THE COMMONWEALTH FUND

February 2000

ISSUE BRIEF

ASSURING THE HEALTHY DEVELOPMENT OF YOUNG CHILDREN: OPPORTUNITIES FOR STATES

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Recent advances in neuroscience have demonstrated that parent-child interactions and the family environment shape and advance the development of a young child's brain.[1] At the same time, decisionmakers in health policy, child health research, and pediatric practice have begun to recognize the critical importance of the first three years of life for the optimal growth and development of children. National guidelines for pediatric care, such as Bright Futures, stress the delivery of health care in a manner consistent with this understanding of early development.[2] In addition to good clinical health care, children age 3 and younger require services that promote cognitive and sensory stimulation. A growing body of literature suggests that family behavior and activities can have a profound impact on a child's brain development, physical health, and emotional well-being.

This issue brief examines opportunities for states to enhance the provision of health-related developmental services to children in low-income families. In particular, it emphasizes the importance of preventive developmental services—formal developmental assessments, assessments of family and social risk factors, and enhanced parent education—in primary, pediatric practices. Current state efforts to encourage the delivery of these services in the Medicaid program are also reviewed, including the specification of developmental services in state contracts with managed care plans, payment for enhanced services outside states' capitated arrangements with plans, and revision of the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) encounter form to improve the quality of physician reporting.

Child Development Services Improve Children's Health

Broadly speaking, child development services fall into four categories: screening and developmental assessment, health promotion, developmental interventions, and care coordination. The following discussion focuses on child development services delivered in the health care setting that emphasize primary, preventive pediatric care, as opposed to special services for children who demonstrate developmental delay.

The provision of health-related developmental services extends beyond good, general pediatrics in two ways. First, it covers child development services that might not be provided in traditional well-child care, such as home visits, telephone counseling on developmental milestones, and the use of methods to encourage early reading. Second, it requires that certain components of well-child care—including infant development assessments and physician-patient counseling to help parents deal with their child's eating, sleeping, routines, and self-control—be delivered in a more formal way.

Child development services improve the health of children and families alike. An evaluation of a home visitation program in a semirural community in upstate New York revealed that participating children made 35 percent fewer visits to the emergency department, had 40 percent fewer injuries, and had 45 percent fewer behavioral

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and parental coping problems noted in the physician's record than did children in the comparison group.[3] Another study found that mothers visited by nurses attempted breastfeeding more frequently and provided home environments that were more conducive to children's development.[4] In addition, culturally appropriate literacy interventions in primary care settings, e.g., reading programs, increased the odds that parents would read to their children by threefold, according to a 1999 randomized, controlled trial with Hispanic families.[5] Such early results suggest that the beneficial effects of comprehensive home visitation or pediatric programs might well spill over into such areas as welfare dependency, teen pregnancy, and violence. If so, society will save money in the long run.[6]

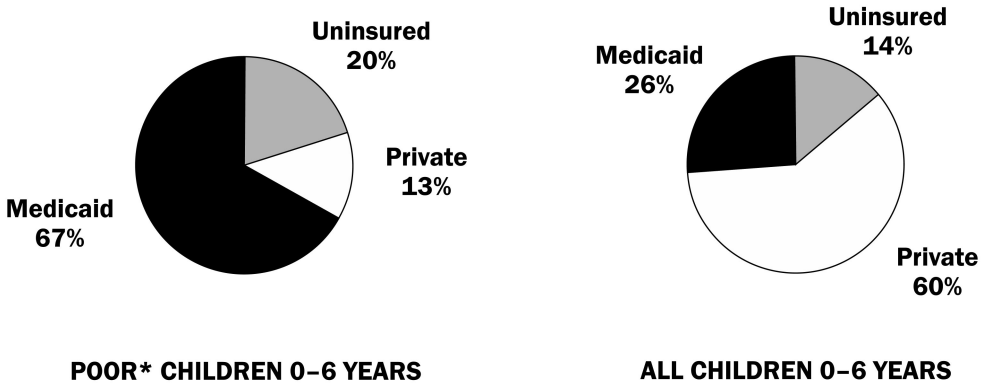
Medicaid and Child Development Services

Serving one-quarter of all American children age 6 and younger, and two-thirds of poor children that age, Medicaid programs offer states an extremely important and regular point of contact with low-income children and their families (see figure 1).[7] The Medicaid Act requires state agencies to cover all developmental screenings, including routine developmental assessments.[8] In addition, health education is a required component of the EPSDT program and is considered a part of every health visit—an expectation that precludes billing for it as a separate Medicaid service.

