BRIEF | JANUARY 2019

CHCS Center for Health Care Strategies, Inc.

What Makes an Early Childhood Medicaid Partnership Work? Insights from Three Cross-Sector Collaborations

By Daniela Lewy and Amelia Vaughn, Social Determinants of Health Consulting[*] and Rachel Yard, Center for Health Care Strategies

IN BRIEF

Early childhood development has a dramatic effect on future adult populations, as the brain experiences its most rapid growth from ages 0-3. Medicaid covers nearly half of all children ages 0-5, putting it in a unique position to improve future population health by supporting early childhood interventions. Such interventions should address physical health and mental health as well as the social determinants of health affecting the family unit — all of which may be accomplished by breaking down silos across sectors to work together. The *Medicaid Early Childhood Innovation Lab,* led by the Center for Health Care Strategies with support from the Robert Wood Johnson Foundation and the David and Lucile Packard Foundation, assisted six sites in pursuing Medicaid-driven strategies to support young children and their families. This brief outlines the activities of three sites to help inform other cross-sector partnerships at varying stages of development – problem identification, program design, and program implementation.

Across the country many government officials, multi-sector agencies, frontline staff, communities, and families have come to the same conclusion: a systems approach is needed to improve outcomes for our youngest citizens. Infants and young children require high quality prenatal care, stable housing, healthy nutrition, thriving families, early education, access to medical care, and positive adult-child interactions — but no single agency can be accountable for all of these supports.

The need for multi-sector strategies is emerging alongside neuroscience research that demonstrates the long-term impact of holistic interventions that support healthy brain development, a nurturing environment, and prosocial relationships in the first three years of a child's life.[1] From birth to three years old, the brain develops at an astonishing rate, reaching 80 percent of its adult volume by age three. Children learn by expecting, perceiving, and modeling their caregiver's reactions, and therefore acquire complex skills for coping with stress at a very young age.[2] When a child experiences unmet basic needs, a non-nurturing environment, or trauma, the brain produces a biological response that may result in poor physical and mental health outcomes decades later. As such, the development of young children, and attention to their cross-sector needs, has major public health implications for our future adult populations.[3]

[*] Daniela Lewy, EdLD, MPH and Amelia Vaughn, MPH, serve as consultants to the *Medicaid Early Childhood Innovation Lab*.

Made possible with support from the Robert Wood Johnson Foundation and the David and Lucile Packard Foundation. The views expressed here do not necessarily reflect the views of the funders.

Increasingly policymakers are responding to these early childhood research findings and developing cross-sector opportunities to improve long-term health and wellbeing outcomes for today's children. Since Medicaid insures 45 percent of children ages 0-5 and covers 81 percent of children under age 6 whose families earn less than 138 percent FPL,[4] Medicaid is well-positioned to be a natural partner in cross-sector work to improve child wellbeing outcomes. Furthermore, Medicaid is both the largest source of health spending, and the largest program in any category of spending on children. In 2017 alone, about $105 billion of Medicaid and Children's Health Insurance Program funds were spent on individuals under 18 years old.[5]

The Medicaid Early Childhood Innovation Lab

In 2017, the Center for Health Care Strategies (CHCS) launched the *Medicaid Early Childhood Innovation Lab* with support from the Robert Wood Johnson Foundation and the David and Lucile Packard Foundation. The project convened early innovating state Medicaid agencies (Connecticut, Maryland, and New York) and regional health systems (Hennepin County, Minnesota, and Health Share of Oregon) to initiate upstream interventions using Medicaid funding. Over 18 months, these sites designed and implemented Medicaid-driven strategies to: (1) create optimal conditions for early childhood (prenatal and ages 0-3) health and development; and (2) intervene with at-risk families to prevent trauma and improve the life outcomes of these children.

This brief provides case studies exploring the design and implementation of Medicaid cross-sector partnerships in three of the pilots: Hennepin County, Minnesota; Maryland; and New York. While each site approached their cross-sector work from different angles, all of the sites are changing the status quo of how government-led initiatives operate. Specifically, they are all working to improve government efficiency, build relationships across sectors, debunk myths about historical ways of working, and most importantly, improve health and wellbeing outcomes for children and families. Each of these pilot projects is in distinct phases — from problem identification to program design and implementation. Hennepin County analyzed interagency data to identify the root cause of child welfare placements for infants and young children; Maryland developed a framework to encourage managed care organizations (MCOs) participation with the Medicaid Home Visiting Services (HVS) Pilots and other early childhood HVS programs; and New York implemented a large-scale, multi-sector partnership called the "First 1,000 Days on Medicaid." The following are brief case studies of each:

