



First 1,000 Days on Medicaid Proposal #: 1

Proposal (Short Title): Create a Preventive Pediatric Care Clinical Advisory Group

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals/Systems Changes:

- Administrative Action, Statutory Change, IT/data infrastructure, State Plan Amend, Federal Waiver, NYS budget request

Proposal Background/Description:

This proposal is for Medicaid to convene a Preventive Pediatric Care clinical advisory group charged with developing a framework model for how best to organize well-child visits/pediatric care in order to implement the Bright Futures Guidelines...

While the issues the group would consider would need to be prioritized, the work would include but not be limited to issues such as:

- How to risk stratify families and match families to a practice's available supportive resources;
How to work collaboratively with a parent/guardian's health providers and health supportive community partners;
Use of care coordination tools and protocols;
Review and selection of proposed models for the integration of maternal and child mental health into pediatric primary care
Selection and timing of specific early childhood screening tools, including developmental screeners and social determinants of health screeners
How to incorporate trauma-informed care into practice, including how to identify and address Adverse Childhood Experiences
Use of multi-disciplinary teams for delivering evidence-based programs
How to incorporate vision, hearing, and dental screens and/or interventions
Development of systems to receive follow-up after screening and referral to offsite programs, including to Early Intervention providers
Delivering culturally and linguistically appropriate care



- Integration of primary prevention programs, particularly those that support families with parenting skills

The end goal of addressing these structural components of well-child visits/pediatric practice is to ensure that all children visiting primary care receive the most effective care possible.

Authentic and meaningful input and participation from family representatives and community groups would be sought. Medicaid would invite other payers to join the process in order to seek an all-payer approach to supporting the workgroup’s recommendations. The group would produce an initial set of recommendations within a year of convening.

**Cross-sector Collaboration Component:** Yes\_X\_ No\_\_\_\_\_

- Child and family-serving sectors that frequently partner with pediatric primary care (e.g. education, Early Intervention, welfare, and non-profit social service providers) will be invited to join the advisory group.

**Cost Assumptions:** Negligible – staff time for convening and managing group.

**Potential Return on Investment:** None

**Metrics to Track Success/Outcomes:**

- Process: Well Child Care clinical advisory group convenes, deliberates, and makes standard of care recommendations to New York Medicaid.

**Benefits of Proposal:**

- Reach: The advisory group’s recommendations, if implemented, would broadly benefit all young children on Medicaid receiving primary care, 80% of whom receive 5 or more well-child visits in the first 15 months of life.
- Addressing the barriers to implementing Bright Futures Guidelines would reduce disparities in care delivered across pediatric practices and optimize health content and connections in routine practice

**Concerns with Proposal:**

- Advisory group convening is at least one step removed from making changes that will improve outcomes for children
- Lack of data/information on what currently happens during routine well-child care visits, and how families fare after pediatric referrals to community resources, could make it challenging for the advisory group to make informed recommendations

**Links to Available Evidence:**

Current *Bright Futures* guidelines: [https://www.aap.org/en-us/Documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf)

**Additional Technical Detail: (If needed, to evaluate proposal)**



The NYS Association of Infant Mental Health has provided additional technical recommendations on how to implement in a manner that is supportive of Infant Mental Health-Endorsement certification.

**Reviewer Name and Organization:** Mary McCord, Gouverneur (H+H)

DRAFT



First 1,000 Days on Medicaid Proposal #: 2

Proposal (Short Title): Promote Early Literacy through Local Strategies

Implementation Complexity: High
Implementation Timeline: Long Term

Required Approvals/Systems Changes:

- Administrative Action, Statutory Change, IT/data infrastructure, State Plan Amend, Federal Waiver, NYS budget request

Proposal Background/Description:

This proposal is for Medicaid to launch one or more three-year pilots to expand the use of Reach Out and Read (ROR) in pediatric primary care and foster local cross-sector collaboration focused on improving early language development skills in children ages 0 – 3.

Children from lower-income homes may hear 30 million fewer words than their more affluent peers by age 3. This vocabulary gap is understood to greatly disadvantage low-income children by resulting in stunted language development at a young age, which subsequently can result in education achievement gaps.

ROR is a national evidence-based program in which child-serving primary care providers promote early literacy by:

- Talking with parents about the importance of reading aloud and engaging with their young children
Demonstrating how best to look at books and talk about the stories with their infants, toddlers and preschoolers
Encouraging them to cuddle up and read together at home and build routines around books
Giving a new book to the child to take home and keep

Studies of ROR suggest that parents served by ROR are twice as likely to read to their children at least three times a week, and that the program improves language development by 3 – 6 months.

Some NY health care providers already participate in ROR but the program is not sustained through Medicaid financing and there is room for expansion across the state.

The pilot program would operate as such:

NY Medicaid would provide three-year pilot funding to any interested mainstream managed care organization sufficient to conduct pilots covering up to 1,500 children age 0-3 per year

- The managed care organization will contract with the ROR program to provide administration of the Reach Out and Read program, including overseeing the credentialing and support of pediatric practices, ordering and delivering culturally and



age-appropriate books, and supporting data collection on program effectiveness. This support is particularly important for engaging small to mid-size practices where administrative resource limitations can be a barrier to adopting ROR.

- Child-serving primary care providers would apply to the managed care organization for pilot funding. Providers that include in their application a cross-sector strategy with non-health programs/initiatives for improving early literacy, especially through family capacity-building, in their respective community will be given preference in funding.
- All eligible providers would need to demonstrate in their application that they follow *Bright Futures Guidelines* well-child visit vision standards and identify areas of improvement, if needed (unfortunately there is not an existing health care quality measure for vision screening or examination in children)

Primary care providers participating in the pilot would be required to complete the national Reach Out and Read online CME training course (1.25 credits) and to share ROR-specific program data with the national organization and the managed care organization

The pilot would be open to all current ROR sites as well as primary care sites that wish to become a ROR site.

Medicaid should share the ROR model with other state agencies to explore opportunities of funding similar programs that promote early literacy in non-health care settings.

**Cross-Sector Collaboration Component:** Yes  No

- Applicants are encouraged to include at least two non-health partner organizations in their early literacy strategy (e.g. existing community early literacy programs, a local library that can sign families up for library cards, adult literacy programs, Child Care Resource & Referral Agencies, etc.)

**Cost Assumptions:**



<b>First 1K Days on Medicaid</b>	
<i>Promote Early Literacy through Local Strategies</i>	
MCO's participating per year	15
Children participating per year	1,500
570 kids x 2 well-child visits per year <sup>(1)</sup>	1,140
930 kids x 3 well-child visits per year <sup>(1)</sup>	2,790
Total well-child visits/books needed	3,930
Average cost per book (from ROR catalog)	\$2.75
Average cost per MCO	\$10,808
Annual Book Cost for Pilot	\$162,113
Additional Costs:	
Cost for training, program administration, non-health partnership facilitation and community outreach per child	\$10
Additional Annual Costs	\$225,000
<b>Total Cost (Gross)</b>	<b>\$387,113</b>
<b>Total Cost (State)</b>	<b>\$193,556</b>
1. The child will receive 1 book for each well-child visit they have throughout the year	

**Potential Return on Investment:**

- No data specific to Reach Out and Read is available, but improved language development is likely to reduce special education costs over the long-term.

**Metrics to Track Success/Outcomes:**

- Increase in days/week parent or guardian reads to child
- Language development scores (receptive vocabulary and expressive vocabulary)

**Benefits of Proposal:**

- Reach Out and Read is scalable: the program currently reaches 1 in 4 low-income families nationally at a cost of \$20 per child
- Both the outcome (language development) and the pilot design are cross-sector in nature, and there is opportunity to partner with a wide range of initiatives/programs seeking to work with medical practices
- ROR is considered by some to be the single most useful primary prevention intervention presently available to primary care
- Technical assistance and program materials can be provided through regional or state Reach Out and Read coalitions
- Reading with infants and children promotes bonding and stimulates child development.

**Concerns with Proposal:**

- Measuring the impact of the collaborative strategy will be difficult and could be discouraging to participants



- The cost does not include the associated costs of measuring language development (language development is not a QARR measure)  
The proposal does not explore public-private partnership or corporate sponsorship opportunities – although this issue could be pursued by DOH during implementation
- While ROR can have broad population health effects, some parents will require additional help — either those with no or low literacy, or those who need more focused work on the “serve and return” skills that are so critical

**Links to Available Evidence:**

Reach Out and Read national site contains a compilation of evidence:

<http://www.reachoutandread.org/our-impact/reach-out-and-read-the-evidence/>

**Additional Technical Detail: (If needed, to evaluate proposal)**

**Reviewer Name/Organization:** Elie Ward, AAP

DRAFT



First 1,000 Days on Medicaid Proposal #: 3

Proposal (Short Title): Task Force on Perinatal Care

Implementation Complexity: Low
Implementation Timeline: Short term

Required Approvals/Systems Changes:

X Administrative Action, State Plan Amend, Statutory Change, Federal Waiver, IT/data infrastructure, NYS budget request

Proposal Background/Description:

This is a proposal for Medicaid to convene a cross-sector Task Force on Perinatal Care, in partnership with Department of Health colleagues, aimed at developing data-driven strategies for enrolling pregnant women in Medicaid more quickly, increasing timely access to prenatal care, and ensuring women receive adequate postpartum and interconception care.

Although many women experience uncomplicated pregnancies, timely and adequate prenatal care can prevent poor birth outcomes. The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend that a woman with an uncomplicated pregnancy be examined every 4 weeks for the first 28 weeks of pregnancy, every 2 to 3 weeks until 36 weeks of gestation and weekly thereafter. They also recommend one postnatal visit. Appropriate perinatal services and education are crucial components of a healthy birth. Understanding how to stay healthy is important for preventing complications that can affect the health of both mother and baby before, during and after pregnancy.

In 2014, 88% of pregnant women enrolled in Medicaid managed care received timely prenatal care, although some managed care plans reported rates as low as 75%. That same year 69% of pregnant women enrolled in Medicaid managed care had a postpartum visit, with some managed care plans reporting rates as low as 61% (NYS Quality Assurance Reporting Requirements).

The Task Force would identify immediate next steps for improving perinatal care such as:

- Identifying best practices, especially from successful perinatal networks, related to identifying and enrolling pregnant women in health coverage, and disseminating these best practices to Medicaid providers and plans;
Identifying methods for notifying immigrant women on Emergency Medicaid of their eligibility for full Medicaid benefits if they become pregnant;
Identifying opportunities for health navigators to work with pregnant women to identify their options for retaining health coverage after pregnancy and to assist with planning a postpartum visit;
Identifying ways to incentivize providers and/or plans to engage patients to complete postpartum visits and make postpartum visits more appealing for women;
Facilitation at a local level of collaborative partnerships between health clinics, physician offices, managed care plans, and community-based organizations to improve care





women receive during the perinatal period, including a focus on social determinants of health, and development of warm handoffs to community-based health supports (e.g. home visiting programs, parenting programs, Family Resource Centers, etc);

- Identifying cultural, linguistic, or other reasons why women may receive delayed prenatal care;
- Identifying special resources and services needed to improve state infrastructure for pregnant women or women of child-bearing age and newborns with opioid addiction

The Task Force would also be charged with analyzing perinatal care data to identify hot spots of high disparities to best target outreach and enrollment efforts to communities or populations with highest disparities. The Task Force would also identify potential collective impact strategies based on the Task Force’s work. Medicaid would seek funds to provide planning grants to communities that initiate collective impact strategies based on the Task Force’s findings.

The Task Force would commence its work with a community listening tour to directly hear from at-risk women of childbearing age and provide communities with updates on the Task Force’s work.

**Cross-Sector Collaboration Component:** Yes  No

- Task Force is charged with identifying partnership opportunities with non-health organizations

**Cost Assumptions:** Negligible – staff time for convening and managing group. Any techniques identified by the Taskforce for improving enrollment/ engagement during the perinatal period or for planning grants would, however, carry a cost that could be borne in full or part by Medicaid.

**Potential Return on Investment:**

- The CDC has estimated a savings of \$14,755 per low weight birth prevented if all U.S. women received adequate prenatal care.(1)
- A study in New Hampshire found that every \$1 spent on prenatal care realized a savings of \$2.57 on medical care for low birth weight babies. (2)
- A study in Missouri of over 12,000 Medicaid births found that every \$1 spent on prenatal care resulted in a savings of \$1.49 in new-born and post-partum costs up to 60 days after birth. (3)
- The Institute of Medicine found that \$1 spent on prenatal care for women at high risk of delivering a low birth weight infant could save \$3.38 in direct medical care expenditures. (4)

**Metrics to Track Success/Outcomes:**

- Improvement on the NCQA’s Timeliness of Prenatal Care component of the Prenatal and Postpartum Care performance measure: *Timeliness of Prenatal Care:* The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

**Benefits of Proposal:**

- Focuses on an ‘upstream’ health issue that drives multiple birth outcomes
- Opportunity to bring a disparity reduction lens to the work

**Concerns with Proposal:**



- NYS has done similar exercises before and has made strides in early entry into prenatal care but improvement in birth outcomes is stagnant. Focusing on a different type of prenatal care delivery, such as centering pregnancy, might be a better investment of time and resources.
- Creation of Task Force is one step removed from making positive changes that will improve outcomes for children 0 – 3 (e.g., other proposals may have a more direct impact on prenatal care and timeliness of that care)

**Links to Available Evidence:**

National Institutes of Health (NIH). Eunice Kennedy Shriver National Institute of Child Health and Human Development. 2012. “What is prenatal care & why is it important?” [www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/prenatal-care.aspx](http://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/prenatal-care.aspx)

American Academy of Pediatrics. American College of Obstetricians and Gynecologists. 2012. “Guidelines for perinatal care.” 7th ed. Elk Grove Village, Illinois, American Academy of Pediatrics, and Washington, D.C.: American College of Obstetricians and Gynecologists. <http://ebooks.aappublications.org/content/guidelines-for-perinatal-care-7th-edition>

**Additional Technical Detail: (If needed, to evaluate proposal)**

- (1): Centers on Disease Control and Prevention, “An Ounce of Prevention: What are the Returns?” (October 1999)
- (2): Robin D. Gorsky and John P. Colby, Jr., “The Cost Effectiveness of Prenatal Care in Reducing Low Birth Weight in New Hampshire,” Health Services Research 24 no. 5 (December 1989): 583-598.
- (3): Wayne F. Schramm, “Weighing Costs and Benefits of Adequate Prenatal Care for 12,023 Births in Missouri’s Medicaid Program, 1988,” Public Health Reports 107 no. 6 (Nov-Dec 1992): 647-652
- (4): Behrman, R.E., Chairman, Committee to Study the Prevention of Low Birth- weight, Institute of Medicine, Preventing Low Birthweight. National Academy Press, Washington D.C., (1985): 237



First 1,000 Days on Medicaid Proposal #: 4

Proposal (Short Title): Expand Centering Pregnancy

Implementation Complexity: High
Implementation Timeline: Long Term

Required Approvals/Systems Changes:

- x Administrative Action
Statutory Change
IT/data infrastructure
State Plan Amend
Federal Waiver
X\_ NYS budget request

Proposal Background/Description:

This proposal is for Medicaid to support a pilot project in the neighborhoods/communities of poorest birth outcomes to encourage obstetrical providers serving Medicaid patients to adopt the Centering Pregnancy group-based model of prenatal care...

The model is designed to enhance pregnancy outcomes through a combination of prenatal education (gestational development, healthy behaviors) and social support. Use of the model has been associated with reduced incidence of preterm birth and low birth weight...

The Centering Pregnancy model brings together for prenatal care 8-10 women who are due at approximately the same time. Group visits, which last approximately two hours, take the place of individual prenatal appointments and fall on the same schedule.

Studies of the Centering Pregnancy model document some impressive results. A review by the University of Wisconsin Population Health Institute concluded in its What Works for Health database:

There is strong evidence that Centering Pregnancy improves birth outcomes, particularly among disadvantaged populations such as low income black and Hispanic women. Participants in Centering Pregnancy are more likely to receive adequate prenatal care than non-participating peers.



*CenteringPregnancy improves infant birth weight and reduces the likelihood of preterm delivery in disadvantaged groups. CenteringPregnancy may also reduce the risk of a NICU stay and fetal demise. CenteringPregnancy participants may engage in healthier behaviors and have more appropriate gestational weight gain than non-participants. CenteringPregnancy participants also appear to be more likely to engage in breastfeeding.*

Since 2013, the federal Strong Start for Mothers and Newborns Initiative, a joint project of CMS, HRSA, and the Administration on Children and Families, has funded multiple projects implementing Centering Pregnancy among Medicaid beneficiaries at high risk of poor outcomes, especially prematurity.

Encouraged by Centering Pregnancy's outcomes data, in 2013 South Carolina Medicaid began offering enhanced reimbursement for CP visits (\$30 per patient per visit up to \$300, with an additional incentive payment of \$175 for each patient that attends at least 5 visits). Other Medicaid programs, as well as some commercial payers have adopted similar incentives, generally enhancing reimbursement by \$25-30/visit.

Under this proposal, the NY Medicaid program would provide explicit financial support of \$30 additional/patient/visit up to a maximum of \$300 for a two-year pilot focused on the neighborhoods with poorest birth outcomes. Practices that are already providing Centering in these neighborhoods would receive the incentive, as would new practices adopting the model (60% downstate, 40% upstate) that would receive staff training and start-up support. The goal is to provide CenteringPregnancy to at least 2,000 women so the sample size is sufficient to demonstrate impact. The State, working with managed care organizations and providers, would collect the data, including cost, which would permit evaluation of the pilot over the two-year period following implementation. Further support, in the form of staff training and start up support, is critical. The state would contract with the Centering Healthcare Institute (CHI) to provide both training workshops for providers as well as on-going implementation support and technical assistance.

Medicaid should work with colleagues in the Department of Health and Department of Financial Services to raise awareness of the model and seek all-payer support. The state should also ensure that implementation of the model also includes screening and referral for social determinants of health (environment, housing, educational attainment, etc.).

Additionally, several First 1,000 Days workgroup members feel that NY Medicaid should consider developing a separate but similar pilot approach to testing the Centering *Parenting* model – a group model of well-child care that grew out of the popularity of Centering Pregnancy. Centering Parenting brings 6-8 moms, partners, support people and their same-age infants together in community with their healthcare providers and other parents who are experiencing similar parenting and child development stages. Centering Parenting focuses on increased safe sleep practices, extended breastfeeding, increase rates of current immunizations, more developmental screenings conducted, more access to oral health services, more mothers with healthy BMI, and more screenings for intimate partner violence & postpartum depression. The model is currently offered by 5 health care organizations in New York State (some of whom also offer Centering Pregnancy). As a newer model of care, less research has been conducted on the Centering Parenting model. If NY Medicaid were to pilot Centering Parenting it would need



to take into account the different resource needs and metrics of success associated with the model.

Cross-sector components: Yes \_\_\_ No\_\_X\_\_

Cost Assumptions:

First 1K Days on Medicaid	
CenteringPregnancy-- <b>New</b>	
Projected Number of Participating Women	2,000
Financial Support per Patient/Visit (\$30 per visit up to \$300 total)	\$ 300.00
MCO 2 Year Pilot Total	\$ 600,000.00
Centering Health Care Institute Training Costs (3 Provider Workshops (with 25 providers) @ \$18,750 ea	\$ 56,250.00
Additional Consulting/Support/On-Site Assistance	\$ 120,000.00
Total Cost	
<b>Total Cost (Gross)</b>	<b>\$ 776,250.00</b>
<b>Total Cost (State)</b>	<b>\$388,125</b>

\*Cost estimate includes pilot for Centering Pregnancy only. Additional resources would need to be sought by the State if it opted to also pursue a Centering Parenting pilot.

