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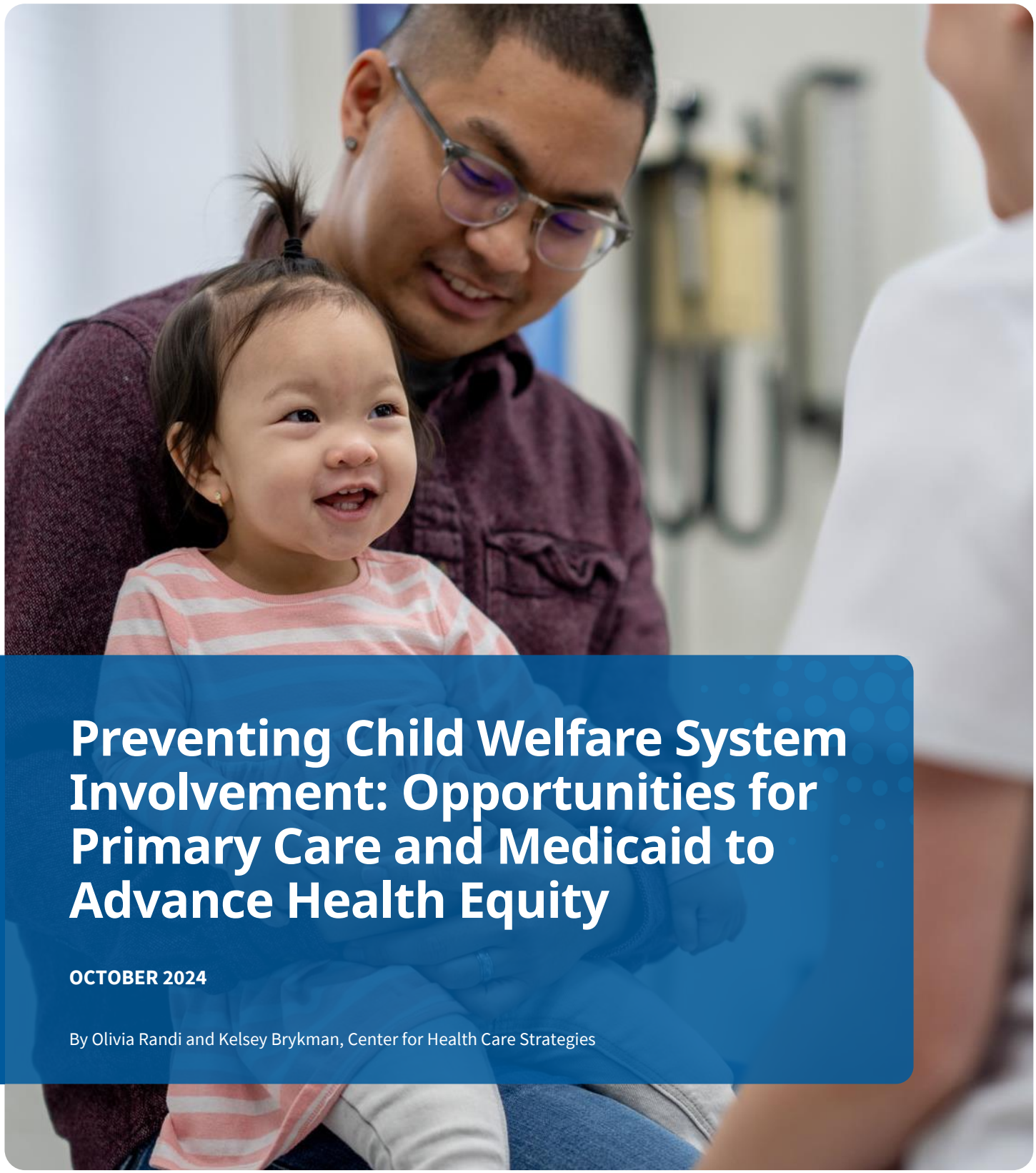

Preventing Child Welfare System Involvement: Opportunities for Primary Care and Medicaid to Advance Health Equity

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Contents

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KEY TAKEAWAYS

- Due to bias and systemic racism, families of color are disproportionately reported to child protective services, and Black children are overrepresented in foster care.
- Primary care practices can help prevent unnecessary child welfare system involvement by holistically supporting child and family health and well-being and reducing unwarranted reporting.
- Team-based care models — as well as education to expand providers' knowledge and expertise in behavioral health, relational health, health-related social needs, and implicit bias — can strengthen primary care practices' capacity to advance child and family well-being and achieve more equitable care.
- State Medicaid agencies can support primary care practices in building capacity to prevent child welfare system involvement through enhanced payment approaches, managed care contract requirements, workforce development efforts, and collaborations with child- and family-serving agencies and community partners.

Introduction

Federal legislation, including the Family First Prevention Services Act of 2018, created pathways for child welfare agencies to offer essential services that are critical to keeping families together and preventing foster care placement, including: mental health services; substance use prevention and treatment; in-home parenting programs; and kinship navigator services.[1,2] The rate of children entering foster care continues to decline as jurisdictions ramp up efforts to deliver services aimed at preventing foster care placement. Still, 187,000 children entered foster care, and a total of 369,000 children were living in foster care in 2022.[3] Families of color continue to be disproportionately reported to child protective services (CPS), and Black children are overrepresented in foster care.[4,5,6] The large number of children involved in the child welfare system and inequities in child welfare involvement reflect a lack of systems and policies to support families, as well as the impact of systemic racism.[7,8]

Any organization that interacts with a child — from schools to health care providers — can help families get the services they need. Primary care providers (PCPs) can play a particularly significant role in ensuring that families are referred to community resources to improve health and well-being. PCPs can also take steps to mitigate bias to prevent inappropriate reporting to CPS. Through Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, state Medicaid agencies are well-positioned to support pediatric PCPs in providing comprehensive, equitable, and family-centered care, including addressing behavioral health and health-related social needs (HRSNs), through policy and payment incentives.

