Early Childhood Developmental Health Systems

EVIDENCE TO IMPACT CENTER

Transforming Pediatrics for Early Childhood:
Illustrative Financing and Payment Mechanisms

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

During the first years of a child's life, nearly every family has repeated contact with a pediatric primary care practice.[1] These visits position care teams to promote healthy development, identify concerns early, and connect families with needed services. Doing so consistently, however, requires specialized early childhood expertise, strong community partnerships, and sustainable financing. The Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau launched the Transforming Pediatrics for Early Childhood (TPEC) program, which funded eight TPEC Resource Hubs to advance the delivery of high-quality and sustainable early childhood developmental services in pediatric practice settings. These Hubs partner directly with pediatric practices serving high proportions of children and families enrolled in Medicaid or the Children's Health Insurance Program (CHIP), as well as those who are uninsured, to improve access to care that promotes early developmental health, school readiness, and child and family flourishing.

In parallel, HRSA funded the Early Childhood Developmental Health Systems (ECDHS): Evidence to Impact Center (Center) to provide training, technical assistance, resources, and expert support to the Hubs. The Center used the early childhood development continuum of care as a guiding framework to support Hubs in advancing services and supports needed to promote healthy development from the prenatal period through age five.

Early Childhood Development Continuum of Care

The continuum, and each of its underlying components, is shaped by longstanding national clinical guidance and federal coverage policy.[2] The continuum includes:

- **Promotion and Prevention:** Universal developmental guidance, prenatal engagement, connections to community supports, and the integration of early childhood development experts into pediatric primary care.
- **Surveillance and Screening:** The use of validated tools during well-child visits to assess developmental risks or delays, autism, social-emotional development, caregiver depression, family well-being, and health-related social needs (HRSN).
- **Care Coordination and Linkage:** Family-centered referral, navigation, and shared intake systems that connect families to the health, early childhood, education, and human services they need.
- **Intervention:** Brief interventions during well-child visits, integrated mental health consultation, issue-focused support from early childhood development experts and mental health specialists, and consultation and training for pediatric primary care teams.

In addition to creating this report, the ECDHS: Evidence to Impact Center developed a suite of tools and resources to support TPEC Hubs in implementing the early childhood development continuum of care and fostering the conditions needed to spread, scale, and sustain transformative efforts. In particular, the TPEC Tools for Developing Sustainable Policy, Financing, and Payment Strategies provides foundational and specialized information that this report builds upon.

ABOUT THIS REPORT

This report features strategies that states, Tribes, and communities – including those participating in TPEC – use to operationalize and finance individual components of the early childhood development continuum of care. Drawing on publicly available information, the examples show how programs across the country have structured, funded, and scaled these components, along with their reported results. Although each example spotlights a particular component, many featured programs span multiple parts of the continuum. The report then examines broader health care financing mechanisms that currently support, or could be leveraged to support, multiple aspects of the continuum.

The examples are intended to illustrate potential approaches to sustaining the continuum of care, not to provide comprehensive program assessments or exhaustive descriptions. References at the end of the report provide additional information about each strategy and its payment mechanisms. Inclusion does not constitute a formal endorsement of any program by HRSA or the ECDHS: Evidence to Impact Center.

This report references Medicaid payment strategies and other health care financing structures, such as managed care and fee-for-service payment. For an introduction to these concepts and terms, see the Evidence to Impact Center's companion resources, *Health Care Financing 101 and Developing Sustainable Policy, Financing, and Payment Strategies*.[3,4]

EXAMPLES AT A GLANCE

Continuum Component	State/ Community	Initiative	Financing Detail
Promotion and Prevention	Maryland	HealthySteps Enhanced Rate Payment	$15 payment per eligible visit for qualifying providers; supported through Medicaid billing.
Promotion and Prevention	Arkansas	Patient-Centered Medical Home Add-On	$3.44 per member-per-month payment for qualifying practices; supported through Medicaid billing.
Surveillance and Screening	California	ACEs Aware	New screening payment to providers and grants, supported by tobacco-tax revenue.
Surveillance and Screening	American Indian and Alaska Native communities (AI/AN)	Tribal PEDS	Federal grants to support the development of validated early childhood screening tools for AI/AN communities.
Care Coordination and Linkage	Vermont; Marin County, California; Ohio	Help Me Grow Coordinated Intake and Referral System	Title V block grant; Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding; tobacco-tax revenue; and philanthropy.
Care Coordination and Linkage	Massachusetts	Community Health Worker Home Visiting and Welcome Family program	MIECHV and Title V; MassHealth 1115 primary care sub-capitation payments to primary care practices.
Care Coordination and Linkage	Oregon	Social-Emotional Metric for Issue-Focused Interventions	Coordinated care organization (CCO) incentive metric: quality pool bonus payments (a percentage of Medicaid capitation) for connecting young children to social-emotional services.
Intervention	Michigan, New Jersey, New York, Pennsylvania	PlayReadVIP literacy and relationship intervention	Philanthropic, institutional, and research funding to participating sites.
Intervention	Alaska, Massachusetts, New Jersey, New York, North Carolina	Z-Code Coverage for Mental Health Services Without a Formal Diagnosis	State guidance, provider manuals, and legislation authorizing payment to treating providers.
Intervention	Oklahoma	Reach Out and Read program for early literacy	CHIP Health Services Initiative funds to the state ROR program (first approved in 2018; oral health component added in 2023).
Intervention	Maryland	Priority Partners Training Support	Managed care organization (MCO) value-based payment ("Enablement Funding") directed to federally qualified health centers (FQHCs).

