State and Federal Officials Explore Opportunities to Promote Healthy Child Development in a New Era

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Introduction

There is increasing recognition of the significant impact of early child development on long-term health and well-being. State and federal policymakers share the goal of reducing adverse childhood experiences and other risks that hinder children's ability to reach their full potential for health, education, and economic prosperity. They concur that the earlier developmental concerns are identified, the more likely they can be addressed to improve success for children and families. Recently, multiple federal proposals have included substantial changes to Medicaid funding and other programs that promote healthy child development (e.g., child nutrition programs, family support, social services block grant, and Temporary Assistance for Needy Families - TANF). In this critical time of increased scrutiny and potential cuts to key programs, federal agencies can collaborate to reduce barriers to state innovation and continue to support increased flexibility for states to innovate.[1] Moreover, states can look to their peers for efficient, innovative delivery system models, data, and payment initiatives that promote healthy child development while maximizing state resources.

Investments in young children can yield long-term returns by improving the likelihood they will succeed in school and have the health and social-emotional development needed to qualify for and succeed in jobs, the armed services, and other paths when they are adults. Studies show benefit-cost ratios typically range from $2 to $4 for every $1 invested in early childhood programs, such as early care and education and home visiting.[2]

Because Medicaid covers the majority of young children, it plays a crucial role in promoting healthy child development. The Medicaid program serves 52 percent of the prenatal to age three population in United States.[3] In 2016, more than 90 percent of children from birth to age five accessed some type of medical care, making health care settings a prime venues for reaching young children.[4] Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit enables coverage for a broad range of services and emphasizes early identification and prevention across physical, mental, developmental, and oral health needs. However, Medicaid alone cannot meet all of the needs of young children, necessitating a coordinated, cross-sector approach that includes health care settings and other early childhood programs and agencies, some of which have oversight of community-based and childcare settings.

State and federal policymakers can promote early child development through well-child visits and appropriate identification, prevention, early intervention, and treatment services for young children. Medicaid programs, in combination with other state and federal programs such as maternal and child health block grants, home visiting programs, infant and early childhood mental health, Early Head Start and Head Start, Part C Early Intervention, and others, can help low-income, young children and their families through two-generation (2Gen)[5] approaches. These provide services to children and the adults in their lives simultaneously and support families in living healthy and productive lives. Medicaid funding

reductions would not only affect states' ability to provide medical services, they would impact their ability to partner with many other state programs that foster healthy child development by delivering screening, assessment, treatment, home visiting, and/or other essential services for young children and their families.

In December 2017, the National Academy for State Health Policy (NASHP) convened state and federal leaders across child-serving agencies, with support from the David and Lucile Packard Foundation, to discuss innovative approaches to advance and prioritize young children's healthy development in a new federal era. Officials shared strategies for leveraging innovative delivery systems, data systems, and financing to promote the healthy development of young children. During the meeting, participants discussed areas in which states need additional flexibility from the federal government to improve care for young children, and described the areas in which they have opportunities to expand their use of existing flexibility. They also explored how state agencies (e.g., Medicaid, Title V, Part C Early Intervention, and education) can collaborate to ensure access to and improve care for young children and parents/caregivers, and how federal agencies can support improved collaboration at the state level.

This document reports on some of the policy levers states are using to improve systems that serve young children, and examines them in the context of possible policy changes under the new Administration. While Congress recently provided long-term funding for the Children's Health Insurance Program (CHIP)[6] and the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program,[7] the future of Medicaid and public health funding remains uncertain. Key recommendations from the meeting that can inform policymaker efforts to efficiently promote healthy child development include:

Delivery System Strategies

- Consider 2Gen strategies to support young children in the context of their families.
- Leverage new health care delivery system models designed to improve care coordination and address social determinants of health.
- Capitalize on the multiple opportunities available to coordinate across systems and service settings to promote healthy child development.

Data Strategies

- Link data from a variety of systems to better understand children's needs and service capacity to address identified needs.
- Develop and clearly communicate a shared rationale for and intended use of an integrated early childhood data system.
- Monitor both individual-level and population-based data for child health and well-being.
- Forge new ground in early childhood outcome measures, such as follow-up to developmental screening, kindergarten readiness, well-being at age three, and 2Gen measures.
- Leverage and learn from emerging data sharing and matching initiatives with implications for children's healthy development.

