaid/CHIP costs. States could prioritize high cost drivers such as long-term care. Health epidemics also affect state priorities. For example, in recent years states have turned attention to addressing the opioid epidemic. In other instances, a single powerful event such as a disaster or a death may drive priorities. This was the case in one state that improved children's dental coverage after a child died from an untreated tooth infection. A state's advocacy groups, as well as its health care provider community, can help elevate different issues, leading to action. Gubernatorial-level leadership can also help shift Medicaid/CHIP agency priorities.

While state Medicaid/CHIP agencies have priorities, they must also be wary of demand which directly impacts cost. Factors affecting the demand for Medicaid/CHIP services include a state's poverty level, unemployment rates, availability of private insurance coverage, age distribution, and rates of disability and chronic disease.⁸ Since Medicaid/CHIP is an entitlement, costs can surge due to major shifts in demand and the state must cover their share of the cost as a match to federal funds.



The medical provider supply within a state, or regions of a state, is also important. A state may hesitate to expand services for which a base of qualified providers does not exist. This may be especially true if a state expands to consider family risk factors and the related needs that can be identified through screenings. For example, decisions to screen all new mothers for maternal depression can be influenced by whether a base of qualified providers exist state-wide to treat mothers identified with that condition.

Federal Priorities

Each federal administration emphasizes a different set of priorities for Medicaid/CHIP, and these priorities create different incentives for state programmatic decisions. Some administrations have signaled interest in increased program efficiency. Other administrations have prioritized state flexibility to test innovative approaches, including through waivers, and delivery systems in which providers are rewarded for improved outcomes and lower costs.

Strategies for Partnerships between Medicaid/CHIP and Early Childhood Sector

Medicaid/CHIP participation in state-level, cross-sector coalitions or partnerships focused on young child wellbeing requires a strategic approach, patience, and an ability to revisit strategies when priorities and elected officials change. Based on Nemours' work in states, we have identified the following helpful strategies, which are iterative and most effective when applied simultaneously.

Strategy 1: Identify a high-level champion within the State Medicaid/CHIP agency who believes in improving child outcomes with the EC sector.

The engagement of a state's Medicaid Director facilitates decision-making and collaboration with counterparts at other state agencies and can build momentum for new initiatives or policy changes. Other leaders, such as the Medicaid Medical Officer or top program staff, are also influencers who can be champions. Finally, each state has a Head Start State Collaboration office and depending on the agency employing the Director, they can be a champion and help negotiate partnerships with EC and Medicaid/CHIP.

Medicaid leaders and staff are often approached by stakeholders for funding, so establish a relationship by first focusing on achieving a set of shared child outcomes. Start by identifying senior level staff who see the potential of Medicaid/CHIP as a partner with the community. Likewise, look for Medicaid staff who have experience in the ECE sector. These individuals tend to have more experience understanding how programs interconnect to service a given family.



After identifying champions, build a relationship and understanding about what they need to promote collaboration within their agency. As in other publicly-funded agencies, Medicaid/CHIP agencies are constrained by their administrative capacity and competing priorities. This affects the degree to which they can take on new programmatic responsibilities. Connecting your initiative and goals to their priorities will help sustain the collaboration, build trust with the leadership, and move your mutual agendas forward.

Strategy 2: Understand current state Medicaid/CHIP priorities and initiatives.

Understanding a state's current Medicaid/CHIP priorities allows for exploration of EC strategies that can be built into existing initiatives. For example, if a state is already developing a waiver with elements that are complementary to overall wellbeing (such as home visiting), adding EC strategies to the waiver would likely face fewer hurdles than advocating for the development of a completely new undertaking. If a state is focused on reducing Medicaid nursing home care costs, they are unlikely to be interested in partnering on prevention for young children.

State advocates and policy makers should know the data and understand the landscape for both adult and child populations in the state to gauge how to shift a focus to young children. In New York for example, the state Medicaid/CHIP agency has developed a priority focus on The First 1,000 Days and developed performance metrics for MCOs based on coverage and care for young children. They are convinced that the return on investment of prevention will have cost savings in the future.

Currently, Medicaid/CHIP agencies voluntarily collect, report and use measures (updated annually by the Secretary) to drive quality improvements. EC and Medicaid/CHIP have an opportunity to partner to ensure that these childhood quality measures, which become mandatory in 2024, reflect their shared goals related to overall child wellbeing.