PROMOTION AND PREVENTION

PAYMENT STRATEGY: Develop payment for staff member(s) or team-based models in pediatric primary care settings that focus on early childhood promotion and prevention activities.

EXAMPLE: Maryland HealthySteps Enhanced Rate Payment

SUMMARY: Maryland provides an enhanced payment to eligible pediatric primary care practices that implement HealthySteps, an evidence-based model that embeds a early childhood development expert in the well-child care team for children from birth through age three and provides additional services and supports. This embedded expert aligns with the Promotion and Prevention continuum component.

HOW IT STARTED: Over several years, HealthySteps champions built support for the model, leading to Maryland's participation in the national ZERO TO THREE Infant and Early Childhood Mental Health (IECMH) Financing Policy Project in 2018.[5] Participation in this learning collaborative increased awareness of the HealthySteps model prior to Medicaid funding implementation.[6] In 2020, Maryland identified maternal and child health as a key priority in its Statewide Integrated Health Improvement Strategy. In response, then-Governor Larry Hogan committed $72 million for maternal and child health, including dedicated funding to support HealthySteps implementation.[7] In 2023, Maryland became the first state in the nation to designate specific, enhanced HealthySteps payment rates to practices that substantiate compliance with the model.[8]

HOW PAYMENT WORKS: Maryland launched the HealthySteps payment as a $15 encounter-based add-on payment. To qualify, a practice must meet or be recognized by the HealthySteps National Office as on track to meet the model's fidelity requirements.[9] Qualified practices bill for the add-on payment alongside payment for an eligible pediatric visit; Medicaid managed care organizations (MCOs) pay the enhanced rate for children enrolled in managed care.[10]

IMPACT: Eligible encounters billed with the HealthySteps code rose from 66% at the start of implementation to 88% two years later, indicating improved uptake of the billing code over time.[11]

EXAMPLE: Arkansas Patient Centered Medical Home Add-On

SUMMARY: Arkansas Medicaid provides a per-member, per-month payment, in addition to a fee-for-service well-child visit payment, to designated Patient-Centered Medical Home (PCMH) practices that participate in an approved team-based, evidence-based pediatric practice transformation model for children from birth through their fourth birthday. By supporting models that integrate developmental, behavioral/mental health, and family support services into routine care, Arkansas operationalizes the Promotion and Prevention continuum component.[12]

HOW IT STARTED: Healthcare providers in Arkansas flagged significant increases in behavioral/mental health needs among children after the onset of the COVID-19 pandemic. In response, the state legislature directed a Mental Health and Behavioral Health Working Group to examine behavioral/mental health conditions in Arkansas. The working group recommended that the legislature explore incentivizing existing medical homes to address prevention and early intervention through team-based, enhanced primary care for children.[13] Ultimately, the state legislature passed Arkansas Act 513 of 2023, establishing this type of financial incentive.[14]

HOW PAYMENT WORKS: Eligible PCMH practices receive a supplemental payment of $3.44 per-member, per-month for Medicaid-enrolled children from birth through 48 months. Participation is voluntary: Practices must enroll in the Arkansas Medicaid Patient-Centered Medical Home program, register and obtain approval under a Department of Human Services-approved model (currently HealthySteps), and bill under the appropriate provider identification number. Practices must also submit an annually renewed HealthySteps National Office letter showing that they meet, or are on track to meet, the model's fidelity requirements.[15,16,17]

IMPACT: By January 2025, Arkansas's seven initial HealthySteps sites had reached 27,171 children, including nearly 3,800 who received more intensive services, and made more than 4,200 referrals addressing needs such as maternal depression, food insecurity, and early intervention. Reported childhood immunization rates increased from 22% at baseline to 59% after 2 years, and an early analysis estimated a 218% return for every Medicaid dollar invested.[18,19]

IMPLEMENTATION INSIGHTS

- Explore strategies such as learning collaboratives to help build awareness and buy-in before formal payment structures are established, as Maryland did with its participation in the ZERO TO THREE IECMH Financing Policy Project.
- Leverage existing studies or commission qualitative research, as Arkansas's legislative working group did, to make the case for investing in promotion and prevention activities.
- Ensure that payment structures focus specifically on promotion and prevention, so they are not overshadowed by other priorities during pediatric visits.

SURVEILLANCE AND SCREENING

PAYMENT STRATEGY: Invest in broad-based surveillance and ensure that screenings are billable at points of care.

EXAMPLE: California ACEs Aware

SUMMARY: California provides funding to Medicaid-enrolled providers to screen patients for adverse childhood experiences (ACEs) and toxic stress.[20] Providers must use validated screening tools (e.g., the Pediatric ACEs and Related Life Events Screener for children) and are encouraged to build a network of care that connects patients to health care, behavioral/mental health care, and community resources. By integrating ACEs screening into primary care, this statewide initiative aligns with the Surveillance and Screening continuum component.

