The Engagement In Action Framework

Toward a Statewide Integrated Early Childhood Health System

Attachment E: A Starting Point Policy Playbook to Advance the Engagement In Action (EnAct!) Framework

A Collaborative Project with Mississippi Thrive! and the Child and Adolescent Health Measurement Initiative

February 2023

Foreword

"A priority for the continued work of MST is to advance policy and financing strategies recommended for the successful implementation of an integrated system approach to early childhood services for children with and without special health care needs." MST Summary Report

Throughout the Engagement In Action Framework design process specific policy levers and strategies, primarily directed at partnering with the Mississippi Division of Medicaid and Coordinated Care Organizations (who provide services to about 96% of Mississippi's children enrolled in Medicaid). State leadership structures to foster cross-agency collaboration and implementation of transformation as well as legislative proposals related to early intervention and other important policy issues were also addressed. This Attachment provides a summary of the policy levers prioritized for consideration for shorter-term action and related policy topics. This Attachment was designed for internal use but is shared here to support others wishing to advance an integrated early childhood health system and my benefit from its contents.

Table of Contents

Citation: Bethell, C, Schiff, J, Bailey, M, Levashkevich, A. Bergman, D. *The Engagement In Action Framework Policy Playbook: Toward a Statewide Integrated Early Childhood Health System*. Attachment E to the Mississippi Thrive! Summary Report. February, 2023, Retrieved [mm/dd/yy] from https://cahmi.org/docs/default-source/ms-enact-documents/attachment-e_enact

Acknowledgement: This work was initiated through a subaward from the Child Health and Development Project: Mississippi Thrive! to the Child and Adolescent Health Measurement Initiative (CAHMI) at Johns Hopkins University. In addition, a grant to the CAHMI from the Robert Wood Johnson Foundation (#79164) and in-kind resources from CAHMI enabled completion of this work. The Child Health & Development Project: Mississippi Thrive! was supported through a $17.4 million, five year (2017-2023) Cooperative Agreement grant (#UK2MC31456) from the Health Resources & Services Administration (HRSA) of the U.S. Department of Health & Human Services (HHS) to the University of Mississippi Medical Center's Center for the Advancement of Youth (UMMC CAY). The contents are those of the authors and do not necessarily represent the official views nor an endorsement of HRSA, HHS, or the U.S. Government.

For more information, please visit www.HRSA.gov

EnAct! Framework Policy Playbook Summary

CAHMI's Policy Playbook Summary Memo for consideration by the Mississippi Thrive! Team and the Early Childhood Development Coalition (December 2022)

Since April 2022, and as part of the process of defining a statewide integrated early childhood health system framework, the CAHMI facilitated a process with the Mississippi Thrive! (MST!) team and partners to identify key levers, partners and approaches related to improving early childhood preventive and developmental services and outcomes in Mississippi aligned with the emerging framework (e.g., Engagement In Action Framework). Early identification of levers led to the prioritizing of levers requiring action by the Mississippi's Division of Medicaid, specifically in how they contract with and hold accountable Coordinated Care Organizations (CCOs) (Mississippi terminology used interchangeably with national terminology, Managed Care Organizations -MCOs), who provide services to about 95% of children enrolled in Medicaid in Mississippi.

Additional policy guidance and research was also conducted related to early intervention legislation, advancing state leadership (e.g., an Office of Early Childhood, a public-private Early Childhood Development Coalition) as well as by addressing many other non-Medicaid focused policy levers. While a comprehensive scan of the policy landscape in Mississippi was conducted to understand the range of policies impacting the health of children and families (e.g., including TANF and income related, WIC, etc.), ultimately, the MST! team wished to focus the policy playbook work in three primary areas:

Area 1: State Leadership Infrastructure: Explorations were conducted to further specify ways to establish strong cross-agency collaboration within State government (e.g., Office of Early Childhood), which is essential to advancing an integrated system framework. Furthermore, research explored strategies to lift-up a public-private sector, sustainable leadership body like the emerging Mississippi Early Childhood Development Coalition (MS ECDC) that was evolving out of the MST effort. Appendix I to this memo sets forth options and considerations in this policy focus area.

Area 2: Division of Medicaid initiated: A set of financial and non-financial strategies the MS Division of Medicaid might employ to advance the integrated health system framework goals and strategies were outlined. Appendix II of this policy memo lays out the high level financial and non-financial levers the Division of Medicaid could use with its contracted CCOs/MCOs as well as other levers not associated with the CCOs. Appendix III goes into further depth and provides more extensive examples related to the levers deemed most likely to be feasible to advance with MS Division of Medicaid in the shorter term.

Area 3: Early Intervention/Other: Other policy opportunities to close gaps in early intervention services availability and coordination with health care and other early childhood systems were identified along with other efforts to promote improvements in early intervention with the MS State Legislature. See Appendix IV for example resources created.

This memo summarizes methods and the approach taken in CAHMI's work to create a "Policy Playbook" for MST! Included are the five appendices noted above. This playbook is meant to spark further action. Substantial implementation work to operationalize these options would have a profoundly positive impact on the young children of Mississippi.

Methods and Approach

The CAHMI conducted numerous listening sessions, facilitated discussions, and conducted policy and program research to evaluate the overall Mississippi policy landscape and discover details related to current policies and strategies used by Medicaid and other state and federal agencies as it relates to promoting early childhood development and well-being. This research set the context for deliberations with the MST! team and informed the identification of priority levers and strategies. Research included curating and analyzing data from:

(1) MS Division of Medicaid State Quality Strategy, External Quality Review Reports, CCO Contracts and related MS specific research and reports related to child and family services.
(2) The Congressionally mandated Medicaid and CHIP Payment and Access Commission (MACPAC) reports with Mississippi specific data (e.g., MACSTATS)
(3) CMS Medicaid Core Set State Performance data reports, benchmarks, and trends
(4) NCQA HEDIS Medicaid MCO performance standards results and rankings.
(5) The National Survey of Children's Health (NSCH) data for Mississippi to document progress, needs. NSCH analysis for other states the MST! team identified as important state comparators (e.g., AL, AR, NC, TN, WV, etc.).
(6) Publicly available information about Medicaid MCO contracting and policy approaches from state comparators and for consideration by MST!
(7) Policy data banks focused on children and families like the Zero to Three State of Babies Yearbook, the Prenatal to 3 Policy Research Center, KidsCount report and many websites and published documents from numerous federal child health program websites (Agency for Children and Families (ACF), DOE, HRSA/MCHB, CMS).
(8) Websites of the range of key partners beyond the Division of Medicaid that are essential to creating an integrated early childhood health system (e.g., Title V, Early Intervention/Part C and B, Home Visiting/MIECHV, Child Welfare/CPS, WIC, Head Start, Early Care and Education/CCDF, community and family organizations, County and City specific health programs, etc.).

(9) In depth review and discussions with representatives of federal committees focused on advancing integrated early childhood health systems in states and review of a wide range of funded initiatives to curate learnings and promising directions.
(10) Published research identified through a comprehensive scan of PubMed to identify evidence related to impact of state policies on improving services and outcomes for children and families, especially as it relates to preventive and developmental services and achieving cross systems coordination.

Results of research and dialogue conducted with and across MST! partners led to the delineation of a range of short- and longer-term policy levers that include advancing issues in partnership with the MS Division of Medicaid and issues that would require legislative action. See Appendix V for an early/initial memo outlining shorter- and longer-term policy levers to consider.

Policy Lever Categories

Ultimately, the CAHMI and MST! teams agreed to focus the policy playbook work in three primary areas as outlined above.

It is important to note that in addition to the methods and focus summarized above, publicly accessible, and statutorily required *Memoranda of Understanding* between the MS Division of Medicaid and other state child health agencies, including Title V and Early Intervention were reviewed. Overall, analysis identified many existing, high leverage policies and agreements that are not being fully implemented, but that if fully implemented would enhance the health and wellbeing of Mississippi's youngest citizens. While we list strengthening Title V and Medicaid collaboration as a key policy lever in Appendix II, we have not specified findings in this memo pending further prioritization of MOUs and other levers (e.g., improving the Division of Medicaid State Quality Strategy) in MST! policy work.

Overall, analysis identified many existing, high leverage policies and agreements that are not being fully implemented, but that if fully implemented would enhance the health and wellbeing of Mississippi's youngest citizens.

Finally, methods used to identify policy levers and priorities also included an extensive MST! partners landscape scan summarized in the development of "Possibility Prototypes" with key MST! partners. In this context, an example "Memorandum of Understandings" for use between community-based family services (e.g., Mississippi Families for Kids/Help Me Grow) and pediatric primary care providers (e.g., Enhanced Pediatric Medical Home Services clinics) was drafted. An approach for bundled payments to pediatric providers for the provision of care enabled through use of the comprehensive Well Visit Planner family engagement tool was also

outlined. The draft MOU, *Possibility Prototypes,* and synthesis from the MST! partners landscape scan resources are available as resource appendices to the MST! Summary Report.

All strategies suggested in this memo and Appendices were collaboratively discerned with MST! partners to advance MST! goals, including the implementation of the EnAct! *integrated early childhood health system framework*. CAHMI simultaneously facilitated the development of this framework which is called the "Engagement In Action Framework."

The 21 priority policy levers are summarized below and in Box 1 and Box 2 and are further elaborated on in the Appendices to this summary memo.

A. Financial levers Medicaid can include in health plan contracts and with providers.

1. **Adequate baseline payment for expected care:** Ensure per member, per month algorithms Medicaid uses with managed care plans adequately reflect planned payments for utilization of high-quality well-child care services for all children anchored to Bright Futures Guidelines
2. **Health plan payment withholds**: Employ a payment withhold using motivating measures and benchmarks sufficient to compel action as specified in the EnAct! framework materials.
3. **Health plan incentive Payments**: Employ a health plan incentive payment for deploying innovative strategies anchored to the EnAct! framework goals and approach as outlined in sections 2-4.
4. **Bundled, enhanced billing codes**: Streamline and incentivize provider/practice uptake with bundled and enhanced billing codes for use when EnAct! framework evidence-based approaches are used (e.g., one stop billing if the comprehensive pre-visit screening, planning, and data sharing Well Visit Planner is used, billing for Family Specialists, etc.)
5. **Expand sites for service: Enable the EnAct! framework "through any door" approach** by establishing new service sites that can bill for services when they lead to engage families in comprehensive assessments and provision of health promotion and care coordination (e.g., community and home-based settings for qualified professionals).

Box 1: Financial and Non-Financial Levers Medicaid Can Use with Managed Care Health Plans to Advance the Purpose and Goals of the EnAct! framework

Financial levers Medicaid can include in health plan contracts and with providers

1. **Adequate baseline payment for expected care:**
   Ensure per member, per month algorithms Medicaid uses with managed care plans adequately reflect planned payments for utilization of high quality well child care services for all children anchored to Bright Futures Guidelines
2. **Health plan payment withholds:**
   Employ a payment withhold using motivating measures and benchmarks sufficient to compel action as specified in the EnAct! Framework materials.
3. **Health plan incentive Payments:**
   Employ a health plan incentive payment for deploying innovative strategies anchored to the EnAct! Framework goals and approach as outlined in sections 2-4.
4. **Bundled, enhanced billing codes:**
   Streamline and incentivize provider/practice uptake with bundled and enhanced billing codes for use when EnAct! Framework evidence based approaches are used (e.g., one stop billing if the comprehensive pre-visit screening, planning and data sharing Well Visit Planner is used, billing for Family Specialists, etc.)
5. **Expand sites for service:**
   Enable the EnAct! framework "through any door" approach by establishing new service sites that can bill for services when they lead to engage families in comprehensive assessments and provision of health promotion and care coordination (e.g., community and home-based settings for qualified professionals).

Non-Financial levers Medicaid can employ with health plans and providers

1. **Enable payment innovations:**
   Create mechanisms to encourage, enable and monitor impact of innovative, value-based payment mechanisms with providers to drive improvement in preventive and developmental health promotion services and outcomes for young children and families
2. **Strengthen provider networks:**
   Specify requirements for adequacy of the provider network to ensure networks are specified to the needs of young children and families as reflected in the EnAct! Framework. Report network adequacy information to family, provider, community partners.
3. **Standardize coding:**
   Require uniform coding and payment rates across heath plans for specific services to streamline provider and system uptake of EnAct! Framework care approach.
4. **Improvement projects:**
   Require health plan Performance Improvement Projects (PIPs) related to the EnAct! Framework goals, approach and strategies, including transparent reporting on actions/results
5. **Targeted demonstrations:**
   Develop Health Services Initiatives pilots (HSIs) with health plans to implement approaches anchored to EnAct! Framework goals and approaches and priority populations.