With support from the Conrad N. Hilton Foundation, this report: (1) explores the role of primary care in preventing families' involvement with the child welfare system; (2) identifies practice-level challenges and approaches for implementing effective interventions; and (3) provides recommendations for how Medicaid programs can help address practice-level challenges and support primary care delivery reforms to mitigate child welfare involvement. Findings are based on a literature review, key informant interviews, and a group convening that included providers, researchers, and Medicaid, child welfare, and health equity experts (see **Appendix**). The recommendations align with recent Centers for Medicare & Medicaid Services (CMS) guidance on strategies and best practices to ensure children's access to the EPSDT benefit.[9]

At-a-Glance: Primary Care and Medicaid Strategies to Prevent Child Welfare Involvement

Primary care, with supports from Medicaid, can help prevent child welfare involvement by: (1) addressing risk factors for child welfare involvement, such as social and behavioral health needs; and (2) reducing bias and unwarranted reporting to CPS.

Practice-Level Approaches to Prevent Child Welfare System Involvement

Opportunities for Pediatric Primary Care to Prevent Child Welfare System Involvement

- ✓ Integrate medical, behavioral health, and social services
- ✓ Emphasize relational health, dyadic care approaches, and child and family developmental supports
- ✓ Adopt policies to advance equity and anti-racism practices
- ✓ Engage families to provide accessible, family-centered care

Strategies to Expand Primary Care Practice Capacity to Better Meet Family Needs

- ✓ Adopt team-based care models
- ✓ Implement trainings, such as on addressing health-related social needs and anti-racist approaches to care
- ✓ Use new tools to enhance capacity and support family-centered care

Medicaid Policy Recommendations to Support Primary Care Practices in Preventing Child Welfare System Involvement

1. Implement payment approaches that support comprehensive, equitable, family-centered care;

2. Leverage managed care contracts to prioritize primary care quality improvement for children;

3. Support primary care capacity and workforce development; and

4. Collaborate with child welfare, behavioral health, and other state agencies to align services, policy, and financing.

Overview of Child Maltreatment and the Child Welfare System

The child welfare system includes entities at the federal, state, and local level.[10] Specific state and local definitions of child abuse and neglect vary widely, as do families' experiences with the child welfare system. When child maltreatment is suspected, any individual can make a report through their state or region's child abuse and neglect hotline.[11] The child welfare agency will investigate the suspected maltreatment, conduct a safety and risk assessment, and determine the need for ongoing child welfare involvement. The investigation can result in a court petition to remove a child from their home and place them in out-of-home care with relatives or in foster care.

Reports are most commonly made by "mandatory reporters," individuals who are legally required to report suspected child maltreatment.[12] Mandatory reporting laws vary by state but common examples of mandatory reporters include social workers, teachers, and health care providers.[13] Most states issue penalties when mandated reporters fail to make a report, which incentivizes overreporting.[14] Mandated reporters may also report to child welfare when they are not able to identify a community resource that can meet the families' needs, leading to the inappropriate involvement of the child welfare system when there is no underlying concern of maltreatment.[15] This inflated reporting overburdens the child welfare system with families it should not be investigating, limiting the resources available for cases that warrant their involvement. Child welfare involvement contributes to trauma for the family, with potential long-term impact on well-being.[16]

Child maltreatment includes abuse and neglect. The majority of foster care placements are precipitated by reports of neglect rather than abuse.[17] Neglect is typically defined as the "failure to provide adequate food, clothing, shelter, or care."[18,19] Poverty is often conflated with neglect and accounts for a large proportion of reported cases of neglect.[20] While some states have revised their definition of neglect to mitigate the association between neglect and poverty, there is variability across states in how the definition is interpreted and applied in the child welfare system.[21] In new guidance, The White House is encouraging states to revise their definitions of child neglect under the Child Abuse Prevention and Treatment Act to ensure that failing to provide adequate housing, child care, or other material needs is not classified as neglect if the family lacks the financial resources to meet these needs.[22] The second most common factor associated with a child being removed from their home is parental substance use.[23] Families with parental substance use are more likely to experience inadequate housing and parental incarceration as co-occurring factors for their children's removal.[24]

Disparities in child welfare involvement exist across multiple demographic measures and are driven by co-existing factors. One cause is discrimination and systemic racism having led to disproportionate poverty rates among families of color — particularly Black families — by limiting access, opportunities, and support within and across systems, including employment, housing, and health care.[25,26] Similarly, stigma, criminalization, and treatment barriers related to substance use disorder disproportionately impact Black and Indigenous families, which may contribute to their overrepresentation in the child welfare system.[27] Families in which parents have disabilities and adolescents who identify as LGBTQ+ are also overrepresented in the child welfare system.[28,29] While this report focuses on pediatric primary care, approaches are also needed within adult health care and other systems to comprehensively address families' needs and reduce discriminatory and biased practices.