HOW IT STARTED: In January 2019, the state identified ACEs and toxic stress as a statewide public health priority. The California Department of Health Care Services (DHCS) and the Office of the California Surgeon General then launched ACEs Aware as part of the "California for All" initiative. The initiative included training and payment for Medi-Cal (California's Medicaid program) providers to screen patients for ACEs and respond using trauma-informed care.[21]

HOW PAYMENT WORKS: Initial funding included $40.8 million in the 2019-2020 fiscal year state budget to support ACEs screenings for Medi-Cal beneficiaries; ongoing funding comes from California Proposition 56 tobacco-tax revenue. Medi-Cal began paying trained providers for ACEs screenings on January 1, 2020. Providers use HCPCS code G9919 for scores of 4 or higher and G9920 for scores from 0 through 3, receiving a $29 flat payment for either code. The state has also awarded more than $64 million in grants to clinics and community organizations to build trauma-informed networks of care.[22,23]

IMPACT: Over a three-year period, providers conducted 2.5 million ACEs screenings for 1.5 million unique Medi-Cal members, including children and adults.[24]

EXAMPLE: Adapting Screenings for American Indian and Alaska Native Children

SUMMARY: The Tribal Early Childhood Research Center (TRC) at the Colorado School of Public Health launched the Pilot Exploration of Developmental Screening in Tribal communities (Tribal PEDS) to address longstanding gaps in developmental screening for American Indian and Alaska Native (AI/AN) children, who experience higher rates of undiagnosed and untreated developmental disorders.[25] Tribal PEDS conducted 53 interviews and 23 focus groups with 157 parents and early child care professionals across four AI/AN communities to better understand community perspectives on developmental screening systems, processes, and fit.[26] Tribal PEDS extends the Surveillance and Screening component of the continuum into AI/AN communities by identifying health literacy, linguistic, and methodological gaps in commonly used screening tools.

HOW IT STARTED: The work responds to evidence that commonly used early childhood screening tools are not formally validated for AI/AN children, leaving Tribal providers and families with screening results that may be less reliable.[27] Tribal PEDS is supported by TRC's PEDS Community of Learning, a multi-Tribal collaboration of early childhood professionals, parents and caregivers, and researchers working in partnership across four AI/AN communities.[28]

HOW PAYMENT WORKS: Tribal PEDS was funded by the Administration for Children and Families, with additional support from a National Institutes of Health Colorado Clinical and Translational Sciences Institute award; the work is sustained through successive federal cooperative agreements, and the pilot is framed as a first step toward a future validation study of screening tools for AI/AN children.[29]

IMPACT: Tribal PEDS developed a community-informed framework for improving developmental screening in AI/AN communities. The framework includes 13 themes and 81 subthemes that informed recommendations to improve screening education, strengthen trust between providers and families, and adapt screening approaches to reflect Tribal contexts.[30]

IMPLEMENTATION INSIGHTS

- Payment is necessary but not sufficient. California's experience shows that separate screening payment should be paired with shared screening and referral data infrastructure, as well as education for parents and providers to enhance screening rates.
- Family input is essential. The Tribal PEDS example illustrates how caregiver input improves the use of tools and ensures that communities are confident in the reliability of surveillance and screening for their community members.

CARE COORDINATION AND LINKAGE

PAYMENT STRATEGY: Finance the infrastructure needed to coordinate care — including standardized care plans, referral tracking, and family navigation – to meaningfully connect children with identified needs to services.

EXAMPLE: Multi-State Help Me Grow Funding

SUMMARY: Help Me Grow (HMG) is a system that promotes healthy development, supports early detection, and coordinates care by giving families with young children a single point of access for linkage to services and supports. The HMG model is built on four core components: a centralized access point, child health care provider outreach, family and community outreach, and data collection and analysis. HMG operationalizes the Care Coordination and Linkage component of the continuum by offering children and families a single point of contact to organize and navigate needed services.

HOW IT STARTED: Help Me Grow launched in 1997 at Connecticut Children's in Hartford and expanded statewide in 2002. Connecticut Children's subsequently established the Help Me Grow National Center within its Office for Community Child Health; the National Center transitioned to the Institute for Child Success in 2025. As of 2024, more than 30 states and the District of Columbia operated over 140 HMG systems. This example highlights financing approaches in Vermont, Marin County, California, and Ohio.[31,32]

HOW PAYMENT WORKS: Vermont funds HMG primarily through the federal Title V Maternal and Child Health Services Block Grant, supplemented by the Early Childhood Comprehensive Systems grant and philanthropic support, with a published annual operating budget of approximately $600,000.[33] HMG Marin, in Marin County, California, began with First 5 Marin funding and later added support from the Marin Community Foundation, federal pandemic relief funds, and other grants; its 2024-2025 fiscal year operating budget was $460,000.[34] Ohio's HMG Home Visiting and Central Intake programs use federal Maternal, Infant, and Early Childhood Home Visiting funding and state general revenue.[35]

IMPACT: Vermont's HMG reached nearly 38,000 families through 47 community outreach events and trained 902 providers and families on early childhood development topics.[36] Ohio's Central Intake program completed nearly 1,500 Ages & Stages Questionnaires (ASQ) Online developmental screenings in the first weeks of its centralized rollout. More recent state reporting shows continued scale: in the second quarter of state fiscal year 2025 alone, Ohio's central intake processed more than 10,200 referrals to early intervention services, assigning approximately 7,800 of these to local providers.[37]

