



## CHILD DEVELOPMENT PROGRAMS IN COMMUNITY HEALTH CENTERS

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January 2002

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

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## EXECUTIVE SUMMARY

Child development services are essential to the healthy physical, emotional, and cognitive development of young children. A growing body of scientific literature recognizes that certain key interventions, rendered in the early years of life, are tremendously important to a child's long-term development. These entail comprehensive preventive health care, family interaction and support, and activities designed to promote cognitive and sensory stimulation. Preventive in nature, such services are especially critical for children from low-income families, who face greater health risks than children from more affluent families and are therefore more vulnerable to developmental delays. The provision of these services—for example, parental education, home visits, the promotion of reading—require programs that go beyond conventional pediatric care.

This report, the third in a series that reviews federal health policy related to child development, examines the role of community health centers in providing child development programs for children age 3 and younger. It also presents an analysis of health centers using the Uniform Data System, a database maintained by the federal Bureau of Primary Health Care (BPHC) that contains user, utilization, and financial information on each reporting center. In addition, the report presents findings from a 2000 survey of four categories of child development programs at 79 health centers; examines the new prospective payment system for health centers and its potential impact on the provision of child development services; and offers recommendations for improved delivery of these services at health centers.

Health centers administered by BPHC rely on public funds to provide comprehensive medical services, as well as a variety of social services, to low-income, medically underserved communities. By 2000, about 700 health centers served more than 9 million people at nearly 3,000 locations.<sup>1</sup> As of 1999, 129 clinics designated by the federal government as meeting all standards applicable to federal health center grantees were serving another 1.8 million patients.<sup>2</sup>

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<sup>1</sup> Barbara E. Bailey et al., *Experts with Experience: Community & Migrant Health Centers Highlighting a Decade of Service (1990–2000)*. Bureau of Primary Health Care, HRSA, USDHHS. 2000. [bphc.hrsa.gov/CHC/CHCDocuments/pdf/tenyear\\_report.pdf](http://bphc.hrsa.gov/CHC/CHCDocuments/pdf/tenyear_report.pdf).

<sup>2</sup> Martha P. King and Stephen M. Christian, "Health Centers and Other Community-Based Providers," *Medicaid Survival Kit* (Washington, D.C.: National Conference of State Legislatures, Update—February 2000), p. 6-4.

Health centers are a major health care provider for children. They care for one of every six children of low-income families, and serve 1.3 million children under age 6.<sup>3</sup> In 1998, births to health center patients accounted for one of five births to low-income families, or one of 10 of all births nationally.<sup>4</sup> Because of their ability to identify at-risk children and to assess their social and primary care needs, health centers are valuable and essential providers of child development services.

Findings presented in this report show that health centers provide many valuable programs and services that promote the healthy growth and development of a large number of young children. Maintaining and expanding their ability to seek out at-risk children, screen and assess their needs, and provide appropriate development services are important to improving the health and welfare of children and their families.

Both the Senate and House of Representatives have increased funding for the community health center program to \$1.3 billion for fiscal year 2002 in their separate appropriations bills—an amount that exceeds President Bush’s recommendation for expanded funding. This will allow centers to increase the number of services and programs they provide. Although our survey results show that the majority of centers provide at least one type of health-promotion and parent-education program, fewer than half offer a home visiting program or parent groups. The combination of increased federal funding for health centers and efforts by the National Association of Community Health Centers (NACHC) to double the number of patients served by them could improve the quality of preventive services for children.

The work of BPHC, in collaboration with the National Initiative for Children’s Health Care Quality (NICHQ) and The Commonwealth Fund, could provide health centers with formal guidance and technical assistance to help them improve their delivery of these services. Efforts also could be made to improve the training of providers and other health center staff in the provision of development services. Health centers should take advantage of the increased attention to improving health care quality and seek out any available technical assistance tools or expertise to focus on early childhood development.

Once innovative practices to enhance healthy child development are tested and implemented, BPHC could disseminate these successful practices to other centers

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<sup>3</sup> National Association of Community Health Centers, Inc., *Access to Community Health Care: A National and State Data Book, 1998* (Washington, D.C., 1998), p. 1.

<sup>4</sup> Martha P. King and Stephen M. Christian, “Health Centers and Other Community-Based Providers,” *Medicaid Survival Kit* (Washington, D.C.: National Conference of State Legislatures, Update—February 2000), p. 6-3.

throughout the country. BPHC also could go one step further and encourage all centers to make the improvement of child development services a priority on grant applications for initial or continued funding. Such an incentive would push centers to develop new ways to improve their enabling services and use existing staff to improve the quality of child development services. In addition, the Health Resources and Services Administration (HRSA) may want to strengthen coordination in the area of child development among its bureaus and other agencies in the federal government.

Changes to the Medicaid reimbursement system for Federally Qualified Health Centers (FQHCs) also provide an opportunity to improve preventive care for young children. States will use the new prospective payment system mechanism to calculate a minimum per-visit rate for FQHCs that serve Medicaid beneficiaries. The prospective payment amount is based on an average of the center's per-visit rate from FY 1999 and FY 2000. Costs of the child development services offered by the health center must be identified and included in the baseline rate, or otherwise reimbursed by the state. If an FQHC adds new child development services after the baseline rate is calculated, the FQHC's Medicaid reimbursement rate should be adjusted to incorporate the change in the scope of services furnished.

# CHILD DEVELOPMENT PROGRAMS IN COMMUNITY HEALTH CENTERS

## I. INTRODUCTION

Child development services are essential to the healthy physical, emotional, and cognitive development of young children. A recent and growing body of scientific literature recognizes that certain key interventions, rendered in the early years of life, are tremendously important to a child's long-term development.<sup>5</sup> These entail comprehensive preventive health care, family interaction and support, and activities designed to promote cognitive and sensory stimulation. Preventive in nature, such services are especially critical for children from low-income families, who face greater health risks than children from more affluent families and are therefore more vulnerable to developmental delays. The provision of these services—for example, parental education, home visits, and promotion of reading—require programs that go beyond conventional pediatric care.

Effective interventions increase the odds for optimal child development.<sup>6</sup> A recent study of the association between adherence to prevailing guidelines for periodic health supervision and the occurrence of adverse health outcomes showed that a series of well-child visits during the first two years of life has a positive effect on health outcomes for poor and near-poor children—including fewer avoidable hospitalizations—regardless of race, income level, or health status.<sup>7</sup> Children treated at health centers tend to be at higher risk for developmental problems than children within the general population.<sup>8</sup> It is thus necessary to understand how health centers—the place where large numbers of young children receive their health care—can be used to foster child development interventions.

Health centers are commonly recognized as important safety net providers for uninsured and low-income families. Less well known is the extent to which these centers play an important role in supplying preventive health services to young children from low-income families in medically underserved urban and rural communities, and the potential of these centers to provide more of these services.

