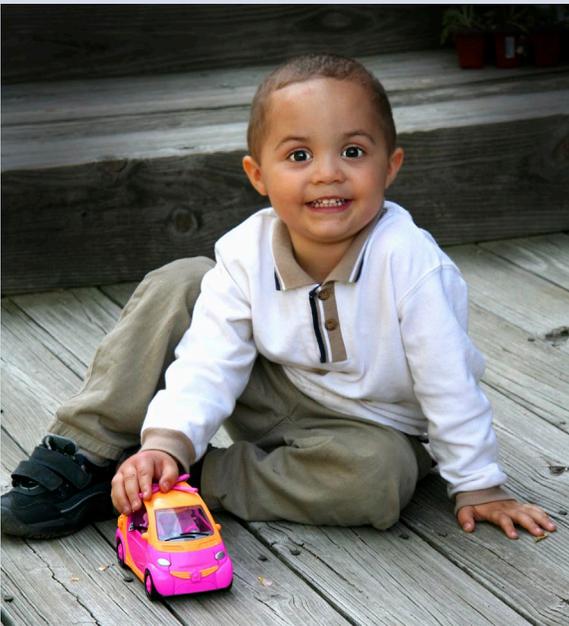


Promoting Young Children's Healthy Development in Medicaid and the Children's Health Insurance Program (CHIP)

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Fourth in a series of briefs on the future of children's health care coverage

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Summary

A child's brain develops most rapidly in the earliest years of life, building the foundation for learning, behavior and health. Medicaid—as the primary source of health coverage for young, low-income children—is a logical system to reach families with young children and set them on a path of healthy physical, social, and emotional development. Any effort to improve young children's healthy development should intentionally involve Medicaid and the Children's Health Insurance Program (CHIP).

Medicaid, along with CHIP, serves four out of five young children in poverty.¹ Yet Medicaid can do more to elevate the needs of these children. Prioritizing young children in Medicaid through cross-sector, innovative practice change has the potential to improve their lifetime trajectories, overall population health and long-run savings.²

This paper examines ways for state and federal policymakers to use Medicaid and CHIP to more effectively put young children on the best path for success in school and in life. These include:

1. Prioritize the health of parents and caregivers as key players in children's healthy development.
2. Maintain continuous, consistent health coverage for young children and their families. Start by ensuring no newborn leaves the hospital without coverage.
3. Measure and ensure that young children receive the full range of preventive care and treatment they need under Medicaid's comprehensive pediatric benefit (EPSDT).
4. Support expert-recommended, research-based interventions that meet the developmental needs of young children.
5. Invest in prevention and pediatric care innovation.



Introduction

A child's experiences and environments early in life have a lasting impact on his or her development and life trajectory. The first months and years of a child's life are marked by rapid growth and brain development. Any parent can see this firsthand, watching her children observe and interact with the people and worlds that surround them.

While the brain can change and adapt throughout a person's life, the foundations of the brain's architecture are constructed early: Its capacity to adapt and change decreases with age.³ A strong foundation of positive early experiences with caregivers in healthy, safe and nurturing environments greatly influences a child's resilience.⁴ Research even shows that a child's early experiences—positive or negative—interact with their biology, ultimately determining how one responds to life's inevitable challenges. A high incidence of adverse childhood experiences, or trauma, in early years can negatively impact a child's long-term physical health and well-being, also affecting learning and behavior throughout life.⁵

The health of parents, caregivers, and other adults in a child's life has a direct influence on his or her healthy development.⁶ Left untreated, maternal depression can impede a mother's ability to bond with and care for her child.⁷ Similarly, providing support and treatment to parents with substance abuse disorders, such as those affected by the growing epidemic of opioid dependence, is as important for children as their caretakers.⁸

Health care coverage offers one important means to connect families with providers and others who, by supporting positive parenting and healthy development, can help to reduce undue stress on families that can negatively affect a child's trajectory. Coverage is a critical first step toward ensuring children can access routine preventive care through well-child visits and address health concerns as early as possible. Just as important, coverage helps protect families from financial insecurity that can come from an unexpected asthma attack or injury at child care.⁹ Continuous, consistent coverage without disruptions is especially critical for young children, as experts recommend 16 well-child visits before age 6, more heavily concentrated in the first two years, to monitor their development and address any concerns or delays as early as possible.¹⁰ These visits allow providers, to closely monitor their a child's development and address any concerns or delays as early as possible.

High quality health care is an important way to support young children and their families. But research is clear that many factors beyond medical care—income, access to healthy food and safe housing, education, and exposure to adversity—can have a greater impact on health in the long run.¹¹ For young children and their families, the health care system can serve as a critical coordinating “hub” to improve linkages to other social and economic supports. States and communities are increasingly looking for innovative ways to address these social determinants of health.¹²

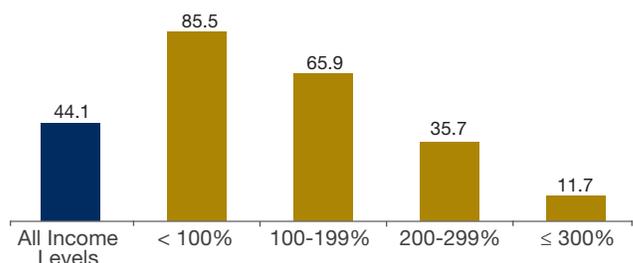
Medicaid—serving nearly half of all young children—is an essential piece of the puzzle.

Medicaid serves nearly half of all U.S. children under age 6.

More than one-third of **all** children rely on Medicaid and CHIP for health coverage¹³, but the programs play an even greater role for the nation's youngest children. Among children under age 6, 44 percent rely on Medicaid for their health insurance. The percentage of young children covered by Medicaid grows as family income declines (See Figure 1) and is highest for the youngest children.¹⁴

Among children under age 6, 44 percent rely on Medicaid for their health insurance.