Consequently, all state Medicaid and Child Health Insurance Programs (CHIP) pay for some health-related developmental services. Only a handful of states, however, have established statewide comprehensive programs, and only a few of these combine Medicaid with other state dollars to pay for a broad array of pediatric developmental services.

Most states have at least one program designed to enhance child development. The approach, level of commitment, and services of each depend on the individual priorities of each state. A 1998 review of initiatives for young children and families by the National Center for Children in Poverty found that 24 states have one or more statewide programs for children age 3 and younger.[9] Home visitation (18 states) and parent education programs (14 states)

Figure 1
Medicaid Is a Critical Source of Health Insurance for Young Children



* 0–99 percent of the federal poverty level.

Source: P. Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey,* EBRI Issue Brief, December 1998.

are the most common types. Eight states draw on Medicaid funds for statewide, health-related programs for children.[10] Most state programs tend to focus on high-risk groups, such as teenage mothers, rather than trying to reach all young children from low-income families. One state, Vermont, provides some level of service to all Medicaid families; more intensive services are targeted for those at higher risk.

Some of the strategies adopted by states to enhance child development include:

- **Requiring the provision of services in Medicaid managed care contracts.** State Medicaid programs have increasingly turned to managed care as a vehicle to deliver pediatric services. In general, state Medicaid agencies have placed few comprehensive or specific requirements on managed care organizations (MCOs) to implement and deliver these services. An analysis of 45 state Medicaid managed care contracts revealed that fewer than half included any provisions covering health-related developmental services. Some states, however, do spell out plans' responsibility to deliver comprehensive programs. Michigan and Delaware, for example, have explicit contractual arrangements requiring comprehensive home visitation programs that include standardized developmental assessments, parent education, nutritional counseling, and care management. Other states specify only one or two discrete services in their contracts, such as newborn home visitation (New Jersey) or standardized developmental screenings (Massachusetts and Virginia).[11]

- **Paying for services outside of managed care contracts.** Some states have chosen to expand their health-related developmental programs outside of the capitated arrangements, paying for services on a fee-for-service basis. Rhode Island and Washington have created Medicaid "carve-out" arrangements to finance home visitation, targeted case management, and comprehensive developmental assessments. Hawaii pays out-of-contract for five child development support services furnished through its early intervention program—parent counseling, home visitation, comprehensive assessments, parent education classes, and case management.[12]

- **Using improved forms to ensure the delivery and quality of services.** Some states have worked with managed care plans to improve the reporting and quality of well-child visits by using the mandatory EPSDT form to report on the visit. The forms serve to remind physicians of the various screenings to be administered at each visit and help them document the services provided. The Neighborhood Health Plan in Massachusetts, for example, studied the use of structured EPSDT forms in managed care settings and found them to be an effective tool for increasing the rate of delivery of developmental services.[13] Maine's Medicaid agency developed 11 different age-appropriate forms to correspond to each well-child visit for children under age 3.[14]

Medicaid Managed Care Support for Child Development Services

Nearly one-quarter of all children under age 20 were enrolled through some type of managed care arrangement in 1994, a proportion that is believed to have grown substantially since that time.[15] The Congressional Budget Office estimates that from 85 to 90 percent of all Medicaid managed care enrollees are women of childbearing age or children.[16] This rapid growth and the continuing trend toward managed care in the United States will have a profound effect on how low-income children receive care and, specifically, developmentally oriented services.

Currently, few MCOs offer a comprehensive array of child development services. A 1998 nationwide mail survey of Medicaid capitated health plans that serve children examined current practice and

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interest in child development services.[17] The survey included several questions about specific services—reading programs, behavior assessment, lactation counseling, counseling on feeding and nutrition, and supporting parent-child interaction—as well as the types of incentives that would stimulate more activities in this area.

The majority of respondents indicated that they actively promote or require key child development screenings and services. Most plans reported that they rely on office-based counseling and other, less intensive methods to provide developmental services. Use of more intensive methods, such as case management, home visitation, and parent education classes, was rare. Among plans that were not currently offering services, most indicated interest in implementing a child development program.