The Role of Primary Care

Because primary care — and especially pediatrics — is largely focused on prevention and is often the main point of contact between families and the health care system, pediatric and family care providers can play an important role in preventing child welfare system involvement. Because much of pediatric primary care is aimed at supporting healthy child development by providing comprehensive and family-centered care, primary care providers can help identify and address risk factors for child welfare involvement (for more on risk factors, see **Exhibit 1**, page 8). The current primary care system, however, is often limited in its capacity to meet the unique needs of children and their families due to factors such as financial constraints, limited staff capacity, and lack of training to support comprehensive, equitable models of care.[30,31] These limitations may lead to an inadequate use of preventive services, as well as services that support early relational health (see *Early Relational Health* sidebar on next page) and address behavioral health and social needs, which are common risk factors for child welfare system involvement.[32]

Additionally, as feasible within state mandated reporting requirements, primary care practices can also implement approaches that limit inappropriate and unwarranted reporting to child abuse and neglect hotlines.[33,34] Since health care providers have been found to disproportionately report Black families to child welfare, strategies to reduce bias are critical to this effort.[35]

It is also important to recognize that primary care alone cannot address the needs of the family. To make the most impact, primary care interventions need to be implemented alongside other policy changes within and outside the health system to adequately address family needs and reduce harms caused by inappropriate involvement with the child welfare system.

Early Relational Health

"Relational health" or "early relational health" is defined as "the role of early relationships and experiences in healthy development across a child's lifetime" with safe, stable, and nurturing relationships (SSNR) enabling healthy child development.[36] Particularly for young children, early relational health emphasizes positive relationships between children and their caregivers.[37] SSNRs mitigate childhood toxic stress, which can result from adverse childhood experiences (ACEs).[38] Given the association between ACEs and child maltreatment, promoting relational health and SSNRs is critical to preventing child welfare system involvement. In this context, focusing on early relational health is particularly important since most child maltreatment reports involve families with young children, especially infants.[39]

The Role of Medicaid

Medicaid policy can support pediatric primary care in addressing barriers to child and family health and well-being. Covering over 40 percent of all children across the nation, including nearly 50 percent of children with special health care needs and over half of Black, Latino, and Indigenous children, Medicaid has a significant opportunity to better meet their needs.[40, 41, 42] This widespread coverage enables state Medicaid agencies to support primary care practices in advancing child and family well-being, promoting health equity, and preventing child welfare system involvement. Medicaid can achieve these goals by implementing payment approaches for comprehensive, equitable, family-centered care; revisiting managed care contract deliverables; developing and training the workforce; and collaborating with child-serving systems and community partners.

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit ensures robust health coverage for children and requires state Medicaid agencies to cover all preventive and medically necessary services for children to "correct and ameliorate health conditions."[43] This may include parental counseling and connection to community-based resources, among other services related to preventing child welfare system involvement.[44,45] However, states have different definitions of what counts as medically necessary.[46] Moreover, just because a service is covered through EPSDT, does not necessarily mean that it is easily accessible to families or delivered in a family-centered, coordinated way. For example, 2020 data shows that across states, a median of only 36 percent of children received developmental screening by age three.[47] In September 2024, CMS released guidance offering examples of best practices that meet the EPSDT requirement, reflecting some of the models highlighted in this report. The CMS guidance frames EPSDT best practices around the following areas: promoting EPSDT awareness and accessibility, expanding and using child-focused (EPSDT) workforce, and improving care for EPSDT-eligible children with specialized needs.[48]

Practice-Level Approaches to Prevent Child Welfare System Involvement

There are a variety of child- and family-level risk and protective factors related to child maltreatment (see **Exhibit 1**). PCPs can play a crucial role in identifying and addressing some factors by comprehensively assessing families' behavioral, social, and relational health risks and needs, and by connecting them to appropriate supports, especially during routine well-child visits. Additionally, primary care practices can implement policies and practices to reduce inappropriate reporting to CPS, as described later in this report.

Exhibit 1. Risk and Protective Factors Related to Child Maltreatment

As illustrated in the below table, studies have identified a range of risk and protective factors related to child maltreatment.[49] These factors may be present at the individual/child, family, community, or societal levels. It is important to recognize that, because of biases that may lead to unwarranted identification and reporting of child maltreatment — such as racism, stigmatization of substance use disorder, and inappropriately conflating poverty and neglect — these factors may also contain and perpetuate biases.[50,51] Assessment of risk has also been unfairly applied within the child welfare system. For example, studies have found that Black children are removed from their homes at a higher rate than white children, but among children who have been removed from their homes, Black families have lower average risk scores than white families.[52]

Risk factors that primary care providers are particularly well-positioned to help address through screening and assessment, intervention, and connections to community-based services include unmet HRSN (e.g., housing and food insecurity), behavioral health needs, caregiver substance use, and relational health risks (e.g., adverse childhood experiences).[53,54,55]

Level	Risk Factors	Protective Factors
Child	• Infancy and young age[56] • Special health care needs • Behavioral health needs[57]	• Self-regulation skills • Social and emotional capacity • Adaptive functioning
Caregiver and family	• Parental behavioral health needs • Poverty and material hardship • Intimate partner violence	• Parental resilience[58] • Social networks • Supportive relationships
Community	• Neighborhood crime and violence • Concentrated poverty rates	• Service and resource availability • Community cohesion
Societal	• Regressive economic policies • Gender inequality • Systemic racism	• Policies that increase household income and reduce child-related expenses (e.g., paid family and parental leave, earned income tax credit, among others)

Opportunities for Pediatric Primary Care to Prevent Child Welfare System Involvement

Leveraging primary care to help prevent child welfare involvement requires transforming pediatric practice to address family needs and advance health equity. Widely recognized guidance on different types of interventions is available to primary care practices. For example, Bright Futures, led by the American Academy of Pediatrics with support from the Health Resources Services Administration, offers age-specific guidance on the opportunities for PCPs to advance child and family health and well-being, including family support, mental health, and healthy development.[59] The Bright Futures periodicity schedule, which aligns with Medicaid's EPSDT benefit, consists of comprehensive, age-based guidance for each well-child visit and recommends screenings and assessments, many of which focus on caregiver and family health, behavioral health, and HRSN. Additionally, there are various other frameworks and recommendations that offer opportunities for improving care quality and equity within pediatric primary care.[60, 61, 62, 63, 64, 65]

While there is some existing evidence regarding which primary care interventions are effective at reducing child welfare system involvement (see **Exhibit 2**, page 11), more research is needed, including studies on how to implement primary care quality improvement initiatives that advance equity.