Figure 1. Percentage of Children Under 6 with Medicaid/CHIP by Federal Poverty Level, 2016



Source: Georgetown University Center for Children and Families tabulations of the 2016 U.S. Census ACS data from IPUMS.



Medicaid requires comprehensive pediatric benefits under Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT).

EPSDT is the child health benefit in Medicaid—and in many states, CHIP.¹⁵ It provides broader coverage as compared to private plans and Medicaid benefits for adults, and it has an explicit focus on prevention.¹⁶ EPSDT is designed to ensure that children's developmental needs are met and that diseases or delays are addressed as early as possible. It seeks to ensure coverage for services that are designed not only to treat a condition but also to prevent it from occurring or worsening. States must provide each child with recommended preventive screens, follow-up diagnostic assessments and, in turn, any resulting "medically necessary" services a medical professional considers essential to prevent, treat or improve the diagnosed condition.¹⁷

Medicaid serves a growing percentage of young children's parents. One in five (20.4 percent) parents of children 3 and younger were enrolled in Medicaid in 2016.¹⁸

Where a parent or adult caretaker lives ultimately determines whether he or she can get Medicaid coverage. Rates of Medicaid coverage among parents of children age 3 and younger range from less than 10 percent (Texas, Kansas and Virginia) to 39 percent (New Mexico).¹⁹ Prior to implementation of the Affordable Care Act (ACA), only the poorest parents qualified for Medicaid in most states. To date, 33 states and D.C. have adopted the ACA Medicaid expansion, which covers all adults up to 138 percent of the federal poverty line (less than \$29,000 for a family of three in 2018).²⁰ In these states, less than 10 percent (8.7 percent) of parents of children age 3 and younger are uninsured, compared to 18 percent in non-expansion states.²¹

Medicaid can help to drive system reforms that prioritize children's development.

State flexibility in program administration combined with the program's purchasing power and large proportion of children served, provide an opportunity to lead health system change that serves young children.

Ensuring all young children and their families access the preventive care and other services they need is challenged by the following issues:

- Where a child lives plays a large role in whether she or he can get the care they need. Medicaid policies and their applications are inconsistent across states.** As a federal-state program, a large share of Medicaid's cost is paid by the federal government. States administer the program, with broad discretion in eligibility/enrollment, payments, delivery systems, and quality improvement above federal minimum requirements.²²
- Continuous, affordable health coverage for children and their parents is essential, but incomplete.** While Medicaid, CHIP, and the ACA have elevated coverage levels to all-time highs, millions of children, their parents, and other adults in their lives remain uninsured or do not have access to consistent, reliable health coverage.²³ More than 900,000 children under age 6 remain uninsured, many of whom are eligible for but not enrolled in Medicaid or CHIP.²⁴ In 2016, seven states—Alaska, Arizona, Georgia, Nevada, North Dakota, Oklahoma, and Texas—had significantly higher rates of uninsured children under 6 than the national average.²⁵ An initial look at 2017 data show an increase in the rate of uninsured young children for the first time in many years.²⁶ Many other children experience gaps in coverage that can impact continuous access to care. Parents of young children are also uninsured at higher rates. Nationally, 12.4 percent of U.S. parents of children ages 3 and under have no health insurance. In non-expansion states, these parents are uninsured at double the rate of those in expansion states (18 versus 8.7 percent).²⁷
- Medicaid's promise of early and periodic screening, diagnostic and treatment (EPSDT) benefits for children is not being fully realized.** Almost 30 years after federal Medicaid set a goal for 80 percent of all children to receive at least one well-child visit each year, few states met the threshold in 2017.²⁸ At the national level, the goal has only been achieved for children under age one (see Table 1 below).

Table 1: Percentage of Children in Medicaid Receiving at Least One Well-Child Visit/Screen, 2017

	All Children	Under Age 1	1-2 Years	3-5 Years
	58%	88%	78%	68%

Source: EPSDT U.S. CMS-416 FFY2017, Participant ratio.



While most states exceeded the 80 percent goal for children under age 1, less than half of states met this rate for children ages 1 through 2, and only two states met the goal for ages 3 through 5.²⁹

Other available, state-reported data provide additional detail on preventive care gaps for young children in Medicaid and CHIP. Figures 2 and 3 shows the geographic distribution of children under age 6 receiving recommended well-child visits for 2017. Best practices for young children during well-child visits, such as developmental screenings, also fall short of the recommended standard: Of the 27 states reporting the measure for 2017, developmental screening for children under age 3 in Medicaid and/or CHIP ranged from less than 4 percent in Alaska³⁰ to 81.1 percent in Vermont, with a median of 39.8 percent.³¹

- **Child health data is limited and/or inconsistent across states, child-serving systems, and payers.**

This limits the ability to gain a comprehensive sense of whether children receive the care they need,

when they need it.³² For example, available data does not show whether children accessed physician-recommended referrals and treatment as a result of preventive screen, or their progress toward desired health outcomes.

- **The traditional health care system is not designed to address a child's family and community context.**

Payments are often linked to treatment for individuals. Yet for young children, a move toward “family-based primary care” and strong care coordination that links families to health and social supports is critical.³³

- **Multiple, fragmented systems—health, mental health, public health, education, social services—serve many of the same children and families.**

While these systems often have overlapping goals, they largely operate in isolation, creating confusion for families. Many children fall through the cracks as uncoordinated systems are stretched by limited resources and lack of integration that could better connect families and services.