Hennepin County: Integrating Cross-Sector Data to Identify the Problem

Hennepin County, Minnesota is leveraging Medicaid and health care payment reform opportunities to invest in early childhood interventions that maximize positive outcomes for children in the child welfare system. Research has shown that removing children from their homes through child welfare placements has lifelong implications for health and wellbeing. While many young people in the child welfare system demonstrate extreme resilience, the majority are vulnerable to poor mental health outcomes.[6] Compared to their peers who are raised in biological families, children in out-of-home care who experience placement instability (i.e., multiple short-term placements, failed family reunification) are more likely to experience complex outcomes such as developmental delays, substance misuse, and sexual and mental health problems. They are also up to 10 times more likely

to use mental health services.[7] Children under the age of three are even more susceptible to trauma, making early childhood out-of-home placements even more damaging.

Removing children from their homes also exhausts resources that could otherwise be invested in opportunities to support families. In Hennepin County, the child welfare system has become increasingly unsustainable due to its high cost and rising rate of children entering the system. Between 2015 and 2016, the rate of young people in child protective services rose 79 percent, and the number of children experiencing out-of-home placements increased by 10.2 percent.

The Hennepin operations team recognized the need to better understand the drivers of these outcomes and redirect resources to prevention, rather than crisis management. For example, instead of putting resources toward removing children from adverse household conditions and then later funding supports to heal the trauma of leaving their homes, it is probably more effective to invest in support programs for parents. According to Jennifer DeCubellis, Deputy Administrator for Hennepin County Health and Human Services, "Instead of pulling the child protection trigger, the easier lever, you can decide to give mental health services to mom instead."[8] With the right data and informed interventions, resources could be reallocated toward preventing adverse outcomes for families.

Hennepin's resulting data analysis strategy is designed to find the cross-sector markers correlated with children going into out-of-home placements and find out how to identify families earlier. The goal is to develop targeted and data-driven solutions that address the root causes of child welfare placements and inform interventions that keep children with their families.

> ***"[Data sharing is] not a 'yes' or 'no' question, but [rather a question of] what data can be shared, and [what data] is needed to be shared. Then, there is a path forward."***
>
> *- Peter Bodurtha, Principal Planning Analyst, Hennepin County Center of Innovation and Excellence*

Hennepin started its work by combining previously separate data sets to look at how systems are currently engaging families, and where those systems must change. Hennepin plans to link datasets across Medicaid, human services (e.g., child protection, housing, food support), public health (e.g., Women, Infants and Children, home visiting), criminal justice, and corrections to look at Hennepin County families that experienced out-of-home placement of a child aged 0-5.[9] The analysis of the merged dataset is expected to:

- Describe patterns and overlap of cross-sector public services prior to out-of-home placement;
- Describe health care utilization patterns in relation to out-of-home placement; and
- Create multivariate predictive models that anticipate the risk of future out-of-home placement.

Integrating data systems is a major challenge in any cross-sector effort. With this in mind, the Hennepin County team worked with four different attorneys to understand the federal data-sharing laws so that it could challenge the policies and statutes that limit data-sharing. Now that the team has overcome this barrier, the door is open for continued data integration. Hennepin County also had serendipitous timing, as the pilot coincided with the County's Internal Audit Department's charge to improve data compliance. The various agencies were required to classify the data sets they

collected, which resulted in universal data transparency. This enabled Hennepin staff to identify the available datasets from each department that held information on the families they were trying to target.

The Hennepin County team also fostered relationships with diverse stakeholders to strengthen the culture of cross-sector data sharing across county agencies. With support from county leadership, the team was able to navigate roadblocks, convene diverse partners, collaborate with practitioners, and effectively support the data analysts in getting what they need. Many data analysts do not have a background in social services, public health, or early childhood, making it essential to engage program staff and content experts in the data analysis process.

Lastly, Hennepin County created a line of communication that connects all county departments' respective 'data shops.' This included talking to analysts in other departments about the project, the data requests, and timeline to confirm feasibility and achieve buy-in at the very outset of project design. Hennepin recommends involving everyone from leadership to practitioners in the research process since they will eventually be the ones to design and implement the intervention. Doing so helps build trust among partners and protect against avoidable bureaucratic obstacles.