Based on available evidence and best practices within health and social service systems, following are promising pediatric primary care approaches that can: (1) address risk factors for child welfare involvement; and (2) support implementation of equity-focused practices to reduce bias and unwarranted reporting to the child abuse and neglect hotline:

- **Integrate medical, behavioral health, and social services**. Primary care practices can implement strategies to identify and address families' behavioral health and HRSN needs, both of which are risk factors for maltreatment.[66] Addressing behavioral health and HRSN may also help reduce the disproportionate barriers that Black, Indigenous, and other families face in accessing behavioral health services and social supports, as well as mitigate the disparate impact of poverty on families of color.[67,68] Activities may include screening children and their families to identify behavioral health needs and HRSN, and referring them to community-based services. Successful integration often requires strengthening partnerships between primary care practices, behavioral health specialists, and community-based organizations. Providers may also implement interventions directly within primary care settings to address families' needs. For example, primary care practices can provide co-located behavioral health services or include behavioral

health providers on care teams to help address families' needs during visits.[69] Outside of pediatrics, integrating parental substance use disorder services into primary care practices, particularly for pregnant women, is deserving of special consideration as it may prompt child welfare system involvement because of specific mandatory reporting requirements.

- **Emphasize relational health, dyadic care approaches, and child and family developmental supports.** Primary care practices can support early relational health by using a dyadic care approach that considers the health and well-being of the child and their caregiver.[70,71,72] This includes implementing relational, family-focused interventions that support safe, stable, and nurturing relationships, social-emotional development, caregiver mental health, and family functioning (as just one example, see the description of HealthySteps in **Exhibit 2**, page 11).[73,74] Additionally, primary care practices can use a strengths-based approach, which focuses on an individual or family's personal, social, and emotional assets. This approach can support families in building protective factors, which help to prevent child welfare system involvement while addressing their priorities and needs.[75,76]

- **Adopt policies to advance equity and anti-racism practices.** Recognizing the impact of individual, interpersonal, and systemic racism on families is critical.[77,78] Collecting and analyzing practice-level data to identify disparities, implementing anti-racist policies, and integrating relevant approaches for people with disabilities and individuals who identify as LGBTQ+ can help promote more equitable care. Examples of practice-level strategies to advance equity include implementing culturally and linguistically effective practices; ensuring the availability of interpretation services for non-English speakers; and recruiting primary care staff who share common racial and cultural backgrounds as the families they serve.[79,80] In order to reduce bias in reporting to the child abuse and neglect hotline, primary care practices can also train staff to strengthen their awareness of inequities in health care and the child welfare system, including the impact of reporting families to CPS.

- **Engage families to provide accessible, family-centered care.** Meaningful family engagement includes authentic partnerships between families, PCPs, and other care team members that are reciprocal and ongoing.[81]This may require developing new ways to engage and gain input from families to inform practice policies and programs, such as through family advisory councils, focus groups, or listening sessions. It is also important for practices to implement processes and work toward a culture focused on building trust and better engaging families during visits. For example, PCPs should respect the expertise of family members regarding their child and communicate with them openly and transparently. This includes sharing accurate and comprehensive medical information, and working with families and

caregivers as equal partners in making decisions for their child's medical care.[82,83,84] Given the time constraints often faced in the health care setting, PCPs are unlikely to effectively engage families without adopting intentional family-centered strategies to support critical relationship-building. These strategies can help families communicate openly and support children in receiving the care they need — including more effectively meeting their needs.[85,86] Strong partnerships with families can also help PCPs build trust and advocate for families that are involved with the child welfare system.[87,88,89]

See **Exhibit 2** for examples of interventions and care models that aim to provide more family-centered and comprehensive primary care that may help reduce the need for child welfare intervention.

Exhibit 2. Examples of Care Models That Address Risk Factors Related to Child Maltreatment in Primary Care Settings

- **HealthySteps:** This model, developed by ZERO TO THREE, provides early childhood development supports for families with children ages 0-3 by embedding HealthySteps specialists in primary care settings to support screening and referral through comprehensive and integrated care visits. HealthySteps specialists also support early relational and social health by building strong relationships with families and providers, and offering expertise on child development and behavioral health prevention. HealthySteps, which aligns with Bright Futures Guidelines, has been shown to improve a range of outcomes, including increased screening and connection to services, social-emotional development, and family and provider satisfaction, while reducing maternal depression and addressing risk factors for child abuse and neglect, including harsh punishment, severe discipline, and behavioral needs.[90]
- **Developmental Understanding and Legal Collaboration for Everyone (DULCE):** This model integrates community health workers (CHWs) into primary care settings to support families with newborns during their first six months of life.[91] This model aims to address HRSN and promote protective factors to improve child development and reduce child maltreatment.[92] CHWs engage families and connect them to services based on their needs and priorities, including those that address HRSN and promote healthy child and family development through parenting skills and positive parent-infant relationships.[93] Through this model, local medical-legal partnerships provide training and resources to CHWs to increase their capacity to support families' needs.[94]

Strategies to Expand Primary Care Practice Capacity to Better Meet Family Needs

Primary care practices, payers, and policymakers may consider how to implement team-based care, provide adequate training for staff in primary care settings to adopt new care approaches, and use new tools and processes to support efficient and high-quality, equitable care. While some primary care practices may be able to implement one or more strategies within their current environment, many practices require resources to support pediatric primary care system improvement efforts. As described in the policy recommendations below, Medicaid can provide enhanced investment and incentives to help primary care practices overcome existing barriers and build practice capacity to achieve more comprehensive, equitable care.