Figure 2. Percentage of Children in Medicaid and/or CHIP Receiving Six or More Well-Child Visits in the First 15 Months of Life, 2017 Child Core Set

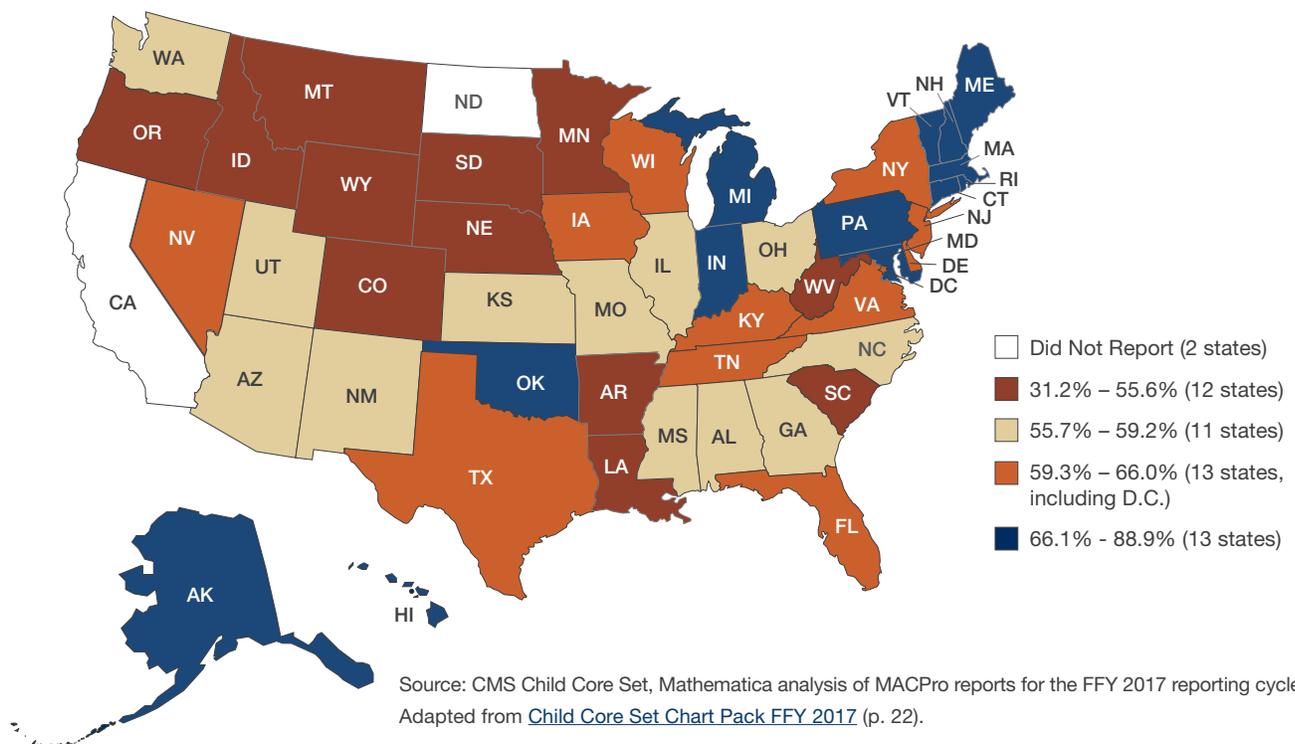
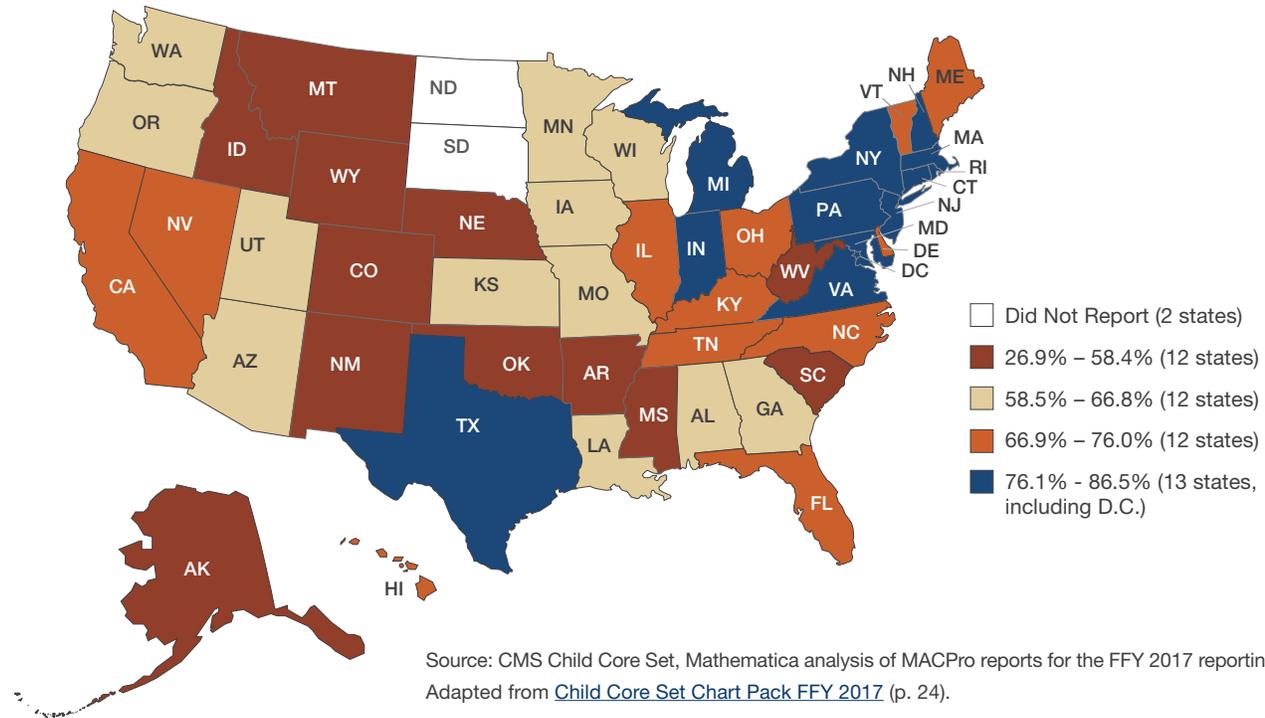