Potential Return on Investment:

A research study published in the Maternal and Child Health Journal in July of 2016\* documents savings in a South Carolina pilot program due to reduced risk of premature birth, low birthweight, and NICU stay. The return on the state's investment of \$1.7 million there was an estimated return on investment of nearly \$2.3 million.

\*Gareau, S., et al., Group Prenatal Care Results in Medicaid Savings with Better Outcomes: A Propensity Score Analysis of Centering Pregnancy Participation in South Carolina, Maternal and Child Health Journal, July 2016, pp. 1384-1393.

Metrics to Track Success/Outcomes:

- Increase in number of providers offering Centering Pregnancy model
- Reduction in incidence of low birthweight, preterm birth, and length of NICU stays among patients participating in Centering program compared to patients with comparable profiles receiving traditional individual care

Benefits of Proposal:

- One of only a few proposals focused on better birth outcomes, which is an important foundation for kindergarten readiness
- Evidence-base shows reduction in racial disparity of birth outcomes. This evidence-based practice responds to addressing the racial and ethnic disparities and increasing rates of prematurity and maternal morbidity/mortality.

Evidence demonstrates this is especially effective with adolescents.

Concerns with Proposal:



- Provider reluctance to change practice pattern to incorporate group model may limit uptake – there could be Information Technology innovations that ease some of the implementation challenges, particularly changes to patient scheduling, but the proposal as written does not identify those IT opportunities
- Pilot is likely to require additional funding for coordination personnel that is not reflected in the proposal

**Links to Available Evidence:**

What Works for Health review of Centering Pregnancy with links to evidence-base:

<http://whatworksforhealth.wisc.edu/program.php?t1=22&t2=16&t3=110&id=433>

Centering Healthcare Institute bibliography:

[https://www.centeringhealthcare.org/uploads/homepage\\_hero/Centering-Bib-2017-with-Branding.pdf](https://www.centeringhealthcare.org/uploads/homepage_hero/Centering-Bib-2017-with-Branding.pdf)

**Additional Technical Detail: (If needed, to evaluate proposal)**

See the Centering Healthcare Institute web site, <https://www.centeringhealthcare.org>, for detailed list of research studies, existing Centering sites, and reimbursement policies.

For list of Centering sites in NY, see

<https://centeringhealthcare.secure.force.com/WebPortal/ListOfCenteringSites?stateName=NY>

DRAFT



First 1,000 Days on Medicaid Proposal #: 5

Proposal (Short Title): New York State Developmental Inventory Upon Kindergarten Entry

Implementation Complexity: Medium
Implementation Timeline: Short term

Required Approvals/Systems Changes:

- Administrative Action, State Plan Amend, Statutory Change, Federal Waiver, IT/data infrastructure, NYS budget request

Proposal Background/Description:

Under this proposal the State Education Department, Medicaid, and other partners would agree upon a measurement tool to assess child development upon Kindergarten entry.

In recent years, unprecedented investments have been made in New York State on behalf of young children, in direct response to the growing body of evidence that shows that the ages between 0 and 5 are the fastest growing, most malleable years for the human brain.

A standardized measurement tool at kindergarten entry would enable (1) population-level tracking of trends over time in child development; (2) assessment of how policy and programmatic changes are possibly affecting child development; and (3) identification of areas (e.g. whether regions of the state, areas within child development) in need of improvement, investment, and policy change.

Such a measurement tool could also be valuable to child-serving health care providers. Providers frequently note that there are few viable outcome measures for assessing well-being in young children, which can make it challenging to invest in and evaluate interventions that promote health and development, especially as the Medicaid program becomes more outcomes-focused.

Many states have used similar tools for numerous years to better understand these critical first years of a child's life. Additionally, at least one other state – Oregon – has embraced the use of such a tool to drive improvements in pediatric care in addition to other early childhood sectors.



collaborate more effectively with early childhood providers, engage more meaningfully with parents, and drive improvement. Institutions of higher education can use the data to better tailor teacher preparation programs, both for k-12 teachers and early childhood specialists, to ensure New York has the best teaching workforce its children deserve. Developmental inventories help maximize the efficiency of government services that serve children and families, particularly those from low-income backgrounds.

This proposal suggests that New York State, in collaboration with its partners- State Education Department, State University, Medicaid program, experts in the field of early childhood development, and others as necessary- agree upon a tool to be implemented state-wide to drive results for children. As experts agree, any such tool needs to be developmentally appropriate and have a holistic approach to child development that includes cognitive, social-emotional, language, and motor development. The tool would need to be affordable, implementable across the state, and evidence-based.. The data from the tool would need to be made available as widely as possible, including to service providers in each relevant sector and parents/caregivers, in the most appropriate form for the use case. The tool also needs to be flexible to respond to advances in the field, such as the evolving tool used in Ohio, which has expanded over recent years to include social-emotional measures as well as cognitive ones. The State should consider how to use the cumulative measure to provide sector-specific information back to all sectors involved in child development, including but not limited to health care, early childhood education, social services, and parents and families, in order to drive sector-specific improvements.

**Cross-Sector Collaboration Component:** Yes  No

**Cost Assumptions:**

N/A—the recommendation herein includes the selection/creation of a tool; the State Education Department would be the implementation partner for this recommendation and would need to develop an appropriate cost estimate, if applicable.

**Potential Return on Investment:**

- Understanding of the ROI of federal, state, and local investments in early childhood
- Better coordination of services across multiple systems for children
- Lower long-term costs of care and social services as children experience better outcomes

**Metrics to Track Success/Outcomes:**

- # of kindergarten students across NYS assessed
- #/% of kindergarten students identify as “developmentally on-track” for kindergarten

**Benefits of Proposal:**

- Understanding of the ROI of federal, state, and local investments in early childhood
- Identify populations of children in need of support as early as possible, reducing high long-term costs as delays intensify
- Creates an outcome measure that could be tied to incentives or new strategies in children’s health care and other sectors
- Such a measurement tool is necessary for measuring year-over-year progress in improving child development





**Concerns with Proposal:**

While a Developmental Inventory is an invaluable tool to measure how we are serving our children, these tools can be used in destructive, inappropriate manners. The tool should not influence whether a child can enroll in kindergarten; should also not be used as a measure of the effectiveness of individual early childhood providers or programs, or for accountability purposes within early learning settings.

- The most critical years of child development are ages zero to three, and some argue measurement at kindergarten is too late. However, since pre-kindergarten is not yet universal in New York State, kindergarten is the first opportunity to universally collect data on children across New York State.
- Measurement tool could create a situation where each sector blames another for poor outcomes in child development

**Links to Available Evidence:**

<https://www.nhsa.org/kindergarten-entry-readiness-assessments>

[http://www.naeyc.org/files/naeyc/file/research/Assessment\\_Systems.pdf](http://www.naeyc.org/files/naeyc/file/research/Assessment_Systems.pdf)

Oregon “Health In All Policies”:

<http://www.oregon.gov/oha/PH/ProviderPartnerResources/HealthInAllPolicies/Education/Pages/index.aspx>

**Additional Technical Detail: (If needed, to evaluate proposal)**

**Reviewer Name/Organization:** State Education Department



First 1,000 Days on Medicaid Proposal #: 6

Proposal (Short Title): Expansion of “Connections: A Value-Driven Project to Build Strong Brains” Project

Implementation Complexity: Medium
Implementation Timeline: Short term

Required Approvals/Systems Changes:

- Administrative Action, Statutory Change, IT/data infrastructure, State Plan Amend, Federal Waiver, NYS budget request

Proposal Background/Description:

Under this proposal Medicaid would join local collective impact efforts focused on improving “kindergarten readiness” by working with counties, Early Intervention programs, local lead prevention authorities, local education authorities, pediatric providers, and managed care plans to improve developmental screening rates, referral to Early Intervention services, and the related systems to track progression of children through these systems of care.

This project is modeled off of a current project NY Medicaid is engaged in called “Connections: A Value-Driven Project to Build Strong Brains”. Under this project, in 2016, NY Medicaid joined the Albany Promise Cradle to Career partnership in a county-based pilot to:

- screen all children between the ages of 0 and 3 with a standard developmental screening tool;
refer all children who screen as developmentally off-track to appropriate care, including most specifically Early Intervention; and
track their progression through these systems of care until they enter school ready to learn.

This project is a Value-Based Payment pilot project, enabling bonus payment for participants who reach certain quality indicators.

Developmental screening, referral, and service provision is a statewide issue that crosses multiple sectors and has not yet seen widespread, scalable success. There are multiple issues regarding this level of service coordination and systematization. The Connections approach uses existing infrastructure (pediatric well-child visits, county-based Early Intervention supports, and managed care organizations capacity) to ensure that all children are given the appropriate level of screening and service. This approach has uncovered many structural issues within the current system, such as workforce shortage, data sharing issues, and connection between siloed systems. The Albany project is also collecting data on how many children are developmentally delayed but do not yet qualify for Early Intervention services, thus building up an important evidence-base that could inform the development of service pathways for these at-risk children. This collective impact approach to ensuring every child receives developmental screening and appropriate intervention is distinct in that it brings all relevant systems to the table in order to redesign the experience parents and families have in order to achieve population-level outcomes for kids.



Under this proposal Medicaid would expand their participation in collective impact strategies, and replicate their general approach to engaging managed care plans and providers around value-based payment for developmental screenings and referral, to two additional communities in New York..

Counties would be eligible to apply for an expansion pilot to bring this approach to their community if they could meet a set of basic requirements as it relates to having a cross-sector team in place to do the work needed for execution. These requirements would include: having an engaged local early intervention program; an engaged Local Education Authority that is the majority provider of kindergarten seats in the county; engaged healthcare systems/providers/pediatric providers; having data-sharing agreements with all parties as appropriate to track program results; having a neutral data team to support the project work.

Communities with existing cradle to career partnerships or other collective impact efforts would be given preferential treatment in the selection process. DOH would also consider whether sites are able to bring together local/municipal authorities and players who can develop approaches to reducing childhood lead poisoning, which can severely affect mental and physical development.

Medicaid would create opportunities for the two additional communities and the current Albany pilot participants to learn from one another.

**Cross-Sector Collaboration Component:** Yes  No

This effort builds upon existing collective impact strategies and specifically engages health care providers, school districts, and Early Intervention providers.

**Fiscal Analysis:**

Expansion of the Connections pilot budget over 1-2 additional sites.



<b>First 1K Days on Medicaid</b>	
<i>Expansion of "Connections: A Value-Driven Project to Build Strong Brains" Project</i>	
<b>Provider incentive:</b>	
Number of Medicaid members under 4 in project (estimated, varies by county)	7,500
Per member per month incentive to practices	\$ 20.00
Annual provider incentive total	\$ 1,800,000
<b>Plan incentive:</b>	
FTE cost (at full implementation, each plan to have 1 FTE devoted) *	\$ 60,000.00
# of plans in project (estimated, varies by county)	7
Annual plan incentive total	\$420,000
Total project cost	\$2,220,000
# of projects	2
<b>Total Cost (Gross)</b>	<b>\$4,440,000</b>
<b>Total Cost (State)</b>	<b>\$2,220,000</b>
* If plans participate in more than one project, they are only eligible for one full-time employee across all projects.	

\*Cost estimates based on current Albany pilot. At full implementation (county-wide), Albany pilot is expected to cost \$1.6M.  
 At current implementation level (reaching ~1800 children), Albany pilot costs ~\$650k annually (gross).

**Potential Return on Investment:**

- Increased rates of kindergarten readiness
- Lower long-term costs of remedial education and/or special education needs
- Lower long-term costs of care due to increased educational outcomes for children

**Metrics to Track Success/Outcomes:**

Population-level outcome:

- Increase the number of students who are kindergarten-ready when entering school

Project-specific measures:

- # of children 0-3 completing their 9, 18, 24, 30 month visit
- # of children 0-3 completing the ASQ-3 at their 9, 18, 24, 30 month visit and completing the ASQ:SE
- # of children who are screened by the ASQ-3 and ASQ:SE as above the cutoff, close to the cutoff, or below the cutoff in the 5 developmental domains
- # of children who are screened for Early Intervention; meet the eligibility requirement; enroll in EI services
- # of children found ineligible for services though Early Intervention Program and referred for other supports/services

**Benefits of Proposal:**



- Builds on high-impact point of care that already exists (well-child visit)
- Engages existing service providers (Early Intervention, school districts)
- Solves a complex problem that plagues multiple systems
- Collective impact approach helps reveal and address cracks in the systems between primary care and Early Intervention services
- Health care payments are outcome-driven (tied to performance)
- Due to Medicaid's experience with this approach in Albany it could quickly expand its involvement to other collective impact efforts

**Concerns with Proposal:**

- Not all counties will be able to receive replication grant
- Data infrastructure must be strong to enable this project's replication
- The "Connections" pilot in Albany is relatively new and findings from the effort have not been reported
- It is unclear whether families/caregivers are engaged in these efforts
- It is unclear how and to what extent other community organizations, such as child care providers or community-based organizations, can be involved in this effort

**Links to Available Evidence:**

<https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx>

<https://www.cdc.gov/ncbddd/childdevelopment/screening.html>

**Additional Technical Detail: (If needed, to evaluate proposal)**

The NYS Association of Infant Mental Health has provided additional technical recommendations on how to implement in a manner that is supportive of Infant Mental Health-Endorsement certification.

**Reviewer/Organization:** Juliette Price, The Albany Promise



First 1,000 Days on Medicaid  
Proposal #: 7

**Proposal (Short Title):** Incentivize Use of Infant Mental Health-Endorsement Credential

**Implementation Complexity:** Medium

**Implementation Timeline:** Long Term

**Required Approvals/Systems Changes:**

<input checked="" type="checkbox"/> Administrative Action	<input type="checkbox"/> Statutory Change	<input type="checkbox"/> IT/data infrastructure
<input type="checkbox"/> State Plan Amend	<input type="checkbox"/> Federal Waiver	<input checked="" type="checkbox"/> NYS budget request

**Proposal Background/Description:**

This proposal is for Medicaid to incentivize attainment of the Infant Mental Health Endorsement® (IMH-E®) to ensure that all those working with infants and young children, birth to age three, provide relationship based, family centered, developmentally appropriate, and culturally competent services. Additionally, this proposal calls for a collaborative effort with SED to work IMH-E competencies into professional curricula.

The Endorsement is a credential that was developed by The Michigan Association for Infant Mental Health, which licenses its use. NYS-AIMH, as a member of the Alliance for the Advancement of Infant Mental Health is one of 29 states (and 5 in the process) and several countries licensed to use this system. Nationwide there are more than 2,000 individuals who have earned this Endorsement, with another 1,000 in the pipeline.

The Endorsement documents that professionals working with children birth to five years of age and their families, have the specific skills, knowledge and experience needed to support children’s general and social-emotional development. It recognizes and documents multidisciplinary professionals’ participation in reflective supervision, attainment of specified levels of education and knowledge, and ability to promote and deliver high quality, culturally sensitive, dyadic and relationship-focused, trauma informed services to children, their parents, and caregivers.

An individual applies for the Endorsement and builds his/her own portfolio. This defines how standards and competencies have been met, through college coursework, specialized training and on-the-job learning. Each applicant's portfolio will look unique. In the process of building the portfolio, it is expected that many applicants will identify gaps and realize that they need training on a particular topic. NYS-AIMH will offer needed training and will serve to help connect applicants to existing opportunities where training is being offered.

Under this proposal, OHIP and SED would work to increase the number of professionals working with young children with IMH-E certification through a two-pronged approach:

1. Incorporation of IMH-E competencies into teacher, medical, and licensed clinical professional curricula. OHIP should partner with SED to engage Teach NY (a teacher education redesign committee), or a subset thereof, in identifying ways of incorporating IMH-E competencies into professional education. The appropriate contacts at SED, and within the Provost offices of SUNY and CUNY would be invited to participate if not already included in Teach NY. Provosts or surrogate experts at the major medical



universities and for the licensed clinical professions, (i.e. social work, psychology, mental health counseling, marriage and family therapy). We feel this step will be critical to ensuring that professionals across child-serving sectors have the competencies within IMH-E upon graduation. Combined with enhanced pay, per step #2 below, the net effect could be making the career path for child-serving providers more appealing.

2. Creation of an incentive payment for Medicaid providers who demonstrate qualifications for IMH-E. NY Medicaid should provide a rate add-on for any provider that receives the accreditation/Endorsement, following the creation of a list of providers with the accreditation/Endorsement. This approach would be similar to Medicaid's current add-on payment for Patient Centered Medical Home certification.

Creation of the IMH-E incentive payment should begin immediately in order for it to reward currently qualified professionals, and in order for it to be functional by the time new graduates begin to have the full suite of IMH-E competencies.

While Medicaid has direct control over payment incentives for Medicaid-billing health care providers, Medicaid can engage other agencies such as the Office for Children and Family Services and the Office for People With Developmental Disabilities to encourage development of similar incentives for IMH-E attainment for providers working in other sectors. For example, a subset of MH training/coaching could be embedded into CCR&R and Infant Toddler Resource Network contracts as well as at required staff trainings.

An additional step at a later date would be for OHIP to reevaluate the incentive system create a plan to phase-in a requirement linking Medicaid reimbursement to the attainment of the standards and competencies called the IMH Endorsement ® that ensures the highest level of consistent service provision across disciplines for 0-5 year olds and specifically for the licensed mental health practitioners listed in the technical specifications section below. This would ensure that children are receiving the best possible care and treatment, overall.

Companion recommendations that Medicaid could consider, beyond the IMH-E certification and enhanced reimbursement, to enhance support for infant mental health services and trained professionals include:

Working with managed care plans to require use of age-appropriate diagnostic classification system, Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-5™) for diagnosing IMH disorders in infants and young children. Crosswalk to adult diagnostic codes, as needed.

Ensuring all qualified, licensed mental health practitioners are eligible to receive Medicaid reimbursement for treatment and assessment (including diagnosis). Additionally, continuing to move toward expansion of agencies and providers that are Medicaid reimbursable (i.e. "Other Licensed Professionals" in settings and practices beyond Article 28 & 31 Clinics).

Working with IMH provider partners to financially support Reflective Supervision for all IMH direct service professionals, as Reflective Supervision is a critical requirement of effective service to the 0-3 population, and ensures fidelity to the model. Using routine screenings with infants and young children that capture social, emotional, and behavioral health and development, as well ongoing screening for trauma exposure, and requiring and supporting



observational measures of relationship quality with assessment after screening, is also needed.

Cross-Sector Collaboration Component: Yes  No

- Intention to work toward cross-sector adoption.

**Cost Assumptions:**

No estimate for the enhanced rate was provided. Eligible professionals include any professional working with very young children and their families, physicians, physician assistants, nurses, physical therapists, occupational therapists, speech therapists/pathologists, social workers, psychologists, etc.