Strategy 3: Make the case for partnership by emphasizing shared goals and shared populations.

Low-income families are served by many different local and state agencies and entities in many different sectors. Engage Medicaid/CHIP by helping leaders understand the shared goals, performance standards, and federal requirements across sectors. For example, home visiting programs work with families to ensure children are getting all well-care visits and immunizations; a goal shared by Medicaid/CHIP.

For some children, special health care needs make it difficult for an EC program without case management support to effectively serve them. For EC programs that do have this capability, staff may spend large amounts of time coordinating appointments, plans, and follow-up with families who may also struggle with work, language and transportation. EC program staff could rely more on MCO case management services to identify, coordinate and manage health care referrals, transportation, and scheduling for children with complex health care needs. If MCO case managers share information with the EC program, the EC program staff could better support the entire program by focusing on non-Medicaid children or on the child/family's broader needs. EC staff could also reinforce the care coordination plan with the family to provide more support when necessary.

Another consideration is the degree of gubernatorial or legislative leadership driving collaboration. If there is a priority from these levels of government to collaborate and partner, it will be easier for state policy makers and advocates to work with Medicaid/CHIP.

Strategy 4: Understand the structure of a state's unique Medicaid/CHIP program.

In order to identify common goals (Strategy 3), there must be a basic understanding of what is allowable within a state's program. For example, understanding the degree to which a state relies on MCOs versus operates the program directly as fee-for-service reimbursement of approved providers is critical. In the former, partnerships need to be with both the state Medicaid/CHIP agency and MCOs. In the latter, working directly with the state agency would be sufficient. The following questions guide research into state programs:

- What relevant authorities does the state already have in place (e.g., what Medicaid/CHIP State Plan Amendments (SPA) and waivers does the state have)? Partnership efforts will be easier if a state does not need to apply for new federal authorities. For example, if a state currently provides Medicaid/CHIP services in community settings (versus clinical) using non-traditional providers (such as community health workers), it would be easier to implement a school-based nurse model that is able to address the health needs of state-funded pre-school children based in public school facilities.
- What populations and services fall under a managed care system? Also, what percentage of the state's Medicaid/CHIP child population is covered by an MCO? As described above, MCO flexibility provides more opportunities to cover new services and coordination functions, and to add community-based providers. For example, if trying to improve well-care visits for children in a region of the state it would be important to partner with the relevant MCO and be aware of their existing health outcome and compliance targets set by themselves or by the state.
- For managed care environments, what is the process and timing for adding new requirements to state contracts with MCOs? Understanding the windows of opportunity for making changes can help with the planning of new initiatives or collaborations. For example, if partnering with Medicaid/CHIP to improve rates of developmental screening, working with a state to require their MCOs to meet certain benchmarks of developmental screening with their covered population may be necessary.
- What are incentives for MCOs to add services voluntarily (e.g., gains in market share, ability to meet quality standards, ability to earn shorter-term quality-based financial bonuses or reduce longer-term costs)? These factors can help convince MCOs of the value of collaboration with the EC sector ([click here for more information on this](#)).⁹ EC advocates and the state Medicaid agency can work together to describe the value, from an MCOs perspective, of investing in EC partnerships.
- How well is the state Medicaid/CHIP agency and/or MCOs doing in meeting their annual goals or performance targets? What is the data showing about areas of concern (e.g. well care visits) and impact that may have on MCO payments? Again, EC and Medicaid can make the case to MCOs regarding how investing in EC partnerships can help MCOs meet performance targets.

Strategy 5: Jointly identify and pilot a small initiative connected to the partnership goal.

Once a partnership has been established around a commonly identified goal, EC state advocates and policy makers can work with their state Medicaid/CHIP agency to identify a specific challenge.

There are a number of key steps within this strategy:

1. **Define the problem.** Start by identifying the need you wish to address, how it interacts with both the EC sector and Medicaid/CHIP, and how it impacts young children so that the policy or programmatic solution is appropriately tailored.

2. **Set goals and objectives.** Local and state level goals must drive efforts at cross-sector collaboration. A clear set of goals and objectives helps ensure that the intervention is responsive to the problem and helps partners identify common ground. It helps to align the goal and objective to those that are priorities for the Medicaid/CHIP agency or MCOs. This way mutual benefit is identified.