Payment Strategies

- Pay for desired outcomes.
- Leverage value-based payment (VBP) opportunities, but tailor them to meet children's and families' needs, and remember that impact might not be measurable in the short term.
- Draw from multiple funding streams, and blend, braid, and maximize funds.

Delivery System Strategies

This is an opportune time for states to consider mechanisms to leverage health care delivery system reforms to ensure they meet the needs of young children. States, in partnership with the federal government, have undertaken a variety of reforms, often through federally-funded initiatives such as Delivery System Reform Incentive Payment (DSRIP)[8] and State Innovation Model (SIM) programs[9] to improve the health care delivery system.[10] These reforms often include leveraging Medicaid authorities to focus on improving quality, reducing costs, and improving health, including efforts to reduce health disparities and address social determinants of health.

Although these programs tend to focus on high-cost populations, they have implications for improving care for young children. Care coordination is an essential component of these efforts. State leaders may consider using state and federal policy mechanisms and lessons from care coordination initiatives to develop innovative delivery system models that provide coordinated screening, referral, and treatment services for young children.

Consider 2Gen strategies to support young children in the context of their families. Because child health is closely intertwined with parental (or caregiver) health, healthy child development is enhanced by parents who are physically and mentally healthy and able to provide nurturing care. States are exploring and have successfully piloted two-generation approaches to support children and their family members through home visiting, primary care, early learning, and services that address health-related social needs. NASHP has reported on a variety of ways that more than a dozen states use Medicaid to finance home visiting.[11] Authorized under its 1115 Health Choice Waiver, **Maryland** is piloting an approach that uses local resources to expand use of two evidence-based home visiting models -- Nurse Family Partnership and Healthy Families America. These programs provide increased opportunities to support Medicaid beneficiaries from pregnancy through age two and for early screening, referral, and care coordination. In recognition of the impact of maternal mental health on children's social-emotional development, **Minnesota**'s Departments of Health and Human Services (Medicaid) are collaborating on a quality improvement project that helps pediatricians incorporate maternal depression screening and referral into well-child visits.[12] The American Academy of Pediatrics recommends[13] and the Centers for Medicare & Medicaid Services (CMS) encourages[14] maternal depression screening during well-child visits.

A two-generation approach is a key component of **Colorado**'s Opportunity Project, a cross-agency systematic approach to foster health, educational attainment, and economic self-sufficiency for low-income residents. As part of the initiative, state government is encouraged to identify sources of flexible funding that can be used to advance 2Gen strategies and determine if there are policy or programmatic barriers to providing services for parents and children simultaneously. The project created a common set of performance indicators and evidence-based interventions for use across agencies. The interventions identified to support early childhood include early literacy and prevention programs, patient-centered medical homes, consistent well-child checks, and programs to help children with physical, emotional or intellectual risks.[15] The Opportunity Framework is being aligned with the newest stage of Colorado Medicaid program's reform, which includes a 2Gen approach by focusing on the health of enrolled children and their caregivers, when appropriate. A small section of this newest phase focuses on non-medical factors that affect health, such as housing, child care, and education. This phase encourages health care providers to collaborate with schools and communities.[16]

Leverage new health care delivery system models designed to improve care coordination and address social determinants of health. Health care delivery system reforms often include care coordination across care settings as a key strategy to improve care and reduce costs. Physical and behavioral health integration is often a critical feature of these reforms. Enhancing care coordination by establishing seamless referral and follow-up procedures for developmental screening and by co-locating services such as primary care and behavioral health are two promising approaches. **Colorado**'s new phase of Medicaid reform has among its core objectives an initiative to connect physical and behavioral health services under one accountable entity, called a Regional Accountable Entity or RAE, and to strengthen coordination of services through team-based care. RAEs will have an expanded scope that includes promoting the population's health and functioning, coordinating care across disparate providers, and collaborating with social, educational, justice, recreational and housing agencies to foster healthy communities and address complex child and adult needs that span multiple agencies and jurisdictions. These efforts build on more than a decade of work on early childhood mental health for Colorado's young children.[17]