<b>First 1K Days on Medicaid</b>	
<i>Incentivize Use of Infant Mental Health- Endorsement Credential for Providers</i>	
New York Estimated MI-AIMH Endorsements*	392
Managed Care PCMH PMPM (based on proposal's suggestion)	\$ 7.50
Estimated Caseload - Social Worker**	25
<b>Estimated Annual Incentive \$</b>	<b>882,000</b>
<b>Investments</b>	
Endorsement Application System ***	\$ 45,000.00
Credentialing and program costs (4 FTEs; \$100k salary and benefits per employee)	\$ 400,000.00
Estimated total investments	\$445,000
<b>Additional Costs</b>	
Provider Training	unknown
Total Cost	\$1,327,000
<b>Total Cost (Gross)</b>	<b>\$1,327,000</b>
<b>Total Cost (State)</b>	<b>\$663,500</b>
* - # of Providers, based on NY Census and Per Capita MI-AIMH	
** - The recommended caseload guideline for a full time social worker is between 20-30 patients (NHPCO, 2007)	
*** - from Proposal citation, Adelphi University Feasibility Study <a href="http://www.nysaimh.org/nysaiw/p15/wp-content/uploads/2015/11/Endorsement-Final-9-8-14-without-appendices.pdf">http://www.nysaimh.org/nysaiw/p15/wp-content/uploads/2015/11/Endorsement-Final-9-8-14-without-appendices.pdf</a>	
**** - not included: annual membership costs, application costs - anticipated to be paid by clinician	

**Potential Return on Investment:**

The goals of having a competent workforce reduce costs in various ways which can include:





- A competent workforce in IECMH, especially within NY's quality early learning initiative can mitigate preschool expulsion, suspension, and improve inclusion practices
- Mitigating entry into the behavioral health system, or shortening length of stay through access to high quality intervention services with specialized professionals
- Mitigating entry into the child welfare and other systems through the use of high quality prevention/promotion services (home visitation, early childhood mental health consultation, integrated physical-behavioral health environments)
- High quality, early childhood supports promotes the social emotional development of young children which in turn prepares them for their entry into school age programming, thus perhaps mitigating special education costs over time.

**Metrics to Track Success/Outcomes:**

- Increased numbers of skilled early childhood behavioral health treatment and education providers;
- Increased early identification of children with developmental, and social-emotional issues;
- Reduction in downstream costs for treatment of maternal depression, behavioral health and trauma support services

**Benefits of Proposal:**

- Proposal would reward providers who are providing evidence-based practice
- Over time the proposal could contribute to common cross-sector curriculum/training for infant mental health
- Addresses a significant workforce training concern
- It is appealing to ensure access to pediatric professionals with the expertise to address mental health issues.

**Concerns with Proposal:**

- Challenging to document the link between provider training, changes in how services are delivered, and outcomes for children.
- Endorsement could be viewed as an additional demand placed upon primary care providers
- Incentives for providers outside the Medicaid system to make these changes are not guaranteed
- Proposal may underestimate the number of professionals that will pursue IMH-E enhanced reimbursement and it is unclear what the appropriate Per Member Per Month reimbursement should be to adequately promote IMH-E credentials

**Links to Available Evidence:**

Krysik J, Rychen A, Mabingani D. Infant/Toddler Mental Health Coalition of Arizona Perceptions of the Infant/Toddler Mental Health Endorsement. May 2016:

<http://www.itmhca.org/pdfs/ITMHCAsurvey-2016.pdf>

Safyer M, Cucharo C, Foley G. Feasibility Study Addressing the Implementation of Infant Mental Health Competencies, Standards and Credentials for Professionals in New York State. August



2014: <http://www.nysaimh.org/nysaiwp15/wp-content/uploads/2015/11/Endorsement-Final-9-8-14-without-appendices.pdf>

**Additional Technical Detail: (If needed, to evaluate proposal)**

- Licensed mental health practitioners include: Psychologists, Licensed Marriage and Family Therapists, Licensed Mental Health Counselors, Licensed Clinical Social Workers, Licensed Creative Arts Therapists, and Advance Practice Registered Nurses.
- Information about the Endorsement: <http://www.nysaimh.org/what-is-the-nys-imh-endorsement>
- NYS-AIMH has begun working with several higher education professors who are in the process of aligning their courses to assure that their students will meet the competencies within that coursework. These include CUNY Brooklyn, SUNY Cobleskill, University of Rochester and Bank Street College. At Adelphi University they have developed a program that embeds the competencies in every course and offers a Master Degree in Infant Mental Health that creates dual title degrees with Social Work, Psychology, and Speech and Language.
- NYS-AIMH has been developing crosswalks with several statewide entities which provide standardized training and credentialing, which approves that their training meets specific competencies. (This includes the Child Development Associate Credential, the Pyramid Model Training series, The Healthy Families America required trainings and the New York State Parenting Education Partnership Credential.)
- NYS-AIMH has been in conversations with New York City Department of Health, Mental Health and Early Intervention regarding the Endorsement.

**Membership:**

- A person must maintain active membership with NYS-AIMH. Cost: \$50/year (This can be paid by the person's employer with an Organizational membership, which grants 5 individuals membership. This costs \$200/year.)

**Endorsement fees:** These are one-time fees associated with applying for the Endorsement

- Category 1 - \$40
- Category 2 - \$115
- Category 3 - \$325
- Category 4 - \$425

**Reviewer Name/Organization:** Wendy Bender, NYS Association of Infant Mental Health;

Additional Information: Estimate of credentialed providers abased on NY Census and Per Capita AI-AIMH:



<b>Provider Payment Component Estimate</b>	
<b>2014 MI-AIMH States</b>	<b>2010 Census</b>
Alaska	710,231
Arizona	2,915,918
Colorado	5,029,196
Connecticut	3,574,097
Idaho	1,567,582
Indiana	6,483,802
Kansas	2,853,118
Michigan	9,883,640
Minnesota	5,303,925
New Jersey	8,791,894
New Mexico	2,059,179
Oklahoma	3,751,351
Rhode Island	1,052,567
Texas	25,145,561
Virginia	8,001,024
West Virginia	1,852,994
Wisconsin	5,686,986
<b>Total MI-AIMH State Census</b>	<b>94,663,065</b>
New York	19,378,102
Total 2013 MI-AIMH Completed Endorsements & In Process Endorsements	1,913
Per Capita MI-AIMH to Census	49,484
<b>New York Estimated MI-AIMH Endorsements</b>	<b>392</b>

DRAFT



First 1,000 Days on Medicaid Proposal #: 8

Proposal (Short Title): Children’s Regulatory Modernization Workgroup

Implementation Complexity: Low
Implementation Timeline: Short term

Required Approvals/Systems Changes:

- X Administrative Action
State Plan Amend
Statutory Change
Federal Waiver
IT/data infrastructure
NYS budget request

Proposal Background/Description:

This proposal is for the formation of a Children’s Regulatory Modernization Workgroup.

New York’s current regulatory landscape is out of alignment with the state’s transformation goals. To address this challenge, the New York State Department of Health is undertaking a comprehensive Regulatory Modernization Initiative with the goal of streamlining and updating existing policies and regulations across a range of areas to create a hospitable environment to ensure that an enabling context exists to support new ways of work (National Implementation Research Network Hub). Throughout the summer and fall 2017 the Department began the work of modernization and alignment by convening a series of Policy Development Workgroup meetings to get input from a broad range of interested parties to help inform potential policy and regulatory changes.

Children’s health issues are often subsumed by high cost adolescent and adult health issues. A focus on children’s issues in the Regulatory Modernization Initiative would allow the state to remove regulatory barriers to providing a hospitable environment for the First 1000 Days. It would also provide a forum to clarify and correct perceived but not real regulatory barriers to caring for children and families.

To ensure a hospitable environment exists for the new children’s initiative, this proposal recommends that the state convene a Children’s Regulatory Modernization Workgroup, a sub-group of the Regulatory Modernization Initiative, and charge them with providing feedback on streamlining and updating of existing policies and regulations across a range of areas to best meet the needs of children. The workgroup would be charged with looking at regulatory and policy barriers directly related to children’s health services, with a special emphasis on modernizing and aligning regulations to transform the Medicaid services for infant and early childhood mental health. Issues to consider include barriers to systems integration, unique documentation requirements across systems, barriers to adopting new technologies (such as telehealth for remote consults), barriers to treating or supporting parents/caregivers when in direct interest of the child, barriers to using a nonclinical workforce, barriers to data-sharing between providers or across clinical and community settings, and barriers to providing offsite care and consultation. It should be expected that these conversations will lead to workforce deliberations – in anticipation of such an event, the State Education Department and State University of New York should be engaged in the process.

The workgroup must inform/recommend modernization guidelines that are consistent with the Triple Aim such as:



- Children preventive health measure will align with increased access to primary care in alignment with evidence based quality standards
- Increased access to early intervention
- Increased access to early childhood education
- Reductions in Emergency service utilization
- Reductions to out of home placements
- Long term population health and reduction of disparities
- Increased integration of cross sector services
- Increased efficiency in health care delivery and lower costs
- Increased involvement/consideration to effects of caregiver Behavioral Health (BH) and caregiver in child(ren)'s treatment.
- Increased policy and regulatory recognition of caregivers' involvement in services and sustainability of treatment outcomes.

Member Eligibility:

- Workgroup members will consist of cross-sector children's health subject matter experts including expertise in all ranges of child development (newborn to adolescent), as well as physical and mental health, and have broad regional representation
  - Workgroup members will be familiar with New York State's transformation goals
  - Workgroup members will be familiar with and align recommendations with Value Based Purchasing
  - Workgroup members will have some crossover membership with the MRT Children's Behavioral Health workgroup (which includes Medicaid, OMH, OCFS, OASAS) and have knowledge of the transition to managed care for children with behavioral health needs
- Workgroup members have expertise in Social Determinants of Health and race, equity and inclusion concepts
- Workgroup members will present recommendations, whenever possible, that have rigorous scientific evidence of improved health outcomes and proven returns on investment. Workgroup members will also seek input and engagement from families and caregivers.

**Cross-Sector Collaboration Component:** Yes \_\_\_ No\_X\_\_

**Cost Assumptions:** Negligible – staff time for convening and managing group.

**Potential Return on Investment (ROI):**

The workgroup will be chartered to look at the policy and regulatory barriers preventing the immediate and long-term benefits for 0-3 year olds, family members and achievement of potential ROIs.

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**Metrics to Track Success/Outcomes:**

- The workgroup will be successful when they complete a set of modernized policies and regulations aligned with the mission and vision of the NYS First 1,000 Days on Medicaid Initiative as evidenced by the consensus approval of the modernized policies and regulations by the Medicaid Redesign Team (or appointed body).



**Benefits of Proposed Children’s Modernization Workgroup:**

- Proposal would address systemic structural barriers that affect many of the First 1,000 Days priorities
- Could lead to related conversations around payment and workforce issues

**Concerns with Proposal:**

- Workgroup charter needs to be carefully written to ensure it is not duplicative or inconsistent with other State Policy Development Workgroups
- Process of making regulatory recommendations is at least one step removed from changing health care practices that can impact outcomes for children ages 0 to 3.
- Implementation of workgroup’s recommendations could require a statutory change.

**Links to Available Evidence:**

1. Inventory of Evidence-Based, Researched-Based, and Promising Practices: For Prevention and Intervention Services for Children and Juveniles in the Child Welfare, Juvenile Justice, and Mental Health Systems  
[http://www.wsipp.wa.gov/ReportFile/1639/Wsipp\\_Updated-Inventory-of-Evidence-Based-Researched-Based-and-Promising-Practices-For-Prevention-and-Intervention-Services-for-Children-and-Juveniles-in-the-Child-Welfare-Juvenile-Justice-and-Mental-Health-Systems\\_Report.pdf](http://www.wsipp.wa.gov/ReportFile/1639/Wsipp_Updated-Inventory-of-Evidence-Based-Researched-Based-and-Promising-Practices-For-Prevention-and-Intervention-Services-for-Children-and-Juveniles-in-the-Child-Welfare-Juvenile-Justice-and-Mental-Health-Systems_Report.pdf)
2. Performance-Based Contracting for Family Support and Related Services: Preliminary Report [http://www.wsipp.wa.gov/ReportFile/1575/Wsipp\\_Performance-Based-Contracting-for-Family-Support-and-Related-Services-Preliminary-Report\\_Report.pdf](http://www.wsipp.wa.gov/ReportFile/1575/Wsipp_Performance-Based-Contracting-for-Family-Support-and-Related-Services-Preliminary-Report_Report.pdf)

**Additional Technical Detail: (If needed, to evaluate proposal)**

**Reviewer Name/Organization:** Sylvia Rowlands, NY Foundling; Marcy Safyer, Adelphi University



First 1,000 Days on Medicaid Proposal #: 9

Proposal (Short Title): Common home visiting training

Implementation Complexity: Low
Implementation Timeline: Long Term

Required Approvals/Systems Changes:

- Administrative Action, Statutory Change, IT/data infrastructure, State Plan Amend, Federal Waiver, NYS budget request

Proposal Background/Description:

This proposal is for Medicaid to provide funding to develop and facilitate orientation, training, and coordination activities for all home visiting staff in New York State, regardless of program model.

New York State's home visiting staff, representing six research-based programs (Early Head Start, Healthy Families New York (HFNY), Home Instruction for Parents of Preschool Youngsters (HIPPI), Nurse-Family Partnership (NFP), Parents as Teachers, and The Parent-Child Home Program, Inc.), provide services to thousands of families across the State. Maternal, infant and early childhood home visiting can improve birth outcomes for newborns, reduce occurrences of child abuse and neglect, and improve school performance and high school graduation rates.

Home visiting staff currently receive model-specific core training, as well as wrap-around training according to need, from their individual home visiting programs. Home visitors do not receive training that provides a basic understanding of other home visiting programs operating in New York State, and no person has the responsibility for helping home visiting programs coordinate their efforts with clinical providers or community organizations to strengthen the continuum of care. As a result, home visiting programs can be fragmented and competitive.

Under this proposal, New York would fund a statewide home visiting trainer and coordinator – a new position – that would work to provide a common orientation to home visiting in New York and increase collaboration across programs. The coordinator would be responsible for providing a common orientation for all New York home visiting staff that focuses on raising awareness of the different home visiting models, and how home visitors can engage New York-specific resources, community organizations, and provider groups. Likewise, the coordinator would be expected to work with community resources (e.g. 2-1-1, child care centers, Planned Parenthood of New York, etc) to facilitate better connections to home visiting programs. The staff person could also develop additional home visiting training opportunities on issues of high priority to New York State, such as issues related to the First 1,000 Days ten-point plan, on an as needed basis.

The coordinator would work with the six home visiting programs to determine which value-added trainings modules are needed. In general, the common training would:

- Provide background on the different home visiting models, including a focus on population served (locations and eligibility requirements) and the strengths of each



- Describe and help implement components of a successful referral system (from one program to another, and from home visiting programs to other community and clinical resources)
- Provide additional education on how to work with families in their homes, including general and State-specific (as available) information on topics such as:
  - Trauma-informed practice/ACES
  - Personal safety
  - Gang-related violence
  - Domestic violence
  - Infant mental health
  - Postpartum depression
  - Safe sleep
  - Mental health/substance abuse
  - Self-care
  - Reflective supervision
  - Family capacity-building
  - Emerging topics (such as the opioid epidemic)

The coordinator would be expected to be experienced in training, supervision, and data collection/evaluation. The curriculum would be designed with input from the six home visiting programs, as well as with an eye to national (but often cost-prohibitive) trainings such as Ounce Achieve on Demand and HRSA Home Visiting Impact. Curriculum development would also be based on information derived by the New York State Home Visiting Workgroup over the past decade (including background on different models and successful implementation of a continuum of care). Curriculum development would take six months. Conceivably, the curriculum could be rolled out in late 2018.

Once a common orientation is developed, the coordinator would focus on enhancing the efficiency and effectiveness of home visiting program operations. This work would focus on strengthening connections of families to local preventive services, increasing coordination between home visiting programs and clinical providers, and establishing/recommending infrastructure for central intake systems and triage criteria for the provision of home visiting programs. These activities would need to be closely coordinated with New York's home visiting programs and the NY Department of Health.

Because this position would facilitate training across and between programs, it would bolster collaboration between models and program sites, and ultimately assist with central intake and allow the State to increase access to high-quality programs in a strategic and thoughtful manner.

**Cross-Sector Collaboration Component:** Yes  No

Home visiting, by design, is a cross-sector intervention. This proposal also focuses on increasing referrals and information sharing between home visiting programs and other child and family supportive services.

**Cost Assumptions:**





<b>First 1K Days on Medicaid</b>	
<i>Statewide Home Visiting Training</i>	
<b>Coordinator:</b>	
The coordinator would be a Masters level position, ideally with home visiting program experience.	
Salary	\$ 70,000.00
Fringe benefits	\$ 30,000
<b>Other costs:</b>	
Curriculum development:	\$ 50,000.00
Curriculum dissemination	\$ 5,000.00
Online training platform	\$45,000.00
<b>Total Cost</b>	<b>\$200,000</b>
<b>Total Cost (Gross)</b>	<b>\$200,000</b>
<b>Total Cost (State)</b>	<b>\$100,000</b>
* Costs expected to not exceed \$145k in subsequent years	

**Potential Return on Investment:**

- Every time a program trains staff, loses staff, and has to recruit and train again, there is an expense, as well as a strain on programs and families. Staff retention means family retention, as well as lower costs to programs.

**Metrics to Track Success/Outcomes:**

- staff participation in orientation/training
- increased retention of home visiting staff
- increased number of families served and retained through completion in home visiting programs
- development of a referral system across home visiting programs
- increase in referrals to home visiting programs from clinical providers

**Benefits of Proposal:**

- Proposal works to coordinate and align home visiting programs as a first step toward making more efficient and effective use of current home visiting resources
- By bolstering the workforce through enhanced training and support, this proposal could help to improve retention of workers and of participating families, and improve outcomes for more children and families.
- Programs are trained on their specific model, but several are more education or child welfare based. A universal training would allow for cross model benefits including addressing preventive health care such as prenatal health topics, birth spacing, nutrition and the critical resources available to meet the needs of pregnant and parenting families.



- Basic training would also support and assist in centralized intake to assure that home visiting resources are fully utilized within communities and families' needs are assessed and met.
- 

#### Concerns with Proposal:

- Unclear whether training and one staff person is sufficient to increase collaboration
- Collaboration at a statewide level is challenging -- local approaches may be more effective
- Training will only be beneficial if it is specific, targeted, high quality, and “value-add” to existing home visiting trainings
- Unclear what the Return on Investment is from coordination and training activities, although improvements in the number of families served by home visiting, and completing the programs, would have a significant ROI across government
- Proposal would possibly serve more people if it focused on training for community health workers/peer navigators working out of a community-based organization or health center

#### Links to Available Evidence:

- According to human resource experts, underfunded onboarding and a lack of training and/or mentoring are to blame for the fact that companies lose a quarter of all employees annually.<sup>vi</sup> A more recent survey found that 40 percent of employees leave those jobs within the first year, citing a lack of skills training and development as the main reason for exiting.<sup>vii</sup>
- According to a report from CLASP and CAP, “New York’s needs assessment identified client and staff retention as a barrier to achieving outcomes for children and families...Administrators plan to work through the Maternal and Infant Health Center of Excellence to provide trainings and technical assistance specifically related to recruitment and retention of both clients and staff.”<sup>viii</sup> Since the Center of Excellence no longer exists, we propose that this coordinator position fill the need that administrators have acknowledged.

#### Additional Technical Detail: (If needed, to evaluate proposal)

The NYS Association of Infant Mental Health has provided additional technical recommendations on how to implement in a manner that is supportive of Infant Mental Health-Endorsement certification.

**Reviewer Name/Organization:** Jenn O’Connor, Prevent Child Abuse New York

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<sup>i</sup> Lee, E., A. Mitchell-Herzfeld, A. Lowenfels, R. Greene, V. Dorabawila, K. DuMont. (2009). Reducing low birth weight through home visitation: a randomized controlled trial; *American Journal of Preventive Medicine*, 36, 154-60.