The Hennepin County team is a data-sharing unicorn. While not all states, counties, and cities have the same legal conditions, relationships, and leadership mandates to recreate its success, the Hennepin County team believes that the, "relevance of [its work] is to demonstrate what is possible."[10] After "nibbling at every 'we can't' and every barrier,"[11] the county now has a system of fluid communication across departments. This has created opportunities to develop data-informed solutions, as well as shift the work away from crisis-intervention and toward data-driven prevention efforts.[12] This type of integrated data analysis is an iterative process that requires buy-in, time, commitment, persistence, and patience.

Maryland: Designing a Cross-Sector Intervention

Maryland used its Medicaid Section 1115 waiver authority to expand an evidence-based home visiting pilot for high-risk pregnant women and children up to age two in several local jurisdictions. The state leveraged existing public health maternal and child health home visiting services models to increase access to, and utilization of, HVS for children and families with Medicaid coverage. The state sought to maximize referral policies and partnerships for connecting families with supports that address social determinants of health (e.g., food insecurity, unemployment, housing instability, and lack of education). In particular, the team designed a process to improve linkages between HVS and MCOs to address families' health, social support, and child development service needs.

The initial impetus for the pilot came after the Maryland Department of Health received stakeholder requests for innovative ways to expand HVS across the state. Although an estimated $49 million was invested in the state from 2010 to 2017 to support home visiting through federal formula funding, state agencies, legislation, and competitive grants, the resources were not available to all jurisdictions or guaranteed.[13,14] Home visiting is not currently covered by Medicaid in Maryland, which led to the Maryland Medicaid Planning Administration's decision to include an evidence-based home visiting services pilot in its 2016 HealthChoice §1115 waiver renewal as a way to secure funding. CMS approved up to $2.7 million in matching federal funds for local governments to pilot an expansion of evidence-based home visiting programs targeting high-risk pregnant women and

children up to age two. Since July 2017, Maryland's Harford and Garrett Counties both implemented pilots using this matched federal funding opportunity.

Since Medicaid has never been a home visiting partner, the Maryland team recognized it had a lot to learn around the intersection of home visiting programs, providers, and Medicaid MCOs. It acknowledged the extensive expertise around the state and sought to add value from its locus within the Department of Health. After compiling an inventory of existing statewide cross-sector early childhood initiatives, the team discovered a void where Medicaid, and MCOs in particular, could fit into Maryland's early childhood landscape.

The Maryland team interviewed eight key programmatic stakeholder groups — including the Maryland Maternal and Child Health Bureau; the Maryland Office of Minority Health and Health Disparities; HealthChoice and Acute Care Administration; Planning Administration; WIC; the Medicaid Chief Medical Officer, and, outside of the Maryland Department of Health, the Governor's Office of Children — on the role and value of home visiting within each of the organizations or agencies. The team also engaged directly with Harford County Health Department leadership and HVS pilot program staff to understand their perspectives and needs. This process uncovered disparate conceptions about home visiting, but identified the importance of these services as part of a local health department portfolio to meet the needs of children and families.

It was clear that the conflicting views of home visiting needed to be resolved in order to improve cross-sector collaboration. The Maryland team organized two small stakeholder workshops, including staff from the Maternal and Child Health Bureau and the Office of Minority Health & Health Disparities, along with MCO program experts, community-based pediatricians, and CHCS consultants, to understand the opportunities for collaboration between early childhood home visiting, physicians, and MCOs. The workshop used a human-centered, design thinking framework[15] to bring together a new group of people for a process that required everyone's voice and participation.

> ***"People appreciated that they were able to engage in open conversation. There were people representing diverse perspectives on home visiting. It highlighted new opportunities."***
>
> *- Sandra Kick, Senior Manager, Maryland Medicaid Planning Administration*

The discussions also revealed that some physicians and MCOs were not aware of early childhood HVS available to their patients and members, and as a result, had not been referring families to these evidence-based programs. At the end of the session, participants identified a set of challenges to tackle that included policy alignment, clear scopes of work, shared vision, organizational coordination, and role clarity. The meeting was a catalyst for further action and partnership, resulting in a new team of advocates committed to supporting the Maryland team's vision of aligning Medicaid, MCOs, physicians, and home visiting services.