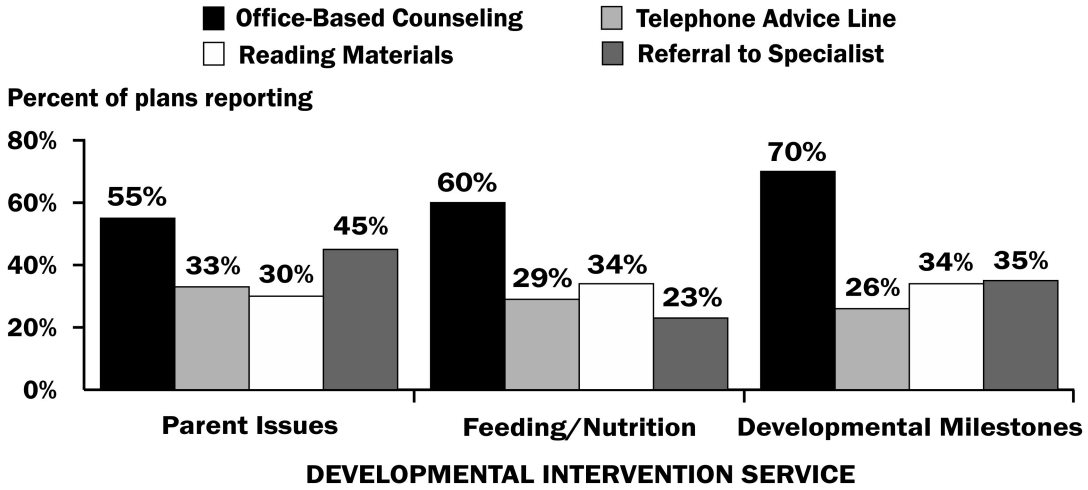
Most plans that offer developmental services do so with no additional funding, or provide them under the EPSDT program. Plans are often creative in their funding mechanisms. Some plans reimburse specifically for screenings and other services, while others have partnered with local agencies to provide care for certain enrollees (see figure 2).

About three-quarters of plans that do not currently offer services in a particular area of child development indicated interest in adding such services. This interest, however, was largely contingent upon additional funding (see figure 3).

Most plans considered Medicaid contract requirements and enhanced capitation rates to be powerful incentives for adding new health-related developmental services. Respondents would also find empirical evidence of reduced health care utilization costs or improved developmental outcomes to be compelling reasons for adding services. Marketing value—either for the Medicaid population or for the commercial parts of their plans—was not rated as an important incentive (see table 1).

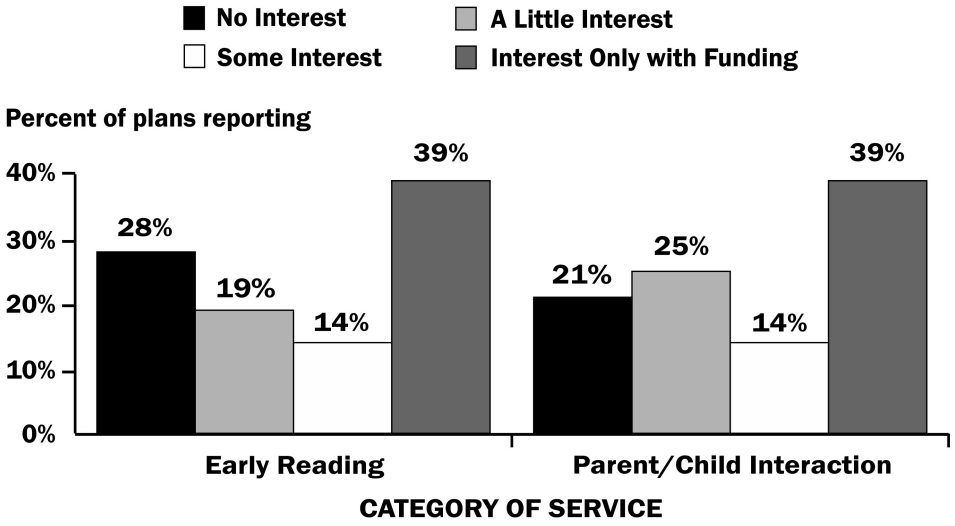
Among MCOs that already have a child development program in place, internal support appears to be essential to its success. Results from interviews with key officials in nine Medicaid MCOs show that both senior-level administrators and pediatricians need to be behind their plan's child development program to ensure the implementation and sustainability of these services.[18] A sense of social responsibility—as opposed to a

Figure 2
Most Commonly Offered Developmental Intervention Services, by Methods of Service Delivery



Source: P. Budetti et al., Institute for Health Services Research and Policy Studies, Northwestern University, report to The Commonwealth Fund, September 1999.

Figure 3
Plan Interest in Adding Selected New Services



Source: P. Budetti et al., Institute for Health Services Research and Policy Studies, Northwestern University, report to The Commonwealth Fund, September 1999.

