First 1000 Days on Medicaid

United Hospital Fund

Schuyler Center for Analysis and Advocacy

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VISION

Quality health care and better health for every New Yorker

MISSION

United Hospital Fund works to build a more effective health care system for every New Yorker. An independent, nonprofit organization, we analyze public policy to inform decision-makers, find common ground among diverse stakeholders, and develop and support innovative programs that improve the quality, accessibility, affordability, and experience of patient care.

Schuyler Center for Analysis and Advocacy

MISSION

Schuyler Center for Analysis and Advocacy is a statewide, nonprofit, policy analysis and advocacy organization working to shape policies to improve health, welfare and human services for all New Yorkers, especially those who are poor or vulnerable. Since 1872, the Schuyler Center has served as a voice for social and economic justice and policies that work for children, people living in poverty, and persons who are chronically ill and disabled in New York State.

About The First 1,000 Days Initiative

- The First 1,000 Days Initiative is a *Medicaid-driven, cross-sector approach* to improving child health and development outcomes in the first three years of life
- 10-point plan was recommended to the New York Medicaid program through an open workgroup process, including practitioners from pediatrics, managed care, education, child welfare, child care, and mental health
- Embraced by Governor Cuomo in his State of the State, enacted by NY legislature in April 2018, now being implemented by NY Office of Health Insurance Programs (Medicaid agency)

The 10-Point Plan (in brief)

1. Braided funding for early childhood mental health consultations—to unite several state agencies to co-fund training for early childhood teachers on how to support healthy development and identify behavioral problems;

2. Statewide home visiting—to expand home visiting programs that have demonstrated improved outcomes;

3. Preventive pediatric care clinical advisory group—to develop model of pediatric care with focus on prevention and addressing poverty-related risks;

4. Expansion of "Centering Pregnancy"—to spread this successful model of group prenatal care for mothers in communities with the poorest birth outcomes;

5. Early literacy through local strategies—to improve early language development by expanding "Reach Out and Read" in pediatric primary care;

6. Requiring managed care plans to have a child-specific quality agenda—to develop quality improvement programs on common child-health quality measures;

7. Developmental inventory upon kindergarten entry—to create a standard measurement tool for use at that milestone;

8. Peer family navigators in multiple settings—to launch nine pilot projects, in homeless shelters, drug treatment programs, and other settings, to help hard-to-reach families connect to resources;

9. Parent/caregiver diagnosis as eligibility criterion for dyadic therapy—to allow children's Medicaid enrollment to cover a proven parent/child therapy model based solely on a parent's mood, anxiety, or substance abuse disorder diagnosis;

10. Data system development for cross-sector referrals—to develop a screening and referral data system that connects families to nearby health and social services

Features of the Process

- Chaired by State Education Commissioner and former SUNY Chancellor
- Public process: no one excluded, 250+ participants
- Crowdsourced proposal ideas: began with 300 issues/suggestions
- Provided technical assistance to identify “Medicaid levers” for each proposal
- Used a modified Delphi voting process to select 10 out of 23 proposals
- Criteria: Affordable, Feasible, Cross-Sector, Evidence-based, High Impact

How we started

Context and Rationale Behind The First 1,000 Days on Medicaid

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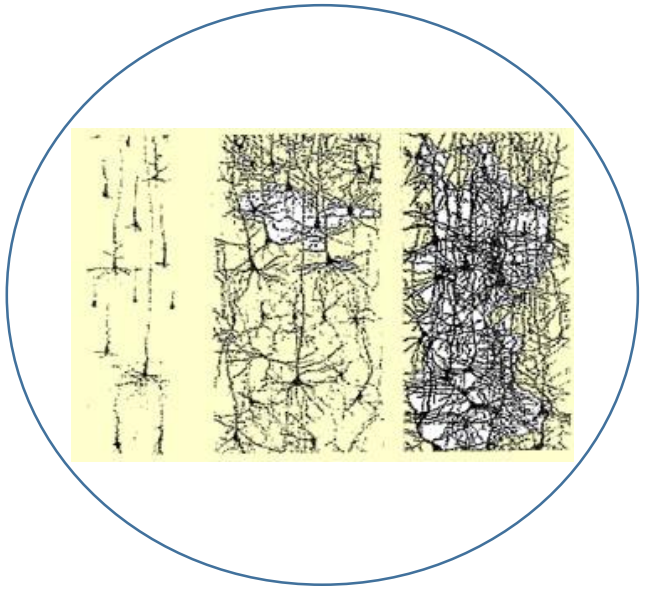
The ‘Big Bang Theory’ of First 1,000 Days