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<sup>5</sup> See, for example, Institute of Medicine (IOM), *From Neurons to Neighborhoods* (Washington, D.C.: National Academy Press, 2000).

<sup>6</sup> Institute of Medicine (IOM), *From Neurons to Neighborhoods* (Washington, D.C.: National Academy Press, 2000), p. 4.

<sup>7</sup> Rosemarie B. Hakim and Barry V. Bye, "Effectiveness of Compliance with Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries," *Pediatrics* 108 (2001): 90.

<sup>8</sup> Health center patients as a whole are sicker than the general population. Ann Zuvekas, Kathy McNamara, and Caryn Bernstein, "Measuring the Primary Care Experiences of Low-Income and Minority Patients," *Journal of Ambulatory Care Management* 22 (October 1999): 68.



This report, the third in a series that reviews federal health policy related to child development, examines the role of community health centers in providing child development programs for children age 3 and younger. It also presents an analysis of health centers using the Uniform Data System (UDS), a database maintained by the federal Bureau of Primary Health Care (BPHC) that contains user, utilization, and financial information on each reporting center. In addition, the report presents findings from a 2000 survey of four categories of child development programs at 79 health centers; examines the new prospective payment system for health centers and its potential impact on the provision of child development services; and offers recommendations for improved delivery of these services at health centers.

## II. BACKGROUND

Community health centers were created in 1965 in response to the discovery of significant health problems and poor access to care in communities targeted by President Lyndon Johnson's War on Poverty. Administered by BPHC—part of the Health Resources and Services Administration (HRSA) within the U.S. Department of Health and Human Services (HHS)—these centers rely on public funds to provide comprehensive medical services, as well as a variety of social services, to low-income, medically underserved communities. Centers also rely on community involvement, and are governed by lay community boards.<sup>9</sup> The federal appropriation for health centers in FY 2001 was approximately \$1.169 billion.<sup>10</sup> By 2000, about 700 health centers served more than 9 million people at nearly 3,000 locations.<sup>11</sup> As of 1999, 129 clinics designated by the federal government as meeting all standards applicable to federal health center grantees were serving another 1.8 million patients.<sup>12</sup>

Health centers use a broad definition of health care, which is provided both on-site and in such satellite locations as schools, child care sites, migrant labor camps, public housing, and homeless shelters. This allows for the provision of a wide range of medical, preventive, educational, environmental, and social services as part of the centers' basic and supplemental federally supported health care activities.<sup>13</sup> These services include basic primary care, prenatal care, substance abuse and mental health services, laboratory tests, X-rays, pharmacy services, health education, child care, and enabling services such as translation and transportation. Health centers also play an important role in outreach and provide links to welfare; Women, Infants, and Children (WIC) programs; Medicaid; and the State Children's Health Insurance Program (CHIP).<sup>14</sup> A recent survey conducted by HHS's Office of the Inspector General found that 83 percent of health centers carry out

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<sup>9</sup> Sara Rosenbaum, Peter Shin, Anne Markus, and Julie Darnell, "Health Centers' Role as Safety Net Providers for Medicaid Patients and the Uninsured." Prepared for the Kaiser Commission on Medicaid and the Uninsured. February 2000, p. 2, [www.kff.org](http://www.kff.org).

<sup>10</sup> Marilyn Hughes Gaston. Letter to All Bureau of Primary Health Care Grantees and National Health Service Corps Sites, #2001-09, "Department of Health and Human Services Fiscal Year 2001 Appropriations, Other Legislation, and Regulation Issuances," (January 16, 2001), see [bphc.hrsa.gov/CHC](http://bphc.hrsa.gov/CHC).

<sup>11</sup> Barbara E. Bailey et al., *Experts with Experience: Community & Migrant Health Centers Highlighting a Decade of Service (1990–2000)*. Bureau of Primary Health Care, HRSA, USDHHS. 2000. [bphc.hrsa.gov/CHC/CHCDocuments/pdf/tenyear\\_report.pdf](http://bphc.hrsa.gov/CHC/CHCDocuments/pdf/tenyear_report.pdf).

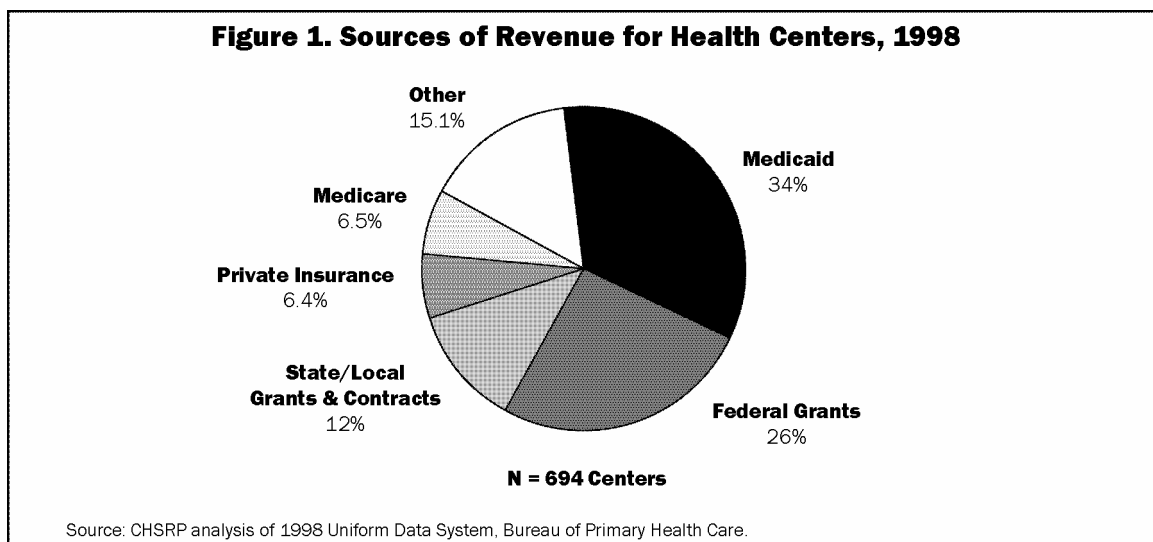
<sup>12</sup> Martha P. King and Stephen M. Christian, "Health Centers and Other Community-Based Providers," *Medicaid Survival Kit* (Washington, D.C.: National Conference of State Legislatures, Update—February 2000), p. 6-4.