3. **Clarify the roles of different partners.** Are there governmental and nongovernmental stakeholders that could help? Is there a clear lead entity or person for planning. In thinking about Medicaid/CHIP as a partner, it is important to ask specifically what Medicaid/CHIP would and would not pay for and the types of professionals that can be reimbursed. Options could be payment for direct services, or payment for individual case management that connects beneficiaries to other services not directly paid for by Medicaid/CHIP (such as housing).



For example, a partnership increasing developmental screenings may struggle to reach Medicaid/CHIP children not enrolled in an EC program and not making well-care appointments. EC partners can help improve access to these children who may be enrolled in home visiting, in homeless shelters, or may come from families with little access to transportation or translation. Funding could come from community foundations, health care foundations or other private funders to pilot a project that identifies families, enrolls them in Medicaid/CHIP, and then facilitates screens in non-traditional settings by a Medicaid enrolled provider. Through the process of pilot testing an approach, the partners can identify barriers and overcome them at a small scale before working on system-wide changes that may require changes to data systems, interagency MOUs and/or Medicaid/CHIP State Plan Amendments or waivers. Appendix 3 includes additional examples of potential pilot projects.

Challenges to Partnering with Medicaid/CHIP

Medicaid/CHIP has a broad scale and the ability to bring new federal revenue into a state as long as there is a corresponding state “match,” or state budget allocation. Therefore, states have brought many of their health-related programs—such as school-based health services or services for individuals with developmental disabilities—under the umbrella of Medicaid/CHIP after meeting Medicaid/CHIP Federal and State requirements. There are some key challenges, however, to working with Medicaid/CHIP.

Administrative Burden

In Medicaid/CHIP, as in private insurance programs, payments are based on individual health care services delivered by participating providers to eligible enrollees. Documentation recording the date each service is delivered by a given provider to a specific enrollee is necessary for states to receive federal funds. Programs that operate outside of a health care model often do not have the administrative infrastructure in place to facilitate the required documentation of services. Medicaid/CHIP, or MCOs, can reject a provider’s bills for a variety of reasons. For bills to be paid, the

service recipient must be eligible on the date of service, the provider must meet the Medicaid/CHIP agency and/or the MCO's enrollment requirements, and the bill must include precise information on diagnosis and service codes. Standards for payment—such as the requirement for a provider to get authorization prior to service delivery—can differ among MCOs operating in a state. It can be complex to navigate any one of these elements.

Provider Requirements

As described above, individuals or entities must meet a state and/or MCO requirements to become enrolled providers able to bill for services. State Medicaid/CHIP agencies establish processes for enrolling Medicaid/CHIP providers, for example ensuring licensure is up to date and that additional “certification requirements” are met. Each MCO may have different criteria in establishing its provider networks. In some cases, this can be more expansive than the state Medicaid/CHIP agency, for example, when MCOs include non-traditional health care providers such as community health workers. In other cases, an MCO may have more restrictive standards, for example requiring not only licensure but also board certification in a given specialty.

Provider Reimbursement

Medicaid/CHIP payment rates have historically been lower than the payment rates of other insurers, such as Medicare or private insurance.¹⁰ Low Medicaid/CHIP provider reimbursement rates means fewer providers accept Medicaid/CHIP patients, which in turn makes it more difficult for individuals to access Medicaid/CHIP services.¹¹

Return on Investment

One of the hurdles for increasing expenditures on Medicaid/CHIP is demonstrating return on investment (ROI), both from a federal perspective as well as in negotiations between a state and MCO. Investments in family support and child wellbeing are widely recognized as valuable, but there is not a transparent, consistent, data set that brings together the services young children and families receive and the benefits that accrue. In addition, savings to Medicaid/CHIP may not come to fruition for a decade or more.



The federal government generally requires states piloting new approaches through Section 1115 waivers to ensure that an innovative initiative will not cost the federal government extra money over the course of a five-year period. If savings are not realized in the short term, this may affect a state's ability to meet federal financial requirements. From an MCO perspective, health care savings may not be realized until long after the end of a member's enrollment in that MCO. Another challenge is that one state agency may make the initial investment (such as Medicaid), but another agency realizes the savings (such as the education system) which does not count towards Medicaid ROI.

