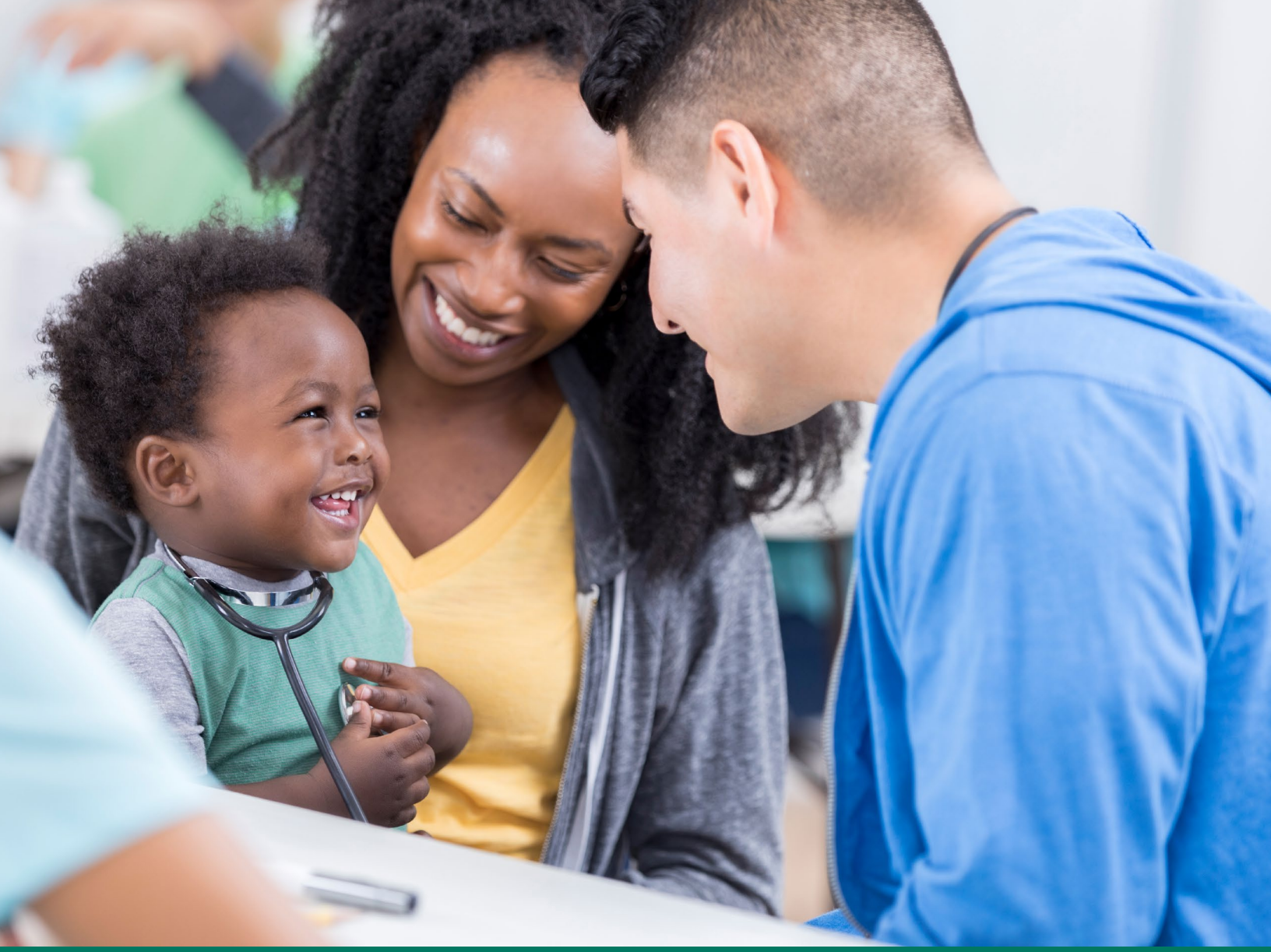

WHOLE CHILD HEALTH ALLIANCE

Advancing the Key Elements of Whole Child Health: State Case Studies and Policy Recommendations

Massachusetts, North Carolina and Washington

NEMOURS CHILDREN'S HEALTH

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Introduction

This report, written by members of the *Whole Child Health Alliance* and informed by more than 30 interviews, includes case studies of three states — North Carolina, Massachusetts and Washington — that have designed and begun to implement the *key elements* of whole child health approaches.[1] The purpose of this report is to:

- Highlight whole child health approaches that advance child and adolescent health care transformation.
- Identify existing policy levers that support these approaches.
- Put forth policy recommendations that would advance the adoption of these approaches across the United States to support the healthiest generations of children.

About the Whole Child Health Alliance

The Whole Child Health Alliance ("Alliance") seeks to accelerate the adoption of whole child health delivery approaches supported by sustainable financing models. The Alliance utilizes various strategies to advance whole child health delivery and financing including informing federal policies, agency rulemaking and guidance, and demonstration models. The Alliance highlights emerging best practices and strategies from the field. The Alliance also identifies opportunities to collaborate with other coalitions and partners on issues impacting children, youth and families.

Background

The Opportunity to Address Whole Child Health

A *growing body of research* demonstrates that a broad array of health, social and economic factors can affect the physical, mental and behavioral health of children. "*Upstream*" factors, systemic and structural factors such as the *communities*, neighborhoods and *environments* in which children live, can impact their growth, *brain development*, education and overall *well-being*. Likewise, children's *relationships* with the adults in their lives as well as the systems (e.g., education, health care, child welfare) that care for them lay the *foundation* for psychosocial functioning. "*Midstream*" factors, such as housing conditions and food security, can also impact health outcomes for children. The health impacts of social drivers of health experienced during childhood can endure into adulthood and ultimately affect *life expectancy*. Notably, *people of color* experience a higher level of unmet social needs (e.g., food insecurity, living in crowded housing, vehicle access) than the general population.

While other child-serving sectors and programs (e.g., *education*, *early care and education*, *housing*, *Supplemental Nutrition Assistance Program (SNAP)*) are positioned to support children and families, they are often *inadequately* funded to provide services commensurate with the need. This underinvestment is a significant gap that policymakers must address. Nevertheless, the health care sector can play a role in addressing social needs for children through strong partnerships rooted in the implementation of whole child health delivery and financing approachess that optimize current resources and supports for families.

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1 An executive summary for this report is available here: Executive Summary: Advancing the Key Elements of Whole Child Health: State Case Studies and Policy Recommendations.

About Whole Child Health Approaches

Whole child health approaches engage *multisector partners* (e.g., community-based organizations, schools, other child-serving organizations, and families) to support the developmental, physical, mental, behavioral and social needs of children and youth. These partners also foster healthy relationships with caregivers, through individual, family-based and community-level approaches. The goal is to create a supportive context to help children and youth thrive. *Key elements* of whole child health approaches include:

- Promoting health equity
- Integrating care delivery and social supports
- Aligning care for families
- Fostering healthy communities
- Supporting a diverse, multidisciplinary workforce
- Incentivizing cross-sector data partnerships
- Advancing financing reforms that incentivize optimal health
- Promoting quality improvement performance[2]

There is a unique opportunity for providers to implement whole child health approaches for the youngest children (i.e., children under 3 years old), who the American Academy of Pediatrics recommends visit their health care provider 12 times by the time they turn three, thereby offering a dozen opportunities for early identification of health and social needs, strengthening early relational health, and promoting health and prevention.[3] *Research* has shown that early experiences affect health across the life-course and effective interventions are needed in the early years and prenatal period. As described above, whole child health approaches take a multifaceted approach to pediatric care through *child health transformation*, which refers to transforming how pediatric care is *practiced*, financed and measured at the individual (i.e., patient), health system, and population health levels.

Impact of Whole Child Health Approaches on Health Equity

As described above, *whole child health approaches* have the potential to play a critical role in advancing *health equity* and reducing disparities. Whole child health approaches should focus on improving health outcomes for historically marginalized populations who disproportionately experience suboptimal health outcomes and care. Approaches should be considered to promote a diverse workforce, implement strategies to specifically address health disparities, and ensure data are collected and evaluated through an equity lens. Notably, the *majority* of Black (60%), Hispanic (55%), Alaska Native and American Indian (59%), and Native Hawaiian and other Pacific Islanders (52%) who are 0–18 years old are covered by Medicaid or other public coverage. Therefore, there is a unique opportunity to address health disparities among children/youth through whole child health approaches driven by Medicaid policy.

2 *Whole child health key elements demonstrated by the profiled states are bolded throughout the case studies.*

3 *This includes the 3-year-old visit.*

Value-Based Payment and Pediatrics

Health care financing is a key component of a whole child health approach that seeks to align financial incentives and delivery models with desired health and well-being outcomes for children. The implementation of *value-based payment* has lagged in pediatrics as compared to the adult population, especially those served by Medicare, which has advanced various value-based payment transformation initiatives for its beneficiaries.

Barriers to financing pediatric value-based payment models include lower potential medical savings, a longer savings time horizon, and a high probability of churn (i.e., when members switch between health insurance plans or lose coverage), which limits payers' opportunities for savings. Additionally, *wrong pocket* problems, where investments in one sector (health care and early care and education) create savings and benefits in another (e.g., education or juvenile justice) can discourage investment and coordination across sectors. Despite these barriers, *public policy*, Centers for Medicare and Medicaid Services (CMS) *guidance*, demonstration models, and *state-managed care requirements and Medicaid initiatives* can help support delivery system reforms that address social factors and support whole child health.