<sup>ii</sup> Dumont, et al. (2010). *Final Report: A Randomized Trial of Healthy Families New York: Does Home Visiting Prevent Child Maltreatment*. NYS Office of Children & Family Services and University at Albany. NIJ Grant 2006-MU-MU\_0002. <https://www.ncjrs.gov/pdffiles1/nij/grants/232945.pdf>



<sup>iii</sup> Daro, D. (2007). Supporting Children and Families through Home Visitation Strategies. *Chapin Hall Center for Children at the University of Chicago*.

<sup>iv</sup> See for example, NYS Office of Children and Family Services, *Prevent Child Abuse New York, and the Center for Human Services Research*. (2014). Healthy Families New York A Home Visiting Program that Works!, pp. 8-9. <http://ocfs.ny.gov/main/reports/HFNY%202013%20Triennial%20Report%203-14-14.pdf>; Olds, et al. (2002). Home visiting by paraprofessionals and by nurses: a randomized, controlled trial. *Pediatrics*; 110, no. 3: 486-496. For more studies referring to various program see: *Home Visiting Evidence of Effectiveness: Child Development and School Readiness*. <http://homvee.acf.hhs.gov/Outcome/2/Child-Development-and-School-Readiness/3/1>

<sup>v</sup> Levenstein, P., Levenstein, S., Shiminski, J. (1998). Long-term Impact of a Verbal Interaction Program for At-Risk Toddlers: An Exploratory Study of High School Outcomes in a Replication of the Mother-Child Home Program. *Journal of Applied Developmental Psychology*; 19(2): 267-285  
[http://www.socialimpactexchange.org/files/high\\_school\\_graduation.pdf](http://www.socialimpactexchange.org/files/high_school_graduation.pdf)

<sup>vi</sup> Smith, N. (May 22, 2012). The Big Thing That's Costing Your Company Employees. *Business News Daily*.

<sup>vii</sup> *Employee Training is Worth the Investment*. (2017). go2HR (<https://www.go2hr.ca/articles/employee-training-worth-investment>)

<sup>viii</sup> Schmit, S., Walker, C., and Herzfeldt-Kamprath, R., (February 2015). An Investment in Our Future. *Center for American Progress/Center for Law and Social Policy*.

DRAFT



First 1,000 Days on Medicaid Proposal #: 10

Proposal (Short Title): Statewide Home Visiting

Implementation Complexity: High

Implementation Timeline: Long term

Required Approvals/Systems Changes:

- Administrative Action, Statutory Change, IT/data infrastructure, State Plan Amend, Federal Waiver, NYS budget request

Proposal Background/Description:

This proposal is for New York Medicaid to take several significant steps to ensure the sustainability of home visiting in New York so every child and pregnant woman who is eligible and desiring of the services receives them.

Studies have shown that certain home visiting models are most effective at improving maternal and child outcomes and yielding strong returns on investment for states. Home visiting consists of a variable but comprehensive set of services including medical care, behavioral health care, social services and health education. There are opportunities for blending funding, as a variety of public and private funds presently support the services that make up home visiting programs. Major federal sources include the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program, Temporary Assistance to Needy Families (TANF), Title V Maternal and Child Health Block Grant, Individuals with Disabilities Education Act (IDEA) Part C, and Medicaid.

As the funder of over half of all births in New York, and 59% of kids aged 0 -3, Medicaid has a significant interest in promoting and spreading evidence-based home visiting programs.

Under this proposal, OHIP would take the following steps:

- 1. Convene a workgroup to identify opportunities for increased Medicaid payment for evidence-based, evidence-informed, and promising home visiting programs by:
a. Identifying common programmatic elements that could be paid for through allowable uses of Medicaid funding beyond what is currently reimbursed through Targeted Case Management and developing a budget model that would approach up to 50% Medicaid financing of home visiting programs.
b. Engaging finance experts to help design and address technical challenges related to implementation of braided funding strategies.
2. Engage NY State Education Department to explore scope of practice changes that would allow non-clinician home visits to be billable.
3. Design and launch a pilot project in 3 high perinatal risk communities to scale up evidence-based home visiting programs using a risk stratification approach to match



families to a home visiting program (or potentially other community-based health supports) that best fits their needs and eligibility. One of the evidence-based models that should be included in this pilot is Nurse-Family Partnership, consistent with recommendations of the Medicaid Evidence-Based Benefit Review Advisory Council (EBBRAC). Medicaid should evaluate the population health impact and return on investment. The pilot should include development of incentives to encourage clinicians to refer families to home visitation programs following a perinatal risk assessment or pediatric screening.

**Cross-Sector Collaboration Component:** Yes  No

- Work with State Education Department to explore scope of practice issues

**Cost Assumptions:**

Convening a work group – costs negligible - staff time for convening and managing group.

Costs for expanding home visiting to three high perinatal risk communities:

**First 1K Days on Medicaid**  
*Increase State Funding for Home Visiting - NEW*

Cost of home visiting per family (annually)*	\$	6,554
Number of families per pilot		200
Number of pilots throughout state		3
Clinician Incentives		TBD
Evaluation of population health impact/return on investment	\$	100,000.00
<b>Total Cost</b>		<b>\$4,032,400</b>
<b>Total Cost (Gross)</b>		<b>\$4,032,400</b>
<b>Total Cost (State)</b>		<b>\$2,016,200</b>

\* Source: NASHP home visiting brief, <http://nashp.org/wp-content/uploads/2017/09/Home-Visiting-Brief.pdf>

**Potential Return on Investment:**

“A recent review of evidence-based programs found the average cost of home visits to a family for 45 weeks was \$6,554 however, every dollar invested in the programs can yield up to \$5.70 in savings in the long run. These sizeable savings result from reduced health services utilization – including emergency department visits – and decreased special education placements and grade repetition, which leads to higher educational attainment and economic success later in life.” – <http://nashp.org/wp-content/uploads/2017/09/Home-Visiting-Brief.pdf>

**Metrics to Track Success/Outcomes:**

- Increase in home visitation enrollment across NYS
- Reduction in child abuse and neglect;



- Reduction in emergency room visits for accidents and poisonings;
- Reduction in child arrests at age 15;
- Reduction in behavioral and intellectual problems at child age six;

**Benefits of Proposal:**

- Proposal addresses an issue of high importance to First 1,000 Days workgroup members
- Strong evidence base behind some home visiting models
- Focuses on expansion in high perinatal risk communities first
- Incorporates and tests a risk stratification approach to connecting families to home visiting programs

**Concerns with Proposal:**

- Numerous policy priorities
- Currently, some home visiting programs that are eligible to receive reimbursement for Targeted Case Management activities are not submitting all claims to Medicaid for payment – this is reportedly because the reimbursement rate is not worth the time/resources expended for submitting claims. This issue is not specifically addressed in the proposal, although could potentially be reviewed and improved upon by the workgroup.

**Links to Available Evidence:**

The Department of Health and Human Services' Home Visiting Evidence of Evidence (HomVEE) website: <https://homvee.acf.hhs.gov/Default.aspx>

**Additional Technical Detail: (If needed, to evaluate proposal)**



First 1,000 Days on Medicaid  
Proposal #: 11

**Proposal (Short Title):** Developmental screening registry demonstration project

**Implementation Complexity:** High

**Implementation Timeline:** Long Term

**Required Approvals/Systems Changes:**

Administrative Action

Statutory Change

IT/data infrastructure

State Plan Amend

Federal Waiver

NYS budget request

**Proposal Background/Description:**

Under this proposal the Medicaid program would catalyze a cross-agency demonstration project that would test the feasibility of establishing a statewide registry that captures both the incidence and results of child developmental screening through the incorporation of the data into the existing child immunization registry, and allows multiple providers/organizations working with that child and family to view the results.

Screening a child for developmental status is frequently done by multiple providers, some within the health care system (hospitals, primary care clinicians) and some outside (Early Head Start and Head Start, other preschool programs, home visiting programs, Early Intervention programs). Often these diverse providers use the same screening tool, like the Ages and Stages Questionnaire (ASQ). Creating a central repository of the resulting data that could be shared by these multiple entities would permit all providers working with that child and his family to minimize the cost and time of duplicative screens and avoid having to request information from other providers. Reports generated from the data can also be used by public health officials to assure children are getting the right screenings/services in a timely manner.

Several states and/or counties are actively exploring or implementing central screening registry projects. These include Rhode Island, Vermont, Minnesota, Oregon, Michigan, Orange County, California, and Maine (see additional technical details for short descriptions). In Rhode Island, the state’s immunization registry expanded over time into an integrated early childhood database called [KidsNet](#), which could serve as a long-term vision for New York.

Funding for these projects generally come from a variety of sources, including federal Department of Education Race to the Top grants, Healthy Tomorrows Partnership for Children (joint effort of AAP and HRSA) grants, Title V programs, SAMSHA grants to promote child wellness, CDC grants, local organizations and foundations, and state and county funds.

Under this proposal, OHIP would issue a call to DOH, SED, and OCFS colleagues, and the early childhood health and education community, to form a design committee for a NYS Developmental Registry Project. The design committee would be charged with mapping potential users of a developmental registry (considering parents, early childhood educators, home visitors, family resource centers, etc.), and reaching consensus on threshold questions such as: whether the registry should be an add-on to immunization registries, standalone, or added to an early childhood database like Help Me Grow, newborn screening registry, or a health data repository like the RHIOs and SHIN-NY; data scope; identification of allowable



survey tool(s), including the potential of a single standardized tool; who can submit and who can access data; and security and confidentiality requirements.

After these threshold questions are answered, the design committee would identify one community to pilot some or all aspects of the registry to get feedback from providers, other potential contributors and users, and from families. Potential communities include those with an existing collaborative impact strategy focused on improving developmental screening, those that have already been working towards a common developmental screening data infrastructure, or those with experience expanding the immunization registry to new domains (e.g. lead screening).

The design committee would award funds to a lead entity to build and test a local developmental registry infrastructure, and assess the value of such an infrastructure through metrics such as usage by different accessor types (e.g. pediatric practice, home visiting program, parent, etc.) and changes to developmental screening rates and referrals.

To maximize federal funding for this effort, OHIP should pursue an advanced planning document with the Centers for Medicare and Medicaid Services (CMS) to obtain enhanced FMAP support through a pre-determined cost allocation to Medicaid. Additionally, OHIP can explore with the design committee opportunities to incentivize Medicaid provider and managed care plan participation in the demonstration project.

**Cross-sector Collaboration Component:** Yes  No

- Inclusion of multiple sectors on design committee and inclusion of multiple sectors as intended users of the developmental registry

**Cost Assumptions:**

<b>First 1K Days on Medicaid</b>	
<i>Developmental screening registry demonstration project</i>	
<b>Cost for Registry Add-on Only (Requires Statute change)</b>	
Initial Build of Platform to include printing of reports - not data analytics*	\$ 150,000.00
<b>Subsequent yearly costs are ~\$264,000 (\$22,000 per month)</b>	
<b>Total Cost (Gross)</b>	<b>\$ 150,000.00</b>
<b>Total Cost (State)</b>	<b>\$75,000</b>
* Start-up costs to build platform in Year 1 are estimated at ~\$150,000. Estimate for building with data analytics capability is \$250-500,000.	
**Would need additional analysis to understand funding source -may not be able to fund through Medicaid dollars	





**Potential Return on Investment:**

Ready access to common database would reduce duplication of effort among the diverse entities caring for the same child

**Metrics to Track Success/Outcomes:**

- Utilization of registry by diverse types of providers (# “hits”)
- Percentage of children screened
- Increase in the number of children screened

**Benefits of Proposal:**

- Common database would help strengthen collaboration between health, education and child care systems in support of children in their joint care
- Data could be used to identify “hot spots” where screening efforts lag and to design community specific interventions based on identified developmental delays
- Proposal focuses on an important infrastructure need and could be step toward the creation of an Early Childhood Integrated Data System, as with the state examples included in the additional technical detail section
- Proposal could begin to integrate or connect the various data systems that are collecting information on young children and families
- . The recommendation for an integrated data system is closely related to ideas being considered by the State Education Department Blue Ribbon Committee.

**Concerns with Proposal:**

- Successful implementation requires “buy-in” by multiple stakeholders
- Getting all appropriate parties to “feed” and appropriately utilize a registry is difficult and can take substantial time to achieve near universal participation
- Requiring reporting into the immunization registry typically requires a statutory change
- A similar previous initiative – CHII2 – was considered to be time consuming and not successful
- Proprietary vendors of existing health record solutions that may include developmental screening results make it especially difficult to connect their systems with outside systems
- Registry alone does not create accountability for addressing developmental delays once identified
- The need for community-based organizations to access to aggregate data (population level) to better understand needs in the community and make adjustments based on outcomes raises questions about whether an immunization registry as a single data point report system would be sufficient for developing a broader systems improvement tool that can deal with the complexities of the multiple component parts of developmental screen results
- A developmental screening registry may inappropriately suggest that, once a screening has been conducted, the child would not be in need of additional screening. No child’s developmental trajectory is fixed; events that may change a child’s developmental trajectory (trauma exposure, attachment disruption, toxic stress, timely receipt of Early Intervention services) should result in a new screening, with updated results, and registry development should consider this reality and encouraged subsequent screenings



- Due to the size and scope of this proposal it would likely need a dedicated workforce to design, implement and monitor over time.

### **Evidence-Based Links:**

#### **Additional Technical Detail: (If needed, to evaluate proposal)**

New York State and New York City have separate immunization registries, but some commenters believed those registries could be built upon and integrated without creating a completely separate developmental screening registry.

Rhode Island – Its 20 year old KIDSNET database has expanded over time to include not only immunizations but also results of newborn screening (bloodspot, hearing, and developmental risk), Early Intervention and home visiting data and WIC participation.

Vermont -- Currently expanding its state immunization registry to incorporate a module that captures Universal Developmental Screening results using the ASQ-3 screening tool with support from Help Me Grow.

Minnesota – Developing system that would permit capture of developmental and social-emotional screening results and sharing, all electronically. It also would use ASQ screening tools.

Oregon – Exploring use of its Health Information Exchange capacity to collect developmental screening data.

Michigan – 3 counties (Wayne, Oakland and Macomb) are exploring various IT infrastructures to establish linkages between various providers.

Orange County, California – Developing a developmental screening registry as part of its initiative to strengthen its countywide maternal and child health system.

**Reviewer:** Early Childhood Advisory Council



First 1,000 Days on Medicaid Proposal #: 12

Proposal (Short Title): Carve-In Fee-For-Service Early Intervention Payments into Medicaid Managed Care

Implementation Complexity: High
Implementation Timeline: Long term

Required Approvals/Systems Changes:

- Administrative Action, Statutory Change, IT/data infrastructure, State Plan Amend, Federal Waiver, NYS budget request

Proposal Background/Description:

This is a proposal for New York’s Medicaid program to carve-in Early Intervention Program services into managed care.

Early Intervention provides therapeutic and support services for children, under the age of 3, with a confirmed disability or exhibiting developmental delay. Approximately 68,000 New York Children are served by Early Intervention services annually. Half of these children are Medicaid beneficiaries.

Under current operations, Medicaid pays for Early Intervention services on a fee-for-service basis through a fiscal intermediary. Including this payment responsibility as part of managed care contracts (a “carve-in”) would mean that managed care organizations would be responsible for ensuring payments are made to Early Intervention providers in a timely fashion and that an adequate network of providers is maintained.

In order to begin this transition, the Office of Health Insurance Programs should engage with the Office of Public Health, which oversees the EI program, in order to determine how EI benefits could be moved into managed care. Considerations in this process would include, but not be limited to, establishing clear credentialing criteria, network adequacy standards (especially transitional standards), provider contracting protections (e.g., must contract with any provider with more than X of the plan’s enrollees in EI), rate protections or phase-in requirements, whether medical necessity is the appropriate standard for approving services, integration of federal EI regulations, etc.

Cross-Sector Collaboration Component: Yes X No

Provider and patient advocacy groups will need to be engaged in a collaborative effort.

Cost Assumptions:

TBD, likely budget neutral for the State (some commenters raised concern that with a neutral budget managed care plans would not be able to provide enhanced reimbursement or network improvements)

Potential Return on Investment:



- Long-term returns from improved network adequacy and payment to EI providers could result in decreased special education services

**Metrics to Track Success/Outcomes:**

- TBD

**Benefits of Proposal:**

- Can be accomplished by DOH through administrative action (TBD)
- Allows plans to track and coordinate care from referral through receipt of EI services, as opposed to current reality where plan has no view of services provided because they are not paying for those services
- Plans could create feedback loops by providing EI service data back to referring providers
- Highly relevant to new child populations being incorporated into managed care (e.g. foster care and intellectual and developmental disabilities)
- Potentially encourages plans to better support EI services in their commercial lines of business
- Plans may be able to increase Medicaid rates for EI providers (similar to how their rates for primary care are higher than fee-for-service rates)

**Concerns with Proposal:**

- This proposal is the only one of the 23 that received vehement opposition with a number of commenters noting that they would actively lobby against its implementation.
- Early Intervention providers took a long time to get comfortable with the current Medicaid fee-for-service reimbursement system and still don't believe the current rates are sufficient
- Early intervention providers are already under significant financial pressure, some have closed down, and certain geographic areas lack providers -- this proposal may further frustrate already struggling providers.
- Managed care "carve-ins" take a significant amount of time and effort by the Department of Health, plans, providers and other stakeholders and can take years to materialize
- Managed care plans would interface with services they do not have experience with – training and education would be required for a successful transition
- Providers who are not accustomed to billing managed care plans would need to learn how to do so and develop the resources necessary to bill multiple plans, they would also need to be credentialed by, and contract with, plans. Administrative burdens and financial cost of this would be difficult for providers to meet and could exacerbate existing capacity issues for EI providers. There is no guarantee that health plans would approve the credentials of EI providers, potentially limiting therapy opportunities for children in the State
- Plans are only authorized to provide health care services but the EI program includes non-medical services (e.g., family respite, training of day care staff). Plans would face a significant burden in developing networks, credentialing providers and managing services they are not authorized to cover and with which they are unfamiliar
- Plans might want to exert influence over early intervention providers in a way that is not necessarily positive for early intervention providers or beneficiaries
- A cost neutral carve-in does not necessarily provide plans with the resources necessary to implement a carve-in effectively



- The proposal does not address the transition from Early Intervention to Committee on Preschool Special Education services, and may create additional barriers to streamlining that transition
- Proposal creates the opportunity for a two-tiered system where children entitled to EI are served differently based on their insurance status/payer
- If children go on and off Medicaid while receiving EI services, there could be challenges with continuity of care for the child and family
- Commercial managed care plans currently deny EI services at a very high rate, many of those same payers participate in Medicaid and may attempt to limit services or create substantial administrative barriers to providers getting reimbursed for appropriate services (e.g., medical necessity determinations)
- A new payment system implemented by NYS DOH in 2013 which requires EI providers to bill commercial insurance companies directly caused payment delays and waiting lists for children to access services. Prior to 2013 counties were responsible for billing services and paying providers. Providers continue to leave the EI program because of the costly administrative burdens associated with the payment system. Providers are not reimbursed for these new costs. They have not had an increase in rates in over 20 years and have suffered significant decreases. This proposal could trigger more providers to leave the EI program and seriously impair children's access to critical therapies.
- Assuming the carve-in could be done on a cost-neutral basis (no additional cost to the state), the benefits don't necessarily outweigh the costs associated with potentially disrupting service delivery system (e.g., not clear that plans are well positioned to ensure receipt of services or successfully track children in short time periods)
- Medicaid is only a source of reimbursement for some Early Intervention services and covers only therapeutic services that are provided by a licensed speech therapist, occupational therapist, physical therapist, psychologist or social worker. Any EI service that is provided by a licensed special education teacher is not billable under Medicaid. Special instruction, family support services, and group developmental services may be impacted by this proposal and could result in significant impact in access to care particularly for children on the autism spectrum
- Risk that Medicaid reimbursement could be reduced if providers had to negotiate rates with managed care plans; this could negatively impact provider capacity.
- If statutory change required to implement a carve-in, unknown likelihood of such a change being supported by the legislature
- Early intervention is not a medical model, and there are open questions whether applying a medical model of reimbursement is feasible and pertinent
- EI system has governing regulations that would have to be upheld by plans (e.g., by federal statute children need to have an individual family service plans meeting with 45 days of evaluation) It is a highly regulated process that may not align with the Managed care process and its own regulations (e.g., mediation or impartial hearing in EI vs. due process requirements in Medicaid managed care)
- Because of the individual family service plans requirement, plans would arguably have limited ability to manage the care of children in the EI program, but would be required to pay for any service included in the service plan
- Under Part C parents have the right to choose their ongoing service coordinator and the providers who will conduct the multidisciplinary evaluation. This could mean that plans would have to contract with all approved providers.