Source: Child and Adolescent Health Measurement Initiative, Feb. 2023

Source: Child and Adolescent Health Measurement Initiative, Feb. 2023

B. Non-Financial levers Medicaid can employ with health plans and providers.

1. Enable payment innovations to providers: Create mechanisms to encourage, enable and monitor impact of innovative, value-based payment mechanisms to drive implementation of innovations that improve preventive and developmental health promotion and services and outcomes for young children and families.
2. Strengthen provider networks: Specify requirements for adequacy of the provider network to ensure networks are specified to the needs of young children and families as reflected in the EnAct! framework. Report network adequacy information to family, provider, community partners.
3. Standardize coding: Require uniform coding and payment rates across heath plans for specific services to streamline provider and system uptake of EnAct! framework care approach.
4. Improvement projects: Require health plan Performance Improvement Projects (PIPs) related to the EnAct! framework goals, approach, and strategies, including transparent reporting on actions/results.
5. Targeted demonstrations: Develop Health Services Initiatives pilots (HSIs) with health plans to implement approaches anchored to EnAct! framework goals and approaches and priority populations.

Box 2: Other Cross Agency and Strategic Levers Medicaid Can Use to Help Implement the EnAct! framework

Other state levers of critical importance that Medicaid can support

1. **Coordinate governance:**
   State leadership requires coordination across state administrative and public-private sector governing bodies related to Medicaid, the Child Care Development Fund required State Early Childhood Advisory Committee, the Individuals with Disabilities Act Part C/B Early Intervention Interagency Coordination Committee, etc.
2. **Leverage Title V:**
   Encourage optimizing the power of the Title V Block grant, which priorities systems building, coordination of services, family engagement, early childhood development and achievement of MCH outcomes/system performance
3. **Establish postpartum coverage:**
   Work to secure Medicaid postpartum coverage, dramatic improvements in early intervention and home visiting resources and coordination with healthcare and support family income support policies
4. **Services and income support program eligibility and access:**
   Monitor and improve processes to streamline eligibility and access to early intervention, home visiting, early care and education and related state health and income support programs essential to the healthy development and wellbeing of young children and families.

Source: Child and Adolescent Health Measurement Initiative, Feb. 2023

Strategic levers Medicaid can use to promote implementation and improvement

1. **State plan amendments:**
   Secure a State Plan Amendment with the federal government to enable innovative payment and service approaches aligned with the EnAct! Framework
2. **State quality strategy:**
   Strengthen the Medicaid state quality strategy to specifically set measurable goals for the healthy development of children aligned with EnAct! Framework goals and strategies.
3. **Family leadership:**
   Include and support family leaders to serve as Medicaid Beneficiary Advisory Panel/medical advisory committee members to shape Medicaid to meet child and family goals
4. **Quality reporting:**
   Enrich Medicaid contracts with External Quality Review Organization (EQRO) to further assess quality for preventive and developmental services that align with the Affordable Care Act, Section 2713 of the Public Health Service Act, EPSDT and the EnAct! Framework
5. **Public reporting:**
   Ensure public transparency of all health plan PIPs, HSIs and quality ratings to the public, families, health systems, providers and system partners in improvement.
6. **Cross-agency collaboration:**
   Further formalize and monitor Division of Medicaid, Title V, Early Intervention and other agency partnerships and resource flows agreements to optimize early access to and quality of early childhood services and using publicly accessible cross-agency agreements, memoranda of understanding that are reviewed for implementation and improved over time.
7. **Administrative improvements:**
   Identify and publicly report on quality metrics related to administrative processes related to child and family enrollment in Medicaid and access to quality services, as well as clarity about and timeliness of payment for providers

Source: Child and Adolescent Health Measurement Initiative, Feb. 2023

C. Strategic levers Medicaid can use to promote implementation and improvement.

1. State plan amendments: Secure a State Plan Amendment with the federal government to enable innovative payment and service approaches aligned with the EnAct! framework
2. State quality strategy: Strengthen the Medicaid state quality strategy to specifically set measurable goals for the healthy development of children aligned with EnAct! framework goals and strategies.
3. Family leadership: Include and support family leaders to serve as Medicaid Beneficiary Advisory Panel/medical advisory committee members to shape Medicaid to meet child and family goals.
4. Quality reporting: Enrich Medicaid contracts with External Quality Review Organization (EQRO) to further assess quality for preventive and developmental services that align with the Affordable Care Act, Section 2713 of the Public Health Service Act, EPSDT and the EnAct! framework
5. Public reporting: Ensure public transparency of all health plan PIPs, HSIs and quality ratings to the public, families, health systems, providers, and system partners in improvement.
6. Cross-agency collaboration: Further formalize and monitor Division of Medicaid, Title V, Early Intervention and other agency partnerships and resource flow agreements to optimize early access to and quality of early childhood services and using publicly accessible cross-agency agreements, memoranda of understanding that are reviewed for implementation and improved over time.
7. Administrative oversight: Identify and publicly report on quality metrics related to administrative processes related to child and family enrollment in Medicaid and access to quality services, as well as clarity about and timeliness of payment for providers.

D. Other state levers of critical importance that Medicaid can support.

1. Coordinate governance: State leadership requires coordination across state administrative and public-private sector governing bodies related to Medicaid, the Child Care Development Fund required State Early Childhood Advisory Committee, the Individuals with Disabilities Act Part C/B Early Intervention Interagency Coordination Committee, etc.
2. Leverage Title V: Encourage optimizing the power of the Title V Block grant, which priorities systems building, coordination of services, family engagement, early childhood development and achievement of MCH outcomes/system performance.
3. Establish postpartum coverage: Work to secure Medicaid postpartum coverage, dramatic improvements in early intervention and home visiting resources and coordination with healthcare and support family income support policies.
4. Services and income support program eligibility and access: Monitor and improve processes to streamline eligibility and access to early intervention, home visiting, early

care and education and related state health and income support programs essential to the healthy development and wellbeing of young children and families.

Appendix I: State Leadership Development**:** Office of Early Childhood and Early Childhood Development Coalition Policy Memo
Appendix II: Overview and key State Medicaid policy tools and levers to improve early childhood preventive and developmental services access and quality.
Appendix III: More In-Depth Illustrations of Priority Policy Levers to Advance with the Mississippi Division of Medicaid
Appendix IV: CAHMI Research and Resources to Support UMMC/MST! Early Intervention Policy Work
Appendix V: Initial CAHMI Overview of Short- and Longer-Term Policy Levers to Consider

Illustration: The EnAct! Framework Possibility Prototype for the Division of Medicaid and Coordinated Care Organizations

Activating the power of the payer to accelerate transformations in child and family well-being.

What's Working Now

The Mississippi Division of Medicaid's (DOM) Mississippi CAN program contracts with three Coordinated Care Organizations (CCOs) who are responsible for providing comprehensive health care services to about 96% of the estimated 47.4% of all children ages 0-5 in Mississippi who are enrolled in Medicaid. Each of Mississippi's three Medicaid CCO health plans maintain a provider network that includes pediatricians, family physicians and other providers supporting young children and their families. Fifteen well visits are recommended by Bright Futures Guidelines in the first five years of life. Yet, only about half of these visits are estimated to occur. As of December 28, 2021, it is federally required that all US health plans provide high quality preventive and developmental services to children that align with Bright Future Guidelines, under Section 2713 of the Public Health Service Act. CCOs under contract with the Mississippi DOM are also required to ensure high quality care by trained providers and have a financial incentive to meet DOM benchmarks on the proportion of children ages 0-15 months who had at least 6 of 9 recommended well visits. One fifth of DOM's 1% withhold of the CCO total capitation amount linked to quality measures is linked to improving rates for early childhood well visit rates. However, the benchmark to meet the incentive is only 52.1%, which is lower than the national average. The Engagement in Action (EnAct!) approach to care and policy playbook recommendations for DOM (see Attachment E) are relevant to the DOM and CCOs and can help them drive improvements in well visits utilization, quality, and outcomes of care, and the equitable use of quality care to promote the healthy development of young children.

The Engagement In Action Opportunity

The Engagement In Action (EnAct!) approach to care provides a pathway for MS DOM and their contracted CCOs to engage families as partners in care and ultimately to improve utilization, quality, and outcomes of preventive and developmental services for young children and families, including those with special health care needs. The EnAct! framework focuses on family engagement, whole child and family assessments, and use of digital tools that 1) give families access to their own screening results, and 2) support data sharing across service providers is aligned with MS Medicaid Quality Strategy objectives. The EnAct! framework recognizes that CCOs are accountable for improving the frequency and quality of well child visits and ensuring provision of high quality, Bright Futures Guidelines aligned services. By advancing EnAct! framework strategies like the Well Visit Planner (WVP) and use of family

specialists, CCOs can strengthen beneficiary engagement and partnership in care. Lastly, through the adoption of the EnAct! approach to care, the CCOs can achieve an interoperable health information technology system that keeps health information secure but readily accessible to patients and across different healthcare and community-based supports for children. See the Mississippi Thrive! online toolkit to learn more about featured resources in the EnAct! approach.

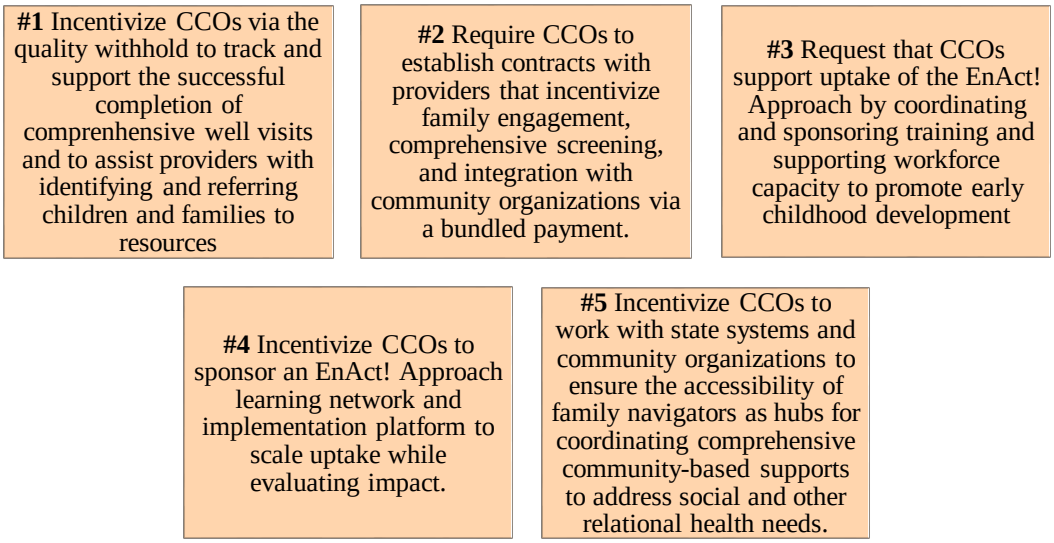
From Possibility to Progress

The EnAct! framework "policy playbook" includes specific strategies that can be used by the Mississippi Division of Medicaid to engage contracted CCOs as they meet their obligation to ensure pediatric and other child health providers are trained and have resources to transform child health services that align with Bright Futures Guidelines. Assurance that guidelines are met can be accomplished by using the EnAct! framework's approach to care resources. CCOs can advance much needed improvements in use and quality of well visits for young children by (1) directly engaging families to ensure they learn about and ensure their children receive well visit services; (2) supporting training and implementation of innovations including in the EnAct! approach (3) engaging essential family navigators and specialists to partner with pediatric primary care providers and (4) ensure fair payment and rewarding providers for providing high-quality, comprehensive screening, personalized care and linking to community-based services and supports. The DOM can include the Online Promoting Healthy Development Survey (PHDS) in External Quality Review Organization contracts to assess quality of well visits, equitable distribution of services, and engage CCOs, providers and EnAct! framework partners to improve services. The PHDS was deployed in this manner in Mississippi in prior years.

Envisioning Success

Activating the power and obligation of Mississippi's Medicaid CCOs to accelerate transformations in child and family well-being will require that concrete expectations and rewards be set forth in CCO contracts by the Mississippi Division of Medicaid (see Figure 1). It also requires specification of performance reporting specific to provision of high-quality preventive services. Performance Improvement Projects or Health Services initiatives with the Division of Medicaid can drive innovation and improvement. The DOM can directly incentivize providers by offering enhanced and/or bundled payment codes for use of evidence-based innovations and communicate their dedication to early childhood development and family well-being to all CCOs and providers receiving payments through the DOM.

Figure 1: Example Recommendations for Consideration by the Mississippi Division of Medicaid



Appendix I: State Leadership Development: Office of Early Childhood and Early Childhood Development Coalition Related Policy Memo

Date: November 16, 2022
To: Dr. Susan Buttross and Kristy Simms
From: The CAHMI Policy Team (Bethell, Bergman, Baily, Schiff)
Re: Considerations for Advancing an Office of Early Childhood and Statewide ECD Coalition

Background

The idea of creating an Office of Early Childhood and a Statewide Early Childhood Development Coalition has been discussed to support a cohesive, cross-agency and cross-sector vision and coordinated action of efforts to promote the healthy development of young children in Mississippi. MS efforts to meet the needs of families and their young children reside in several distinct governmental entities. The efforts of those entities are dependent on collaboration across multiple levels of the organization. Having a shared vision, understanding each other's roles, a governance structure that sets the tone of working together and leadership that models those expectation and find ways to put aside difference in service delivery to find commonalities in benefit of young children and their families is essential.