Medicaid payment and delivery system reform created forum for discussing long-term value of investing in young children

Growing knowledge of ‘brain science’ and ACEs led to recognition of ages 0 – 3 as window of opportunity

Local collective impact efforts demonstrated cross-sector work and importance of policymakers learning from the field

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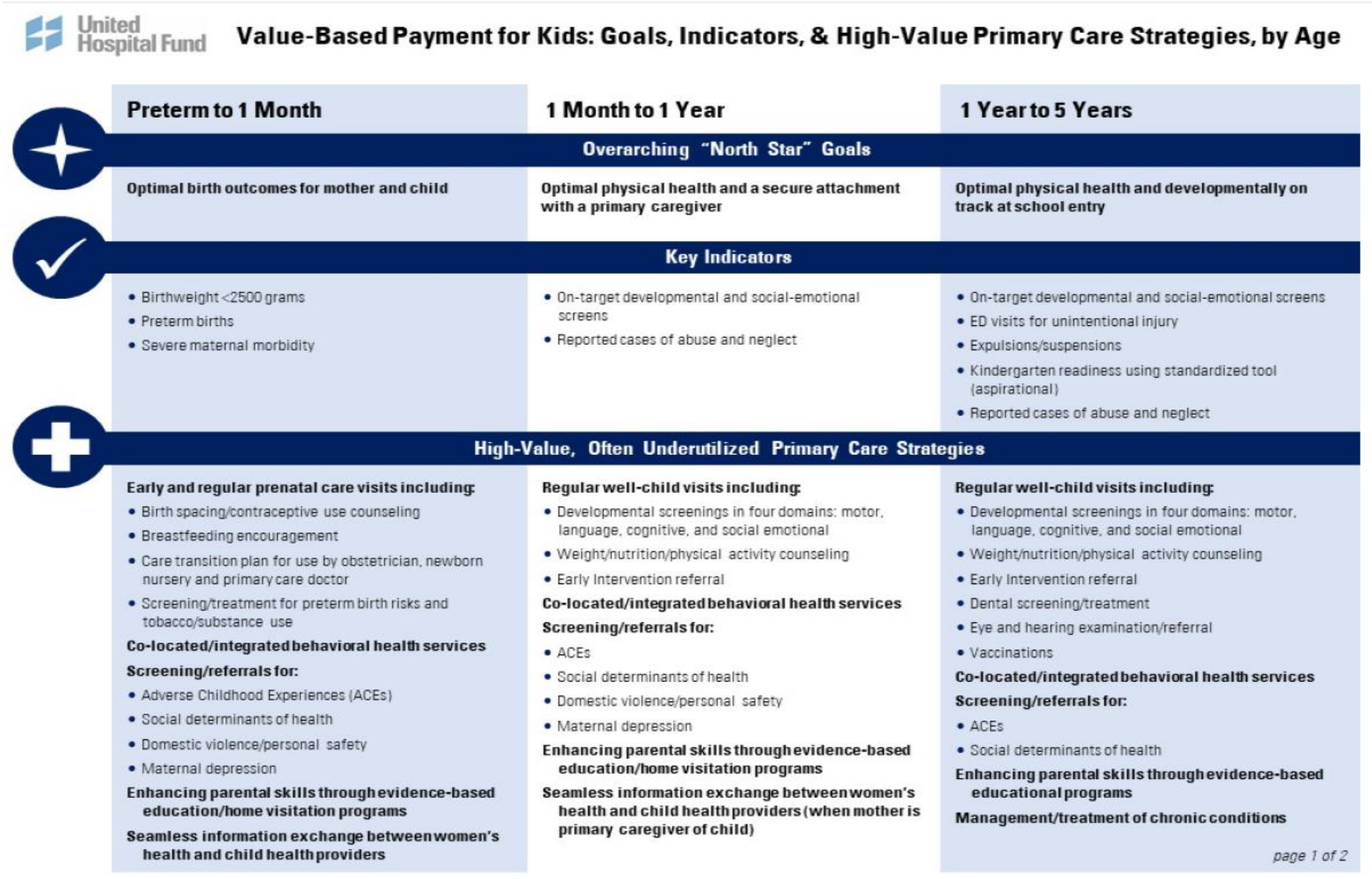
System Reform Efforts Need Intentional Focus on Kids

- Adults account for most expenditures, so have been focus of payment reform.
- Children perceived as inexpensive, mostly healthy.
- Risk of system redesign that ignores children.

