Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed Care
http://www.Medicaid.la.gov/assets/HealthyLa/MEDICAID_MCO_RFP_WP.pdf
Due by April 17, 2018 to healthy@la.gov

Background:
Over the past six months, the Office of Public Health-Bureau of Family Health has been engaged in a consultative process with Johnson Group Consulting on maternal and child health policy services at the request of Secretary Gee. We welcome the opportunity to meet with Medicaid to discuss these suggestions in more detail. The following is a response to the Healthy Louisiana White Paper provided by the Office of Public Health – Bureau of Family Health with technical assistance from Johnson Group Consulting (led by Kay A. Johnson, MED, MPH, President http://johnsongci.com).

Overview: Building on Louisiana Capacity & Priorities
The Louisiana Department of Health (LDH), Medicaid agency (Bureau of Health Services Financing) provides health coverage for more than 734,000 children. Given the level of poverty among families with children, 60% of all children in Louisiana are covered by Medicaid, including more than half of children with special health care needs (CSHCN). This means the state has an extraordinary opportunity to invest in a lifetime of health and well-being by getting young children off to a strong start.

Louisiana Medicaid is seeking public input as the state moves to improve its managed care program in order to achieve the "triple aim" of better care for individuals, better health for the population overall, and lower costs. As Medicaid prepares for release of a Request for Proposals (RFP) from qualified Managed Care Organizations (MCOs) to provide healthcare services for Medicaid enrollees participating in the Healthy Louisiana program, this is an important opportunity to strengthen the health and development of young children.

The Healthy Louisiana Program should aim to achieve an array of results, including: a patient-centered medical home for all Medicaid recipients; improved coordination of care; increased quality of care as measured by standard metrics; better health outcomes; greater emphasis on disease prevention and management of chronic conditions; earlier diagnosis and treatment of both acute and chronic illness; improved access to essential specialty services; outreach and education to promote healthy behaviors; a reduction in avoidable hospital stays; and cost savings to the state.

Better serving young children is part of achieving each of these aims for today and for decades to come. Studies show a strong return on investment for using evidence-based practices and professional standards of care to deliver: high performing pediatric medical homes, developmental screening and interventions to address risks among young children, home visiting for high risk families during pregnancy and early childhood, and early childhood mental health interventions. With high performance in the health care system and effective implementation of the American Academy of Pediatrics Bright Futures guidelines for well-child care, Louisiana can reduce unnecessary chronic illness and disability in childhood, with reductions in associated health and educational costs, as well as improve health and well-being for the life span of the child.

Building on research, existing systems, and provider capacity, the following recommendations define the key next steps for Louisiana Medicaid:

1. Improve performance of pediatric medical homes (corresponds to section "h")
2. Adopt tiered reimbursement for case management (corresponds to section "h")
3. Increase use of developmental screening (corresponds to section "b")
4. Increase access to developmental supports among young children who have problems and risks identified in developmental and related screening (corresponds to sections "b", "c" and "h")
5. Finance additional home visiting capacity (corresponds to sections "b" and "g")

6. Increase access to early childhood mental health services (corresponds to sections “b”, “g” and “h”)
7. Adopt a shared measurement and accountability framework for perinatal and early childhood services (corresponds to section “g”)

For each of these areas of recommendation, the Title V/Title XIX Coordination Workgroup has begun to define specific action steps to be taken in terms of: 1) Medicaid policy and procedures, 2) RFP and MCO contract language, 3) quality improvement activities, and 4) potential implementation support from the LDH Office of Public Health - Bureau of Family Health. The current draft of the proposals that the group has worked on are included below. We welcome the opportunity to discuss and to continue to refine together with you. Thank you for your time and consideration.

