

Emerging Family Focus in Medicaid: A Two-Generation Approach to Health Care

The health and well-being of parents and caregivers and their children are inextricably linked. Parents and caregivers' physical, social, emotional, and economic well-being, plus their ability to attain an education, hold a job, and pursue their own personal goals are dependent on the health of their children. Similarly, children's physical, social, emotional, and economic well-being are dependent on their parents and caregivers' well-being. Two-Generation care provides opportunities to meet the needs of adults and their children together with the greatest potential for impact in the Medicaid population.

Medicaid, a joint federal-state funded program, is the largest health insurance program in the United States, covering more than 70 million people, of whom more than 28 million are children.¹ Medicaid insurance in the United States is an individual, rather than a family, benefit; resulting in parents, caregivers, and children often having different coverage plans or a parent or caregiver having no insurance. Since the passage of the Affordable Care Act and the resultant increase in the federal poverty level metric, most parents or caregivers have coverage in Medicaid expansion states (n=36), but this continues to be problematic in non-expansion states.²

Two-Generation Health Model

Two-Generation care combines interventions for health and well-being, education, social capital, and economic assets for families to have a greater opportunity to thrive among generations.³ Providing interventions to a child, parent, or caregiver in isolation ignores the interconnectedness of family resources, strengths, barriers, and challenges to good health. For instance, children whose mothers have depression are more prone to have poorer peer relationships, lower levels of school performance, higher instances of aggressive behavior, and increased health care utilization than are children of mothers without depression.⁴ In addition, adult behaviors such as smoking can increase the incidence of heart conditions and cancer for parents and caregivers and contribute to the exacerbation of their children's asthma and incidence of low birthweight.^{5,6} Furthermore, there is a strong correlation between children's overall trajectory and their parents and caregivers' economic stability and education.^{3,7,8,9}

Table 1 provides examples of some programs that are providing Two-Generation care.

Table 1. Programs/Organizations that Utilize Two-Generation Health Models

Program/Organizations	Population Served	Goals	Two-Generation Initiatives
Head Start ¹⁰	Low-income families (parents/caregivers, children)	Provide opportunities for both children and parents/caregivers to break the cycle of poverty from one generation to the next.	Supports school readiness through early childhood care that encompasses medical, dental, and mental health care. Provides caregiver/parent focused services including nutrition counseling and family support services.
Health First Colorado ¹¹	Low-income families (parents/caregivers, children)	Ensures that all Medicaid covered individuals in the family have access to their physical and behavioral health benefits	Each member of the family has an assigned primary care provider and a link to a regional care collaborative. Transportation, food assistance, and other social services the family needs are coordinated.
Parents and Children Thriving Together: Two-Generation State Policy Network (PACTT) ¹²	Low-income families (parents/caregivers, children)	Another provider handles this care Provide support to parents/caregivers to serve as advocates for their children.	Coordinates health, childcare, early childhood education, and workforce development. Provides home visiting and behavioral and physical health screenings. Focuses on peer, community, and social service support.
CAP Tulsa ¹³	Low-income families (parents/caregivers, children)	Support families to create safe and nurturing environments that allow children to lead healthy and economically successful lives.	Provides families individualized development plans for children birth through 36 months that include health, vision, and hearing screenings. Ensures access to high-quality early childhood education plans that support academic success
Nurse-Family Partnership (NFP) ¹⁴	Low-income mothers and children	Empower first-time mothers and their babies to create brighter futures by providing support during the crucial first years of a child's life.	A nurse works with each mother and child to provide advice, answer child health questions, promote and support breastfeeding, and facilitate access to maternity health benefits.

Innovative Models in Medicaid

Community-based organizations, clinics, and managed care organizations that serve the Medicaid population are designing and implementing innovative Two-Generation models. The programs highlighted in this fact sheet serve as examples that other Medicaid stakeholders could potentially replicate.



Welcome Baby

Program Description

Since January 2019, First 5 LA (<https://www.first5la.org/>) and Blue Shield of California Promise Health Plan (<https://www.blueshieldca.com/promise/>) have been engaged in a home visiting partnership program. This program is provided by First 5 LA. In this pilot, physicians at two primary care clinics run by Blue Shield of California Promise Health Plan directly refer women in the Los Angeles County, Antelope Valley region (an area of high priority for both organizations) to First 5 LA's home visiting program immediately upon pregnancy diagnosis.

The program includes nine prenatal and postpartum home-based visits, including a hospital visit at the time of the child's birth, and extends to nine months postpartum. The goal is to improve parents' knowledge and skills; help them develop their social support systems; improve access to education, health, and community services; and provide a measurable impact on health care utilization and family outcomes. This collaboration highlights the importance of family-centered care to both organizations and a commitment to models of care to better serve the maternal-child dyad.