Following the roundtable, the Maryland team drafted a two-page home visiting brief directed toward the MCOs to demonstrate the value of home visiting. It focused on areas of alignment with MCO quality measures, improving enrollee satisfaction, and potentially mitigating high-cost utilization of health services. Moreover, it reinforced that these benefits come at no cost to the MCOs other than developing a referral system with the local health departments. In order to better understand the audience and potential value-add, the Maryland team also administered a survey to

MCO leadership to learn how they were currently addressing their members' unmet social determinants of health needs.

The Maryland team presented the survey findings to MCO leadership representatives at their December 2018 meeting. MCOs were excited to continue the dialogue about opportunities to align with public health programs and activities that compliment and expand access to necessary social services. The Maryland team hopes that MCOs will increase their engagement with home visiting programs and see home visitors as a resource for referral coordination for their clients. Such efforts would ultimately help with the coordination and care of many vulnerable families' social determinants of health needs.

New York: Implementing a Broad Medicaid Early Childhood Strategy

The New York State Medicaid agency collaborated with The Albany Promise, a local cradle-to-career collective impact partnership focused on ensuring all children have a fair shot at economic mobility through improved education outcomes. The pilot in Albany County provided enhanced Medicaid payments to MCOs to encourage pediatricians to use a standardized developmental screening tool for all children, provide warm handoffs for children needing care, and collect screening and referral data for children up to age five in the county. The goal was to improve kindergarten readiness of all low-income children.

Inspired by this work, the New York team worked with the state to launch the "First 1,000 Days on Medicaid," a statewide cross-sector initiative that selected 10 major policy and programmatic steps for Medicaid to improve outcomes for its 2.2 million beneficiaries under the age of five. This new focus will expand upstream prevention efforts, like those done in Albany, across New York to address the social determinants of health in young children.[16] The initiative included more than 200 stakeholders from education, child development, child welfare, pediatrics, and mental health to develop recommendations for improving outcomes for 0-3 year-old New Yorkers, nearly 60 percent of whom are covered by Medicaid.[17]

This cross-sector workgroup was charged with ensuring the 10 recommendations were: affordable, cross-sector, feasible, evidence-based, and high impact. More than 300 proposals were voted on to become agenda items based on these criteria. The Governor included $2.9 million ($1.45 million State) in Medicaid funds in his 2018-19 budget for implementation, with the expectation of $11.16 million ($5.8 million in State) in 2019-2020. The 10 prioritized ideas were:[18,19]

1. Braided Funding for Early Childhood Mental Health Consultations
2. Statewide Home Visiting
3. Create a Preventive Pediatric Clinical Advisory Group
4. Expand Centering Pregnancy
5. Promote Early Literacy through Local Strategies
6. Require Managed Care Plans to have a Kids Quality Agenda
7. New York State Developmental Inventory Upon Kindergarten Entry
8. Pilot and Evaluate Peer Family Navigators in Multiple Settings
9. Parent/Caregiver Diagnosis as Eligibility Criteria for Dyadic Therapy
10. Data System Development for Cross-Sector Referrals

The New York team recognized that in order for its initiative to thrive, it needed to be larger than a set of 10 projects — it needed a new way of coming together across different agencies to improve the lives of New York's youngest citizens. According to Kalin Scott, Director of the Medicaid Redesign Team, "Supporting these kids is more important than any other issues, including political dynamics."[20] Building on this theory, New York established a team that included partners, champions, and voices beyond the usual early childhood players, which were critical to the initiative's success.

One instrumental leadership decision was to engage New York State's Department of Education, an agency that has historically worked in parallel, rather than together with, the health sector. In order to bridge this gap, the team asked the State Education Commissioner, MaryEllen Elia, and former State University of New York Chancellor, Nancy Zimpher, to co-chair the First 1,000 Days initiative. According to Commissioner Elia, "those systems of health and education have not talked…so sometimes you see the end results and outcomes for children are not as great as they could be if we were able to have shared information."[21]

Pediatricians were another crucial stakeholder group that the NY Medicaid team sought to mobilize for this initiative. Initially warned that pediatricians would be too busy to engage, the effort was able to gain three local pediatricians' support after the collaboration showed real action being taken. Today, this growing pediatric cohort is one of the initiative's biggest champions, even holding a regional lobby day explicitly focused on the First 1,000 Days of Medicaid.

The commitment of New York Governor Andrew Cuomo was a third essential element to the success of First 1,000 Days on Medicaid. Since the Governor had prioritized a redesign of Medicaid, with special attention to New York's most vulnerable populations, the First 1,000 Days of Medicaid was a natural fit and received funding through the 2018-2019 budget. Scott said that having a champion like the governor is an important element to their success, but not essential. She does not want to dissuade those without high-level support from completing great work. However, she acknowledged that the governor's financial investment and exposure has advanced the First 1,000 Days further than it would have gone on its own.