Understanding the benefits of advancing any new "office" is important as well as recognizing the innate limits and sustainability of any "office" placed in the Governor's office or any single governmental agency. Overall, the key to success will be leadership and relationships that endure and having a clear mandate that is funded with some decision-making power and agency to influence change. Additionally understanding how an Office structure would interface with and be supportive or potentially duplicative of existing and emerging collaborative bodies is important. This includes: (1) the emerging Mississippi Thrive! Early Childhood Development Coalition (MST ECDC) as well as the existing (2) Department of Human Services' led State Early Childhood Advisory Council (SECAC) and (3) the Department of Health's Interagency Coordinating Council, among others.

Many states have offices or advisory boards to help coordinate early childhood services in health, education and social services agencies and sectors. The scope of responsibility and the governance is quite variable across different states ranging from councils or cabinets where participating agencies meet to help coordinate goals but have separate budgets, governance and

accountability (i.e. *Early Childhood Advisory Council; South Carolina, Cabinet for Health and Family; Kentucky*), to additional structures where participating agencies are consolidated within an Office of Early Childhood and are accountable to it for achievement of their goals (i.e. *Office of Childhood; Missouri; Office of Early Childhood; Connecticut*). Furthermore, there are also community-based groups that work to coordinate the various government agencies involved in early childhood.

"It really comes down to the will, commitment, and ability to really work together. I've seen well resourced, gov office supported private public partnerships flounder because some key element was missing. I'm not trying to be negative just realistic. I think any structure can work – what's needed is the leadership, resources and everyone has to not care who gets credit."
Melissa Bailey, Former Vermont Commissioner of Mental Health

In general, Early Childhood offices primarily focus on childcare, early intervention services and early childhood education/Head Start. We find few examples where health and in particular medical care are addressed in a comprehensive manner and integrated with early care and education, early intervention and community and family-based supports, which is essential. Similarly, we find few that meet the two generational economic and mental health need of whole families. A concept to consider is that the MST ECDC endeavors to be a private-public entity that ensures the truly cross sector partnerships needed and that provides depth of vision and consistent coordinate and expertise and request funding to do so. The MST ECDC could then engage leadership of an Office of Early Childhood (or Office of Childhood to span the continuum of development) in the Governor's office which is charged with advancing concrete changes to optimize the integration and quality of state services and supports to promote early childhood development and well-being that emerge from MST ECDC.

We find few examples where health and in particular medical care are addressed in a comprehensive manner and integrated with early care and education, early intervention, and community and family-based supports, which is essential. Similarly, we find few that meet the two generational economic and mental health needs of the whole family.

Whatever approach is pursued it is important to first reflect on the potential for any new Governor appointed "office" to be limited by the political perspectives of the Governor and fail to coordinate across agencies and partners as envisioned, perhaps leading to further silos among these various agencies and making it more difficult to develop an agenda that addresses the whole child. In states that have maintained or are seeking to advance a stable public-private leadership body to coordinate and optimize early childhood development services, they can play three roles:

(1) Defining a vision and set of measures to track positive change and success.
(2) Producing a continuously updated big "P" and small "p" agenda to foster changes need to improve coordination, quality, and outcomes and that emerges through a transparent process that is deeply informed and expert.
(3) Direct to public education to shift public understanding, engagement, will and cultural shifts needed to foster healthy development of young children.

Overall Pros and Cons are outlined below and are followed by Options and the subsequent pros and cons for each option.

Pros:

- Sets the north start entity that directs efforts for early childhood.
- Brings together by design various child serving entities.
- Elevates the importance of this work by establishing such an office.
- Sets an expectation for accountability in the work that needs to be done.
- Allows for the potential for braiding of funding streams from different child serving agencies for more efficiency and effectiveness.

Cons:

- Does not assure that collaboration will happen at key funding and decision- making levels.
- Would have to account for varied expectations from Federal agencies that may not support the collaboration needed break down state agency silos.
- Distracts from the focused work by diverting energy into creation of this office.
    - Could deflect energy from other important efforts such MCO withhold or EI.
    - People tend to struggle with this kind of change, roles change, power changes and people fight that rather than put their energy into the work.
- Holding other agencies e.g., Medicaid or DOH accountable for achieving goals to further early childhood wellbeing would be difficulty without an appropriate governance structure.

Things that can help the work take root:

- Create a governance structure to support the work (see VT State Interagency Team structure that brings together various governmental leadership focused on children's services to address structure and service challenges and focus on common goals via Results Based Accountability).
- Provide leadership coaching/TA to help the leaders in how to manage the change efforts and work more effectively together.
- Consider a preliminary step of dedicated leadership oversight for a more focused project such as managing the MCO withhold to meet objectives for improving early child health

and wellbeing. If this effort is successful, it could then evolve into further cross agency projects including an Office of Early Childhood.

- Focus on incorporating "one doable thing" into Medicaid MCO contracts to create the energy towards success.

Options for placement and function

In addition to the concepts outlined above, below are further details to consider regarding the placement and function of an "Office of Early Childhood" as has been discussed during the MST and CAHMI policy discussion call.

Option 1: Office of Early Childhood within the state government

An office of Early Childhood will bring together various government leaders and agencies focused on children's services. Using a structure such as Results Based Accountability can help these various entities learn to work together towards common goals. This Office would distinguish itself from other coordinating entities in the state government by having a separate budget and personnel. With participating agencies working collaboratively to develop objectives and goals for early childhood and all the agencies being held accountable and willing to share personnel and resources to meet these goals. The office budget could be generated by the braiding of funding streams from the different agencies or have a separate budget from the state legislature.

Pros:

- Would help to illuminate opportunities to advance standardized approaches to screening and assessment and data sharing needed to foster effective collaboration and coordinated services and supports for children and families.
- Would help identify and alleviate the inefficiencies of the many early childhood serving agencies in state government each operating within their own silo, yet with similar goals and needs.
- Would enhance collaboration and synergy among the participating agencies that result in more powerful and effective programs.
- Would provide a single site for seeking and receiving extramural funding through grants or philanthropy.
- Shows the importance and state commitment of this work by establishing such an office.
- Sets an expectation that better work needs to be done.
- Potential for braiding of funding streams from different child serving agencies for more efficient and effective spending.
- Provide for strong advocacy within the state government for early childhood service.

Cons:

- Doesn't necessarily mean collaboration will happen.
- Each participating agency is managing their own budget and program goals and may be reluctant to give personnel and resources to any collaborative efforts.
- Early childhood efforts still will have various Federal expectations that may not support the kind of collaboration needed.
- The creation of such an office may be difficult and time consuming and the energy used will distract from the focused work and other work may suffer.
- Competing priorities will still pull funding and energy in various directions.
- Existing coordinating entities may be reluctant to consolidate their work into an Office of Early Childhood raising the likelihood that an Office of Early Childhood may increase redundancy and inefficiencies in planning for early childhood services.

Option 2: Council or Cabinet of Early Childhood Agencies

A Council or Cabinet of Early Childhood Agencies will oversee a convening of the different early childhood serving agencies within the state government and ensure integration of health care, public health with high risk (EI, Child Welfare, Home Visiting) and early care and education programs (others). It would provide an opportunity to review current programs and better identify redundancies and inefficiencies. This group may also be able to propose cross cutting programs for future budgets. The participating agencies would not necessarily have accountability to a common set of goals or a mandate to share personnel and resources to meet these goals. It would require a small budget to cover administrative costs and a part time coordinator.

Pros:

- Similar to the Office of Early Childhood, the Council would enhance collaboration and synergy between agencies, demonstrate the importance of the work, provide for strong advocacy, and provide a locus for seeking and receiving extramural funding.
- Much less complicated with a smaller budget.
- Less likely to distract from current work.
- Does not require participating agencies to braid funds or share personnel and resources and thus would be less politically difficult to achieve.

Cons:

- Likely to be less effective in creating strong programs that consolidate current programs.
- No mandated accountability to achieve a shared set of goals and objectives.
- Because of lack of ability to develop effective programs there may be waning interest over time.

Option 3: Mississippi Thrive! Early Childhood Development Coalition Focused Charge

Here a management structure could be put in place to oversee the completion of specific goals and objectives proposed by Mississippi Thrive! overall and in the EnAct! framework, specifically. Specific work would be advanced to obtain the policy shifts and resources needed to fund the EnAct! approach implementation plan, including advance such use of the Medicaid withhold to incentivize Coordinated Care Organizations to work with EPMHS sites and community-based supports (MFFK/FAA) to engage families and promote improved care. This could also include advancing new performance measures and influencing External Quality Review Organization contracts to monitor performance of CCOs and the use of CCO Performance Improvement Programs compelling their engagement to support high-quality, family-engaged, community coordinated preventive and developmental services. Management of these objectives could build on the existing structures put in place after MS Thrives! Efforts would be supported through explicit allocation of funds and personnel with a minimum cost of two million per year.

Pros:

- Implementation of key EnAct! framework goals as reflected in the new MST! Early Childhood Development Coalition would achieve many of the goals of an Office or Council for Early Childhood if coordinated with the Governor's office.
- Could allow a more focused approach where resources would be sought to only manage specific objectives.
- Implementation of objectives can be spaced over time.
- Specific goals, objectives and methods are already in place in the EnAct! framework
- There is already widespread buy-in to the EnAct! framework among the new MST! Early Childhood Development Coalition members.

Cons:

- Requires buy-in to the EnAct! framework by Medicaid, MCO's and EQROs to allow for the repurposing of funds.
- Creating specific management structures for different objectives may lead to fragmentation and siloing of the implementation effort.
- Does not foster as much collaboration between Early Childhood Serving Agencies as the Office or Council model.

Additional Considerations

An added piece, more specifically for option 2 or 3 and including working within current structures would be the creation of a governance structure to support the early childhood efforts (see VT State Interagency Team). This structure brings together various governmental leadership focused on early childhood services to address policy, structural and other service challenges within a set of common goals. Considering an interagency structure that appoints a high-level

leadership tier (e.g., cabinet level leadership to meet regularly to review progress and approve of state goals) and a similar cross agency director level tier that is responsible to execute the goals and report progress to cabinet level officers could also more priorities forward more strategically and successfully. Key here would be to ensure inclusion of Medicaid, Title V along with other Department of Health, Education, Human Services and Mental Health agencies.

It is recognized that MS has a variety of committees and Governor appointed committees related to Early Childhood, all committed to improving the lives of young children and their families. However, most of these focus on a specific aspect of a comprehensive Early Childhood system, not the system as a whole or the interconnection of efforts towards successful metrics that can be driven by things like well child visits. Since the idea of advancing a new Office of Early Childhood has arisen

We provide this summary of options and their associated pros and cons for consideration. This memo hopes to lay out the possibilities and value of an "Office of Early Childhood" functionality, which could sit within the MS State Governor's Office. Consideration of the other existing and emerging Early Childhood committees (e.g., SECAC, MST ECDC, ECCS) should be carefully considered as well as the lifting up of the MST! ECDC to lead this work. The goal should not be another entity with similar goals yet no clear path to better align, coordinate, and impact the efforts and their associated outcomes. In closing we would propose the development of a criteria to use to consider the need, focus areas and activities of an Office of Early Childhood in MS. That criteria should include at a minimum a clear understanding of:

- Current offices, committees, or councils' mandates.
- Associated personnel.
- Budget.
- Governance.
- Federal or state requirements.
- Any measure of return on investment.
- Restrictions or limitations.
- Areas of improvement needed. If an Office of Early Childhood would influence any of these and if so, is the efforts to develop such an office less than the efforts to improve any of the above criteria.

Additional Resources

1. A Framework for Choosing a State-Level Early Childhood Governance System
2. The Nuts and Bolts of Building Early Childhood Systems through State/Local Initiatives
3. Early Childhood Governance: A toolkit of curated resources to assist state leaders
4. Video: How Governance Influences State Early Childhood Systems

Appendix II: Overview and key State Medicaid policy tools and levers to improve early childhood preventive and developmental services (well-child care) access and quality.

Below is a high-level list of a range of Medicaid policy levers important to driving innovation and action in order to improve access and quality of early childhood preventive and developmental services for young children enrolled in Medicaid in Mississippi. We hope this quick glance summary might support UMMC and the ongoing policy work for the newly formed Mississippi Thrive! Early Childhood Development Coalition as they further specify the policy priorities they will pursue as they work to advance the *integrated early childhood health care and systems framework* (and related efforts) CAHMI has co-created with UMMC and MST! partners. Note that the tools and levers noted below can be applied to any access or quality issue deemed important to the state Medicaid program. Our goal is that these tools and levers are applied to improve well-child visit rates and support other child health issues. They could apply to other issues (e.g., other Medicaid Core Set measures).