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White Paper Feedback: Improve Care Management/Care Coordination

Improve Performance of Pediatric Medical Homes

Recommendations: Define high performing pediatric medical homes, select performance measures, and incentivize practices and clinics to deliver quality services and high performance. For example:

- *Medicaid policy and procedures*
  - Define high performing pediatric medical homes (provider definition, criteria and qualifications).
  - Specify performance measures (see Table 1).
- *RFP and MCO contract language*
  - Incentivize practices and clinics to deliver quality services and high performance.
    - State offer performance bonuses or other incentives (e.g., enrollment) to MCOs (see measures).
    - MCOs offer performance bonuses or other incentives to providers for demonstrated high performance in pediatric medical home.
  - Offer opportunities to pilot test value-based purchasing approaches designed for child health.
- *Quality improvement activities*
  - Conduct quality improvement projects that support provider practice change.
  - Within their plans and networks, MCOs can incentivize Medical Home transformation for children by:
    - Incentivizing NCQA certifications (or other evidence based certification programs).
    - Make greater use of Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH).
    - Incentivizing the use of national, standardized CSCHN screening tool (five questions).
- *Implementation support from the Bureau of Family Health, OPH, LDH*
  - Provide technical assistance related to pediatric medical home and implementation of Bright Futures guidelines.

Table 1. High Performing Pediatric Medical Homes for Infants and Young Children

High rates of access to care*
High percentage of children receiving well-child visits*
High rates of children who are up-to-date on immunizations*
High performance on developmental screening measure*
Satisfaction with the experience of care as measured with the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H*
Use of CSCHN screener
High rates of maternal depression screening
Low rates of unnecessary emergency department visits*
High performance on measure for weight assessment and counseling*
Family engagement demonstrated through use of recommended Bright Futures pre-visit tools or the electronic Well-Visit Planner
Plus documentation of additional resources provided in practice (e.g., Reach Out and Read, integrated mental health, Healthy Steps model, Project DULCE model)

*Medicaid-CHIP Core Measure: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html Child health quality core measurement set for 2018. https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-core-set.pdf

Background and rationale: Pediatric primary care providers (e.g., pediatricians, family physicians and nurse practitioners) are the primary professional point of contact for children under age 3, with 9 out of 10 young children seeing a health provider for a well-child preventive visit annually. These are critical opportunities for improving health outcomes during childhood and for a lifetime. Operating as a high performing medical home, pediatric primary care providers can better achieve the triple aim of improving the quality and experience of care for the individual, improving the health of populations, and reducing the cost of health care.

The American Academy of Pediatrics (AAP), the Maternal and Child Health Bureau, Health Resources and Services Administration (MCHB-HRSA), and the Centers for Medicare and Medicaid Services (CMS) all recommend that each child have a patient/family centered medical home. An increasing body of research identifies the key characteristics of a pediatric medial home.

Quality improvement and measurement activities can accelerate practice change. States such as Oregon have demonstrated the role of quality improvement and measurement activities for increasing developmental screening rates. In Cincinnati, for example, adopting a pediatric primary care bundle and using quality improvement approaches led to significant improvements in practice—from 58% to 92% of visits where full bundle of preventive services was received for patients 0 to 14 months of age, with sustained the improvement for over 1 year.

Practice redesign and transformation is a trend, with exemplary practices nationwide. For example, many pediatric primary care practices are augmenting their services or increasing linkages with other community providers to better address risks and concerns related to child development, emotional-behavioral factors, or social determinants of health. Evidence-based models to augment primary care—such as Reach Out and Read, Healthy Steps, Project DULCE, and integrated mental health—are being used in thousands of practices across the nation.

White Paper Feedback: Improve Care Management/Care Coordination

Adopt Tiered Reimbursement for Case Management

Recommendations: Define and structure Medicaid risk-stratified, tiered (e.g., basic, moderate, and intensive) levels of care coordination/case management.