> ***"Our key to success is stakeholder engagement, transparency, inviting all those that want to participate, and giving members a very, very clear charge."***
>
> *- Kalin Scott, Director, New York Medicaid Redesign Team*

The governor's support, alongside leadership from pediatricians and the education sector, were important but not sufficient to ensure statewide implementation success. The Medicaid team also engaged local collective impact groups since localities have the relationships, capacity, and nimbleness to rapidly test new ideas. Scott believes that creating a framework "falls on the shoulders of the state," but nuanced, culturally relevant, context-specific implementation is best left to communities.

In addition to bringing together a wide-range of stakeholders to agree on a common goal, it was also essential to use a data-driven process to organize diverse partners toward shared goals. The team received technical assistance from the United Hospital Fund to help align stakeholders, develop the 10-point agenda, and begin implementing the recommendations.[22]

New York adopted two successful philosophies in the design and implementation of the First 1,000 Days on Medicaid: (1) it never hurts to ask; and (2) do what is best for kids, not what has always been done. These principles allowed it to succeed in inviting everyone to the table, building on existing political momentum, considering fresh voices to lead the work, partnering with localities, and following an organized, data-driven, transparent process.

Recommendations

Those interested in forging Medicaid early childhood interventions in their own states may glean lessons from Hennepin County, Maryland, and New York for each stage of development. The following are recommendations for the problem identification, intervention design, and intervention implementation stages:

Identify the Problem

1. **Challenge antiquated policies -** The Hennepin County team was not deterred by obstacles brought on by old ways of thinking, and instead sought to understand, and ultimately debunk, the antiquated policies that stood in the way of the team's goals.

2. **Dive into cross-sector data smartly and with persistence -** Knowing the major challenges to cross-sector data analysis, the team built in time for innovation, tenacity, and trial and error. It also capitalized on the data-crunching expertise and previous success with cross-sector data analysis.

3. **Seek allies across agencies -** The Hennepin County team knew that to understand age 0-5 child welfare placements, it had to include data sets from multiple sectors that had not previously collaborated with the health care sector. Going one step further, it also recognized that it cannot do data analysis in a vacuum and included practitioners throughout the research process to validate or debunk some of its hypotheses. The team also aligned its work with the County's Internal Audit Department data compliance mandate to strike some additional symbiosis.

Design an Intervention

1. **Leverage cross-agency relationships -** The Maryland team participated in a design thinking process that engaged home visitors, clinicians, maternal and child health experts, and MCOs to ensure field-level perspectives were included in its approach to learning about the landscape prior to any program design proposals.

2. **Establish baseline definitions -** When speaking with various early childhood experts across agencies, the Maryland team found varying definitions of home visiting, as well as disparate awareness of the benefits it can provide. To overcome this information-gap across agencies, the team crafted a single document to establish a baseline understanding for those joining the conversation.

3. **Engage potential partners early -** The Maryland team sought MCO feedback early on to ensure their voice and interests were captured in the team's strategy, and to identify and prioritize topics for further consideration.

Implement the Intervention

1. **Create a dynamic team -** The New York team engaged partnerships across an expanse of players, from pediatricians to the Department of Education, to the governor. This wide reach allowed each partner to fulfill a link across the team's work for farther reach — including additional budgetary support.

2. **Align with existing policy levers -** New York married its recommendations and implementation plan with the state's shift toward value-based payment.

3. **Develop an intentional planning and implementation process -** New York recognized the value of external, objective facilitators to ensure that the initiative included all perspectives and progressed in a data-driven, results-oriented way.

Conclusion

Lessons from these case studies could apply to almost any cross-sector collaboration. However, investing in early childhood and young families has exponential health and economic benefits, both for today's youngest generation and tomorrow's long-term societal wellbeing. As these examples illustrate, there is no technological platform or policy adoption that can make interagency partnerships succeed. Instead, agencies are made up of people that must begin by articulating a compelling reason to work together, align missions, overcome historical hurdles, generate new relationships, take calculated risks, think creatively, be extraordinarily persistent, and always keep the goal of enabling children to thrive front and center.

ENDNOTES

[1] R.A. Thompson. "Development in the First Years of Life." *The Future of Children*, 11, no.1 (2001): 20-33. Available at: https://www.jstor.org/stable/1602807?seq=1#page_scan_tab_contents.