Federal Policy Context

The federal policy landscape plays a key role in determining states' and providers' ability to design and implement whole child health approaches. CMS encourages state-level innovation that can address the unique needs of each respective state and the populations served, including pediatric populations. Policy levers states have used to advance pediatric health system transformation include but are not limited to:

- ***Early and Periodic Screening, Diagnostic and Treatment (EPSDT).*** Under *EPSDT*, states must provide comprehensive pediatric health care to Medicaid-enrolled children under age 21 focused on prevention, early detection, and medically necessary treatment. EPSDT provides broad authority to cover an array of medically necessary services. In 2022, the *Bipartisan Safer Communities Act* (Pub. L. 117–159) put into place several requirements to strengthen federal oversight of state implementation of EPSDT.
- ***Medicaid Section 1115 Demonstration Waivers***. Medicaid Section 1115 waivers, which must have a research or evaluation component, offer states the opportunity to waive certain federal requirements and test innovative Medicaid reforms.
- ***Delivery System Reform Incentive Payment (DSRIP) Program***. State DSRIP programs were implemented as part of broader 1115 waivers. DSRIP programs allowed states to make supplemental payments to providers to support projects that advance statewide delivery-system goals.
- ***State Innovation Models (SIM) Initiative***. CMS Innovation Center SIM Initiatives partnered with states to advance multipayer health care payment and delivery system reform models, aiming to improve quality, lower costs, and improve population health.
- ***Integrated Care for Kids (InCK) Model***. Through the InCK Model, CMS has awarded $126 million to states and local providers to improve child health, reduce inpatient stays and out of home placement, and create alternative payment models.
- ***Children's Health Insurance Program (CHIP) Health Services Initiative (HSI)***. States may apply for CHIP HSIs to leverage CHIP funding to cover activities that protect the public or individual health, improve or promote state health care delivery capacity, or strengthen the resources necessary to achieve public health goals related to improving the health of low-income children.

Leveraging the authorities and policy reform opportunities described above, states have significant authority to provide a broad array of services to children and youth. Notably, EPSDT establishes a strong foundation on which to build. Waivers and other federal programs can help states continue to innovate to promote optimal health for children and families. This report examines how Massachusetts, North Carolina and Washington have leveraged these policy tools to advance core elements of whole child health approaches in their respective states.

State Case Studies

Massachusetts

In September 2022, Massachusetts received approval from the federal government to implement a comprehensive *suite of changes* to the state's Medicaid and CHIP program ("MassHealth") as part of a Section 1115 waiver from CMS. One explicit goal of the waiver was to implement reforms and investments in pediatric care to expand access and move beyond fee-for-service health care. The pediatric reforms emerged from a set of recommendations compiled by a coalition of child advocates and built upon previous MassHealth reforms that addressed behavioral health and health-related social needs, defined by *CMS* as an individual's unmet, adverse social conditions that contribute to poor health. This original set of reforms did not specifically focus on children.

Background

Massachusetts has been a pioneer in terms of expanding *coverage* and implementing health system reform efforts aimed at improving population health, including addressing health-related social needs among its members. Covering 40% of births and *one-third* of the state's children and youth, MassHealth serves as a critical resource to promote whole child health in Massachusetts.

Over the past decades, Massachusetts has used several strategies to implement key reforms to its MassHealth program, including an 1115 waiver, DSRIP, a CMS SIM model, and other strategies. In the Massachusetts' 2017 1115 waiver, the state implemented a *number of approaches* to address health-related social needs and promote behavioral health integration. These included:

- Creating accountable care organizations (i.e., groups of providers that collaborate to improve population health under value-based payment agreements)
- Supporting mental/behavioral health integration within primary care
- Requiring providers to screen for health-related social needs
- Implementing the Flexible Services Program, which allows MassHealth funds to be spent on targeted food instability and housing supports for those who meet certain medical and needs-based criteria
- Strengthening care coordination for people with chronic conditions

To ensure delivery system reforms adequately addressed the unique needs of children, a group of child providers and advocates came together through the *Child and Adolescent Health Initiative* to develop *10 recommendations* focused on child health and deeply rooted in an advanced model of primary care. This group worked with MassHealth to inform an *1115 waiver request* that CMS approved in 2022. This high level of **community engagement** was a key factor in catalyzing the pediatric segments of the 1115 waiver.

> "Although there are many specific, important improvements in the new MassHealth 1115 waiver program for children, to me the most important element is that MassHealth recognizes that the needs of children and families are different than those of adults, and that programs need be designed to specifically address these needs. That is what makes this waiver program different from what had come before."
>
> **— Charlie Homer, MD,** Associate Clinical Professor of Pediatrics, Harvard Medical School

Massachusetts' Model for Promoting Whole Child Health Model

Massachusetts ultimately included many of the recommendations laid out by the Child and Adolescent Health Initiative in the state's *1115 waiver request* to CMS that was approved in the fall of 2022 and runs through 2027. Primary care providers, community-based organizations, and accountable care organizations all play significant roles in implementing the various elements of the program designed to address whole child health. Major components of the waiver include:

1. Strengthening Primary Care

Health care financing reforms are a key element of whole child health approaches, as traditional fee-for-service financing does not typically give providers sufficient ability or incentive to invest in preventive measures that optimize child development, support early relational health, and address social needs.

Under the most recent 1115 waiver, primary care providers receive prospective, panel-based capitation payments for a defined set of services to support multidisciplinary care for their patients, allowing the providers to invest in a wider range of upstream interventions. Providers can qualify for one of three different tiers of payment depending on the range of services they offer. Examples of services and supports providers are incentivized to provide under this approach include:

- Behavioral health screening, referral and medication management (Tiers 1, 2, & 3)
- Postpartum maternal depression screening and referral (Tiers 1, 2, & 3)
- Brief interventions for behavioral health conditions (Tiers 2 & 3)
- Assistance with applications for the SNAP and the Women, Infants, and Children (WIC) program (Tiers 2 & 3)
- Three team-based staff roles, such as community health workers or family partners, including at least one licensed behavioral health clinician (Tier 3)
- Education liaisons who coordinate with schools around the medical and educational needs of children (Tier 3)

The most recent 1115 waiver also takes other steps to strengthen primary care, including setting a requirement that MassHealth rates for primary care providers are at least 80% of equivalent Medicare payments. Furthermore, financial incentives are designed to increase the size of the workforce.

2. Flexible Services Program

The most recent 1115 waiver allows MassHealth, through the state's accountable care organizations, to pay for specific services related to housing and food instability (including the state's Food is Medicine program) for certain eligible at-risk members. Building on the state's previous waiver, under the Flexible Services Program, accountable care organizations may now pay to provide certain nutrition supports to the household when the eligible member is a child (newborns–20 years) or experiencing a high-risk pregnancy, including up to 12 months post-partum. This change will allow accountable care organizations to address food security at the household level to ensure the member experiences the full impact of the nutrition services being provided. Massachusetts ensured children would be included in Flexible Services by requiring the proportion of children in an accountable care organization's Flexible Services Program is roughly proportional to the percentage of the accountable care organization's members who are under age 21.

3. Care Coordination

The most recent 1115 waiver strengthens existing MassHealth elements related to care coordination. The 1115 waiver requires accountable care organizations to screen enrollees for physical, behavioral and health-related social needs and ensure enrollees who screen positive for such needs receive referrals to appropriate supports or services. Accountable care organizations must coordinate care for all enrollees and must evaluate enrollees, including children, to determine their appropriateness for enhanced care coordination. Where appropriate, accountable care organizations must also make referrals to, and coordinate with, other entities including school and early childhood supports, agencies who provide the Children's Behavioral Health Initiative services, and other state agency supports and services for enrollees under the age of 21.

4. Care Management

MassHealth aims to better meet the care coordination needs of children and youth with medical complexity through the new MassHealth Coordinating Aligned, Relationship-centered, Enhanced Support (CARES) for Kids Program that provides targeted case management services. MassHealth CARES for Kids provides comprehensive, high-touch care coordination for eligible children and their families. This service is provided in certain primary care or specialized settings where medically complex individuals under age 21 receive medical care. MassHealth CARES for Kids providers will serve as lead entities to coordinate prompt and individualized care across the health, educational, state agency and social service systems.

> "The Massachusetts [1115] waiver provides substantial resources and incentives to transform pediatric practice, expanding team care with integrated mental/behavioral health, active inclusion of community health workers, and greater integration of families in their care. These will help Massachusetts better meet the needs of younger populations."
>
> **— James Perrin, MD,** Professor of Pediatrics, Mass General Hospital for Children/Harvard Medical School

5. Health Equity Incentive Program

Given the high rates of traditionally underserved populations in Medicaid, reforms that strengthen Medicaid also help address **equity**. Additionally, the most recent 1115 waiver takes several specific steps to directly improve equity. One challenge in addressing disparities has been a lack of sufficient social risk data. Under the most recent 1115 waiver, acute hospital providers will be financially incentivized to collect self-reported data on race, ethnicity, disability, language, sexual orientation and gender identity of their MassHealth patients. Acute hospitals must then use this data to analyze what quality and access disparities are present, including disparities related to access to care for members and quality of preventive, perinatal and pediatric care, care for acute and chronic conditions, care coordination, and member experience. In later years, acute hospitals will be held accountable for reducing identified disparities. Accountable care organizations and other MassHealth providers will be incentivized toward similar health equity goals under separate authorities.