Category A: Financial Levers to Embed in MCO Contracts

1. **Adequate payment for expected care:** Ensure per member, per month rate setting algorithms used by Medicaid with managed care plans adequately reflect planned payments for utilization of high-quality well-child care services for all children anchored to Bright Futures Guidelines. Current PMPM algorithms are not published, limiting an assessment of how preventive services for young children is currently accounted for or incentivized with managed care health plans.

2. **Employ a payment withhold:** Payment withholds are contractual vehicles used by Medicaid as the purchaser to encourage improvement in a specific aspect of care or access. Here, Medicaid would withhold typically one to five percent of the managed care contract total payment amount for the year pending their performance on specific performance targets. The withhold percent is limited by the requirement for "actuarial soundness" to ensure an MCO is not at risk for having insufficient funds to cover the medical expenses they incur to serve their beneficiaries. Note that capitated payments also include administrative payments. The ratio of payments for services to administrative expenses defines the MLR. This

methodology (primarily which services are considered administrative) is specific to each state and could be specified in a way that may alter the degree to which a withhold might translate into a real incentive for improvement. It is important to note is that MCO payment is typically based on risk adjusted historical service use and costs for an MCO.

Due to the constraints noted above, withhold percentages are in actuality very small and usually closer to one percent. Withholds are also generally tied to NCQA HEDIS measures because of the ability of the state (mostly via the External Quality Review Organization – EQRO) to validate MCO performance. A withhold with multiple measures or with thresholds for achievement of goals that are easy to attain dilutes the effectiveness of this mechanism. A specific example is in Appendix II of the CAHMI Policy Playbook memo, which providers more detailed illustrations and information about key Medicaid policy levers.

3. **Employ an MCO incentive payment**: Some states allow Medicaid to put emphasis on certain measures by adding money to the MCO contract for attainment of certain quality or access goals. These can be more tailored and unique for a specific goal. A state Medicaid plan generally needs to have legislatively appropriated funds for this mechanism. States have used incentive payments to support the expansion of services.

4. **Bundled, enhanced billing codes**: Streamline and incentivize provider/practice uptake with bundled and enhanced billing codes for use when EnAct! framework evidence-based approaches are used (e.g., one stop billing if the comprehensive pre-visit screening, planning, and data sharing Well Visit Planner is used, billing for Family Specialists, etc.) Medicaid can direct an MCO to contract with providers using a specific provider payment approach (e.g., a specified minimum amount for bundled payment for set of well-child services). Medicaid programs can require specific payments (and minimum rates) by the MCOs for a specific complete service (e.g., the Well Visit planner, comprehensive well visits). Two specific examples of this are provided in Appendix II to this CAHMI Policy Playbook memo.

5. **Expand sites for service: Enable the EnAct! framework "through any door" approach** by establishing new service sites that can bill for services when they lead to engage families in comprehensive assessments and provision of health promotion and care coordination (e.g., community and home-based settings for qualified professionals; early care and education, home visiting, child welfare, etc.).

Category B: Non-Financial Levers to Embed in MCO Contracts

1. **Enable payment innovations to providers:** Create mechanisms to encourage, enable and monitor impact of innovative, value-based payment mechanisms between managed care

plans and providers that drive implementation of innovations that improve preventive and developmental health promotion and services and outcomes for young children and families.

2. **Strengthen provider networks**: Specify requirements for adequacy of the provider network to ensure networks are specified to the needs of young children and families as reflected in the EnAct! framework. Report network adequacy information to family, provider, community partners to foster accountability.

3. **Require MCO Performance Improvement Projects (PIP**): Medicaid requires MCOs to participate in PIPs that are designed to improve a specific aspect of quality. The PIPs have a specific format that includes measurement of outcomes, an improvement strategy, and a remeasurement of the outcomes. The PIP work cycle is generally implemented over three years and cannot be closed/dismissed until results are achieved. A specific example is set forth in Appendix II of the CAHMI Policy Playbook memo.

4. **Health Services Initiative Pilots**: Like is underway with Magnolia Health and the MS Division of Medicaid to promote EPSDT/preventive services/well-child visit and coordinated care for children with complex medical needs, MS Division of Medicaid could advance other health service initiative pilots with MCOs; or consider appending the Magnolia Health existing pilot to integrate elements of the emerging *Engagement In Action integrated early childhood health care and systems model* being finalized with CAHMI. Pilot programs with a specific MCO can be used to test a broader Medicaid effort/program to achieve a specific goal, like improved use and quality of preventive and developmental services for young children.

5. **Standardize coding**: Medicaid could require MCOs to use standardized coding for specific services using alternative billing codes (HCPCS G codes) (Healthcare Common Procedural Coding System - HCPCS) that allow for identification of completion of specific quality goals (e.g., all the screenings in the Well Visit Planner). In addition to creating a code for a group of screening services developing a code might be expected take the form of a bundled payment for implementation of the Well Visit Planner in the future as has been discussed with UMMC and MST! ECDC and is set forth as a recommended option for improving early childhood preventive and developmental services in the *Engagement In Action Framework for a statewide integrated early childhood health system.* Use of this code would be a preliminary step prior to linking the code to an enhance payment to providers that exceeds the payment for each service individually as suggested in Category A, option 3 above.

Category C. Other Levers Medicaid Can Use Outside of MCO Contracting

1. **State plan amendment**: The Medicaid state plan spells out the eligibility and services provider by a state Medicaid program and the conditions for federal fund participation (FFP). This is not a specific quality lever, but can include aspects of service provision (e.g., Health Home, expansion of postpartum care to 12 months) that can have quality measures embedded in the service. This mechanism is included here for context.

2. **Medicaid federal waivers**: Medicaid could apply for a Medicaid 1115 waiver to innovate inside of their Medicaid programs and introduce novel and promising payment incentives tied to priority areas for quality improvement. Waivers vary significantly in their covered population and goals, allow Mississippi to shape an approach that best matches their goals and context. Many 1115 waivers focus on enrollment and eligibility while some seek to restructure service delivery and payment.

3. **State quality strategy**: States are required to have a quality strategy that addresses the unique needs of the Medicaid program in their state. This strategy is required whether the state provides care via managed care or directly via fee for service (FFS). State quality strategies are submitted to CMS. A state quality strategy should provide the framework for many of the specific strategies (e.g., managed care withholds) discussed here. CAHMI's analysis of Mississippi's State Quality Strategy identified many elements aligned with MST! goals and that are also aligned with the emerging *Engagement In Action integrated early childhood health care and systems model and framework*. However, while MS Medicaid priorities patient/person/family engagement, prevention and services integrated across health care and community-based settings, there is not a specific mention of children or language that would compel the state to support pilots or use the financial and other non-financial levers summarized above.

4. **External Quality Review Organization (EQRO) contract specifications**: States with managed care organizations are required to have an independent EQRO to oversee the contract provisions and quality results. Often the EQRO is the collector of Medicaid Core Set measure results. EQROs also oversee other provisions of the MCO contract (e.g., follow up of positive screens for developmental delays identified by pediatric providers). MS Division of Medicaid may enrich its EQRO contract to require measurement innovations like the Online Promoting Healthy Development Survey (PHDS), which MS Medicaid did in 2005 in partnership with the CAHMI. Medicaid can enrich their contracts with External Quality Review Organization (EQRO) to further assess quality for preventive and developmental services that align with the Affordable Care Act, Section 2713 of the Public Health Service Act, EPSDT and the EnAct! framework

5. **Ensure Public Transparency of MCO Quality**: Medicaid can advance accountability and action by ensuring that all EQRO findings on MCO quality, including results of Performance Improvement Projects (PIPs) and performance on metric linked to payment withholds, are published, and disseminated to ensure public access and accountability. While not a specific mechanism, transparent publishing of results of performance and quality measures or of other Medicaid and MCO functions acts as a lever for MCOs and Medicaid to be accountable for results with the public and the state leadership.

6. **Requirement for network adequacy**: MS Division of Medicaid could use the MCO EQRO review process or separate FFS reviews to evaluated and prove that Medicaid beneficiaries (in this case young children) can adequately access needed care. Network adequacy reviews can be directed to services for young children to assure that a focus in placed on adequate availability of services for this population.

7. **Family Leadership: Medicaid Beneficiary Advisory Panel or "medical advisory committee"**: Each State Medicaid program is required by Federal Regulations to have a Medical Care Advisory Committee (MCAC), which includes provider, consumer, and government representatives and which participates in policy development and program administration. The effectiveness of these bodies may vary, but this provides an opportunity for advocates to surface concerns. It is unclear if the MS Beneficiary Advisory Panel is managed in a way that leverages its potential to advance efforts and quality for children or if families of children are represented on the advisory panel. UMMS and MST! ECDC could take action to ensure this important body is leveraged and actively engaged families as members and consultants.

8. **Cross Agency Collaboration: Medicaid and MCH Title V Partnership**: Medicaid and Title V's MCH program are required to have a cooperative agreement (or Memorandum of Understanding) about how these two state departments will collaboratively care for children's health in the state including the direct provision of services, identification, and referral between departments. These agreements are intermittently and inconsistently enforced but provide a framework for coordinated action. These agreements could be more carefully monitored and enforced and shaped with input from UMMC/MST! ECDC partners.

Category D. Non-Medicaid Specific Levers to Consider

In addition to the shorter- and longer-term policy strategies outlined in the cover memo to CAHMI's Policy Playbook, below are important areas to consider related to improving Mississippi State's efforts to improve services and outcomes for young children and families.

1. **Support Broader Policy Improvements**: Work to secure Medicaid postpartum coverage to 12 months after birth along with improved access to early intervention, home visiting family income supports.

2. **Optimize the Title V Block grant**: The Health Resources and Services Administration's Maternal and Child Health Bureau provides block grant funding to states for both direct care and system planning/ development for state programs. Specific requirements for these block grants are outlined by HRSA/MCHB but have flexibility to orient system development to specific state goals. Measures of performance are included in the block grant that align closely with the goals of MST! See Attachment C of the Engagement In Action Framework document for in depth specification of Title V performance measures and goals aligned with the MST! effort). In particular, MST! could work to ensure Title V state funding for child health systems integrated infrastructure support priority goals related to early childhood preventive and developmental services and outcomes. As noted earlier, states require functioning inter-departmental systems to coordinate care for children to improve identification and care of children with special needs. Both Title V and Medicaid administrative funds can be put towards creating this infrastructure. (See: Guide to Leveraging Opportunities Between Title V and Medicaid for Promoting Social-Emotional Development)

3. **Optimize Existing State Governing Bodies:** In addition to further establishing the MST! ECDC and advocating for stronger governance and cross-agency coordination and leadership related to early childhood preventive and developmental services and outcomes, MST! could assist in optimizing the power and impact of existing state government established committees, especially the Child Care Development Fund required State Early Childhood Advisory Committee, the Individuals with Disabilities Act Part C/B Early Intervention Interagency Coordination Committee, etc.

4. **Improve services and income support program eligibility and access**: Monitor and improve processes to streamline eligibility and access to early intervention, home visiting, early care and education and related state health and income support programs essential to the healthy development and wellbeing of young children and families.

Appendix III: More In-Depth Illustrations of Priority Policy Levers to Advance with the Mississippi Division of Medicaid

Purpose & Layout

As Mississippi Thrives! (MST!) reflects on the outcomes of the initiative and continued work to advance implementation of the ***Engagement In Action (EnAct!) Framework*** this section of the "Policy Playbook" includes an example memo that could be used to begin to address Medicaid officials and other policy makers (e.g., legislators) and a compendium of policy lever options that could be employed to advance early childhood health goals.

The example memo below is meant to inform, and guide involved policy makers on a set of implementable Medicaid & Managed Care Organization (MCO) policies that would sustain and scale the MST! initiative and improve the healthy development of young children in the state. Recommendations in this example include more traditional levers for change and innovative policy proposals. This example memo also includes examples of best practices from other comparator states for policy makers to reference.

At the heart of this memo, is the importance of providing whole child and family preventive and developmental services as set forth in the national Bright Futures Guidelines by the American Academy of Pediatrics and the Health Services and Resources. Central to achieving this is ensuring availability and payment for comprehensive well-child visits, including identification the needs of young children via comprehensive developmental and surveillance and screening in combination with assessing and addressing family priorities for health promotion. Effective impact at early ages begins with early identification of needs and close partnership with families, community-based family services and supports and other services related to addressing needs of children with greater and more complex developmental needs. Comprehensive screening includes assessments of developmental cognitive and motor milestone, social/emotional milestones, social (economic) risks, relational risks, and child resiliency. The use of comprehensive screening is a key component of the Bright Futures Guidelines. Implementation of these guidelines if mandated of all health care plans in the US through the Affordable Care Act through Section 2713 of the Public Health Service Act, which became active December 28, 2021.