- Technical infrastructure would have to be created to communicate which services are approved in an individual family service plan into the Medicaid managed care plan's claims processing systems. This may be especially problematic because children enrolled in EI receive frequent evaluations, which may result in changes to the services for which they are eligible. This is likely to result in both inappropriate denials and payments for services by the plans
- Services that are not covered by Medicaid managed care plans would have to be covered by municipal EI programs, potentially imposing a financial burden on municipal governments

**Links to Available Evidence:**

**Additional Technical Detail: (If needed, to evaluate proposal)**

DRAFT



First 1,000 Days on Medicaid Proposal #: 13

Proposal (Short Title): Expand Value-Based Payment to Child Health Plus

Implementation Complexity: Medium
Implementation Timeline: Short term

Required Approvals/Systems Changes:

- Administrative Action, Statutory Change, IT/data infrastructure, State Plan Amend, Federal Waiver, NYS budget request

Proposal Background/Description:

Under this proposal, NY Medicaid would work with Child Health Plus (CHP) staff to make Value-Based Payment arrangements available to CHP plans and providers.

In September 2017 more than 350,000 New Yorkers were enrolled in the CHP program (New York's version of the federal/state Children's Health Insurance Program). These children are covered by 15 CHP managed care plans, most of whom are also Medicaid managed care plans. Historically these plans and their network providers have delivered care under a fee-for-service model that neither incentivizes nor provides adequate flexibility for effective pediatric primary care that promotes healthy development, especially for children ages zero to three.

New York Medicaid has spent more than two years working with hundreds of stakeholders to develop value-based payment models and measures for the majority of the Medicaid population served by managed care plans. Most recently a specific set of recommendations for a children's value-based payment model and associated measures were presented to the State's VBP Workgroup. The children's VBP measures were adopted for Medicaid VBP beginning in 2018, while some work remains on the details of the payment model.

Building on the work of the Children's VBP Subcommittee, and the impending final recommendations of the broader VBP Workgroup, the Department of Health should extend the opportunity for CHP plans and their network providers to enter into value-based payment arrangements for children in CHP. Specifically, the state should formalize the availability of VBP model options (especially the finalized Children's VBP model and associated required measures) in CHP plan contracts and identify ways to incentivize CHP plans to adopt VBP payment models and quality measures (e.g., incentives for adoption similar to those in the VBP Roadmap for Medicaid plans). Consistent with requirements for higher level VBP arrangements in Medicaid, all CHP VBP arrangements should be required to address at least one social determinant of health and include a community-based organization partner to address that social determinant.

Successful implementation of this proposal will require close cooperation between Medicaid and CHP staff to ensure that the VBP models, which have been designed for Medicaid, can be successfully adopted by CHP.

Cross-Sector Collaboration Component: Yes \_X\_ No \_\_\_



- The social determinant requirement will encourage plans, providers and community-based organizations to partner on community level social needs (e.g., early childhood literacy, food insecurity, etc.).

**Cost Assumptions:**

N/A – Value-based payment in CHP can be accomplished within the existing CHP plan rate structure.

**Potential Return on Investment:**

- Short-term returns from decreased CHP utilization (e.g., emergency department and inpatient visits) would be reinvested in additional preventive and social determinants services.
- Long-term returns could include reduced juvenile justice and education expenditures.

**Metrics to Track Success/Outcomes:**

- Percent of CHP enrollees served by providers that are in a VBP arrangement
- Improvement and high performance on Children's VBP measures

**Benefits of Proposal:**

- Leverages existing Medicaid VBP stakeholder work
- Can be accomplished by DOH through administrative action
- By expanding Value-Based Payment to Child Health Plus and creating more parity between Medicaid and Child Health Plus, providers and Community Based Organizations can serve all children in the same manner and equally regardless of whether they have Medicaid or Child Health Plus.
- Provides opportunity for cross-sector focus on social determinants at the provider/community level by encouraging plans and providers to focus on more than just medical issues

**Concerns with Proposal:**

- Implementation cannot begin until Medicaid VBP Workgroup details on Children's VBP model are finalized
- Requires additional engagement with CHP plans over details of contract amendments and incentive structures
- It is unknown how much potentially preventable utilization exists in the CHP program and whether there are unique VBP model considerations for this population such that the existing and emerging Medicaid models and measures would not be appropriate for this population
- Savings alone may be insufficient to support necessary preventive and social determinant flexibility for providers
- Proposal is broader than children ages zero to three

**Links to Available Evidence:**

**Additional Technical Detail: (If needed, to evaluate proposal)**





First 1,000 Days on Medicaid Proposal #: 14

Proposal (Short Title): Require Managed Care Plans to have a Kids Quality Agenda

Implementation Complexity: Medium

Implementation Timeline: Short term

Required Approvals/Systems Changes:

- Administrative Action, Statutory Change, IT/data infrastructure, State Plan Amend, Federal Waiver, NYS budget request

Proposal Background/Description:

Under this proposal the Department of Health would develop a two-year effort to improve managed care plan performance on children and perinatal health care quality measures.

While overall performance on Medicaid managed care plan quality measures related to young children is relatively high, and often exceeds national averages, there remains room for improvement. For example, only 80 percent of children in Medicaid managed care in 2015 received the recommended five or more well-child visits with a primary care provider in their first 15 months of life. Performance on prenatal and postpartum care is even lower. In 2014, only 74 percent of women continuously enrolled in Medicaid managed care for 10 or more months who delivered a live birth had their first prenatal care visit during the first trimester of pregnancy. A mere 70 percent of Medicaid managed care mothers that gave birth in 2015 had a postpartum care visit between 21 and 56 days after the birth.

Managed care plans have had some incentive to focus quality improvement efforts on young children and the perinatal health of mothers that can greatly influence child health because measures of well-child visits, timely prenatal care, and postpartum care were among the 33 included in the Quality Incentive program in 2016. In 2009 and 2010 the Department of Health and its External Quality Review Organization (IPRO) focused plan Performance Improvement Projects (PIPs) on childhood obesity prevention, providing a model for how DOH can require plans to focus on early childhood health and perinatal health improvement.

DOH working with its External Quality Review Organization would develop a two-year common PIP for all Medicaid managed care plans called the "Kid's Quality Agenda." The focus of the common PIP could be threefold: 1) to increase performance on young child related Quality Assurance Reporting Requirements (QARR) measures (well-child visits, lead screening, child immunization combo); 2) to enhance rates of developmental, vision, hearing and maternal depression screenings and/or evaluations; or 3) to improve select performance on existing QARR perinatal health measures.

Under the PIP each plan would be required to develop, implement and evaluate a supplementary intervention that aims to address the three focus areas. Each PIP would be evaluated by the External Quality Review Organization which would publish a compendium of PIP abstracts per CMS requirements.

To encourage Medicaid managed care plans to adequately invest in the Kid's Quality Agenda PIPs, DOH would provide an extra one measure's worth of points (currently 3.03 points) in



calculating the Quality Incentive program results, for any plan that was in the 90<sup>th</sup> percentile on all three of related measures in that program (well-child visits first 15 months, timeliness of prenatal care, and postpartum care). An additional one bonus point in the Quality Incentive program calculation would be available to any plan that effectively engaged non-health sector community based organizations in its intervention (as validated by the External Quality Review Organization).

**Cross-Sector Collaboration Component:** Yes  No

The additional Quality Incentive bonus point for engaging non-health sector CBOs in the intervention should encourage plans to actively work cross-sector in designing and implementing their PIPs.

**Cost Assumptions:**

N/A – There is no state costs associated with this proposal. Plans contracts already require that they conduct PIPs as directed by the state, and the additional points associated with the Quality Incentive program measures would merely give high performing plans a higher score to improve their potential distribution from the existing Quality Incentive pool.

**Potential Return on Investment:**

- Short-term return on investment could include better birth outcomes, which could potentially lead to lower costs.  
Long-term return on investment would likely include reduced education expenditures as a result of earlier detection and intervention on developmental delays

**Metrics to Track Success/Outcomes:**

- Improvement on QARR measures over a multi-year period
- Improved measurement of, and enhanced rates of developmental and maternal depression screening.

**Benefits of Proposal:**

- Utilizes existing managed care performance improvement infrastructure to focus on interventions that will improve child and perinatal health
- Zero cost to the state
- Will focus improvement on specific measures that already exist and on three specific measures that can increase plan bonuses from the Quality Incentive program, an approach that has proven to work in the past

**Concerns with Proposal:**

- PIPs have had variable success moving the needle on health outcomes by plan and topic. Managed care plans are resource constrained with other transformation efforts (e.g., VBP) and may not be able to devote resources to make Kid's Quality Agenda PIPs sufficiently robust
- PIPs, as a plan level intervention, are likely insufficient to facilitate the broader provider practice level transformation (e.g., integration of physical and behavioral health, trauma-informed care) necessary to generate systems level change
- Proposal has some overlap with children's Value-Based Payment, as the same quality and outcome measures are being suggested for the PIP as are in the VBP on menu arrangements. Therefore, plans and providers are already being incentivized to improve on some of these measures



- Proposal does not comprehensively use all available managed care levers (e.g., network adequacy and other model contract changes) to comprehensively encourage a “kids focus” in managed care. There is no current quality measure for vision screening and the existing audiological evaluation quality measure is limited to children ages zero to three *months* of age.

**Links to Available Evidence:**

**Additional Technical Detail: (If needed, to evaluate proposal)**

DRAFT



First 1,000 Days on Medicaid Proposal #: 15

Proposal (Short Title): Insure All Kids Task Force

Implementation Complexity: Low
Implementation Timeline: Short term

Required Approvals/Systems Changes:

X\_ Administrative Action
State Plan Amend
Statutory Change
Federal Waiver
IT/data infrastructure
NYS budget request

Proposal Background/Description:

This proposal is for Medicaid to create an "Insure All Kids" Taskforce charged with identifying ways to insure the remaining children in New York that do not have health insurance. The U.S. Census Bureau estimates that, based on 2016 data, 101,066 children in New York have no health insurance. The Task Force would partner with stakeholders to identify uninsured kids, identify barriers preventing their enrollment in coverage or preventing re-certification of coverage, identify barriers that create gaps in coverage for children (including between Medicaid and CHP, and at other coverage transitions), and identify sector-specific strategies for connecting all kids to coverage regardless of documentation status or family ability to pay. The Task Force would also prioritize issues around federal regulations, such as mandated annual eligibility review, which prevents the state from doing more than 12 month continuous enrollment, for discussion with the Centers for Medicare and Medicaid Services (CMS). Additionally, the Task Force would closely monitor federal policy and anticipate and plan for "shocks" to New York's health system that might result in coverage losses for children (e.g., elimination of continuous eligibility for children). The Task Force would also address how to provide assistance to families to help them understand how to use insurance once their child is covered.

The effort should build upon and coordinate with other activity in this area, including the work of Health Care For All New York's Children, Youth and Families Task Force, Fidelis' Our Goal is Zero: Let's Get Every Child Covered awareness campaign, New York State of Health campaigns, and perinatal network and exchange navigator enrollment efforts.

The Task Force would be expected to be racially and ethnically diverse in its composition and include representatives from many sectors, including health, education, child welfare, social services, business, cultural institutions and media.

Cross-Sector Collaboration Component: Yes X\_ No\_\_

- Taskforce composition would be from many sectors

Cost Assumptions: Negligible - staff time for convening and managing group. Any techniques for improving coverage rates identified by the Taskforce would, however, carry a cost that could be borne in full or part by Medicaid.



**Potential Return on Investment:**

- Each additional year of Medicaid eligibility from birth to age 18 increased cumulative tax payments in adulthood of \$186 per person (a 0.9 percent increase) and reduced receipt of the Earned Income Tax Credit receipts by \$75 (a 2.4 percent decrease) by age 28. - D. Brown, A. Kowalski, and I. Lurie, “Medicaid as an Investment in Children: What is the Long Term Impact on Tax Receipts?” National Bureau of Economic Research (January 2015).

**Metrics to Track Success/Outcomes:**

- Decline in children’s uninsured rate

**Benefits of Proposal:**

- Evidence suggests Medicaid coverage yields improved outcomes for children
- Clear and measurable goal
- Presents opportunity to have a group looking at the insurance landscape for children at the exact time a group like that may be needed to think about challenges/changes that may put more children at risk of losing coverage

**Concerns with Proposal:**

- Proposal does not specifically target children ages 0 – 3, don’t know how many ages 0-3 are among the number of uninsured children
- Proposal does not specifically target Medicaid population

Task Force can identify barriers, but resources would need to be identified to ameliorate those barriers. Some barriers that workgroup members would like to see addressed, such as continuous eligibility for children ages 0 – 3, are determined at the federal level

**Links to Available Evidence:**

**Additional Technical Detail: (If needed, to evaluate proposal)**



First 1,000 Days on Medicaid  
Proposal #: 16

**Proposal (Short Title):** Data system development for cross-sector referrals

**Implementation Complexity:** High

**Implementation Timeline:** Long term

**Required Approvals/Systems Changes:**

Administrative Action

Statutory Change

IT/data infrastructure

State Plan Amend

Federal Waiver

NYS budget request

**Proposal Background/Description:**

Numerous community efforts to link and support the multiple sectors that touch the lives of young children are currently underway in New York. A common challenge across these efforts is the inability to easily share information and resources across a community to fully benefit the families that are served by different systems. Under this proposal, Medicaid would direct competitive grant funds to at least 3 communities for the purchasing of a Medicaid-determined hub-and-spoke data system that enables screening and referrals across clinical and community settings.

New York lacks a system-level mechanism to coordinate and connect families to community-based services that promote healthy development and prevent poor health, educational, and social outcomes for children. These services and supports range in type and intensity, but include parent and family supports (e.g. home visiting programs, group parenting classes), social services (e.g. food pantries), and education services (center-based early care and learning sites, GED programs, library programs), among others.

The absence of systems-level mechanisms to connect families to these programs is apparent: evidence-based preventative programs are underutilized despite being located in high need areas; families living in areas rich in early childhood programs may be directed to services that don't best fit their needs; obstetricians and pediatric providers, who should be a prime source for making referrals to preventive programs, often do not make referrals; parties responsible for the care of a parent or a child often do not receive critical information; and there is a lack of feedback to providers who initiate referrals.

There are several efforts underway in New York to create stronger referral and handoff pathways between early childhood programs and providers. One essential component of improving referral pathways, across the many programs that can promote health and development for young children, is creating the data infrastructure to support service referrals and document connections. Well-developed data systems can document the results of family assessments, send referral information to other community entities, and include information about whether or not a family received a particular service as part of the referral. The systems should also be easy to use across sectors, interoperable across Electronic Medical Records, HIPAA and FERPA compliant, and scalable.

Seamless screening and referral systems are especially important for creating pathways to services for young children who fall within the developmental "grey zone" – children with developmental delays, often due to social or environmental conditions, but who do not-qualify



for Early Intervention services. Having a service pathway for these children and the opportunity to intervene early – so long as children are connected to high quality community programs – benefits multiple government programs including Medicaid, the Early Intervention Program, and public schools.

Centralized data systems can also aid in future systems planning for early childhood services by documenting demand for, and availability of, services in particular communities. For example, when the 1<sup>st</sup> Five central intake program was developed in Iowa – through a mix of Medicaid administrative funding and legislative appropriations – it was discovered that of the over 9,000 needs identified among nearly 7,600 families, 46 percent were for child health or developmental concerns (including speech and hearing) while another 37 percent of referrals were related to family stress and day-to-day resource needs. This aided both policymakers and advocates in making data-informed decisions around resource allocation.

Under this proposal, New York Medicaid would direct competitive grant funds to purchase a Medicaid-determined hub-and-spoke data system that enables screening and referrals across clinical and community settings for at least 3 communities (if fiscally feasible grants would ideally be available to two urban, two suburban and two rural communities). The data system should be:

- Web- or cloud-based and accessible across sectors;
- Interoperable across Electronic Medical Records, regional health information exchanges (RHIOs), and the Statewide Health Information Network (SHIN-NY);
- Interoperable with existing screening and referral tools already in use;
- HIPAA compliant;
- Free to “spoke” users (community organizations and health care providers);
- Able to connect profiles for children and their parent/guardian(s)

Through an RFP process, communities would be required to:

- Identify the entity that will serve as the “technology hub”: eligible entities are either a managed care plan or a health care provider organization
- Demonstrate the following components for integrating the data system into a broader systems-building process:
  - A training and technical assistance approach for helping clinical providers and community organizations integrate the technology into their workflow;
  - A user group of participating partners dedicated to analyzing and sharing data, disseminating positive outcomes and best practices, and developing quality improvement processes for all users;
  - The “technology hub” is committed to making access available to a wide range of early childhood and family serving providers in the community;
  - Involvement of the health care community in an early childhood systems-building effort such as the Early Childhood Comprehensive Systems Impact Initiative or a cradle-to-career partnership;
  - Creation or use of a community-led board to provide oversight of which organizations have access to the web-based platform to ensure diverse cross-sector availability of the tool



- Use of the technology either directly builds upon the Early Childhood Comprehensive Systems Impact Initiative (ECCS), led by the Council on Children and Families, or is consistent with the ECCS aims and goals;
- A dedicated person (full-time FTE) – funded through private or alternative public funding sources – who is responsible for connecting early childhood and family-serving providers across sectors to the data system, and who monitors referral follow-up (or lack thereof) and works with providers and community organizations to encourage families to utilize appropriate resources;
- A plan for populating the data system with local community resources (e.g. with 2-1-1 data or through other methods), if necessary; Involvement of the local health department with data sharing agreements and support for Title V reporting requirements, in order to ensure compatibility with current DOH efforts to support information and referral related to Children with Special Health Care Needs (CSHCN).

**Cross-Sector Collaboration Component:** Yes  No

- Proposal facilitates cross sector referrals and coordination

**Cost Assumptions:**

<b>First 1K Days on Medicaid</b>	
<i>Data system development for cross-sector referrals</i>	
<b>Pilot costs (each region)</b>	
Purchase of data system & two year use	\$ 30,000.00
Initial programming costs	\$ 20,000.00
Number of sites	3
<b>Total Pilot Costs</b>	<b>\$ 150,000.00</b>
<b>Evaluation (across all 3 regions)</b>	
Evaluation costs	\$ 100,000.00
<b>Total Cost</b>	<b>\$250,000</b>
<b>Total Cost (Gross)</b>	<b>\$250,000</b>
*Fiscal based on author's assumptions. Would need additional analysis to understand if/how Medicaid funds could support initiative.	