6. Aligning Care for Families

The newly relaunched accountable care organization program also included other new provisions consistent with a whole child health model by recommending that accountable care organizations and managed care organizations include representatives from parents or guardians of pediatric enrollees on their *Patient and Family Advisory Committees*. The Patient and Family Advisory Committees provide feedback on issues related to the care and services of MassHealth members, including the cultural and linguistic appropriateness of various offerings. In April 2022, MassHealth also extended continuous coverage to all pregnant individuals through 12 months postpartum.

7. Data Sharing to Promote Cross Program Enrollment

Massachusetts participated in a *pilot* project from 2019 to 2020 through which the state matched WIC enrollment data with Medicaid, SNAP and Temporary Assistance for Needy Families data to identify individuals who were eligible for WIC, but not enrolled. After identifying eligible households, the state conducted targeted text message outreach to encourage enrollment. The pilot demonstrated that conducting cross-agency data matching and targeted outreach to individuals who are not enrolled in WIC can increase its enrollment, which could improve health and developmental outcomes. More recently, Massachusetts *began allowing* MassHealth applicants to simultaneously apply for SNAP by checking a box on their MassHealth application permitting for data sharing between agencies to facilitate enrollment in both programs at the same time.

Local Examples

The local examples below highlight a handful of providers exemplify elements of whole child health. Note this list is not exhaustive of all Massachusetts providers practicing whole child health.

Boston Children's Hospital and the Pediatric Physicians' Organization

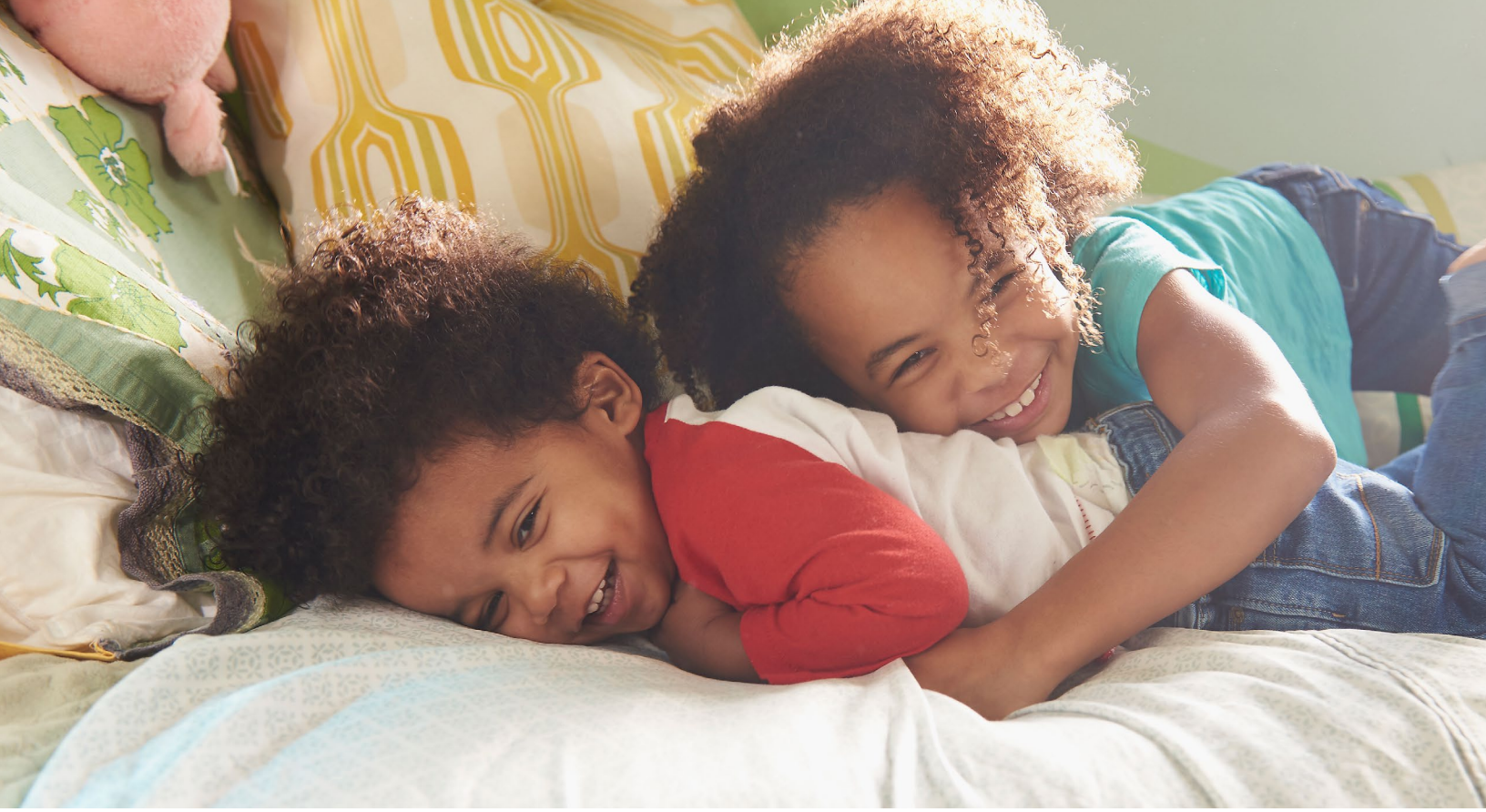
Boston Children's Hospital has three primary care clinics and an affiliated network of outpatient pediatric primary care providers called the *Pediatric Physicians' Organization at Boston Children's Hospital*. According to Michael Lee, MD, the executive director and medical director of the Department of Accountable Care and Clinical Integration at Boston Children's, the tiered capitation system for primary care has supported ongoing efforts to integrate behavioral health providers in pediatric primary care offices and encouraged their practices to provide additional services such as fluoride varnish. The health system has also expanded the hours of urgent care settings to help keep children out of the emergency department. The health system is currently working on integrating educational liaisons into some practices, in alignment with the third tier under the state's 1115 waiver.

Baystate Health

Matthew Sadof, MD, at *Baystate Health* based in Springfield, Mass., focuses on providing care to medically complex children. He and a dedicated nurse care coordinator work closely with the region's accountable care organization to provide needed support services to the families in his practice to coordinate durable medical equipment, home care, food and transportation supports as well as communication between specialists. The Child Life specialist in his office helps connect children with services the school district is required to provide. Dr. Sadof explained the capitation model aligns the incentives so that he can use his time in a way that will lead to improved outcomes for the children in his practice. This could include providing home care visits and spending time coordinating care among the various specialists that provide care to his pediatric patients with medical complexity.

Vital Village

Boston *Vital Village Network* is a place-based *network* of residents and organizations committed to maximizing child, family and community well-being through a collective impact approach between educators, clinicians, social service providers, legal advocates and residents. The network focuses on the root causes and generational implications of poor health outcomes and draws on the lived experience of residents to understand existing data and acknowledge and address community and social context as a health-related social need. Vital Village builds community capacity through a service learning and leadership model that employs a community-driven, solution-finding approach; uses a trauma-informed framework; curates and shares data; and commits to iterative improvement. It also includes peer-to-peer advocacy models to address hardships through civic capacity, economic, and preventive legal strategies. Vital Village embodies the whole child health model core elements of **centering families** and **promoting health equity.**



North Carolina

North Carolina has emerged as a national leader in developing policies and programs to promote whole child health. The state's long history of collaboration between the pediatric community, advocacy groups and government has laid the groundwork for innovative approaches that advance key elements of the Alliance's framework. This case study highlights examples in North Carolina that exemplify components of its whole child health approach.

Background

North Carolina has benefited from strong partnerships among pediatric providers, family medicine, specialists, advocates, early care and education practitioners, and state officials over many years. In addition, visionary leaders in and outside of government have made important contributions to the state's level of innovation.

Community Care of North Carolina

Over the past few decades, numerous leaders in North Carolina recognized changes in the national health care landscape's movement toward value-based payment and greater financial responsibility for state Medicaid programs. Various organizations took steps to reshape the state's health care landscape in response. One aspect was the launch of *Community Care of North Carolina* (CCNC) in 2001 and its expansion over the following decade. CCNC — a statewide network of over 2,000 primary care providers including pediatric practices — has strengthened a medical home model across the state. It has formed regional care networks, provided population health management tools and care management support to practices, and supplied performance data to enable quality improvement.

Managed Care Transition

In 2015, the *North Carolina General Assembly* passed legislation directing the state's Department of Health and Human Services to transition the North Carolina's Medicaid program from fee-for-service to managed care. This major delivery system reform was authorized to begin in July 2021. The goal of the effort is to improve quality, access and efficiency through coordinated care and alignment of financial incentives. Following the transition to managed care, the state now delegates much of its population health activities to its managed care organizations.