The Precursor to First 1,000 Days

- **Consensus on desired outcomes for young children, and recognition that they are cross-sector in nature – esp. with education**

- **Recognition Medicaid is uniquely positioned for impact, but must include focus on social needs and parent supports**



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Value-Based Payment for Kids: Goals, Indicators, & High-Value Primary Care Strategies, by Age

	Preterm to 1 Month	1 Month to 1 Year	1 Year to 5 Years
Overarching "North Star" Goals	**Optimal birth outcomes for mother and child**	**Optimal physical health and a secure attachment with a primary caregiver**	**Optimal physical health and developmentally on track at school entry**
Key Indicators	• Birthweight <2500 grams • Preterm births • Severe maternal morbidity	• On-target developmental and social-emotional screens • Reported cases of abuse and neglect	• On-target developmental and social-emotional screens • ED visits for unintentional injury • Expulsions/suspensions • Kindergarten readiness using standardized tool (aspirational) • Reported cases of abuse and neglect
High-Value, Often Underutilized Primary Care Strategies	**Early and regular prenatal care visits including:** • Birth spacing/contraceptive use counseling • Breastfeeding encouragement • Care transition plan for use by obstetrician, newborn nursery and primary care doctor • Screening/treatment for preterm birth risks and tobacco/substance use **Co-located/integrated behavioral health services** **Screening/referrals for:** • Adverse Childhood Experiences (ACEs) • Social determinants of health • Domestic violence/personal safety • Maternal depression **Enhancing parental skills through evidence-based education/home visitation programs** **Seamless information exchange between women's health and child health providers**	**Regular well-child visits including:** • Developmental screenings in four domains: motor, language, cognitive, and social emotional • Weight/nutrition/physical activity counseling • Early Intervention referral **Co-located/integrated behavioral health services** **Screening/referrals for:** • ACEs • Social determinants of health • Domestic violence/personal safety • Maternal depression **Enhancing parental skills through evidence-based education/home visitation programs** **Seamless information exchange between women's health and child health providers (when mother is primary caregiver of child)**	**Regular well-child visits including:** • Developmental screenings in four domains: motor, language, cognitive, and social emotional • Weight/nutrition/physical activity counseling • Early Intervention referral • Dental screening/treatment • Eye and hearing examination/referral • Vaccinations **Co-located/integrated behavioral health services** **Screening/referrals for:** • ACEs • Social determinants of health **Enhancing parental skills through evidence-based educational programs** **Management/treatment of chronic conditions**

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The First 1,000 Days: Rationale As Presented to Public

Point 1: A child´s brain develops rapidly in the first 3 years of life, and we now know what kinds of interventions can help or hinder this process.

Point 2: Early experiences´ effect on the brain and body partially explain significant disparities in health and learning by school entry – especially for children living in poverty.

Point 3: These early experiences have serious, long–term consequences for children in the education pipeline. And it's our collective responsibility to fix this.

Point 4: Medicaid has a big role to play.

Brain Science, Sector Alignment, and Health Equity

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NEW YORK STATE | Department of Health | Medicaid Redesign Team

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Long-term Goal

All children in New York are well and thriving

Desired Outcomes for Children Ages 0 - 3

Optimal birth outcomes for mother and child

Secure caregiver-child attachment established by age 1

Optimal physical health and developmental trajectory (motor, language, cognitive, and social-emotional) by age 3.

Primary Drivers for Brain Development and Lifelong Health

Stable, responsive, and nurturing caregiving early in life lays the groundwork for the development of a wide range of basic biological processes that support emotion regulation, sleep-wake patterns, attention, and ultimately all psychosocial functioning.

Access to comprehensive, patient-centered medical care for pregnant women and children can help prevent threats to healthy development as well as ensure correction and/or management of health problems.

