Collaboration Among Medicaid and Early Care and Education Policy Makers: Insights From Three States

August 2019

Nemours® Children's Health System

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Summary

Nemours provided technical assistance to several states—the District of Columbia, Maryland, and Washington—to bring together Medicaid and early care and education (ECE) partners to devise solutions for better meeting the needs of families served by both systems. The states planned or implemented pilots addressing barriers at the programmatic or operational level, as well as the broader policy level. The pilots fostered trust and understanding across systems, with the purpose of ultimately leading to the spread of effective strategies. This work highlighted a number of lessons and strategies.

Lessons for Engaging Partners to Foster Cross-Sector Collaboration

- Develop a strong case for a collaboration by emphasizing shared goals and populations.
- Identify and work with a state leader who values cross-sector collaboration, and promote "integrators." An integrator is an entity that serves a convening role and works intentionally and systemically across various sectors to achieve improvements in health and well-being.
- Understand the priorities of each sector and identify areas of alignment that can build on existing momentum.
- Jointly identify and develop a cross-sector pilot at a small scale.
- Respect the available time and resources of everyone involved in the initiative, even when it requires making hard decisions.

Strategies for Serving Families through a Coordinated and Consistent Approach

- Initiatives focused on information sharing and service coordination should be bi-directional, meaning that communication flows from health care provider to ECE provider as well as from ECE provider to health care provider. A focus on information sharing and service coordination is a practical starting place, avoiding the challenges of more ambitious or expensive projects until investment in additional resources exists.
- Bring together representatives from both sectors, providing a chance to build rapport and trust.
- Better information sharing and coordination across the ECE and Medicaid sectors can optimize scarce resources.

Strategies for Improving Cross-Sector Coordination

- Identify current ECE care coordination requirements.
- Similarly, identify current managed care organization (MCO) care coordination requirements.
- Identify opportunities for information flow and develop supportive resources.

Introduction

State ECE agencies and Medicaid are natural partners to promote the health and well-being of young children and their families. The connection between children's health status and learning is well documented,[1] and the importance of early intervention to identify and address developmental delays and disabilities is widely recognized.[2] In addition, research shows that addressing the social determinants of health—a frequent role of ECE programs—positively affects health status.[3]

Most children under age five spend a substantial number of hours per week in out of home care, and there is a high degree of overlap in the populations served by publicly funded ECE and Medicaid. For example, virtually all children in Head Start and Early Head Start are eligible for Medicaid/CHIP, and state funded pre-kindergarten tends to target low income children. Given their regular interaction with low-income families, ECE programs are well positioned to promote health and access to health care.

Within both the health policy and early childhood fields, alignment between Medicaid and ECE programs is increasingly prioritized. This is evidenced by recent initiatives within government and the private sector. For example, the Center for Medicare and Medicaid Innovation (CMMI) announced a new Integrated Care for Kids (InCK) Model to facilitate the ability of states and localities to implement a framework of child-centered care integration across behavioral, physical, and other child providers, including early care and education.[4] Within the private sector, the Robert Wood Johnson Foundation, the Alliance for Early Success, and Nemours among others are funding a range of initiatives to promote Medicaid and ECE alignment.

Nemours has provided technical assistance to several states—the District of Columbia, Maryland, and Washington—to plan and implement pilot projects that advance upstream prevention by strengthening coordination across the Medicaid and ECE sectors.[5] This effort brings together Medicaid and ECE partners to devise solutions to better meet the needs of families served by both systems. The pilots address barriers existing at the programmatic or operational level. In addition, the pilots highlight broader policy-level barriers. The scale of the pilot approach helps to build trust and understanding across systems, to ultimately lead to the spread of effective strategies, through policy change.

This work builds on an earlier Nemours project which was funded by AcademyHealth and the Robert Wood Johnson Foundation, and which produced a number of **briefs**.[6] The purpose of this issue brief is to share lessons from the three states with other state Medicaid agencies and Medicaid managed care organizations (MCOs) considering collaboration with the ECE sector. The brief also briefly describes how federal Medicaid rules allow and encourage Medicaid interaction with ECE programs.

In **Washington, D.C.** the **Medicaid agency, Office of the State Superintendent of Education, and Children's National Health System** are jointly embarking on a pilot to improve coordination of developmental screening, given that screening is provided in both physician offices and ECE settings. Goals include (1) increasing coordination between ECE providers and primary care providers on completion of developmental screening; and (2) ensuring families receive consistent information about screening results and any follow-up that may be necessary.

In **Maryland**, the **Medicaid agency**, a **Medicaid MCO**, a Baltimore **Head Start program**, and a **dietitian practice** came together to embed Medicaid-covered group and individual nutritional counseling services within the Head Start. The dietitian would be reimbursed by Medicaid, through the MCO, for children who met MCO enrollment and medical-necessity criteria. The team worked through processes for the dietitian to complete provider enrollment and MCO credentialing, and to identify the standardized medical necessity assessment and the group education curriculum. Due to the small number of eligible children at the pilot site, the partners decided not to implement the formal pilot. However, the partnership led to important lessons regarding the operational steps needed for implementation.

The **Washington** state **Medicaid agency** and the **Washington Department of Children, Youth, and Families** are exploring care coordination strategies to improve well-child visit rates for three- to six-year-olds. Washington wants to expand the successful strategies of Head Start and the state-funded pre-kindergarten program (Early Childhood Education and Assistance Program – ECEAP) to other ECE settings, leveraging the support of MCOs and physicians. The goal is to design a pilot to test and support care coordination and increased communication of developmental screening results across the ECE and health care systems, encouraging MCOs to take a more holistic approach to child and family well-being and skill-building, beyond the traditional clinical focus.