Child Advocacy Community

North Carolina also has a robust child advocacy community working to advance child health and well-being. From 1999 through 2019, the North Carolina Assuring Better Child Health and Development Program, under the Office of Rural Health and then CCNC, was a cross-sector initiative that established developmental, autism and perinatal depression screening, brief intervention, and partnering with families for linkage and referral in primary care. With the transition to managed care, the Assuring Better Child Health and Development Program state advisory group transitioned to the EarlyWell project with an emphasis on social-emotional development. *NC Child*, a 501(c)3 nonprofit, operates the *EarlyWell Initiative*, an advocacy effort aiming to strengthen North Carolina's system for promoting infant and early childhood mental health. By convening over 100 service providers, clinicians and advocates, EarlyWell has mapped the current landscape of social, emotional and mental health efforts for children from newborn to age 8 in the state. It is now developing the North Carolina Young Children's Social-Emotional Health Action Plan, which lays out state policy solutions focused on prevention, early identification, treatment and coordination of care. This initiative effectively aligns care for families by partnering with local organizations that can facilitate receiving feedback directly from family members and caregivers. Such initiatives exemplify how North Carolina's child advocacy organizations collaborate with government leaders, families and other stakeholders to catalyze change.

Medicaid Expansion

In October 2023, North Carolina received federal approval to *expand Medicaid* through the Patient Protection and Affordable Care Act (*P.L. 111-148*). Medicaid expansion, launched December 1, 2023, extended coverage to adults ages 19–64 earning up to 138% of the federal poverty line. The *state* expects Medicaid expansion will provide Medicaid coverage to over 600,000 additional residents.

Division of Child and Family Well-Being

In 2021, the North Carolina Department of Health and Human Services took a significant step toward integrating care delivery and social supports by establishing the Division of Child and Family Well-Being, which "works to promote healthy and thriving children in safe, stable and nurturing families, schools and communities." The division explicitly aims to promote whole child health by improving coordination and integration of services for children and families across physical health, behavioral health and other programmatic areas. Some of its focus areas include food and nutrition services, school and community-based services, and early intervention approaches.

North Carolina's Model for Promoting Whole Child Health

North Carolina has implemented numerous policies and practices that advance whole child health. These include an October 2018 Medicaid Section 1115 Demonstration waiver, the *NC Integrated Care for Kids* (NC InCK) model, various coverage extensions, innovative programs and funding sources, and technology platforms.[4] The sections below describe highlights from these approaches.

1. Strengthening Primary Care

Advanced Medical Homes

As part of the state's transition to managed care, North Carolina launched its voluntary *Advanced Medical Home* (AMH) program, which certifies primary care practices, including general, family medicine, internal medicine, OB/GYN and pediatric practices as AMHs that provide *enhanced services* beyond medical services. Practices are divided into Tier 1, 2 or 3 AMHs, where Tier 1 and 2 AMHs are required to:

- Perform primary care services.
- Create and maintain patient-clinician relationships.
- Provide direct patient care for at least 30 hours a week.
- Provide access to medical advice and services 24/7.
- Refer to other providers when necessary.
- Provide oral translation services at no additional cost.

4 North Carolina submitted an application to extend its 1115 waiver demonstration for another 5-year period on October 31, 2023. CMS has not yet approved the application.

In addition to the requirements enumerated above, Tier 3 AMHs must provide care management services. Tier 1, 2 and 3 AMHs receive a *medical home fee*, paid per member per month and they are also eligible to participate in a negotiated Performance Incentive Payment. Tier 3 AMHs receive a care management fee, which they negotiate with managed care organizations. North Carolina requires its managed care plans to monitor AMH performance leveraging a set of quality metrics. The establishment of AMHs **advances financing reforms to incentivize optimal health**, while also assessing **quality improvement and performance.**

Collaborative Care Codes

In 2001, the North Carolina Pediatric Society worked with leadership of North Carolina Medicaid to allow the use of nonspecific diagnosis codes for the first six visits with a mental health clinician. This policy, along with the allowance for community mental health clinicians to directly credential with Medicaid, allowed for practices to integrate a mental health clinician as a member of the medical home team. North Carolina Pediatric Society has since partnered with North Carolina Academy of Family Physicians, North Carolina Psychiatric Society, and CCNC on various Medicaid reforms. These efforts have led to North Carolina Medicaid's activation of the Collaborative Care Management Current Procedural Terminology (CPT) codes, which enabled primary care physicians to utilize the Collaborative Care Model. This involves integrating behavioral health care in their practices through collaboration with behavioral health care managers and psychiatric consultants.

2. Healthy Opportunities Pilots

In October 2018, CMS approved *North Carolina's 1115 waiver* to transition its Medicaid program to managed care; integrate physical health, behavioral health and pharmacy benefits; and launch the innovative *Healthy Opportunities Pilots (HOPs)*. The HOPs represent a comprehensive effort to **integrate care delivery and social supports** by testing evidence-based, nonmedical interventions addressing housing, food, transportation, interpersonal violence and toxic stress. HOPs also **advance financing reforms that incentivize optimal health** by utilizing up to $650 million in federal and state funds to support the pilots. In addition to targeting high-risk adults, North Carolina designed the pilots to focus on improving outcomes for high-risk infants and children. The initiative has also involved the creation of a standardized *fee schedule*, which details reimbursement levels for a variety of medical and nonmedical services intended to positively impact health outcomes, such as healthy food boxes, transportation services and home safety modifications. Operating in three rural regions, the HOPs exemplify how North Carolina is leveraging Medicaid to address social drivers of health and **foster healthy communities**. Future evaluations will assess return on investment and opportunities to scale successful interventions. The Millbank Memorial Fund and Duke Margolis Center for Health Policy conducted a qualitative *study* of implementation of the HOPs to date, which suggests the importance of building local capacity, scaling service delivery, leveraging multiple funding streams (including Medicaid), engaging stakeholders in the design and implementation process, and ensuring data and technology can support the program.

3. NCCARE360

In 2019, North Carolina launched *NCCARE360*, a statewide network that uses a uniform technology platform to connect health care and human services organizations, **incentivizing cross-sector data partnerships** to assist in identifying unmet social needs and making electronic referrals to social services available in the community. Its goal is to enable coordinated, community-oriented, person-centered care delivery through data integration and shared care plans. The network also promotes outcomes tracking on referrals and connections to resources to help close the care loop for individuals. Specifically for the HOPs initiative, care managers use the platform to complete assessments, record consent, request health plan authorization, and confirm receipt of referrals. The platform also facilitates invoicing for HOPs services.

4. NC Integrated Care for Kids

In 2019, CMS published a notice of funding opportunity for the *Integrated Care for Kids Model (InCK)*. CMS currently funds seven awardees across six states, including North Carolina.[5] The model aims to promote early identification and treatment of children with multiple physical, behavioral, or other health-related needs and risk factors, integrate care coordination and case management, and develop state-specific alterative payment models.

In January 2022, North Carolina launched *NC InCK* for Medicaid- and CHIP-insured children living in five central North Carolina counties. Partners include the North Carolina Department of Health and Human Services, Duke Health System, UNC Health System, and various child health leaders from the target region. NC InCK seeks to holistically understand the needs of children by implementing **data integration** across multiple sectors (e.g., health, education, juvenile justice) to identify children with physical, behavioral and social needs. Children with higher needs are offered integrated, longitudinal care management, which includes convening a cross-sector care team and connecting families to services such as early care and education, schools, food programs, housing, legal aid, and others. In addition, NC InCK **advances financing reforms that incentivize whole child health and assesses quality improvement and performance** through an *alternative payment model* that rewards participating providers for achievement on six child-centered process measures:

- Kindergarten Readiness Promotion Bundle
- Screening for Food Insecurity & Housing Instability
- Shared Action Plan[6]
- Depression Screening & Follow Up
- Emergency Department Utilization
- Racial and Ethnic Disparities in Infant Well-Child Visits

The NC InCK alternative payment model was codesigned with leaders from North Carolina Medicaid, all five Prepaid Health Plans (i.e., North Carolina's Medicaid managed care organizations) and clinically integrated networks (CINs) in NC InCK's five counties. The NC InCK alternative payment model is a 5-year, targeted incentive program in the five NC InCK counties that launched in January 2023 and will run through December 2026. The alternative payment model includes AMH incentive payments through health plan contracts, which are linked to reporting and performance against benchmark targets.

NC InCK **aligns care for families** by convening a paid *Family Council* to advise program leaders on key strategic decisions, ensuring families play a role in the NC InCK program and policy design. The initiative seeks to inform practices about the health-related social needs of families by providing data on the kindergarten readiness rate, school attendance, housing instability, food insecurity and total cost of care. It is testing strategies like embedding care managers in practices to coordinate services for children identified as high risk and accepting direct referrals from community partners, including schools and juvenile justice counselors. It **promotes health equity** *in numerous ways*, including its hiring processes and equity-focused measures. The state will evaluate results over several years and hopes to scale successful innovations statewide. NC InCK is an innovative approach aiming to serve the whole child by integrating services and addressing needs that can positively impact the health outcomes of children and families.

5. Medicaid Coverage Extensions

North Carolina has also adopted two important Medicaid policies to **align care for families** and promote continuity of coverage for mothers and children. It provides 12 months of continuous Medicaid eligibility for children enrolled in Medicaid and CHIP. In addition, the state recently *extended Medicaid postpartum coverage* to 12 months, recognizing the critical period for addressing maternal health needs after birth.

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5 InCK awardees include Connecticut, Illinois (Egyptian Health Department, Lurie Children's), North Carolina, New Jersey, New York and Ohio.