- *Medicaid policy and procedures*
  - Define three levels of care coordination/case management.
  - Turn on billing codes for three levels of care coordination.
- *RFP and MCO contract language*
  - Describe three levels of care coordination/case management in managed care contracts.
- *Quality improvement activities*
  - Use the national, standardized CSCHN screening tool (five questions) to identify children who would qualify for more intensive care coordination based on special needs and overall health status.
  - Pilot algorithms or criteria for medical complexity, developmental status, and/or psychosocial risk among children and their families.
- *Implementation support from the Bureau of Family Health, OPH, LDH*
  - Provide technical assistance related to CSCHN screening tool.
  - Provide technical assistance related evidence-based care coordination models for CHSCN, including physical, mental, and developmental conditions.

Background and Rationale: Research shows that care coordination/case management is positively associated with whether or not a child receives the care they need for physical, mental, and developmental conditions. Study after study has shown that when a problem is suspected, young children often fall into the gaps between different health care providers, and systems for mental health, child development, and early childhood education. Moreover, many see care coordination/case management as a key metric in managed care because it can drive toward cost savings and may be associated with improved health outcomes and appropriate services utilization.

The terms "care coordination" and "case management" are both used, often interchangeably to describe a set of activities in child and family health, used to promote optimal access to a range of services and supports. Notably, while the American Academy of Pediatrics and other child health leaders generally use the term care coordination, Medicaid traditionally finances under the case management benefit. One type of care coordination/case management is for those with health conditions in "normal range," designed to reduce barriers related to language, health literacy, culture, geographic access, economic and social environments, etc. For those with special health needs, care coordination provides additional help navigating health care system and communicating with multiple providers. For some families a combination of medical and social needs call for more intensive case management.

While the definition of a medical home includes some level of care coordination, and most pediatric primary care providers want to be a medical home for their patients, the cost of more intensive care coordination is substantial. National recommendations and research point to the importance of varied types or levels of care coordination/case management, within and/or outside of the medical home. Some states (e.g. New Mexico) are using three levels of tiered case management in Medicaid managed care. Some states use algorithms or criteria for medical complexity, developmental status, and/or psychosocial risk among children and their families.

White Paper Feedback: Expect MCOs to Operate as Innovators to Achieve the Triple Aim

Increase use of Developmental Screening

Recommendations: As part of pediatric primary care, Medicaid can improve use of developmental screening that fits with the national standard of care.

- *Medicaid policy and procedures*
  - Adopt and report on CMS Medicaid/CHIP developmental screening measure.
  - Adopt appropriate codes for measurement reporting.
  - Shift to collecting and reporting data from providers/plans, not just a sample.
- *RFP and MCO contract language*
  - Require plans and their providers to use of the CMS Medicaid/CHIP developmental screening measure (with appropriate codes for measurement reporting).
  - Recommend use of validated tools as specified in the *Louisiana Developmental Screening Guidelines*.
  - In developmental screening measure in pediatric medical home performance.
- *Quality improvement activities*
  - Medical homes /pediatric primary care to adopt more comprehensive screening approach including for general development, social-emotional development, special health care needs, maternal depression, and social determinants of health (convened by Bureau of Family Health).
- *Implementation support from the Bureau of Family Health, OPH, LDH*
  - Convene QI collaborative(s) on developmental screening.
  - Maintain and update *Louisiana Developmental Screening Guidelines* and list of recommended tool.

Background and rationale: For decades, developmental screening for young children has been a standard of care in pediatrics, and it is a required component of the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) child health benefit. Since developmental risk is correlated with poverty, attention to screening is particularly important for young children in Medicaid. Without support for practice change, pediatricians may face challenges in implementing recommended screening. While Louisiana is using the recommended periodicity schedule for developmental screening, data indicate that a majority of pediatric primary care providers are not performing according to the national standard of care. A majority (63%) of Louisiana children ages 10-71 months do not receive developmental screening.