State Medicaid Agency Administrative Capacity

The high level of turnover among Medicaid/CHIP directors—the median tenure is less than two years¹²—can impede the momentum of policy changes. State advocates and policy makers must strategically identify existing leaders in their Medicaid/CHIP agency, state legislature and/or governor’s office who are driving state transformation and innovative efforts in Medicaid/CHIP.

Technological capabilities also affect the ability of a Medicaid/CHIP program to refine its coverage of different services or populations. Effective health information technology is essential for states to run their programs and provide adequate accounting for the use of federal funds. However, state Medicaid/CHIP information technology infrastructure may be out of date and limit the innovation a state is willing/able to make.

Next Steps

Nemours is currently working with three states that have employed strategies 1 through 4 and are working on pilot projects under strategy 5. Their projects are focused on the following areas and additional information will be available in 2019 that details lessons learned, implementation steps, and relevant policy levers for consideration and would be a complementary brief to this paper.

Washington, D.C. Medicaid Agency, Office of the State Superintendent and Children’s National Medical Center are working on a project to improve coordination of developmental and mental health screenings in ECE settings. The project will explore how screening results can be shared more effectively across child care, Medicaid primary care providers and Medicaid MCOs. Two specific goals include: reducing duplication of developmental screening; and ensuring timely referrals to specialty services for children with abnormal developmental screens.

Maryland Department of Health planned to pilot an obesity prevention initiative in a Baltimore Head Start in Fall 2018. The State worked with one Medicaid MCO and an enrolled dietitian to develop a model to deliver group nutritional counseling services to children in a Head Start program center. The dietitian would be reimbursed by the MCO for children who meet MCO enrollment and medical necessity criteria. Due to the small number of eligible children at the pilot site, the partners decided not to move forward with the project. However, the partnership led to important lessons regarding how to address the operational steps needed for implementation.

Washington State Health Care Authority (that includes the Medicaid Agency) and the Department of Early Learning are working to improve well-child visit rates for three- to six-year-olds. The pilot is exploring and creating a workflow to share screening results between Head Start centers, primary care providers, and Medicaid. The pilot project will also determine if preventative and developmental screenings at Head Start centers meet standards for the EPSDT benefit and can be covered by Medicaid.

The primary purpose of this paper is to **encourage partnerships between the EC sector and Medicaid/CHIP to improve child health and wellbeing outcomes**. There are many options under Medicaid/CHIP to focus on child health and wellbeing as illustrated in this paper. We also provided an initial set of strategies for the engagement between EC sector and Medicaid/CHIP stakeholders. An additional set of tools and materials will be developed by the end of 2019 that provides more operational information and templates. Working together, we can create system changes that would help children grow up healthy and thrive.

APPENDIX 1: Definitions of Key Terms

Adverse Childhood Experiences (ACEs): Adverse childhood experiences (ACEs) are potentially traumatic events that can have negative, lasting effects on health and wellbeing. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act, also known as the Affordable Care Act or ACA, is the landmark health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The legislation includes a long list of health-related provisions that began taking effect in 2010. Key provisions are intended to extend coverage to millions of uninsured Americans, to implement measures that lower health care costs and improve system efficiency, and to eliminate industry practices that include denial of coverage due to pre-existing conditions. Millions also gained coverage due to the law's expansion of Medicaid in many states.

Children's Health Insurance Program (CHIP): CHIP is a joint federal-state program that provides health insurance to children whose families earn too much money to qualify for Medicaid.

Early Care & Education (ECE): A field, sector or industry that includes nurturing care and learning experiences for children from birth to age 5.

EC Sector: A broad and diverse set of early childhood agencies, programs and supports (formal and informal) including health (e.g. health care, public health) and early learning (child care, preschool, family friend and neighbor care), child welfare, early intervention, and family intended to support improved quality and advance equitable access to the opportunities and resources associated with the healthy growth and development in young children.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Federal requirement that Medicaid covers age-appropriate screenings, preventive health care services, and medically necessary treatments to promote children's healthy growth and development.

Health Insurance Portability and Accountability Act (HIPAA): HIPAA does the following: provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs; reduces health care fraud and abuse; mandates industry-wide standards for health care information on electronic billing and other processes; and requires the protection and confidential handling of protected health information.