New York's Medicaid redesign requires health care providers to partner with community-based organizations to address social determinants. One collaborative, for example, includes partnerships between health care providers and a community-based perinatal network, and another supports a fruit and vegetable prescription program. In **Massachusetts**, the federally-funded Project LAUNCH[18] integrates early childhood mental health services into pediatric primary care medical homes by providing enhanced screening and assessment for young children to identify social, emotional, and behavioral problems and provide services and referrals. A 2016 evaluation showed declines in both participating children's risk level for social, emotional, or behavioral problems and caregivers' stress level.[19] In more than 20 states, Help Me Grow grantees provide a systems approach to designing a comprehensive, integrated process to ensure early identification, referral, care coordination, and service linkages to promote healthy development and address developmental concerns.[20]

Capitalize on the multiple opportunities to coordinate across systems and service settings to promote healthy child development. The delivery system, in the context of health reform, is commonly considered to include sites that deliver health care services, so that opportunities for improving care and reducing costs across settings is often conceived as between primary care, behavioral health, and acute care settings (e.g., hospitals and long-term care facilities). However, addressing the developmental needs of young children requires consideration of a broader array of services for children and families. Rather than identifying new services in a time of diminishing resources, states can focus on integrating networks of systems around place-based activities and take advantage of existing resources to promote child development.[21] States can also use policy levers to integrate, align, and monitor progress toward ensuring high-quality child-care settings, primary care medical homes, home visiting programs, and Early Childhood Comprehensive Systems Impact grant programs (ECCS-I), **New York** leaders worked across systems and silos in a public-private process that set out a First 1,000 Days agenda for Medicaid. The 10 high priority proposals – ranging from home visiting and early childhood mental health consultants to dyadic therapy and family navigators – include elements with an array of costs but with high likelihood of promoting healthy child development statewide.[22]

In **Oregon**, Coordinated Care Organizations,[23] Early Intervention agencies, and Early Learning Hubs[24] share a common goal of achieving school readiness. Developmental screening is an incentive metric for Coordinated Care Organizations, a requirement of primary care practices that wish to become recognized as patient-centered medical homes (PCMHs), known as patient-centered primary care homes in the state, and included in the first set of reporting requirements for Early Learning Hubs. Child-care

centers also must conduct developmental screening to obtain high quality ratings. These metrics in varied systems have created motivation to focus on cross-system collaboration and communication and enhanced focus on follow-up after screening and pathways to early learning supports. **Vermont**'s Children's Integrated Services, which receives Medicaid financing under a global waiver, offers Early Intervention, family support, and prevention services for the healthy development and well-being of children up to age five. The services are family-centered and delivered through a network of community-based agencies that receive capitated funding.[25]

Data Strategies

Data are critical to monitoring, understanding, and addressing factors affecting young children's healthy development. Gathering a complete picture of a child's health and well-being, or the health and well-being of children overall, may depend on having information from any number of agencies and programs that serve young children, such as Medicaid/CHIP, Title V, education, public health, Part C Early Intervention, child welfare, Head Start or Early Head Start, other child-care programs, and WIC. Some data may come directly from parents.[26] A 2016 joint report by the US departments of Education and Health and Human Services draws on the efforts of nine states to synthesize key themes and considerations for integrating early childhood data across many of these programs.[27] Information about social determinants of children's health, such as housing or substance use in the household, may be found in other programs or systems. To develop a more comprehensive picture of children's health and well-being at the individual and population level, states are exploring integrated data systems and new measures.