The policy levers included in this memo follow extensive work by Mississippi Thrive! and now ECDC to improve screening. The Well Visit Planner/ Cycle of Engagement model and tools used by MST! and developed by CAHMI (Child and Adolescent Health Measurement Initiative) support comprehensive screening and provide a mechanism to collect and track data for improvement and accountability. This model and mechanisms to implement it are well documented in the framework document developed by CAHMI in collaboration with the MST! team. Most recent data (as of November 2022) about the MS Medicaid children and its support for young children is in the table below:

Table 1: CAHMI's 2022 Synthesis of Mississippi Medicaid for Young Children (Sources: 2021 MACPAC "MACSTATS" report; CMS State Performance and NCQA Managed Care Reports and CAHMI analysis of the 2018-2019 National Survey of Children's Health). See Attachment A for more updated data.

Topic	MS
Medicaid Child Enrollment Count ('19) Ex.14	480K All; 379K 321K Full year; 480 w/CHIP (Ex 32)
Proportion of Children Enrolled in Different Health Insurance Models: Comprehensive or Limited MCO's, PCCMs, FFS ('19) Ex. 30	Comprehensive MCO's: 95.8%; 3.9% Limited MCO's; 0% PCCM
Eligibility for Medicaid as % of poverty. Ex. 35	Infants: 194% Medicaid Infants: ? CHIP Age 1-5: 143% Medicaid Age 1-5: ? CHIP
Proportion of the State budget spent on Medicaid (15.8% nationally). Ex. 4	11.0%
Medicaid Federal match rate -FMAP Ex 6	78.31% Medicaid; CHIP: 84.10%
Federal Administrative Costs Match Rate (QI work here!)	84.82%
State Medicaid Expenditures (total) and proportion spent on children enrolleees. Ex. 21	5.297M; 24.2% for children
The average per child enrollee dollars in Medicaid. Ex. 22 (and CHIP if available)	$3,994
Well-Child Visits in the First 15 Months of Life (at least 6 of 9 in 1st 15 months) 2020 most recent.	57.5% 2020 (most recent) [Bottom quartile of all US states)
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (2020 MOST RECENT DATA)	60.3% 2020 (most recent)
Developmental Screening in the First Three Years of Life	Not Reported in 2020; 27% NSCH
Proportion children 0-5 with any medical/develop/mental, social or relational risk-NSCH	68.4% ICRI+; 18.0% 2 ICRI; 11.4% all 3 ICRI;
Proportion children 0-5 with either or both marked social and/or relational health risks-NSCH	56.6%
Proportion with OP visit counseled (Wt/Nutrition/Exercise) Age 3-17	61.4% 2020

Note that as dialogue begins with the Division of Medicaid, it is the Division's decision on how these policy concepts can be enacted (e.g., via contract provisions in the new CCO contracts or if they would require legislative authority). We note where our understanding of Division authority allows for the Division of Medicaid to act without legislative action, such as in specifying components of CCO contracts. If it is determined that legislative authority is required, then the Division could assess if these legislative proposals should be a stand-alone effort or tied to twelve-month postpartum expansion or early intervention improvement efforts

being discussed for legislative consideration this year. Offering an integrated legislative "ask" is our recommendation, but that might also not be feasible based on opportunities that arise.

Proposing legislation with a legislative bill sponsor outside of the Division of Medicaid is also an option, but the probability of success would have to be carefully assessed before this effort was made.

Appendix III - Example text for a memo to MS Medicaid and other policy leaders

To: Mississippi Medicaid Policy staff and Leadership
From: UMMC, MST! ECDC
Re: Options for Improving Care for Young Children Served by the MS Medicaid program through CCOs contracting and related opportunities
Date: xx/xx/xxxx

Introduction

Mississippi aspires to improve the health and wellbeing of its youngest citizens. Key to this goal is the identification and amelioration of medical, developmental, social, and relational risks. Identifying and addressing these risks is best done via a comprehensive ("through any door") approach to screening, identifying problems, and providing of services to address these concerns. Mississippi, via the UMMC and its broad coalition in the Mississippi Thrive! program (funded by HRSA MCHB) has piloted the structure and created the broader vision for this work. This policy brief outlines reasonable first steps to keep Mississippi on track to sustain these improvements.

For Medicaid nationally, well-child visits early in life and developmental screening have been identified as first steps/markers of the quality of an early childhood system. Mississippi's reporting and rates on the federal Child Core measures of well-child visits and developmental screening are below the national median. Reporting by every state and territory on both measures is mandatory beginning in 2024. (Mississippi's 2019 rate for six or more of the 9 recommended well visits for children under age 15 month (now incorporated into the well visits in the first 30 months of life) was 57.2% (55.8% for CHIP) compared to a national state median of 64%. (source MS Medicaid)). Mississippi does not currently report the developmental screening measure in the first three years of life.

The majority of children age 0-3 in Mississippi receive health insurance through Medicaid. And over 95% of these children are estimated to be served by Coordinated Care Organizations

(CCOs). Mississippi Medicaid should consider use of CCO contracting to improved MS rates for well-child visits and developmental screening as a starting point for collective statewide action to benefit the youngest residents of the state. More will be required to create a fully integrated care system for Mississippi's young children as is outlined in the Mississippi Thrive! integrated early childhood health care and systems model summarized in the ***Engagement In Action Framework***.

States have a multitude of CCO contract flexibilities to incentivize improvements in provision and access to preventive and developmental services for young children on Medicaid. As a result, most US states are leveraging combinations of policy levers and it follows that MS would choose their own combination of levers that are the best fit for the state. Proposals made here can be implemented through more traditional CCO contract provisions. Other ideas include that that require MS Division of Medicaid to be directive to the CCOs to ensure, for example, adequate availability of providers across the system. The memo outlines opportunities and provides some comparator state examples for consideration.

A. Key Opportunities

1. ***Recommended proposals for contracting with the CCOs using traditional mechanisms:*** Recommendations that include limited changes to the structure of the current Medicaid program and are more traditionally used.

    a. Modification of the performance withhold mechanism to emphasis well-child care for young children.

    b. Requiring CCOs to implement performance improvement projects (PIP projects) when they do not achieve the federally mandated CMS 416 rates [explain 416] for well-child visits.

2. ***Recommended proposals that are more innovative and directive to CCOs to improve provider system capacity:*** recommendations that will require collaboration with the Mississippi Division of Medicaid to identify the proper mechanism and language for implementation.

    a. The creation of a "healthy development" bundle that would enhance payment if all components of comprehensive screenings (as part of a larger goal of comprehensive EPSDT services) were conducted.

    b. The creation of a directed payment that the CCOs would make to healthcare systems and other early childhood care providers to build out additional early childhood care

infrastructure (e.g., “no wrong door” screening in WIC)

B. Traditional Contracting Mechanisms

1. ***Modifying the Performance Withhold Mechanism*:** Quality withholds are one of the ways states can assure that their quality strategies incentivize CCOs to improve outcomes. MS currently has a 1% performance withhold (1% of the total CCO contract amount) with six metrics that were reported out in 2020, based on the 2021 quality strategy it appears that four more metrics were added. There is currently one pediatric focused metric: the well-child visit first 15 months (W15), the metric was previously weighed 20% of the withhold but will presumably take on a smaller weight in the future with the addition of the new metrics. We are encouraged by the inclusion of this metric in the withhold. We urge MS to pursue progress on this metric by raising its weight in the withhold. The payout for progress in the metric currently requires only small improvements not tied to national benchmarks. We also encourage MS to raise the benchmark for the metric to the national median.

Incremental payout could be tied to this benchmark. Based on the comparator states (Missouri and South Carolina) expanded upon in Section E below we recommend the following:

a. *Raising the weight of the W15/W30 metric to 50% of the withhold alone or adding another pediatric well-child visit metric (e.g., WCV 3-11 yrs.) so that the cumulative weight of the metrics equal 50% of the withhold.*

b. *Raising the benchmark on the W15/W30 metric to a national benchmark such as the Medicaid state median or the NCQA Quality Compass for MCO managed care organizations median for this metric.*

c. *Requiring the stratification of reported quality metrics by race/ethnicity, gender, and county.*

d. *Add developmental screening to the withhold with appropriate weighting of this measure now. Over the three- year course of the new CCO contract add the other comprehensive aspects of well-child screening (social emotional screening, social and relational risk screening, and resiliency assessment). [reference Bright Futures]*

The above would incentivize CCOs to improve their performance to meet the national Medicaid median and would assign a weight to the metric that is meaningful and aligned with other comparator states. Additionally, the state would be better able to track racial/ethnic, gender, and geographic disparities by requiring the CCOs to stratify the tracking of their metrics. The mechanisms the CCOs would use to improve performance could be tracked by the Division via their contract oversight.

2. ***Performance Improvement Projects:*** Performance Improvement Projects are another common tool for states to pursue improvement in priority focus areas. Performance Improvement Projects are required for managed care entities and provide a mechanism for the CCOs to work over the contract cycle to make measurable improvements in key goals. MS does mandate a PIP within the realm of maternal and child health by mandating that CCOs have a PIP focused on preterm delivery. However, MS does not mandate that CCOs create a PIP to address EPSDT rates, which comparator states (Kansas and North Carolina) do include in their Quality Strategies. See illustrations in Section F below. To continue to build on the state's interest in driving improvements in child health we recommend including the following requirement within the state quality strategy and within the CCO contracts:

    a. *The CCOs should implement a PIP to improve CMS 416 rates when the rates are below 75%-85%.*
    b. Sequentially add aspects of the comprehensive screens in the WVP/COE to the PIP
    c. Engage the ECDC in the improvement in the PIP by requiring reporting on PIP progress to both the Division and the ECDC.

Exploring Innovative Levers to Improve Provider Capacity:

3. ***The Creation of a Healthy Development Payment Bundle:*** Currently in MS there is no provider incentives for comprehensive early childhood screening. Numerous billing codes are being billed by providers for various pediatric screeners. The rates for these screenings are insufficient to cover the time it takes to administer the screenings and for providing appropriate follow up of identified problems. Even if provided, providers & provider systems find it difficult to capture codes for every screening and bill them. MST! has promoted the use of the Well Visit Planner (WVP) which combines many of the Bright Futures recommended screeners for development, socioemotional wellbeing, and resiliency into one tool. Some of the screeners include: Developmental Screening (SWYC), Autism spectrum disorder (M-CHAT-R™), Baby/preschool pediatric symptom checklist, Caregiver depression (PHQ-2 or EPDS), ACEs, etc. Unfortunately, the MS billing code structure does not provide any incentive to be comprehensive. The MST! team would like to work with the MS Department of Medicaid and the Medicaid CCOs to create bundle that adds a payment incentive for a comprehensive screen. The payment bundle would provide incentive for implementation of tools that include multiple screenings included in the WVP and ease the burden on the provider and the involved staff therefore encouraging the use of these tools. An appropriate coding modification could be made by the CCOs or the Division to ease administrative burden and more easily track improvement. CCOs could adopt this mechanism to meet their goals in the withhold or the PIP discussed above. An incentive for the comprehensive bundle above current rate of at least $50 is suggested. The payment for this bundle could be limited to xx times in the first three years of life. Such an incentive,

while significant for the provider, would have minimal impact on the capitation expenses of the CCO and likely would save the CCO costs by prospectively addressing concerns.

a. Collaborate to create a payment bundle that would encourage the use of tools that combine screeners, ensure an appropriate rate, and allow for population-based analysis.

4. ***The Creation of a Directed Payment for Early Childhood Infrastructure Reform:*** During the work conducted by MST! many health system issues have been raised that prevent providers from efficiently conducting screenings and interacting with families pre, during, and post the well-child visit. Some of these issues include IT challenges with outreaching to patients, pre-appointment to distribute the [contextualize with definition including linking] WVP tool, incorporating the screening results into the patient's EMR, and billing. In addition, care coordination gaps exist between providers, community services such as EI, and CCO care management programs could begin to be resolved through an investment in improved infrastructure. The MST! team is looking forward to collaborating with the Department of Medicaid and the CCOs to determine the best structure for a directed payment to support the development of linked clinical and community-based systems to coordinate comprehensive screenings and assure completion of referrals.

   a. Collaborate to create a directed payment for early childhood system reform to improve service provision at the healthcare system level and community base organization (CBO) level, as well as to create seamless coordination between all parties.

C. Comparator State CCO/MCO Payment Withhold Examples

The states selected in the examples below were chosen because aspects of their Medicaid programs aligned well with the MS Medicaid programs. For example, a lot of neighboring states have enforceable benchmarks for the Well-child Visit First 30 months (W30) metric within their quality strategies, but the enforcement mechanism is not always a performance withhold. However, states leveraging the withhold methodology are used as examples here. Performance withholds are a fairly common quality or value-based purchasing (VBP) strategy for states but are not universal and there is significant variability within how states set up their performance withholds. Therefore, there is no identical example to the Mississippi withhold but two similar states have been identified: **Missouri and North Carolina**. A couple of generalizable findings could be inferred from the multitude of other states that were looked at:

- Many states use around 5 metrics that make up their withholds, some states use significantly more in the realm of 15-20 metrics, metrics are a mix of adult and pediatric metrics.