6 A Shared Action Plan is a care plan developed collaboratively by a family and the child's cross-sector team.

6. Quality Improvement

Through CCNC and other initiatives, North Carolina has consistently demonstrated its commitment to improving children's health care while **assessing quality improvement and performance**. The state won a $9.2 million federal grant from the Children's Health Insurance Program Reauthorization Act (CHIPRA) between 2010–2015. This funded a partnership with the North Carolina Pediatric Society, North Carolina Academy of Family Physicians, and CCNC on *various activities*, including evaluating quality measures. North Carolina CHIPRA supported practice transformation for strengthening medical homes for children with special health care needs, specifically those in foster care and those with sickle cell disease with a focus on those with developmental, and/or mental health disorders. North Carolina was one of only two CHIPRA grant states to evaluate the pediatric electronic health record format.

7. Innovative Programs and Funding Sources

North Carolina benefits from multisector commitments to test and scale programs that create positive impact for children and families. In the late 1990s, pediatric practices in North Carolina began implementing the *Reach Out and Read Program*. In more recent years, the state utilized a CHIP Health Services Initiative to support the implementation of the program across all 100 counties. This evidence-based program fosters healthy social/emotional and language development through the promotion of shared reading and stories. Through this evidence-based intervention, parents and caregivers are supported at each checkup between birth and 5 years by their clinician. They are provided with guidance and a book to take home hoping to build into their daily routines. In June 2023, North Carolina announced plans to transition the Reach Out and Read funding to *new initiatives*, including a statewide breastfeeding hotline and a parenting intervention for caregivers with substance use.

North Carolina also has an active philanthropic sector focused on children and families that has made innovation in behavioral health, school-based care (including oral health and vision care) and telehealth possible in the state. For example, *CaroNova* — a health incubator that addresses the common needs of North and South Carolina, in partnership with the North Carolina Healthcare Association, the South Carolina Hospital Association, and the *Duke Endowment* — has focused on collaborating with the states to enhance youth behavioral health prevention programming and redesigning the system to support the behavioral health needs of children in the Carolinas.

Furthermore, the *State Employees' Credit Union Foundation* and *UNC Health Foundation* funded the University of North Carolina School of Medicine Department of Psychiatry to implement a *pilot program* to expand telehealth into schools to address the child/youth behavioral health crisis. These examples are a small subset of the substantial contributions philanthropic organizations have made toward advancing a whole child approach in the state.

Local Examples

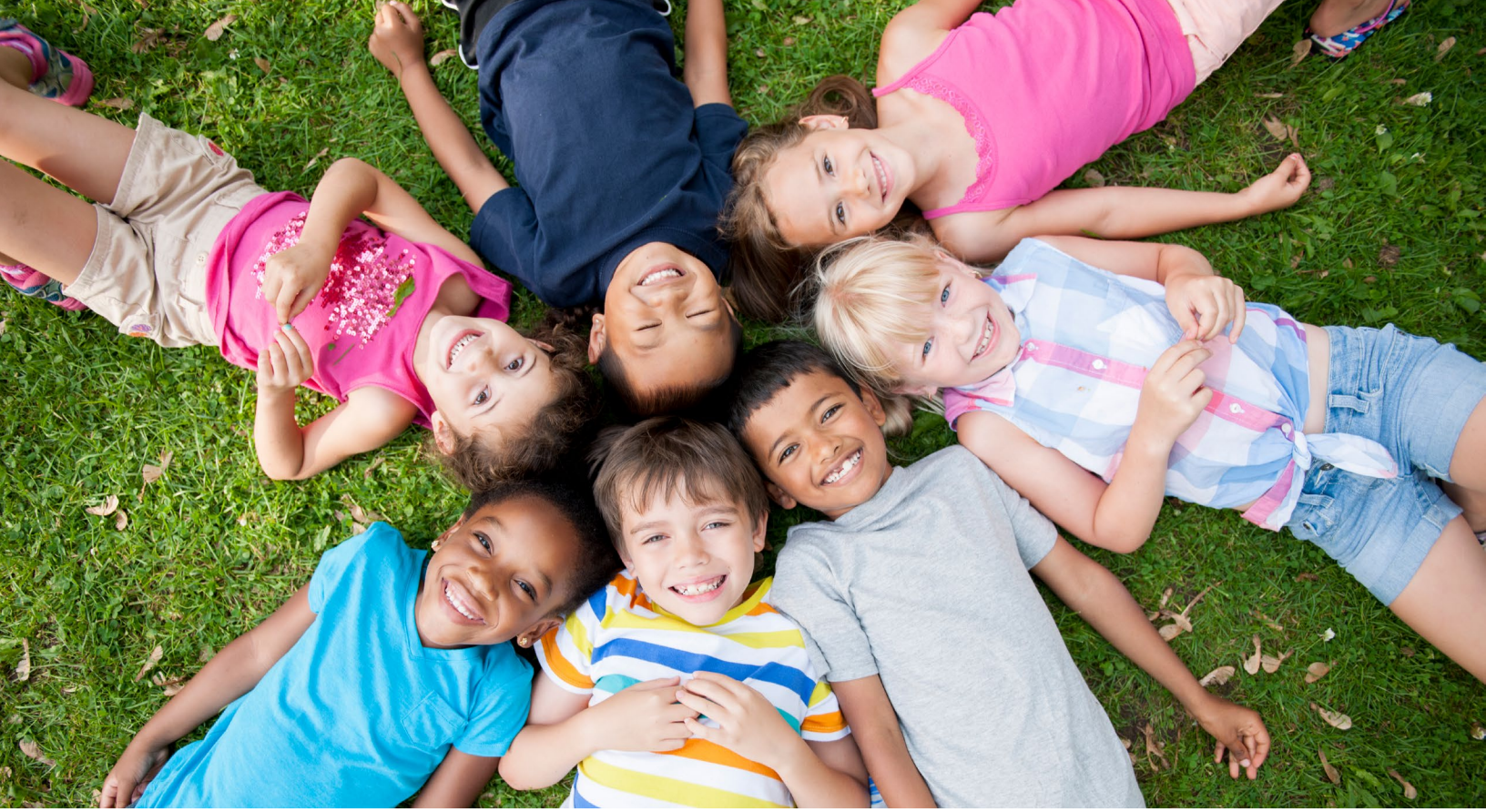
The local examples below highlight a handful of local providers that exemplify elements of whole child health. Note that this list is not exhaustive of all North Carolina providers Practicing whole child health.

Burlington/Mebane Pediatrics

Originally founded in 1971, *Burlington Pediatrics/Mebane Pediatrics* serves families through a 14-provider practice across four suburban and rural counties. The practice implements strategies like integrated behavioral health, universal screening, and support for caregivers of newborns. It facilitates care coordination with various health care settings, early childhood mental health specialists, and community-based services. As part of NC InCK, it **supports a diverse, multidisciplinary workforce** through funding for an embedded care manager to coordinate services for its Medicaid patients. In addition, it builds early literacy skills and **aligns care for families** by implementing *Reach Out and Read*. The practice also seeks to fulfill their patients' behavioral health needs by utilizing the *North Carolina – Psychiatry Access Line* and facilitating a training program for physicians. The organization's commitment to team-based care and addressing nonmedical factors demonstrates how a small practice can advance the principles of whole child health.

Pediatric Accountable Care Organization

Focused on commercially insured populations, North Carolina is home to an innovative *pediatric accountable care organization* led by Aledade, Inc. and Blue Cross Blue Shield of North Carolina. Launched in 2020, the accountable care organization includes 14 primary care practices serving approximately 15,000 Blue Cross North Carolina members under age 18. Aledade provides data analytics, care coordination support, and other resources to help independent pediatricians succeed under value-based payment contracts — an example of **advancing financing reforms that incentivize optimal health**. As described in a *January 2023 episode* of Aledade's "The ACO Show" podcast, the accountable care organization achieved exceptional quality scores with Blue Cross North Carolina during 2021, triggering a $2.6 million bonus payment. This partnership demonstrates how payers and providers can work together to implement whole child health approaches.



Washington

Washington has been a pacesetter in adopting initiatives that advance whole child health. The state's executive and legislative branch leadership, child advocates, and local philanthropy have coalesced to create an environment ripe for innovation.

Background

Over the past several decades, Washington has advanced whole child health by expanding coverage across the state, while also transforming the way care is delivered. In 1987, Washington launched its *Basic Health Plan*, which allowed the state to offer a state-subsidized health insurance program to cover uninsured Washingtonians. Six years later, the state passed the *Health Services Act of 1993*, which guaranteed universal access to health care through an *employer* mandate. With the passing of the Health Services Act of 1993, all individuals gained access to coverage through the Basic Health Plan, employer coverage, Medicare or Medicaid. Increasing coverage across the state allowed children and families to access preventive care. This increased access to preventive care created a foundational opportunity for the state to invest in establishing and advancing "medical homes" for children and families.