<sup>13</sup> *Ibid.*

<sup>14</sup> Karen Davis, Karen Scott Collins, and Allyson Hall, *Community Health Centers in a Changing U.S. Health Care System* (New York: The Commonwealth Fund, May 1999), p. 3.

their own CHIP outreach, which usually involves screening current clients for CHIP eligibility.<sup>15</sup>

U.S. health centers receive revenue from both public and private sources, but they rely heavily on Medicaid and federal, state, and local grant funding (Figure 1). In 1998, Medicaid accounted for 34 percent of total revenues for all reporting health centers, federal grants for 26 percent, and state and local grants and contracts for 12 percent. Revenue from private or commercial insurance made up 6.4 percent and Medicare represented 6.5 percent of total revenue.<sup>16</sup> In contrast, private physician practices predominantly serve commercially insured patients and so are less sensitive to declining payment rates for Medicaid patients and stagnant federal funding levels for the growing uninsured population.<sup>17</sup>



The patient population of health centers is largely low-income, nonelderly, and ethnically diverse. Of the 8.6 million patients health centers served in 1998, approximately 76 percent (6.6 million) had family incomes at or below 200 percent of the federal poverty level (FPL). More than half (5.0 million) had incomes below 100 percent of FPL. In the same year, 41 percent (3.5 million) were uninsured and 33 percent (2.8 million) had Medicaid coverage. Only 15 percent (1.3 million) of health center patients had private insurance. The rest (11%) had either Medicare or other public funding (Figure 2).<sup>18</sup>

<sup>15</sup> Office of Inspector General, USDHHS, "Federally Funded Health Centers and Low-Income Children's Health Care: Improving SCHIP Enrollment and Adapting to a Managed Care Environment," OEI-06-98-00321. December 2000, p. i. [www.hhs.gov/oig/oei/reports/a499.pdf](http://www.hhs.gov/oig/oei/reports/a499.pdf).

<sup>16</sup> The George Washington University Center for Health Services Research and Policy (CHSRP) analysis of 1998 Uniform Data System, Bureau of Primary Health Care, USDHHS.

<sup>17</sup> Rosenbaum, Shin, Markus, and Darnell, 2000.

<sup>18</sup> CHSRP analysis of 1998 Uniform Data System, Bureau of Primary Health Care, USDHHS.

In 1998, 35 percent (3.0 million) were white, 32 percent (2.8 million) were Hispanic, 25 percent (2.2 million) were African-American, 2 percent (175,000) were Asian, and 1 percent (90,000) were Native American. Rural centers served just over half of all patients.<sup>19</sup>

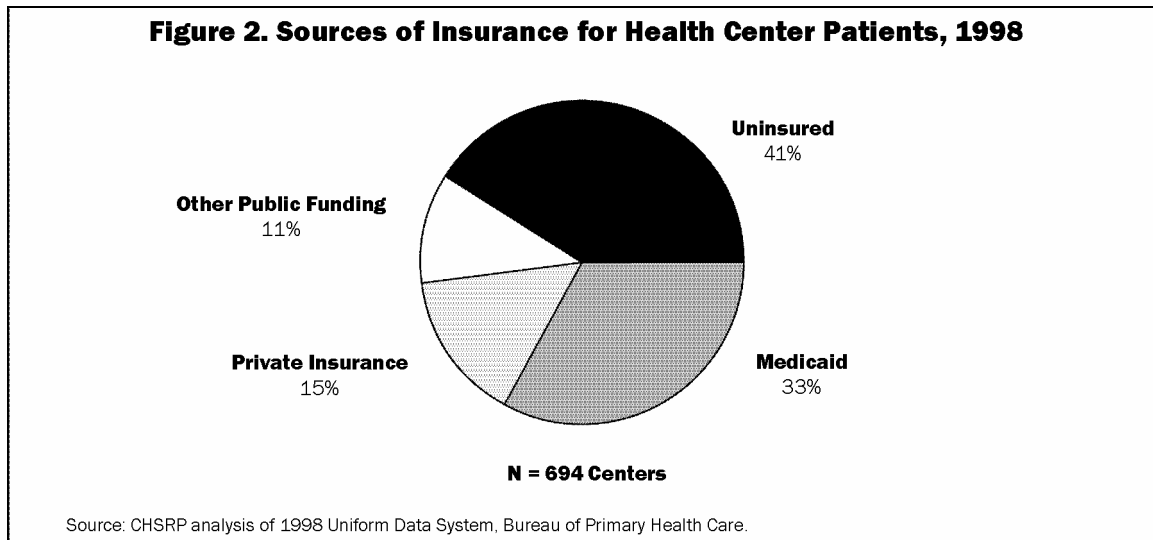


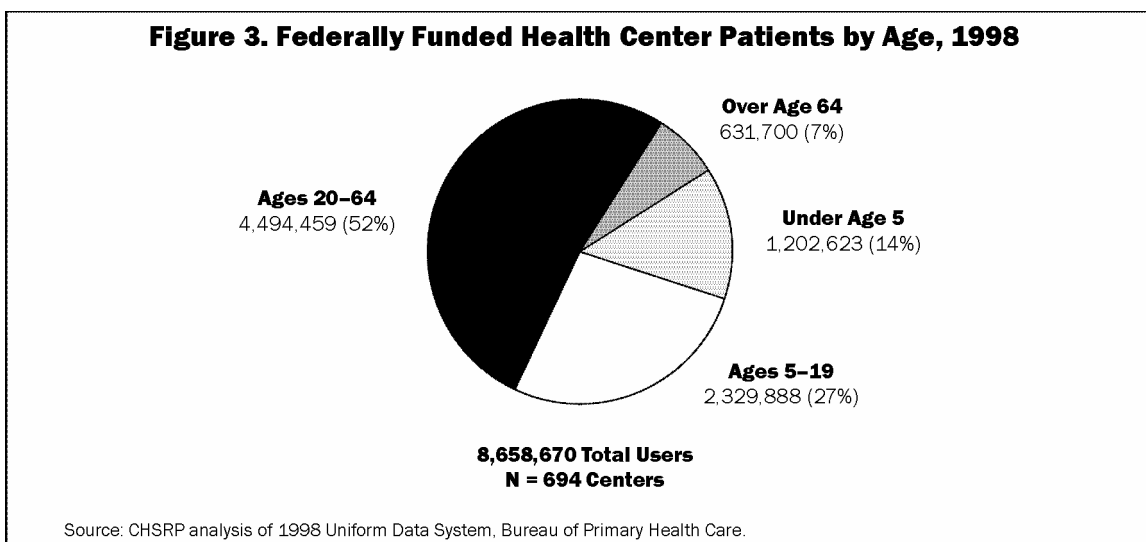
Figure 3 shows the age distribution of health center patients in 1998. The more than 1.2 million children younger than age 5 served that year amounted to 14 percent of all patients. Children younger than 20 years of age made up 41 percent (3.5 million), and adults ages 20 through 64 made up 52 percent (4.5 million) of patients. Approximately 276,000 patients were known to be pregnant in 1998. Of the 126,000 infants born to prenatal care users in 1998, 6 percent had low birth weights that ranged between 1501 and 2500 grams. Just 2 percent had birth weights less than 1500 grams, attesting to the importance of prenatal services at health centers.<sup>20</sup> The percentage of low-birth-weight babies born to users of health center prenatal care services was less than the national average of 7.6 percent in 1998, although the percentage of very low birth weights was slightly higher than the national average of 1.4 percent the same year.<sup>21</sup>

<sup>19</sup> Ibid.