- Value based purchasing is another strategy frequently included in performance withholds in combination with quality metrics that MS could consider including. The development of a WVP payment bundle, if taken up by the state would be an example of this strategy.
- States use a combination of previous MCO performance as well as national MCO performance to benchmark the metrics within the performance withhold. States do not rely solely on prior MCO performance in the state to set benchmarks for the metrics.

1. State Example: Missouri

Missouri was selected because the state has a performance withhold quality strategy that includes the W30 metric, it is also a neighboring state for MS and is a good comparator state. The main "best practices" coming out of MO is benchmarking the use of the national average standard, and the reporting of the withhold metrics stratified by race, ethnicity, gender, and county- this is a shift occurring more broadly in Medicaid and allows states to better understand disparities in care, as this data has historically been a pain point for MCOs and states. The wording below illustrates these best practices and is pulled from the Missouri state quality strategy.

"In State Fiscal Year 2020, the MHD introduced a new Performance Withhold Program using HEDIS measures calculated and reported by the MCOs' certified HEDIS vendors. Prior year baseline data was utilized to determine the percentage point improvement of 14 different measures. In addition to percentage point improvements, the MHD analyzed ***the program to determine how Missouri's MCOs compared to national rates in the NCQA's Quality Compass. The MHD and the MCOs established a program goal to reach the 50th percentile for each HEDIS measure.*** *Although some measures continue to be below the 50th percentile, significant improvements have been made due to the implementation of this revised model. HEDIS information by MCO for performance years 2018 and 2019 are shown in Appendix 3…*

With the ***revised Performance Withhold Program, MCOs are now including race/ethnicity, gender, and county in their measurement data****. This additional detail will allow the MHD and MCOs to improve efforts to reduce disparities within our managed care populations and evaluate the need for programs focusing on social determinants of health."*

- *MO 2021 State Quality Improvement Plan*

The tables illustrated on the following page are also pulled from the 2021 MO Quality Strategy and include historic performance on the reported metrics by MO MCOs and the metrics included in the withhold program. The WC15/WC30 metrics are highlighted in yellow. The first chart is a full list of the performance withhold measures and the corresponding withhold weights. The second shows MCO performance relative to the benchmark as percentiles. In general, pediatric metrics in MO make up 62% of the withhold or 1.55% of the overall withhold of 2%. As a

whole, the health plans are performing below the threshold of the 50th percentile set by the state. The MO Quality Strategy can be found here: https://dss.mo.gov/mhd/files/2021-quality-imprvmnt-strategy.pdf.

In the case of the performance withhold most of the language changes here would be implemented within the quality strategy itself as the current MS CCO contract references to the compliance of the quality strategy unless MS wishes to change the withhold percentage. Within the Quality strategy likely simple changes could be implemented such as adding a section to describe the new benchmarks being based off the Medicaid Median or the NCQA benchmark similar to the MO language in the quality strategy.

MoHealthNet

Performance Withhold State Fiscal Year 2022
HEDIS Measures

Appendix 2

Category	Portion of Total Withhold per Category	Acronym	Healthcare Effectiveness Data and Information Set (HEDIS) Measure	Portion of Total Withhold Per HEDIS Measure
Access to Care for Children	1.00% (Note: W30, WCV, and ADV measures include trailing decimal to equal a total of 1.00%)	W30	**Well-Child Visits in First 15 Months of Life (0-15 Months):** Percentage of children who turned 15 months old during the measurement year and had six or more well-child visits.	0.167%
			Well-Child Visits in First 30 Months of Life (15-30 Months): Percentage of children who turned 30 months old during the measurement year and had two or more well-child visits.	0.167%
		WCV	**Child & Adolescent Well-Care Visits (3-11yrs):** Percentage of members age 3-11 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	0.167%
			Child & Adolescent Well-Care Visits (12-17yrs): Percentage of members age 12-17 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	0.167%
			Child & Adolescent Well-Care Visits (18-21yrs): Percentage of members age 18-21 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	0.167%
		ADV	**Annual Dental Visits (Total):** Percentage of members 2–20 years of age who had at least one dental visit during the measurement year.	0.167%
Screening & Immunizations for Children	0.55%	CIS	**Childhood Immunization Status (Combo 10):** Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	0.20%
		IMA	**Immunizations for Adolescents (Combo 1):** Percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (DTaP) vaccine by their 13th birthday.	0.20%
		LSC	**Lead Screening in Children:** Percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	0.15%
Chronic Disease Management - Children	0.10%	AMR	**Asthma Medication Ratio (Total):** Percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	0.10%
Chronic Disease Management - Adults	0.10%	CDC	**Comprehensive Diabetes Care:** Percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c Control (<8.0%).	0.10%
Women's Health	0.40%	PPC	**Timeliness of Prenatal Care:** Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.	0.15%
			Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	0.15%
		CHL	**Chlamydia Screening in Women (Total):** Percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	0.10%
Behavioral Health	0.25%	FUH	**Follow-Up After Hospitalization for Mental Illness (30 Days):** Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge.	0.25%

The following measures are report-only measures. Health plans will receive 0.10% of the Performance Withhold by reporting the HEDIS rates. These rates will be utilized as a baseline for consideration in SFY2023. No evaluation will be done on these measures in SFY2022.

Category	Portion of Total Withhold per Category	Acronym	Healthcare Effectiveness Data and Information Set (HEDIS) Measure	Portion of Total Withhold Per HEDIS Measure
Behavioral Health		UOP	**Use of Opioids from Multiple Providers.** This measure assesses the rate of health plan members 18 years and older who receive opioids from multiple prescribers and multiple pharmacies (to monitor for possible inclusion in future years).	0.10%
Risk Adjusted Utilization		PCR	**Plan All-Cause Readmissions:** For Medicaid members 18-64 years of age, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	
Cardiovascular Conditions		CBP	**Controlling High Blood Pressure**: Percentage of members 18-85 of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	
Prevention and Screening		CCS	**Cervical Cancer Screening:** Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: * Women 21-64 years of age who had cervical cytology performed with the last 3 years * Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years * Women 30-64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years	
Prevention and Screening		BCS	**Breast Cancer Screening:** Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	

MoHealthNet

HEDIS Measure Results 2018-2019

Appendix 3

	Measure Name	Missouri Care 2018		Home State Health 2018		Missouri Care 2019		Home State Health 2019		UnitedHealthcare 2019	
		% Point Difference	Current Percentile (Goal 50th)	% Point Difference	Current Percentile (Goal 50th)	% Point Difference	Current Percentile (Goal 50th)	% Point Difference	Current Percentile (Goal 50th)	% Point Difference	Current Percentile (Goal 50th)
W15	Well-Child Visits in the First 15 Months of Life: Assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life.*	-1.7	25	-9.76	33.33	7.59	25	2.63	10	10.47	10.00
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life: Assesses children 3–6 years of age who received one or more well-child visits with a primary care practitioner during the measurement year.*	-2.5	10	-5.69	10.00	4.27	10	-0.14	5	7.05	5.00
AWC	Adolescent Well-Care Visits: Assesses adolescents and young adults 12–21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.*	5.83	33.33	6.33	10.00	4.24	50	2.43	25	-1.22	33.33
ADV	Assesses Medicaid members 2-20 years of age with dental benefits, who had at least one dental visit during the year.*	4.3	25	6.19	10.00	6.15	33.33	5.42	25	5.46	25.00
LSC	Assesses children 2 years of age who had one or more blood tests for lead poisoning by their second birthday.*	2.75	10	0.52	10.00	4.55	25	1.12	10	8.52	10.00
CIS	Assesses children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.*	0.97	10	-5.36	10.00	0	10	8.52	25	3.41	5.00
IMA	Assesses adolescents 13 years of age who had one dose of meningococcal vaccine and one Tdap vaccine series by their 13th birthday.*	3.4	10	0	0	1.46	5	4.63	0	3.4	0
CHL	Assesses women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.*	-10.35	10	-5.18	25.00	1.45	0	1.17	10	1.24	10.00
PPC	Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.**	-5.84	33.33	-3	10.00	15.57	50	8.91	75	-8.24	10.00
PPC	Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.**	-0.73	10	-8.78	95.00	20.44	50	11.46	50	8.89	25.00
CDC	Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had controlled HbA1c.*	-2.92	10	-4.87	10.00	3.17	10	3.41	10	6.33	25.00
MMA	Medication Management for People With Asthma: Assesses children 5-11 years of age who were identified as having persistent asthma and were dispensed appropriate asthma controller medications that they remained on for at least 75 percent of their treatment period.*	4	33.33	9.51	50.00	9.29	75	-0.93	75	-8.73	75.00
MMA	Medication Management for People With Asthma: Assesses children 12–18 years of age who were identified as having persistent asthma and were dispensed appropriate asthma controller medications that they remained on for at least 75 percent of their treatment period.*	1.45	50	8.04	50.00	4.49	66.67	0.56	75	-3.75	90.00
FUH	Assesses adults and children 6 years of age and older who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. The measure identifies the percentage of members who received follow-up within 30 days of discharge.*	-2.67	33.33	-3.19	33.33	5.48	50	1.13	33.33	10.40	10.00

2. State Example: South Carolina

South Carolina is also a good comparator state that leverages a withhold methodology. The SC methodology is a bit different from the MS and MO ones and actually utilizes even more stringent benchmark in order for the Health Plan to receive back the full amount of the withhold. SC has a 1.5% withhold with each index (as defined below) receiving equal weight. The main "best practices" in SC is utilizing a methodology in which the MCO earns cumulative portion of the withhold as they increasingly meet various thresholds as opposed to one specific benchmark Please see below for charts and language from the SC Medicaid Policies and Procedures document which can be located here: https://msp.scdhhs.gov/managedcare/sites/default/files/Final%20MCO%20PP%20July%202022%20-%20update.pdf

There are two charts below one that defines the "indexes" and one that assigns points for various percentiles of the benchmark as defined by the HEDIS percentiles, the last chart demonstrates the amount of withhold earned back via the point value.

SC Medicaid MCO Quality Withhold Indices, Reporting Year 2022/Measurement Year 2021

HEDIS Measure	Weight	HEDIS Abbreviation
Index 1: Diabetes		
Hemoglobin A1c (HbA1c) Testing	35%	CDC
HbA1c Poor Control (>9.0%)	35%	CDC
Eye Exam (Retinal) Performed	30%	CDC
Index 2: Women's Health		
Prenatal Care, *Timeliness of Prenatal Care*	50%	PPC
Breast Cancer Screening	25%	BCS
Cervical Cancer Screening	25%	CCS
Index 3: Pediatric Preventative Care		
Well-Child Visits in the First 0-15 Months of Life (w30), *6+ Visits*	25%	W30
Well-Child Visits in the 15-30 Months of Life, 2+ visits (w30), 2+ Visits	25%	W30
Child and Adolescent Well-Care Visits, Total	50%	WCV

Calculating the Index Score:

Step 1: Assign a point value to each of the HEDIS measures within the Quality Withho index based on the table below:

HEDIS Score	Point Value
< 10 Percentile	1 Point
10-24 Percentile	2 Points
25-49 Percentile	3 Points
50-74 Percentile	4 Points
75-90 Percentile	5 Points
> 90 Percentile	6 Points

For the purposes of determining the HEDIS percentile score, SCDHHS w use HHS-Atlanta data from the NCQA *Quality Compass* that was release during the measurement year.

Step 2: Multiply the number of points for each score, as determined in Step 1, by th weight assigned to each measure.

Step 3: Sum each of the weighted scores calculated in Step 2 for the Quality Withho Index to calculate the Quality Withhold index score.

Withholds will be returned based on the following parameters:

Index Score	Withhold Action
1 Point	75% of Index withhold amount forfeited and eligible for liquidated damages as described below.
1.01 to 1.99 Points	75% of Index withhold amount forfeited.
2.00 to 2.99 Points	50% of Index withhold amount forfeited.
3.00 to 3.99 Points	25% of Index withhold amount forfeited.
4.00 to 4.99 Points	Full Index withhold amount returned to Plan.
5.00 to 6.00 Points	Full Index withhold amount returned to Plan and Plan is eligible for forfeited funds in each index.

D. Comparator State Performance Improvement Project Examples:

1. **EPSDT Services PIP Language:** EPSDT is often a point of emphasis in Medicaid contracts, including MS as these services are mandated by the federal government and must at a minimum have an 85% completion rate for members under age 1. Some states are also leveraging EPSDT focused Performance Improvement Plans as another tool to emphasize the importance and focus of these services.

State Language Examples: Comparing Kansas and MS EPSDT Language

Kansas MCO Contract Language
A. The CONTRACTOR(S) **shall develop a PIP on EPSDT Screening and Community outreach plans in addition to the above required PIP's when overall CMS 416 rates drop below eighty-five percent (85%).**
North Carolina MCO Contract Language
If the PIHP performs below seventy-five percent (75%) for overall CMS 416 rates for EPSDT screening, the PIHP shall submit one (1) PIP on EPSDT screening and community outreach plans in addition to the three (3) required clinical and non-clinical PIPs annually

Appendix IV: CAHMI Research and Resources to Support MST Early Intervention Policy Work

Preamble in Recognition of the February 2023 Legislative Action to Appoint an Early Intervention Task Force Study: Advancing Early Intervention workforce, resources, and capacity to closely partner with pediatric primary care and other early childhood systems is essential to the implementation of the EnAct! framework and achievement of its goals to promote the healthy development for all children. Ensuring Early Intervention Part C and B programs implement robust Child Find program in alignment with the EnAct! framework approach with leadership through the MS State Part C Interagency Coordinating Councils is a high priority and MS is well positioned to advance this, especially with the success to advance a new, legislatively appointed effort to study and promote recommendations across the state.