Team-Based Care Models

Challenges to providing comprehensive care, such as inadequate staffing and time constraints, often result from financing barriers that persist in primary care. For example, well-child visits are often limited to 20 minutes, making it difficult to screen for and address families' behavioral health and HRSN.[95] Additionally, when pediatric providers are unable to meet families' needs through referrals due to a scarcity of community services and/or a lack of awareness of these services, they may be more likely to report families to the child abuse and neglect hotline to connect them to services, even in the absence of a maltreatment concern.[96,97] Working as a multi-disciplinary team can increase PCP staff capacity and expertise, allowing the expanded care team to spend additional time with families to build trust and credibility, identify risk factors associated with child maltreatment, and possibly lessen the likelihood of PCPs referring families to child welfare in a misguided effort to connect them to services.

Expanding the pediatric primary care team to include patient navigators, peer support professionals, and CHWs — whether in the PCP clinic or connecting the clinic to organizations in the community — is an evidence-based approach to build PCP capacity to better serve children and their families.[98] An expanded care team can support more holistic care, improve family engagement and support, and address a broad range of families' needs through care coordination, screening and assessment, health literacy support, and other functions.[99] Because they often share common background or are part of the communities they serve, including CHWs and peers in care teams can also increase cultural competence and humility, which may decrease bias and ultimately reduce reporting to the child abuse and neglect hotline.[100] As described in **Exhibit 2** (page 11), HealthySteps and DULCE integrate specialists into primary care settings to support child and family health and development, provide screening and referral services, and address early relational health and HRSN. HealthySteps has been shown

to reduce risk factors associated with maltreatment, such as harsh punishment and severe discipline, and improve relational health.[101] One of the primary goals of DULCE is to reduce child maltreatment by meeting families' HRSN.[102]

Training

To adequately address risk factors for child welfare system involvement, primary care staff need a variety of skills and competencies related to HRSN screening and assessment, early relational health, and behavioral health. They also need community-based services, resources, and referral systems available to address behavioral health and HRSN. Yet, staff may lack resources and capacity in these areas. For example, in one study, while over 60 percent of pediatricians agreed that screening for HRSN is important, less than 40 percent reported that it is feasible or that they feel prepared to do so.[103] Providers and other primary care staff may feel unprepared given that HRSN screenings sometimes identify highly sensitive, stigmatized, private, and risky topics, such as financial hardship and social circumstances.[104] Without adequate training, screenings may be perceived by families as insensitive and judgmental, and can potentially re-traumatize or further marginalize an individual or family.[105] Primary care staff may also feel unprepared to provide referrals to community resources and treatment options due to their lack of knowledge and time, and/or the limited availability of services in the community, which can result in insufficient treatment and referrals for families.[106,107]

Training can help mitigate these barriers. For example, the SEEK Model, described in **Exhibit 3** (page 15), provides training to PCPs to address psychosocial risk factors associated with child maltreatment.[108] Training can also be beneficial to effectively incorporate new staff, such as CHWs and peers, into primary care teams. Training can include topics like racial bias; cultural effectiveness and humility; systemic racism; the disproportionate impact on families of color in the child welfare system; and equity. Trainings that incorporate anti-racist policies and practices may help mitigate over-reporting based on race, ethnicity, disability, substance use, and Medicaid eligibility. Additional training is also needed to improve primary care staff's understanding of child maltreatment, the child welfare system, mandatory reporting requirements, and guidelines to support non-discriminatory and objective decision-making.[109]

Tools to Enhance Capacity

Children and their families often face structural and administrative barriers to accessing comprehensive care. For example, families have expressed frustration for not having enough time during a visit to communicate their social needs to pediatricians.[110] To improve primary care practices' capacity, new tools — often using technology — and processes are needed to support family-centered screening approaches, track referrals, and improve coordination between health and social systems and community-based services.

There are a variety of tools that can improve efficiency and enhance capacity of primary care practices, particularly for well-child visits. One type of tool supports pre-visit planning, often as an online platform that primary care practices use to gather information from families, including their responses to screening questions, prior to (or during) their primary care appointment.[111] For example, primary care practices can use the Child and Adolescent Health Measurement Initiative's Cycle of Engagement Well-Visit Planner (WVP), described in **Exhibit 3** (next page), to engage families with children ages 0-6. Families enter information into the WVP prior to a well-child visit and receive a personalized guide, and providers receive a clinical summary to inform the visit.[112] Families have reported that this tool supports family-centered care.[113] The WVP and similar tools such as those described above may also provide resources directly to families based on their responses, and track referrals to better enable families to receive needed services.

Similarly, primary care practices can use community-based resource directories and referral platforms to direct families to available services that help address their HRSN, behavioral health, and relational health needs.[114] Other tools, such as care planning templates, can help streamline workflows by guiding primary care practices and families in identifying and summarizing key information to support their child's care.[115] Additionally, one promising new approach is implementing information exchanges between primary care practices and other child- and family-serving organizations, which can facilitate the coordination of care across systems. For example, San Diego County created a community information exchange that is used by a multidisciplinary network of partners as a shared resource database and integrated technology platform to deliver community care planning.[116]

Primary care practices can also conduct organizational assessments to identify bias within their current policies and practices. There are a variety of tools and models that can guide this assessment.[117,118] Primary care practices can focus on assessing mandated reporting policies and practices, which may help reduce unwarranted reports to child abuse and neglect hotlines.