Link data from a variety of systems to better understand children's needs and service capacity to address identified needs. A handful of states, some with foundation support, are launching integrated data systems with information from health care and early care or education providers. Most data-linking efforts are still evolving, and there is limited information about how states use their linked data, yet, they hold potential for program and system improvement. **Georgia**'s Department of Early Care and Early Learning (DECAL) developed the Cross Agency Child Data System (CACDS), a longitudinal data system that houses birth to age five data from multiple child-serving government funded programs and organizations.[28] This integrated data system provides a detailed picture of service distribution across the state and allows stakeholders to better understand participation trends in critical services and programs. The data can be matched across multiple programs, services, and other data sources. CACDS has the potential to link data from Georgia's early childhood data system to the state's pre-K-through-workforce longitudinal data system, Georgia's Academic and Workforce Analysis and Research Data System (GA AWARDS).[29] Through data sharing agreements with DECAL and unique identifiers provided by GA AWARDS, CACDS can provide information about various programs that serve young children and their families, especially those with high needs. Data contributors include Head Start and Early Head Start grantees, foster care, preschool special education, Part C Early Intervention, Children 1st (single entry point for public health services),[30] and the pre-K program.

The **Utah** Department of Health (UDOH) is in the process of launching its Early Childhood Data System (ECIDS). It is anticipated that Utah's ECIDS will include developmental screening data, Medicaid/CHIP data, and additional early childhood data from Part C Early Intervention, Help Me Grow Utah (an information and referral helpline for parents and providers),[31] Head Start grantees, child-care, home visiting and the Special Supplemental Nutrition Program for Women Infants and Children (WIC). Utah's ECIDS will interact with the states' Longitudinal Data System in order to facilitate outcome-based research related to the impact of early intervention on school readiness and continued school and life success. With support from the W.K. Kellogg Foundation and the University of Pennsylvania, UDOH also is constructing an interactive, dynamic data tool that will complement ECIDS data reports. This data tool will

provide valuable birth to age five population information, poverty and race/ethnicity data along with risk factors at birth data. It also will display early childhood services available throughout the state.

Develop and clearly communicate a shared rationale for and intended use of an integrated early childhood data system. States seek to develop integrated data systems for a variety of reasons, including ongoing population monitoring and to improve quality of care or services for children. The rationale affects the parameters of a data system, including the unit of measurement and who can access data. A system designed to help providers from different systems track the services they provide to individual children will require different privacy settings and data fields compared to a system designed to help school districts monitor county-wide performance in a public health metric (e.g., documenting kindergarteners' immunization status). With ECIDS, **Utah** aims to address five key policy questions.[32]

- Are children birth to age five on track to succeed when they enter school?
- Which children and families are and are not being served by which programs and services?
- What program features are associated with positive outcomes, and for which children?
- What are the education and economic returns on early childhood investments?
- How are data currently used and how will data be used in the future to inform policy and resource decisions?

Participants noted the importance of early transparency and consensus about how data will be used and what the information represents. Unclear or shifting guidance can lead to mistrust and concern among participating programs and providers. Child-serving providers and programs agree to share their data within a specific context, and any changes to a system, such as new access for a particular program or the introduction of additional data elements, without agreement among all partners can affect program or reduce a provider's willingness to share information.

Some states develop a structure to bring stakeholders together to identify a shared rationale and reach consensus about how data will be used. **Rhode Island** created state governance for its Early Care and Education Data System (ECEDS) through its Race to the Top Early Learning Challenge grant from the US Department of Education.[33] Similarly, **Vermont** has a council for its state data system, and the **Georgia** Children's Cabinet oversees the state's Cross Agency Child Data System.[34] These mechanisms can provide a neutral forum for advisors, stakeholders, and agency representatives to discuss and outline processes for addressing sensitive, yet critical, data-sharing concerns. A description of the purpose and any limitations of system data helps clarify what the system information does and does not show about a program, a provider, a service, or a geographic region.

Monitor both individual-level and population-based data for child health and well-being. As noted above, some states focus data-sharing and integration efforts on aggregate population monitoring, which allows the information to be publically available. **Vermont** Insights, for example, includes child-care and kindergarten readiness data that local Head Starts and others regularly access. Some stakeholders wonder if individual-level data are needed to fully understand barriers to care or gaps in services. At the same time, introducing individual-level data raises privacy concerns. Health care and education data privacy laws[35] continue to be a challenge for officials seeking to link health care and education data. For example, **Georgia**'s system (CACDS) does not include health data due to difficulty addressing health care privacy law concerns. Ultimately, participants agreed that individual-level data are important for tracking children across systems, and population-based data are necessary for assessing overall improvement among children in a state.