October 2022 Memo:

Language and data to support MST! EI legislative testimony and planning (Oct 2022)

A. Data—See accompanying slides.

See **Table 1 below** for a summary of Developmental Screening (age 0-3) across four states and the national: **Highlights include**:

1. MS had an 83% increase between 2016/2017 to 2020-2021. MS is not statistically lower than the nation. This took MS from 50th in the US (of 51) to 33rd in rank. Increase was lower for publicly insured children, with a 45% increase observed between 2016 and 2021. (22% to 32%)
2. None of the other three states you wanted to compare to (NC, TN, WV) for this EI testimony had an even close to MS rate of increase between 2016 to 2021 (range from 8.5% increase for NC to a 39.4% increase in WV).
3. Note, however, that TN (the state with the "HUB" model) did have a 94% increase for their publicly insured children (is the Hub model focused on low-income children?). This is 23.4 percentage points higher than MS (or 73% higher rate than for MS publicly insured children)

Table 1: Trends in Prevalence of Developmental Screening (age 0-3): National, MS, NC, TN, WV

Year	Nation (state range)	MS (Public ins.)	NC (Public ins.)	TN (Public ins.)	WV (Public ins.)
2016-2017	31.1% (16.0 FL – 60.0 OR)	18.6% (22.0%)	36.4% (49.4%)	37.2% (28.5%)	32.0% (33.9%)
2018-2019	36.4% (20.6 AR-62.6 CN)	28.0%	48.1%	35.6%	47.3%
2020-2021	34.8% (18.9 AZ-50.6 OR)	34.1% (31.9%)	39.5% (22.0%)	44.1% (55.3%)	44.6% (31.8%)

Source: CAHMI Analysis of the National Survey of Children's Health, CAHMI (10.17.22)

Below is another table with information on two other key indicators (specialized services use and having an IFSP or IEP for young children). The slides include trend findings across the comparison (nation, MS, NC, TN, WV).

Table 2: National, MS, NC, TN, and WV 2020-2021 findings on "receipt of specialized services for developmental needs" and "had a IFSP and/or IEP" (EI Part C and Part B)

Prevalence of children aged 0-5 who currently receive specialized services for developmental needs	Nation 6.8% (3.1% MN – 11.2% AR)	MS 3.4%	TN 5.9%	WV 7.3%	NC 6.4%
Prevalence of children aged 1-5 who currently receive special education or early intervention plan. (IFSP or IEP)	Nation 5.0% (2.1% MN* – 10.0% VT)	MS 2.9%	TN 2.8%	WV 4.8%	NC 2.7%

B. Some Language to Consider on Making the Case for Legislative Action for EI and the Framework

Call to Action and How it Works: Our children are our treasure. And creating a healthy and productive population requires prioritizing the healthy development of all infants and young children. In doing so, the evidence is clear. The health of an infant and young child's mother and other caregivers and each child's caregiving, social and physical environment and experiences interact to promote or diminish their healthy development. In turn, these factors directly impact their readiness for school, as well as their health and productivity as an adult.

The Opportunity: Fortunately, advances in the science of healthy development point to unprecedented opportunities to dramatically improve the healthy development of all infants and young children and to mitigate risks to their healthy development by fostering positive childhood experiences and protective factors, especially safe, stable, and nurturing relationships and supporting the well-being of caregivers and families of young children.

MS Can! Existing services and strengths in Mississippi's early childhood system can be leveraged to dramatically improve the healthy development of its young children by building a "through any door" cross-system approach to ensuring all infants and young children receive high quality, comprehensive preventive and developmental screening and health promotion services and supports. Positive transformations in the States EI program are

essential to success.

MST! Progress: The five-year, federally funded Mississippi Thrive! initiative (2016-2021) has established a deliberate focus on improving the healthy development of Mississippi's young children by raising public awareness about ways to promote healthy development, building the skills of the early childhood workforce, advancing partnerships across state early childhood systems, coordinating access to resources for young children and families and by piloting an enhanced model for the provision of preventive and developmental services in pediatric primary care well visits.

Due to these efforts, Mississippi is now poised to build on progress made by further advancing cross-sector strategies to ensure high quality preventive and developmental services for all young children that fully engage families and address the range of factors essential to the healthy development of infants and young children. Mississippi can lead the nation by modeling and integrated, whole child and family approach.

C. Quick Update on Initial Findings on TN EI Funding Level (Per Request):

> **TN EI Funding:** TN seems to run a well-funded EI program (at least relatively to MS and WV), they also just added " a recurring $21,837,500 to extend services in the Tennessee Early Intervention System (TEIS) to a child's fourth birthday, which is one year longer than the current third birthday." Please see the details of the funding scheme below including the federal dollars v. the state dollars directly from the FY2023 TN Budget. **The federal investment is $9,261,900 and $60,804,800 is contributed by the state, in addition $29,495,400 is contributed through "other funds" all in all the recommended amount for this year is almost $100 million.**

Source for TN Budget:
https://www.tn.gov/content/dam/tn/finance/budget/documents/2023BudgetDocumentVol1.pdf.
Detailed Breakdown Can be Found here(search Early Intervention):
https://www.tn.gov/content/dam/tn/finance/budget/documents/2023BudgetDocumentVol3.pdf

D. Narrative Data Summary from the EnAct! Framework Long Version to Consider:

1. A strength-based summary (see August and October 2022 Longer EnAct! Documents)

It is commonly stated that Mississippi ranks among the lowest in indicators of child and family health and wellbeing. However, this depends upon the data that is examined and requires consideration of the larger context in which Mississippi children and families live, including historical and cultural factors. Measurement systems that heavily focus on economic and income and services policy indicators of well-being (e.g., Annie E. Casey Foundation's KidsCount Data Book or Zero to Three's State of Babies Yearbook) typically rank Mississippi in the lowest few states for child and family health. Yet, other measurement systems like the National Survey of Children's Health or the Prenatal to Three Policy Impact Center's state reports (which draw on the NSCH as well) paint a different picture.

As summarized below, Mississippi's performance related to young children has actually improved over the course of the MST! Initiative on several critical indicators.

This includes indicators such as whether children under age three have received any development screening. Here we saw Mississippi go from 50th in the nation in 2016-2017 with a rate of 18% of children to 33rd in the nation in 2020-2021 with a rate of 34.1% (p=.02). Mississippi's new rate is not lower than the nation as a whole. Other indicators trending upward have been whether a child was ever breastfed (57.8% in 2016-2017 to 66.9% in 2020-2021; p=.06) and the proportion of children ag 0-5 who live in a household where someone smokes (27.2% in 2016-2017 to 21.2% in 2020-2021).

2. Areas for continued improvement

At the same time, some indicators seem to indicate a worsening in conditions for young children. For instance, population based NSCH data for Mississippi indicate **some increase in the proportion of children who were born premature or with a low birth weight since 2016-2017 to 2020-2021** (14.4% in 2016-2017 to 21.3% in 2020-2021;). Mississippi has also maintained a significantly higher than national average rate of children aged 3-17 who are diagnosed with Attention Deficit/Hyperactivity disorder as well higher rate of children age 10-17 who are obese (26.1% in 2016-2017 ranked highest in the nation to 23.1% in 2020-2021 ranked 48th highest of 51 states). In addition, **while the proportion of children age 0-5 who live in a home where someone smokes has declined since 2016-2017 (27.2% to 21.2% in 2020-2021), Mississippi still ranks among the worst performance states on this important indicator (national average is 13.8%)**

3. Critical importance of children's emotional and mental well-being (call for EI to focus here!)

Importantly, there has been a striking drop in the proportion of children meeting criteria for demonstrating good self-regulation of emotions and behavior, which is critical to a child's readiness for and success in school and socially (66.0% good self-regulation in 2016-2017 to 39.9% in 2020-2021; p=.001). While factors related to the COVID-19 pandemic may account for this change, it nonetheless should catalyze strong efforts to help children develop self-regulation of their emotions and behavior, which many evidence-based strategies are available, including ensuring caregivers/parent are cooping well and the family also practices resilience when things are difficult (e.g., maintaining hope, seeing strengths to draw on, staying connected to work out problems, etc.). The proportion of children living with families exhibiting two important aspects of resilience (staying hopeful and knowing they have strengths to draw on) was only 54.7% in 2020-2021. Yet, we have strategies to improve family resilience, and this has a direct impact on whether children flourish and are ready for school. Mirroring the tremendous opportunity that exists in Mississippi to promote children's readiness for school are findings from the NSCH "Healthy and Ready to Learn" measure assessing a child's health, language, motor, and social skills critical to school success, which shows that fewer than 2 in 5 children age 3-5 in Mississippi are ready for school. Another measure of "Kindergarten Readiness" reported in 2022 by the Mississippi Department of Education and that focuses primarily on reading and language skills estimates that about 57.5% of kindergarteners were ready for school—with wide variations across Mississippi School Districts (29.7% in Baldwyn School District to 83.3% in Armory School District).

One Solution: The EnAct! framework and early development bundle are specifically focused on leveraging the pediatric primary care visits using a "through any door" model so that community and family based services and supports, early care and education programs, state child welfare, early intervention and home visiting programs and, importantly, Medicaid and their contracted Coordinated Care Organizations can partner to close the utilization gap in well visits (about 50% of recommended visits do not occur) as well as drive high quality services that ensure comprehensive, family centered services can be efficiently and effectively provided to address and improve the well-being of the whole child, family and community.

Appendix V: Overview Initial CAHMI Overview of MST! Short- and Longer-Term Policy Levers to Consider

September, 2022

Re: Starting point memo outlining short and longer terms policy opportunities and priorities based on initial discussions

This memo documents the range of policy levers that have emerged to date in our work. This initial outline of shorter- and longer-term opportunities for continued discussion are listed below and are categorized by those related to legislative action vs. actions that can be taken by state agencies without legislative action (as we understand it), especially the Division of Medicaid. Each initial lever is also categorized based on CAHMI's understanding of what might be possible to address in the shorter term vs. longer term, using the following key:

Key: Priority levels
1= short term 6-12 months
2= intermediate 12-36 months 3=long term 36 months +

1. Legislature Priority Level 1 (short term)

a. **Ask**: Support and fund Medicaid funding for 12 months postpartum. Base the pitch on the desire to make Mississippi a welcome place for mothers, to decrease state costs downstream caused by lack of healthcare. Emphasize the low cost for this program because of the significant federal match. Some specifics to make sure are included in the legislation if possible:

- *Screening for postpartum depression and substance use disorder can occurring at well baby visit and be compensate. Legal mechanisms for protecting mom's data on*

the child's chart are explored and enacted.

- *Other state examples – Arkansas, Alabama, TN, NC, WV?*

b. **Ask**: Support and fund early intervention services that are community based

- *Legislation should include support for training and local community-based intervention. Align/build on the existing MS ICC and CSPD actions and state IDEA Part C and B plans. Who in the state is "eagle eye" on EI legislation and services? Partner with them?*

- *Links to Medicaid via the WVP/COE in tracking referral needs from WVP and MCOs overseeing referral completion. Use EQRO for this function and place in MCO and EQRO contracts. For example, track the total number of MCO enrollees screened at preset intervals, number needing referral, number referred and number completing referral. These would be based on CAHMI/ data center except for completed referrals which would be based on EQRO survey.*

- *See:* **https://sites.ed.gov/idea/state/mississippi/** for the MS EI Part C and B plans and Federal response—that mostly says "You need our help"

- *Legislation that includes "no wrong door" approach to screening with data sharing across healthcare, EI, Community based, etc. could be supported by the Well Visit Planner—requires coordination, MOUs, permissions to receive results from others (e.g., provider to EI, EI to provider, MFFK to EI, Family to EI?) and assurance to all that they "get credit" for screening and all do not have to repeat it (very NOT family centered) in order to claim having screened or to bill (mostly relevant to pediatric providers).*
- *Training is run from Department of Health (EI) and overseen by an advisory committee (MS ICC? SECAC?).*
- *[Lift out of the framework to write legislative language and set parameters for program – and timeline (Department of Health- EI)]*
    -

c. **Ask:** Fund state infrastructure to link Early Intervention and Medicaid referrals while requiring the Medicaid MCO contract to 1) pay providers and 2) MCOs to pay for comprehensive screening tools, training, a mechanism to support families understanding and owning their data, and a mechanism to collect and report on the data in a timely and accurate manner

- *State funding for MST! like grant to (using DOM Admin Match and HSI authorities?)*
    - *Fund MST! ECDC coordination and related leadership staff*
    - *Fund infrastructure to create resources, train providers (medical and*

community) and run a pilot, learning network.