Washington has leveraged *federal* opportunities, including CMS Innovation Center SIM grants as well as an 1115 waiver, to reform its Medicaid program (known as Apple Health). In 2013, Washington received a $1 million *Round 1 SIM Model Pre-Test Award* to continue work on its State Health Care Innovation Plan, which included a focus on improving maternal and infant care and management of chronic conditions. The state used the funding to create accountable care organizations and support the development of an aligned transformative design model that prioritized community health and behavioral health integration, among other priorities. Subsequently in 2015, Washington received a $65 million *Round 2 SIM Model Test Award* to implement the Healthier Washington Project, which aimed to facilitate the adoption of value-based payment across the state, improve population health, and advance whole-person health — with all three goals applying to pediatric as well as adult care models. One key strategy for achieving these goals was the establishment of Accountable Communities of Health (ACH), as well as movement towards the adoption of value-based payment. While not focused on children, these initiatives contributed to a culture of transformation.

In addition to leveraging two rounds of SIM funding to finance the Healthier Washington project, Washington also sought federal approval through a Medicaid 1115 waiver to implement a Medicaid transformation initiative, called the Medicaid Transformation Project. CMS approved the state's first *1115 waiver* in 2017, which was designed to complement the existing SIM-funded activities. *The Medicaid Transformation Project* aimed to improve quality of care and test innovative approaches through the states DSRIP program, among other initiatives.

In June 2023, CMS approved Washington's five-year renewal application to continue the state's transformation project through a second phase called *Medicaid Transformation Project 2.0*. The Medicaid Transformation Project 2.0 included new *provisions* to cover health-related social needs services, establish Community and Native Hubs to coordinate the delivery of health-related social need services, provide prerelease services for individuals who are incarcerated, and establish 12 months of continuous postpartum coverage and continuous coverage for children birth through age five.

Washington's Model for Promoting Whole Child Health

Strong leaders in policy, philanthropy and health care have paved the way for innovative policy that supports whole child health in Washington. Through its SIM funding and 1115 waivers, Washington has established several programs that contribute to the state's work to advance whole child health. Additionally, support from the Washington Chapter of the American Academy of Pediatrics and local child health champions have contributed to local initiatives that promote the state's whole child health approach. Additionally, the Perigee Foundation funded two positions in Washington's Health Care Authority to focus on Medicaid and advance early relational health initiatives.

1. Accountable Communities of Health

Originally authorized by *2014 state legislation* and funded by the CMMI SIM Round 2 Test Grant, Washington established its *ACH* network in 2015 to promote whole-person health by **integrating care delivery and social support, fostering community health,** and **promoting health equity** for all community members, including children and families. Through the *ACH model*, the state delegates authority to ACHs — nine *regional organizations* comprised of providers, managed care organizations, tribal representatives, community-based organizations, and others — to design and implement an approach to ensure health care transformation responds to local community needs. Specifically, *ACHs*, in partnership with providers, local health care jurisdictions, community-based organizations and others, aim to:

> "Whole child [and] whole family approaches take an incremental, or evolutionary approach to take root, then can be more expansive once some early successes are celebrated or a proof of concept is made. Those first steps often need to come from outside the health care entity."
>
> **— Benjamin Danielson, MD,** Clinical Professor of Pediatrics, University of Washington

- Align resources and sectors to improve whole-person health.
- Support Medicaid transformation, including workforce development and value-based payment.
- Support the integration of physical and behavioral health.
- Help coordinate health care and social services.
- Address the opioid crisis.
- Invest in community infrastructure (e.g., electronic health records).

Furthermore, Washington's *1115 waiver renewal* authorized the establishment of regional *Community Hubs* and a statewide Native Hub, which will provide care coordination and address social needs within the community. Existing *ACHs* will be overseeing the Community Hubs, while oversight of the Native Hub is still to be determined by the state. Notably, Community Hub- and Native Hub-contracted providers do not need to be licensed unless otherwise required by the state, but they must demonstrate sufficient experience in providing the health-related social need services for which they are responsible, thus **supporting a diverse, multidisciplinary workforce.** While Washington's ACHs, Community Hubs and Native Hubs do not specifically target children, their overarching goals align with the key elements of whole child health by transforming care for the **whole family** while also **fostering healthy communities.**

2. Value-Based Payment

VALUE-BASED PAYMENT THROUGH MEDICAID 115 WAIVERS

As authorized by the state's 2016–2022 and 2023–2027 Medicaid 1115 waivers, the Health Care Authority implemented a value-based payment strategy that aims to move 90% of state-financed health care payments into value-based payment contracts. The state's nine ACH's have played a critical role in the implementation of value-based payment, having leveraged Medicaid Transformation Project funds to provide technical assistance, coaching and infrastructure investments to support regional providers as they transition to new payment models. ACH's can receive incentives if their regions achieve value-based payment participation targets.

Washington's Common Measure Set lists specific pediatric measures, which are included in value-based payment contracts to measure provider performance. Examples of pediatric value-based payment metrics include child and adolescent well-care visits, childhood immunization status, immunization for adolescents, depression screening and follow up and remission/response for adolescents, follow up for children prescribed ADHD medication, as well as prenatal and postpartum care. In addition to supporting the state's **financing reforms to incentivize optimal health**, the common measure set helps Washington assess **quality improvement and performance.**

Other Key Provisions of Washington's 1115 Waiver Renewal

In July 2023, Washington received CMS approval through its *1115 waiver renewal* to provide a targeted set of Medicaid services to youth and adults who are *incarcerated*, becoming the second state in the nation to receive approval to do so. The waiver renewal also includes provisions to provide supportive housing and supportive employment services to individuals 16 or older with a qualifying social risk. Under the previous 1115 waiver, only adults 18 and older were eligible for this benefit.

These initiatives **promote health equity** by covering services that mitigate the health and social risks children and youth experiencing homelessness or involvement in the criminal justice system, who are disproportionately people of color, may face.

TRANSFORMING CLINICAL PRACTICE INITIATIVE

Prior to Washington's recent 1115 waiver, CMS awarded the state *$16.3 million* between 2015 to 2019 to participate in the *Transforming Clinical Practice Initiative* designed to support clinician practices to achieve large scale health care transformation, including transitioning to value-based payment models. Washington's Transforming Clinical Practice Initiative was one of only two pediatric transformation networks, which the Washington State Department of Health implemented in *collaboration* with the Washington Chapter of the American Academy of Pediatrics and Molina Healthcare. The initiative aimed to support pediatric primary care, specialty care and behavioral health providers to transition to family-centered care and value-based payment through the implementation of the Regional Care Coordination Project, which leveraged the Medical Home Neighborhood model of care for the pediatric Medicaid population. The initiative was implemented through each region's ACH and local health department via Regional Care Facilitators. The overarching goal of the initiative was to improve health outcomes for children covered by Medicaid and reduce costs.

3. Integrated Pediatric Medical Home

COLLABORATIVE CARE CODES

Washington has strengthened pediatric medical homes throughout the state by instituting new payment methods that leverage a **multidisciplinary workforce** to promote **integrated physical and behavioral health care delivery** and **social supports.** Specifically, Washington has leveraged *collaborative care billing codes* as a critical component of its *Collaborative Care Model*, an integrated care model developed at the University of Washington to treat mild and moderate mental health conditions in the primary care setting. Introduced by CMS in 2017 and adopted by *Apple Health* in March 2018 through *legislative action*, Collaborative Care Model services codes are billed for services provided in a calendar month with a maximum of 120 minutes of services a month, under the billing provider (i.e., behavioral health services provided by a therapist in the primary care setting are billed by physician or nurse practitioner). While uptake of the Collaborative Care Model has been limited to date due to administrative complexity and shortage of behavioral health providers, this payment has allowed primary care practices – including Pediatrics Northwest, profiled below – to integrate behavioral health services into the primary care setting in a financially sustainable way, since it allows a **diverse, multidisciplinary workforce** (i.e., associate therapists) to be compensated for services. To facilitate implementation of the Collaborative Care Model, the Washington state legislature offered Behavioral Health Integration Grants for up to $200,000 to primary care clinics to establish behavioral health integration for children and adolescents. The Washington Chapter of the American Academy of Pediatrics also hosts cohort calls and coaching sessions to help these practices prepare for implementation. Ongoing technical assistance and support will be necessary for increased spread of the program.

COMMUNITY HEALTH WORKERS

Additionally, Washington has incentivized primary care providers to embed community health workers into their practices through a *grant opportunity* that aims to integrate social supports into pediatric clinical care for children age newborn to 18 by facilitating access to community-based services.

In 2022, Washington's *Children and Youth Behavioral Health Workgroup* and the Washington Chapter of the American Academy of Pediatrics *First Year Families* steering committee put forth legislative recommendations to fund community health workers in primary care settings, which ultimately was included in the *Engrossed Substitute Senate Bill 5693*, directing the Health Care Authority to establish a two-year community health worker grant and explore longer-term reimbursement methods in collaboration with key partners. The grant opportunity offered funding to 24 primary care clinics to embed community health workers into their care team to support children and their families with outreach, informal counseling, and social support for health-related social needs. The community health workers supported through this grant support either early relational health (newborn through age 5) or K12 mental health (ages 5–18). Furthermore, the Health Care Authority established a parallel grant opportunity for community health workers and Community Health Representatives specifically for Tribes and Urban Indian Organizations. This was made possible through drawing down federal match funding resulting in a $2 million investment in the Tribal Community Health Worker Program. Integrating community health workers into pediatric clinics has not only **supported a diverse, multidisciplinary workforce** in Washington, but it has also **promoted health equity** and **fostered healthy communities** by engaging members of the community to ensure cultural competency in service delivery.