EXAMPLE: Oregon Social-Emotional Metric for Issue-Focused Interventions

SUMMARY: Oregon delivers Medicaid through coordinated care organizations (CCOs), regional entities that operate similarly to Medicaid managed care organizations and are accountable for meeting state-defined quality metrics. To strengthen early childhood social-emotional health, the Oregon Pediatric Improvement Partnership (OPIP), housed at Oregon Health & Science University, developed a CCO incentive metric focused on whether children ages one through five receive clinically recommended issue-focused interventions or treatment. By rewarding connections to needed services (not simply screenings), the metric supports the Care Coordination and Linkage continuum component.[38]

HOW IT STARTED: From 2022 through 2024, Oregon used a system-level social-emotional health metric that required CCOs to assess service reach, map available services, engage community partners, and develop plans to improve capacity and access. Building on that work, OPIP developed the child-level "Young Children Receiving Social-Emotional Issue-Focused Intervention/Treatment Services" metric for the 2025 CCO metric incentive set. More than 160 parents, providers, advocates, and health-system leaders informed its development, including three parents with lived experience who served as paid advisors.[39]

HOW PAYMENT WORKS: Oregon places a percentage of CCO capitation and maternity case-rate payments into a statewide quality pool. CCOs that meet the program's performance requirements receive a share of that pool; the state does not assign a separate payment amount to each metric or require CCOs to pass a fixed amount directly to individual practices. The pool equaled 4.25% of CCO capitation – more than $300 million — in 2024 and approximately $238.5 million, or 3.0% of applicable payments, in the initial 2025 calculation. Each CCO's ultimate payment depends on its performance across the full incentive set.[40,41]

IMPACT: Because a new metric was launched in 2025, Oregon has not yet published results. For initial implementation, the state set an 11% benchmark and a 5-percentage-point improvement target for the measure.[42]

EXAMPLE: Massachusetts Community Health Worker Home Visiting and Primary Care Investment

SUMMARY: Massachusetts finances care coordination both in clinics and in homes. The Welcome Family program offers all families with newborns (up to eight weeks postpartum) a one-time, roughly 90-minute postpartum home visit from a maternal and child health nurse, who can provide referrals into evidence-based home visiting and intervention services.[43] At the same time, MassHealth's community health worker (CHW)-led asthma home visiting model targets high-risk pediatric Medicaid members with uncontrolled asthma or recent emergency department use through accountable care organizations (ACOs), MCOs, and contracted community organizations.[44] Together, these efforts support an integrated approach to the Care Coordination and Linkage continuum component.

HOW IT STARTED: The Massachusetts Department of Public Health (MDPH) has used federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) funding since 2010 to operate the Massachusetts Home Visiting Initiative, including Welcome Family. In September 2022, the Centers for Medicare & Medicaid Services (CMS) approved an extension of the MassHealth Section 1115 Demonstration (October 1, 2022-December 31, 2027), authorizing investments in pediatric care, HRSN services, and CHW workforce development.[45] In 2023, MassHealth launched a primary care sub-capitation payment model through its ACO program, enabling practices to fund team-based care that includes CHWs delivering home visits; see the Evidence to Impact Center's *Developing Sustainable Policy, Financing, and Payment Strategies* resource for additional information on ACOs and sub-capitated models.[46]

HOW PAYMENT WORKS: Welcome Family is operated by MDPH using federal MIECHV formula funds and Title V Block Grant resources.[47] MassHealth's pediatric sub-capitation tier payments ranged from approximately $5.20 to $13.52 per member per month in 2024 and 2025.

IMPACT: Families who participated in Welcome Family were more than twice as likely to enroll in evidence-based home visiting services by age 1 and were 1.39 times more likely to receive an Early Intervention Individualized Family Service Plan by age three, compared with families who did not participate.[48]

IMPLEMENTATION INSIGHTS

- Braided funding (e.g., Title V, MIECHV, tobacco tax revenue, philanthropy, and Medicaid) help sustain care coordination infrastructure that no single funding source would cover on its own.
- Pairing universal touchpoints (e.g., Welcome Family) with targeted services for families with higher levels of need helps connect them to the right services through a single coordinated system.

INTERVENTION

PAYMENT STRATEGY: Establish payment for evidence-based intervention services, such as embedded coaching, preventive behavioral/mental health visits, and consultation and training for pediatric primary care teams.

EXAMPLE: Multi-State PlayReadVIP Payment Models

SUMMARY: PlayReadVIP (formerly the Video Interaction Project) is an evidence-based parenting program delivered one-on-one in pediatric offices by a trained PlayReadVIP Coach. The coaching sessions, which last approximately 25-30 minutes, take place during scheduled well-child visits from birth through age three (extended to age five at some sites).[49] As of 2024, the program operates across 15 sites in four states (Michigan, New Jersey, New York, and Pennsylvania), serving approximately 3,500 parent-child dyads per year, with a primary focus on families enrolled in Medicaid. PlayReadVIP operationalizes the Intervention continuum component by embedding a structured, coach-delivered supportive service into routine well-child visits.

HOW IT STARTED: The model was developed at New York University Grossman School of Medicine and NYC Health + Hospitals/Bellevue. A series of randomized controlled trials beginning in the early 2000s established the model's efficacy in promoting responsive parenting and early language development among families receiving safety-net pediatric primary care.[50] This evidence helped build the case for Medicaid funding.