Sound and appropriate nutrition is essential at every stage of the life course, beginning with the mother's pre-conception nutritional status, extending through pregnancy to early infant feeding and weaning, and continuing with diet and activity throughout childhood.

Safe environments, free from toxic chemicals and toxic stress, are necessary for protecting children's immediate physical well-being as well as their future health and development.

Source: NYS Children's VBP Subcommittee and Clinical Advisory Group

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Source: Harvard Center on the Developing Child (2010). *The Foundations of Lifelong Health Are Built in Early Childhood*. Retrieved from www.developingchild.harvard.edu.

Medicaid Aligning With Other Sectors

Approach	In Practice
Leadership can demonstrate collaboration	Health and education leaders appear together; Medicaid Director invited education leaders to chair the initiative
Medicaid efforts can focus on common cross-sector outcomes of interest	Recognize Medicaid contributions to education outcomes; strive for common/joint quality measures like school readiness
Other sectors can be invited into Medicaid policy deliberations	All First 1,000 Days proposals related to workgroups/committees include a requirement that there be cross-sector participation
Learn from collective impact networks	Policy changes at the state level will be informed by what works in local communities when sectors partner together
Require cross-sector participation in Medicaid funded pilots	Proposals ranked in part on All First 1,000 Days pilot funding likely to be contingent on commitment to cross-sector community participation; Collective impact training likely to be offered to Medicaid pilot sites
Use all available Medicaid levers	Helped people brainstorm how all Medicaid levers could be used to achieve a certain aim – see next slide.

NEW YORK STATE | Department of Health | Medicaid Redesign Team

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pK-12 Education Levers

- Provider of pre-kindergarten services (3- and 4-year-old seats)
- Compulsory education beginning at age 5
- Student achievement data
- Regulatory and State-level policy

Higher Education Levers

- Largest provider of post-secondary opportunity
- Reconnection efforts (EOC, non-credit/degree programs)
- Workforce development & credentialing
- State-level policy

Healthy and Ready Children and Families

Social Service Provider Levers

- Largest provider of family support services
- Family income support
- Connection to child & family services
- State-level policy

Medicaid Levers

- Medicaid payment and incentives
- Quality improvement infrastructure
- Medicaid managed care contracts
- Non-federal regulatory changes
- Enabling innovation through pilots and more
- Continuity of health coverage
- Convening power
- Provider and Community Education

Medicaid Provider Levers

- Continued access to children and families during key years (0-5)
- Ability to influence family decision-making
- Connection to child & family services
- Patient data
- Practice-level policy

Approach to High Risk, High Need Families

- Goal was broad population level improvement in child health and development: *"Moving upstream to prevent future super–utilizers“*
- Initial phase recommendations focused on the large majority of children ages 0–3 not already receiving specialized services (e.g., OPWDD, children with medically complex conditions);
- Overall initiative tied to reducing education inequities
- Included disparity reduction in impact criteria
- Recommended targeting certain pilot efforts in communities with poorest birth outcomes: Centering Pregnancy; Home Visiting
- Incorporated charge to develop risk stratification approach to the statewide home visiting proposal

Effective Approaches

Enablers of Success

- Innovative and collaborative education and health leaders
- Exposing leadership to local cross-sector efforts
- Engaging in value-based payment discussions and pointing to need for long-term and cross-sector outcomes
- Inviting and listening to broad group of stakeholders who became ambassadors for early childhood investment
- Willingness of State to partner externally and availability of non-state organizations to lead process and write policy proposals
- Including "degree of cross-sector collaboration" as proposal criteria
- Being comfortable with “seed investments”

Appendix

Voting Structure

Part 1: Scoring based on five criteria areas:

- Affordability
- Cross-sector
- Feasibility
- Evidence-base
- Overall Impact

Part 2: Ranking of proposals in order of preference

Voting Tool in Context

- In August 2018, the workgroup collectively identified 44 discrete problems to be addressed across 8 domains of early childhood
- Hundreds of comments on those problems began to identify potential solutions and raised new problems for consideration
- That feedback was compiled into 14 broad issue areas, many containing multiple potential solutions, presented back to the workgroup in September 2018
- Another round of workgroup comments on the 14 approaches resulted in 23 detailed policy proposals which were presented to the workgroup in November 2018
- Proposals were subsequently amended based on feedback
- Workgroup members then scored the 23 proposals based on five criteria, and ranked the 23 proposals in order of preference
- The top ten proposals were recommended to the Medicaid program in December 2018 for implementation.