Figure 3. Percentage of Children in Medicaid and/or CHIP Receiving at Least One Well-Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life, 2017 Child Core Set



New York's One-of-a-Kind Initiative to Prioritize Care for Young Children in Medicaid

In 2014, New York's Medicaid agency set out a goal to move to value-based payment for up to 90 percent of all managed care payments by 2020. As stakeholders gathered to inform the system change, advocates and child development experts pointed to the fact that for children, more upfront spending on primary care, attention to healthy caregivers, and stronger linkages to non-health supports drive more value for children in the long term.³⁴ Based on this input, Medicaid officials developed [the First 1000 Days in Medicaid](#), a collaborative process to identify opportunities for the Medicaid program to improve health, educational and economic outcomes for children in close partnership with education and other state agencies. Recommendations were prioritized by a broad-based stakeholder working group and funded in the state's 2018 budget to be implemented and evaluated starting in 2019. Highlights include: requiring all Medicaid managed care plans to adopt a children's quality agenda, making changes to billing practices to increase access to services for parents and their children together, and creating a database to facilitate information-sharing across systems.



Recommendations



State



Federal

Child development experts tell us that to be most effective, public policies to improve outcomes for young children and their families should aim to support responsive relationships between children and adults, strengthen core life skills, and reduce sources of stress in the lives of children and families.³⁵ Recommendations below offer a starting place for Medicaid to more effectively serve young children and their families. The table on page 14 summarizes these recommendations by federal and/or state actions.

1 Prioritize health care for parents, future parents, caregivers, and early childhood educators as essential contributors to children's healthy development.

Providing health coverage helps to ensure all adults that care for young children have their own health needs met while providing additional economic security, which can help to reduce stress experienced by low-income families.



Expand Medicaid to all adults up to 138 percent the federal poverty level (FPL).

In non-expansion states, the median income eligibility for parents is just 43 percent FPL, ranging from 18 percent in **Alabama** and **Texas** to at or close to 100 percent in **Tennessee** and **Wisconsin**.³⁶ In most cases, adults without dependent children remain ineligible for public coverage if their income falls below the poverty line.³⁷ Parents and caregivers in this coverage gap are subject to added stress of unmet health needs and financial insecurity that can directly impact the quality of interactions with young children in their care.

The benefits of the ACA's adult Medicaid expansion for young children's development are not limited to coverage for their parents. Children interact with many adults in their early years, most often with caregivers at child care or family day care homes while parents work. Medicaid expansion could also benefit many of these early childhood educators who influence young children daily. In 2017, the average annual salary for child care workers in the United States was \$22,290, just under the income threshold for Medicaid expansion (138 percent FPL).³⁸ Early childhood educators often do not have health insurance available through their small employers.³⁹

In states that expanded Medicaid, adults have seen improved access to treatment—including behavioral and mental health care—which can only improve the positive, nurturing relationships children need for health development.⁴⁰ Evidence also points to improved financial security, as well as health coverage gains for children through the “welcome mat” effect—as parents gain coverage for the first time, they also enroll their eligible children.⁴¹ Children whose parents gain coverage are also more likely to access preventive care through regular check-ups.⁴² Medicaid expansion also supports healthy birth outcomes and can influence health equity. One study linked states with Medicaid expansion to significantly greater declines in infant mortality rates compared to non-expansion states, which were even more dramatic for African-American infants.⁴³ First-time mothers in Ohio were significantly more likely to access prenatal care after the state expanded Medicaid.⁴⁴



Ensure all eligible parents are enrolled in Medicaid.

Regardless of Medicaid expansion status, all states can do more to ensure eligible parents are enrolled in Medicaid. In 2016, more than one in four uninsured parents were eligible for Medicaid but not enrolled; two-thirds of these parents had a child who was already enrolled in Medicaid.⁴⁵ Just under 80 percent of parents eligible for Medicaid were enrolled in 2016, with participation rates ranging from a low of 44 percent in Texas to 95.6 percent in Massachusetts.⁴⁶ States can use targeted outreach efforts, as well as streamlined eligibility and enrollment policies, to reach these unenrolled parents (See #2).



2 Maintain continuous, consistent health coverage for young children and their families.

Medicaid/CHIP eligibility and enrollment policies can have significant impact on both whether children and families access Medicaid and CHIP, and whether the coverage remains stable. Providing real-time eligibility determinations and continuous coverage in Medicaid/CHIP as long as a child remains eligible helps to prevent unnecessary lapses in coverage and care, especially in the early years of rapid development.

Consistent coverage is also a key factor—a prerequisite, even—in accurately measuring the quality of care delivered to children in Medicaid. Quality measurement often excludes individuals who are not enrolled for at least 12 months.⁴⁷ Until all Medicaid beneficiaries—especially children—have at least 12-month continuous coverage, it is impossible to get an accurate, complete picture of how many are getting the services they need and whether the intended outcomes were achieved.

Federal and state technology upgrades are moving states closer to real-time eligibility determinations for children and their families in Medicaid and other public programs. This not only cuts red tape for families but can also save time and money for states by reducing administrative burdens. The following steps can further support consistent coverage for eligible children.