**Potential Return on Investment:**

A report in the grey literature out of Orange County CA showed potential savings of approximately \$2000 per child referred due to de-medicalization of developmental issues. However it is unclear whether the methodology or the results can be generalized outside of that setting: [https://helpmegrwnational.org/wp-content/uploads/2017/04/PolicyBrief\\_FINAL\\_31MAY2012.pdf](https://helpmegrwnational.org/wp-content/uploads/2017/04/PolicyBrief_FINAL_31MAY2012.pdf)





## Metrics to Track Success/Outcomes:

### How Much

- #of families referred to services through the system
- # data sharing agreements in place between MCO's and community organizations
- # of participating cross-sector organizations
- # EMR's successfully linked within the system
- #/% of families for whom social determinants of health are identified

### How Well

- Increase in the #/% families whose children do not qualify for EI successfully linked with at least one community resource or support and are satisfied with that linkage
- Increase in the #/% families served within system who report strengthened protective factors (parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, social and emotional competence of children).
- Increase in the connectedness of the early childhood community as measured by social network analysis.

### Difference Made

- Improved school readiness
- Improved developmental health
- Decrease in special education usage – either in total number served or number of quantity of services per student
- Savings in reduced health/mental health, behavioral, and criminal justice costs.
- Improvement in population health, educational outcomes, quality of workforce, family stability.

## Benefits of Proposal:

- Proposal begins to address systemic data infrastructure challenges
- Proposal requires integration into a broader systems-building framework at the community level, increasing conversation across sectors and encouraging collaborative action
- Proposal uses bulk purchasing to provide tools for social determinants of health screening and referral
- Activities under grant could help position managed care plans to work collaboratively with community organizations
- Would create data for better understanding referral patterns and where children and families are accessing and finding value in community services and supports
- Can be integrated into existing evidence-based early childhood screening and connection initiatives that are already operating or beginning in several NYS regions (Albany, Chemung, Long Island, Onondaga, Rochester, Western New York)
- The proposal is cited as beginning to address systemic data infrastructure challenges. The State Education Blue Ribbon Committee is also considering a recommendation for an integrated early childhood data system across state agencies (health and education) for children birth to age 8.



### Concerns with Proposal:

- Many social determinants of health screening/referrals tools are still in development and testing phase
- Medicaid managed care plans are unlikely to take on the role of “technology hub” for fear of taking on additional unreimbursed administrative costs
- Broader than developmental screening proposal, but potentially creates more systems which would be built separately and then ideally need to be connected to one another
- Proprietary solutions are already entering the market piecemeal (especially via DSRIP Performing Provider Systems), and their existing penetration may frustrate a broader community collaboration approach. An open RFP risks, at minimum, creating yet another health and social service coordination silo with limited utility and added costs in time and resources.
- This proposal merely pilots an approach and serves as proof of concept, not clear how an approach like this would be taken to scale
- Creation of new data resources runs the risk of creating “data rubber-necking” where users look at the data, but don’t take or know how to take appropriate action with that data
- Prior efforts to introduce cross-system data tools have been burdened by expense, the challenges of managing multiple data systems, and issues with confidentiality and access.
- Not clear how or if parents/caregivers would be engaged in the development of these systems or whether they would be able to utilize the systems to help navigate services for their families

### Links to Available Evidence:

Robinson L et al. CDC Grand Rounds: Addressing Health Disparities in Early Childhood: <https://www.cdc.gov/mmwr/volumes/66/wr/mm6629a1.htm> [Discusses importance of integrating support services for children]

U.S. Department of Education and U.S. Department of Health and Human Services. Collaboration and Coordination of the Maternal, Infant, and Early Childhood Home Visiting Program and the Individuals with Disabilities Education Act Part C Programs. Joint Policy Statement. January 19, 2017: <https://www.choc.org/news/u-s-departments-education-health-human-services-encourage-states-adopt-early-childhood-system-model-like-choc-childrens-help-grow/>

The Commonwealth Fund. Improving Care Coordination, Case Management, and Linkages to Service for Young Children: Opportunities for States: <http://www.commonwealthfund.org/publications/fund-reports/2009/apr/improving-care-coordination-case-management-and-linkages> [Identifies need for states to develop data and information technology systems to support Early Childhood Comprehensive Systems]

United Healthcare and Connecticut Children’s Office for Community Health. Promoting Children’s Health: How a unique relationship is creating a more connected care experience for children, families, and communities. [https://newsroom.uhc.com/content/dam/newsroom/PDF\\_CTstory.pdf](https://newsroom.uhc.com/content/dam/newsroom/PDF_CTstory.pdf)

### Additional Technical Detail: (If needed, to evaluate proposal)



Department  
of Health

Medicaid  
Redesign Team



**Reviewer Name/Organization:** Lynn Pullano, Help Me Grow Western NY; Liz Isakson, Docs for Tots

DRAFT



First 1,000 Days on Medicaid Proposal #: 17

Proposal (Short Title): Braided funding for Early Childhood Mental Health Consultations

Implementation Complexity: High
Implementation Timeline: Long term

Required Approvals/Systems Changes:

- Administrative Action, Statutory Change, IT/data infrastructure, State Plan Amend, Federal Waiver, NYS budget request

Proposal Background/Description:

This is a proposal for OHIP to convene a design committee with colleagues in the Office of Mental Health, Office for People with Developmental Disabilities, Office of Alcoholism and Substance Abuse Services, Office of Child and Family Services, and potentially the State Education Department (Adult Career and Continuing Education Services) to explore a braided funding approach for paying for mental health consultation services to early childhood professionals in early care and education settings.

While access to focused therapeutic approaches in treatment settings has an important role in bolstering the socio-emotional needs of birth-3 year olds and identifying the mental health needs of their parents, population impact requires reaching children and parents in more places, and supporting the skills and capabilities of caregivers in a sustained and scaled way. Early care and education professionals have limited training in children's social and emotional development. Similarly, many parents face challenges and stress in raising children. Ameliorating these challenges means utilizing behavioral experts as consultants, coaches, capacity builders to early care and education professionals, parents, and other caregivers. Doing so would improve the knowledge and tools they need to make young children feel supported and valued and help them develop important foundational social-emotional skills

Infant and Early Childhood Mental Health Consultation is an evidence-based approach to building the early learning workforce's capacity to support children's social-emotional and behavioral development. An estimated 9 to 14 percent of young children from birth to age five experience social and emotional problems that negatively affect their functioning and development. These problems can be challenging for early learning providers to identify and manage. Mental health consultation supports these providers by helping them learn about and adopt effective discipline practices, promote positive behaviors in the classroom, and provide classroom-wide behavioral health prevention services. Classroom-based behavioral health consultation reduces prekindergarten expulsions.

While Infant and Early Childhood Mental Health Consultation (IECMHC) is an approach championed by SAMHSA, HHS, and the federal Department of Education, states have struggled to sustainably fund mental health consultation models. Because mental health consultation to early care and education setting is at the nexus of child health, development, and education, it requires a braided funding approach to sustain it.

New York State has demonstrated its interest in developing its mental health consultation capacity. The Council on Children and Families (CCF) recently received a 3-year SAMHSA



award for technical assistance on mental health consultation in early care and education settings from the National Center of Excellence for Infant and Early Childhood Mental Health Consultation. However, a dedicated funding source is lacking.

A current pilot in NYC present a potential comprehensive approach to early childhood mental health consultation consisting of several components. This pilot is comprised of mental health consultants who are licensed mental health clinicians (master's level) with expertise in early childhood development and trained to provide consultation in early care and education settings. In this model, consultants visit each site one day per week for approximately a one-year period. (Note that frequency and 'dosage' of consultation can vary in different models of consultation and may be increased based on need.) The consultants form collaborative relationships with early care and education staff to build their capacities to understand, prevent or address challenging behaviors and to foster social-emotional competencies in young children. Specific components include:

- **Programmatic consultation** where consultants collaborate with center directors to ensure the centers' policies and climate support young children's social-emotional development.
- **Classroom consultation** where the consultants work alongside teachers to share strategies and model approaches to promote the social-emotional development of all children in the classroom, for example focusing on classroom routines.
- **Child and family consultation** involves an individual child as the focal point, with the consultant working with teachers and parents to support a child with challenging behaviors and promote positive behaviors.
- Consultation is most effective when paired with a process and mechanism for **referral to individualized evidence-based treatment** for young children with demonstrated mental health need (e.g. involving both parent and child). Ideally, consultants make a 'warm hand-off' to the treatment provider. In the NYC pilot, some clinicians serve a dual role, providing both consultation in early care and education settings, and treatment in an Article 31 clinic, allowing continuity of care for the family<sup>1</sup>.
- **Family Peer Support Specialists** can play a useful role in engaging parents/caregivers and assisting them with (a) referral and linkage to treatment and (b) reinforcing practices and strategies that consultants have advised teachers on and that parents could use at home.

The NYC pilot includes training, coaching, and reflective supervision for the consultants to ensure high quality services.

In the NYC pilot, consultation services are paid for through City funds; however, it could be further scaled and better sustained using cross-system sources of funding. In the first six months of implementation of the NYC pilot, consultation was provided to over 1,500 individuals in 221 classrooms at 75 early care sites, reaching 3,273 young children in those classrooms. Demand from early care staff for mental health consultation exceeds the capacity of the program.

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<sup>1</sup> Note that while treatment provided in an Article31 clinic may be billed to Medicaid, consultation services cannot.



Given the high demand for mental health consultation, and its strong evidence-base as a tool for promoting mental health and school readiness, this proposal is for Medicaid to form a design committee with OMH, OPWDD, OASAS, OCFS, SED, CCF and any other relevant sister agencies and stakeholders (e.g., ECDCs, school districts, CCR&Rs), dedicated to identifying a braided funding structure to sustain IECMHC approaches.

The SAMHSA Center of Excellence for Infant and Early Childhood Mental Health Consultation offers a comprehensive list of funding sources that could potentially be used as braided funding for a NYS consultation model. For example, below are a few which may be considered alongside Medicaid service or waiver funds:

- 1) Medicaid Administrative Funds (CMS) for training for mental health consultants
- 2) Federal block grants - Child Care and Development Fund and Community Mental Health Services Block Grant
- 3) Head Start and Early Head Start funding

The following two resources provide a full list of potential funding sources:

- SAMHSA Center of Excellence for Infant and Early Childhood Mental Health Consultation, National Financing Guidance for IECMHC Consultation [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/IECMHC/financing-guidance-infant-early-child-mental-health-consult.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/IECMHC/financing-guidance-infant-early-child-mental-health-consult.pdf)
- *Supporting Early Childhood Mental Health Consultation* from the U.S. Department of Health and Human Services [https://www.acf.hhs.gov/sites/default/files/ecd/supporting\\_early\\_childhood\\_mental\\_health\\_consultation.pdf](https://www.acf.hhs.gov/sites/default/files/ecd/supporting_early_childhood_mental_health_consultation.pdf)

After identifying potential funding sources, and a strategy for allocating revenues and expenditures by categorical funding source, the design committee should select one or more communities to test the feasibility of the new funding approach. These efforts should be coordinated with OMH's Project TEACH to build on existing capacity, training and support efforts. In general, working across state agencies will ensure professional expertise is leveraged and shared.

**Cross-Sector Collaboration Component:** Yes  No

- Both the funding proposal and mental health consultation activities are cross-sector

**Cost Assumptions:**

Design Committee costs: Negligible – staff time for convening and managing group.

Would need more detail on design committee's recommendations to develop a fiscal analysis. Below costs provided by author:

NYC program:

Estimated average cost of consultation per child = \$565.51



This assumes that the consultation time (and affiliated program costs) are allocated in the following way:

- 50% programmatic/classroom consultation at a cost of \$282.75 per child
- 50% child and family consultation at a cost of \$2,172.38 per child

Based on NYC experience, 13% of children may need child and family consultation.

Program assumptions include

- 7 consultants, 1 supervisor and 0.25 Director.
- One consultant (master's level licensed mental health professional) serves 5 sites, visiting each site one day per week. On average this represents 3 classrooms per site.
- Total costs include training of consultants, rent, travel, data support and EHR/Billing software.

#### Potential Return on Investment:

- Research has shown that ECMH consultation leads to increased preschool attendance and reduced expulsion and to reduced teacher stress and increased job satisfaction
- Every dollar spent on high-quality, birth-to-five early childhood education programs for disadvantaged children offers a 13% per annum return on investment.

#### Metrics to Track Success/Outcomes:

- % of early care and education sites that have received consultation.
- % of all children with Medicaid who are enrolled in early care and education sites in which consultation has been provided<sup>2</sup>.
- # or % decrease in early learning site suspensions and expulsions

#### Benefits of Proposal:

- Tackles a systemic funding challenge that has prevented widespread use of IECMHC
- IECMHC is supported by SAMHSA's [Center of Excellence for IECMHC](#)
- Successful implementation would be a big step forward in aligning health and early learning systems, and could prove to be a promising model for other braided funding activities
- Proposal creates the opportunity to reduce long term costs by focusing on appropriate capacity development that will arguably have a positive impact on long-term mental and physical health

#### Concerns with Proposal:

- Currently unknown what flexible funding streams are available through sister agencies

#### Links to Available Evidence:

U.S. Department of Health and Human Services and U.S. Department of Education, Policy Statement to Support the Alignment of Health and Early Learning Systems, Page 12:

<https://www2.ed.gov/about/inits/ed/earlylearning/files/health-early-learning-statement.pdf>

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<sup>2</sup> Num: # of children with Medicaid who are enrolled in early care and education sites in which consultation has been provided; Den: # of children with Medicaid in all early care and education sites



US Department of Health and Human Services and US Department of Education. Policy statement on expulsion and suspension policies in early childhood settings.

<https://www2.ed.gov/policy/gen/guid/school-discipline/policy-statement-ece-expulsions-suspensions.pdf> Pages 7, 10

SAMHSA, The Center of Excellence for Infant and Early Childhood Mental Health Consultation. Available at <https://www.samhsa.gov/iecmhc>

Gilliam, W.S. (2005). *Prekindergarteners left behind: Expulsion rates in state prekindergarten programs*. New York, NY: Foundation for Children Development.

Gilliam WS, Maupin AN, Reyes CR. Early Childhood Mental Health Consultation: Results of a Statewide Random-Controlled Evaluation. *J Am Acad Child Adolesc Psychiatry*. 2016 Sep;55(9):754-61. doi: 10.1016/j.jaac.2016.06.006. Epub 2016 Jun 28. PubMed PMID: 27566116.

[Hunter A, Davis A, Perry DF, Jones W. The Georgetown Model of Early Childhood Mental Health Consultation. Washington, DC: Georgetown University Center for Child and Human Development, September 2016](#)

Perry, D.F., Dunne, M.C., McFadden, L. et al. Reducing the risk for preschool expulsion: mental health consultation for young children with challenging behaviors. *J Child Fam Stud* (2008) 17: 44. <https://doi.org/10.1007/s10826-007-9140-7>.

Brennan et al. The evidence base for mental health consultation in early childhood settings: research synthesis addressing staff and program outcomes. *Early Education and Development*. 2008;19(6)

**Additional Technical Detail: (If needed, to evaluate proposal)**

Illinois' Behavioral Health Transformation – 1115 Overview, Illinois Dept of Healthcare and Family Services, 2016

[https://www.illinois.gov/hfs/SiteCollectionDocuments/1115\\_waiver\\_2page\\_overview.pdf](https://www.illinois.gov/hfs/SiteCollectionDocuments/1115_waiver_2page_overview.pdf)

The NYS Association of Infant Mental Health has provided additional technical recommendations on how to implement in a manner that is supportive of Infant Mental Health-Endorsement certification.





First 1,000 Days on Medicaid Proposal #: 18

Proposal (Short Title): Parent/Caregiver Diagnosis as Eligibility Criteria for Dyadic Therapy

Implementation Complexity: Low
Implementation Timeline: Short term

Required Approvals/Systems Changes:

- X- Administrative Action
State Plan Amend
Statutory Change
Federal Waiver
IT/data infrastructure
X NYS budget request

Proposal Background/Description:

This proposal is for Medicaid to allow providers to bill for the provision of evidence-based parent/caregiver-child therapy (also called dyadic therapy) based solely on the parent/caregiver being diagnosed with a mood, anxiety or substance use disorder.

The quality of early relationships affects the ability of young children to learn, regulate themselves and form relationships. These developmental processes can be impaired when a parent/caregiver (including extended family and foster parents) has a mental health condition because the relationship with the child is often interrupted as a result of the parent/caregiver's condition. Research has found that when depressed mothers receive treatment for depression only (e.g., medication, cognitive behavior therapy), parenting and relationship problems persist unless there is a specific focus on repairing the parent-child relationship (Center on the Developing Child at Harvard University, 2009). Evidence-based dyadic treatment models (e.g., Child-Parent Psychotherapy, Parent-Child Interaction Treatment, Parent-Toddler Therapy) are therapy models in which parents/caregivers and very young children are seen together, and coaching is provided to follow and respond to infant/toddler cues. The goal of these therapies is to repair the parent/caregiver-child relationship.

Currently, New York's Medicaid program pays for dyadic therapy but only in instances where the child has a diagnosed mental health condition. Under this proposal, New York Medicaid would:

- (1) Ensure that existing Medicaid payment policy for dyadic therapy is inclusive of age-appropriate child mental health diagnoses as defined by Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-5™)
(2) Allow evidence-based dyadic therapy to be paid for under the child's Medicaid number in circumstances in which the parent/caregiver has a mood, anxiety, or substance use disorder but the child does not have a diagnosed condition. Such a change in billing policy would allow parent/caregiver-child therapy to be used in a preventative fashion by preventing the emergence of poor behavioral outcomes in children through an increased focus on repairing the parent/caregiver-child relationship. This therapy would be provided in addition to any individual mental health treatment available to the parent/caregiver. Michigan and Minnesota both report allowing for billing based on parent diagnosis without the use of a federal waiver.



- (3) Explore paying for evidence-based early childhood mental health-focused group parenting programs such as Triple-P.

New York Medicaid should develop a list of evidence-based dyadic treatment models that would be eligible for payment under this model, the parental/caregiver mood, anxiety, substance use, and any other appropriate disorders (e.g., PTSD, complex trauma) that would make a parent/caregiver and child eligible for dyadic therapy, and the provider qualifications that are required for delivery of dyadic treatment. Provider qualification decisions should take into account non-clinical staff for the parenting support interventions, such as credentialed family peer support specialists. New York Medicaid should then issue guidance to plans and providers explaining the expanded eligibility criteria for dyadic therapy and how providers can bill for such therapy under the child's Medicaid number. The dissemination of this guidance should account for different caregiver and child pathways into care, and be sent to both adult and pediatric providers.