[2] J.R. Lally and P. Mangione. "Caring Relationships: The Heart of Early Brain Development." *Young Children*, 72, no.2 (2017). Available at: https://www.naeyc.org/resources/pubs/yc/may2017/caring-relationships-heart-early-brain-development.

[3] A. Agorastos, P. Pervanidou, G.P. Chrousos, G. Kolaitis. "Early Life Stress and Trauma: Developmental Neuroendocrine Aspects of Prolonged Stress System Dysregulation." *Hormones*, 17, no.4 (2018): 1-14. Available at: https://www.ncbi.nlm.nih.gov/pubmed/30280316.

[4] Georgetown University Health Policy Institute Center for Children and Families. "Medicaid's Role for Young Children." December 2016. Available at: https://ccf.georgetown.edu/wp-content/uploads/2017/02/MedicaidYoungChildren.pdf.

[5] J.B. Isaacs, C. Lou, H. Hahn, A. Hong, C. Quakenbush, C.E. Steuerle. "Kids' Share 2018: Report on Federal Expenditures on Children Through 2017 and Future Projections." Urban Institute, July 2018. Available at: https://www.urban.org/research/publication/kids-share-2018-report-federal-expenditures-children-through-2017-and-future-projections/view/full_report.

[6] S. Rice, S. Cotton, K. Moeller-Saxone, C. Mihalopoulos, A. Magnus, C. Harvery, et al. "Placement Instability Among Young People Removed from Their Original Family and the Likely Mental Health Implications." *Shanghai Archives of Psychiatry*, 29, no.2 (2017): 85–94. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5518265/.

[7] L.M. McWey, A. Acock, B. Porter. "The Impact of Continued Contact with Biological Parents upon the Mental Health of Children in Foster Care." *Children and Youth Services Review*, 32, no. 10 (2010): 1338-1345. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2928481/.

[8] Interview with Jennifer DeCubellis, Deputy Administrator, Hennepin County Health and Human Services, to Daniela Lewy, Amelia Vaughn, and Jamila McLean, October 11, 2018.

[9] R. Owen. "Cross-Sector Data Analysis to Understand the Role of Medicaid in Out of Home Placement of Children Aged 0-5." Proposal for Policies for Action: Funded by Robert Wood Johnson Foundation. 2018.

[10] Interview with Peter Bodurtha, Principal Planning Analyst, Hennepin County Center of Innovation and Excellence to Daniela Lewy, Amelia Vaughn, and Jamila McLean, October 11, 2018.

[11] Ibid.

[12] Ibid.

[13] Note: Between 2010 and 2017, Maryland has been awarded $19.9 million in formula grants and $21.45 million in competitive funding.

[14] Governor's Office for Children and the Children's Cabinet. "Report on the Implementation and Outcomes of State-Funded Home Visiting." December 2015. Available at: https://phpa.health.maryland.gov/mch/Documents/HV/FY15_Data_Report_FINAL.pdf.

[15] For more information on design-thinking, see: Ideo Design Thinking. Available at: https://www.ideou.com/pages/design-thinking.

[16] Center for Health Care Strategies. "Medicaid Early Childhood Innovation Lab." May 2017. Available at: https://www.chcs.org/project/medicaid-early-childhood-innovation-lab/.

[17] Schuyler Center for Analysis and Advocacy. "New York's First 1,000 Days Initiative." February 2018. Available at: http://www.scaany.org/wp-content/uploads/2018/02/1st1K_Budget_overview_02-18.pdf.

[18] New York State Department of Health Medicaid Redesign Team. "First 1,000 Days on Medicaid Proposals." Available at: https://www.health.ny.gov/health_care/medicaid/redesign/1000_days/docs/2017-12-01_proposal_desc.pdf.

[19] Schuyler Center for Analysis and Advocacy, op. cit.

[20] Interview with Kalin Scott, Director, Medicaid Redesign Team, to Daniela Lewy, Amelia Vaughn, and Jamila McLean, October 11, 2018.

[21] D. Champagne. "NY's Focus: Kid's First 1,000 Days." *Daily Messenger*, June 5, 2018. Available at: http://www.mpnnow.com/news/20180605/nys-focus-kids-first-1000-days.

[22] United Hospital Fund. "UHF and New York State Partner to Benefit Youngest Children." April 2018. Available at: https://uhfnyc.org/news/881306.