<sup>20</sup> Ibid.

<sup>21</sup> March of Dimes, *The March of Dimes Data Book for Policy Makers: Maternal, Infant, and Child Health in the United States* (Washington, D.C., 2001), pp. 65, 67.

**Figure 3. Federally Funded Health Center Patients by Age, 1998**



### Health Centers' Role in Providing Child Health and Development Services

Health centers served 3.5 million children from low-income families in 1998.<sup>22</sup> Approximately 45 percent of those children were enrolled in Medicaid or CHIP and 36 percent were uninsured. The remaining 19 percent had either private insurance or other public insurance (e.g., Civilian Health and Medical Program of the United States [CHAMPUS] or state insurance programs).<sup>23</sup> During the same year, births to health center patients accounted for one of five births to low-income families, or one of 10 of all births nationally.<sup>24</sup> Tables 1 through 3 show the types of health centers with the greatest proportion of young children in 1998, broken down by selected patient and health center characteristics.

Table 1 shows that the patient load of centers where a majority of patients had incomes below 200 percent of poverty was associated with a greater proportion of children younger than age 4. In centers where more than 50 percent of patients had incomes under 200 percent of FPL, 14.4 percent of patients were young children. Health centers with fewer than 50 percent of patients under 200 percent of FPL had 10.6 percent of patients who were young children.

<sup>22</sup> The National Association of Community Health Centers estimates that 4.5 million children were served in approximately 1,000 community health centers across the country in 1998. National Association of Community Health Centers, Inc., *Access to Community Health Care: A National and State Data Book, 1998* (Washington, D.C., 1998), p. 1.

<sup>23</sup> Percentages based on CHSRP analysis of 1998 Uniform Data System of children under age 20, Bureau of Primary Health Care, USDHHS.

<sup>24</sup> Martha P. King and Stephen M. Christian, "Health Centers and Other Community-Based Providers," *Medicaid Survival Kit* (Washington, D.C.: National Conference of State Legislatures, Update—February 2000), p. 6-3.

Table 1. Children Age 4 or Younger as a Percentage of Low-Income Patients

Percentage of patients with incomes below 200% of FPL	Number of health centers	Number of children ages 0–4	Children ages 0–4 as a percentage of all patients
Less than or equal to 50% of patients	137	127,402	10.6%
Greater than 50% of patients	557	1,075,221	14.4%
Total	694	1,202,623	13.9%

Source: CHSRP analysis of 1998 Uniform Data System, Bureau of Primary Health Care, USDHHS.

The distribution of children age 4 and younger also differs across health center types, sizes, and urban or rural locations. Table 2 shows that health centers with a greater proportion of young children as patients tend to be migrant health center (MHC) grantees, large in size, and located in urban areas. In migrant health centers, young children represent 16.3 percent of patients, compared with 14 percent in community health centers and centers serving homeless children and adults. At large health centers, children account for 14.6 percent of patients compared with 11.7 percent in small health centers. Patients who are children amount to 14.5 percent of all patients at urban centers; that number is 13.1 percent at rural health centers.

Table 2. Children Age 4 or Younger by Selected Characteristics of Health Centers

	Number of health centers	Number of children ages 0–4	Children ages 0–4 as a percentage of all patients
Grant type*			
Migrant health	111	320,196	16.3%
Community health	611	1,168,412	14.1
Health care for homeless children	11	19,292	14.2
Health care for the homeless	126	242,584	13.9
Size			
Large (more than 10,000 patients)	309	963,538	14.6
Small (fewer than 10,000 patients)	385	239,085	11.7
Total	694	1,202,623	13.9
Urban/Rural**			
Urban	308	628,080	14.5
Rural	347	531,480	13.1

\* Health centers that received at least one grant type. These are the four grant types defined by HRSA.

\*\* Thirty-nine health centers did not report urban/rural location.

Source: CHSRP analysis of 1998 Uniform Data System, Bureau of Primary Health Care, USDHHS.

Enabling services, such as translation services, transportation, and case management, help individuals and families access appropriate health services that they may otherwise have difficulty obtaining. The individuals who provide these services include case managers, health education specialists, outreach workers, and others who help identify

and monitor at-risk pregnant women and children. Health centers with a greater proportion of enabling services staff also were more likely to have a greater proportion of patients who were young children (Table 3). Health centers in which enabling staff represented more than 20 percent of total staffing reported that approximately 15 percent of patients were young children, whereas health centers with fewer than 10 percent enabling staff reported less than 14 percent of patients were young children.

Table 3. Enabling Service Staff as a Percentage of Total Health Center Staff

<b>Enabling staff* as a percentage of total health center staff</b>	<b>Number of health centers</b>	<b>Number of children ages 0–4</b>	<b>Children ages 0–4 as a percentage of all patients</b>
0% of total staff	95	81,589	13.5%
0%–5% of total staff	147	262,263	13.1
5%–10% of total staff	155	319,844	13.9
10%–20% of total staff	168	320,142	14.1
Greater than 20% of total staff	127	214,315	15.4

\* Enabling services staff include caseworkers, health education specialists and outreach workers, and others who help identify and monitor at-risk pregnant women and children.

Source: CHSRP analysis of 1998 Uniform Data System, Bureau of Primary Health Care, USDHHS.

Because of their ability to identify at-risk children and to assess their social and primary care needs, health centers are valuable and essential providers of child development services. Various grants from BPHC and state and local governments allow health centers to identify children likely to be at risk for developmental problems, and to offer a wide range of enabling and medical services for the promotion and development of mental and physical health. Health center programs been shown to reduce the incidence of infant mortality, low birth weight, and childhood illnesses such as inner-ear infections, and to increase the usage of prenatal care, preventive health services, and the proportion of children immunized.<sup>25</sup>

Health centers employed nearly 870 full-time equivalent pediatricians in 1998. The UDS provides encounter information on select conditions and services for that year (Figure 4 and Table 4). Figure 4 shows that there were more than 3.3 million pediatric health encounters with children of all ages and nearly 1.8 million encounters related to child health supervision in that year.<sup>26</sup>

<sup>25</sup> Martha P. King and Stephen M. Christian. “Health Centers and Other Community-Based Providers.” *Medicaid Survival Kit* (Washington, D.C.: National Conference of State Legislatures, Update—February 2000), p. 6-7.