**Cross-Sector Collaboration Component:** Yes \_\_\_ No X

**Cost Assumptions:**

<b>First 1K Days on Medicaid</b>	
<i>PROPOSAL #18: Parent Diagnosis as Eligibility Criteria for Parent-Child Therapy</i>	
Live Births Medicaid (2014 Basis)	109,772
Depression rate	25%
Mothers with maternal depression	27,443
Assumption for participation in dyadic therapy	70%
Participating mothers with maternal depression	19,210
30 min psychotherapy rate (1)	\$97.81
Estimated annual spending	\$3,757,880
State Share	\$1,878,940
<b>Total Cost (Gross)</b>	<b>\$3,757,880</b>
<b>Total Cost (State)</b>	<b>\$1,878,940</b>
<small>(1) assumes 2 sessions average</small>	

**\*NOTE: Proposed expansion to include parent/caregiver substance use disorders in eligibility criteria would require additional funding not included in current cost estimate.**

**Potential Return on Investment:**

- Short-term returns from decreased use of Early Intervention services due to developmental delay



- Long-term returns could include savings from reduced cases of abuse and neglect, fewer out of home placements, and reduced incidence of youth behavioral and emotional disorders
- Additional return on investment may inure to Medicaid if the parent/caregiver is a Medicaid beneficiary and their longer-term behavioral and/or physical health is improved

**Metrics to Track Success/Outcomes:**

- Percent of child health providers billing for dyadic therapy under the child's Medicaid number
- Percent of scores on child developmental and behavioral health screens above-risk thresholds

**Benefits of Proposal:**

- Expands upon New York's existing use of parent-child therapy and support of maternal depression screening in the pediatric office
- Can be accomplished by DOH through administrative action
- Policy change is evidence-based and supported by the Harvard Center on the Developing Child, improving both attachment and parenting skills
- Policy is consistent with recent federal CMS guidance (CMS, 2016)
- Expands access to a service that fills a gap in much-needed early childhood mental health services
- Providing supports to children based on the parent having a significant mental health diagnosis is a step toward providing two-generational care for families

**Concerns with Proposal:**

- Policy change alone may be insufficient for encouraging increased use of evidence-based dyadic therapy models
- Reinforces a medical model of healthy development promotion
- Diagnosis based criteria doesn't reach the full population for which dyadic therapy would be helpful, broader risk factors as measured by social determinants ICD-10 Z Codes could be more appropriate, but few providers use Z-codes and there is no current system for Medicaid to track Z-codes
- It is important not to stigmatize parents with mental health or substance use disorders by assuming their parenting is impaired. Medicaid could clarify for providers that a parent with a mental health or substance use disorder does not inevitably require dyadic treatment. This modality is for those whose disorder/risk of disorder is interfering with their ability to parent successfully.

**Links to Available Evidence:**

Center on the Developing Child at Harvard University (2009) Maternal Depression Can Undermine the Development of Young Children. :

<http://46y5eh11fhgw3ve3ytpwxt9r.wpengine.netdna-cdn.com/wp-content/uploads/2009/05/Maternal-Depression-Can-Undermine-Development.pdf>

Paper states that depressed parents need an intervention that is focused on parent-child interactions as well as the parent's depression, and shows positive findings of one dyadic model, Parent-Toddler Therapy, on cognitive development.



**Additional Technical Detail: (If needed, to evaluate proposal)**

CMS, 2016 Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf>

This guidance states that mothers may benefit from treatment that involves mothers and children *together*, and that under EPSDT, this treatment could be billed under Medicaid if child is present since the treatment would have an important benefit for the child.

The NYS Association of Infant Mental Health has provided additional technical recommendations on how to implement in a manner that is supportive of Infant Mental Health-Endorsement certification.

**Reviewer Name/Organization:** Sheila Smith, National Center for Children in Poverty; Rahil Briggs, Montefiore Medical Center; Evelyn Blanck, New York Center for Child Development

DRAFT



First 1,000 Days on Medicaid Proposal #: 19

Proposal (Short Title): Increasing In-Office Detection of Elevated Blood Lead Levels

Implementation Complexity: Medium

Implementation Timeline: Long term

Required Approvals/Systems Changes:

- Administrative Action, Statutory Change, IT/data infrastructure, State Plan Amend, Federal Waiver, NYS budget request

Proposal Background/Description:

Children exposed to neurotoxins in early childhood experience profound health, cognitive, and behavioral consequences that limit their ability to succeed in school. Lead poisoning specifically has been identified as a condition that cannot be cured but can be prevented. In 2009 New York State updated its laws and regulations to require blood lead testing and simplify the provision of blood lead testing in various venues. While 87 percent of 2 year olds in Medicaid managed care had their blood tested for lead poisoning at least once by their 2nd birthday in 2015 (QARR), only 58 percent of all children in New York born in 2012 had at least two lead screenings by 36 months of age (NYS Community Health Indicator Reports).

One long-standing barrier to increased blood lead testing was the requirement that tests be conducted, or at least analyzed, at labs disconnected from the point of care. The 2009 amendments helped ameliorate this barrier, as did the proliferation of a relatively inexpensive and portable testing device (LeadCare II). That said, there are still significant numbers of children who do not receive testing. Testing results suggest geographic pockets where children may be at especially high risk of lead exposure and elevated blood lead levels, and increasing point of care testing in those communities could lead to earlier detection, Early Intervention Program supports, and environmental remediation through New York's already robust local health department and Regional Lead Resource Center resources.

While blood lead testing is a Medicaid reimbursable service, the up-front cost of obtaining a point of care testing device, training and getting appropriate certifications likely keeps some providers from pursuing this option. The Department of Health should create a grant program that targets Medicaid providers in communities with a high share of Medicaid-covered lives that have lower than average blood lead testing rates or higher than average elevated blood lead level results. Grants would support the purchase, training, and certification costs for providers in those targeted communities who agree to implement point of care blood lead testing and strive for 100 percent testing of all children at or around ages one year and two years (consistent with NYS statutory and regulatory requirements). The Department of Health should also provide information to these providers on the existing lead poisoning prevention and management provider guidelines, with a special focus on the management requirements for those children that test positive for elevated blood lead levels. Additionally, the Department of Health should provide clarification about the difference between the current health care quality measure (one



lead test by age two) and NY law, which is more protective, and requires one test at age one and another at age two.

Cross-Sector Collaboration Component: Yes \_\_\_ No\_X\_

Cost Estimate:

<b>First 1K Days on Medicaid</b>	
<i>Increasing In-Office Detection of Elevated Blood Lead Levels</i>	
Number of grants	200
Cost of grant (estimated based on online machine costs, Maryland report estimate)*	\$ 3,000.00
<b>Total Cost (Gross)</b>	<b>\$600,000</b>
<b>Total Cost (State)</b>	<b>\$300,000</b>
* ~\$2,000 for machine procurement ~\$500 for certifications ~\$500 for training and proficiency testing as required	

Potential Return on Investment:

- Short-term return may actually be negative if testing rates increase, but since most children are in managed care, these costs will be covered by the existing capitation payment

Metrics to Track Success/Outcomes:

- Increase in the total percentage of children in Medicaid managed care who receive blood lead testing (existing QARR measure)
- Increase in the number of children age 2 in Medicaid managed care who receive blood lead testing
- Reduction in the percentage of children who test positive for blood lead levels >= 10 mcg/dcl at age 1 or age 2

Benefits of Proposal:



- Targets enhanced testing resources to communities and providers that can have the most impact
- Builds on substantial history of Department of Health focus on lead testing

#### Concerns with Proposal:

- Increased testing without increased remediation of sources provides better measurement of the problem but neither mitigates nor prevents lead poisoning
- State performance testing performance already relatively high and well above national average
- Cost per number of increased tests unknown and could be relatively high Proposal addresses one important environmental health issue but does not address others such as mold, pests, etc.
- Proposal does not address underlying issues with interoperability and usability of blood lead screening results across systems
  - There are some inherent issues related to point of care testing technologies that should be considered including:
    - *Sensitivity of Point of care testing devices to accurately detect blood lead levels at the current CDC reference level (5 mcg/dL):* These devices have been shown to be unreliable for blood lead levels of 8 mcg/dL or higher.
    - *Maintenance costs including reagents and other supplies:* this proposal does not cover them.
    - *Lead care II users must manually enter blood test results into NYSIIS,* which could have a negative impact on blood lead surveillance efforts.

#### Links to Available Evidence:

Boreland F et al. Effectiveness of introducing point of care capillary testing and linking screening with routine appointments for increasing blood lead screening rates of young children: a before-after study. Arch Public Health. 2015 Dec 29;73:60:

<https://www.ncbi.nlm.nih.gov/pubmed/26715987>

Maryland Department of Health and Mental Hygiene. REPORT TO THE GENERAL ASSEMBLY BY THE TASK FORCE ON POINT OF CARE TESTING FOR LEAD POISONING CHAPTER 365. January 2014.

[https://phpa.health.maryland.gov/Documents/Final%20Report\\_Lead%20Poisoning%20Point%20of%20Care%20Testing.pdf](https://phpa.health.maryland.gov/Documents/Final%20Report_Lead%20Poisoning%20Point%20of%20Care%20Testing.pdf)

Advisory Committee for Childhood Lead Poisoning Prevention. Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention Report of the Advisory Committee on Childhood Lead Poisoning Prevention of the Centers for Disease Control and Prevention. January 2012. [https://www.cdc.gov/nceh/lead/acclpp/final\\_document\\_030712.pdf](https://www.cdc.gov/nceh/lead/acclpp/final_document_030712.pdf)

#### Additional Technical Detail: (If needed, to evaluate proposal)

**Reviewer Name/Organization:** Kallana Manjunath, Better Health for Northeast New York



First 1,000 Days on Medicaid Proposal #: 20

Proposal (Short Title): Pilot and Evaluate Peer Family Navigators in Multiple Settings

Implementation Complexity: High
Implementation Timeline: Long term

Required Approvals/Systems Changes:

- Administrative Action, Statutory Change, IT/data infrastructure, State Plan Amend, Federal Waiver, NYS budget request

Proposal Background/Description:

Many high-risk families with young children struggle to navigate available resources to help them address both health needs and the social determinants impacting their health. These often hard to reach families may be more likely to consistently interact with non-health resources in their communities rather than the health care system. Research shows both low screening of African American and Hispanic children for developmental delays and heavy reliance of mothers on peer networks (rather than clinicians) to decide if intervention is needed. Peer navigators have had success in the HIV and behavioral health arenas, connecting homeless people with appropriate health and supportive services, keeping people engaged in those services, and generally helping people take charge of their own well-being. This concept has not been adopted for at-risk families with young children.

This proposal would develop, implement and evaluate a total of nine pilots that would provide peer family navigator services.

The first set of sites would evaluate the use of peer family navigator services in community settings outside of the acute care physical health system. DOH would develop an RFP and make grant funds available to support a total of 5 pilots across the state (two upstate, three downstate) in community-based sites (e.g., family homeless shelters, supportive housing, early education providers, community mental health clinics, drug treatment programs, WIC offices, and existing Help Me Grow sites).RFP respondents (either the sites themselves, or organizations with expertise in peer navigation in collaboration with a site) would be required to address the following components of developing and implementing a peer family navigator program in their community.

- Assessment of needs for families and young children in their unique setting
Existing resources available in the setting and the unique role of peer family navigators in that setting; ability of peer navigators to link to a range of other services – from mental health to “Mommy and Me” activities that can be accessibly provided at the site to service providers that can address social determinants of health
Existing or planned connections across sectors allowing peer family navigators to facilitate effective warm handoffs to services
Recruitment strategy for peer family navigators
Design and delivery of a curriculum for training peer family navigators
Operational details for the day-to-day work of peer family navigators once trained (e.g., in-office, co-location in other settings, individual visits in the community, group classes, etc.)





- Evaluation plan, including the ability to collect and report Medicaid client identification numbers (CIN) for purposes of external evaluation

An additional pilot with four sites would focus on family health navigation services in primary care offices. The family navigator could be a peer support specialist, although some workgroup members advocate for the navigator being a licensed clinical worker with training working with families (e.g. a Masters level social worker or equivalent) given the complexity of systems and issues encountered. The family health navigator would focus on a subset of at-risk families determined by either a positive child developmental or social-emotional screen or a positive maternal depression screen. RFP respondents would be required to address the same RFP components as outlined above, but tailored to a primary care context as needed.

DOH would conduct internally or contract externally for a qualitative and quantitative evaluation of the pilots. The qualitative portion would describe each of the pilot models and survey clients served regarding their impressions of the navigator services delivered. The qualitative evaluation would look at CIN level data for individuals served by navigators and compare their health utilization, cost and clinical risk group to a comparison cohort of Medicaid enrollees in the community that did not receive navigator services.

**Cross-Sector Collaboration Component:** Yes  No

By definition some of the peer family navigator services would be based out of sites from other sectors and coordinate with the health sector. The primary care-based navigator would coordinate with non-health services as well as health services.

**Cost Assumptions:**



First 1K Days on Medicaid	
<i>Pilot and Evaluate Peer Family Navigators in Multiple Settings</i>	
Number of Pilot grants	9
Cost of Pilot	\$ 220,000.00
Cost of qualitative and quantitative evaluation of the grants	\$ 300,000.00
<b>Total Cost</b>	<b>\$2,280,000</b>
<b>Total Cost (Gross)</b>	<b>\$2,280,000</b>
<b>Total Cost (State)</b>	<b>\$1,140,000</b>
* \$60,000 Six month Start-Up and Training: - Sites coordinate to develop curriculum material design, peer and evaluation criteria engaging expert consultants as appropriate, 8-week Peer Training at each site (Training, peer stipend expenses) \$160,000 One Year Demonstration: - \$100,000 Key Personnel: - \$50,000 Supervision/Q.I./Data Collection - \$50,000 Peers (3 peers for 20 hours per week at \$15/hr) each with a yearly caseload of 25 to 35 families -\$25,000 Host site OTPS, rent, utilities, IT -\$15,000 Program Costs - Materials, transportation for peers, staff, clients, nutritional snacks for client meetings, etc.	

**\*Please note this estimate is based on using peer-level navigators only. If higher-level professionals are required for primary care sites then additional resources would be required.**

**Potential Return on Investment:**

TBD – The evaluation would be designed such that actual 1-year return on investment to Medicaid could be calculated.

- Potential near-term returns/costs could include additional referrals to early intervention and reduced family emergency/crisis utilization.
- Longer-term returns could include decreased special education and juvenile justice costs, and lower Medicaid utilization than the comparison cohort throughout childhood

**Metrics to Track Success/Outcomes:**

- Performance on grantee defined evaluation plan outcomes
- Reduced (or more appropriate) Medicaid utilization by the intervention groups in comparison to the formal evaluation control groups
- Increased Developmental Delay screening/appropriate interventions
- Parental engagement in activities/services that enhance bonding with young children

**Benefits of Proposal:**

- Innovative application of peer supports to a new high-risk, hard-to-engage population for which it could be uniquely effective
- Can be formally evaluated and cohorts could be followed longitudinally over time
- Could be incorporated into a central intake model in other parts of DOH



- Addition of a primary care component would test whether incorporation of a navigator in primary care can increase screening rates due to increased confidence among providers that there can be appropriate resolution to conditions flagged in screens.

**Concerns with Proposal:**

- No specific evidence base for providing peer family navigators in the proposed settings
- Sites need to coordinate to minimize program differences that may impact evaluation
- Some commenters have raised concerns about whether there will be sufficient funding for these pilots

**Links to Available Evidence:**

- Peer Navigators Address the Integrated Health Needs of African Americans who are Homeless: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5371353/>
- Beliefs Regarding Early Development Intervention Among Low-Income African American and Hispanic Mothers: [http://pediatrics.aappublications.org/content/early/2017/10/12/peds.2017-2059?sso=1&sso\\_redirect\\_count=1&nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription](http://pediatrics.aappublications.org/content/early/2017/10/12/peds.2017-2059?sso=1&sso_redirect_count=1&nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription)
- New Haven Mental Health Outreach for MOMS Partnership: <https://medicine.yale.edu/psychiatry/moms/>

**Additional Technical Detail: (If needed, to evaluate proposal)**

**Reviewer Name/Organization:** Chris Norwood, Health People



First 1,000 Days on Medicaid Proposal #: 21

Proposal (Short Title): Use of Neurosequential Model of Therapeutics for Traumatic Stress

Implementation Complexity: High
Implementation Timeline: Long term

Required Approvals/Systems Changes:

- \_X\_ Administrative Action
\_\_ Statutory Change
\_\_ IT/data infrastructure
\_\_ State Plan Amend
\_\_ Federal Waiver
\_X\_ NYS budget request

Proposal Background/Description:

Under this proposal, Medicaid would support a pilot of one model of trauma-informed care, the Neurosequential Model of Therapeutics, for children who have been exposed to traumatic stress.

The proposal has two dimensions:

- (1) Expanding funding of the EI screening and interventions to include all children ages birth to three whose cases have been "indicated" by Child Protective Services (CPS) to include children that are mandated to receive preventive services, or are entering foster care and other out of home placements. These children are at high risk of a trauma history by nature of CPS involvement.
(2) Expanding the EI assessment process to include an evidence-based protocol for assessing specific neurodevelopmental deficits resulting from abuse/neglect, and designing, implementing, monitoring, and modifying interventions appropriate to their neurodevelopmental needs.

In addition to the group cited above, a smaller cohort of older children in the care and custody of DSS would be included in the pilot. They will similarly undergo the neurosequential assessment and receive the resulting recommended services.

While this demonstration project focuses on a small group of high-risk children, these are the exact children who, without intervention, consume a disproportionate percentage of health, behavioral health, special education, juvenile justice, and social services: these "heavy users" constitute 10 to 20 percent of the Medicaid population, but can consume 80 to 90 percent of the resources.

Background:

Research has documented the relationship between Adverse Childhood Experiences (ACE) and a heightened risk of illness and premature death, and poorer mental and physical health and worse quality of life. Teens with higher ACE scores are more likely to engage in health-risky behaviors, including smoking, overeating, unprotected sex, and substance abuse. The CDC has



identified adverse childhood experience as one of the nation's leading causes of poor health (and increased expenses for healthcare.) Further, research in neurodevelopment has identified the neuropsychological effects of abuse and neglect at different developmental stages, and evidence-based interventions that can ameliorate the resulting damage.

A typical course of intervention with a child exposed to trauma is to wait until the child displays symptoms and functional impairments, then refer them for mental health services, where they will receive some form of cognitive-behavioral therapy (for which their cognitive functioning is unsuited) and medication for symptoms of restlessness, poor concentration, and impaired impulse control. The latter are often diagnosed as some form of Attention Deficit Hyperactivity Disorder, rather than the inevitable consequences of psychological trauma, and are prescribed stimulant medication. A neurosequential assessment will tease out the developmental deficits underlying the problem behaviors, and recommend specific interventions appropriate to the developmental risk.

#### Expansion of Eligibility:

Medicaid currently covers the cost of assessment for about 60% of the children referred to the EI program. Most others are on a New York State regulated health insurance plan such as Child Health Plus.

Children whose reports of abuse and neglect are founded by Child Protective Services (CPS) have experienced adverse childhood experiences, and are at high risk of suffering the resulting developmental deficits. Such children who are three years of age and younger are referred to the Early Intervention (EI) program, where they undergo assessment for a confirmed disability or established developmental delay, as defined by New York State, in one or more of the following areas of development: physical, cognitive, communication, social-emotional, and/or adaptive. This proposal is to include in this cohort of young children all those receiving mandated preventive services as well as those entering foster care.

#### Neurosequential Model of Therapeutics:

The Neurosequential Model of Therapeutics (NMT) is a developmentally sensitive, neurobiologically-informed approach that integrates core principles of neurodevelopment and traumatology to inform work with children, families, and the communities in which they live. It has three components: training/capacity building, assessment, and specific recommendations for the selection and sequencing of therapeutic, educational, and enrichment activities that match the needs and strengths of the individual.

Adding the Neurosequential Model of Therapeutics (NMT) component to EI will provide a systematic way to identify children with neurodevelopmental compromise, and provide evidence-based interventions to ameliorate the resulting deficits. Medicaid should allow for the expansion of NMT assessment and intervention for ALL cases referred to EI in order for all trauma exposed young children be evaluated. NMT is an evidence-based practice (see The Neurosequential Model of Therapeutics as Evidence-based Practice.)

NMT is currently implemented in some thirty sites in the United States, Canada, Australia, and Europe. Providers undergo a three-tiered training process, each tier requiring a year of study. Lewis and Jefferson counties has a cohort that have completed Phase 1 training, and another that is currently studying for Phase 2.



