InCK Marks

Medicaid, Managed Care, and Value-Based Payment Systems:

State Roles in Contracting for Healthy Child Development

InCK Marks Working Paper Eight

Child Health Care Transformation Series

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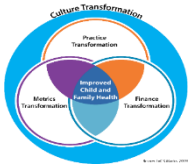
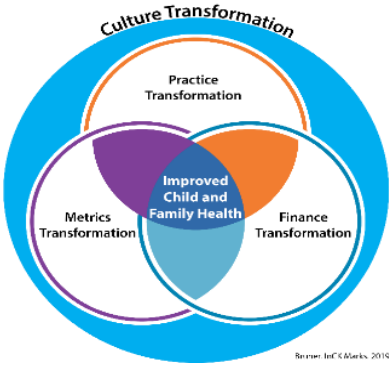


Framework for Transforming Children's Health Care



Children's primary care providers include: pediatricians in solo or group practice, family practitioners in rural and urban clinics, nurse practitioners and physician assistants in community health centers, and others. All aim to be a family-centered medical home.

Research and professional guidelines such as *Bright Futures* point to a need for more family-centered medical homes that emphasize: 1) prevention, attachment, and healthy development, 2) meaningful family engagement, and 3) connections to other services in the community. In addition to providing high quality medical care, child health practitioners are being called upon to identify and initiate responses to social determinants of health, including stress and adversity (economic, social, and psychological). In short, they are being called upon to transform their practice.

Changing the culture of children's primary care will require transformation in practice, measurement, and financing. Most important, transforming child health care will require a culture of practice with emphasis on health equity and long-range outcomes, not short-term costs.

Across the country, exemplary practices demonstrate how to create high-performing medical homes, which deliver more team-based, relational, and family-centered primary and preventive services. We have the knowledge base to move toward broader diffusion and adoption of child health care transformation.

InCK Marks encourages child health practitioners, experts, advocates, researchers, and policy makers to help advance child health care transformation and promote health equity for all children.

- Practice Transformation – Moving toward more high performing, family-centered medical homes with preventive, developmental, behavioral, and other services that respond to both bio-medical and social determinants of health. This includes reaching the standards set by *Bright Futures* and the expectations set by Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.
- Metrics Transformation – Using measures and measurement tools to guide performance and support practice transformation, including those related to the child, home environment, and family strengths and goals. Practice-level measurement tools and system-level metrics are both needed.
- Finance Transformation – Providing financing that recognizes how preventive and primary care for young children can have lifelong positive impact and long-term cost savings across multiple public systems, that rewards the greater value of high performing medical homes over existing practice. This is particularly true for Medicaid financing.
- Culture Transformation – Advancing health equity via transformed medical homes that value and build from family culture, strengths, and goals and are connected to the neighborhoods and communities served. Assuring family-centered care focused on healthy development (cognitive, social/relational, emotional/behavioral, and physical) requires advancing equity and combatting bias in all its forms.

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Preface

Medicaid now covers over forty percent of all children and half of young children (birth to three), and an even greater share of children with special health care needs or vulnerabilities.[1] While half of all persons served under Medicaid are children, however, they represent only one-fifth of overall Medicaid costs. States have given a great deal of attention to expanding coverage for children under Medicaid and its companion federal program, the Child Health Insurance Program (CHIP), but have done much less to enrich the content of that coverage. As states grapple with the costs of the Medicaid program, they often have focused primarily upon adult and high cost populations. They also increasingly have moved toward managed care for their Medicaid populations but often not differentiating in the structure of their contracting for managed care related to the specific health needs of children. The fifth working paper in this series reviewed current state Medicaid contracts with managed care providers for their attention to specific child health issues, concluding that much work still needs to be done to recognize child health needs within state Medicaid contracts.[2]

Current efforts to develop "value-based" payment systems represent both a challenge and an opportunity to children's health care. The challenge is that value-based payment systems designed to contain health care costs for high cost and adult populations are not appropriate for what we know about what constitutes high value child health care. The opportunity is that payment systems which reward high value child health care, even when this requires increased health systems investments, can contribute to improving child health care quality and the trajectory of children's health, with huge benefits over the child's life course.