<sup>26</sup> CHSRP analysis of 1998 Uniform Data System, Bureau of Primary Health Care, USDHHS.

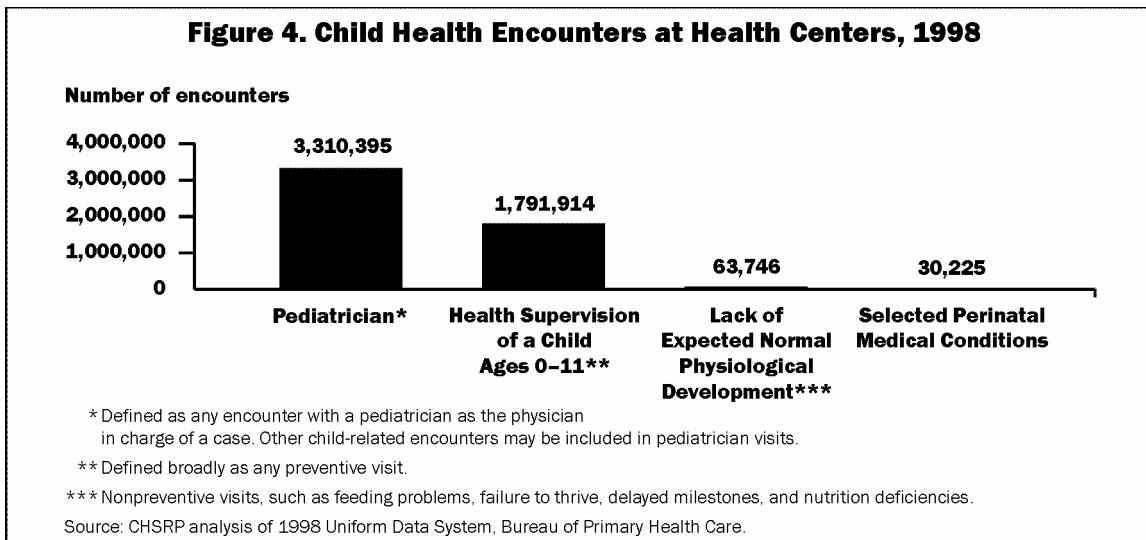


Table 4 lists the type and number of separate encounters commonly associated with children’s health care per health center. Because migrant health centers have a higher-than-average proportion of young children as patients, the table also compares health centers with and without MHC grants.

Table 4. Average Number of Developmental Encounters per Health Center

	Number of immunization encounters	Number of child health encounters*	Number of developmental encounters**	Number of encounters for perinatal conditions
All health centers (694 total)	2,858.8	2,732.7	95.3	58.2
Health centers without MHC*** grants (583 total)	2,582.9	2,515.8	97.3	41.7
Health centers with MHC grants (111 total)	4,228.8	3,872.0	8.5	145.2

\* Child health encounter refers to a visit between a physician and a child for health supervision of an infant or child ages 0 through 11 years.

\*\* Developmental encounter refers to a visit between a physician and a child for lack of expected normal physical development.

\*\*\* Migrant Health Center.

Source: CHSRP analysis of 1998 Uniform Data System, Bureau of Primary Health Care, USDHHS.

Migrant health centers appear to experience fewer developmental encounters than nonmigrant health centers (8.5 vs. 97.3); however, MHCs reported larger numbers of visits per center for perinatal conditions, child health supervision, and immunizations. This suggests that these centers might be providing services for perinatal conditions and child health supervision as substitutes for developmental care.



Child development services that go beyond traditional pediatric care include a variety of formal education, assessment, intervention, health promotion, and care-coordination activities. Examples of such services include nutritional and lactation counseling, injury prevention, parenting classes, home visits, case management, infant health tracking (i.e., monitoring infant health supervision), oral health and education, and behavioral health. The discussion below focuses on the findings of a 2000 survey of health centers conducted by the George Washington University Center for Health Services Research and Policy (CHSRP) that focused on these types of services to examine the extent to which health centers deliver child development services.

### III. NATIONAL SURVEY OF CHILD DEVELOPMENT PROGRAMS IN COMMUNITY HEALTH CENTERS

#### Purpose and Methodology

This survey was intended to identify the types of formal child development programs health centers provide to children age 3 and younger that go above and beyond what is normally provided during pediatric encounters. The survey defined child development programs as “any kind of program established by a community health center to promote the healthy growth and development of a child ages 0 to 3.” Because the survey’s focus was on preventive and health promotion activities, it did not examine the content of each service, and it did not include programs that target children with developmental delays.

The survey instrument was a page-long check-off list of programs that fall within the following categories: health promotion programs, health education for parents, programs with home visiting, and selected developmental therapy programs. An “other” category allowed respondents to include additional formal programs. The programs listed were derived after viewing pediatric program literature from several health centers, as well as the National Public Health and Hospital Institute’s survey findings from National Association of Public Hospitals and Health Systems members on innovative child development services for children at risk.<sup>27</sup> This survey was funded by The Commonwealth Fund.

Health centers queried responded to a fax sent to all health centers by CHSRP in conjunction with the National Association of Community Health Centers, Inc. (NACHC). This fax requested a response if the center provided child development programs on site and if it was able to provide additional information. Finally, a series of phone calls to centers that responded affirmatively was made to solicit participation in the survey.

The survey was faxed during the spring of 2000 to representatives of 103 health centers in the United States and Puerto Rico. These centers represent roughly one of seven health centers nationally. Follow-up faxes and phone calls helped secure a 76.7 percent response rate. Staff members who were familiar with all child development programs provided by that center (e.g., pediatric program managers or medical directors) completed the surveys. Note that respondents may have included both formal and informal programs for all children, rather than just those three years and younger.

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<sup>27</sup> See Betsy Carrier and Sheila Madhani, *Innovative Programs for Children 0–3* (Washington, D.C.: National Public Health and Hospital Institute, 1999). The authors also met with CHSRP to provide some helpful information on survey design.

## Findings

The UDS shows that the 79 responding health centers served approximately 186,000 children, or 15.4 percent of all health center patients younger than age 5. The Commonwealth Fund’s Assuring Better Child Health and Development (ABCD) program and the survey focus on children age 3 and younger. The UDS identifies children as a combination of the two youngest groups—users under age 1 and users from one to four years old. The UDS also shows that these 79 health centers had patient, revenue, staffing, and utilization characteristics similar to all other health centers. Survey results indicate that these health centers provide a variety of health education, home visiting services, and health promotion programs for children; however, there appears to be no minimum or standard set of programs for child development and health education. The following series of tables describe the types of programs available to young children at health centers.