Forge new ground in early childhood outcome measures, such as follow-up to developmental screening, kindergarten readiness, well-being at age three year, and 2Gen measures. To gain a more accurate and complete picture of children's health and well-being, states need outcome measures. As noted previously, states need access to data from a variety of state programs and systems in order to measure outcomes. Ultimately, health care system data can identify acute health care needs (potential developmental delays or health problems), but services needed to address that need might fall outside of the health care system. Moreover, the benefits of early identification or prevention for children are also likely to fall outside of the health care system (e.g., reduction in special education or juvenile justice spending). Tracking and demonstrating improvement in outcomes requires a comprehensive analysis of data across these systems. With more and more state Medicaid agencies considering social determinants, and state agencies exploring connections between adverse childhood experiences, trauma, and health, meeting participants said they feel confident that the nation is closer than ever to implementing meaningful outcome measures for healthy child development. Data on social determinants shed light on family and environmental context (such as housing and trauma), and enable states to consider children and their parents/caregivers as an interdependent unit. Exploring data with this two-generation lens opens the door to showing return on investment or improved outcomes. The collective information might help demonstrate the amelioration of underlying issues, such as food insecurity, unsafe housing, or home environment, that contribute to children's health and development and cannot be captured by a single system.

Oregon has been at the forefront of health care and early learning reform,[36] and is a leader in advancing the Developmental Screening in the First Three Years of Life measure included in CMS' core set of children's health care quality measures.[37] Oregon has had a Medicaid incentive metric for developmental screening in place since 2013,[38] and managed care performance improvement projects focused on referral follow-up and care coordination after a positive developmental screening.[39] Through these efforts, Oregon's Medicaid agency and key partners have helped providers and accountable care entities monitor their performance data and identify areas for improvement. The focus of developmental screening within Early Learning Hubs has stimulated data-sharing efforts related to developmental screenings conducted in home visiting, early Head Start, Head Start, and child-care settings.[40] The committee tasked with identifying potential measures for the state's Coordinated Care Organizations has requested the development of a metric focused on kindergarten readiness. The Children's Institute, with support from the Oregon Health Authority, will convene a Health Aspects of Kindergarten Readiness Technical Workgroup beginning in 2018.[41] The purpose of this new technical workgroup is to identify and recommend a health system accountability measure that:

- Drives health system behavior change, quality improvement, and investments that meaningfully contribute to improved kindergarten readiness;
- Catalyzes cross-sector collective action necessary for achieving kindergarten readiness; and
- Can be applied to services provided by coordinated care organizations or paid for by health benefit plans sold through the health insurance exchange or offered by the Oregon Educators' Benefit Board or the Public Employee's Benefit Board.

This workgroup will tackle the difficult and important work of clarifying the health system's role in improving kindergarten readiness and how it can be measured. Questions remain, such as:

- How does a state decide who can be held accountable for which parts of the outcome?
- And, how does a state capture the health and non-health elements of kindergarten readiness?

Colorado has implemented C-Stat, a performance-based analysis strategy that uses data to identify areas of focus, measure impact, and improve collaborative decision-making. The Office of Early Childhood has identified three outcomes to improve access to collaborative, coordinated, quality early childhood programs, and support to children and families:

- School readiness – all Colorado children are ready for school;
- Safe, stable, and nurturing environment – all Colorado children develop positive relationships within safe and stable environments free of toxic stress; and
- Resilience in early childhood – all Colorado children have the tools necessary to successfully adapt and overcome challenging situations and/or stressful environments.