This working paper provides several different cuts for informing states regarding developing value-based and managed care contracts under Medicaid, which correspond to advancing high value child health.

Chapter One provides an overview of what constitutes high value child health care, with some takeaway messages regarding developing value-based payment systems under Medicaid for child health, based upon current knowledge.

Chapter Two offers a three-step, sequenced approach for states to consider in developing contractual provisions under Medicaid managed care to support high value child health care, with specific reference to young children.

Chapter Three describes elements for states to consider including within Medicaid managed care contracts to advance high value care.

The Appendix offers a perspective on Medicaid agencies themselves and the demands upon them, in providing a context for approaching and supporting them in advancing child health transformation.

The major thrust of this working paper is that, when it comes to children (and particularly young children), advancing high value child health care requires enhanced investments and reimbursements in health and health-related services. Therefore, payment systems that involve capitation for child health services and/or offer incentives based upon containing or reducing Medicaid expenditures will not optimize value in child health care nor improve healthy developmental trajectories. Without specific attention to designing payment systems with the specific needs of children in mind, best practices will not be advanced and high value care will not be realized. This is a time for innovation, diffusion, and developing a transformed systems of child health care, which must not be bounded by the tools developed for adult and chronic care populations.

Acknowledgements and Disclaimer

This working paper was made possible with generous funding from the Robert Wood Johnson Foundation and the Perigee Fund for the establishment of InCK Marks, but all opinions and views expressed are those of the author and not necessarily the funders. The purpose of InCK Marks is to support child health champions – child advocates, practitioner leaders, family and community voices, health experts, Medicaid agency staff, and policy makers – to advance child health care transformation through integrated approaches that build upon evidence and science. InCK Marks itself is a resource network of over twenty-five child health care research, policy, and advocacy organizations. InCK Marks seeks to share resources from Network members and summarize and synthesize the current state-of-the-field in advancing child health transformation.

This working paper is part of a series of working papers on child health care transformation, focusing upon the financing element within the InCK Marks' National Advisory Committee (NAC) framework for child health care transformation. Other working papers are devoted to practice transformation, metrics transformation, and culture transformation. Page Two shows that framework.

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Berwick, D, Nolan, T, & Whittington, J (2008). The Triple Aim: Care, Health and Cost. *Health Affairs.*

Improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. …

Preconditions for this include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organization (an "integrator") that accepts responsibility for all three aims for that population. The integrator's role includes at least five components: partnership with individuals and families, redesign of primary care, population health management, financial management, and macro system integration. …

The components of the Triple Aim are not independent of each other. Changes pursuing any one goal can affect the other two, sometimes negatively and sometimes positively. … The situation is made more complex by time delays among the effects of changes. Good preventive care may take years to yield returns in cost or population health. … Pursuit of the Triple Aim is an exercise in balance. …

[A]ny effective integrator will strengthen primary care for the population. To accomplish this, physicians might not be the sole, or even the principal, provider. [The] expanded role includes establishing long-term relations between patients and their primary care team; developing shared plans of care; coordinating care; and providing innovative access to services through improved scheduling, connection to community resources, and new means of communication among individuals, families, and the primary care team.

Chapter One: Overview and Takeaway Messages

There are various definitions of what constitutes high quality primary and preventive health services for children[3] – but these definitions all extend well beyond what currently is general child health care practice and its reimbursement. They represent a transformation of child health care, particularly in enhancing responses to social as well as medical determinants of health through providing additional health-related services and strengthening family agency in caring for and nurturing healthy child development.[4]

In short, they entail:

- additional screening for children's early developmental concerns and for home and family environments (social determinants of health) that can compromise healthy development;
- establishment of office protocols and environments that are welcoming to children and families and provide additional resource materials and supports related to the child's development (often including books for young children as part of Reach Out and Read);
- greater anticipatory guidance provided during the office visit, based upon the standards established in the 4th edition of *Bright Futures*[5];
- provision of enhanced care coordination for a substantial share of Medicaid children (e.g. one-half of young children[6]) to address social determinants and to support families in responding to children's developmental concerns; and
- referral to and scheduling of additional health-related services, both inside and outside the practice, to address parent and child relationships and respond to developmental concerns (including reimbursement for such programs and services as Healthy Steps, home visiting, and other preventive and treatment services identified by the screening).[7]

