WHOLE CHILD HEALTH ALLIANCE

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

Massachusetts, North Carolina and Washington

NEMOURS CHILDREN'S HEALTH®

Executive Summary

Introduction

Informed by interviews with more than 30 key stakeholders, the *Whole Child Health Alliance* (the "Alliance"), developed case studies that showcase how three states – Massachusetts, North Carolina and Washington – have implemented the *core elements* of whole child health that help children and youth thrive. These case studies describe how multisector leaders across these states have leveraged momentum from broader health care transformation efforts, federal policy tools, and public sector and philanthropic funding to support the developmental, physical, mental, behavioral and social needs of children and youth. The initiatives in these states could provide an example for other states seeking to promote whole child health.

Key Takeaways

State Strategy to Advance Whole Child Health

The whole child health approaches in these three states' are comprised of several separate initiatives that come together as part of a broader strategy to advance whole child health. Over time, they have utilized various policy levers (e.g., Medicaid 1115 waivers, Integrated Care for Kids (InCK), State Innovation Model) and funding streams (e.g., public and philanthropic) to support each initiative. Notably, the states built on the momentum of larger health care transformation projects to initiate pediatric health care transformation, often by ensuring children were eligible to receive services or be included in initiatives that were not specific to the pediatric population.

State-Level Initiatives Driving Whole Child Health

While the key initiatives that comprise Massachusetts', North Carolina's and Washington's whole child health approaches vary, each approach advances several common key elements. Each model:

- Implemented **financing reforms that incentivize optimal health**, which can include moving towards value-based payment
- **Integrated care delivery and social supports** by reforming their Medicaid programs to cover a set of services that address social drivers of health for children and their families
- Enhanced primary care by **integrating behavioral health** services into the primary care setting and offering programs that promote prevention and **align care for families**

Policy Recommendations

Based on the learnings from the case studies, the authors developed a set of policy recommendations[1]. The federal government can kick-start the spreading and scaling of whole child health approaches across the United States by implementing policies that prioritize, fund and enable stakeholder innovation towards whole child health. Specifically, the following recommendations could be considered:

- The United States Congress could support and fully fund the Centers for Medicare and Medicaid Services (CMS), the Center for Medicaid and CHIP Services (CMCS), and Center for Medicare and Medicaid Innovation to develop and implement initiatives that support whole child health, including but not limited to a whole child health demonstration model.
- CMS could establish a learning collaborative or a new *Medicaid Innovation Accelerator* program among interested states in partnership with pediatric providers regarding implementation and financing of prevention- and/or population health-driven whole child health delivery models.
- The White House could continue its leadership on health equity, while also specifically focusing on addressing health equity in the pediatric population.
- CMS could emphasize whole child approaches to care that integrate team-based primary care, mental health and oral health, alongside all other covered services as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) implementation review and technical assistance mandated by the *Bipartisan Safer Communities Act* (Public Law No. 117-159).
- CMS could also conduct an analysis to identify any gaps in behavioral health services covered for children and youth under each state's Medicaid state plan as compared to the full spectrum of behavioral health services coverable under EPSDT as part of the EPSDT implementation review.

Lastly, the authors applaud CMS and CMCS for releasing *State Health Official Letter #21-001* and a *CMCS Informational Bulletin* to provide guidance to states on leveraging Medicaid to address health-related social needs. CMS could continue to update this guidance with new examples on a regular basis, including highlighting best practices for managed care plans to address social drivers of health.

Conclusion

Massachusetts, North Carolina and Washington serve as early examples of what whole child health approaches can look like on the ground. Notably, each state has tailored its approach to meet the unique needs of its population as well as its policy environment. For more comprehensive descriptions of these initiatives, an analysis of the conditions that made implementation possible, an assessment of barriers to implementing whole child health approaches, and a detailed set of policy recommendations, please see *Advancing the Key Elements of Whole Child Health: State Case Studies and Policy Recommendations*.

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