### Health Promotion Programs

Every health center surveyed reported that it offers at least one health promotion program for young children (Table 5). Nearly all (92%) indicated that they provide well-child checkups, and most (66%) reported that they provide oral health and education; however, the percentage of health centers reporting that they provide services for high-risk infants and behavioral health was relatively low—39 and 30 percent (31 and 24 centers), respectively. The centers may coordinate these types of services with other providers—one, for example, reported that it coordinates well-child checkups with private physicians.<sup>28</sup>

Table 5. Health Promotion Programs

	Number of centers	Percentage (N=79)
Well-child checkups	73	92
High-risk infant tracking/clinic	31	39
Oral health and education	52	66
Behavioral health clinic	24	30
None of the above	0	0

### Health Education for Parents

Most health centers surveyed indicated that they provide nutritional and lactation counseling (Table 6). Approximately 75 percent (59 centers) reported that they provide nutritional counseling and 63 percent (50 centers) provide lactation counseling. More than half (45 centers) reported offering parenting classes and approximately 52 percent reported

<sup>28</sup> Three health centers originally did not report any health promotion programs as defined by this survey. When contacted to find out why, each one said they had mistakenly neglected to check off a health promotion program. During this round of phone calls in April 2001, one center informed CHSRP that it does not provide on-site well-child services because it coordinates them through private physicians.

offering a reading promotion program. Only 16 percent (13 centers) said that they offer a parenting program for teenagers. Seventy-four health centers reported at least one parent education program; only five do not provide any health education programs, as defined by the survey. Three health centers reported parent support groups, resource centers, and smoking cessation as additional educational activities.

Table 6. Health Education for Parents

	Number of centers	Percentage (N=79)
Nutritional counseling	59	75
Lactation counseling	50	63
Injury prevention programs	30	38
Reading promotion programs	41	52
Teen-tot programs*	13	16
Parenting classes	45	57
None of the above	5	6

\* Teen parent and child program.

### Programs with Home Visiting

Home visiting programs tend to target families with young children, and are generally reported as case-management activities. These programs have produced positive effects, such as preventing child abuse and neglect and decreasing cigarette smoking, as well as increased birth weights for children of teens and increased use of community services.<sup>29</sup> In assessing programs with home visits, the survey addressed environmental observations (i.e., visiting families to assess the child’s health in his or her own home), homebound child services (i.e., the delivery of services to a homebound child in his or her own home), and general case management. Although more than half of the health centers (44 centers) reported case management, it is unclear to what extent the respondents distinguished the various services (Table 7). Ten percent (8 centers) indicated that they provide homebound child services, and 35 percent (28 centers) indicated that they provide environmental observations, both as separate activities from case management. On the whole, most health centers do not provide the kind of home visiting programs identified by the survey—62 percent (49 centers) did not report any of these services; however, 15 health centers added that they also provide prenatal/postpartum care as part of their “other” home visits. Three of these did not report environmental observations, homebound child services, or case management.

<sup>29</sup> See, for example, David Olds, et al., “Prenatal and Infancy Home Visitation by Nurses: Recent Findings,” *The Future of Children* 9 (Spring/Summer 1999): 44–65, [www.futureofchildren.org/hv2/index.htm](http://www.futureofchildren.org/hv2/index.htm).

Table 7. Programs with Home Visiting

	Number of centers	Percentage (N=79)
Environmental observations	28	35
Homebound child services	8	10
Case management	44	56
None of the above	49	62

### Selected Developmental Therapy Programs

Survey data also show that health centers generally do not provide physical, speech, and play therapy for children (Table 8). Five percent (4 centers) of the centers surveyed provide physical therapy and another 5 percent (4 centers) reported offering therapeutic day care. Fewer than 10 percent (7 centers) reported providing speech therapy and only 15 percent (12 centers) reported providing play therapy. Fifteen health centers provide at least one type of developmental therapy program as defined by the survey; the remaining 64 health centers reported that they do not provide any. The low percentage of centers providing these services may mean that many centers, unable to provide these services, instead refer patients to other providers.<sup>30</sup>

Table 8. Selected Child Developmental Therapy Programs

	Number of centers	Percentage (N=79)
Physical therapy	4	5
Speech therapy	7	9
Play therapy	12	15
Therapeutic day care	4	5
None of the above	64	81

### Survey Conclusion

The majority of responding health centers provide at least one type of health promotion and parent education program. Every center surveyed reported providing at least one health promotion activity and 94 percent reported at least one type of health education activity for parents; however, fewer than half of the centers provide at least one program with home visits, and a much smaller number provide at least one developmental therapy program such as physical therapy. The limited information available in the UDS and the survey makes it impossible to identify the factors that influence health centers' ability to provide such programs on site; however, resources and reimbursement for such services remain a concern for health centers.

<sup>30</sup> For a brief discussion of rural health centers establishing relationships with hospitals, see Barbara A. Ormond, Susan Wallin, and Susan M. Goldenson, "Supporting the Rural Health Care Safety Net," The Urban Institute, March 2000. Available online at: [newfederalism.urban.org/html/op36/occa36.html](http://newfederalism.urban.org/html/op36/occa36.html).

Future research should examine the effectiveness of these programs, determine the extent to which health centers are able to identify and treat children at high risk of developmental problems, and identify the factors that influence the ability of centers to provide child development programs on site. In addition, further research should identify the content of the services provided for children who experience developmental delays and the extent to which centers have the capacity to refer and coordinate care for children and families.

## IV. HEALTH CENTER PAYMENT PROVISIONS

The recently enacted Medicare, Medicaid, and CHIP Benefits Improvement and Protection Act (BIPA) of 2000 replaced cost-based reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) with a prospective payment system (PPS). The goal of PPS is to move away from retrospective payments, which required reviews and reconciliations, and toward a system in which rates are set on a prospective basis. The new payment system has the potential to affect whether health centers add or continue services—including child development services—that are reimbursable under Medicaid. PPS may change how and how much health centers are reimbursed for such services.

### The New System

Beginning in 2001, each center received a base-year allotment that could be adjusted in accordance with the scope of the health center's services. This enables centers to develop and establish new types of services that they may or may not have provided in the past, allowing for an adjustment to the base rate to be made on the basis of these new services. A health center could therefore add a major child development component to its scope of service.

PPS took effect on January 1, 2001, and states had until March 31, 2001, to alter their State Plan Amendment to comply with the new law.<sup>31</sup> Under PPS, each health center has a unique baseline rate that defines its funding level for a given year. A health center's 2001 baseline rate is the average of the center's FY 1999 and FY 2000 reasonable cost per visit, adjusted for any increase or decrease in the scope of services in 2001.<sup>32</sup> After 2001, the PPS rate equals the previous year's rate adjusted for the Medicare Economic Index (MEI) for primary care and any increase or decrease in the health center's scope of service.<sup>33</sup>

Initial payments for FQHCs or RHCs that begin operation after FY 2000 are determined by reference to payments to nearby centers with similar case loads or, in their absence, by Medicare FQHC reporting methods or other reasonable tests specified by the Secretary of Health and Human Services. After the initial year, new centers will follow the payment methodology described above as it is applied in their state.<sup>34</sup>

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<sup>31</sup> Most states issued a "placeholder" amendment indicating that they will comply with BIPA's requirements.