PUBLIC-PRIVATE PARTNERSHIPS TO SUPPORT EFFECTIVE PRIMARY CARE PROGRAMS

Lastly, Washington has leveraged public and private funding to support health promotion in the early years. Two examples include the Reach Out and Read and Help Me Grow programs. Public and private funds have supported further integration of *Reach Out and Read*, an evidence-based model to support early relational health and learning that was originally launched in Washington in 2007 funded by the Washington State Department of Early Learning.[7] As of 2023, Reach Out and Read has been integrated into 250 clinics across the state. Reach Out and Read leverages a two-generation approach **aligning care for families** to **integrate social supports** that promote brain development and a love for learning into the pediatric primary care setting. During the 2021–22 program year, more than *220,000* well-child checkups incorporated Reach Out and Read; of the families who received services, 64% were families with low incomes and 46% were families of color. Key Funders for Reach Out and Read in Washington include Indian Health Service (supports Northwest region, including Washington and Oregon), *Washington State Department of Children, Youth and Families*, Bezos Family Foundation, Valley Medical Center, Pitney Bowes Corporation and others.

Additionally, *Within Reach*, an organizing entity, began to lead the expansion of *Help Me Grow* across Washington starting in 2008. Help Me Grow connects parents and caregivers to community-based resources related to health, development, behavior and learning. Help Me Grow is supported by Premera Blue Cross, Washington State Department of Health, and King County Best Starts for Kids. More recently, the Washington State Department of Children, Youth and Families began to fund the program.

4. Washington Medical-Legal Partnership

Washingtonians can access legal services that **align care for families** by **integrating care delivery and social supports** through the *Washington Medical-Legal Partnership*, which was founded in 2008. While the Washington Medical-Legal Partnership was kickstarted with support from the Robert Wood Johnson Foundation, the program is now supported by the Washington State Attorney General's Office, foundations, law firms, individual donors as well as Seattle Children's Hospital (see Local Examples section below for further details) and Harborview Medical Center. *Washington Medical-Legal Partnership* assists families with housing, public benefits, education, immigration, consumer protection and family law cases through referral by a provider or health care team member.

7 *The Washington State Department of Early Learning became part of the Washington State Department of Children, Youth and Families.*

5. Continuous Medicaid Enrollment for Children Newborns-6 Years

Washington has prioritized efforts to ensure access to health insurance for children and families during early childhood. The state's *1115 waiver* renewal authorized continuous Apple Health enrollment for children ages newborn–5, providing continued benefits for Medicaid-eligible children through the month that they turn six years old. Additionally, in service of **aligning care for families,** the 1115 waiver renewal authorized postpartum coverage expansion to extend Apple Health coverage from the end of pregnancy until 12 months postpartum.

6. Paid Family Leave

Washington also implemented a *Paid Family and Medical Leave* benefit in 2020, *funded* through premiums paid by employers and employees. Medical leave may be used during pregnancy and family leave may be used to care for a family member with a serious health condition or to bond with a new baby or child in the family. Job security is guaranteed for the duration of the Paid Leave. This policy **aligns care for families** by ensuring parents and caretakers can afford to take time off work to bond with newborns and/or new children entering the family. It also acknowledges parents and guardians must be able to take time to care for their own health to care for the children in their families.

Local Examples

The local examples below highlight a handful of local providers exemplifying elements of whole child health. Note this list is not exhaustive of all Washington providers practicing whole child health.

Seattle Children's Care Network

Seattle Children's Care Network has undertaken several initiatives that advance whole child health. One of Seattle Children's key initiatives includes implementing **financing reforms,** including participating in *value-based payment contracts* with commercial, Medicaid and direct-to-employer plans. Seattle Children's was a "top performer" in its value-based payment arrangement with Regence BlueShield for three years (2019–2021), based on its performance on seven pediatric quality metrics, which include performance for well-child visits and immunizations. Seattle Children's *Odessa Brown Children's Clinic* also exemplifies a whole child approach, providing medical, dental, behavioral health, nutrition and other services on site, while also providing *community* programs and classes on food, fitness, emotional well-being, safety and other topics.

Other key initiatives advancing whole child health include the following:

- Seattle Children's Care Network's *Pediatric Integrated Behavioral Health Initiative*, which established a financially sustainable model in which behavioral health care is integrated into primary care practices, resulting in increased behavioral health screenings across all age groups
- Seattle Children's Care Network's Quality and Care Transformation program, which provides coaching and facilitation to support preventive care, immunizations, asthma, behavioral health, outpatient antibiotic stewardship and patient-centered medical home recognition
- Standardized data and reporting tools to increase transparency, provide real-time reports, and identify gaps in care
- Access to legal services via the *Washington Medical-Legal Partnership*, described above

HopeSparks and Pediatrics Northwest

Since 2018, *HopeSparks Family Services*, a behavioral health and family services provider in Pierce County, Washington, and *Pediatrics Northwest*, a comprehensive pediatric group practice serving the South Puget Sound region, have partnered to integrate behavioral health care into the pediatric care medical home, leveraging the *Collaborative Care* model from the Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington. The care team is comprised of the primary care pediatrician, integrated therapist, and the pediatric psychiatric provider who provides routine case consultation. Through this model, the primary care provider universally screens children and youth ages 4 through young adult for behavioral health needs. An integrated therapist provides children with mild to moderate behavioral health conditions with behavioral health services via telehealth. Therapists leverage brief, evidenced-based interventions including the First Approach Skills Training (FAST) curriculum, which includes weekly 15- to 30-minute sessions with children and youth and their parent/caretaker (i.e., a two-generation approach) based on cognitive behavioral therapy. The providers use a registry to track progress. Pediatrics Northwest bills collaborative care codes to provide this integrated service.

Tubman Center for Health and Freedom

The *Tubman Center for Health and Freedom*, located in Seattle's Puget Sound region, is an example of a local community-based organization that advances whole child health as part of its mission addressing health and wellness through systemic and clinical approaches. Among a myriad of *services* and resources, the Tubman Center provides culturally appropriate clinical services and social services, while also leading policy and advocacy work to address health injustice. In 2025, the Tubman Center will open a flagship clinic to serve the whole family, expanding current operations beyond the Freedom Clinic school-based health center. The Freedom Clinic serves students through a whole child health approach that provides primary care, holistic preventive care and advocacy work.

Lessons Learned

Massachusetts, North Carolina and Washington serve as key examples of how states can implement the key elements of whole child health. Though each state implemented its own unique model, the case studies illuminate a common set of "facilitators" — circumstances that allowed the model to succeed, and "barriers" — circumstances that made implementation more challenging. The following section of this report outlines key facilitators and common barriers to whole child health model implementation. Finally, the report concludes with a set of policy recommendations to advance the implementation of whole child health approaches across the country.

Facilitators

Across the three states profiled, certain factors helped foster a positive context for whole child health reforms. Key factors gleaned from interviews included the importance of the following:

- **Leveraging federal policy levers**. Each state has leveraged underlying EPSDT authority to provide screening and preventive services in addition to other federal authorities, flexibilities and funding streams (e.g., 1115 waivers, SIM awards, InCK awards, etc.). These core funds and policy levers help to catalyze and create an environment to sustain whole child health approaches.
- **Visionary leadership at state, regional and local levels inside and outside of agencies**. Across each state, multisector child advocates advanced a clear vision and advocacy strategy centered on equity and the experience of children and families. These advocates built relationships with state Medicaid agencies and legislative champions to catalyze change.
- **Creating dedicated funding and state-level infrastructure to prioritize child health.** State-level positions or departments (e.g., *North Carolina's Division of Child and Family Well-Being*) help focus policy efforts on children and create continued momentum to focus on the unique needs of children and families.
- **Leveraging philanthropic funding to kickstart and provide ongoing support for upstream approaches**. The Perigee Fund supported two staffers at Washington's Health Care Authority focused on Medicaid and early relational health, and philanthropic donations help support the Vital Village program in Boston. States have also tapped into cross-agency state funding to support upstream approaches (e.g., Reach Out and Read in Washington).
- **Ensuring pediatric transformation is included as a part of broader health care reforms.** Many states are amid health care transformation efforts that reform how health care is paid for and delivered for all populations, which can kickstart pediatric-specific transformations. Child health transformation efforts in Massachusetts, North Carolina and Washington were all born out of larger transformation efforts that reformed health care for the broader population.

