

FEDERAL OPPORTUNITY TO PROMOTE HEALTH EQUITY FOR YOUNG CHILDREN

Young children are the most diverse age group in society and the age group most likely to live in and be adversely affected by poverty. Health and other disparities start very early, but public investments do not. Social determinants – the social gradient, stress, social exclusion, and the absence of social support – all contribute to adverse childhood experiences (ACEs), the dangers of toxic stress, and, ultimately, profound health inequities.

Fortunately, there is a growing array of innovative programs and initiatives, starting in the earliest years of life and in the health practitioner’s office, which can reach young children and respond to these social determinants by strengthening protective factors in the family.

The Administration has an opportunity to further diffuse such innovations – through establishing within the Center for Medicare and Medicaid Innovations (CMMI) a Federal Opportunity Announcement (FOA) for young children. Such an FOA has been endorsed and promoted by many child health practitioner leaders in the field and by a broad array of child advocacy leaders across the country.

While children are not drivers of health care costs, they can be the solution to future health needs and costs. An FOA for Young Children is entirely consistent with the goals for CMMI of achieving the triple aim – improved health quality, improved population health, and reduced per capita health care costs. The Administration has both the authority and current funding to construct a \$500 million FOA for Young Children through the Center for Medicare and Medicaid Innovation.

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For further information on this opportunity please contact: Dr. Charles Bruner, Director, Child and Family Policy Center and the Center for Health Equity and Young Children (cbruner@cfpciowa.org)

July 26, 2013

Patrick Conway, Acting Director
Center for Medicare and Medicaid Innovation
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Conway:

We applaud the work of the Center for Medicare and Medicaid Innovation in fostering new approaches to health service delivery and finance through a portfolio of demonstrations testing various payment and service delivery models that aim to achieve better care for patients, better health within communities, and lower costs through improvement of the health care system.

We also recognize the importance of focusing attention on achieving reductions in costs to the Medicare, Medicaid, and CHIP systems through these actions, with explicit requirements in the different Federal Opportunity Announcements (FOAs) to rigorously track such cost impacts and savings over time. These efforts are essential to achieving the triple aim of improving health quality, improving population health, and reducing per capita health costs.

To date, however, most of the focus of the FOAs has been on current high cost populations – persons with chronic conditions or persons particularly vulnerable to incurring medical expenses in the short-term.

While it is critically important to address these populations, achieving the triple aim ultimately will require much greater attention to and innovation within the delivery of primary and developmental health services to children, and young children in particular. We therefore recommend that the Center for Medicare and Medicaid Innovation develop a new demonstration and FOA focused explicitly upon improving health trajectories for the young child population.

We believe that the growing knowledge in the field regarding healthy child development, as well as the emergence of many exemplary practices within primary pediatric care delivery, can be substantially accelerated and enhanced through precisely the type of FOAs which CMMI has been sponsoring.

Children are not immediate drivers of health care costs, but improving their health trajectories is essential to reducing the prevalence of preventable health conditions which necessitate long-term medical attention and now constitute those major drivers of overall health care costs. Further, there is growing recognition that improving these health trajectories requires innovation and diffusion within child health practices through effective responses to social as well as bio-medical determinants of health. The research base on adverse childhood experiences, toxic stress, social determinants of health, and epigenetics all point to the critical importance of the earliest years of life to lifelong health.

While children account for only a small share of current federal health systems costs, they represent half of all individuals served by Medicaid or CHIP. Moreover, together Medicaid and CHIP provide coverage for approximately half of all the nation's youngest children (0-5), and an even greater share of those most at-risk of experiencing poor child health outcomes. Young children represent by far the most diverse age group in American society and, if we are to be successful in eliminating health disparities and inequities, we also must start in these

earliest developmental years. And it is in precisely the earliest years of life that child health practitioners often represent the only professional seeing the child and therefore in a position to identify and commence responses to the child's developmental concerns.

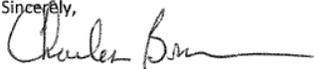
There is a growing base of innovative practice and an emerging field of research and knowledge on the efficacy of early childhood primary practices which respond to social as well as bio-medical determinants of health. A number of these practices have been subject to rigorous evaluation showing significant positive impact upon child health trajectories.

