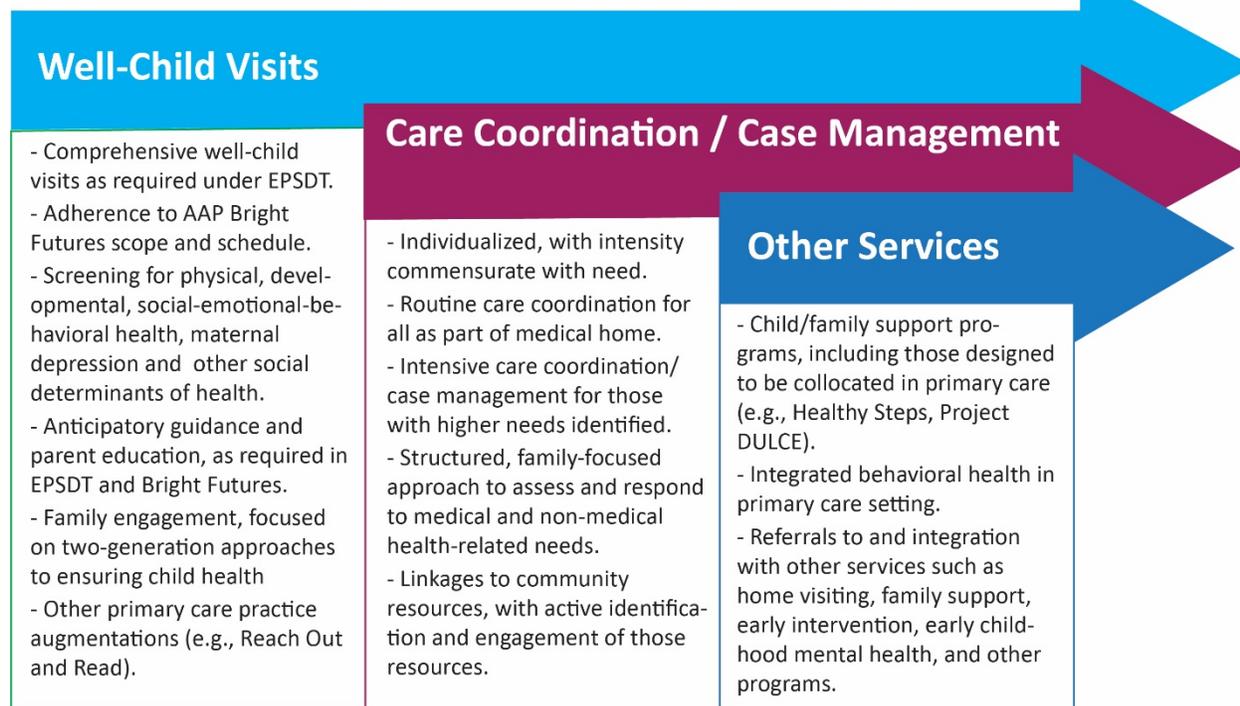


# High Performing Medical Homes In Brief

Adapted from: Johnson K and Bruner C. *A Sourcebook on Medicaid's Role in Early Childhood Advancing High Performing Medical Homes and Improving Lifelong Health*. Child and Family Policy Center. October, 2018. [https://www.cfpciowa.org/en/issues/health\\_equity/sourcebook\\_on\\_medicaids\\_role\\_in\\_early\\_childhood/](https://www.cfpciowa.org/en/issues/health_equity/sourcebook_on_medicaids_role_in_early_childhood/)

## Design for High Performing Pediatric Medicaid Homes in Medicaid



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This figure illustrates the characteristics of high-performing pediatric medical homes for young children in Medicaid, reflecting best practices and approaches and based on the goals and *Bright Futures* guidelines and the principles for a family-centered medical home for pediatrics. Medicaid can finance services in each of the three areas to support and sustain high performing medical homes.

Exemplary pediatric primary care practices for low-income young children in Medicaid share important characteristics related to their approaches and functional components that define high performance and high value. Specifically, they:

1. **Provide comprehensive well-child visits and preventive services** based on *Bright Futures* and Medicaid's Early Periodic Screening, Diagnostic, and Treatment (EPSDT) child health benefit standards, including screening, anticipatory guidance and parent education, that extend beyond the physical/bio-medical health of the child to the social and environmental factors that affect healthy child development (e.g. family stress and adversity, maternal depression, food insecurity), with a two-generation emphasis on improving child health.
2. **Provide care coordination/case management at appropriate levels** (low, moderate, and more intensive levels), depending on child and family presenting concerns. This includes supports for an effective, warm "handoff" from the health practitioner to a care coordinator (based inside the medical home and/or in the community and consistent with the concept of team-based care for a medical home) to identify concerns, strengths, and needs, and to ensure referral and follow-up that connects

families with resources and supports that meet needs and build strengths. A part of this care coordination also is to identify and network with other resources in the community to facilitate effective care coordination and ensure completed referrals, connecting young children and their families to services and supports in their communities.

3. **Increase use of other services and supports for healthy development.** This can include augmented services located within the primary care setting, such as integrated behavioral health, developmental specialists, or community health workers to support families. Primary care practices also should link to or integrate with other services such as home visiting, parent-child dyadic therapies, early intervention for developmental delays and disabilities, early childhood mental health therapy, and parenting programs.