Exhibit 3. Examples of Tools That Address Risk Factors Related to Child Maltreatment in Primary Care Settings

- **Safe Environment for Every Kid (SEEK):** The SEEK model includes training for PCPs to address risk factors associated with child maltreatment, a screening tool to identify psychosocial problems, and guidelines to address positive screens. The screening aims to identify risk factors in the domains of home safety, child behavior, parental well-being, and food insecurity.[119,120]

- **Child and Adolescent Health Measurement Initiative's (CAHMI) Cycle of Engagement (COE) Model:** CAHMI's COE was created to advance partnerships between providers, families, and communities, promote child- and family-centered care, and provide resources to support care teams in using data.[121] This includes:

  - → **Well Visit Planner (WVP)** is a digital tool that engages families before and/or during well-child visits to build trust and ensure personalized, strengths-based care that operationalizes Bright Futures Guidelines. PCPs can use this evidence-based tool to optimize time with families, provide comprehensive screening, and address their health-related social and medical needs and relational health risks.[122] Once a family adds their information to the tool, their PCP and they automatically receive a personalized report and visit guides with resources to address child and family needs.

  - → **Personalized Connected Encounter** is an approach to the well-child visit using the guides for families and providers resulting from the WVP.[123] Using these guides allows providers to focus on families' priorities and needs.

  - → **Promoting Healthy Development Survey** is a validated measure that assesses the quality of care for families with children ages three months to six years.[124] Primary care practices and health plans can invite families to complete the survey, and families can anonymously complete the survey to report on the quality of their well-child care. This tool gives aggregate results to providers to inform quality improvement and provides families with information based on their responses.

Medicaid Policy Recommendations to Support Primary Care Practices in Preventing Child Welfare System Involvement

Medicaid has a key policy and programmatic role to play in supporting primary care practices in taking the above steps to reduce child welfare involvement. As described on page 7, even though federal Medicaid regulations require states to provide medically necessary services for children under the EPSDT benefit, many children and families still do not access important preventive services.[125,126] More work is needed to enhance widespread access to preventive services and ensure that such services are provided in a family-centered way. Following are four broad recommendations for state Medicaid agencies to help primary care practices address risk factors for child welfare involvement:

1. Implement payment approaches that support comprehensive, equitable, family-centered care;

2. Leverage managed care contracts to prioritize primary care quality improvement for children;

3. Support primary care capacity and workforce development; and

4. Collaborate with child welfare, behavioral health, and other state agencies to align services, policy, and financing.

These policy recommendations are mutually reinforcing, and states can make the most impact by implementing more than one of these approaches. These recommendations align with and can help enhance access to EPSDT services.

Recommendation 1: Implement payment approaches that support comprehensive, equitable, family-centered care.

States can implement payment approaches that provide enhanced financial resources and incentives for primary care practices to cover services or personnel that are critical to improving care for children and their families. States can take a variety of coverage and payment approaches, such as expanding Medicaid benefits to include a wider range of service provider types (e.g., CHWs) and adapting value-based payment models to address children's health needs. State Medicaid agencies can expand payment related to team-based care approaches, early intervention behavioral health and relational health services for children and their caregivers, and services to address

families' social needs.[127] This expanded service coverage can also potentially contribute to a broader array of services in the community, providing additional referral options for PCPs. Expanded service coverage may include:

- **Enhancing benefits or allowing coverage of new provider types to support team-based care.** States may expand benefits or enhance payment to support inclusion of primary care staff such as CHWs, patient navigators, peers, and care managers into care teams. States can consider offering enhanced rates to primary care practices to support prevention-focused, team-based care models. For example, in Maryland, as of January 2023, provider practices that implement HealthySteps are eligible to receive an additional $15 per visit for children under age four.[128,129]

  As another example, state Medicaid agencies can cover services provided by CHWs. As of July 2022, more than half of all states cover CHW services through state plans, managed care arrangements, 1115 demonstration waivers, and the ACA Health Home option.[130] New Jersey implemented health homes, which connect physical and behavioral health care through an intensive care coordination model, Care Management Organizations (CMO).[131] CMOs are the designated health home agencies that provide care coordination and planning for children and their families, working within child family teams. The health home adds a wellness coach and nurse practitioner to facilitate access to a full range of integrated services. The team works with PCPs and other medical specialty providers to ensure whole health is addressed, including HRSN.

- **Removing diagnosis requirements to improve access to behavioral health, relational health, and dyadic services.** Increasing access to mental health services may help prevent child welfare system involvement.[132] Many children and their families face barriers to receiving preventive or early behavioral health services because without a diagnosis the child does not meet medical necessity requirements and providers cannot be reimbursed.[133,134] Several states are moving away from requiring a diagnosis to determine service eligibility.[135] For example, New York updated its medical necessity requirements in 2023 to allow individual, group, and family psychotherapy services to be provided to Medicaid enrollees under 21 years of age without a specific behavioral health diagnosis. The goal of this policy is to support two-generational and preventive approaches to behavioral health care.[136,137]

- **Paying for services to identify and address social needs.** States can use various Medicaid authorities to cover services to identify and address HRSN. While screening for HRSN can be covered through a range of existing authorities, addressing these needs under Medicaid is more limited. One key opportunity is for

states to leverage recent CMS guidance for use of Section 1115 demonstrations and "in lieu of" services to finance HRSN interventions.[138] These services can also be provided by managed care organizations (MCOs) as value-added services that the MCO voluntarily provides and through quality improvement activities.[139] Several of these 1115 demonstrations have been approved, including in Arkansas, Arizona, California, Massachusetts, and Oregon.[140] For example, Arkansas is providing intensive supports, including enhanced housing and nutrition supports, through its Life360 HOMEs program. The state included young adults at risk of long-term poverty as a key population to receive services through this demonstration.[141]