What has been missing, and what an FOA also could help to produce, are rigorous, actuarial estimates of these impacts upon health care costs over time. While some of these practices have demonstrated cost-offsets even in the short-term (particularly for young children where early identification and response to an emerging health condition has occurred), most of the impacts upon health and health costs are in the longer-term. The three-year time horizon for demonstration cost savings in prior FOAs is appropriate for programs serving individuals with existing health conditions, but the greatest gains in health care costs may well come from improving the life course trajectory of development. It is the first few years of life, rather than the last few, where the opportunity for impact upon an individual's health, and health costs, is greatest.

Fostering innovation to more effectively respond to social determinants of health through a life-course approach also requires a different locus than does controlling costs for those who already have chronic conditions requiring care. While short-term gains often can be achieved for individuals with chronic conditions in reducing hospitalization and emergency room use and expenses – and therefore accountable care organizations and other health management structures focused upon payment and delivery reforms with hospitals as key partners makes sense – innovations in child health require a different array of leaders and champions. The locus for innovation is much more at the practitioner and community level, rather than within medical institutions.

Our primary child health system faces both a major challenge and opportunity. For the first time in our nation's history, children face the prospects of growing up less healthy and living less long lives than their parents. There have been major advances in medical care and the child health practitioner community now largely provides that medical care, but children's healthy development is dependent upon much more than treatment of medical conditions. Research, science, and the experiences of exemplary pediatric practices all point to the need for innovation and diffusion in child health delivery if, as a nation, we are to address the health challenges our children face. We believe that the Center for Medicare and Medicaid Innovation was developed to catalyze such innovation and diffusion and are eager to work with you to achieve that goal.

Sincerely,



Charles Bruner, PhD.

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Paul H. Dworkin, MD

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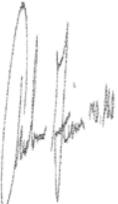
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August 9, 2013

Patrick Conway, Acting Director
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Dear Dr. Conway:

As child advocates, we recognize that health is the foundation for children's overall development and success – educationally, socially, and economically.

This starts with ensuring that all children have health insurance coverage. There have been major gains to achieve this end through enactment of the Child Health Insurance Program Reauthorization Act (CHIPRA) and the Affordable Care Act (ACA). Yet improving children's health and development does not stop there.

We are excited about the many opportunities within the Affordable Care Act to promote more primary and developmental health services to young children, including recognition of *Bright Futures* as the standard for well-child care and the requirement that all preventive health services within public and private health plans be provided without co-payments or deductibles. We applaud the requirement to cover habilitative services and the emphasis upon medical homes and care coordination in many of the reform efforts.

More, however, needs to be done to realize the potential of these provisions. For the first time in our country's history, children face the prospect of growing up less healthy and living less long lives than their parents. Disparities in health, by race and socio-economic status, are profound at the same time that children are the most diverse age group in society and most likely to be living in poverty.

Particularly when children are very young (birth to five), the child health practitioner often is the only professional who sees the child and must serve in a first responder role to addressing the child's needs, including those related to social determinants of health as well as bio-medical biomedical ones.

Early childhood research shows that the returns-on-investment in the earliest years can achieve much higher levels than for investments made at any other point in an individual's life. There are many exemplary child health practices which have shown success in addressing social determinants of health and affecting the life course trajectory of children which show great promise in achieving similar long-term returns-on-investment. What does not yet exist in the research on these programs is the long-term tracking or actuarial estimations of their health benefits in relationship to their investment costs.

We believe the Center for Medicare and Medicaid Innovation is uniquely positioned to support both the development and diffusion of innovative child health practices and begin to build the base of evidence about their cost effectiveness and their returns-on-investment.

We encourage you to establish a Federal Opportunity Announcement (FOA) to meet the "triple aim" that focuses upon children in the earliest years of life (birth to five) and supports further innovation in young child health delivery. We believe this would spur additional community and state actions which will foster the goals of improving health quality, improving population health, and reducing per capita health costs – through establishing much healthier trajectories for young children by addressing social determinants of health and reducing current health disparities and inequities.

Children are not the immediate drivers of health care costs, but improving their healthy development is key to long-term efforts to reduce chronic health conditions that lead to so many of the costs that the health system will need to address in the future. Again, we encourage you to establish a Federal Opportunity Announcement to foster further innovation and diffusion of exemplary practices that promote healthy child development among our youngest children.