- *Set up linkages with local EI and other child resources addressing any official policy changes to enable coordination and "through any door" access by families.*
- *Fund efforts to track impact, learning and report back to legislature on progress- time limited with reporting to continue program.*
  - *Set up milestones to report – rates of screening/ referral obtaining services.*
- *State directed MCO payment to providers (bundled payment?), care coordinators and provide integrated screening, reporting, family engagement resources.*

2. Priority Level 1 For Medicaid Action

(Potentially without Legislative authorization needed)

a. **Medicaid CCO Contracts and HSI's:** Support and require MCO contracts to create a healthy development bundle (care expectations and payment rate) for primary care comprehensive screening, health promotion and coordinate for referrals. Options for initiating a bundle include:

- ***Option 1****- Services and follow up covered under a two-year pilot funded by Medicaid – [Can this be done in quality strategy without Legislative approval?]*
  - *Require the state SECAC or other public committees to define this bundle to get buy in*
  - *Magnolia may be example to screen via its Health Services Initiative (HSI) for this as a two-generation solution.*
  - *Propose bundled rate at a premium over cost of all screens individually and a rate that will move providers to want to participate ($50 per screening with x intervals in the first 3 years)*
- ***Option 2*** *- Consider focusing the MCO withhold (with no change in PMPM from Medicaid to MCOs)*
  - *Focus withholds on postpartum and early childhood measures.*
    - *Include MCO requirement for bundled payment for WVP/COE/PHDS to providers.*
    - *Start with a "pay to play" withhold to report current results and to set up WVP system with the CCO's provider organizations. MCO will supply resources to practices to*
      - *Provide integrated "one stop shopping" screening services for development, social emotional, relational etc. health such that these may be tracked by the MCO and provider.*
      - *Support family engagement as a practice*

- *Help engage families directly and direct families to schedule/receive well-child visit care (do much more to track and reel in "Gap Cases" with the providers*
- *Will support tracking cases needing follow up from referral (collaborate with CAHMI in this for those using the WVP)*
- *Data shared with provider via Clinical Summary, but MCO can also help with EMR integration and auto billing, etc.*
- *Data entered for provider review by community organizations.*
- *Date is received by and can be shared by the family.*
- *Etc.*

- *Focus on known measures to start (well visits and developmental screening) with expansion to WVP/COE measures. Removed other measures from the withhold to add emphasis here. We can outline the measures and codes suggest.*
- *Move to a "pay to improve" approach in later years. Create benchmarks for progress with the community and based on meeting/ exceeding national standards.*
- *Have MCOs support the Engagement In Action framework care bundle via training and quality work. Create EQRO metrics to evaluate the MCOs in their progress on this work. This includes assessing MCOs processes for use of comprehensive screening tools, training, a mechanism to support families understanding and owning their data, and a mechanism to collect and report on the data in a timely and accurate manner.*

- ***OPTION: CAHMI and UMMC can draft model points for MCO contract language using either pilot or withhold pending Medicaid approval.***

- ***QUESTION:*** *We could write specific code sets and rates for the bundle or specific withhold parameters if Kristy Simms/ MS team think it would be helpful. Maybe internally helpful for them without presenting to Medicaid?* ***DISCUSSS!***

OTHER OPTIONS*: Other options for delineating MCO duties could include creating a required Performance Improvement Project or giving best performing MCOs the opportunity to auto-enroll more children compared to the competition.*

<u>Additional Ideas For Medicaid Providers</u> - Priority Level 1,2 and 3 considerations

Priority Level 1-Medicaid will work with MST! to develop the fiscal model for the provider component of the key services and mechanism to track their uptake and cost avoidance *[do a mockup of this]. Lay out existing vs. desired billing code and bundled payment options to reflect the enhanced care model with assurance of screening, family engagement and focusing on family risks and priorities "on the spot". Can integrate VROOM tips into WVP summaries anchored to priorities and risks (new work but doable). Can also link to the Centralized Resource Sheets on MST! Website for each county, add other local resources.*

Determine mechanism to build out these costs so they are consistent with the ask of the legislature and MCOs/CCOs via Medicaid

Priority Level 2-require and track a core set of early childhood development metrics/activities (e.g., via the EQRO and EI, others)
-well visits
-full whole child and family screening for children (enabled by the Well Visit Planner)
-referral completion
- EI services access, quality, and coordination
-Practice level engagement in quality review in closer to real time.
-Use yearly NSCH data to track school readiness, flourishing, family resilience, screening, etc.

Priority Level 2-Require use of the common EnAct! framework early developmental care approach, including a Well Visit Planner type resource to help providers to conduct comprehensive, personalized services and optimize time for counseling and referrals.

Priority Level 1,2,3-require annual reports of interventions and cost avoided – report linked to community oversight (e.g., DOM, SECAC, MS ICC, other?)

<u>Additional MCO engagement concepts</u>: These reflect Medicaid priorities delineated above, with a focus on the Engagement In Action Framework approach to services.

Priority 1-*support and require provider systems to start using WVP/Health Promotion bundle, including MCO active help to engage families, get families into visits and support community and family supports.*

Use WVP API/HL-7 bridge – to automatically put Clinical Summaries and/or data elements into the EMR if scanning is not sufficient.
Create codes and enable auto-populating when WVP Clinical Summary/data is pulled in
Understand expectation for a bundled payment process to reflect effort of whole child screening

[need to set a rate to providers and frequency or propose that the rate is a pass through in the contract from Medicaid] and personalized health promotion and referral linkages.
Priority 1-*require reporting of screening rates at x interval to Medicaid Priority 1 - training for providers/ community-based providers.*
Priority 2-require support for integration of screening into the EMR.

Discuss parameters for integration and steps and roadmap to integration.

Priority 2-require delineation of a process by the MCO with community to follow up on referrals made Priority 2-require regular reports and progress linked to withhold.

For providers *and health systems*
Priority 1-understand, help develop and agree to the bundled rate for WVP/COE – aligns with EPSDT Priority 1-develop resources in practice and linked to community to screen (e.g., CHW)
Priority 2-develop plan to receive funds for WVP/COE from MCO/Medicaid
-training and recruitment of staff supported by the MCOs
-incorporation of information into EMR and clinic flow with the MCOs
Priority 2,3-develop plan to bill for codes for WVP/referral at practice –*back-end IT codes get.*
Priority 2-develop plan to receive PHDS information (and practice rates of screening) for quality review.

For community resources and families
Priority 1 - *support community navigators/ family navigators from DHS (early intervention) Consider using existing MCO resources (gift cards)*
Priority 1 -support 12-month postpartum care for women that includes interventions at the pediatrician's (family practice) office – depression screening and follow up.
Priority 1,2-Develop and support "no wrong door screening."
-develop mechanism to capture work and revenue from early intervention (or Medicaid?) to screen
Priority 2,3-develop and sustain community based early intervention Develop community lay person led models.
Priority 2- consider group visits for postpartum and early child care.
Priority 2,3-community directed use of resources to support young parents (moms and dads)

C. Goals and Design Parameters (to be discussed, refined, and edited)

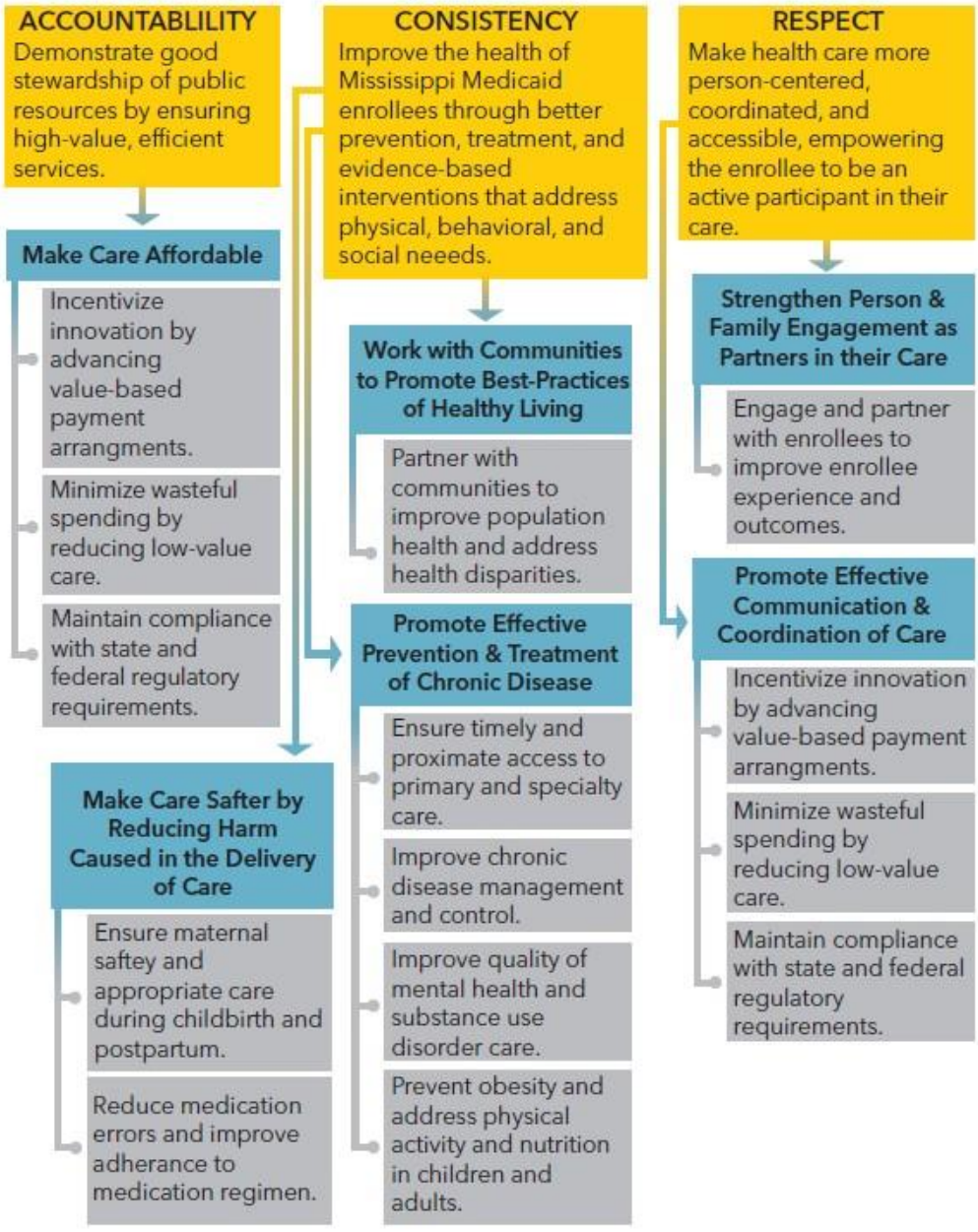
Overall goals are similar to those set forth in the EnAct! framework and its Implementation Action Plan. Design parameters for the policy playbook we discern so far are:

1. **Be bold to set a high vision** and call out or work around obstruction as is politically possible.
2. Outline specific objectives for the Policy Playbook with a focus on improvements and

changes in MS State agency and legislative policies and **starting with Medicaid/CCOs and DOH/Part C/EI** (postpartum coverage, universal/whole child/integrated well-child visits and strong capacity and linkages with EI and related high-risk services.

3. **Advance through the MST! ECDC as possible (and SECAC), with UMMC leadership?** Or is it key that all entities act independently but perhaps in a coordinated way through sharing of common goals and objectives and "talking" materials/asks?
4. Present goals, objectives and "starting point" ideas to Medicaid and Legislature and then **co-develop with them. Do not show up with it "all worked out"** –relationship building will be essential to buy in and enduring change and support.
5. **Articulate and support a plan for short term** action building to further actions that focus on the long haul to gain trust and momentum and positive change. Lead advocacy with the **goal to engage community/family/local provider ownership** of the process with enabling state policies and support.
6. **Always articulate the role and accountability of all** involved—private and public sector, all involved, including joint resource allocation and accountability across state agencies and systems players
7. **Use "like-us" examples/comparators** from AR, AL, TN, NC (not the other states like RI, PA, WA, OR, VT, MN, CA, etc.)
8. **Leverage existing policy work** like *Payment for Progress* that outline needs that are also mirrored in the EnAct! framework related to: (1) advancing evidence-based strategies to promote each childhood development that are guidelines based, personalized and systems oriented (GPS); (2) workforce and capacity building; (3) strategies that enable effective cross sector collaboration; (4) aligned measurement and data systems; and (5) robust learning and improvement platforms.
9. **Use an "adaptive planning" model** based on iterative learning and adaptation (key in complex systems where there is ongoing change, learning and uncertainty)

Table 3: Mississippi Division of Medicaid, Comprehensive Quality Strategy Aims, Goals, & Objectives



Source: Mississippi Division of Medicaid, Comprehensive Quality Strategy, 2021.