- **Implementing value-based payment models (VBP) to support comprehensive and family-centered primary care and enhanced care coordination.** VBP models move away from payment based on volume to payment tied to quality of care.[142] One example is the Integrated for Kids Model (InCK), a CMS Innovation Center model currently implemented regionally in Connecticut, Illinois, New Jersey, New York, North Carolina, and Ohio. The InCK model aims to develop sustainable alternative payment models with goals to improve child health outcomes and reduce inpatient stays and unnecessary out-of-home care. Providers using the InCK model, which seeks to identify health risks and needs early, must integrate physical and behavioral health, as well as coordinate with other service providers to provide family-centered care.[143] Specific payment models vary by state and, in some cases, are still in development — example elements include tying payment to measures of preventive care and providing enhanced payment for additional care management services.[144]

  VBP models can also be an important mechanism for holding provider organizations accountable for advancing health equity. For example, Minnesota's Integrated Health Partnerships program ties a portion of provider's performance-based payment to reducing racial and ethnic disparities on certain quality measures.[145] In developing VBP models, states should clearly define the types of care interventions they want to encourage and ensure that rate development is sufficient to sustain implementation. This may include considering how to ensure resources are sufficient to advance improvements in pediatric primary care needed by children and adolescents with varying levels of medical, social, and relational complexity. States may consider refining approaches for risk adjustment or tiering payments based on population characteristics.[146]

Recommendation 2: Leverage managed care contracts to prioritize primary care quality improvement for children.

In states with managed care, state Medicaid agencies can align contract requirements and incentives for MCOs to provide care that can help prevent child welfare system involvement.[147] Developing a strong quality measurement approach that focuses on child and family well-being and advances health equity is one critical step to this effort. States already commonly track measures related to primary care access and prevention, such as those in the CMS Child Core Set.[148] However, many children still fail to receive well-care visits and screenings recommended by clinical guidelines such as Bright Futures, and children enrolled in Medicaid are less likely to receive this care compared to children with commercial health insurance.[149,150,151] States can consider setting higher benchmarks and implementing MCO performance incentives for measures currently in use to more strongly incentivize quality improvement. States may also collaborate with families, providers, and researchers to address gaps in existing quality measures, including more explicitly measuring and incentivizing reductions in health disparities.

Additionally, interviewees and the literature indicate that quality measures used by states and MCOs often do not adequately capture processes and outcomes associated with comprehensive pediatric primary care. State Medicaid agencies can encourage the development and use of measures related to key domains targeted for improvement, including HRSN, integrated behavioral health care, relational health risks, and family engagement.[152,153] This approach can help identify gaps and target resources for families with higher needs. Some states have developed new measures to encourage MCOs to support child health quality improvement efforts. For example, in January 2022, Oregon implemented an incentive measure for its contracted coordinated care organizations (i.e., MCOs) focused on enhancing equitable access to cover social-emotional services for birth to five that span across primary care, integrated, and specialty behavioral health. The metric includes an intentional focus on improving services overall, but particularly for children with social complexity factors known to be associated with child welfare involvement.[154] This may also include measurement rates for children in therapeutic foster care and residential treatment, which are performance measures for Ohio's specialized managed care plan for children and youth with complex behavioral health needs, OhioRISE (Ohio Resilience through Integrated Systems and Excellence).[155]

Quality measurement also offers an opportunity to focus on health equity. As states enhance their data collection capabilities (e.g., such as for race, ethnicity, language, and disability), they may consider setting goals and tying financial incentives to reducing identified disparities in children's health measures.[156] For example, Michigan rewards MCOs for statistically significant improvement in reducing disparities for Black and

Latino populations relating to several measures, including some focused on children's health.[157] Michigan also monitors and publicly reports on quality measures stratified by factors such as race and language in annual Health Equity Reports.[158] States may consider how to implement such approaches for measures related to risk factors for child maltreatment. Finally, family-reported data and measures that account for families' experiences of care are critical to informing improvements and often provide information that cannot be gleaned from administrative and services data sets. The Promoting Healthy Development Survey, described in **Exhibit 3** (page 15), is one tool that has been implemented by several state Medicaid agencies and health plans to inform quality improvement efforts.[159]

States can also include contract requirements and incentives for MCOs to support primary care practices in developing capacity to better support child and family well-being. Some states incentivize MCOs to contract with providers that use team-based care.[160, 161]For example, in Texas, children with disabilities are enrolled in a specialized Medicaid plan, Texas STAR Kids. In this plan's managed care contract, the state requires the MCO to ensure that enrolled children have access to team-based care through a health home.[162] States may also require that MCOs train staff in primary care settings to respond to implicit bias in care, address behavioral health needs, provide guidance related to building strong referral systems, and support implementation of new technologies within primary care practices that are informed by children and their families.[163] For example, Mississippi's MCO contracts require that initial provider training include information on health equity, implicit bias, and cultural competency.[164]

Recommendation 3: Support primary care capacity and workforce development.

State Medicaid agencies can provide training, technical assistance, and peer-to-peer learning for providers to integrate behavioral health and HRSN services into their practices. For example, South Carolina's Medicaid agency, in partnership with the state's chapter of the American Academy of Pediatrics, operates the *Quality Through Technology and Innovation in Pediatric Practice* program, which supports pediatric primary care quality improvement strategies and skill-building related to mental health.[165,166] State Medicaid agencies can also consider workforce development initiatives that can help reduce unwarranted reporting to child abuse and neglect hotlines, including training on mandatory reporting requirements and implicit bias. New York's Medicaid agency requires that children's home- and community-based service providers receive mandated reporter training, which is provided by the state's child welfare agency.[167] This training includes a focus on implicit bias to prevent unwarranted reports to CPS.[168]

Additionally, states can invest in technology that helps improve primary care practices' capacity to coordinate and integrate care across systems. For example, Rhode Island dedicated funding to implement a statewide community referral platform to better coordinate care between the state's MCOs, health care providers, and community-based services.[169] Such tools are an important strategy for helping to eliminate traditional health and social service silos and enabling PCPs to comprehensively address children's needs.