Lessons for Engaging Partners to Foster Cross-Sector Collaboration

The health care sector increasingly recognizes the many factors influencing health beyond traditional health care. To keep children healthy, Medicaid must partner with other agencies and community-based organizations such as ECE to address social determinants of health. The experience with three states suggests that the ECE sector is willing to work with Medicaid to ensure children get needed services, and to improve families' experiences with receiving services from multiple sectors. Below are four foundational steps for engaging partners outside of the traditional health care domain.

Develop a strong case for a collaboration by emphasizing shared goals and populations.

The identification of shared goals can ground and help sustain a new collaboration as partners embark on the hard work of breaking down policy, financing, and operational silos. Examples of goals shared among multiple child-serving sectors are kindergarten readiness, improved rates of well-child visits, developmental screening, and expansion of home visiting.

Low-income families are often served by multiple programs. Medicaid and the federal Head Start program, for example, have similar eligibility requirements—virtually all children enrolled in Head Start are eligible for Medicaid—and Head Start is accountable for ensuring that children gain access to preventive health care and needed treatment. It is important to understand the populations covered by state-specific ECE programs, and the program requirements. For example, Washington's Early Childhood Education and Assistance Program (ECEAP) has many of the same health requirements as Head Start. More than 90 percent of Washington children enrolled in ECEAP or Head Start have timely well-child visits and developmental screens. Washington seeks to extend that success more broadly by starting a pilot with one or more MCOs and affiliated health care providers with an ECE setting that integrates Head Start, ECEAP, and subsidized child care.

In each state, Medicaid agencies can look to the following types of entities to better understand the universe of ECE programs and populations served:

- State Head Start Collaboration offices facilitate partnerships between Head Start agencies and other state agencies serving low-income families and children;
- The Center of Enhancing Early Learning Outcomes (CEELO), a project funded by the U.S. Department of Education, makes available state-specific information available on early learning guidelines.

Identify and work with a state leader who values cross-sector collaboration, and promote "integrators."

Engage a high-level state official who can facilitate decision-making, collaborate with counterparts at other state agencies, and build support and momentum for initiatives and policy changes. Similarly, champions at the local level can help facilitate change. In addition, the presence of legislative or gubernatorial support for cross-sector work is powerful.

Some states have dedicated staff who act as "integrators," working intentionally and systematically across sectors to achieve improvement in health and well-being. Nemours described the integrator role in a 2012 paper.[7] In 2016, the Washington Health Care Authority (HCA), which includes the Medicaid agency and the Washington Department of Children Youth and Families (DCYF), jointly funded a full-time staff position to explore Medicaid funding opportunities for home visiting services, and to identify gaps and leverage points across health and early learning. In 2018, HCA fully funded the position and DCYF fully funded an early childhood health systems coordinator. The two positions complement each other, extending each agency's capacity to work on intersections of health and early childhood.

Understand the priorities of each sector and identify areas of alignment that can build on existing momentum.

The three states found alignment by building on existing initiatives and adding to that momentum. For example, in Washington, D.C., a number of initiatives were underway that focused on developing cross-sector early childhood collaborations. These included the Quality Improvement Network, the Districtwide Early Head Start Child Care Partnership grant; a cross-sector learning collaborative sponsored by Children's National Health

System to improve effective and collaborative referral systems among primary care, early childhood mental health and ECE; a BUILD initiative focused on early childhood systems building; and a ten-state Learning Collaborative convened by the ZERO TO THREE organization to promote infant and early childhood mental health services across child-serving systems. Building on this momentum, Nemours' technical assistance focused on improving coordination of developmental screening between primary care and ECE. Many of the same leaders are involved in these initiatives, allowing for opportunities to share findings, reduce duplication of work, and coordinate future work to achieve sustainability.

Similarly, in Maryland, local initiatives and private funding laid the groundwork for the state Medicaid agency to focus on children's nutritional services and obesity prevention within Head Start settings. Prior to the implementation of this pilot, Head Start had partnered with a community public health campaign targeting sugary drink consumption, and the local Horizon Foundation funded an initiative in Howard County Head Start programs to develop healthy eating habits through the EatPlayGrow curriculum. These earlier initiatives contributed to Maryland's application and approval in 2016 for a Medicaid State Plan Amendment to begin covering group nutritional counseling for children.

Jointly identify and develop a cross-sector pilot at a small scale.

Each of the three states identified a priority issue at the nexus of Medicaid and ECE, and then worked toward a pilot-level test of implementation feasibility. Each of the state's experiences reinforced the importance of convening a small group of partners who focused on identifying barriers and developing concrete solutions to overcome them. Pilot projects enable states to improve program operations in incremental ways and surface policy barriers and solutions, without requiring significant financial investments beyond staff time. Starting at this scale also provides the opportunity for cross-sector relationship building, which is needed for more ambitious policy initiatives.

It is particularly helpful to involve state-level policy makers as well as providers at the forefront of service delivery. For example, hearing directly from an MCO regarding the populations it targets with care coordination, and the scope and intensity of that care coordination, helps to illustrate how MCO care coordination intersects with the services provided by Head Start or another ECE program. If duplication is uncovered, the state level policy makers can help navigate the individual program rules and policy implications to improve efficiency. This level of collaboration helps to keep the focus of service delivery centered on the child and family.