S★ Ensure no newborn leaves the hospital without health coverage. States can improve technology and processes to immediately enroll newborns in available coverage: In 2016, nearly 115,000 (3 percent) children under 12 months of age were uninsured.⁴⁸ Babies born to mothers enrolled in Medicaid or CHIP are immediately eligible as “deemed newborns” for one year.⁴⁹ States should ensure their enrollment systems reflect this requirement and easily allow medical providers and staff to check on a child or family members’ coverage and take steps to quickly enroll them if needed. Oklahoma uses [an automated newborn enrollment system](#), which allows hospital staff to enter newborn information and receive an assigned Medicaid number before the mother and baby are discharged.⁵⁰

S★ Make a newborn’s CHIP coverage effective on their birth date. Regardless of when they are enrolled in their first 90 days, a CHIP-eligible newborn’s coverage should be effective retroactive to their birth date. If a Medicaid-eligible newborn falls through the cracks and leaves a hospital without coverage, Medicaid’s retroactive eligibility can pay for his or her health care during the three months prior to their enrollment.⁵¹ But this coverage protection is not available in separate CHIP programs. States may elect to pre-date a newborn CHIP enrollee’s coverage eligibility to their birth date during their first three months of age.

S★ Adopt presumptive eligibility in Medicaid and CHIP for children, pregnant women, and other adults. [More and more states](#) are moving toward real-time eligibility decisions⁵² but it can take up to a month or more to determine Medicaid eligibility in some cases.⁵³ Presumptive eligibility helps children and families enroll in health coverage on a temporary basis while full eligibility is determined. States should fully adopt presumptive eligibility until a real-time, seamless eligibility and enrollment system can be realized. Medicaid, CHIP, and the ACA provide many tools to extend presumptive eligibility to new populations or in hospital settings.⁵⁴

Table 2: Number of States Adopting Presumptive Eligibility in Medicaid or CHIP, by Population, January 2018

	Medicaid	CHIP	
	Children	20	11
	Pregnant Women	30	3
	Parents	9	n/a
	All adults	6	n/a

Source: [Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey](#) (Washington, D.C.: Kaiser Family Foundation, March 2018).



S★ Adopt Express Lane Eligibility (ELE) for children.

ELE, used by nine states, allows Medicaid agencies to consider findings from other public, income-based programs, such as Supplemental Nutrition Assistance Program (SNAP), to enroll a child in Medicaid or CHIP or renew their coverage. As of January 2017, nine states used ELE for Medicaid/CHIP enrollment, renewal, or both.⁵⁵ Federal law allows states to use several means-tested programs in ELE, including the Child Care and Development Block Grant, Head Start, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which reach many young children.⁵⁶ To date, other than WIC⁵⁷, no state has used these programs in ELE; most use SNAP.⁵⁸

F Require 12-month continuous coverage for all children in Medicaid and CHIP.

S★ Continuous eligibility allows a beneficiary's Medicaid or CHIP enrollment to remain stable for a set period of time, regardless of changes in family size or income, which can fluctuate from month to month, even as their annual income remains relatively low.⁵⁹ Research shows that 12-month continuous eligibility for children increases the coverage continuity and reduces churn, or the rolling on and off coverage that disrupts consistent care.⁶⁰

Beyond the required 12 months of coverage available to deemed newborns, federal policy allows states to adopt 12-month continuous eligibility for all children. [Thirty-two states](#) adopt the practice in Medicaid or CHIP for all children (see Table 3). Eight states provide 12-month continuous eligibility in separate CHIP programs but not in Medicaid, potentially leaving children in families with lower income levels with less stable coverage than their higher income peers. States may also consider continuous eligibility for parents, caregivers and other adults.⁶¹

- **Congress** should standardize children's continuous eligibility by requiring all states to adopt a minimum of 12-month continuous coverage for children in Medicaid and CHIP.
- **States** should adopt 12-month continuous coverage for all children in Medicaid and CHIP.

Table 3: Number of States Adopting 12-month Continuous Eligibility (CE) in Medicaid or CHIP for Children, January 2018⁶²

All Children			Limited to young children
Medicaid or CHIP	Medicaid	CHIP	
32	24	26	3
AR, DE, FL, NV, PA, TN, TX and UT provide 12-month continuous eligibility in separate CHIP programs, but not in Medicaid.			FL: Under age 5 PA: Under age 4 (Medicaid) ⁶³ IN: Under age 3

Source: [Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey](#) (Washington, D.C.: Kaiser Family Foundation, March 2018).

F Extend the continuous eligibility period up to five years for children under age 6.

S★ beyond a 12-month continuous eligibility period for young children would recognize the significance of early childhood development, frequency of recommended check-ups, and the higher share of young children in poverty and the income volatility faced by many poor families.⁶⁴

- **Congress** could give states the option to adopt up to five years of continuous eligibility for children under age 6.
- Absent Congressional action, **states** could pursue a Medicaid Section 1115 research and demonstration waiver to test the practice.⁶⁵





3 Measure and ensure that young children receive the full range of services they need under EPSDT.

The first step is ensuring higher quality and more consistent data. Ideally, data should be publicly and consistently reported at multiple levels—national, state, managed care plans, provider practices—to allow policymakers, families, and others to assess Medicaid's performance for children. A focus on children's health quality improvement can improve data collection and reporting to inform and prioritize policies. Importantly, it can also unify a variety of stakeholders around common goals, offering a concrete way to engage other child and family-serving systems in the quest to improve child health, which Medicaid cannot do in isolation.

Publicly available Medicaid data currently does not provide a full picture of whether children are getting the preventive and treatment services they need, when they need it.⁶⁶ Data are also typically not disaggregated in a way that can allow for comparisons across race and ethnicity, which could inform state efforts to improve health equity. The Child Core Set (see box), as it evolves, offers one important opportunity for consistent child measures across states and over time, in conjunction with state-reported EPSDT participation data.⁶⁷

Medicaid and CHIP Child Core Set: States Must Report All Measures Starting in 2024

Created in 2009, the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP offers a standard set of universal measures to allow tracking and reporting within and between states over time.⁶⁸ State reporting is currently optional, with all states reporting at least one measure in 2017, ranging from one to 25 of the total 27 measures.⁶⁹ Starting in 2024, states will be required to report on all Core Set measures, including well child visits, immunizations, developmental screenings and other key services for young children.⁷⁰ Required reporting offers a significant opportunity for states to coalesce child- and family-serving systems around Medicaid quality improvement for young children.