### **Elements for Transforming Pediatric Primary Care Practice toward High Performing Medical Homes**

- **Bright Futures and Transformation.** Child health practice is undergoing a transformation, broadening its focus from treating disease and managing health conditions to promoting healthy development. Children's primary care providers are expanding their role in responding to social as well as bio-medical determinants of health. *Bright Futures* guidelines describe this role and a patient/family-centered medical home, defining expanded relationships with children, their families, and other community services. This is in keeping with the National Academy of Medicine, Engineering, and Science's report on *Vibrant and Healthy Kids: Aligning Science, Practice, and Policy to Advance Healthy Equity*, which emphasizes that "the single most important factor in promoting positive psychosocial, emotional, and behavioral well-being in children is having safe, stable, and nurturing relationships with their mother, father, or other primary caregivers".
- **Building from Exemplary Practices.** A growing base of exemplary primary care practices demonstrate the feasibility and value of providing enhanced primary care for young children, called here "**high performing medical homes**" to distinguish them from the current general standard of care. While current general primary child health practice provides value in identifying medical concerns, this practice falls short for the one-quarter to one-third of young children for whom social determinants jeopardize healthy development and who are at very early stages of compromised development.
- **Paying for Quality and Value.** High performing medical homes move beyond current general practice and have much more value in promoting healthy development, but require more time and resources to achieve optimal outcomes. Medicaid financing can support and sustain best practices, including comprehensive well-child visits and the additional care coordination, practice enhancements, and linkages to community services needed to address children's healthy development. To do so, states need to differentiate between general pediatric practice and that provided by high performing medical homes. Medicaid reimbursement rates and incentives should be set accordingly. This includes reimbursements for the well-child visit itself and other practice activities and evidence-based augmentations.
- **Care Coordination/Case Management.** The terms "care coordination" and "case management" are both used, often interchangeably, to describe a range of activities that link children and families to supports, promote access, ensure follow up and address needs. While the definition of a medical home includes basic, routine care coordination, some children and their families need more intensive care coordination. A high performing medical home in Medicaid would provide care coordination (and team-based care) capable of responding to both bio-medical and social risks and conditions.
- **Screening.** Practice in the high performing medical home should include but go beyond traditional screening for general development in young children, using separate screening tools for social determinants of health and emotional-behavioral risks. This is essential for identifying and responding to social determinants of health and related early childhood risks and adversity, with emphasis on improving health trajectories over the life course, not just immediate health conditions.

- **Augmenting Primary Care.** Many pediatric primary care practices are augmenting their services or increasing linkages with other providers to better address risks related to child development, emotional-behavioral factors, or social determinants of health. Evidence-based models to augment primary care — such as Healthy Steps and Project DULCE — are being used across the nation.
- **Financing Other Services.** Several examples of other services describe the potential. Medicaid is financing an array of preventive and therapeutic early childhood mental health services for young children and their families, including services to ameliorate parent risks that affect child health. Medicaid also plays a role in financing home visiting and early intervention services. While dedicated federal funding exists through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program and the IDEA Part C Early Intervention Program, in 2019, Medicaid financed some of Part C services in virtually every state, and home visiting in more than 20 states. Medicaid also provides opportunities for financing other services related to parenting training, education, and group interventions that respond to developmental, social, emotional, and health risks.
- **Monitoring Medical Home Performance.** States need quality measures to monitor high performing medical homes to assure they provide the expected level of care and qualify for enhanced reimbursement. A set of measures specifically designed to monitor high-performing medical homes for young children is suggested in the Sourcebook. The table below shows measures that reflect key characteristics of high performing medical homes for young children in Medicaid.
- **Cross System Accountability.** States have an opportunity to advance measure alignment and shared accountability across health and related programs. For example, creating a common, shared set of early childhood measures across Medicaid (CMS core set), Medicaid managed care (HEDIS), Title V Maternal Child Health Block Grant, and federal home visiting (MIECHV) program could help to drive program performance, as well as improve outcomes for young children and their families.
- **Need for Improvement.** While a national Medicaid performance goal states that 80 percent of 1- and 2-year-olds have at least one well-child visit, only 23 states met this minimum standard in FFY 2017. The Medicaid/CHIP primary care measure for well-child visits in this age group is the percentage of children receiving six or more visits by 15 months. In FFY2017, the national average was 59%; however, states' performance ranged from 33 percent to 80 percent. (CMS)

### Monitoring High Performing Pediatric Medical Homes for Young Children in Medicaid

High rates of access to care*
High percentage of children receiving well-child visits*
High rates of children who are up-to-date on immunizations*
High performance on developmental screening measure*
Satisfaction with the experience of care as measured with the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H*
Use of validated CSCHN screening tool
Use of SDOH screening tool, including maternal depression
Low rates of unnecessary emergency department visits*
Family engagement demonstrated through use of recommended Bright Futures pre-visit tools and/or the electronic Well-Visit Planner
Documentation on rates of referrals, follow up and completed referrals
Documentation of augmented resources and supports provided in practice (e.g., integrated mental health, Healthy Steps, Project DULCE, Reach Out and Read)

\* Measures for this topic are part of CMS Medicaid-CHIP Core Child Set.