Federally- and state-funded health care and ECE programs are understandably complex, with a myriad of rules that need to be followed. Another benefit of building a collaborative that involves both state-level policy makers and on-the-ground providers is the ability to identify potential misconceptions about existing policy. As discussed in an earlier issue brief, Maryland's pilot process uncovered misconceptions among providers regarding Medicaid enrollment and credentialing processes.[8] The pilot provided an opportunity for the Medicaid agency and the MCO to provide clarification to dietitians regarding the policies in place, and to point the dietitian association to resources for enrollment on the Medicaid agency website.

Given the breadth and complexity of any state's Medicaid program, it is necessary to invest in internal partner engagement in addition to broadening the scope to external partners. For example, it is important to bring on board Medicaid agency colleagues who oversee Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT) and other aspects of children's health services.

Example from the Washington, D.C. Pilot

The Washington, D.C. experience reinforced the need to be realistic about achievable goals. While the partners all agreed with a long-term goal of reducing duplication of developmental screenings, they decided that there was important work to be done before they could achieve that goal, and they recognized that some duplication may be necessary to ensure that the greatest number of children are screened. The Washington, D.C. team chose to strengthen communication across sectors regarding the completion and results of developmental screens, with the recognition that encouraging conversations between ECE and primary care providers about a child's care is a critical first step in improving coordination and providing consistent information to families.

The pilot approach enabled the Washington, D.C. team to build on existing ECE and primary care workflows. Washington, D.C. requires children to have a Universal Health Certificate to enroll in licensed child care or public school. A child's primary care provider completes the Universal Health Certificate and gives it to the parent to return to the ECE program or school. Washington, D.C.'s pilot approach is to share developmental screening results between primary care and ECE providers participating in the Quality Improvement Network by attaching them to the Universal Health Certificate. This approach minimizes additional paperwork or administrative burden by building on current processes.

This work demonstrates the importance of examining process flows in bi-directional ways: from health care provider to ECE provider as well as from ECE provider to health care provider. The pilot worked to ensure that participating ECE centers would send a form with the family advising the primary care provider of the most recent developmental screen performed in their center and any actions taken to address concerns.

The recently launched pilot will operate through the end of 2019. The pilot is addressing operational issues and identifying policy barriers. At the conclusion of the pilot, the Washington, D.C. team will evaluate the results and assess how learnings from the pilot can inform next steps and potentially be applied more broadly across the jurisdiction. The team will look for vehicles to expand to more sites—potentially using the Early Childhood Innovation Network, a local collaborative of health, education, community providers, researchers and advocates—as a means of spreading this policy and any best practices that are identified.

Example from the Maryland Pilot

Maryland's pilot approach—convening a core group of representatives from the Medicaid agency, an MCO, a Baltimore City Head Start program, and the dietitians who would deliver the service—resulted in a great deal of progress leading up to implementation. The group identified a number of key implementation elements described in Figure 1 on Page 6, including leveraging MCO leadership to fast-track the dietitians' credentialing process for the pilot; developing intake and service delivery workflows and documentation templates; and developing a strategy and materials for conducting outreach to families regarding the new service. Some of the decisions made for this pilot would not be feasible to implement on a larger scale. The draft documents and processes would have been further vetted by the State had the pilot moved forward. In addition, had the pilot moved forward, the team would have needed to further address data sharing among providers.

Ultimately, the volume of eligible children at the one pilot site was too small to make the pilot feasible. Very few children met the State- and MCO-set medical necessity criteria for individual or group nutritional counseling. The potential revenue from MCO billing was too low to support dietitian travel time to and from the Head Start center. A lesson from this experience is the need to balance the benefits of starting small, while still ensuring that the scope of implementation can support provider involvement. Another lesson is to identify early on the criteria for participation and the potential size of the eligible population, to determine whether the scale is sufficient to justify resource investment.

Figure 1: Examples of Challenges and Solutions from Maryland's Experience

Milestone	Challenge	Solution
Fast-track Medicaid Provider Enrollment	To be paid through Medicaid fee-for-service, licensed health care providers or qualified nontraditional providers must enroll with the Medicaid agency as a provider type covered under the Medicaid State Plan. **Provider enrollment processes can be lengthy.**	Medicaid agency representatives clarified the policy for fee-for-service enrollment (already documented on the Medicaid agency website).
Fast-Track MCO Provider Credentialing	To be paid by a given MCO, licensed health care providers or qualified nontraditional providers must be credentialed by that MCO. The MCO credentialing process is separate from the State Medicaid agency provider enrollment process, and some of the criteria may differ. For example, an MCO may require Board Certification for specialty physicians, while the State Medicaid agency does not. **Each MCO has its own credentialing process.**	For the pilot, the MCO representative took the special step of fast-tracking the dietitian provider application through the MCO credentialing process. The 2016 21st Century Cures Act (P.L. 114-255) requires states to screen and enroll all MCO providers in fee-for-service Medicaid. However, this requirement does not extend to MCO network provider types who are not eligible to enroll in Medicaid fee-for-service.
Document Intake and Service Delivery Workflows	The pilot involved an innovative place of service (the Head Start center) and a particular sequence of individual and group nutritional counseling. **The new approach and workflows could have resulted in miscommunication, and MCO denial of dietitian bills for services.**	The team developed a detailed workflow for the Head Start program's intake of children eligible for the intervention and service delivery by the dietitian. The workflow included requirements for care plan documentation, billing codes to be used, processes for confirming the child's eligibility on the dates of service, and feedback to the child's pediatrician/ medical home. The MCO representative worked with the MCO's medical review team to receive sign-off on the proposed service delivery workflow.
Streamline Referral Pathways	Typically, for the MCO to pay for the service, the child's primary care provider would need to make a referral. **This could delay service delivery or result in the MCO denying dietician bills for services.**	The workflow relied on documentation of eligibility (medical necessity and MCO enrollment) by the Head Start to refer the child to the dietitian. A separate referral from the pediatrician was not required.
Streamline Prior Authorization Requirements	The MCO typically would need to grant prior authorization for more than four counseling sessions, making difficult the implementation of a multi-session group nutritional counseling curriculum. **This could delay the sequencing of service delivery or result in the MCO denying dietician bills for services.**	The MCO representative worked with the MCO's medical review team to receive sign-off on the prescribed number of individual and group counseling sessions, without requiring prior authorization for each session.
Develop Family Outreach Strategy and Materials	Parents/guardians need to opt in to service delivery for their children. They need to understand the purpose and nature of the service, and have meaningful opportunities to participate. **Sufficient uptake among parents/guardians is necessary for a successful pilot.**	The team developed a process and template for documenting family consent to participate and to have their contact information shared between the Head Start and health care provider. The team also developed a brief information sheet for families, to ensure they receive clear and consistent information about the initiative. Based on their experience and expertise, Head Start program staff provided input on how to structure opportunities for parent engagement to maximize participation.