Proposal for New York Medicaid:

Conduct a demonstration project in two New York counties (Jefferson and Lewis) in which all children ages birth to three who are referred to EI by CPS due to their cases being indicated for child maltreatment and who receive mandated preventive services or are entering foster care, are entered into the NMT assessment protocol as part of their EI participation. In addition, a smaller cohort of older foster children will participate in the project. Focusing the demonstration project on two counties is meant to test the feasibility of applying the NMT approach to these high-risk populations before encouraging broader expansion and additional use of other trauma-informed therapies.

Jefferson and Lewis Counties have begun implementation of NMT through a grant focused on juvenile justice through the NYS Regional Youth Justice Teams. Jefferson and Lewis County have a history of joint project success, specifically in the Child Welfare Arena and these counties are contiguous allowing for a more focused pilot program allowing a broader array of referrals. Population metrics show that typical household movement is between these 2 counties in the Child Welfare system and these counties share 2 districts.

Jefferson and Lewis County; through the work of the Regional Juvenile Justice Teams; has already trained a critical mass of mental health professional in private and public service in the bi-county area. Child Welfare staff has already received basic orientation to the NMT model and are ready to move to implementation. The DSS Commissioners of both counties strongly endorse this initiative, and have actively participated in its design.

Those children identified as having significant developmental risk would undergo interventions appropriate to their deficits and developmental age. Greene County DSS Commissioner Kira Prospel has agreed to have her county serve as a control group. In addition to comparing the group receiving NMT with a control group from another county, we would also be comparing the cohort of preschoolers to those older children in care. The evaluation plan would include assessing the Return on Investment of each, testing the hypothesis that earlier interventions reap a more favorable ROI (Heckman and Fontaine.)

Funding would be needed to train CPS and EI personnel including staff and service coordinators, in the NMT methodology, to complete the evaluations necessary to complete the NMT "Brain Map," and to conduct multi-disciplinary team meetings to develop and monitor appropriate interventions. Additional training and support would also be provided to foster parents.

**Cross-Sector Collaboration Component:** Yes X No    

- Demonstration project would require collaboration with Child Protective Services

**Cost Assumptions:**

- \$650 per assessment
- Training and consultation @ \$120 per hour
- Fees for a consultant to design the evaluation model: TBD
- Total estimated cost: \$250,000/year



First 1K Days on Medicaid	
<i>Use of Neurosequential Model of Therapeutics for Traumatic Stress</i>	
Estimated Cost per year*	\$ 250,000.00
Number of years	3
<b>Total Cost (Gross)</b>	<b>\$ 750,000.00</b>
<b>Total Cost (State)</b>	<b>\$375,000</b>
* No further breakdown on annual costs provided by author	

Because this is a demonstration project to test the feasibility of expanding the model to multiple counties, even state-wide, there are additional costs. We estimate that it will require three years of operation to adequately test it.

**Potential Return on Investment:** In addition to comparing the group receiving NMT with a control group from another county, we would also be comparing the cohort of preschoolers to those older children in care. The evaluation plan would include assessing the Return on Investment of each, testing the hypothesis that earlier interventions reap a more favorable ROI (Heckman and Fontaine.)

**Metrics to Track Success/Outcomes:**

- **Short-term:** Children receiving NMT assessment and intervention will score significantly higher improvement than controls in measures of central nervous system functionality: sensory integration, self-regulation, and relational and cognitive measures, as well as in the cortical modulation ratio
- **Mid-term:** Children and families receiving NMT assessment and interventions will exhibit lower rates of subsequent CPS involvement and services
- **Long-term:** Children receiving NMT assessment and interventions will engage in lower rates of high risk behaviors (such as smoking, substance abuse, obesity, unprotected sex, unwanted pregnancy, and violence) and have fewer major health problems, require fewer medical interventions/services, and live longer.



### Benefits of Proposal:

- The ROI is potentially very high, both short- and long-term, for a very specific, high-risk population.
- NMT is a promising practice for dealing with the effects of trauma
- Identified outcome areas suggest broad range of behavioral and physical health improvements, as well as social and educational benefits.
- This is the only proposal to specifically focus on children in foster care
- Proposal would provide additional services to children with CPS “indicated” cases, thus providing an opportunity for professionals to provide services to this very at-risk population. Demonstration project could build upon the work of Children’s Health Homes and the state’s focus on complex trauma.

### Concerns with Proposal:

- Targeted to a narrow, albeit high risk, subset of the population
- Assumes Early Intervention changes not under purview of Medicaid program
- Proposal endorses a specific model of trauma-informed therapy
- It is unclear whether the proposed model – NMT – could be scaled across the state

### Links to Available Evidence:

Anda, Robert F., et. Al. “The Enduring Effects of Abuse and Related Adverse Experiences in Childhood: A Convergence of Evidence from Neurobiology and Epidemiology.” European Archives of Psychiatry and Clinical Neuroscience. (2006) 256:174-186.

“Children in Foster Care Show Poorer Health”

<http://www.medpagetoday.com/Pediatrics/General/Pediatrics/160819>

Felitti, et. Al. “Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults.” *American Journal of Preventative Medicine*, May 1998. doi:10.1016/s0749-3797(98)00017-8.

Heckman and Fontaine. “Returns to a Unit Dollar Invested are Highest in Earliest Years.” Investing in a Strong Start for Children. The Center for High Impact Philanthropy. University of Pennsylvania. 2017.

“How America’s Overmedicating Low-Income and Foster Kids.” <http://www.governing.com/topics/health-human-services/gov-america-overmedicating-poverty.html> March, 2015.

Nelson, Charles A. “Hazards to Early Development: The Biological Embedding of Early Life Adversity.” Neuron. October 11, 2017. Elsevier.

Perry, Bruce D. “Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children.” Working with Traumatized Youth in Child Welfare. Edited by Nancy Boyd Webb. The Guilford Press. New York. 2006.

Perry, Bruce D. “Trauma- and Stressor-Related Disorders in Infants, Children, and Adolescents.” Textbook of Child and Adolescent Psychopathology. Wiley. New York. 2017.

Perry, Bruce D. “Child Maltreatment: A Neurodevelopmental Perspective on the Role of Trauma and Neglect in Psychopathology.” Child and Adolescent Psychopathology. Wiley. Hoboken. 2008.

Schwartz, Alan. ADHD Nation. Scribner. New York. 2016.





Walker, Molly. "Evaluate Children in Foster Care 'Early and Often.'" American Academy of Pediatrics.  
[http://www.medpagetoday.com/Pediatrics/GeneralPediatrics/53762?xid=nl\\_mpt\\_DHE\\_2015-09-29&eun=g911664dDr](http://www.medpagetoday.com/Pediatrics/GeneralPediatrics/53762?xid=nl_mpt_DHE_2015-09-29&eun=g911664dDr)

**Reviewer Name/Organization:** Jennifer Jones, DSS Commissioner, Lewis County;  
Sam Rubenzahl, Ph.D.; Philip McDowell, LCSW-R; Bruce D. Perry, MD, Ph.D

DRAFT



First 1,000 Days on Medicaid Proposal #: 22

Proposal (Short Title): Evaluate Healthy Steps Outcomes with Goal Toward Value-Based Payment

Implementation Complexity: Low Implementation Timeline: Short term

Required Approvals/Systems Changes:

- Administrative Action, Statutory Change, IT/data infrastructure, State Plan Amend, Federal Waiver, NYS budget request

Proposal Background/Description:

This is a proposal for Medicaid to partner with the Office of Mental Health (OMH), the National Healthy Steps team at ZERO TO THREE to evaluate the multi-year outcomes of OMH's pilot of the evidence-based primary care prevention intervention, Healthy Steps.

Healthy Steps represents an approach to primary health care that offers families enhanced well-child visits emphasizing the promotion of children's development. The program consists of the following components:

- The addition of a Healthy Steps Specialist, a professional with expertise in child and family development, to the pediatric or family medicine practice. This Healthy Steps Specialist delivers many of the program's components and serves as a link between the members of the clinical team, the child and the family.
Team-Based enhanced well-child visits emphasize the promotion of child development including: strategies to improve "the goodness of fit" between parent and child; closer attention to parental questions and concerns; and the use of "teachable moments" to support better parental understanding of their child's behavior.
Screening for maternal depression, Adverse Childhood Experiences (ACES) and social determinants of health.
Screening for Child development, including social-emotional and behavioral screening
Positive parenting guidance and information.
Home visits offered by the Healthy Steps Specialist based on family needs.
Access to Healthy Steps Specialist between visits
A dedicated child-developmental information line as well as utilizing a broad range of media and communication strategies.
Support for Early Learning via participation in the Reach Out and Read program.
Providing parenting education groups that increase caregiver knowledge of child development, strategies to positively address challenging child behaviors and decrease use of harsh discipline.
Referrals to and tighter linkages with community resources.
English- and Spanish-language written materials for parents that emphasize prevention and health promotion within the context of their relationships with family, pediatric and community resources.



In late 2016 OMH awarded \$6.5 million total to 17 pediatric primary care practices across NYS (with a payer-mix that averages approximately 80% Medicaid) for three years for implementation of the Healthy Steps program. As part of this pilot program, participants are required to report on an aggregate set of program process and performance measures, such as participant enrollment, number of well-child visits, number of maternal depression screens with identified linkages to supports/services when indicated, number of children participating in Reach Out and Read and number of caregivers participating in parenting groups. An implementation evaluation of NYS Healthy Steps is underway within OMH.

The current proposal is to conduct an outcome evaluation of NYS Healthy Steps using Medicaid claims. Medicaid claims would be used to examine costs and utilization patterns over time for Medicaid eligible children who received Healthy Steps compared to similar children in Medicaid who did not receive Healthy Steps (longitudinal cohort study with comparison group). If feasible, the evaluation would also include Medicaid claims of the parent/caregiver of the child (if parent/caregiver is a Medicaid beneficiary) in order to assess whether the program has family-wide utilization or cost benefits.

However, to conduct this outcome study, an initial solution is needed to collect Medicaid Client Identification Numbers (CINs) and other personal identifiers as well as Healthy Steps enrollment dates for each enrollee in the Healthy Steps initiative. The support of OHIP to provide a web-based system for the collection of this information on Healthy Steps enrollees is critical to the success of this evaluation. In order to speed implementation and encourage systems integration, OHIP could build off of an existing data platform rather than creating a separate platform. Given that OHIP has a proven track record for developing such systems for the oversight of Health Homes and Managed Long Term Care (for example) in NYS this solution seems feasible.

This outcome evaluation would be enhanced by a partnership with OMH, ZERO TO THREE, and OHIP. This evaluation would bridge the current OMH implementation evaluation with OHIP's technological resources and OMH and OHIP's analytic capability and ZERO TO THREE programmatic expertise to evaluate multi-year cost-savings and utilization changes for Healthy Steps children. This would extend the national research on Healthy Steps to date. The design phase of this evaluation would begin in 2018. The analysis of Medicaid claims could be conducted using in-house (OHIP and OMH) capabilities or by working through a research partner with access to Medicaid's claim database. This study would expand the research base and provide generalizable information to support Medicaid payment for the program in NYS and across the nation.

The results of this study could then be used to assess opportunities to sustain Healthy Steps as part of Medicaid's value-based payment designs for children. Implementation lessons from this pilot and evaluation should be considered by the Pediatric Preventative Clinical Advisory Group (if developed under proposal 1) and should include which components of the model might be generalizable to practices of different sizes and settings.

**Cross-Sector Collaboration Component:** Yes \_\_\_ No X

- While facilitating connections to community resources is a component of the Healthy Steps program, this proposal does not contain explicit cross-sector work.



**Cost Assumptions:**

- If research is conducted using OHIP's and OMHs own analytic capabilities, the data analytic cost would be minimal.
- If research is conducted using a Medicaid research partner, the cost is estimated to be \$150,000.
- Development of Web-based portal for collection of Healthy Steps Enrollees CINS and other to be specified data elements (Minimum data set). OHIP in-kind cost to be determined

**Potential Return on Investment:**

- No ROI on the research itself, but the findings could point to significant ROI for Medicaid through Healthy Steps.

**Metrics to Track Success/Outcomes:**

- Successful completion of research study
- Use of research findings to inform future VBP decisions

**Benefits of Proposal:**

- Feasible to begin the research in the short-term
- Supports evidence-based policymaking
- Builds upon a signature initiative of the Office of Mental Health

**Concerns with Proposal:**

- No guarantee the research will result in policy changes that improve population health outcomes for children
- Healthy Steps has had several evaluations. The question is whether this pediatric health care model can go to scale (although arguably sustainable funding through value-based payment would be an component of going to scale)

**Links to Available Evidence:**

[Healthy Steps for Young Children: Sustained Results at 5.5 Years \(2007\). Pediatrics, 150\(4\), 658-668.](#)

<https://www.healthysteps.org/article/national-and-site-level-evaluations-9>

[https://www.jhsph.edu/research/centers-and-institutes/womens-and-childrens-health-policy-center/projects/Healthy\\_Steps/index.html](https://www.jhsph.edu/research/centers-and-institutes/womens-and-childrens-health-policy-center/projects/Healthy_Steps/index.html)

[http://modernmedicaid.org/medicaid\\_solutions\\_healthysteps/](http://modernmedicaid.org/medicaid_solutions_healthysteps/)

**Additional Technical Detail: (If needed, to evaluate proposal)**



First 1,000 Days on Medicaid Proposal #: 23

Proposal (Short Title): Telemedicine Pilots

Implementation Complexity: High
Implementation Timeline: Long term

Required Approvals/Systems Changes:

- Administrative Action, State Plan Amend, Statutory Change, Federal Waiver, IT/data infrastructure, NYS budget request

Proposal Background/Description:

In late September the Telehealth Workgroup of the Regulatory Modernization Initiative recommended a series of changes to facilitate additional adoption of telehealth in the Medicaid program.

Under the Telehealth Workgroup recommendations, Medicaid managed care plans would be allowed to use the in-lieu-of-service request process to receive a waiver from the state to allow for billing of telehealth services and expand the locations in which those services can be reimbursed beyond licensed medical facilities.

The Telehealth Workgroup also recommended that OHIP create incentives for managed care plans to develop telemedicine approaches by providing five bonus points under the annual Quality Incentive program for plans that submit a telehealth innovation plan.

Based on initial deliberations of the First 1,000 Days on Medicaid Workgroup, The Castleton Group, a telehealth solutions provider, suggested a number of ideas for how managed care organizations could build on existing telehealth programs and technologies to design and deliver on their innovations plans.

- Replication of the Health-e-Access telemedicine model originated in Rochester.
Delivery of Centering Pregnancy / Parenting services through telehealth platforms,
Replication of the Antenatal and Neonatal Guidelines, Education and Learning System (ANGELS) developed by the University of Arkansas for Medical Services.



at risk of having a complicated pregnancy receives the best possible perinatal care. The approach could be applied by managed care plan(s) to improve regionalization of perinatal services in New York.

- Utilizing telehealth to provide culturally and linguistically appropriate services in the community to Medicaid children and families that may not otherwise have access to such services. In addition to providing the necessary services remotely in homes and community based organizations, telehealth could also be used to counsel and guide these especially vulnerable populations on the importance of a healthy lifestyle and monitoring of health conditions during pregnancy, birth and early childhood, and early childhood health and development more broadly.
- Leveraging telehealth platforms to develop central intake and referral systems for health and social services, potentially leveraging avatar technology to engage children and their families at intake and for ongoing patient engagement.

To further support the implementation of telehealth approaches through Medicaid managed care plans, under this proposal OHIP would make available grant funds for infrastructure and training, and initial startup operations for up to five Medicaid managed care organizations that included high-risk pregnancies or children in their first 1,000 days of life in their telehealth innovation plans. OHIP would create a request for proposal for managed care organizations to apply for these funds. The applications would detail the infrastructure and training costs associated with the telehealth innovation plan interventions for women with high risk-pregnancies or children in their first 1,000 days of life, the number of providers that would be engaged, and an estimate of the number of Medicaid enrollees that would be served. OHIP would determine grant awards based on both the quality and feasibility of the underlying telehealth innovation plan, and the reasonableness of the infrastructure and training costs requested, in the context of that plan. Applications that included delivery of telehealth services in non-health settings outside the home that would reach children and families in the communities in which they live (e.g., WIC offices, early childhood education centers, etc.) --thereby encouraging additional cross-sector collaboration--would receive preference in the award process.

**Cross-Sector Collaboration Component:** Yes  No

To the extent managed care plans develop telehealth innovation plans that would provide in-lieu-of-services in community settings, there are opportunities for cross-sector collaboration around the provision of these services.



First 1K Days on Medicaid	
Telemedicine Pilots	
Number of pilots	5
Cost of Pilot*	\$200,000
<b>Total Cost (Gross)</b>	<b>\$1,000,000</b>
<b>Total Cost (State)</b>	<b>\$500,000</b>
* \$100,000 equipment, software, customization \$50,000 training \$50,000 subsidized provider user fees during start-up	

**Potential Return on Investment:**

TBD – To the extent these pilots allow managed care organizations to provide in-lieu-of-services that save money, the up front investment could be recouped.

**Metrics to Track Success/Outcomes:**

- Metrics dependent on telehealth approach

**Benefits of Proposal:**

- Proposal might accelerate adoption and use of telehealth technologies
- Good potential to inform medical and cross-sector practices in improving access for families
- Proposal could improve access to pediatric behavioral health services, especially if Medicaid can recognize additional behavioral health specialists, and benefit underserved areas

**Concerns with Proposal:**

- Managed care plans are already incentivized through quality bonus to focus on pregnant women or children ages 0 – 3 in their telehealth plans. Unclear if additional incentive is needed.
- A telehealth approach to the delivery of CenteringPregnancy and CenteringParenting would seem to undermine the social nature and benefits of group prenatal/pediatric care. Therefore a translation of the research benefits of CenteringPregnancy to the telemedicine setting seems unlikely
- Not necessarily sufficiently cross-sector, nor sufficiently focused on social-emotional components of development



- Too medical treatment/intervention focused, does not provide a lot of upside in creating a conducive environment for the child to grow or on prevention (other than ED visits, which are more a result of the environmental factors than health access factors)

**Links to Available Evidence:**

American Academy of Pediatrics. The Use of Telemedicine to Address Access and Physician Workforce Shortages. Policy Statement. June 2015, Pediatrics:

<http://pediatrics.aappublications.org/content/early/2015/06/23/peds.2015-1253>

Ashwood J et al. Direct-To-Consumer Telehealth May Increase Access To Care But Does Not Decrease Spending. *Health Affairs*: 36:3. March 2017, p. 485-491.doi:10.1377/hlthaff.2016.1130

[https://www.rand.org/pubs/external\\_publications/EP67074.html](https://www.rand.org/pubs/external_publications/EP67074.html)

**Additional Technical Detail: (If needed, to evaluate proposal)**

One commenter noted that implementation of many of the other proposals could benefit from telehealth supported approaches. In addition to the managed care specific pilots the commenter suggests the state consider the creation a universal telehealth network that could be used across First 1000 Days interventions and to ensure collaboration and alignment with the program's goals across interventions, while improving communication, screening and referral data collection and sharing, and virtual service provision in individual interventions.

Health-e-Access - Ronis SD, McConnochie KM, Wang H, Wood NE. "[Urban Telemedicine Enables Equity in Access to Acute Illness Care](#)." *Telemedicine journal and e-health* : the official journal of the American Telemedicine Association.. 2017 Feb 0; 23(2):105-112. Epub 2016 Jul 06.

Centering - <https://www.centeringhealthcare.org/>

Arkansas ANGELS - <http://angels.uams.edu/angels-in-the-news/angels-program-evaluation/>

**Reviewer Name/Organization:** The Castleton Group