Another outcome measure policymakers can consider is well-being at age three. The Health Resources and Services Administration's ECCS-Impact Grant Program aims for participating communities to show a 25 percent increase in age-appropriate developmental skills among three year-old children in their communities.[42] National experts also recently discussed child well-being indicators and measures including "flourishing by [age] three."[43]

Leverage and learn from emerging data sharing and matching initiatives with implications for children's healthy development. Several participants noted they had statewide data-sharing initiatives in place that were not singularly focused on children's health, but that brought together key stakeholders who tackled foundational issues related to sharing information for individual and population level improvement. For example, the opioid crisis has led several states to develop databases or data systems that draw from multiple agencies and programs serving individuals in need. In **Massachusetts**, Chapter 55 of the Acts of 2015[44] mandated an examination of trends in opioid prescribing, treatment, overdoses, and deaths to address specific questions about the crisis. As a result, the state developed a comprehensive analysis of data from five different agencies that required matching data from multiple systems, including birth and death records, post-mortem toxicology reports, medical claims, prescriptions for scheduled medications, and data related to cancer staging, ambulance trips, substance abuse treatment, and incarceration and treatment.[45] Interestingly, the Chapter 55 datasets were cross-walked rather than "truly linked" or "actually merged."[46] This strategy could minimize the risk of re-identifying individuals with information in two or more datasets. Additionally, the unique identifiers in each dataset are not recorded in any other project, which means if a data breach occurred, the information could not be linked back to a source data file. These might be helpful considerations for using data from multiple datasets for 2Gen approaches.

Colorado recently released its first *Health Information Technology Roadmap*, a plan designed to improve and enhance existing health information technology infrastructure and leverage innovation to attain the best health for all Coloradans. Priority initiatives include supporting care coordination in communities statewide, harmonizing and advancing data-sharing capabilities, integrating behavioral, physical, claims, social, and other health data, and creating an approach that can uniquely identify individuals across multiple systems and points of care. States also are connecting disparate data systems through federal programs such as the State Innovation Models (SIM) initiative. Participants wondered if these data sets and emerging data initiatives might open the door to exploring community-level data to match parent/caregiver and child needs, and then match those needs to available services as a way to implement 2Gen approaches that consider children (and adults) within the context of their families.

Payment Strategies

Payment is a primary driver for enabling providers across a variety of systems and programs to deliver the services that are fundamental to young children's health and development. Increasingly, pay-

ment also has become a mechanism to drive quality improvement and attention to population health.[47] Meeting participants underscored the role of payment in calling attention to healthy child development. One participant commented, "There was a palpable shift when money was tied to [a service supporting healthy child development]." Several states are implementing innovative pediatric-focused payment strategies that facilitate coordination of cross-agency health and health-related services for young children and reflect the nation's movement toward health care payment models that reward value (high quality care at a reasonable cost).

Pay for desired outcomes. State Medicaid agencies reward providers and accountable or managed care entities for supporting healthy child development, for example, by increasing children's access to critical preventive services. As noted earlier, **Oregon** Medicaid includes developmental screening as an incentive measure that carries extra payment if providers and Coordinated Care Organizations meet performance thresholds. States also can link PCMH components (e.g., tiering and recertification criteria) to processes and services that support healthy child development.[48] In other words, states can set guidelines to ensure that provider eligibility for enhanced payment meets specific pediatric services delivery, such as referral follow-up and care coordination after positive developmental, social-emotional, autism, or other screenings, or linking children and families to community supports. **Connecticut** Medicaid offers enhanced payments to PCMHs for meeting benchmarks on pediatric quality measures, such as developmental screening and well-child visits.[49] Oregon Medicaid also requires PCMHs to meet specific criteria for mental health, substance abuse, and developmental services to qualify for higher tiering and enhanced reimbursement.[50] In **Colorado**, Medicaid is one of seven payers offering alternative payment models to practices participating in the state's SIM initiative. To remain in "good standing," pediatric practices must report on a set of clinical quality measures that include depression screening, weight assessment, and counseling for nutrition and physical activity for children and adolescents, maternal depression screening, and developmental screening in the first three years of life. In addition to these examples, meeting participants noted other services that could be enhanced through payment approaches, including coordination of care and integration of care services and behavioral and parenting supports to address children identified with delays before they develop diagnosis and substantial delays.