Respect the available time and resources of everyone involved in the initiative.

Program administrators and direct service providers across both sectors already have full and challenging schedules, with limited time for new activities. It is important to acknowledge at the onset of an initiative that collaboration takes time, due to competing demands on staff and the challenges of coordinating staff schedules from multiple agencies and organizations. In Maryland, for example, the development of the pilot took over a year. It is also necessary to be nimble to accommodate unexpected delays. In Washington, D.C., a turnover in ECE grantees led to a several-month delay in implementation until the transition to a new grantee was completed. The team used this time to work on a side issue that had emerged related to communication between an MCO and its providers.

Respecting team members' availability can also require partners to make hard decisions. In Maryland, despite the progress in overcoming administrative and operational barriers, the team decided to halt work when it was discovered that the volume of children who met medical-necessity criteria was inadequate to support implementation. This respect for partners' time and resources helped preserve the relationships built, which may be leveraged for future efforts. Although the pilot implementing service delivery in the specific Head Start ended, Maryland Medicaid still covers group nutritional counseling for eligible children. MCOs have the option to cover medically necessary group nutritional counseling in a Head Start setting.

Serving Families through a Coordinated and Consistent Approach

A common theme among the three states was the potential to improve information sharing and service coordination across the Medicaid and ECE sectors. Sending and receiving information across sectors, and incorporating that information into service delivery, may not be routinely built into the workflows of already busy health care and ECE providers. In addition, there may be a lack of clarity regarding parent or guardian consent for information sharing.

Initiatives focused on information sharing and service coordination should be bi-directional, so both sectors benefit from new efforts or workflows and gaps and duplication can be identified. This ultimately drives a better experience for the families served by multiple systems, and a clearer path for meeting the needs of children. For example, it is not unusual for a child to receive a developmental screening both at the ECE setting and at a pediatric well-visit. This duplication may be confusing for families, and it results in public programs (e.g., Medicaid and Head Start) paying twice for the same service. Moreover, if one set of results indicates the need for follow-up, and the other set of results does not, there may be a delay in early intervention if parents are confused by results.

There is a practical advantage to focusing on improved information sharing and service coordination. While all three of the states expressed interest in the ability of Medicaid to directly reimburse ECE programs for the provision of direct services, most ECE programs do not qualify as existing Medicaid provider types. Although MCOs have additional flexibility to contract with non-traditional providers, they may not take up this option due to funding constraints or limitations on the ability of ECE providers to meet administrative requirements (such as contracting, documentation, and billing). Launching a collaboration focused on information sharing and service coordination avoids these challenges.

A lesson from Maryland is the importance of bringing together representatives from both sectors to address the many different elements of coordinated service delivery. The group had regular in-person meetings and conference calls, providing a chance to build rapport and trust. This helped facilitate MCO medical review team agreement on different aspects of the initiative. For example, the group agreed on a process in which the Head Start Family Service Coordinator would document the child's eligibility (based on medical necessity and MCO enrollment) for nutritional counseling on the intake form and—with consent from the parent/guardian—would then refer the child directly to the dietitian practice. A separate referral from the pediatrician was not required. This dramatically streamlined the service delivery model.

The MCO medical review team also signed off on the frequency of the group nutritional counseling curriculum to be delivered, without requiring prior authorization for each counseling session. The group spent time addressing the logistics of service delivery, including working through specific billing processes and how the space at the Head Start would be used for service delivery. It was also important to hear from the Head Start program regarding how best to engage parents in the nutritional counseling service—for example, based on experience with other initiatives, the Head Start recommended making counseling sessions available to parents in the morning rather than in the evening, and tying participation to credit at an annual "holiday store."

An earlier **issue brief** explored how better information sharing and coordination across systems can optimize the scarce resources of publicly-funded programs.[9] As noted earlier, closing communication gaps between Medicaid and ECE has the potential to reduce spending on duplicate services. For example, sharing the results of a pediatrician-conducted screening with the child's Head Start program prevents the screening from being unnecessarily repeated and paid for by the Head Start. Greater collaboration among MCOs and ECE programs offers an additional vehicle for engaging vulnerable children and families to help them access needed preventive health care and treatment. This has potential benefits in helping MCOs meet quality performance standards for prevention. Some states reward performing MCOs with direct financial incentives through value-based purchasing initiatives. In addition, high performing MCOs can attract more enrollees and benefit from increased market share.