Respectfully,



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Karen Crompton, Voices for Utah Children



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MOCK FUNDING OPPORTUNITY FOR TESTING NEW
APPROACHES FOR PRIMARY CARE FOR YOUNG CHILDREN
Center for Medicare and Medicaid Innovation

Child and Family Policy Center Preliminary Draft, September, 2013

I. FUNDING OPPORTUNITY DESCRIPTION

1. Purpose

The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) is interested in testing new care and payment models that have the potential to improve healthy child development for young children enrolled in Medicaid and/or Children's Health Insurance Program (CHIP) who are at-risk of early childhood adversity or other social determinants adversely impacting health, or experiencing early but otherwise unaddressed developmental issues and concerns. This initiative is a partnership between the Innovation Center and the Center for Medicaid and CHIP Services (CMCS) and part of a larger effort to improve children's healthy development, reduce disparities in child health outcomes, reduce overall cost, and prevent or mitigate the impacts of adverse childhood experiences and their consequences to health and educational development.

In this four-year initiative the Innovation Center will offer a funding opportunity to eligible applicants to test the impact of providing enhanced primary, preventive and developmental health services for young children that extend beyond the provision of clinical care to effectively respond to social determinants of health.

This ultimate purpose of this initiative is to achieve the three-part aim of better care, improved health and reduced costs by improving the developmental trajectories of young children through a life course approach to primary, well-child care. There is a growing body of research that shows the critical importance of the first years of life to long-term healthy development and the importance of identifying and responding to social determinants of health during those years. The research on adverse childhood experiences, toxic stress, epigenetics, resiliency, and risk and protective factors all provide the basis for focusing upon family- and community-, as well as child, conditions as key to improving healthy child development and, in particular, closing disparities in child health by race, language, and socio-economic status. While young children, overall, are not high-cost users of health services in the present, both health conditions and health behaviors they develop in the early years have profound implications to future health needs and costs. With respect to the third part of the triple aim, within the funding opportunity, emphasis will be placed upon the long-term cost benefits to improving healthy child development in the early years.

2. Authority

Section 1115A of the Social Security Act (added by Section 3021 of the Affordable Care Act) authorizes the Innovation Center) to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and CHIP spending while maintaining or improving the quality of beneficiaries' care. Under the statute, models must address defined populations for which there are deficits in care leading to poor clinical outcomes and potentially avoidable expenditures. The Innovation Center will use its authority to test alternative models for payment and service delivery for young children in Medicaid and CHIP.

3. Background

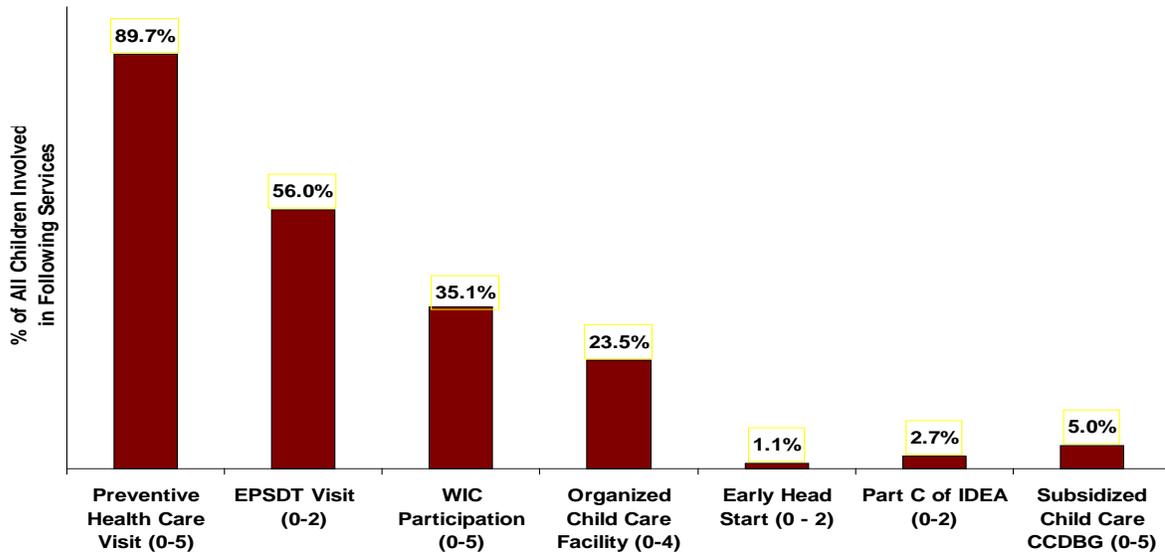
Together, Medicaid and CHIP programs provide health coverage for four in ten children in the United States, but these figures are even higher for young children. And, it is in the earliest years that primary care practitioners most frequently see the child. Table One shows the number of children who are covered under Medicaid by child age ranges, and the mean number of EPSDT visits children have during the year for different age ranges.