Workforce development initiatives can also focus on including community members as trusted partners in team-based care, such as CHWs and individuals who can provide peer support. For example, Massachusetts' 1115 demonstration includes funding to train and certify CHWs to increase the state's infrastructure to address HRSN.[170] These initiatives can be especially impactful when they are focused on recruiting CHWs from the communities they serve, which may help reduce bias. California's Medicaid agency is funding the establishment of youth peer-to-peer mental health support programs as one component of its Children and Youth Behavioral Health Initiative.[171]

Recommendation 4: Collaborate with child welfare, behavioral health, and other state agencies to align services, policy, and financing.

Child- and family-serving systems and the state agencies that support them, such as Medicaid, can operate in silos despite often serving the same populations. At the local level, a lack of coordination or integration among primary care, behavioral health care, and social service systems, as well as limited cultural and linguistic effectiveness of services, limits the capacity to comprehensively support children and their families. Collaborations across these systems at both the state and local level, in partnership with families, can help to better coordinate services for youth and families at risk of child welfare system involvement by addressing their health and HRSN.[172] These collaborations can also be leveraged to support a broader, system-wide approach to better care for families.[173] The CAHMI Engagement in Action is an example of a framework that outlines key goals and provides an implementation roadmap that states can use to move toward a statewide, integrated system that better supports early childhood health.[174]

Improved interagency collaboration at the state level, including identifying key partners, implementing communication processes, and developing shared vision and goals can help to equitably advance child health quality improvements and prevent families' involvement in the child welfare system. For example, in July 2022, Ohio implemented its specialized managed care plan for children and youth with complex behavioral health needs, OhioRISE.[175,176] The design and implementation of this program was led by the

state Medicaid agency in collaboration with an interagency council that included the state child welfare agency. This initiative centers around shared goals across several state agencies to improve services and outcomes for children with complex behavioral health needs and their families. Additionally, the state is partnering with community care management entities to provide intensive care coordination, including coordinating with the OhioRISE plan for covered services.[177]

It is also important to identify alignment opportunities and challenges through activities like fiscal mapping and data analysis. This may include analysis of child welfare referrals and system outcomes to identify inequities. One key opportunity for states to consider is how to align policies and braid Medicaid and Title IV-E funding, given that both funding streams can cover a variety of services to prevent out-of-home placement. States can also consider braiding or blending funding streams to improve coordination of services across state agencies and avoid service cliffs. Another opportunity to support integrated care for children and their families is to integrate data across agencies through data-sharing agreements, which can help identify families that may need additional services and supports, such as behavioral health needs and HRSN. More broadly, integrated data may also help establish stronger links between primary care interventions and their effect on preventing child welfare system involvement.

Collaboration across state agencies can also promote coordination across health care, behavioral health, and social service providers. For example, states may support cross-sector education and training to build providers' understanding of each system's processes, which can help promote better connection to services for families. Additionally, state Medicaid and child welfare systems may consider standardized screening and assessment tools and common measures related to prevention and support for child well-being across Medicaid and child welfare systems. For example, in New Jersey, the Child and Adolescent Needs and Strengths (CANS) tool is used within the Department of Children and Families by the Children's System of Care and its system partners for populations with behavioral health needs, intellectual and/or developmental disabilities, and autism who may also have multi-system involvement with child welfare and juvenile justice.[178] Through New Jersey's implementation of health homes, the state modified their CANS assessment to include a medical module to ensure better coordination of care and promote physical and behavioral health integration. The use of such tools should be routinely revisited to address potential biases and identify inequities in referrals and outcomes for families.[179] These approaches can help streamline processes and align goals and incentives across systems.

Conclusion

Primary care can play an important role in preventing families' involvement in the child welfare system. Team-based care models, as well as tools and training, especially when focused on advancing equity, can support primary care practices in these efforts. State Medicaid policies are key to supporting primary care in implementing these strategies to address risk factors related to child maltreatment and strengthen child and family well-being. The recommendations described in this report outline actions that states and primary care practices can take to better support families' needs. These actions may become increasingly relevant, particularly given the need to address inequities, align services across health care and child welfare systems, maximize funding, and improve the quality of care for children and their families. States seeking to improve family well-being and prevent child welfare system involvement can consider implementing these recommendations, along with other policies and practices, through a cross-system approach that supports the sustainability of these efforts.

Appendix. Interviewee and Small Group Convening Participants

Interviewee and Small Group Convening Participant List

NAME	ORGANIZATION
Clare Anderson	Chapin Hall
David Bergman	Stanford Medicine Children's Health
Christina Bethell	Child and Adolescent Health Measurement Initiative, Johns Hopkins University
Rhea Boyd	California Children's Trust
Ben Danielson	University of Washington School of Medicine
Howard Dubowitz	University of Maryland Medical System
Teresa Fuller	Main Street Pediatrics
Yuan He	Children's Hospital of Philadelphia
Carey Howard	Franciscan Children's
Kristin Kan	Ann & Robert H. Lurie Children's Hospital of Chicago
Colleen Reuland	Oregon Pediatric Improvement Partnership
Katie Rollins	Chapin Hall
Robert Sege	Tufts University School of Medicine
Kate Shamszad	New Jersey Health Care Quality Institute
Kimá Joy Taylor	Anka Consulting
David Willis	Center for the Study of Social Policy

Emma Monahan, Chapin Hall, and Stefanie Arbutina, Children First PA, also reviewed and provided key feedback for this report.

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