Managed care: The state contracts with private health insurance plans to arrange networks of health care providers, and to pay providers for services delivered to enrollees. Most children in Medicaid are enrolled in managed care. The health insurance plans are referred to as managed care organizations or MCOs.

Medicaid State Plan: The basic contract between the state and the federal government regarding Medicaid coverage of populations and services. A state may need to apply to the federal government to revise its Medicaid State Plan through State Plan Amendment (SPAs) to change, add, or detail eligibility, services, payment rates, provider types or other areas that are within the scope of federal rules.

Medicaid Waiver: Medicaid program elements for which the federal government has “waived” federal statutory requirements (e.g. benefits limits or requirements, statewideness, limits on home-based or institutional care) to test or accommodate a state’s unique initiative. States generally have a number of different waiver programs in place. There are different types of waivers with different requirements:

- Section 1915(a) Waiver Authority. This authorizes voluntary managed care through execution of a contract with companies a state procures through a competitive process.
- Section 1915(b) Waiver Authority. The four types of 1915(b) Waivers are:
 - (1) Freedom of Choice, which restricts Medicaid enrollees to receive services within the managed care network;
 - (2) Enrollment Broker, which utilizes a central broker;
 - (3) Non-Medicaid Services Waiver, which uses cost savings to provide additional services to beneficiaries; and
 - (4) Selective Contracting Waiver, which restricts enrollees’ choice of provider.
- Section 1115 Waiver Authority. The Secretary of Health and Human Services has broad authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. Under this authority states can expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible and provide services not typically covered by Medicaid.

APPENDIX 2: Basic Medicaid Information

Federal Eligibility and Coverage Requirements

The federal government sets basic Medicaid requirements for eligibility and covered health care services. For example, a state must cover populations of poor children and pregnant women under certain income levels to participate and receive federal funding. Although Medicaid eligibility policy varies greatly by state, all states must cover children from families with income up to 138 percent of the federal poverty level.¹³ In addition, all state Medicaid programs serve special populations of children, such as those receiving Supplemental Security Income (SSI)—a federal cash assistance program for individuals with disabilities—and those in foster care.

Similarly, a state must cover a core set of mandatory health care services; other services are optional for adults, for example dental services. In general, federal rules require that Medicaid services are the same throughout the state for all enrollees, and that enrollees have a choice of health care providers.¹⁴ States have a high degree of flexibility—subject to federal approval—in how they administer their Medicaid programs beyond the basic federal requirements.

State Variation of Coverage

State Medicaid programs vary significantly. States benefit from the range of different avenues to maximize federal authority and align their Medicaid and CHIP programs with the state's unique needs, priorities, and environment. Knowledge of the [options that a state has in place](#) helps to understand what services are covered for whom, and how those individuals can access services.¹⁵ Resources that describe state Medicaid programs include the [federal government's State Medicaid and CHIP Overviews](#), and the [Kaiser Family Foundation's Medicaid State Fact Sheets](#). It can be challenging to navigate the nuances of federal requirements; a high-level overview of federal Medicaid requirements is included below.

Each state has a Medicaid “State Plan” which is the basic contract between the state and the federal government regarding coverage of the required populations and services. The Medicaid State Plan also offers a state many options to expand its program through State Plan Amendments (SPAs). For example, a state could choose to cover different types of case management to pay for the costs associated with helping enrollees gain access to needed medical, social, and educational services as well as to other services such as housing and transportation.¹⁶ States can choose to pay non-licensed providers, such as community health workers, to deliver preventive services.¹⁷ The federal government has provided guidance on how states can coordinate Medicaid home visiting services with services available through other programs.¹⁸ Another type of State Plan option allows states to establish “Health Homes” to provide coordinated care for Medicaid enrollees with chronic health conditions.¹⁹ The federal government provides a [searchable database of State Plan Amendments by state](#).

Some relatively recent federal changes have given states even more flexibility under their State Plans. In the past, the federal government did not allow Medicaid payment for services that are typically provided free of charge to the community at large. For example, if a school provided a free health care screening service to all students, it was not able to bill Medicaid. This changed in 2014, and Medicaid can now pay for these kinds of services as long as all other Medicaid requirements are met.²⁰

In addition to the Medicaid State Plan, the other contracts between a state and the federal government are referred to as waivers. The federal government has authority to “waive” federal requirements to accommodate a state's unique initiatives. Some waiver programs are very targeted, for example, providing additional services and supports to children with autism. Other waiver programs are comprehensive, encompassing the delivery of services for most of a state's Medicaid population. States

generally have a number of different waiver programs in place. The federal government provides a [searchable database of waivers by state](#). The [Kaiser Family Foundation's Medicaid Waiver Tracker](#) provides information on approved and pending comprehensive waivers.