| NATIONAL DATA ON MEDICAID ENROLLMENT BY CHILD AGE AND AVERAGE NUMBER OF EPSDT VISITS ANNUALLY – 2010-11 INFORMATION | % of the Age Group Served |
|--|----------------------------------|
| 0-2 Medicaid/EPSDT enrollment as % of all 0-2 year olds (416 forms and ACS) | 56.0% |
| Average number of EPSDT visits annually by those enrolled | 2.2 |
| 3-5 Medicaid/EPSDT enrollment of % of all 3-5 year olds (416/ACS) | 51.5% |
| Average number of EPSDT visits annually by those enrolled | .71 |
| 6-17 Medicaid/EPSDT enrollment as % of all 6-17 year-olds (416/ACS) | 35.6% |
| Average number of EPSDT visits annually by those enrolled | .42 |

Moreover, when children are very young, the primary care practitioner often is the only professional source of contact with the child and family with the opportunity to identify developmental, behavioral, or environmental concerns that can impact the child's healthy development. As Table Two shows, while nine in ten children birth to five see a primary care practitioner for a well-child visit at least annually

(and half do so under Medicaid), the contact of the child with other public services and supports extends to many fewer children.

Children’s Healthy Development: Who Sees Young Children?



Most of this data is available at a state level as well as the federal level. The following are specific sources of information for the data in the chart.

Preventive Health Care Visits: National Survey of Children’s Health – available online: <http://www.nschdata.org/Content/Default.aspx>
 EPSDT: Centers for Medicare and Medicaid Services (CMS) – available online: http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp
 WIC Participation: U.S. Department of Agriculture, Food and Nutrition Service, Office of Analysis, Nutrition, and Education – available online: <http://www.fns.usda.gov/oane/menu/Published/WIC/WIC.htm>
 Organized Child Care Facility : Census Bureau Special Report: Who’s Minding the Kids? – available online: <http://www.census.gov/population/www/socdemo/childcare.html>
 Head Start/Early Head Start Participation: National Head Start Association – available online: http://www.nhsa.org/advocacy/advocacy_facts.htm
 IDEA Part C Participation: U.S. Department of Education, Office of Special Education Programs, Data Accountability Center – available online: <https://www.ideadata.org/default.asp>
 Subsidize Child Care CCDBG:

These primary care, well-child visits, provide a key opportunity to identify and respond to young children’s healthy development. The research – on brain development, toxic stress, epigenetics, social determinants of health, resiliency, and risk and protective factors – all points to the critical importance of providing safe, consistent, and nurturing environments for infants and toddlers in these earliest years to lifelong health and development. The research on adverse childhood experiences shows that failure to do so has far-reaching physical health consequences in terms of the prevalence of chronic health conditions in the adult years, with potentially huge cost impacts in the adult years. During the earliest years of life, improving health outcomes requires clinical care to identify and respond to disease, congenital conditions, and injuries, but the primary opportunities to improve healthy development are through addressing social and not bio-medical determinants of health.

The role of the primary health practitioner during this period includes anticipatory guidance, screening and surveillance, and effective referrals and follow-up services to respond to both clinical and social

determinants of health. Medicaid's EPSDT provision provides for coverage for a broad array of services that are determined to be "medically necessary," which can extend beyond clinical care. The Affordable Care Act itself now requires insurers to cover primary and preventive care, including well-child visits, based upon evidenced-informed guidelines developed by HRSA, a reference which refers to Bright Futures and its detailed guidelines for providing well-child care. Bright Futures adopts a "life course" perspective to well-child care which includes this attention to social determinants as well as presenting clinical conditions in the child.