There is a growing array of evidenced-based programs and practices which are advancing the field in this direction and there is recognition and support from within the child health practice professions (pediatricians, family practitioners, and other health care practitioners) for this response.[8]

This transformation is reflected in the definition of child health, [9] in the delineation of core principles of operation of a medical home,[10] and in professional standards and guidelines for well-child practice.[11] It is foundational to achieving health equity and reducing preventable disparities by race, place, and socio-economic status.[12]

At the same time, child health care financing largely does not provide reimbursement to provide this level of high-quality primary and preventive health services.[13] While Medicaid includes the Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit which supports such practice, states largely have sought to define EPSDT narrowly and often to provide insufficient reimbursement to providers to both do the additional screening and diagnosis and to finance the treatments indicated by EPSDT screening and diagnosis. There is growing consensus in the field on the need for Medicaid to play a greater role in improving child health through expanding the application of the EPSDT benefit.[14]

To date, much of the movement toward payment reform and health care transformation, both under Medicaid and more broadly, has been directed to adult and to chronic and high-cost populations, often with an emphasis upon containing costs. Much of the work in designing value-based payment systems has been upon achieving equivalent or better health quality and population health outcomes while

containing or reducing health expenditures. Value-based care sometimes has been described as paying for "value" and not for "volume," with the implication that better results can be achieved by alternative (and lesser) treatment approaches than currently employed. In the case of children, and young children in particular, however, improving "value" often involves increasing "volume." When value-based payment reforms are limited to changes in financing and reimbursement that are cost neutral, many effective high value preventive and early intervention services may be left out. The takeaway messages represent a set of assertions to inform state actions to advance value-based payment systems under Medicaid that speak to the specific needs of children and child health care transformation.

Takeaway Messages: Child Health Care Transformation and Value-Based Payment Systems

1. Medicaid can and should play a lead role in advancing transformed (and enhanced) primary and preventive health services for young children. This means payment systems must cover the costs of providing those transformed services and incentivize their adoption and diffusion, as well as providing effective oversight regarding their practice.

2. This can be achieved either through direct, fee-for-service payment systems or under managed care arrangements. In either case, **states must establish billing codes, service definitions, provider qualifications, and measurements necessary to support such transformed practice**.

3. For Medicaid provided through managed care, states must incorporate into managed care contracts specific expectations and requirements to advance transformed primary and preventive service for children. **Contracts need to require differential (and enhanced) compensation for transformed primary and preventive health practice compared with current, usual practice.**

4. Payment approaches common to managed care contracts — **per member per month payments, pay-for-performance, and use of "shared savings"** — also can be used to advance the adoption of transformed practice but **are not a substitute for the actions described above**.

5. Medicaid administrative claiming (and CHIP administrative funds[15]) also can be used to cover administrative activities needed to maximize the diffusion and effectiveness of transformation and for continuous improvement. State Title V Maternal and Child Health programs often are in the position to provide or contract for administrative services related to Medicaid (e.g., related provider training, system coordination, measurement) and bill for administrative costs.

Transformation is a term that should not be taken lightly, involving foundational (and certainly non-incremental) shifts in both practice and its financing. This involves a rethinking of basic goals and principles. Chapter Two describes three basic elements for such rethinking as applied to value-based health care for young children. Chapter Three identifies specific contractual provisions states can develop to implement this rethinking within Medicaid and state Medicaid contracts. Both Chapters Two and Three recognize that these changes require innovation – and that state Medicaid systems need to take leadership in advancing this innovation, not expecting managed care organizations to do so within current contractual expectations. The Appendix provides a perspective on issues and concerns that need to be addressed for Medicaid agencies and their staff to develop and implement such transformations.

Chapter Two: Rethinking the Goals for Value-Based Payment Systems and Young Children

> *Formulating the right questions, in the right sequence, is basic to getting the right solution. It's simple, but it's hard.*

There has been and continues to be much work in developing value-based payment systems in health care, most directed to adult and high-cost populations. There also is growing recognition that "children are not little adults" and health care for children should be based upon a life course model related to advancing healthy child development trajectories (physical, cognitive, social, emotional) and not simply maintaining health and functioning. Still, most of the current work to extend value-based payment systems in health care to children has been based, implicitly or explicitly, upon adapting adult and chronic care value-based payment models to children.