Required Medicaid Services Coverage for Children

Children can be covered by Medicaid and CHIP even if their parents do not meet eligibility criteria. Medicaid benefits for children tend to be more generous than what is offered by private insurance. For example, certain categories of service—such as long-term services and supports—are even more robust in Medicaid than in private insurance. A key element of Medicaid is the broad federal mandate that all states must cover *any* health care treatment or procedure for Medicaid-enrolled infants and children—within any category of Medicaid-covered services—“to correct or ameliorate physical and mental illness or conditions.”²¹ This is the “Early Periodic Screening Diagnosis and Treatment” (EPSDT) provision of Medicaid. Categories of Medicaid-covered services include but are not limited to: physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health and substance use disorders; and treatment for vision, hearing and dental diseases and disorders.²²

This provision means that Medicaid covers age-appropriate screenings, preventive services, and medically necessary treatments to promote children’s healthy growth and development, considering “all aspects of a child’s needs, including nutritional, social development, and mental health and substance use disorders.”²³ There is recognition of the importance of delivering care in different settings, including health care practitioners’ offices, maternal and child health facilities, community health centers, and schools.²⁴ States can choose to extend this level of coverage to children enrolled in CHIP or decide on a private health insurance benefit package meeting CHIP guidelines. The implications are that many of the types of health care screenings and services delivered in ECE settings are covered by Medicaid, and in some states CHIP.

Managed Care Systems

A key characteristic of a state’s Medicaid program is the degree to which it relies on a managed care system. Most children in Medicaid (approximately 68 percent) are enrolled in comprehensive managed care, where the MCO covers most of an enrollee’s benefits.²⁵ Under a managed care system, the state contracts with one or more private health insurance plans to arrange networks of health care providers. These health insurance plans are frequently referred to as “managed care organizations” or “MCOs.” The state pays the MCO a fixed dollar amount per enrolled member per month to cover a certain package of benefits. In turn, the MCO pays health care providers for delivering services to enrollees. Some of the largest Medicaid MCOs operating in multiple states are Centene, Anthem, United, Amerigroup, and WellCare.²⁶

States differ in how they structure their contracts with MCOs. In some states, almost all services are part of the MCO benefit package. In other states, certain services (such as dental services or behavioral health services) are not part of the MCO benefit package; in those cases, health care service providers are paid directly by the state for each service delivered to a Medicaid enrollee. Information on specifics of state Medicaid programs including the details of managed care can be found at <https://www.medicaid.gov/state-overviews/index.html>.

One of the advantages of a managed care system is that it has greater flexibility to cover additional services or to add non-traditional providers to its networks. MCOs have a financial incentive to keep their members healthy. If the costs of delivering the benefit package are less than the fixed payment received from the state, the MCO gets to keep the difference. For example, by providing supports

or services to help a family better manage a child's asthma, the child may have fewer acute asthma attacks and need fewer emergency department visits, resulting in savings to the MCO. Also, where multiple MCOs operate in a region, an MCO may opt to provide services that are not otherwise covered as a competitive advantage. For example, an MCO may offer adult dental services, even though it is an optional service, to attract more enrollees.

There is a key distinction between a single MCO opting to offer additional services and a state requiring MCOs to cover additional services through contractual or regulatory requirements; the latter provides states more authority to enforce requirements. Beyond added services, another advantage of managed care is that, relative to the State Medicaid agency, MCOs tend to be better able to leverage relationships with health care providers through their development of provider networks. For example, an MCO that is sponsored by a health system may have close relationships with the health care providers who are also part of that health system. MCOs also have the ability to offer health care providers more incentives to accept Medicaid patients, for example by guaranteeing a certain level of patient volume by virtue of the providers' participation in an MCO's network.

