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Charles Bruner, Child and Family Policy Center, December 7, 2015

As Iowa seeks to become the "healthiest state in the nation," achieving this goal over the long-term will require that Iowa produce the "healthiest kids in the nation." This will not occur without explicit recognition to the fact that children's health services need to address child needs as growing and developing beings – physically, socially, emotionally, and cognitively. While one can think of adult health services from a health maintenance and health wellness perspective, child health services also must give attention to ensuring healthy developmental trajectories, including prevention and early identification and response, and to do so, particularly with young children, from an ecological, family-centered perspective.

The key to ensuring that children receive the health services they need to establish positive health trajectories requires explicit attention to and direction from the state within the contracts, oversight, monitoring, and review it does of managed care or accountable care organizations. This contracting must recognize that the incentives that work to maintain health in the adult population will not work for the child population.

Managed care organizations often are provided substantial incentives to better manage chronic health conditions among adults and maintain levels of functioning so that high cost medical interventions are less needed. The payoffs in terms of reduced uses and expenses of high cost medical services are immediate and within the contract period, providing an incentive for such management.

The same is not true for children. Children are not major users of high cost health services today, although they are setting health trajectories which will determine how much they become drivers of health and other costs in the future. The Early, Periodic, Screening, Diagnosis, and Treatment provision (EPSDT) within Medicaid recognizes that children have broader needs – and that providing for them has long-term health benefits even if this does not result in immediate health costs savings.

As Iowa develops any managed care relationships for the provision of health care for children (and sixty percent of the Medicaid and hawk-i population is children and Medicaid and hawk-i provide health coverage for nearly two in five Iowa children), the contract itself needs to ensure that MCOs:

- meet evidenced-informed guidelines for well-child care;
- ensure that practitioners participate and are provided sufficient reimbursement to provide for that well-child care;
- be concerted in providing EPSDT services known to improve health trajectories (whether or not there are immediate cost savings); and
- provide sufficient incentives and monitoring and sanctions to guide MCO activities to these ends.

Iowa does not need to start from scratch in this respect; it can draw upon other states' experiences in constructing such contractual expectations and the metrics for their oversight. It also can and should draw from and build upon its own experiences with EPSDT Care for Kids program and with First Five.

While MCOs may recognize the long-term benefits of providing more preventive and developmental health services and supports for children, they will not be able to pursue those unless their contracts are clear and set expectations and provide fiscal incentives and sanctions that are appropriate to providing that care.

It is in the first years of life, not the last, that health practitioners have the greatest impact upon health – in setting positive health trajectories. Without explicit and concerted attention to developing contracts and payment systems that recognize this fact, however, the movement to managed care could actually reduce the likelihood that health practitioners will play this important role.

CFPC would call upon the Committee and the Department to place much more emphasis upon child health – and particularly primary health care – in developing Iowa's health care system, whether through managed or accountable care or other vehicles. CFPC can provide more detail on how this can be done – and how the federal SIMs grant can play a particular role in bringing expertise to bear in doing this. To fail to do so would be to neglect the very population within Iowa's Medicaid system that can most contribute to Iowa's goals for being the "healthiest state in the nation."

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The following are beginning recommendations for inclusion into MCO contracts to ensure children are provided with access to the high-quality care that will set them on a path to become healthy, productive adults. CFPC can provide additional specific language on these and recommend experts in this area to inform Iowa's work.

- **Explicit guidance regarding the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit should be clearly outlined in the contract between the State and the managed care organizations (MCOs).**
    - The EPSDT benefit is designed to ensure that eligible children receive early detection and preventive care, so that health problems are averted or diagnosed and treated as early as possible.
    - Particularly for young children, services covered under this benefit need to include services directed to strengthening the child's home health and safety environment and parental ability to effectively meet children's developmental health needs. Contractors should be required to cover case management and targeted case management services designed to assist children in gaining access to necessary medical, social, education, and other services.
- **All MCOs should be required to use the same definition and criteria for determining pediatric medical necessity and the state should retain close oversight of this provision.**
    - An enhanced definition for pediatric medical necessity should be considered (as recommended by the American Academy of Pediatrics): "health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals, such as the AAP, to

promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, behavioral, or mental conditions, injuries, or disabilities."

- Coverage for treatment interventions that promote family driven and family centered care and habilitative services for children is vital.

- **MCOs should leverage the strength and success of existing initiatives (e.g. the 1st Five Healthy Mental Development Initiative, Title V Maternal and Child Health care coordination services, the EPSDT Care for Kids Program and its coordinators, etc.)**
  - Programs like the Iowa Department of Public Health's 1st Five Healthy Mental Development Initiative have demonstrated success in both identifying and responding to family stress, instability, and inconsistent home environments—all of which have a significant impact on children's healthy development. These initiatives have the necessary infrastructure, expertise, capacity, and relationships to provide services that promote optimal health for children. As such, these existing initiatives should continue to be supported and expanded into mainstream and routine practice.
  - The EPSDT Care for Kids Program and its coordinators play a key role in assisting children and their families in understanding and accessing primary, preventive, and developmental health services and securing family-centered health homes. Care coordination is needed at this level for all children enrolled in Medicaid or hawk-i.
- **Quality measures should be used to incent high-quality pediatric care. The quality measures under the Pay for Performance program should be expanded to include a more comprehensive set of pediatric-specific measures.**
  - Many of the proposed measures (e.g. well-child visit rates) are process measures. These existing process measures should be paired with outcome measures that better reflect pediatric wellness. The standard for primary care, as set forth in *Bright Futures*, goes well beyond a periodicity schedule to set out expectations for developmental screening and surveillance and anticipatory guidance.
  - Particularly for very young children, the key to healthy development is a safe, consistent, and nurturing home environment which responds to children's developmental needs. This represents a health goal and outcome for young children that deserves measurement and focus.
- **Network adequacy provisions should have specific components to ensure network adequacy for primary pediatric providers, including family practitioners, and pediatric specialists.**
  - Network adequacy for primary pediatric care requires that virtually every primary practitioner serving children is part of the network.
  - Since most of the services provided to children are not high cost services, network adequacy also requires that there be simplicity and greater uniformity across managed care entities in defining, establishing protocols for, and reimbursing services. The state needs to create standards in its contacts so that practitioners do not have to contour individual primary practice elements (such as well-child, EPSDT, and screening visits and activities) based upon what MCO is covering the child.

- **The provision of culturally and linguistically responsive services should be ensured. Expectations and incentives should be incorporated into managed care contracts to ensure the provision of translations services, the capacity to communicate with families who speak a language besides English, and the ability to understand and respond to health needs of their children in the context of the family's own cultural beliefs and practices.**
    - Children are the most diverse age group in Iowa and a large share of these children come from different cultural and linguistic backgrounds, many where English is a second language.