HOW PAYMENT WORKS: Publicly available information indicates that PlayReadVIP sites rely primarily on philanthropic, institutional, and research funding, rather than on dedicated health care payment. Community foundations support the Flint, Michigan, program; the university-led Pittsburgh Study supports the Pennsylvania program; and philanthropy, health systems, and a New York City Council early literacy initiative support New York City sites. The New York City Department of Health and Mental Hygiene's pediatric bundle

identifies PlayReadVIP as an evidence-based service without a dedicated payment pathway. Its "Promising" rating in the federal Title IV-E Prevention Services Clearinghouse may help child welfare agencies consider the model for inclusion in federally supported prevention plans, subject to Title IV-E eligibility and state implementation requirements.[51,52,53,54,55,56]

IMPACT: Randomized controlled trials found cognitive and expressive-language improvements (approximately 0.5-0.75 standard deviations) among children whose mothers had limited formal education, along with reductions in parenting stress and excessive media exposure at 21- and 33-month follow-up.[57]

EXAMPLE: Multi-State Z-Code Diagnosis Coverage for Mental Health Treatment

SUMMARY: Several states, including Alaska, Massachusetts, New Jersey, New York, and North Carolina, allow Medicaid payment for specified behavioral health services provided to children without first requiring a formal mental health diagnosis. Massachusetts managed care plans must cover up to six preventive behavioral health sessions without prior authorization for members younger than 21 following a positive behavioral health screen or, for an infant, a caregiver's positive postpartum depression screen.[58] Several states facilitate payment of these services by using Z-codes, or specialized billing codes used to document HRSN.[59] For example, New Jersey requires NJ FamilyCare and state-regulated plans to reimburse children's screening, prevention, and treatment services billed with an at-risk diagnosis, including an appropriate Z-code. New York permits Children and Family Treatment and Support Services providers to use an appropriate Z-code when a behavioral health need has been identified, but a diagnosis is not yet known. North Carolina allows medically necessary behavioral health therapy for members younger than 21 to be billed with Z-codes for up to six visits without a diagnosed behavioral disorder.[60,61] Alaska permits selected Z-codes as primary diagnoses for Home-Based Family Treatment under its Medicaid Section 1115 demonstration. Together, these policies support the Intervention continuum component by reducing diagnosis-based barriers to early services.[62,63,64]

HOW IT STARTED: These policies emerged through different pathways. North Carolina's approach dates to 2013, when Medicaid began allowing intake and psychological assessments to be billed with nonspecific V-codes, the predecessors to today's Z-codes. Alaska's policy developed through Tribal efforts to expand culturally responsive behavioral health care in rural communities and the state's Medicaid Section 1115 reform, which sought to broaden services, improve access, and reduce administrative barriers. Massachusetts established its preventive benefit through 2021 MassHealth guidance, allowing short-term services after a positive behavioral health screen – or a caregiver's positive postpartum depression screen – without first requiring a diagnostic assessment. New York incorporated Z-codes into its children's behavioral health service manuals, while New Jersey's 2026 law addressed a coverage gap for children who could benefit from early support but did not yet have a formal diagnosis.[65,66,67,68,69,70]

HOW PAYMENT WORKS: Massachusetts managed care plans cover up to six preventive behavioral health sessions without prior authorization, after which they may request documentation to support continued preventive services. New Jersey law requires NJ FamilyCare and its contracted MCOs to accept and pay claims using an at-risk diagnosis, including an appropriate Z-code. New York's Children and Family Treatment and Support Services are payable through Medicaid managed care and fee-for-service delivery systems, with provider manuals allowing an appropriate Z-code during screening and assessment when a diagnosis is not yet known. In North Carolina, eligible licensed practitioners bill the applicable assessment or psychotherapy CPT code with an allowable Z-code, subject to coverage and visit limits. Alaska permits designated providers to use selected Z-codes as the primary diagnosis for Home-Based Family Treatment under its Section 1115 demonstration.[71]

IMPACT: A targeted review did not identify published state evaluations or peer-reviewed studies measuring how these specific payment pathways have affected service use, access, costs, or child outcomes.

EXAMPLE: Oklahoma Reach Out and Read CHIP Health Services Initiative

SUMMARY: Reach Out and Read (ROR) is a national, evidence-based early literacy and relational health model in which clinicians provide developmentally appropriate books and literacy guidance during well-child visits for young children. ROR Oklahoma focuses on SoonerCare (Medicaid) members in communities with limited access to medical services and operates at 84 clinical locations in 38 counties, including private pediatric and family practices, hospitals, Tribal clinics, county health departments, and residency programs. By funding books, training, and developmental screening tools, Oklahoma enables the Intervention continuum component in pediatric primary care. In 2023, Oklahoma expanded the initiative to include oral health: The Oklahoma Health Care Authority partners with ROR Oklahoma and the University of Oklahoma College of Medicine Department of Pediatrics to train practices to discuss oral health and provide fluoride varnish and supplies books, toothbrushes, toothpaste, and fluoride-varnish starter kits.[72,73]

HOW IT STARTED: In 2018, Oklahoma became the first state to use CHIP Health Services Initiative (HSI) funding – discussed further in the next section – to support ROR. The initiative began under Oklahoma's CHIP state plan through[74] a state plan amendment, effective November 1, 2018, with a first-year budget of approximately $101,000, about 97% of which was federal funding. From the outset, the statewide initiative sought to address low well-child visit and developmental screening rates by training SoonerCare pediatric and primary care practices to implement ROR alongside standardized developmental screening tools.[75,76]