Table 1
Percentage of Plans Rating the Importance of Incentives for Implementing Child Development Services

Incentive	Very Important
Required by Medicaid contract	81%
Plan savings through reduced health care utilization	80
Enhanced Medicaid capitation rates	76
Improved developmental outcomes	70
Scientific evidence of effectiveness	66
Helps plan comply with regulatory standards	65
Fulfills an aspect of plan's mission	60
Targets population, based on medical necessity criteria	52
Matching dollars	46
Private external funding	38
Marketing advantage within Medicaid population	29
Professional education/continuing medical education credit	14
Marketing advantage for commercial part of plan	14

Source: P. Budetti et al., Institute for Health Services Research and Policy Studies, Northwestern University, report to The Commonwealth Fund, September 1999.

primary focus on financial motivations or marketing considerations—was also a common theme in a review of successful, long-term child development service programs.[18] Most MCOs in the evaluation had addressed such issues as transportation, literacy, and translation of materials into English—barriers that would otherwise prevent Medicaid enrollees from taking full advantage of services.[19]

As with the states, some especially innovative practices among MCOs emerged from the evaluation—albeit with targeted, rather than comprehensive, child development services. CarePlus Health Plan, an MCO in New York serving primarily low-income families, implemented its Healthy Beginnings Program "to promote children's total health by addressing their emotional, cognitive, physical, and social development." The program is designed for expectant mothers and for children age 3 and younger and their mothers. It has three components: home visits and support for new mothers, a telephone information line, and a reading program. Support for new mothers involves trained "Mom Coaches"—women from the community who coordinate care between the plan and expectant and new mothers—

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who make monthly home visits to observe each mother's physical and emotional health and provide referrals as needed. Mom Coaches also look for potential hazards in the home and use informational videos to help address newborn issues, such as sleep patterns, feeding, and mothers' concerns and anxieties. The telephone information service, which links parents to the plan's early childhood development office, allows parents to discuss parenting issues, fears, and anxieties with trained staff. The reading program staff reads stories to children and teaches parents about the importance of reading to their infants and toddlers at home.

Another program, Reading R_X, provides on-site reading corners in several pediatric medical and dental waiting rooms. Developed at Minnesota-based HealthPartners, the program also distributes take-home brochures on how and why to read aloud to children, how to create an atmosphere in the home that fosters reading, and how to evaluate the appropriateness of television programs, movies, video games, and other media. The office receptionist provides the first contact with children and their parents at each visit and encourages families to make use of the reading corners and take brochures home with them. Primary care providers who work in pediatric, obstetric, family practice, and dental clinics attend a formal education session on developmental literacy and receive training to enable them to communicate the importance of reading to families and encourage program participation.

Opportunities to Broaden the Reach of Child Development Services

State health agencies and Medicaid managed care organizations have a significant opportunity to provide pediatric care that includes health-related developmental services for children age 3 and younger. Several states could build on current programs: for example, home visits and parent education provided during pregnancy and the newborn period could be continued throughout early childhood. States could also test payment strategies such as carve-outs or enhanced capitation rates for providers or plans that deliver comprehensive child development services. In addition, they could emphasize the scope of services covered by Medicaid and EPSDT to plans and pediatric providers. Improved encounter or EPSDT reporting forms facilitate reporting strategies that document which services are being delivered and improve the quality of care.

Furthermore, states could use their flexibility in the design and administration of health care programs for low-income families to take the lead in:

- Creating new strategies to enhance child development services and to complement and support the family's medical home by linking community providers with pediatric providers and health plans.
- Developing contracts between the state Medicaid program and Title V programs to leverage additional funds to support child development services and integrate service delivery.
- Designing incentives for pediatric providers to screen children and families for risk factors and provide parent education and counseling.

Medicaid managed care offers additional, specific opportunities. States could work collaboratively with plans to improve care, using their power as purchasers to ensure that important services are properly provided. These options may include:

- Using specifications in contract language to communicate policies on pediatric development services to managed care plans.
- Encouraging agreements between plans and public health agencies to ensure the proper delivery of services.

- Making additional payments to MCOs to cover incremental costs associated with specific child development services, and enhancing capitation rates for those plans and pediatricians that provide more comprehensive child development services.

- Enhancing capitation payments for primary care clinicians.

Health care services that enhance standard well-child care with information for parents, early detection of factors that may impede normal development, and better coordination of care could improve the well-being of low-income families and their young children. Providing children with such a system of care is likely to have benefits that range from more appropriate use of health care services, to reduced injuries, to stronger parent-child relationships. In the long term, these services might reduce risky behaviors among older children. States are in a particularly strong position to make such improvements for the millions of children of low-income families cared for through Medicaid.

NOTES

[1] R. Shore, *Rethinking the Brain: New Insights into Early Development* (New York: Families and Work Institute, 1997); Carnegie Task Force on Meeting the Needs of Young Children, *Starting Points: Meeting the Needs of Our Youngest Children* (New York: Carnegie Corporation of New York, April 1994).