In recent years, many state Medicaid agencies have succeeded in increasing developmental screening by using guidelines, quality improvement projects, and incentives for pediatric primary care providers. States such as North Carolina use Medicaid policy coupled with quality improvement collaboratives to create significant increase in screening. Oregon has led the way in improving and measuring performance. Best practices from the past 20 years of focus on developmental screening in Medicaid include the following:

- Require use under EPSDT of the American Academy of Pediatrics Bright Futures recommended periodicity schedule and guidelines for well child visits (*done currently in Louisiana*).
- Recommend or require age-appropriate, validated screening tools in EPSDT rules or contracts.
- Adopt the available billing codes and communicate them to plans and providers.
- Use the national Medicaid developmental screening measure.
- Expand payment to include enhanced pediatric primary care screening (e.g. social-emotional, maternal depression, SDOH and ACE), including screening delivered on the same day as the well-child visit.

- Clarify that EPSDT interperiodic visits (as defined in federal law) are permitted for developmental screening when parents or other providers have concerns about development.
- Permit separate billing for screenings.
- Use performance incentives (financial and non-financial) for pediatric primary care providers and/or health plans.

White Paper Feedback: Expect MCOs to Operate as Innovators to Achieve the Triple Aim & Improve Care Management/Care Coordination & Enhance Network Adequacy and Standards

Increase Access to Developmental Supports among Young Children who have Problems and Risks Identified in Developmental and Related Screening

Recommendations: Use administrative levers, interagency collaboration, and Medicaid managed care plans to improve referrals, provider capacity, and efficiency.

- *Medicaid policy and procedures*
  - Adopt/assign billing codes for developmental specialist in pediatric primary care (can be done without adjustment to Fee Schedule.
- *RFP and MCO contract language*
  - Encourage/pay for use of staff in the pediatric primary care/medical home to provide/augment developmental services and supports (e.g. CSHCN coordinators/ specialists and Healthy Steps specialists).
  - Specify providers and EBP models approved by Medicaid.
- *Quality improvement activities*
  - Medical homes/pediatric primary care may pilot approaches for increasing completed referrals to Early Steps when children have an adverse developmental screen result.
- *Implementation support from the Bureau of Family Health, OPH and OCDD*
  - Conduct interagency projects between Medicaid, Part C Early Intervention (Early Steps), Bureau of Family Health to implement best practices from other states.

Background and rationale: While research demonstrates that the earlier interventions are begun for children the greater the effect and that those early interventions have a substantial return on investment, there are substantial numbers of missed opportunities in every state for preventing disability and its long-term costs. Medicaid, special education, and other public programs often pay the lifelong costs incurred as a result of such missed opportunities to optimize development, improve health, and reduce disability.

Children with confirmed disabilities—physical, developmental, or mental—generally qualify for programs that support their families' efforts to care for them. In particular, Medicaid, the Supplemental Security Income and associated Medicaid eligibility, the Individuals with Disabilities Education Act (IDEA) Part C Early Intervention for Infants and Toddlers and Part B Special Education for children 3 to 21, and the Maternal Child Health Block Grant Title V Children with Special Health Care Needs (CSHCN) programs operate in every state. Medicaid plays a particularly important role, financing for services to children with severe disabilities or chronic medical conditions, including those in IDEA and Title V CSHCN programs.

At the same time, intervening for an estimated 10-15% of young children who have developmental risks or mild-to-moderate delays is important for reducing long-term disability and costs. In many states, more than one-third of children with identified developmental concerns do not qualify for Part C.

Building developmental services capacity in the pediatric primary care, medical home is a highly promising strategy. Typically, this is done by adding a staff person who has developmental knowledge and clinical skills. Evidence-based models such as Healthy Steps have been implemented across the country. In addition, Louisiana has developed and evaluated a model for adding specialists who identify, support, and assist with care coordination for CSHCN.

In many states, Medicaid has developed partnerships with Part C and Title V maternal and child/family health programs to maximize the funds and improve outcomes. Medicaid financing is used by virtually all states to finance a portion of Part C Early Intervention services. Making referrals, service delivery, and payment practices efficient and effective helps to reduce the costs and improve outcomes. Projects

across the country have demonstrated ways to streamline administrative practices, achieve cost efficiencies, maximize available providers, and better serve families with young children.