Under federal managed care regulations, MCOs must coordinate health care services for all enrollees.[10] Given that 78 percent of children are in managed care or primary care case management delivery systems, this is a requirement for most children enrolled in Medicaid or CHIP.[11] CMS describes care coordination for children as "improv[ing] the communication flow among all: health care practitioners, patients, systems, and agencies."[12] CMS, recognizing the challenges of cross-sector coordination, states that "[c]oordinating care across systems is even more difficult than coordinating care within a single system."[13] The National Academy for State Health Policy (NASHP) led a multi-year program, Assuring Better Child Health and Development, focused on improving the delivery of child development services to young children enrolled in Medicaid. In its report, "Improving Care Coordination, Case Management, and Linkages to Service for Young Children: Opportunities for States," NASHP identified the following types of barriers to better linkages across sectors:

- Constraints on primary care provider capacity to refer to and link to other community services;
- Inadequate service capacity for early childhood developmental and mental health services;
- Differences among service delivery systems driven by policy, program design, or categorical funding—these can create gaps between referral resources and the programs that provide follow-up;
- Insufficient payment/financing for time spent in referral and coordination efforts; and
- Different practice cultures and customs.[14]

Barriers may be significant, but so are the potential benefits to families and providers upon overcoming them. Better coordination can help providers (both primary care physicians and ECE providers) meet their performance goals. For example, there were anecdotal reports in Washington state that local health care providers do not always complete hearing and visions screens on younger children due to the belief that the children are too young to comply. However, ECE settings—where children spend a significant amount of time and, therefore, may be more comfortable than in a pediatrician's office—are successful at administering the screenings.

Strategies for Improving Cross-Sector Coordination

Technical assistance focused on strategies for improving bi-directional information sharing and service coordination across providers in the Medicaid and ECE sectors to better meet the needs of children and families. Investing time in these activities was necessary to move collaboration forward. The experience from the three states echoes some of the strategies described earlier by CMS:

- Develop and promote tools and resources;
- Offer technical assistance to providers; and
- Build care coordination into electronic data transmittal systems.[15]

Identify current ECE care coordination requirements.

Medicaid staff involved with collaborative efforts will need to understand at a high level the main categories of publicly-funded ECE in the state, and for each category the different requirements related to health and the role and scope of care coordination. For example, federal Head Start defers to a state's Medicaid Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT) requirements for frequency of dental visits. The Washington ECEAP program requires contractors to work with parents to ensure that children who have not had a dental exam within the last six months receive a dental exam or screening by a dental hygienist within 90 days.[16] It is important to understand the baseline of ECE requirements for performance to facilitate the identification of gaps in coordination between systems, and potential leverage points for improvement.

Categories of publicly-funded ECE include federal Head Start as well as state-funded and federally-subsidized child care. Health requirements and the role of family engagement in Head Start are described in the issue brief, **"Medicaid and Head Start: Opportunities to Collaborate and Pay for Upstream Prevention."**[17]

Similarly, identify current MCO care coordination requirements.

To clarify how Medicaid MCO and ECE care coordination functions might align or overlap, it is necessary to clearly understand the scope and intensity of care coordination required by MCOs under existing state contracts or regulation. This helps ensure that no cross-system duplication in service delivery is introduced. MCOs may have robust care coordination programs for certain populations (e.g. children with complex medical needs) under the Medicaid targeted case management benefit. However, not every child is assigned an MCO care manager. Moreover, for children who do receive case management, the scope may be limited to medical care rather than including non-medical support services. MCOs can provide direct input regarding the challenges they face in meeting care coordination requirements for young children, which may help highlight potential supportive roles for the ECE sector or handoffs between sectors. Under Medicaid managed care, MCOs can provide care coordination of clinical and non-medical support services; this qualifies as medical expenses for purposes of calculating medical loss ratios and setting capitation rates.[18]

Identify opportunities for information flow and develop supportive resources.

Once partners have a clearer idea of the workflows and care coordination operating in each sector, then work can begin to identify barriers to greater sharing of information, and potential solutions to test in a pilot. Documentation of these approaches helps systematize and sustain initiatives, even in the midst of staff turnover. The following are some examples.

- The Washington, D.C. Collaborative for Mental Health in Pediatric Primary Care is developing a flyer on child development to educate families and providers on different programs, services, their purpose, and referral information to help coordinate across the health and ECE sectors. The completed flyer will be available on the Washington, D.C. **HealthCHECK training and resource center** (www.dchealthcheck.net).
- One significant barrier to sharing information across sectors is concerns about privacy and the need for documented parental consent. To overcome this, Minnesota's Interagency Developmental Screening Task Force developed **guidance for clinics and schools** on communication regarding early childhood special education referrals, including clear information on when signed parental consent is required.[19]