Criteria: Affordability

Costs – Defined as amount of state Medicaid dollars ("Total Cost (State)" in proposals) necessary to implement a proposal.

Score 1-5 based on…

1) Proposal costs more than $2,000,000
2) Proposal costs between $1,000,000 and $2,000,000
3) Proposal costs between $500,000 and $1,000,000
4) Proposal costs less than $500,000 but is not cost neutral
5) Proposal has no cost or cost is negligible

Criteria: Feasible

Feasibility – Defined as the complexity of implementation considering the amount of time necessary to implement, and the scope of the approvals and system changes necessary for implementation. Note that the top of each proposal indicates whether the implementation timeline is short-term or long-term. This reflects an estimate of how long it would take to move from concept to implementation of the proposal. Short-term was defined as less than six months. Long-term was defined as six months or more.

Score 1-5 based on…

1) Proposal is HIGHLY UNLIKELY to be successful due to known potential implementation barriers
2) Proposal is PROBABLY UNLIKELY to be successful due to known potential implementation barriers
3) Proposal is LIKELY to be successful and could move from concept to implementation over a ***medium- to long-term*** time period
4) Proposal is LIKELY to be successful and could move from concept to implementation over a ***short-term*** time period
5) Proposal is EXTREMELY LIKELY to be successful, regardless of the time it might take to move from concept to implementation

Criteria: Cross-Sector

Cross Sector – Defined as the scale and scope of cross-sector collaboration inherent in the implementation of a proposal. Cross-sector can be both at the system level (multiple state agencies and offices working together), and at the community implementation level (for example, health care providers working with community based organizations or other non-health service providers e.g., early education). Potential cross-sector *outcomes* are not to be included in your assessment.

Score 1-5 based on…

1) Recommendation does not have a clearly specified cross-sector component and could inadvertently create new barriers to future cross-sector collaboration
2) Recommendation does not have a clearly specified cross-sector component, but the door remains open to identifying useful cross-sector collaboration during implementation
3) Recommendation has clearly identified cross-sector component with at least one non-Medicaid sector and/or is SOMEWHAT likely to encourage cross-sector collaboration during implementation
4) Recommendation has clearly identified cross-sector component with at least two non-Medicaid sectors and/or is VERY likely to encourage cross-sector collaboration during implementation
5) Recommendation has clearly identified cross-sector component with at least two non-Medicaid sectors and/or is EXTREMELY likely to encourage cross-sector collaboration during implementation

Criteria: Evidence-Based

Strength of Evidence – Defined as the quality of the evidence-base regarding effectiveness (improved outcomes and/or return on investment) supporting the proposal or the specific intervention(s) that could be implemented under the proposal.

Score 1-5 based on…

1) No peer-reviewed or other type of evidence is available to support the effectiveness of the recommendation
2) Some peer-reviewed evidence exists on this strategy, but the conclusions are mixed in terms of its effect on outcomes
3) Limited peer-reviewed evidence or non-peer reviewed publications/evidence (e.g. implementation in other states) suggests potential for effectiveness
4) Peer-reviewed evidence suggests strategy would improve outcomes but not necessarily any return on investment (or if proposal is not for a specific intervention, the proposal would significantly enable adoption of evidence-based strategies that improve outcomes)
5) Peer-reviewed evidence suggests both improved outcomes and return on investment (or if proposal is not for a specific intervention, the proposal would significantly enable adoption of evidence-based strategies that improve outcomes and result in a return on investment)

Criteria: Overall Impact

Overall Impact – Taking into account all other criteria and additionally considering the broad effect on the health and development of all children on Medicaid (e.g., the number of children that would be reached), and the impact on child-serving professionals (inclusive of, but not limited to, health care providers). Also consider any other factors that would affect quality of care and reduction of disparities for children on Medicaid.

Score 1-5 based on…

1) The overall effect will negatively impact children and/or child-serving professionals
2) The overall effect will have no impact on children and/or child-serving professionals
3) The overall effect will have a moderately positive impact on children and/or child-serving professionals
4) The overall effect will have a significantly positive impact on children and/or child-serving professionals
5) The overall effect will have a significant positive impact on children and/or child-serving professionals and will catalyze broader positive system change(s)