As described in a recent Nemours [issue brief](#), an MCO can cover the coordination of community-based social services with medical services, as long as the community-based social services help meet a patient's health needs. This coverage of "community care coordination services" is particularly relevant to the ECE sector because it can help bridge the care management and health related services a child receives in an ECE setting with the health care delivery system. Federal regulations help make coverage of community care coordination services financially advantageous to an MCO, in part because the costs of the services are considered by the state when determining the MCO's future fixed payments. This can result in a higher fixed payment to the MCO. The federal government allows states to require that MCOs pay for community care coordination services.

Using home remediation of asthma triggers as an example, community care coordination services could consist of the following:

- identifying and screening individuals who may have home-based asthma triggers;
- sharing information about home remediation services;
- obtaining authorization for (but not covering the cost of) home remediation services;
- helping to set up an appointment to receive the services; and
- following up on the results of the assessment and any remediation efforts and communicating those results to a child's pediatrician.²⁷

An MCO can also cover additional services that are outside of the health care benefits that it is obligated to cover per its contract with the state. An example of this type of "value-added service" is an MCO's payment to remediate asthma triggers in a child's home, such as mold removal. Federal regulations make MCO payment for value-added services somewhat financially advantageous to an MCO. Federal regulations limit allowable MCO spending on administrative costs versus medical services and the way that "value-added services" are counted under federal regulations helps MCOs meet the required ratio of spending. However, the costs of the services are *not* considered by the state when determining the MCO's future fixed payments, that is, this does *not* result in a higher fixed payment to the MCO. The federal government does *not* allow states to require that MCOs pay value-added services. Continuing the asthma trigger example, value-added services would consist of the in-home assessment for asthma triggers and services related to remediating those triggers, such as mold removal.

Medicaid Funding Structure

Medicaid is jointly governed and financed by the federal and state governments. The federal government's share of the Medicaid program cost is called the federal medical assistance percentage (FMAP) which is set annually for each state and is based on state per capita income relative to the national average, with states with lower per capita incomes receiving higher FMAPs. The Kaiser Family Foundation releases a [list of the FMAPs by state](#) annually. As long as program expenditures fit within the bounds of the state and federal government's agreed-upon parameters, there is no cap on federal Medicaid funding or enrollment. This is different from the capped grant approach of other types of federal funding such as federal Head Start grants. It is notable that federal Medicaid funds are the largest source of federal revenue in state budgets.²⁸

APPENDIX 3: Examples of Early Childhood Sector Collaboration with Medicaid

(1) Coordination and Sharing of Information to Better Serve Children and Save ECE Program Resources

Increase the sharing of information and coordination between ECE programs and large pediatric practices and/or Medicaid MCOs so the two systems are fully coordinated. Ideally, a shared data system would support this coordination, which could also reduce screening duplication and free up ECE program resources for other needs. For example, Medicaid children should be receiving ongoing developmental screenings under EPSDT. With parental consent, a pediatric practice could conduct developmental screenings, share the results with the child's ECE program and bill Medicaid. The ECE program could then avoid screening the child again and instead use the information from the pediatrician to talk with the parent, individualize experiences that promote the child's development, and provide follow-up activities to address milestones. Concerns regarding the child's development could also flow from the ECE program to the child's medical home to allow the pediatrician to make necessary referrals and promote Medicaid coverage and payment.

Minnesota's Interagency Developmental Screening Task Force identified standardized screening instruments used by ECE providers which facilitated the physicians' acceptance of results. The Task Force also serves as a resource for quality improvement projects such as efforts to improve referral links between clinics and the education sector. There is training on how information should flow and of the types of consent required for different scenarios. The Task Force identifies referral options for families needing resources and provides guidance on how follow-up should happen with families, for example, promoting warm referrals. Another focus is making electronic screening tools available online and via mobile platforms.

In Atlanta, the Healthy Beginnings initiative integrates ECE and health services for children enrolled in ECE programs serving low-income infants and toddlers. Nurse health navigators help families access existing services, provide health literacy coaching, track service provision and coordinate care. These navigators could be reimbursed by Medicaid. Because the RN works as part of the ECE program staff, she helps teachers understand each child's health needs so they can better adapt their teaching to the needs of individual children. The Healthy Beginnings database supports the coordinated approach by providing a unified health history for each child, with information on health needs and service use.

In Vermont, physicians help train ECE program staff to conduct screenings, which could be paid for by Medicaid. Coordinated training and agreed upon screening tools enable physicians to trust the quality of screening results so they can be incorporated into the medical record.