<sup>32</sup> §1902(aa)(2) of the Social Security Act, 42 U.S.C. §1396a(aa)(2).

<sup>33</sup> *Ibid.* at §1396a(aa)(3).

<sup>34</sup> *Ibid.* at §1396(a)(aa)(4).

BIPA allows states and health centers to opt out of PPS by developing an alternative methodology. The methodology must be agreed to by each health center to which it applies and by the state.<sup>35</sup> The formula must pay health centers amounts equal to or greater than the reimbursement the health center would have received under PPS.<sup>36</sup>

States with Section 1115 waivers also need to comply with the new PPS system. On January 19, 2001, the Health Care Financing Administration (HCFA) issued a State Medicaid Director Letter (SMDL) explaining that states with Section 1115 waivers based on the old cost-based reimbursement methodology had waived Section 1902(a)(13)(C) of the Social Security Act as it existed prior to the enactment of BIPA.<sup>37</sup> Because BIPA repealed those provisions, the waivers are no longer valid. “All states, including those operating under Section 1115 waiver demonstration programs, are subject to the new Medicaid PPS requirement in sections 1902(a)(15) and 1902(aa) of the Act.”<sup>38</sup>

BIPA also upholds the states’ responsibility to make supplemental payments to FQHCs and RHCs that subcontract with Medicaid Managed Care Entities (MCEs). This payment must make up any difference between the payment received for treating an MCE enrollee and the payment a center is entitled to under the Medicaid PPS. The state plan should include a description of this payment methodology.<sup>39</sup>

### **The Effect of PPS on Child Development Services**

Although BIPA provides the broad outline for how to determine the PPS rate for each health center, states have significant discretion when defining various terms in the PPS methodology. The way in which a state defines or implements each term may significantly affect the amount a health center is reimbursed for child development services. Because each state must develop its own PPS or alternative methodology, the effect of BIPA on

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<sup>35</sup> Ibid. at §1396a(aa)(6)(A).

<sup>36</sup> Ibid. at §1396a(aa)(6)(B).

<sup>37</sup> SMDL #01-014 (Jan. 19, 2001); [www.hcfa.gov/medicaid/smd119a1.htm](http://www.hcfa.gov/medicaid/smd119a1.htm).

<sup>38</sup> A separate but important question is whether states may reapply for a Section 1115 waiver to avoid implementing the new PPS system. PPS is to be codified under 42 U.S.C. §1902a(aa). The Secretary of Health and Human Services has the authority to approve Section 1115 requests for waiver of any provisions of Section 1902a, unless the provision explicitly prohibits waiver. See 42 U.S.C. §1315(a). Although BIPA does not prohibit waiver of PPS and the Secretary has broad authority to issue Section 1115 waivers, there are logical arguments against allowing such waivers. The new PPS system allows health centers and states to agree to any alternative methodology as long as that methodology provides as much reimbursement to health centers as the PPS system would have had it been used. Therefore, if a state is opposed to the PPS system and health centers in that state agree to work with the state to implement a different system, the only reason a state would need a Section 1115 waiver would be to implement a system at a lower cost. It would be difficult to argue that providing less reimbursement to health centers promotes the goals of the Medicaid program, as required for approval of Section 1115 waiver requests; however, given the Secretary’s broad discretion to approve Section 1115 waivers and courts’ reluctance to overturn administrative decisions, it is not certain whether such arguments would prevail if a Section 1115 waiver approval were challenged.

<sup>39</sup> SMDL #01-014.



child development services may vary from state to state. The two most important terms with regard to reimbursement of child development services are “scope of service” and “visit.”

The statute instructs states to calculate health centers’ PPS by using the prior year baseline rate plus an adjustment for the MEI and “any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.”<sup>40</sup> It is assumed that all states will include the addition or deletion of a service in its definition of change in scope of service; however, a state must also decide whether increasing the intensity of an existing service at an existing site or providing a current service in a new site is a change in scope of service. States must also develop a process for determining when a change in scope of service occurs. Does the health center apply for a change or is it up to the state to determine if there has been a change? How often is the scope of service reviewed? Does the change have to meet a materiality threshold before there is a payment adjustment? Are capital costs included in new service costs? The way each of these questions is answered will determine how much health centers are reimbursed for adding or increasing child development services and how often their reimbursement rates might be adjusted based on decisions about child development services.

A health center’s PPS rate is determined on a per-visit basis.<sup>41</sup> States must define what services are included in a visit and how many visits may be reimbursed per patient per day.<sup>42</sup> How many visits have occurred if a patient sees a medical provider and a nutritional counselor or speech therapist? How will the state define services that are incidental to a medical visit? Because health centers will be reimbursed on a per-visit basis, the way states answer these questions will help to determine whether a health center can afford to add to or increase its child development services.

Because each state may devise its own PPS definitions or alternative payment systems, health centers must review their state’s State Plan Amendment to understand fully how Medicaid-eligible child development services may be reimbursed and how to structure any new services to receive full payment.

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<sup>40</sup> §1902(aa)(3)(B) of the Social Security Act, 42 U.S.C. §1396a(aa)(3)(B).

<sup>41</sup> Ibid. §1396a(aa)(2)-(3).

<sup>42</sup> It is uncertain how much discretion states have to determine how many visits per patient per day they can choose to reimburse. Because DHHS has not promulgated Medicaid regulations, the applicable law is derived from the Medicare regulations and SMDLs and other pronouncements from HHS. As a practical matter, it is unlikely that HCFA would challenge a state’s decision to allow several visits per day or to allow a wide variety of services to be considered incident to a medical visit.

## V. CONCLUSION AND RECOMMENDATIONS

Community health centers are a major health care provider for children. They care for one of every six children of low-income families and serve 1.3 million children under age 6.<sup>43</sup> Findings presented in this report show that community health centers provide many valuable programs and services that promote the healthy growth and development of a large number of young children. Maintaining and expanding the ability of health centers to seek out and identify at-risk children, screen and assess their needs, and provide appropriate child development services are important to improving the health and welfare of young children and their families.

Congress has increased funding for the community health center program by \$175 million to \$1.3 billion for fiscal year 2002—an amount that exceeded President Bush's recommendation for expanded funding. This will allow health centers to increase the number of child development services and programs in these centers.<sup>44</sup> Although our survey results show that the majority of community health centers provide at least one type of health promotion and parent education program, fewer than half provide at least one program with home visits or parent groups. The combination of increased federal funding for health centers and efforts by NACHC to double the number of patients health centers serve could improve the quality of preventive services that enhance the development of young children.