HOW PAYMENT WORKS: Federal CHIP HSI funding covers books, training, technical assistance, and provider tools, including free developmental screening instruments. The federal fiscal year (FFY) 2019 budget was $101,400 (including a federal share of $98,024), and approved HSI budgets increased to as much as $529,479 through FFY 2024.[77]

IMPACT: Developmental screening rates were 48% at ROR sites versus 36% at non-ROR sites, an approximately 33% relative increase associated with program participation. SoonerCare well-child visit attendance was 72% at ROR sites versus 51% at non-ROR sites.[78,79]

EXAMPLE: Maryland Priority Partners Training Support

SUMMARY: Priority Partners Managed Care Organization (Priority Partners), a Maryland Medicaid health plan jointly owned by Johns Hopkins Health Plans and the Maryland Community Health System, serves more than 200,000 enrollees and directs a portion of its value-based payment funding to train pediatric teams in federally qualified health centers (FQHCs). Training focuses on HealthySteps implementation and infant and early childhood mental health (IECMH) skill-building, including reflective practice, dyadic care, developmental and social-emotional screening, and care coordination for children birth to age three. The model finances workforce development that operationalizes the Intervention continuum component within FQHCs.

HOW IT STARTED: Priority Partners established the FQHC Primary Care Collaborative (FPCC) to give seven participating FQHC networks prospective, flexible funding for outreach, care coordination, and delivery-system infrastructure that encounter-based payment did not readily support. Within that broader model, Priority Partners designated Enablement Funding to support IECMH and integrated-care-team training.

HOW PAYMENT WORKS: The FPCC provides prospective payments based on each participating FQHC's patient population and historical costs. Each FQHC must meet annual health-outcome targets to maintain funding and may also earn incentive payments. Priority Partners directs a portion of this funding — referred to as Enablement Funding — to integrated care, IECMH training, and quality infrastructure.[80]

IMPACT: Over the FPCC's first three years, participating FQHCs experienced a 35% reduction in emergency department visits and an 11% reduction in hospitalizations among Medicaid beneficiaries. A $4.4 million investment generated $19.4 million in cumulative savings, a reported 3:1 return on investment. These outcomes reflect the broader FPCC rather than the pediatric workforce investment alone, but they show how an MCO can use prospective and performance-based payment to finance practice transformation and integrated care infrastructure.[81]

IMPLEMENTATION INSIGHTS

- Remove diagnostic challenges so providers can deliver billable interventions that address behavioral/mental health risks, rather than waiting for a diagnosable condition, as Alaska, New Jersey, New York, North Carolina do with Z-code policies.
- Pay for the workforce, not just the service. Models like PlayReadVIP and Maryland's Enablement Funding demonstrate that financing training and embedded staff roles are as critical as paying for visits.

CROSS-CUTTING FINANCING STRATEGIES

The preceding examples show that states combine multiple funding sources rather than relying on a single mechanism to sustain the early childhood development continuum of care. The strategies below highlight approaches beyond core Medicaid benefits, Title V, and education funding that can support or supplement multiple continuum components. Because some approaches have not yet been used extensively for early childhood development, each subsection concludes with potential next steps for states, Tribes, and communities considering them. For complementary strategies from pediatric primary care innovators, see the Center for Health Care Strategies' 2023 brief on financially sustainable child health transformation.[82]

COMMUNITY REINVESTMENT

Community reinvestment refers to state Medicaid requirements that MCOs direct a defined share of profits or premium revenue to community-level health and social investments. At least 10 states – including Arizona, California, Georgia, Michigan, Nevada, New Mexico, North Carolina, Ohio, Oregon, and Tennessee – have implemented such requirements, generally ranging from 3% to 7.5% of MCO profits. Many initiatives focus on HRSN and priorities identified by communities. In Ohio, for example, MCOs must contribute 3% of after-tax profits to community reinvestment, increasing by[83] one percentage point annually to a maximum of 5%. In the program's second year, Ohio plans awarded more than $6.9 million to 26 nonprofit organizations, with early childhood development among the priority areas[84].[85]

POTENTIAL NEXT STEP: Examine state Medicaid MCO contracts, provider agreements, and related guidance to determine whether community reinvestment requirements exist and identify the share of profits or revenue subject to reinvestment, eligible investment

categories, governance structures, and community-engagement requirements. Assess whether existing categories could explicitly include early childhood priorities. Where reinvestment mechanisms already exist, identify opportunities for families, community-based organizations, and early childhood champions to influence priorities and direct a greater share of investments toward early childhood health and development.

EXCISE TAX REVENUE

Excise (or "sin") taxes on tobacco, alcohol, cannabis, and sweetened beverages have become an important source of sustained funding for early childhood developmental health. Under this mechanism, ballot measures or state legislation dedicate a portion of excise tax revenue to a special fund for children's services, helping protect the revenue from general fund appropriation cycles.

California offers a long-running example. Proposition 10, approved in 1998, imposed a $0.50-per-pack cigarette tax and established the First 5 network of county commissions, which has invested billions of dollars in early childhood services over more than two decades. First 5 Marin, for example, convenes Help Me Grow Marin, described earlier. California Proposition 56, approved in 2016, added a $2-per-pack tobacco tax that supports ACEs Aware and other Medi-Cal screening incentives.[86] Vermont applies a 14% excise tax to regulated cannabis sales. Since its inception, sales-tax revenue, projected at approximately $9.7 million in FY26, has been dedicated to a universal afterschool and summer learning special fund.[87] Under Act 27, 30% of excise tax revenue (up to $10 million per year) is also directed to a Substance Misuse Prevention Special Fund at the Vermont Department of Health.[88]

POTENTIAL NEXT STEP: Identify dedicated excise-tax revenue – such as taxes on tobacco, alcohol, cannabis, sweetened beverages, or gambling – that could support early childhood developmental health investments. Because successful excise taxes may reduce use of the taxed product and therefore shrink revenue over time, pair them with other sustainable funding sources.