White Paper Feedback: Improve Care Management/Care Coordination & Promote Population Health

Finance Additional Home Visiting Capacity

***Recommendations*:** Use of a Medicaid State Plan Amendment (SPA) for the Targeted Case Management benefit to finance Nurse-Family Partnership (NFP) services. Targeted Case Management gives the state levers to contain costs, specify populations, and target areas. This approach would augment capacity and current spending under the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program and federal Early Head Start.

- *Medicaid policy and procedures*
  - Renew Medicaid State Plan Amendment (SPA) using the Targeted Case Management benefit to finance Nurse-Family Partnership (NFP) services.
  - Adopt/assign billing codes.
- *RFP and MCO contract language*
  - MCOs that want to provide HV under SPA must subcontract with the states' NFP (Louisiana MIECHV/BFH-OPH-LDH) program as the provider.
  - Specify providers and models approved by LDH.
- *Quality improvement activities*
- *Implementation support from the Bureau of Family Health, OPH, LDH*
  - Shift MIECHV resources from NFP to Parents As Teachers (PAT) or other Evidence Based Home Visiting models.
  - Continue to collaborate with MCOs on data and referrals for home visiting programs, including data arrangements with MCOs for NFP.

Background and rationale: Evidence-based home visiting has a strong return on investment, with home visiting programs such as NFP saving $5.70 per $1 invested. NFP emphasizes prevention, begins during pregnancy and has demonstrated impact on maternal and child health outcomes. Louisiana currently leverages federal MIECHV funds to implement NFP and PAT. Other home visiting models—such as federally funded Early Head Start— operate in the state. This helps Louisiana build a continuum of home visiting services that can address varied needs among higher risk families during pregnancy, infancy, and early childhood. At the same time, the National Home Visiting Yearbook estimates that more than 85,000 families have risks indicating they could benefit from home visiting.

While it cannot be blended with federal funding from the MIECHV program, Medicaid can be one among several sources of funds states use for home visiting services. After two decades of state experience using Medicaid to finance home visiting, a 2016 Joint Informational Bulletin of the Centers for Medicare and Medicaid Services (CMS) and Health Resources and Services Administration (HRSA) affirmed the flexibility and opportunity states have to do so.

> *"Medicaid coverage authorities offer states the flexibility to provide services in the home.… However, home visiting programs may include some component services, which do not meet Medicaid requirements, and may require support through other funding options.…state agencies should work together to develop an appropriate package of services... may consist of Medicaid-coverable services in tandem with additional services available through other federal, state or privately funded programs."*

Approximately a dozen states are currently using Medicaid financing for home visiting through a variety of mechanisms. In most states, home visiting services are added through a simple SPA. Other states have made home visiting part of larger Medicaid 1115 or 1915(b) waivers. The most notable and unique waiver examples already approved by CMS are in Maryland and South Carolina. States use fee-for-service, capitated, and managed care approaches.

Most states have used the Targeted Case Management benefit option to finance home visiting. While it requires that the state submit a SPA, this approach offers states flexibility and controls. Under the Targeted Case Management benefit, the state may define risk criteria for family eligibility, set provider qualifications (e.g., select models), define the structure of the service, set payment rates, and even select specific geographic areas if it so chooses. This option was originally written into federal law to permit states to target such services for pregnant women, infants, and others. It permits states to operate a targeted program that need not meet federal requirements for "statewideness" and "comparability" for Medicaid recipients.

It is important to note that no state implementing Medicaid financing for home visiting has experienced "run-away" costs, "woodworking" effects, or unexpectedly large budget impact. Not all mothers and young children enrolled in Medicaid qualify for home visiting based on model criteria, and not all of those served by home visiting would qualify for Medicaid coverage (although the majority do). Even among those who qualify for home visiting and are enrolled in Medicaid, not all will participate in voluntary home visiting.

Any state using Medicaid to finance some home visiting services must continue funding from other sources staff training, evaluation, central intake, and similar home visiting system elements. Such activities would not typically qualify for Medicaid payment, even in the health system.