Policymakers should:

S **Implement a comprehensive focus on young children's quality improvement.** States should determine where gaps exist or where additional or revised data may be necessary. For states with children served in managed care, this means requiring each contracted Medicaid managed care organization (MCO) to have an explicit focus on pediatric quality, as recently adopted in **New York** (see box above).⁷¹ In **North Carolina**, new Medicaid MCOs will be required to adopt three performance improvement projects based on a list of priority areas for the state, one of which is early childhood health and development. The state will also require plans that do not meet a 75-percent threshold for well-child screenings during a year to adopt an additional performance improvement project on EPSDT screening and community outreach.⁷²

States should also engage other child-serving systems in quality improvement to identify shared goals and outcomes that can be addressed in partnership. For example, in **Oregon** and **New York**, Medicaid and education agencies have committed to use the shared goal of school readiness to inform improvements and move toward shared accountability across sectors.⁷³ State adoption of cross-system goals, or even common measures, could help provide a road map for these efforts, such as those detailed in federal guidance for cross-system early childhood and health alignment.⁷⁴

F **Publicly report the Child Core Set quality measures for young children, with additional detail.** Eleven

S of the 26 measures in the 2018 Core Set focus on prenatal or early childhood health.⁷⁵ Only 26 states currently report the Core Set developmental screening measure, an important starting place to help drive improvements in universally-recommended screens for young children.

- **Federal** officials should require additional detail and transparency in both EPSDT and Core Set reporting for states and MCOs alike.⁷⁶ Federal officials can also support development of new measures that seek to move beyond screenings to capture follow-up referrals and treatment received by young children.



- **States** can get a head start reporting additional measures before they become mandatory in 2024, creating cross-system learning communities to support the quality of data collection and measure performance. The developmental screening measure should be prioritized if not already reported.

State and federal officials should move toward systems that can publicly report Core Set and EPSDT data aggregated by child demographics (e.g. race/ethnicity), service delivery type (e.g. managed care versus fee-for-service), and service location (e.g. region, plan, provider) to better understand specific areas of need.

S **Ensure EPSDT reporting, and outreach/ education, service requirements are explicit in state agency agreements with Medicaid MCOs.** For states serving children in managed care arrangements, agreements with MCOs must be explicit on data reporting, services, and family outreach responsibilities with regard to EPSDT to ensure clear lines of accountability when corrective action is needed.

4 Support expert-recommended, research-based interventions that meet the developmental needs of young children.

The American Academy of Pediatrics' (AAP) *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*⁷⁷ sets the standard for preventive care. Supported by multiple agencies of the federal Department of Health and Human Services, *Bright Futures* provides an evidence-based template for well-child visits and screenings, including a recommended periodicity schedule for universal and periodic screens, which specifies the number and frequency of screenings that cover many aspects of child development.

Once a problem is identified, effective treatment is key. Yet policy discussions around EPSDT often focus on screenings and preventive care, rather than whether children ultimately receive interventions necessary to address conditions identified.⁷⁸

States have quite a bit of latitude in how they deliver EPSDT services and set payment rates for providers. In particular, states have wide discretion, under federal parameters, to decide who is able to be reimbursed and where a service may be provided.⁷⁹ Yet a lack of clear billing policies and procedures, sometimes influenced by limited awareness of interventions and services young children need, can mute service delivery in practice.⁸⁰ Policymakers can employ the following strategies to help more young children get the services they need, when they need them.

S **Fully adopt AAP Bright Futures preventive care guidelines in Medicaid and CHIP.** States determine their own policies and guidelines for preventive care in Medicaid, including a periodicity schedule, or the state's reimbursement timetable for preventive screens. Full adoption of *Bright Futures*—including the periodicity schedule—can move toward a more uniform preventive care framework across states and primary care settings. Since these guidelines are updated regularly based on research, states should also ensure that state policy reflects or refers to *Bright Futures* recommendations and subsequent updates.⁸¹

As of 2018, Medicaid programs in 40 states and Washington, D.C., use *Bright Futures* as the preventive care standard or use a similar standard.⁸² Policies in 11 states (Alabama, Arizona, Arkansas, Delaware, Massachusetts, Minnesota, Missouri, New Jersey, Utah, Washington, Wisconsin) do not align with *Bright Futures*. These states specify fewer well-child visits for young children and/or do not reflect preventive screening guidance.⁸³

Even among states with recommendations similar to *Bright Futures*, specific screening schedules and reimbursement policies vary.⁸⁴



Prioritize the 'T' in EPSDT by reviewing and updating state policies and procedures where necessary.

States should review current policies and procedures to address barriers to treatments. Any updates should be accompanied by a robust education and training efforts for providers, on top of ongoing training and education on existing processes. Examples of areas to review include:

- **Definition and application of pediatric “medical necessity.”** EPSDT should account for preventive care as well as comprehensive child development services, including a child’s family and environmental factors.⁸⁵ This should be done in light of the requirement for medical necessity decisions to be based on an individual child’s condition, not on arbitrary cutoffs or condition lists.⁸⁶

As of 2018, 40 states and Washington, D.C. incorporate a preventive care purpose in Medicaid’s pediatric medical necessity definition, while nine states did not (Hawaii, Illinois, Indiana, Iowa, Kentucky, Mississippi, Nebraska, North Dakota, South Carolina). Arizona does not have a pediatric medical necessity definition.⁸⁷