OTHER ASSESSMENT AND FINANCING STRATEGIES

As states evaluate the potential fiscal implications of evolving federal and state health care financing policies, some are adopting new assessment and revenue-generation strategies to strengthen the sustainability of Medicaid and other public programs. Although these approaches have not been specifically designed to support early childhood investments, they illustrate financing mechanisms that could be adapted to support such priorities. For example, in 2026, New Jersey implemented new fees on large employers with workers enrolled in Medicaid, generating additional state revenue to support the Medicaid program. Virginia also enacted a tax on electricity consumption by large data centers, dedicating a portion of the resulting revenue to a Medicaid reserve fund and a federal contingency fund intended to help the state respond to future changes in federal health care financing.

SETTLEMENT FUNDS

National opioid settlements direct substantial funds to states and localities, and the settlement agreements explicitly authorize spending on young children and families. The settlements' core abatement strategies include supports for pregnant and postpartum women (screening, brief intervention, and referral to treatment for uninsured and non-Medicaid-eligible pregnant women; medication-assisted treatment for up to 12 months postpartum; and wraparound services, including childcare), as well as expanded treatment for babies with neonatal abstinence syndrome, including a stronger continuum of care for the infant dyad.[89]

States are directing these funds toward early childhood systems: In May 2026, the Colorado Opioid Abatement Council awarded $637,959 to the Colorado Department of Early Childhood, in partnership with Illuminate Colorado and the Family Resource Center Association, for provider training, childcare access, and peer support for parents in recovery, and $750,000 to the City of Alamosa for a family-centered Early Childhood Learning Center.[90]

POTENTIAL NEXT STEP: Review state opioid settlement spending plans and abatement council processes (the National Academy for State Health Policy maintains a tracker of state spending decisions) to identify openings for early childhood investments consistent with the settlement agreements' core strategies.[91]

MEDICAID PROCUREMENT

In states with Medicaid managed care, procurement – the competitive process used to select and contract with MCOs – can advance early childhood developmental health priorities because plans must comply with requirements written into the solicitation and resulting contract. A KFF tracker shows that most states with managed care report contract requirements in at least one HRSN category, and roughly half report requirements related specifically to children's services.[92]

Three states illustrate procurement-driven early childhood requirements. As described earlier, Oregon's Coordinated Care Organization contracts include social-emotional performance metrics for children ages 0 through 36 months.[93] California's Medi-Cal contract requirements (DHCS APL 19-016) require developmental screening at nine, 18, and 30 months.[94] North Carolina's Standard Plan procurement required coordination with the Infant–Toddler Program for children from birth through age three and integration with the Healthy Opportunities Pilots (since concluded).[95]

POTENTIAL NEXT STEP: Map state Medicaid procurement calendars and identify the next opportunity (e.g., a request for proposal or contract amendment) to insert specific early childhood performance metrics, such as developmental screening rates, well-child visit completion, or dyadic care utilization.

CHIP HEALTH SERVICES INITIATIVES (HSIs)

HSIs use a portion of a state's CHIP allotment to improve the health of low-income children. Because HSIs draw on CHIP administrative funds rather than claims-based payment, they can support population-level strategies outside traditional service billing. A March 2026 analysis by the Georgetown University Center for Children and Families found that most states have substantial unused capacity under the 10% CHIP administrative cap. As described earlier, Massachusetts uses HSIs to fund the Healthy Families home visiting program and Young Parent Support. Michigan's HSI response to the Flint water crisis directed approximately $24 million annually for five years to target lead abatement for Medicaid- and CHIP-eligible pregnant people and children. [96,97,98,99]

POTENTIAL NEXT STEP: Assess whether the state has unused room under the 10% CHIP administrative cap and, if so, identify early childhood initiatives – such as early literacy programs, home visiting, or lead abatement – that could be financed through a Health Services Initiative, drawing on approved state plan amendments from other states as models.

MEDICAID COVERAGE AND SERVICE-BASED PAYMENTS

Unlike grants, dedicated revenue, and other non-service-based investments, the mechanisms in this section use Medicaid to pay for defined services delivered to eligible members. These pathways include payment for CHW and doula services and for HRSN services authorized through Section 1115 demonstrations or managed care. Although they operate through different Medicaid authorities and payment arrangements, each can establish an ongoing service-payment pathway that supports early childhood development or strengthens the transition from prenatal to pediatric care.