These have primarily involved providing incentives to managed or accountable care organizations to contain health care expenditures through providing alternative services (often including some form of health-maintaining care coordination) to reduce high cost medical episodes, with managed or accountable care organizations sharing in any savings they secure as a result. In exchange for more flexibility in how they manage health care expenditures, states often impose capitated payments to limit overall spending at a level that is at or below current projected costs. Value then generally means both a "better" and "cheaper" medical response to the Medicaid population.

For children, however, this can represent putting a round peg in a square hole. Higher value care for children often involves more care and requires greater reimbursements and investments. While there may be cost trade-offs in some instances with respect to other reimbursed services, in many instances there are not. Benefits to providing high value care for children are substantial, but most savings or "returns on investment" occur outside the time frame or purview of the managed care contract. Some may produce substantial savings overall but not in the health system, itself.

Rather than moving backward from financing tools that have been used with adult populations and working to adapt them for children, working forward from what the child health care system should produce is key to developing financing tools, under fee-for-service systems or within managed or accountable care, that advance high value child health care.

This involves three sequenced steps: (1) Delineating what constitutes high value child health care to improve child outcomes; (2) Developing ways to effectively measure that within practice; and (3) constructing payment models and reimbursement systems that advance such care. At least the first two of these are the responsibility of the contractor (in the case of Medicaid, the state) to define and spell out, even before getting to the point of developing payment models.

1. Delineating what constitutes high value child health care.

The first step is to delineate what constitutes high value child health care in ways that are concrete and therefore distinguishable and measurable in practice. These then need to be part of service definitions, the qualifications and staff certifications and settings in which these services can be provided, and the billing codes that will be used to provide them.

In taking this first step, states can build upon a substantial base of both practice evidence and professional standards for providing child health care. Regarding practice, this includes much enhanced responses by the practitioner and the office during preventive and well-child visits over current common practice, greater engagement of children and families and relational health services through care coordination, and increased referral to and financing of health-related services, particularly in responding early to child developmental concerns and to social determinants in the home compromising healthy development. These themselves are aligned with professional standards, including the definition of child health itself, the core principles for providing a patient-centered medical home, and the specific guidelines for providing primary and preventive, well-child services. Further, the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) benefit within Medicaid requires a different and enhanced response to child health than for adult health.

Due in large measure to the limitations within the current financing and reimbursement systems, this does not represent common or current standard practice. At the same time, there are practitioner champions and innovators and child health care systems, as well as model programs, which are moving toward such transformed child health care and can be enlisted in delineating these elements and providing guidance on the "devil in the details" in developing reimbursement structures which support them. The InCK Marks working paper on practice transformation spells out in much greater detail the substantial knowledge base and array of evidenced-based practices and their attributes of this transformation.

2. Measuring high value care within practice.

The next step is to develop ways to effectively measure these within practice so that they can be billed for and reimbursed when they are provided. In terms of office practices and transformed primary and preventive health services, at least initially this requires distinguishing between the types of office and well-child visits that currently occur with office visits that embody this transformed care.

Current well-child care generally does a physical examination of the child, checking for congenital conditions and physical growth and development, treats identified special health concerns, immunizes, and performs some screening for and anticipatory guidance regarding developmental issues – but only begins to perform the preventive and developmental surveillance and responses set forth in *Bright Futures*, the recognized guidelines for high quality visits and care.

Current core child health quality measures now include only a small portion of what practice transformation is directed to do – or to measure outcomes such care is designed to produce. Current measures generally are limited primarily to responses to medical conditions in the child, with very modest anticipatory guidance offered to parents on child development concerns. The core measures for child health care currently reflect this.

Within a transformed child health care system, practitioners still need to conduct these activities and be measured for performing them. Yet practitioners also have a much greater responsibility to identify and respond early to any developmental or behavioral concerns the child may be experiencing AND identify and respond to social determinants that impact healthy child development. For young children, these are particularly important and relate to the safety, stability, and nurturing that is present in the child's home environment. This then includes measures for screening and surveillance regarding that home environment, practitioner engagement of and provision of anticipatory guidance to parents and family

members around parental roles and actions to support healthy child development, and monitoring and follow-up to assess children's progress in their development, with particular attention in the early years to their bonding and attachment, early self-regulation, and positive identity.