Barriers

Similar barriers also emerged across the states. Interviewees reported the following:

- **Capitation is new for many pediatric providers, and transitioning to new financing models can be initially challenging.** Although many adult providers have prior experience with capitation or other alternative payment models, these models are relatively new for many pediatric providers. Providers require education and supports to develop the infrastructure, staffing and training to implement new financing models.
- **New financing models can be challenging for practices to adopt.** For all practices — no matter the size — incentive payments or subcapitation rates tied to care coordination enhancements may not be large enough to meaningfully support the additional staff needed to address patient and family social needs. Moreover, the add-on payment must be sufficient to support salaries for additional care coordinators or community health workers or direct services. These challenges may be particularly acute for small or rural practices that have less experience incorporating alternative financing models. Developing approaches to help practices in accountable care organizations or clinically integrated networks develop shared infrastructure to invest in care coordination and upstream interventions could be beneficial in the future.
- **Pediatric reform initiatives do not always include multipayer participation**. While focusing on the Medicaid population helps direct resources to children with the greatest needs, having different payment models across different payers can weaken the effectiveness of any one payment approach. Including privately insured populations in state-based reform efforts would help create multipayer alignment of incentives for providers.
- **The current pediatric workforce pipeline is not sufficient to meet demand.** Across pediatrics, shortages in behavioral health providers and specialists are rampant. Primary care redesign will necessitate a strong workforce pipeline, which may be difficult to build. Creating a robust workforce as part of the medical home team requires creative thinking around how to leverage a diverse staff at all organizational levels (e.g., leadership, direct service providers) while also providing additional compensation, training and support for this workforce. Organizations should strive for racial/ethnic, gender, experiential and professional diversity.
- **Developing tailored pediatric quality measures can be challenging.** Pediatric populations require tailored metrics aligning with their specific developmental milestones and needs. Providers must continually work with states to develop, test and refine metrics that meet the mark for children and youth.
- **Many programs in child- and family-serving domains (e.g.,** *early care and education*, *housing*, some *nutrition* programs) **are not entitlements and are often underfunded commensurate to the need.** This can mean that such social service providers may not have capacity and/or funding to meet the needs of new referrals, which may result in increased strain on these providers or turning families away. Administrative barriers, multiple applications with different funding cycles and reporting requirements all serve as barriers to ensuring children, youth and families have the services and supports they need to thrive.

Policy Recommendations

The above examples highlight the important role federal and state policy plays in creating a supportive context for child health transformation efforts. The following recommendations, informed by these case studies and the prior work by Nemours Children's Health and the Alliance, could support state and provider readiness to adopt, spread and sustain whole child health approaches in additional jurisdictions. Note that all the policy recommendations below would apply to children and youth age newborn to 21.[8] If enacted, the recommendations would help spread existing best practices and provide incentives to further catalyze design and testing of whole child health approaches rooted in primary care transformation.[9]

United States Congress

- Congress could pass and fully fund legislation directing the Center for Medicaid and CHIP Services (CMCS) to develop a demonstration model to support additional states in implementing whole child health approaches providing significant resources upfront to support the capacity, workforce and infrastructure needed for practice transformation. The model should be targeted to all beneficiaries (newborn to age 21) with Medicaid and CHIP coverage and should focus on upstream prevention and health promotion to support optimal health.
- Congress could consider supporting and incentivizing states to adopt approaches that move Medicaid towards increased utilization of value-based payment models in pediatric care. Such approaches may build on existing CMS efforts to promote the adoption of Medicare or Medicaid value-based payment models such as the *Advancing All-Payer Health Equity Approaches and Development* (AHEAD) and *Making Care Primary* models.
- Congress could build upon the lessons from the *Performance Partnership Pilots for Disconnected Youth* to launch a pilot program to help states test approaches for braiding and blending federal funds from a vanguard set of cross-sector agencies, in addition to private or state funds. This should be accompanied by clear guidance from the Office of Management and Budget.

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8 If adopted and implemented, the recommended policies could generate additional evidence in support of whole child health approaches. To do so, such policies should include requirements for data collection around a standard set of metrics, including measures related to race, ethnicity and language. Such data collection requirements should leverage and/or build upon existing data collection standards, so as not to create an additional burden for the data collecting entity (e.g., provider, state). Health policymakers (e.g., CMS) and thought leaders (e.g., philanthropy, think tanks, associations) should ensure that any lessons learned, including challenges and best practices related to implementing whole child health approaches, are disseminated through the field in real-time, as practicable.

9 The policy recommendations listed here reflect the viewpoints of the authors and do not necessarily reflect the viewpoints of others engaged in the development of this report (e.g., interviewees, reviewers).

Federal Executive Branch

Centers for Medicare and Medicaid Services (CMS)

- CMS, through CMMI and CMCS, could establish whole child health demonstration models that address upstream factors through prevention, health promotion and cross-sector collaboration that connects the agencies and programs serving children. While these models should consider a definition of "success" beyond cost savings (i.e., quality, scalability, equity), CMS could also aim to generate evidence on the long-term return on investment and/or cost savings produced by such models. This demonstration should include national infrastructure support and should share key learnings in real-time.
  - One potential demonstration could include a new iteration of **Making Care Primary**, which could include a pediatric focus that promotes whole child health approaches in the pediatric primary care setting.
- CMCS could establish a learning collaborative or partner with CMMI on a new *Innovation Accelerator Program* among interested states in partnership with pediatric providers regarding implementation and financing of prevention- and/or population health-driven whole child health delivery approaches.
- CMS could further prioritize local family and community engagement in its initiatives. This could include allowing grant dollars from CMMI models to support stipends to engage Medicaid beneficiaries in model design and implementation, ensuring that some grant dollars from CMMI models flow to local communities, and requiring that any Medicaid policy innovation (e.g., 1115 waivers) include involvement from Medicaid beneficiaries.
- CMS could describe how to incorporate community health worker services (e.g., *health promotion* and education, translation services, care coordination, social support services), including evidence-based community health worker models to serve children and families, into Medicaid-managed care plan capitation rates (i.e., per member per month payments).[10] In the guidance, CMS could also highlight exemplary community health worker models that focus on maternal and early childhood health and provide technical assistance to states on the implementation of such models.
- As part of the EPSDT *implementation review* and technical assistance mandated by the *Bipartisan Safer Communities Act* (Pub. L. 117–159), CMS could emphasize whole child approaches to care that integrate team-based primary care, mental health, and oral health, alongside all other EPSDT covered services. CMS could also conduct an analysis to identify any gaps in behavioral health services covered for children and youth under each state's Medicaid state plan as compared to the full spectrum of behavioral health services coverable under EPSDT.
- The authors applaud CMS and CMCS for releasing State Health Official Letter #21-001 and a *CMCS Informational Bulletin* in 2023, respectively, to provide guidance to states on leveraging Medicaid to address health-related social needs. The authors encourage CMS and CMCS to update this guidance with new examples on a regular basis. CMS and CMCS could also consider highlighting best practices for managed care plans to address social drivers of health, including example managed care plan contract language.

10 As of January 2023, at least 29 states allowed Medicaid payment for community health worker services, and a number of states planned to implement Medicaid coverage for community health worker services.

Other Executive Branch Opportunities

- The White House could develop cross-governmental coordinating entities that prioritize equity and whole child health. Options include:
  - Creating a *White House Office of Children and Youth*, a Children's Cabinet and related guidance, with a focus on equity and whole child health. This entity should center health equity as directed by the *Executive Order on Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government*.
  - Building on the National Academies of Sciences, Engineering and Medicine's recent *recommendations* to establish an entity within the federal government charged with improving racial, ethnic and tribal equity across the federal government.[11] If established, this new entity should include a focus on children and youth.
- The White House could continue its leadership in addressing racial inequities in health, with an additional focus and emphasis on children.
- The Office of Management and Budget could issue guidance to clarify how states and federal awardees can legally braid and blend funds from separate programs that serve a similar population or need.
- The Office of Management and Budget could consider updating its minimum standards for collecting and presenting race, ethnicity and language (REaL) data to require further stratification of REaL data elements (i.e., require increased specificity of REaL data elements) to allow for more nuanced analyses and targeted interventions to address health disparities.

States

- States could fully leverage their state plan authority and EPSDT benefit to implement new services and evidence-based programs that support child and family well-being.
- States could incentivize managed care organizations to invest in social drivers of health by partnering with community-based organizations to help engage and support families and communities. States should also develop standard reporting requirements for managed care organizations that measure provision and quality of services aimed to address social drivers of health.
- States could incentivize achieving health equity, including setting metrics and benchmarks by race/ethnicity and socioeconomic status on top of required metrics in contracts that explicitly measure equity.
- States could require meaningful engagement of families and community members with lived experience in the implementation and continuous quality improvement of whole child health approaches and should facilitate such engagement through compensation for participation and ensuring meetings are accessible via public transportation.
- States could follow CMS guidance in the *CMCS Informational Bulletin* on Medicaid/CHIP coverage of services and supports to address social drivers of health and *State Health Official Letter #21-001* as they consider an approach to fund services that address health-related social needs.[12] States could consider how they can provide such services at the family-level, as opposed to the individual level, leveraging North Carolina's Health Opportunities Pilot as an example.

11 This recommendation was included in NASEM's report entitled Federal Policy to Advance Racial, Ethnic, and Tribal Health Equity, published in July 2023.

12 Additional information is available in "Addressing Health-Related Social Needs in Section 1115 Demonstrations" (CMS).

Conclusion

Our nation's investment in children reflects our common values and our down payment on our future. Yet, as the nation approaches health care transformation, the predominant focus remains on the adult population, where there are greater opportunities for short-term savings, but fewer opportunities for long-term impact on health and well-being.

The advancement of whole child health approaches has great potential to improve child health outcomes and reduce health disparities. To do so, the federal government, states, localities and health systems should incorporate the key elements of whole child.

A shifting mindset in pediatric payment and delivery reform needs to be coupled with adequate investment, training, workforce development and incentives. Federal and state programs can be important catalysts for sustainable change. Powered by strong multisector collaborations and leveraging federal and state Medicaid policy mechanisms and philanthropic funding, North Carolina, Massachusetts and Washington are among the early adopters of many of the core elements of whole child health approaches. The federal government, states, providers, and payers can learn from their approaches and continue to innovate in support of the healthiest generations of children.