- Another barrier that can arise is hesitation by the providers of one sector to accept the results of screenings administered by another sector. Pediatricians may not be familiar with the credentials of ECE providers and/or the screening tool used in the ECE setting, and thus believe they need to repeat screenings that were already administered in EC settings. Statewide standardization of screening instruments can address this. For example, a core element of Minnesota's Interagency Developmental Screening Task Force is the review and recommendation of standardized developmental and social-emotional screening instruments for use in Minnesota's public screening programs. The instruments must meet validation criteria for accuracy and reliability to be recommended by the Task Force.[20]
- Training in the administration of screening tools further supports cross-sector information sharing and coordination. The Minnesota Interagency Developmental Screening Task Force assures access to training and consultation for screening programs. Vermont is another state that has prioritized training; physicians help train ECE providers to conduct screenings using standardized instruments. As a result, physicians are willing to accept ECE screening results and incorporate them into the child's medical record.
- A key issue to explore is the delineation of care coordination responsibilities between Medicaid and the ECE sector for a given child's health or developmental need. Handoffs between systems need to be clear to ensure the child receives all necessary follow-up on referrals in a way that is seamless to the parent. Development of a template for pathways of system handoffs and tracking can help clarify the roles and responsibilities of different providers. Appendix B shows a template that was drafted for Washington, D.C.
- Sharing of electronic data regarding screening results, referrals, and follow-up would clearly facilitate coordination. However, this raises not only the privacy concerns mentioned above, but also the IT limitations that may exist in either or both sectors. The **Columbia Gorge Health Council**, a partner with PacificSource Community Solutions in a Community Care Organization in Oregon, has successfully implemented a health information exchange—**Reliance eHealth Collaborative**—that enables organizations across health and social services sectors to access data for population health monitoring and improvement. The health information exchange includes a secure closed loop referral system that is not restricted to health care professionals, overcoming the common barrier of siloed information on access to community resources. A previous AcademyHealth, RWJF, and Nemours **issue brief** explores how CMS' 2016 Medicaid Managed Care regulations enable MCOs to help fund closed loop referral systems as community care coordination services.[21]

Federal Regulatory Considerations and Next Steps

As Medicaid programs innovate, they must navigate existing federal regulatory frameworks. Fortunately, federal Medicaid rules allow and encourage Medicaid interaction with ECE programs. Medicaid is rightly referred to as a payer of last resort. However, the Centers for Medicare & Medicaid Services (CMS) distinguishes entities that are "legally liable" for payment of services covered under the Medicaid State Plan from entities that have a general responsibility to ensure needed access to health care.[22,23,24,25] Medicaid is the payer of last resort in reference to legally liable entities. However, Medicaid pays before entities that have only a general responsibility to ensure access to health care. Given that ECE programs are not considered legally liable third parties for health care costs, Medicaid payment should precede ECE program payment for health care services.[26]

A joint policy statement from the U.S. Department of Health and Human Services and the U.S. Department of Education, "Policy Statement to Support the Alignment of Health and Early Learning Systems," provides strong encouragement for collaboration.[27] Its recommendations emphasize building on existing structures to establish and sustain alignment across health and early learning programs, and co-locating services to meet families where they are. The joint policy statement describes school-based health centers as a model for embedding health supports in education settings for preschool-age children. It suggests that "[s]tates and communities can promote the expansion of school-based health centers in elementary schools, and encourage these centers to serve preschool- and school-aged children enrolled in the school, and also the broader community, including parents, infants, and toddlers who may be siblings of students at the school." A future area to explore is how ECE programs, particularly those co-located with elementary schools, might become party to a school district's existing contract with Medicaid.

As described above, the three states were interested in ways screenings or other health services delivered in ECE settings might be covered by Medicaid. CMS' issuance of guidance on "free care" in December 2014 facilitates this.[28] CMS enables Medicaid to reimburse school districts for delivery of health care services. The services must be furnished by a Medicaid provider to Medicaid-enrolled students. Previously, Medicaid payment was not allowed for services—including school health services—provided free of charge to the community (or school) at large. CMS withdrew that guidance, so that there is no longer any prohibition of Medicaid payment for covered services delivered to eligible individuals by qualified providers, even if the services are provided without charge to the community at large. Many states are reviewing their Medicaid State Plans to determine if any changes are needed to their school health services.

In 2019, Nemours is continuing to provide technical assistance to several states to increase collaboration across health care and ECE and advance upstream prevention. A potential area of future work is development of a toolkit to help the ECE sector leverage its existing data to evaluate trends relevant to the health care sector.

Conclusion

Cross-sector collaboration is not easy, but it is valuable to promote the well-being of children, better serve families, and efficiently use public resources. Federal rules provide a facilitating framework for collaboration across the health and ECE sectors. The experience from three states helps to highlight strategies other state Medicaid agencies and MCOs might consider to promote greater connection across health and ECE.

Appendix A: Maryland Pilot Draft Detailed Workflow

Step One

- **Identification of Target Population**
  - Head Start Family Service Coordinator completes **nutritional counseling intake form**, verifying child's Medicaid eligibility and MCO enrollment and medical necessity of nutritional counseling.
    - All information available in Head Start records
    - BMI at or above 85th percentile, based on height and weight.

      BMI at or above 85% percentile is the medical necessity threshold for nutritional counseling.