Leverage value-based payment (VBP) opportunities, but tailor them to meet children's and families' needs, and remember that impact might not be measurable in the short term. Meeting participants echoed what national organizations have noted[51] -- children are not a primary cost driver in Medicaid or CHIP programs and with few exceptions (e.g., ambulatory-sensitive conditions such as pediatric asthma admissions or potentially avoidable operating room use for dental care), high-value pediatric care is unlikely to result in immediate or short-term cost savings. The impact of prevention and early identification on child health, well-being, and development is best measured over time and with consideration for non-medical system interventions and expenses. Despite this, current VBP models require cost savings and a demonstrated return on investment in one to two years.

Both federal and state governments have acknowledged the need to develop VBP models that support healthy child development by encouraging development of coordinated care across health and health-related services. The Center for Medicare & Medicaid Innovation issued a 2017 request for information on pediatric alternative payment model design elements, including integrated service delivery models, payment and incentive arrangements, and measures.[52] The Medicaid Innovation Accelerator Program Children's Oral Health Initiative provides technical support for VBP approaches for children's oral health services.[53] **New York** Medicaid has acknowledged and seeks to address this disconnect between traditional VBP models and the needs of children through a children's advisory group on VBP,

one part of the state's overarching Medicaid redesign. Among the advisory group's recommendations are child-specific VBP principles and a payment model, VBP quality measures (e.g., developmental screening), and future work in VBP for children with medically complex needs.[54] The state has drawn on local and national stakeholder expertise along with state-specific experience, including a VBP pilot in one county that incentivizes pediatricians to collect additional data on developmental screenings and ensure that children are ready for kindergarten.[55] The pilot includes key cross-sector and cross-agency partnerships between health care, education, and early childhood providers.

Meeting participants noted that one of the challenges of moving to a VBP approach is that states often lose the ability to track Medicaid or CHIP claims for specific preventive services that become part of a bundled payment (e.g., tracking CPT 96110 for developmental screening). Participants agreed that unbundling developmental screening or other preventive services remains the most effective way to track the services through claims. Lessons from Medicaid redesign in New York may shed light on strategies to track critical services while promoting value-based care. The New York Department of Health is currently working on dashboards that will provide data to VBP contractors and managed care organizations (MCOs), however, the state encourages providers and MCOs to collaboratively identify ways to use data to support the goals of VBP arrangements because state-level data have a lag time of several months until complete.

Draw from multiple funding streams, and blend, braid, and maximize funds. Because a number of agencies serve young children and families, it makes sense for states to consider options for leveraging the respective program funds to support child health and well-being. Over two decades ago, the **Virginia** General Assembly passed legislation to support at-risk youth by establishing a pool of funds from at least seven different funding streams, including mental health, education, social services, and juvenile justice.[56] Virginia's experience leveraging local, state, and federal dollars may offer a model for states interested in drawing from multiple funding sources to meet the needs of young children.

Through its Section 1115 waiver, **Maryland** Medicaid allows approved Pilot Lead Entities to braid federal home visiting (MIECHV), federal Medicaid, and local matching funds to support evidence-based home visiting models. Drawing from different funding sources allows the state to support all aspects of the models, something one agency or program could not do alone. For example, in order to increase staffing levels necessary to expand services under the pilot, MIECHV funds may be used to pay for initial home visitor training because Medicaid cannot.

As noted earlier, a key component of **New York** Medicaid's redesign is the First 1,000 Days on Medicaid Initiative, a strategic effort to encourage collaboration across health, education, and other systems to support each child's healthy development in the critical first three years of life. A related workgroup has developed a 10-point agenda for improving access to services and outcomes for children on Medicaid in their first 1,000 days of life.[57] One of the 10 proposals is braiding funding from different sources to finance Infant and Early Childhood Mental Health Consultation services by early childhood providers in early care and education settings.

Looking Ahead

States are already leveraging existing authorities to implement a variety of innovations that promote healthy child development. The federal administration's recent emphasis on breaking cycles of poverty, giving children a strong start in life, and helping them reach their highest potential could support greater focus on healthy child development and support for children and families to achieve health and well-being. However, the uncertainty and potential for diminished resources requires states to continuously

innovate and align programs as much as possible. While it is unclear how future federal policies will impact state efforts, participants shared their existing approaches to improve systems that serve young children and recommendations to promote healthy child development through delivery system, data, and payment strategies that leverage opportunities and resources across agencies and partners.

Notes

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