The following, none of which are in regular use as metrics but relate to what the research shows is foundational to improving healthy young child development, are provided in a list below:

- Engagement and building of family agency in response
    - Follow-up and participation in any referred services
    - Satisfaction with visits in addressing concern, providing guidance, and ability to employ that guidance in the home
    - Self-reporting and evidence of actions to strengthen protective factors supporting child health
    - Increased frequency and quality of nurturing activities with child
    - Increased optimism and enthusiasm about parenting
    - Reduced levels of discord, stress, adversity in child's home environment

- Children's early development
    - Bonding and secure attachment
    - Exhibited curiosity
    - Early self-regulation
    - Positive self-identity
    - Achievement of developmental milestones

Ultimately, child health care transformation involves a much more ecological response to children – and metrics and measurement systems need to represent that. Without metrics and measurement systems that measure this and are used both to inform practice and to ensure accountability to a higher standard of practice, practice transformation will find itself at direct odds with the financing and accountability systems. The InCK Marks working paper on metrics transformation discusses in more depth this important element of health care transformation.

3. Establishing financing systems to advance such care.

The third step involves using the delineation of what constitutes high value child health care and the measures and metrics that reflect its practice to establish financing systems that advance that care. Given that current child health practice does not represent this practice, state Medicaid agencies themselves should provide this delineation between current and transformed practice and provide reimbursements for such care under fee-for-service or require managed care providers to create reimbursements that differentiate between current and transformed practice and provide the latter with greater reimbursement at a level that can sustain that practice transformation. Incentives for managed care providers should be structured to increase the uptake of that transformed practice (e.g. its diffusion to become the general standard of practice) and advance continuous learning and quality improvement. Where states use managed or accountable care entities for child health care, below are some expectations that states need to spell out, in measurable and accountable ways, in developing managed care contracts (see Chapter Three for further enumeration).

- Differentiation between current general practice of well-child care and this high value standard of care (high performing medical homes) and provision of sufficient incentives to practitioners (within fee-for-service or through managed/accountable care) to move to adopt high value standard and sustain it within practice
    - Provide sufficient funding for individual well-child visits to provide high value standard of care
    - Provide sufficient financing for the number of well-child visits necessary to provide ongoing high value care
    - Provide sufficient financing for enhanced, relational care coordination to enhance response and family agency
    - Provide sufficient financing for health-related services to directed to outcomes established
- Incentives to managed care organizations to diffuse this high value standard of care to become standard of practice
    - Provide additional payments for demonstrating the expanded adoption of high value care,
    - Provide additional payments for demonstrating improved child and family outcomes as a result of that adoption
- Supports and directions for quality improvement and innovation
    - Provide directions for the use of shared savings or additional payments to further engage in quality improvement and innovation.

These all speak to the need to start with the goals for the system and child health transformation and then establish payment systems to achieve that end. This must recognize that current Medicaid financing systems do not support transformed practice as both more than and different from current standard practice – and must do so if transformation is to occur. In most states, the current Medicaid financing system for child health care does not provide sufficient reimbursement to move toward, let alone fully sustain, such transformed practice.

Chapter Three: Developing Managed Care Contracts That Promote Value-Based Care in the Context of High-Value Medical Homes for Children

States have the responsibility to establish managed care contracts under Medicaid, which often are documents hundreds of pages in length. These set out how managed care organizations will be reimbursed, monitored, and held accountable. They spell out what managed care organizations are required to do in establishing provider networks and ensuring the delivery of health services and adherence to state and federal Medicaid requirements and provisions. As states make increasing use of managed care organizations (or accountable care organizations), they have increasing responsibility to establish structures that ensure that child health practice transformation expertise oversees and guides child health care coverage and that reimbursement and specific provisions exist within the managed care contracts that support such transformation.

Incorporating Child Health Transformation Expertise within Medicaid Managed Care.