- **Payment policies, procedures, and codes.** In some cases, new and/or underutilized services and treatment may require explicit billing policy or guidance for providers. State or MCO policy and procedure manuals should explicitly signal an ability for providers to bill for certain services, including how and where a child or their parent may be served. For example, several states have adopted new diagnosis criteria and billing codes for infant-early childhood mental health services.⁸⁸ States can also improve developmental and other preventive screenings through increased reimbursements or financial incentives to plans or providers that improve rates or exceed a standard.⁸⁹
- **Standardized referral/follow-up tracking.** Streamlining processes with clear cross-sector responsibilities and feedback loops can aid understanding of whether children receive necessary

referrals and follow-up care when a screen identifies a need. Thirty-three states promote standardized referral processes to connect children or families to follow-up services such as early intervention.⁹⁰

- **Delivery system barriers.** Colorado recently started allowing all Medicaid beneficiaries to receive mental health treatment, such as parent-child therapy, in the primary care setting for up to six visits without a diagnosis.⁹¹ Other states, including North Carolina and Oregon, also use pre-diagnosis codes to provide mental health interventions to young children at risk of mental health disorders.⁹²



Support interventions that recognize the role of parents and caregivers in a child’s healthy



development. Experts and policymakers are increasingly identifying ways to promote two-

generation approaches in Medicaid that nurture parent or caregiver-child relationships through federal guidance and state policy.⁹³

- **Issue federal guidance to states.** This is one important way the federal agency signals its priorities for states to address young children’s healthy development and clarifies promising strategies and practices in Medicaid. In 2016, the federal Department of Health and Human Services (HHS) provided guidance to states on the ways Medicaid can support home visiting—a service with clear evidence of cost-effective positive outcomes for mothers and their children.⁹⁴ Also in 2016, HHS guidance clarified that maternal depression screening during a child’s well-child visit—a *Bright Futures* recommended practice for new parents—can be billed to a child’s Medicaid number, along with any resulting parent-child therapy.⁹⁵ A follow-up information bulletin issued in 2018 built on earlier guidance, outlining ways Medicaid can support infants experiencing opioid or other substance abuse withdrawal. Referencing the previous administration’s efforts, the bulletin from HHS Centers for Medicare and Medicaid Services (CMS) clarified the opportunity for states to support mothers together with their infants as part of treatment.⁹⁶



- Clarify allowable payments for two-generation services or referrals to other systems.** [Thirty-three states](#) use Medicaid to finance home visiting for pregnant women or young children, through a variety of mechanisms.⁹⁷ [Thirty-seven states](#) allow, encourage, or require maternal depression screenings during well-child visits.⁹⁸ [Twenty-five states](#) reimburse maternal or caregiver depression screenings under a child's Medicaid enrollment.⁹⁹ States may also use a parent diagnosis to trigger eligibility for other supports or allow for reimbursement for parent-child treatment to aid child development. **New York** is providing additional guidance to clarify reimbursement for parent-child therapy under a child's Medicaid ID when a parent or caregiver is diagnosed with a mood, anxiety, or substance abuse disorder. **Michigan** and **Minnesota** take a similar approach.¹⁰⁰

S★ Strengthen linkages between health care and other community services through improved care coordination. Care coordination aims to link families with services within and outside the traditional health care system and break down barriers to care.¹⁰¹

Medicaid provides care coordination activities through case management—a required service under EPSDT—but its application is uneven.¹⁰² States should assess the extent and quality of care coordination currently available, starting with a review of existing policies (e.g. guidance, contract requirements, etc.) and practices with the goal of identifying opportunities to strengthen linkages and handoffs among primary care practices and other systems serving children and their families (e.g. early intervention, public health, maternal and child health, home visiting and other social services and supports).¹⁰³ States may also use payment policies to improve, enhance and incentivize care coordination, with payment rates based on the intensity of families' needs.¹⁰⁴

S★ Extend Medicaid benefits to CHIP. States can extend Medicaid's EPSDT benefit to separate CHIP programs to ensure all young children can access the full range of preventive care and treatment they need and create uniformity across both programs. [Eleven states](#) extend Medicaid EPSDT benefits to children in separate CHIP programs. Twelve states with separate CHIP programs do not extend Medicaid benefits to CHIP.¹⁰⁵

5 Invest in prevention and pediatric care innovation as a key component of health reforms.

Even as there is more to be done to ensure children and their families get services and supports in the existing systems, the broader evolution of the health system must do more to ensure that the needs of children—and specifically preventive care for young children and their families—are adequately addressed. Prioritizing young children in system reform offers a comprehensive approach to encapsulate many of the recommendations included throughout this paper.

Health care delivery and payment reform efforts are happening at the local, state and national levels. As reform efforts seek to save money in the short term, the needs of children are often overshadowed by adult-focused models, despite their real potential for long-term savings.¹⁰⁶ Medicaid can play a role in helping to spread and sustain practice changes that both elevate the preventive and developmental needs of young children and address conditions before they

become costlier down the road. This should include testing new approaches to address social determinants of health through improved linkages between the healthcare and social service systems.¹⁰⁷

F Use payment and delivery system reforms to advance high-performing pediatric medical

S★ homes. States, directly or through managed care contracts, determine payments for providers.

Reimbursement rates for pediatric care are relatively low compared to care for other populations, and typically don't allow for extended time and resources necessary to provide comprehensive screenings or guidance.¹⁰⁸ More than 30 states have implemented some type of pediatric medical home initiative in Medicaid or CHIP.¹⁰⁹ Figure 5 offers key elements in any progression toward high-performing pediatric medical homes.¹¹⁰



- The **Department of Health and Human Services** should further invest in pediatric payment innovations focused on improved outcomes for young children. Evaluations of new approaches should include a comprehensive analysis of the long-term costs and savings both within and outside the health system of Medicaid & CHIP specific budget line item(s).¹¹¹ A new CMS funding opportunity for states to test pediatric care models in response to the opioid crisis provides an important first step and may also yield important lessons on the integration of physical and behavioral health more broadly.¹¹²
- **State payment policies should seek to improve pediatric primary care as a central care hub for young children in Medicaid.** *Increased* primary care expenditures for young children will be required to provide and coordinate proven care interventions, such as behavioral health integration, and tailored care coordination using a broader, family-focused approach.¹¹³ Models should also consider innovative or promising approaches to address social determinants of health that play an important role in children and families' long-term well-being.¹¹⁴

Figure 5. Design for High Performing Pediatric Medical Homes in Medicaid



Source: K. Johnson and C. Bruner (2018, forthcoming), *A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health*, Child and Family Policy Center. (Adapted with author permission.)