White Paper Feedback: Improve Care Management/Care Coordination & Promote Population Health & Expect MCOs to Operate as Innovators to Achieve the Triple Aim

Increase Access to Early Childhood Mental Health Services

Recommendations: Use Medicaid financing to increase access to early childhood mental health services, specifically:

- Operationalize coverage for parent-child dyad therapy (billing codes, provider guidance, and reimbursement).
- Use of the DC:0-5 or DC:0-5 crosswalk by providers and to establish medical necessity and for payment and utilization review purposes.
- Approve reimbursement for early childhood mental health consultation to individual children under age 6.

- *Medicaid policy and procedures*
    - Operationalize coverage for parent-child dyad therapy (define benefit, assign billing codes, provider protocols and professional services manuals).
    - Approve reimbursement for/assign billing codes for early childhood mental health consultation to individual children under age 6.
- *RFP and MCO contract language*
    - Require MCO coverage for parent-child dyad therapy for children under age 6.
    - Add early childhood mental health consultants to provider networks and provide services individual children under age 6 (i.e., delivered by mental health professionals in settings outside of typical provider practices or clinics).
    - Encourage use of the DC:0-5 (or use the DC:0-5 crosswalk) by providers and to establish medical necessity and for payment and utilization review purposes.
- *Quality improvement activities*
- *Implementation support from the Bureau of Family Health, OPH, LDH*
    - Provide training in use of DC:0-5.
    - Provide technical assistance on early childhood mental health consultation for individual children (i.e., instruct how it is different from program consultation).

Background and rationale: Louisiana has many experts and a history of work to improve infant/early childhood mental health, in clinical and community settings. To date, however, Medicaid policy has not kept pace with national trends for financing early childhood mental health services in using more age-appropriate, evidence-based, and effective approaches. States have approached the design of early childhood mental health services and Medicaid financing in a variety of ways and Louisiana has an opportunity to make small changes that can yield large returns.

Background: States are using a variety of partnerships, mechanisms, training, and funding approaches, to increase access to early childhood mental health services. For example, in 2016, state Medicaid agencies cover early childhood mental health services delivered in the home (46 states), a primary care (45), via care coordination (44), in dyadic/parent-child treatment (38), and in early care and education (34). More than a dozen states pay for maternal depression screening during a pediatric primary care visit, with most requiring use of a validated depression screening tool.

Parent-child (dyad) treatment acknowledges that for young children, mental and behavioral concerns can best be address by treating both the parent and the child, increasing parenting capacity to be responsive, nurturing, promote positive behavior, and appropriately interact with the child. In 2016, a large majority of states (41) provided Medicaid coverage for child treatment, including 38 states that explicitly covered parent-child dyadic therapy.

Young children may not yet have clearly defined or diagnosable mental or behavioral health conditions. Instead, the youngest children may exhibit abnormal development, poor attachment to caregivers, or other early signs of serious risk. This means that age-appropriate diagnostic codes are needed for young children. The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (originally DC:0-3 and now DC:0-5) supports clinicians in diagnosing and treating mental health problems in the earliest years. Crosswalks have been developed to aid providers in this converting DC:0-5 into the diagnostic codes used for adults by most health insurance plans in order to receive compensation for their services. In some states (e.g. Florida and Minnesota), Medicaid uses several mechanisms for increasing access to early childhood mental health services, including adoption of the DC:0-5 for diagnostic purposes.

Many states have early childhood mental health consultation programs (e.g. Arizona, Arkansas, Colorado, Connecticut, and Louisiana). They use a variety of funding sources, including mental health (e.g., Project LAUNCH), child care, Title V MCH, and Medicaid dollars to fund such efforts. In 2016, 34 states reported that Medicaid paid for an early childhood mental health specialist to provide services to address a young child's mental health needs in early care and education programs. Medicaid is generally used only when the service is provided for individual children. No states are reported to cover consultation to improve program staff skills or other training.