Step Two

- **Outreach to Families**
  - Head Start Family Service Coordinator contacts families of eligible children (by phone or in person) regarding opportunity to receive nutritional counseling services at the Head Start site at no cost
    - Contact and parent/guardian interest and consent to share contact info with [dietitian practice] documented on **nutritional counseling intake form**
    - **1-page information sheet** is a resource for Family Service Coordinator when reaching out to parents/ guardians

Step Three

- **Referral and Coordination**
  - For families responding "yes," Head Start Family Service Coordinator *faxes or emails* **nutritional counseling intake forms** to [dietitian practice]
  - Family Service Coordinator and [dietitian practice] identify possible dates, times, frequency for individual and group sessions
  - [Dietitian practice] calls parents/guardians to provide introduction and schedule initial assessment
  - [Dietitian practice] informs Family Service coordinator of schedule for individual assessments

Step Four

- **Initial Dietitian Assessment**
  - [Dietitian practice] conducts individual assessment with each child and parent/guardian to identify needs and strengths and determine goals and care plan
    - [Dietitian practice] asks parent/guardian to identify pediatrician, and lets parent/guardian know she'll share care plan with pediatrician
  - Care plan documented according to requirements below *
  - Method of sharing care plan at discretion of [Dietitian practice] and pediatrician (i.e., fax, email)
  - Initial assessments help inform the content of individual/group sessions
  - [Dietitian practice] tracks parent/guardian participation and shares with Family Service Coordinator for Super Store point allocation
  - [Dietitian practice] bills MCO for individual nutritional counseling (97802)

Step Five

- **Group Counseling**
  - [Dietitian practice] conducts eight group counseling sessions, structured as follows:
    - Individual assessment, first four group sessions, individual reassessment, second four group sessions, final individual assessment
    - Group does not close to new participants because it's delivered to entire class
    - [Dietitian practice] holds classroom group sessions for all children in the class
    - [Dietitian practice] develops related information for Head Start to send home (Head Start makes copies)
    - [Dietitian practice] documents group sessions in eligible children's care plans
    - [Dietitian practice] tracks parent/guardian participation and shares with Family Service Coordinator for credit towards incentive program.
    - [Dietitian practice] bills MCO for individual nutritional counseling (97802) only for children meeting BMI criteria and enrolled in the MCOS, per Eligibility Verification System on date of service
    - Head Start confirms school attendance on date of services

Step Six

- **Individual Reassessments**
  - Conducts individual reassessments (97803) after the **fourth and eighth** group counseling sessions
  - [Dietitian practice] calls parents/guardians to schedule reassessment to assess progress towards goals
  - [Dietitian practice] informs Family Service coordinator of schedule for reassessments
  - [Dietitian practice] conducts reassessments and documents in care plans
  - [Dietician practice] sends care plan and consultation summaries or appropriate progress notes to child's pediatrician, per the MCO's provider guidelines.

* **Care Plan Documentation**

Must include date and at least one of the following:

- Discussion of eating habits and/or dieting preferences.
- Statement "Patient has an adequate diet or well-balanced diet."
- Checklist indicating nutrition was addressed.
- Counseling or referral for nutrition education, weight or obesity.
- Member received educational materials on nutrition during a face-to-face visit. Obtain a copy of documentation.
- Anticipatory guidance for nutrition
- Services count if the specified documentation is present, regardless of the intent of the visit.

Non-acceptable Documentation

- Notation of "health education or "anticipatory guidance" without any specific mention of nutrition.
- A physical exam finding or observation alone (e.g., well-nourished) does not indicate counseling nutrition.
- Statement "Healthy lifestyle habits."
- Documentation related to a member's appetite
- Assessment of an acute or chronic condition
- Notation of "well-nourished" in the physical exam/doctor's observations.

Appendix B: Washington, D.C. Template for System Handoff and Tracking Pathways

	ECE Referral Pathway*	Medicaid MCO Referral Pathway**
Initial Developmental Screening	All community based Early Head Start Children supported by the Quality Improvement Network (QIN) are screened by their classroom teachers using standardized screening tools (i.e., ASQ and ASQ-SE) within the first 45 days of the child's enrollment at the center. Screenings are completed at regular intervals after enrollment.	Primary care providers (PCPs) provide well-child visit. DC Medicaid requires PCP to do developmental screening at 9 months, 18 months and 30 months. The MCO does not require pre-authorization if specialty services are needed.
Screening results reviewed	The QIN coach (early learning specialist) reviews the screening results and inputs them into the Child Plus database where information on all screenings (e.g., vision, hearing) conducted for EHS children are stored.	
Children with abnormal screening results are flagged	The coach flags any concerns about results of the screening and informs the center director.	Children are flagged if there is a gap in care (e.g., preventive health care, pharmacy care) or the child has a diagnosis (e.g., chronic disease).
Referral to specialty services	If the screening results indicate concerns, the coach, teacher and the center director meet with the parents to share results and determine next steps. They may decide to re-test the child in two months. In that case, they may develop classroom strategies for the teacher or strategies for parents to work on at home. Alternatively, the child may be referred to Strong Start, DC's Part C (of IDEA) Early Intervention Program for evaluation, with parental consent. The Center Director is also responsible for explaining the process and obtaining consent from the parent for sharing information with Strong Start. In addition, they have the option to ask a parent to complete a medical release form to share the information with the pediatrician though this does not always happen.	If a child has a diagnosis (of any kind), then the MCO will offer case management. It is an opt-in process so the family can refuse. If the family accepts, the case management team formally assesses their needs and creates a plan. • The MCO does a pediatric assessment ranging from SDOH screening to physical and mental health history. The SDOH is a set of questions within the initial assessment. If the child has a chronic disease, the assessor does an additional disease specific assessment. • Based on the assessment, the MCO develops an individualized plan of care with the parent including short- and long-term goals. • Some of the services might include setting up appointments, setting up transportation, coordinating pharmacy orders, connecting them to community resources, educating on self-management, specific needs of family such as housing or food. They use a tool called Aunt Bertha which allows them to refer families based on specific needs by zip code. They also can track referrals, referral type, and referral locations as well as whether families sought services.
	ECE Referral Pathway	Medicaid MCO Referral Pathway

* This is an example of the pathway in one ECE center in DC.