Improving the quality of care in community health centers is already a priority of HRSA's Bureau of Primary Health Care (BPHC), the agency that oversees Federally Qualified Health Centers. In fact, initiatives to develop curricula and training modules to assist centers in their delivery of developmental services for young children are currently under way. The work of BPHC, in collaboration with the National Initiative for Children's Health Care Quality (NICHQ) and The Commonwealth Fund, could provide health centers with formal guidance and technical assistance to help centers improve their delivery of these services. Programs to improve the training of providers and other health center staff in offering such services are also desirable. Health centers should take advantage of the increased attention to improving health care quality and seek out any available technical assistance tools or expertise to focus on early childhood development.

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<sup>43</sup> National Association of Community Health Centers, Inc., *Access to Community Health Care: A National and State Data Book, 1998* (Washington, D.C., 1998), p. 1.

<sup>44</sup> In mid-December, Senate and House conferees finalized a joint Labor–Health and Human Services–Education appropriations bill and sent it to the President. The President is expected to sign the bill into law.

Once innovative practices to enhance healthy child development are tested and implemented, BPHC could disseminate these successful practices to other centers throughout the country. BPHC could also go one step further and encourage all centers to make the improvement of child development services a priority on grant applications for initial or continued funding. Such an incentive would encourage centers to develop new ways to improve their enabling services and use existing staff to improve the quality of child development services. In addition, HRSA may want to strengthen coordination in the area of child development among its bureaus and other agencies in the federal government.

The changes to the Medicaid reimbursement system for FQHCs also provide an opportunity to improve preventive care for young children. States will use the new prospective payment system mechanism to calculate a minimum per-visit rate for FQHCs that serve Medicaid beneficiaries. The prospective payment amount is based on an average of the center's per-visit rate from FY 1999 and FY 2000. Costs of the child development services being offered by the health center must be identified and included in the baseline rate or otherwise reimbursed by the state. If FQHCs add new child development services after the baseline rate is calculated, the FQHC's Medicaid reimbursement rate should be adjusted to incorporate the change in the scope of service furnished by the FQHC.

Child development services are an important part of health centers' mission to ensure access to preventive health care. This report takes a critical step toward informing federal and state policymakers about the importance of supporting health centers in their efforts to improve the healthy growth and development of young children. Health centers, federal agencies, pediatricians, and child health experts should continue to work together to generate information, test innovative strategies, and disseminate promising approaches to develop a national program to improve child development services for children from low-income families throughout the country.

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**#481** *Using the Title V Maternal and Child Health Services Block Grant to Support Child Development Services* (January 2002). Sara Rosenbaum, Michelle Proser, Andy Schneider, and Colleen Sonosky, George Washington University. This report, the fourth in a series of analyses exploring federal and state health policy in the area of early childhood development, argues that states can potentially increase reimbursements to CHCs under a change enacted in the Benefits Improvement and Protection Act (BIPA) of 2000. CHCs served 4.5 million low-income children in 1998, including 1.3 million under age 6.

*Primary Care Services Promoting Optimal Child Development from Birth to Age 3 Years* (December 2001). Michael Regalado and Neal Halfon. *Archives of Pediatrics and Adolescent Medicine*, vol. 155, no. 12. Copies are available from Michael Regalado, M.D., Cedars Sinai Medical Center, 8700 Beverly Blvd, MOT 475W, Los Angeles, CA 90048, E-mail: Michael.Regalado@cshs.org.

**#451** *Room to Grow: Promoting Child Development Through Medicaid and CHIP* (July 2001). Sara Rosenbaum, Michelle Proser, Andy Schneider, and Colleen Sonosky, George Washington University. This report, the second in a series of analyses exploring federal and state health policy in the area of early childhood development, examines how public insurance programs covering low-income children—namely, Medicaid and the State Children's Health Insurance Program (CHIP)—can be used to support and foster optimal child development interventions.

**#450** *Health Policy and Early Child Development: An Overview* (July 2001). Sara Rosenbaum, Michelle Proser, and Colleen Sonosky, George Washington University. This report is the first in a series of analyses exploring federal and state health policy in the area of early childhood development. It provides an overview of the evolution of federal health policy related to the financing and provision of preventive health services for young children.

**#452** *No Place Like Home: State Home Visiting Policies and Programs* (May 2001). Kay A. Johnson, Johnson Group Consulting, Inc. This report summarizes the results of a survey of states regarding home visiting activities, assessing the direction of state policies and programs through a nationwide examination of state-based home visiting programs targeting low-income families with young children.

**#448** *Child Development and Medicaid: Attitudes of Mothers with Young Children Enrolled in Medicaid* (March 2001). Susan Kannel and Michael J. Perry, Lake Snell Perry & Associates. This report on mothers with young children enrolled in Medicaid finds that while generally pleased with the overall care their sons and daughters receive, many mothers feel that the program—as well as pediatricians—could do a better job of providing guidance on early development.

**#404** *Appraisals of Parenting, Parent-Child Interactions, Parenting Styles, and Children: An Annotated Bibliography* (September 2000). The Commonwealth Fund Pediatric Parenting Project. Few measures of parenting skills offer an appraisal that is brief, comprehensive, parent-sensitive,

psychometrically sound, nonintrusive, and appropriate to child development. This annotated bibliography provides clinicians, clinical researchers, and researchers interested in applied issues with information about those parenting skills measures that are available.

*Child Development Services in Medicaid Managed Care Organizations: What Does It Take?* (July 2000). Carolyn Berry, Pamela Butler, Linda Perloff, and Peter Budetti. *Pediatrics*, vol. 106, no. 7. Copies are available from American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL 60007-1098, Phone: 888-227-1773, Fax: 847-434-8000, E-mail: journals@aap.org.

**#367** *Assuring the Healthy Development of Young Children: Opportunities for States* (February 2000). Peter Budetti, Carolyn Berry, Pamela Butler, Karen Scott Collins, and Melinda Abrams. This issue brief examines opportunities for states to enhance the provision of health-related developmental services to children in low-income families, particularly by emphasizing the importance of preventive developmental services in primary, pediatric practices.

**#304** *Improving the Delivery and Financing of Developmental Services for Low-Income Young Children* (November 1998). Karen Scott Collins, Kathryn Taaffe McLearn, Melinda Abrams, and Brian Biles. This issue brief examines the effects of inadequate health care services on the development of young children, and discusses efforts at the federal and state level to improve access and developmental outcomes for young children in low-income families. It also introduces the Fund's new Assuring Better Child Health and Development Program.