Early results show positive outcomes for members who enrolled in home visiting services. These results will provide information to use for partnering to further expand countywide and create a structure for evaluation and reimbursement. This type of collaboration with Blue Shield of California Promise Health Plan require First 5 LA to develop the infrastructure & support for technology systems that will facilitate referrals and allow a mechanism for quality data collection and reimbursement, including linking the member to a health plan with their Medicaid ID, sharing program enrollment information with the health plan, indicate in the health plan care management system that the member is enrolled in the program, and integrate the home visit health screening results into the member's record.

This program aims to bolster health system engagement in preventable services. As a Two-Generation model, it is a platform for providing developmental screening for children, reducing the impact of parental depression or resource deprivation on children's health, and enhancing parental capacity to support children's health.

Metrics

The partnership program between Blue Shield of California Promise Health Plan and First 5 LA tracks these metrics:

- Adverse birth outcomes
- Maternal depression screening rates
- Avoidable C-section rates
- Post-partum visit rates

Funding

This program is funded by California Tobacco Tax money.





MOM Matters®

Gateway Health ® LLC

Gateway Health Plan (<https://www.gatewayhealthplan.com/>), a Pennsylvania Medicaid Health plan, has developed two distinct programs focused on a Two-Generation approach. The health plan utilizes a holistic Behavioral, Environmental, Economic, Medical, Social, and Spiritual (BEEMSS) assessment to inform its case/care management plan. The health plan assists members in addressing their social determinants of health, enabling members to focus on their health care needs. The holistic approach is central to care coordination.

Program Description

The first, “MOM Matters®” (<https://www.gatewayhealthplan.com/medicaid/plan-benefits>), focuses on women who are pregnant. Based on multiple factors, the health plan segments the woman into various risk levels that drive targeted interventions. All participating members receive newsletters with articles about preventive care, nutrition, and maternal and children’s health and wellness.

The goal of the program is to increase the timeliness and frequency of prenatal and postpartum care. Pregnant members are stratified into risk levels and assigned to navigators or high-risk case managers as deemed necessary, based on the results of the risk screening. For about one year after delivery, moms and children continue to receive information, support, and ongoing care coordination to connect members with medical and social needs resources.

Maternity Case Managers and Outreach Representatives/Navigators provide telephonic and face-to-face assessment and education to help facilitate healthier outcomes and improved prenatal and postpartum care visits. Expectant mothers are offered assistance in making appointments, and the Case Managers/Outreach Representatives follow up to ensure that scheduled appointments are being attended. Members identified as low risk in specific zones of the state are offered face-to-face visits from Community Healthcare Workers provided by a community partner.

Metrics

The program tracks HEDIS measures, including:

- Timeliness of Prenatal Care
- Frequency of Ongoing Prenatal Care
- Timeliness of Postpartum Care

The program also tracks the impact of the program on participants compared to the non-intervention cohort for:

- NICU events
- Prematurity
- Low Birthweight Rates

Funding

Health Plan Administrative Costs





Pediatric Shift Care Unit

Gateway Health Plan

Program Description

The Shift Care program provides support to members <21 years of age who receive shift care services and medical day care. This program features a specialized **Pediatric Shift Care Unit** of licensed nurses and social workers who are focused on this unique population. Case managers coordinate care for children with a multitude of conditions and disabilities, including extreme prematurity, intellectual disability, autism, and chronic illnesses such as leukemia, HIV, and traumatic brain injuries.

These case managers serve as the single point of contact for the members, caregivers, and healthcare providers, facilitating communication and coordination. The case manager adapts the member's care plan based upon the individual member/family dynamic to maintain the member within his or her home and/or support prompt return to the home setting in the event of a hospitalization. Case managers coordinate with families and home care agencies to ensure that approved medically necessary services are provided to members.

Coordination with the member and his or her household occurs through telephone calls and face-to-face visits to identify and address health and social needs. During these calls and visits, trained staff assess social needs, educate, and provide linkages to community resources, provide assistance with obtaining preventive care, and encourage participation in focused disease management programs for target conditions. The focus is to address gaps in care for the entire household, not just for an individual member.

Metrics

Performance metrics for the Pediatric Shift Care Unit include:

- Degree of case manager interaction with the member/their family
- Impact on total cost of care
- Degree of family engagement
- Satisfaction with the program

Funding

Health Plan Administrative Costs

For a complete list of sources, please contact the Institute for Medicaid Innovation at info@MedicaidInnovation.org