Successful child health care transformation within Medicaid requires child health care expertise both at the state level of Medicaid administration and oversight and at the managed care level of administration and management. This is different and distinct from other needed health care expertise around the provision of services for adult and chronic care and disability populations. Most Medical Assistance Advisory Councils predominantly focus upon and are represented by experts in adult and chronic care and disability populations – which represent most of the health care costs and the areas where health care cost containment is of greatest concern and attention. The same holds even more so within most managed care organizations, which focus a great deal of their attention on containing health care costs.

At the state level, states which seek to transform child health need to ensure that they have the expertise and the interface with practitioners in the field to do so. This includes expertise within the Medicaid office or department. It also includes connections with expertise among the child health community. To that end, within or in addition to a Medical Assistance Advisory Council (MAAC), states need to enlist experts from child health to inform and guide their work. In short, there needs to be a Child Medical Assistance Oversight Council within or distinct from the MAAC, whose responsibilities and authority include reviewing and approving the child-specific portions of state managed care contracts.

In addition, states can and should require that managed care organizations demonstrate that they have expertise in child health transformation and an organizational structure that gives authority to that expertise in developing child health care reimbursement systems. At a minimum, states can require that managed care organizations include a high-ranking staff with expertise regarding and authority over child health care reimbursement within their organizations.

Constructing Specific Provisions within Managed Care Contracts to Advance child Health Transformation.

Most current state managed care contracts include very few provisions or requirements that relate specifically to child health. In order to advance child health transformation, state managed care contracts need to have provisions that are specific to children and treat child health services as distinct from adult health services – recognizing that they must be more preventive, developmental, and

ecological and that they must meet the requirements of the Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit and the standard for primary care provided in *Bright Futures*. The following are elements that should be developed and included within such managed care contracts in order to advance child health transformation.

1. Define EPSDT:
    a. Employ IOM definition of child health and clarify that child health involves physical, social, emotional/behavioral, and cognitive development.
    b. Clarify that screening includes developmental and relational health and that identifies social determinants that impact child development.
    c. Provide treatment definitions for health-related services (including dyadic and group services) and examples of how MCOs should use these to cover health-related services.
    d. Define medical necessity for children from a child-specific perspective with an emphasis upon family home factors and prevention of development or worsening of health conditions.
2. Define medical homes in the context of well-child care and the practices set forth in Bright Futures and direct MCOs to provide enhanced and sufficient funding for those meeting such definitions as high performing homes.
3. Provide incentives for MCOs to increase the number of practices adopting and sustaining such transformed practices, so MCOs can provide incentives and supports for any start-up and transition costs for practices in doing so.
4. Define enhanced relational care coordination as an addition to medical home care coordination and its application to an estimated 30-50 percent of the Medicaid population of children; describe functions of care coordination and the manner it can be delivered (in office, through telephone referral, through home visiting, community health workers, etc.); and reimburse it at a level that can sustain it in practice.
5. For young children, adhere to metrics that relate to family and home environment (safety, stability, and nurturing in the home environment) and to child's early developmental progress (e.g. in first three years bonding and attaching, positive self-identity, early self-regulation, etc.) that represent outcomes from a value-based care perspective.
6. Define additional health-related services that improve child health, such as home visiting and dyadic therapies and parenting education and patient support groups, that require Medicaid financing as preventive services.
7. Identify areas of particular focus for shared savings and redirection of resources to further innovation in advancing child health, with specific direction to build upon existing known actions that do so, e.g.
    a. Perinatal care and reductions of re-hospitalizations of infants released from NICUs
    b. Responses to children experiencing asthma and emergency/room hospital use through home remediation practices to reduce future episodes
8. Require a portion of all shared savings achieved within Medicaid (including adult populations) to go to further demonstration efforts around child health, with an emphasis upon long-term benefits that cannot be expected to produce current gains: and
9. Provide incentives for MCOs to work with communities and the state to leverage federal Medicaid funding for child health services currently funded by state- or community-only funds that can be made eligible for Medicaid under the contractual criteria.

The state contract can and should delineate these within Medicaid managed care contracts, going into the depth necessary to ensure that managed care organizations will be accountable to them. Further, doing so should ensure that all Medicaid managed care organizations with which the state contracts provide some core level of reimbursement and coverage of services and care coordination, so that practitioners and providers are not faced with treating differently children differently, based upon the managed care provider under which they are served.