➤ Community Health Workers (CHWs)

The National Academy for State Health Policy reports that more than 20 states authorize Medicaid payment for CHW services, with State Plan Amendments approved in at least 15 states. Oregon and Washington provide widely cited examples of detailed, operational payment guidance. Both states allow CHW services in homes, schools, and community settings, making the benefit relevant to early childhood developmental health services delivered outside the clinic.[100,101,102]

➤ HRSN Services Through Section 1115 and Managed Care

Section 1115 demonstrations and managed care authorities offer distinct pathways for HRSN services. Section 1115 demonstrations give states time-limited federal approval to test services or delivery approaches not otherwise available under the Medicaid state plan and may support both HRSN services and implementation infrastructure. In lieu of services and settings (ILOS) are medically appropriate, cost-effective substitutes for state-plan services that a state authorizes in its MCO contracts; enrollment is voluntary, and ILOS costs are reflected in capitation.[103,104] Using value-added service design, MCOs may voluntarily offer services beyond the contracted benefit package, generally without including their costs in Medicaid capitation-rate development. California's CalAIM Community Supports offers

14 ILOS, including services for eligible young people involved with child welfare. New York's Section 1115 demonstration authorizes HRSN services through nine regional Social Care Networks, along with separate infrastructure funding. These mechanisms can finance useful supports, but their eligibility rules, federal approval requirements, and connection to early childhood services differ. [105,106, 107]

➤ Doula Services

As of March 2026, 26 states and the District of Columbia provided Medicaid payment for doula services, while 46 states and the District had taken some legislative or administrative steps toward coverage. Covered benefits typically include a defined number of prenatal visits, continuous labor and delivery support, and postpartum visits. Total payment ranges from approximately $459 to $3,500 per pregnancy. Oregon, for example, uses a $1,505 global payment with payment available for up to four additional visits, while Washington State Apple Health allows payment of up to $3,500 per client.[108,109] Doula payment can strengthen the prenatal-to-pediatric transition and support the Promotion and Prevention continuum component.[110]

POTENTIAL NEXT STEP: Review whether the state Medicaid program covers doula services and, where it does, assess payment levels, covered visits, and uptake. States can also strengthen the connection between doula services and pediatric care — for example, by incorporating newborn care guidance and warm handoffs to pediatric practices and home visiting programs into covered postpartum visits.

STATEWIDE EARLY CHILDHOOD STRATEGIC ASSESSMENTS

States use comprehensive assessment and planning tools to guide policy and investment decisions that impact young children and their families. These efforts may include fiscal mapping, landscape analyses, stakeholder and family engagement, and strategic planning to identify funding opportunities, strengthen coordination, and establish implementation priorities across agencies.

➤ Mississippi THRIVE!

In 2017, the University of Mississippi Medical Center received funding from the Health Resources and Services Administration to launch the Mississippi Thrive! Child Health and Development Project, which sought to strengthen the statewide system of early developmental health promotion, screening, and intervention.[111]

A major product of the initiative was the Blueprint for Improving the Future of Mississippi's Children, a statewide strategic assessment combining quantitative data analysis, stakeholder interviews, surveys, focus groups, and national evidence. The Blueprint examined child health and developmental screening, early childhood education, the digital divide, family economic supports, and other determinants of child well-being. It recommended coordinated strategies involving Medicaid policy and financing, quality measurement, workforce development, data sharing, cross-sector governance, parent engagement, and implementation. The Blueprint created a roadmap for strengthening Mississippi's early childhood system and informed subsequent initiatives, including TPEC.[112]

➤ First 5 Nevada Early Childhood Fiscal Map

First 5 Nevada, a public information and system-coordination initiative housed at The Children's Cabinet and funded through Nevada's federal Early Childhood Comprehensive Systems grant and Preschool Development Grant Birth Through Five, partnered with the Children's Funding Project to develop an interactive dashboard and analytic report released in May 2024. The dashboard catalogs more than 130 state and federal funding sources supporting children from birth through age 8 and their families across four service categories: Early Education and Care; Health, Mental Health, and Nutrition; Economic Well-Being; and Family Supports.[113]

The fiscal map documented $2.04 billion in early childhood spending in FY2021, with about 60% directed to Early Education and Care. It also found that state-generated dollars for children from birth through age eight averaged only 5% of state-generated funds, even though this age group represents approximately 10% of Nevada's population.[114]

POTENTIAL NEXT STEP: Commission a statewide strategic assessment that combines fiscal mapping with a broader analysis of the early childhood system. A shared evidence base can help state agencies, Medicaid, early childhood partners, advocates, and policymakers identify gaps, prioritize investments, and develop a coordinated roadmap for strengthening the developmental continuum.

CONCLUSION

The state, Tribal, and community examples in this report show that organizations can operationalize the early childhood development continuum of care in varied policy environments. Sustaining that work, however, requires clearly defined program models, accountable implementation partners, and financing arrangements that maintain a dedicated focus on the prenatal period through age five. The examples also show that long-lasting approaches typically combine funding mechanisms rather than relying on a single source.

Those funding mechanisms serve different purposes. Medicaid service payments can support defined benefits and providers, such as HealthySteps, behavioral health services, CHWs, and doulas. Managed care and demonstration authorities, including quality incentives, procurement requirements, ILOS, value-added services, and Section 1115 demonstrations, can finance services, infrastructure, or both. Grants, CHIP HSIs, community reinvestment, dedicated tax revenue, settlement funds, and institutional or philanthropic support can fund population-level activities and capabilities that do not fit readily within a claim. Fiscal mapping and strategic assessment can help states and communities identify gaps and determine how these sources can work together.

Taken together, the examples shared above offer a practical starting point: define the developmental service or system capability to be sustained, identify who will deliver and oversee it, and match it to a financing pathway suited to that function. Doing so can help states, Tribes, and communities move from time-limited initiatives toward a more durable and comprehensive continuum of support for young children and their families.

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