[2] M. Green (ed.), *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (Arlington, VA: National Center for Education in Maternal and Child Health, 1994).

[3] D.H. Olds, C. Henderson, and H. Kitzman, "Does Prenatal and Infancy Nurse Home Visitation Have Enduring Effects on Quality of Parent Caregiving and Child Health at 25 to 50 Months of Life?," *Pediatrics* 93 (January 1994):89–98.

[4] H. Kitzman, D.H. Olds, C. Henderson et al., "Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries and Repeated Childbearing," *Journal of the American Medical Association* 278 (August 1997): 637–643.

[5] N. Golova, A.J. Alario, P.M. Vivier et al., "Literacy Promotion for Hispanic Families in a Primary Care Setting: A Randomized, Controlled Trial," *Pediatrics* 103 (May 1999):993–997.

[6] L.A. Karoly, P.W. Greenwood, S.S. Everingham et al., *Investing in Our Children: What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions* (Santa Monica, CA: RAND, 1998).

[7] P. Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey,* EBRI Issue Brief, December 1998.

[8] Ibid.

[9] J. Knitzer and S. Page, *Map and Track: 1998 Edition* (New York: National Center for Children in Poverty, 1998).

[10] Knitzer and Page, 1998. States are Delaware, Florida, Kansas, Massachusetts, Michigan, Nevada, New York, and Vermont.

[11] H. Fox, M. McManus, and D. Kim, *State Medicaid Managed Care Contract Provisions Regarding Developmental Support Services for Families with Young Children,* report to The Commonwealth Fund, December 1998.

[12] Ibid.

[13] J. Perkins and K. Olson, "Medicaid Early and Periodic Screening, Diagnostic, and Treatment as a Source of Funding Early Developmental Services," draft report to The Commonwealth Fund, January 1999, citing a letter from the Commonwealth of Massachusetts Executive Office of Health and Human Services to Primary Care Clinicians (May 1996).

[14] Fourteen different forms are used for well-child visits at 1–2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 years, and 3 years. Ibid., appendix 1.

[15] S. Leatherman and D. McCarthy, "Opportunities and Challenges for Promoting Children's Health in Managed Care Organizations," in *Health Care for Children: What's Right, What's Wrong, What's Next,* R.E.K. Stein (ed.) (New York: United Hospital Fund, 1997).

[16] A. Schneider, *Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33* (Washington, D.C.: Center for Policy and Budget Priorities, 1997).

Continued on page 8

[17] Surveys were mailed to all 409 Medicaid managed care plans in 1998; 155 plans completed and returned the survey. P. Budetti, C. Berry, and P. Butler, draft report to The Commonwealth Fund, October 1999.

[18] C. Berry, P. Butler, P. Budetti et al., "Developmental Services in Medicaid Managed Care: What Does It Take?," submitted to *Pediatrics,* December 1999 (under review).

[19] The MCOs included Blue Cross of California, CarePlus Health Plan (New York), Group Health Northwest, Harvard Vanguard Medical Associates (Massachusetts), HealthPartners (Minnesota), HealthNet Health Plan of Foundation Health (California), Kaiser Permanente of Northern California, Keystone Mercy Health Plan (Pennsylvania), and Neighborhood HealthPlan (Massachusetts).

Developing the Capacities of Young Children

Two goals inform the Fund's current efforts on behalf of children: maximizing opportunities for healthy development and ensuring access to high-quality health care. In particular, the Fund's programs are based on the premise that early intervention—through developmental services and other efforts to foster physical, cognitive, and emotional growth—can dramatically influence children's lifelong health and well-being.

The Fund's goals are pursued through two major programs:

- **The Healthy Steps for Young Children Program.** Established in 1994, Healthy Steps is testing and disseminating a new approach to pediatric care, one that explicitly stresses the use of innovative health education and preventive health interventions aimed at supporting the role of parents in child development during the first three years of life. Healthy Steps, which is cosponsored by the American Academy of Pediatrics, is being implemented at 24 sites around the country. A national evaluation of this model is under way to examine outcomes for children, parents, and pediatric practices.
- **Assuring Better Child Health and Development Program (ABCD).** The ABCD program is an action-oriented initiative that seeks to identify and implement effective health care practices conducive to the healthy development of young children in low-income families. Program strategies include working with Medicaid officials and others to improve the capacity of the health care system to provide well-child health care for low-income families, enhance parents' knowledge and practices to promote healthy development, and help to identify family risk factors that can impede healthy development. The ABCD program is working with four state Medicaid agencies to improve health and development for low-income children. These projects will serve as models for other states interested in incorporation of health-related developmental services.

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