Appendix: Understanding the Medicaid Administrator's World

Ultimately, making changes to Medicaid managed care contracts requires the time, expertise, involvement, and leadership of state Medicaid agency staff. Generally, Medicaid staff are doing the best and most effective jobs they can, under the circumstances in which they operate. If they are to do something more, this requires understanding those circumstances and changing them, when necessary.

Medicaid represents one of the most complex programs that states administer. State Medicaid offices must communicate with and interpret federal policies governing Medicaid, establish eligibility criteria and service definitions for multiple populations with very different health care needs (children, low-income adults, persons with disabilities, and seniors), construct billing codes and reimbursement schedules for a broad array of services, negotiate and oversee managed care contracts as well as fee-for-service providers, manage information and payment systems, respond to executive and legislative branch officials as well as providers and patients in the system, maintain an Advisory Council and a complaint and appeal system for resolving issues, and do what planning and research they can to improve the Medicaid system and respond to new opportunities, challenges, and medical technologies. They usually have relatively small staff in comparison to those they regulate and oversee, with far fewer resources to plan and negotiate. Given their current staffing and time, there are limits to how much they can do to explore new options as they seek to manage what they already are required to do.

In addition, Medicaid administrators are faced with overseeing what is the fastest growing part of most state budgets. The first three demands upon them from the outside likely are: cost containment, cost containment, and cost containment.

It is within this context and set of circumstances that state Medicaid systems generally operate. This does not mean that Medicaid administrators and their staff are not committed to improving health through their work, but that they have challenging jobs with many demands. In particular, the following are issues that Medicaid administrators and their staff are likely to have on their minds when approached by any request to expand or enhance child health services.

Breaking the bank. Children are not drivers of Medicaid costs, but they are a major share of the Medicaid population. While half of all persons receiving Medicaid benefits, children constitute only one-fifth of the costs. Persons with disabilities and seniors in intermediate care facilities represent the major loci for health costs. At the same time, any increase in enrollment or payment rates or the provision of new services to the Medicaid child population will have costs. Like airlines attaching new fees for luggage or cutting back on snack services, Medicaid agencies may look to areas where Medicaid can tighten its belt and cut costs, even though the impact is very small compared with overall Medicaid costs. Unless there are some specific directives to the Medicaid agency to expand Medicaid enrollment, payments, or services (typically from the Governor or legislature and accompanied by funding), Medicaid administrators themselves feel they are responsible to manage Medicaid and control expenditures and growth, wherever they can. This puts them in the position of being very wary of increased benefits, particularly when they may go to a large population (e.g. children).

Opening the floodgates. Even when Medicaid administrators are provided or take discretion to expand services, such as for care coordination or home visiting or a preventive two-generation service, they worry that the way they do so can open the floodgates to much wider utilization (and cost). Therefore, they look for ways to limit exposure, use, and cost – through limiting access by requiring the presence or

severity of a particular condition, limiting who is eligible to provide the service, or limiting what can be claimed as eligible for reimbursement within the service provided. In doing so, they can make it fiscally and administratively unattractive or infeasible to provide such service.

Arousing the feds. Particularly when entering into new territory for coverage and reimbursement, Medicaid administrators generally must secure approval, often through a Medicaid Plan amendment. They also become subject to federal oversight and audit, which can result in denials of federal payments. They generally are in continuous communication with federal Medicaid offices over a whole range of issues, and adding additional services, in particular, often is viewed as triggering increased federal attention and scrutiny of Medicaid.

Creating a can of worms. Particularly when going outside the medical professions to cover services, including to providers who have not been Medicaid providers and do not have sophisticated documentation and reimbursement systems, Medicaid administrators can fear that, without extensive training and adoption of new reporting systems by providers, there will be many glitches in claims processing and increased state regulatory responsibilities. This is particularly true for fee-for-service systems, but applies to managed care, as well. Further, in order to address this, administrators may opt for the most restrictive definitions and impose the most documentation requirements on providers, which then results in the least uptake of providers for the provision of services.

Adding an unfunded work mandate. Making any change to Medicaid – in a state plan amendment, a billing code designation, a regulatory document, or a procedure manual for providing or verifying a service – takes time and energy. Most state Medicaid offices have limited staff whose time is fully consumed in managing the status quo. Medicaid staff workloads rightfully have to be recognized and addressed and the work of staff valued when seeking changes whose implementation falls upon them.