In Washington, D.C., the Medicaid Agency, Office of the State Superintendent and Children's National Medical Center are embarking on a project to improve coordination of developmental and mental health screenings in ECE settings. The goal of the DC technical assistance is to improve coordination of developmental screening between child care providers and Medicaid. The efforts will focus on two goals – reducing duplication of developmental screening and ensuring timely referrals to specialty services for children with abnormal developmental screens. The project will explore the current referral pathways in these two sectors and pilot ways for screening results to be shared more effectively between child care, Medicaid primary care providers and Medicaid MCOs.

In Washington State, the Health Care Authority (that includes Medicaid Agency) and the Department of Early Learning are working to improve well-child visit rates for three- to six-year-olds. The pilot project will determine if preventative and developmental screenings at Head Start centers meet standards for the EPSDT benefit and can be covered by Medicaid. The pilot also looks to create a workflow to share screening results between Head Start centers, primary care providers, and Medicaid.

(2) Rely on Medicaid Care Coordination for Children with Complex Medical Needs

For some children, special health care needs make it difficult for an early childhood program without case management support to effectively serve them. For early childhood programs that do have this capability, staff may spend large amounts of time coordinating appointments, plans, and follow-up with families who may also struggle with work, language and transportation. Early childhood program staff could rely more on MCO case management services to identify, coordinate and manage health care referrals, transportation, and scheduling for children with complex health care needs. If MCO case managers share information with the early childhood program, the early childhood program staff could better support the entire program by focusing on non-Medicaid children or on the child/family's broader needs. Early childhood staff could also reinforce the care coordination plan with the family to provide more support when necessary.

(3) Address Social Determinants of Health (SDOH) with Medical Providers and ECE Programs

Health care providers could support child health by **making connections between health care delivery and social determinants of health such as a family's access to child care**. For example, a pediatrician's office could administer a social determinants of health screening at the child's checkup (paid for by Medicaid), identify the family's need for child care, and refer the family to ECE programs that provide support for identified area of social determinants of health. With parental permission, results of the social determinants of health screener could be shared with the ECE program to provide information on other family needs, referrals from the health care provider to community resources, and child health issues being impacted by social determinants of health. At the ECE program, such as Head Start, family support workers can provide support with housing, mental health services, food access and other needs that impact the parent's ability to manage their child's health.

States could invest Medicaid waiver savings into system reform that breaks down silos between health care and social services, criminal justice, employment, housing, and education. In this case, Medicaid is measured on increased kindergarten readiness.

States could conduct public health campaigns targeting ECE settings to promote healthy screen habits for children birth through age 5, using CHIP-related funding.

In Maryland, the Department of Health planned to pilot an obesity prevention initiative in a Baltimore Head Start in Fall 2018. The State worked with one Medicaid MCO and an enrolled dietitian to develop a model to deliver nutritional counseling services to children in a Head Start program center. The dietitian would be reimbursed by the MCO for children who meet MCO enrollment and medical necessity criteria. Due to the small number of eligible children at the pilot site, the partners decided not to move forward with the project. However, the partnership led to important lessons regarding how to address the operational steps needed for implementation.

(4) Medicaid Funding to Directly Support ECE Staff or Services in ECE Settings

Existing Medicaid coverage of school-based health services could be extended to cover ECE programs based in these schools if **ECE programs could be included in these contracts between the state Medicaid agency and public school districts**. Medicaid payment for direct health care screenings or services may be a possibility due to a relatively recent change in federal policy. Previously, if a school provided a free health care screening service to all students, it was not able to bill Medicaid. This changed in 2014, and Medicaid can now pay for these kinds of services if all other Medicaid requirements are met.

Medicaid funding could potentially support ECE staff time linking children to health coverage (e.g., case management). Considerations include whether a state Medicaid program pays community health workers or only licensed health care professionals. States (through a SPA) and MCOs could choose to cover different types of case managers to pay for the costs associated with helping enrollees gain access to needed medical, social, and educational services as well as to other services such as housing and transportation.

Another option may be to **work directly with Medicaid MCOs to promote community health workers** who address needs beyond the traditional realm of health care delivery. States could also explore whether ECE family support staff could fulfill a role as a CHW with the MCO and therefore be supported by the Medicaid MCO.

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