



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:

- \_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 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  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 #: 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, Statutory Change, IT/data infrastructure, State Plan Amend, Federal Waiver, 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 #: 10

Proposal (Short Title): Statewide Home Visiting

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:

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 #: 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 #: 16

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

**Implementation Complexity:** High

**Implementation Timeline:** Long term

**Required Approvals/Systems Changes:**

- |   |   |  |
|---|---|--|
| <input checked="" type="checkbox"/> Administrative Action | <input type="checkbox"/> Statutory Change | <input checked="" 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:**

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)



**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.

---

<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>

---

<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 #: 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.

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.

- 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
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



- 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