Conclusion

State and federal lawmakers can use Medicaid as a catalyst for improved care and support to young children and their families, reaching them before they require more involved, complex interventions within and outside the healthcare system later in life. While necessary for change, Medicaid and the health care system cannot successfully serve young children in isolation. Improving outcomes for

children, such as school readiness or long-term economic success, also requires a broader focus on the child as part of a family and their needs as a whole. This wider lens demands authentic collaboration and shared accountability between Medicaid and other public systems (e.g. public health, education, child welfare and others), as well as the private sector, to get the job done.



Policy Options to Promote Young Children’s Healthy Development in Medicaid

CONGRESS	
<ul style="list-style-type: none"> Require 12-month continuous eligibility for all children in Medicaid and CHIP. 	p. 8
<ul style="list-style-type: none"> Allow states to extend the continuous eligibility period up to five years for young children under age 6. 	p. 8
FEDERAL AGENCY	
<ul style="list-style-type: none"> Require additional detail and transparency in state data reporting, with goal of disaggregating by child demographics (e.g. race/ethnicity), service delivery type (e.g. managed care versus fee-for-service), and service location (e.g. region, plan, provider) 	p. 9
<ul style="list-style-type: none"> Support development of Child Core Set measures that move beyond screenings to capture follow-up referrals and treatment received by young children. 	p. 9
<ul style="list-style-type: none"> Support interventions that recognize the role of parents or caregivers in a child’s healthy development (e.g. behavioral health care, home visiting) through new guidance. 	p. 11
<ul style="list-style-type: none"> Invest in pediatric payment innovations that both focus on improved outcomes for young children and allow for a comprehensive analysis of the long-term costs and savings both within and outside the health system. 	p. 13
STATE (by program administrative functions)	
Eligibility and Enrollment	
<ul style="list-style-type: none"> Expand Medicaid to all adults up to 138% FPL through ACA Medicaid expansion. 	p. 6
<ul style="list-style-type: none"> Ensure all eligible parents are enrolled in Medicaid. 	p. 6
<ul style="list-style-type: none"> Ensure no newborn leaves the hospital without health coverage by improving technology and processes to immediately enroll them in available Medicaid or CHIP coverage. 	p. 7
<ul style="list-style-type: none"> Make a newborn’s CHIP coverage effective on their birth date, regardless of when they are enrolled in their first 90 days.* 	p. 7
<ul style="list-style-type: none"> Adopt presumptive eligibility for children and pregnant women, or all adults. 	p. 7
<ul style="list-style-type: none"> Adopt Express Lane Eligibility (ELE) for children. 	p. 8
<ul style="list-style-type: none"> Require 12-month continuous eligibility for all children in Medicaid and CHIP. 	p. 8
<ul style="list-style-type: none"> Extend the continuous eligibility period for up to five years for young children under age 6.** 	p. 8
Quality Improvement	
<ul style="list-style-type: none"> Implement a comprehensive children’s quality improvement focus in Medicaid. Engage other child-serving systems to identify shared goals and outcomes to address through cross-system action (e.g. goal of school readiness). 	p. 9
<ul style="list-style-type: none"> Publicly report all Child Core Set quality measures, disaggregating by child demographics (e.g. race/ethnicity), service delivery type (e.g. managed care versus fee-for-service), and service location (e.g. region, plan, provider). 	p. 9
<ul style="list-style-type: none"> Move toward standardized tracking of service referrals and follow-up. 	p. 11
<ul style="list-style-type: none"> Ensure EPSDT data reporting, outreach/education, service requirements are explicit in state agency agreements with Medicaid managed care organizations (MCOs). 	p. 10
Benefits	
<ul style="list-style-type: none"> Adopt Bright Futures preventive care schedule and guidance in Medicaid and CHIP policy and practice. 	p. 10
<ul style="list-style-type: none"> Review state pediatric medical necessity definition and application to ensure it accounts for preventive care and comprehensive child development services. 	p. 11
<ul style="list-style-type: none"> Extend EPSDT benefits to CHIP.* 	p. 12
Payment and/or Delivery System**	
<ul style="list-style-type: none"> Review and update policies or procedures for new and/or underutilized services (e.g. developmental screenings, infant-early childhood mental health). 	p. 11
<ul style="list-style-type: none"> Support interventions that recognize the role of parents or caregivers in a child’s healthy development (e.g. behavioral health care, home visiting). 	p. 11
<ul style="list-style-type: none"> Strengthen linkages between health care and other community services through improved care coordination. 	p. 12
<ul style="list-style-type: none"> Advance high-performing pediatric medical homes that serve as a care “hub” for young children and their families. 	p. 13

* Only applies to states with separate CHIP programs.

** May require demonstration waiver depending on Medicaid beneficiary served (child or parent) service, service location, geographic area, and/or individual providing the service.



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About this Series

This issue brief is fourth in a series of papers from Georgetown University Center for Children and Families on the future of children's health coverage. Other briefs in the series include:

[The Future of Children's Coverage: Children in the Marketplace](#). *Focuses on ways to improve marketplace coverage and the associated financial assistance for children.*

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[How Medicaid and CHIP Shield Children from the Rising Costs of Prescription Drugs](#). *Focuses on how Medicaid and CHIP protect most children from the rising costs of prescription drugs.*



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