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In working effectively with Medicaid and its staff, advocates need to recognize these administrative concerns and staff demands and constraints – as well as their expertise on what it takes to manage and administer changes. Some of the issues above must be recognized and addressed at a policy level above the internal workings of the Medicaid office, but to be well-implemented all must be recognized by providing the needed administrative priority and staffing within the Medicaid office for the work.

ENDNOTES

[1] Bruner C & Johnson K (2018). *Federal Spending on Prenatal to Three: Developing a Public Response to Improving Developmental Trajectories and Preventing Inequities.* Appendix C: Estimating Medicaid Enrollment and Expenditures for Very Young Children and for Maternity and Newborn Care. Center for the Study of Social Policy. pp. 40-41. Available at: https://cssp.org/wp-content/uploads/2018/08/CSSP-Prenatal-to-Three.pdf

[2] Johnson K, Bruner C. (January 2021). *Medicaid Managed Care: Transformation to Accelerate Use of High Performing Medical Homes for Young Children.* InCK Marks Working Paper Series. No. 5. InCK Marks Initiative: Des Moines, IA.

[3] Bruner, C, Dworkin, P, Fine, A, Hayes, M, Johnson, J, Sauia, A, Schor, E, Shah, R, & Shaw J (2017*). Transforming Young Child Primary Health Care Practice: Building Upon Evidence and Innovation.* Child and Family Policy Center and Build Initiative's Health Equity and Young Children Collaborative. See Appendix.

[4] InCK Marks (2018). *Guiding Framework for Health Service and Payment Reform.* Retrieved at: http://www.inckmarks.org/docs/multiplepagepdfs/InCKMARKSGuidingFrameworkSection.pdf

[5] Hagan, J, Shaw, J, & Duncan, P (2018). *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition*. American Academy of Pediatrics.

[6] Bruner, C, & Johnson, K (2019). *Scope and Scale: Developing a Risk/Opportunity Strategy for Engaging Young Children and their Families to Achieve Gains in Population Health.* InCK Marks Resource Network.

[7] Johnson K, and Bruner C. (2018). *A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health*. Child & Family Policy Center.

[8] InCK Marks (2020). *Young Child Health Transformation: What Practice Tells Us.* InCK Marks Resource Network Child Health Transformation Working Paper Series.

[9] World Health Organization, as cited by First Things First Work Group (2007). Retrieved at: https://www.buildinitiative.org/Portals/0/Uploads/Documents/Early%20Learning%20Left%20Out.pdf. Definition of child health. Office of Disease Prevention and Health Promotion. (2016). *Healthy People 2020.* Washington, DC: United States Department of Health and Human Services. Definition of Health Equity.

[10] American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association (2007). *Joint Principles of the Patient-Centered Medical Home*. www.medicalhomeinfo.org/Joint%20Statement.pdf. Bruner, C (2009). *Medical Homes and Young Children: State Policy Opportunities to Improve Children's Healthy Development as Part of Early-Childhood Systems Building*. Build Initiative and Child and Family Policy Center.

[11] Office of Disease Prevention and Health Promotion. (2016), *op. cit*. Braveman, P, Arkin, E, Orleans, T, Proctor, D, & Plough, A. (2017). *What Is Health Equity? And What Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation.

[12] Bruner, C. ACE, place, race, and poverty: Building hope for children. *Academic Pediatrics*. 2017;17 (7S) S123-S129

[13] Johnson and Bruner (2018), *op.cit.*

[14] Consensus Statement (2019). *Opportunities for Medicaid to Transform Pediatric Care for Young Children To Promote Health, Development, and Health Equity*. Ascend at the Aspen Institute, BrunerChildEquity, Center for Health Care Strategies, Center for the Study of Social Policy, Georgetown University Center for Children, Johnson Group Consulting, National Institute for Children's Health Quality, and Zero to Three.

[15] Cohen Ross D, Guyer J, Lam A., Toups M (2019). *Fostering Social and Emotional Health through Pediatric Primary Care: A Blueprint for Leveraging Medicaid and CHIP to Finance Change*. Center for the Study of Social Policy and Manatt Health.