** This is an example of the pathway in one Medicaid MCO in DC. It does not reflect the pathway during the aforementioned pilot.

Reporting to DHCF on children referred to Strong Start		The MCO provides a monthly report to DHCF on children with developmental delays who are referred to Strong Start (Part C of IDEA). Whenever a child enrolled in the MCO gets referred to Strong Start, they get a notification through the Strong Start Child and Family Data System (SSCFDS). The MCO then looks for a provider to do an evaluation for eligibility for Strong Start. The MCO captures the number of children with developmental delays, the number enrolled in Strong Start and the number of families who withdraw from the process. They also track families who disenroll from the MCO to see if it is for failure to recertify for Medicaid and, if so, will help the family re-apply and enroll. They also track children who are deemed not eligible for Strong Start.
Follow up after referral	If the child is referred to Strong Start, the parent and Strong Start are responsible for further follow up services. The Center Director is responsible, with support from the coach and family engagement specialist, for all follow up to ensure that the child is evaluated and to support the family since children will stay in EHS for up to three years. For example, they will request a copy of the IFSP. The center director and coach will stay involved with the families as the children age out and transition into the school system. If the child is evaluated and found eligible for Part B or Part C services, a meeting will be scheduled with parents to determine a service plan (IEP for Part B, IFSP for Part C). The center director should ensure the child's teacher is present at the meeting and the plan includes classroom strategies.	The services that the MCO offers to families are exactly the same if they are on Strong Start or not. (The MCO finds it more difficult to connect with families enrolled in Strong Start because their key contact for coordination is with OSSE so the families are more engaged with OSSE than the MCO team. For families not involved with OSSE, the MCO finds it easier to engage them since they can be the advocate.)
Children found ineligible for Strong Start	The center continues to assess developmental milestones through screening and addresses any weaknesses in a child's growth and development in the child's individual plan, especially when they are deemed ineligible.	The MCO will reach out to families that are deemed ineligible for Strong Start or who withdraw from Strong Start as they assume these families may be in need of case management services.

Note: Not all children who are eligible to receive services receive them through Strong Start. Some parents opt to receive the services through private providers.

Endnotes

1. Georgetown University Health Policy Institute Center for Children and Families. Webb, C. Tackling Health Barriers to Learning – Does Your State Mandate Student Health Screenings? January 29, 2018. Available at: https://ccf.georgetown.edu/2018/01/29/tackling-health-barriers-to-learning-does-your-state-mandate-student-health-screenings/
2. Georgetown University Health Policy Institute Center for Children and Families. Burak, EW and Odeh, M. Developmental Screenings for Young Children in Medicaid and the Children's Health Insurance Program. March 6, 2018. Available at: https://ccf.georgetown.edu/2018/03/06/developmental-screenings-for-young-children-in-medicaid-and-the-childrens-health-insurance-program/
3. Taylor L.A., Tan A.X., Coyle C.E., et al. Leveraging the social determinants of health: what works? PLoS One. 2016;11(8):e0160217. DOI: 10.1371/journal.pone.0160217. Available at: https://sirenetwork.ucsf.edu/tools-resources/resources/leveraging-social-determinants-health-what-works
4. CMMI InCK Model Fact Sheet available at: https://www.cms.gov/newsroom/fact-sheets/integrated-care-kids-inck-model.
5. The definition of early care and education (ECE) for this issue brief includes environments serving children from birth through age five and their families, inclusive of child care, Early Head Start, Head Start, and other pre-kindergarten settings.
6. Available at: https://www.movinghealthcareupstream.org/medicaid-payment-strategies-for-financing-upstream-prevention/
7. Available at: https://www.improvingpopulationhealth.org/Integrator%20role%20and%20functions_FINAL.pdf
8. Available at: https://www.movinghealthcareupstream.org/wp-content/uploads/2018/06/embedding-medicaid-dieticians-in-head-start.pdf
9. Available at: https://www.movinghealthcareupstream.org/wp-content/uploads/2018/06/medicaid-and-head-start.pdf
10. CFR Section 438.208
11. From: https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-care-coordination-strategy-guide.pdf
12. Ibid.
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15. From: https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-care-coordination-strategy-guide.pdf
16. See D-207 Dental Screening. https://www.dcyf.wa.gov/sites/default/files/pdf/eceap/2018-19_ECEAP_Performance_Standards.pdf
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21. https://www.movinghealthcareupstream.org/wp-content/uploads/2018/06/implementing-social-determinants-of-health.pdf

22. CMS. State Medicaid Director Letter #14-006 Re: Medicaid Payment for Services Provided without Charge (Free Care). Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf

23. CMS. Medicaid Third Party Liability & Coordination of Benefits. Available at: https://www.medicaid.gov/medicaid/eligibility/tpl-cob/index.html

24. MACPAC. How Medicaid interacts with other payers. Available at: https://www.macpac.gov/subtopic/how-medicaid-interacts-with-other-payers/

25. CMS. Medicaid and CHIP FAQs: Identification of Medicaid Beneficiaries' Third Party Resources and Coordination of Benefits with Medicaid. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/faq-09-04-2014.pdf

26. State laws have flexibility to mandate how individuals get services, but even if state law requires schools to cover health services, federal statute requires Medicaid to be the primary payer for IEP or IFSP services.

27. Available at: https://www2.ed.gov/about/inits/ed/earlylearning/files/health-early-learning-statement.pdf

28. CMS. State Medicaid Director Letter #14-006 Re: Medicaid Payment for Services Provided without Charge (Free Care). Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf

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