White Paper Feedback: Promote Population Health

Adopt a Shared Measurement and Accountability Framework for Perinatal and Early Childhood Services

Recommendations: Adopt a set of perinatal and early childhood measures to monitor performance in Medicaid financed primary care, MIECHV and Medicaid funded home visiting, and other programs. Use the data and measurement framework as the basis for quality improvement projects, value-based payment approaches, and similar activities.

Rationale: State Medicaid agencies increasingly emphasize accountability, quality, and outcomes. Use of performance measures also can be part of a shared accountability, across services and systems. Louisiana has an opportunity to adopt a set of process and outcome measures to monitor the results of increased Medicaid investments in during pregnancy, infancy, and early childhood. Data on this set of measures can be collected and used to monitor the performance in primary care, home visiting, and other early childhood programs.

Background: The table below shows the alignment between measures defined in Medicaid-CHIP, MIECHV, HEDIS, and other national maternal and child health measurement sets. Many of the topics included are among the MIECHV performance measures. In addition, most are among the Title V Maternal and Child Health Block Grant national performance measures. Half are part of the Healthcare Effectiveness Data and Information Set (HEDIS) used by more than 90 percent of America's health plans to measure performance. Most are also aligned with the CMS child core measure set defined by CMS for Medicaid and the Children's Health Insurance Program (CHIP). They also align with various other maternal and child health measurement sets (e.g. Healthy People 2020 not shown here).

Table 2. Crosswalk of Select Health and Home Visiting Measures for Monitoring Perinatal and Early Childhood Health

	Maternal, Infant, and Early Childhood Home Visiting (MIECHV)	Title V Maternal and Child Health Block Grant National Measures	Healthcare Effectiveness Data and Information Set (HEDIS)	Core Set of Children's Health Care Quality Measures for Medicaid and CHIP
Preterm birth	✓	✓		Low birthweight
Prenatal care visits		✓	✓	✓
Postpartum care visits	✓		✓	✓
Contraceptive care – postpartum women			✓	✓ Child and adult sets
Breastfeeding	✓	✓		
Maternal depression screening & follow up	✓		✓	Behavioral health assessment
Well child visits first 15 months	✓	Medical home	✓	✓
Well child visits 3rd, 4th, 5th, and 6th years	✓	Medical home	✓	✓
Immunization status		✓	✓	✓
Access to primary care		Medical home	✓	✓
Developmental screening	✓	✓		✓
Lead screening			✓	
Preventive dental visit		✓	✓	✓
Safe sleep	✓	✓		
Tobacco use / cessation	✓	✓	✓	Adult set
Child injury	✓	✓		
Emergency visits	✓		✓	✓
Weight assessment and counseling		✓ (surveillance)	✓	✓
Children with special health care needs (CSHCN)		✓		
Experience of care (child and CSHCN) - CAHPS® 5.0H			✓	✓
Insurance coverage	✓	✓	(assumed)	(assumed)

Sources:

- Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program: https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting/home-visiting-program-technical-assistance/performance-reporting-and-evaluation-resources
- Pew: http://www.pewtrusts.org/en/research-and-analysis/reports/2015/10/using-data-to-measure-performance-of-home-visiting
- Title V Maternal and Child Health Block Grant program: https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalPerformanceMeasures
- Health Plan Employer Data and Information Set (HEDIS): https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/chtoolbx/measures/measure4.html Aligned with HEDIS measures from standard set HEDIS 2018. http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2018 Also see: https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/chtoolbx/measures/measure4.html
- Medicaid-CHIP: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html Child health quality core measurement set for 2018. https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-core-set.pdf Maternity/perinatal core measurement set: https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-maternity-core-set.pdf
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH) http://www.ncqa.org/hedis-quality-measurement/data-reporting-services/cahps-5-0-survey/cahps-5-0h-survey Also see: https://www.medicaid.gov/medicaid/quality-of-care/downloads/cahpsbrief.pdf And CAHPS set for Children with Chronic Conditions https://www.ahrq.gov/cahps/surveys-guidance/item-sets/children-chronic/index.html