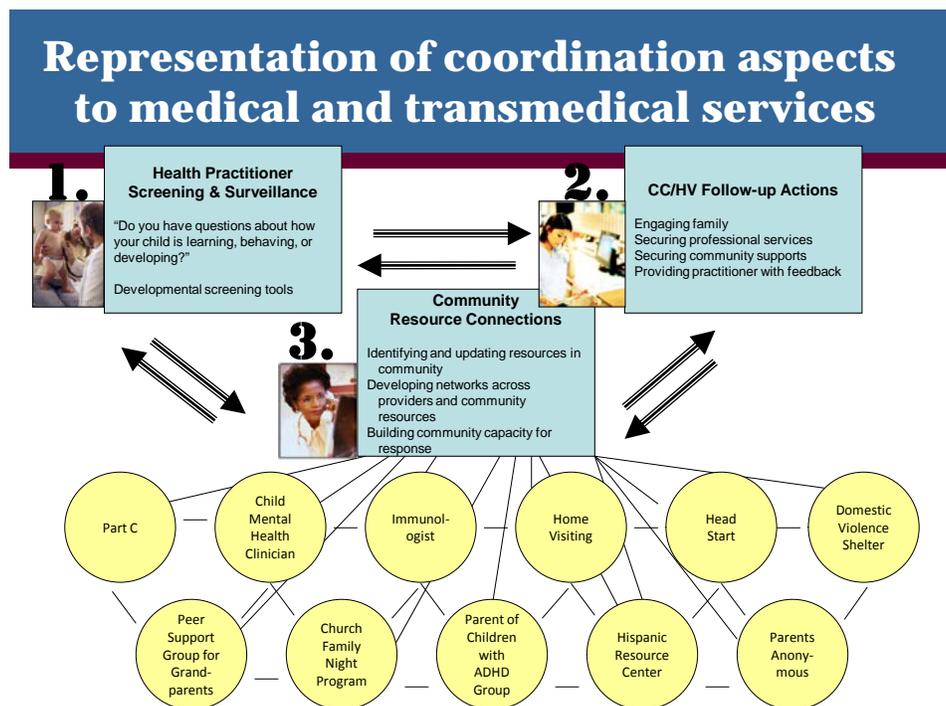
While research and recommended practice guidelines support such a comprehensive, developmental approach to well-child care, these have not yet been incorporated into payment and service delivery strategies nor have models been developed for making them standard or routine practice. There is a growing array of exemplary practices which have developed at the community level and through selected foundation efforts. Some have focused upon providing developmental screening and surveillance to detect and respond to behavioral and developmental disabilities and delays (Help Me Grow and many of the activities under the Assuring Better Child Health and Development/ABCD Initiative sponsored by the Commonwealth Fund and . Others have focused upon linking families of children to concrete services and supports to stabilize the home environment (Health Leads). Others have supported clinical practices which include care coordination and social work to link children and their families to other needed social supports (Healthy Start for Children). Others have focused upon strengthening the parent-child relationship through both home visiting and group visits (Child FIRST). Others have provided broader anticipatory guidance to support healthy home environments (Reach Out and Read). Many have included some form of care coordination that is responsive to the families being served, in the context of their home environment, language, and culture (Abriendo Puertas).

There is a growing research base on the efficacy of these efforts both to improve the home environment (address social determinants of health), identify and respond more quickly to social and emotional concerns, and to produce gains in children's healthy development, particularly social and emotional development. At their heart, these different initiatives all have some of the following common elements in providing for well-child care that initiates the process of responding to social as well as clinical determinants of child health:

- Developmental screening and surveillance: a much more rigorous effort to identify factors that affect healthy child development (family stress, depression, and other social determinants) and earlier responses to presenting child developmental issues and concerns, often with a formal screening tool or protocol;
- Anticipatory guidance to families, with some practical resources provided at the well-child visit (including Reach Out and Read activities);
- Referral to culturally and linguistically responsive and competent care coordination, where that care coordination incorporates motivational interviewing, ensures that families know about and can access services to meet concrete needs, and focuses upon how protective factors can be strengthened to support healthy child development;

- Identification of available services and supports in the community and established relationships with these services and supports, so families can be connected where needed to them, including peer support and mutual assistance programs (which may also be developed as part of the program, as in the case of Child FIRST); and
- Further connections to community services and supports that go beyond referral to scheduling and follow-up – which include relevant community programs that can strengthen positive connections with the families.

The Chart below graphically depicts different elements – broken out by the responsibilities of the primary care practitioner, the care coordinator, and the network of community resource referrals.



Incorporating these features into standard or routine practice will require different approaches for different child populations, different communities, and different practice settings. There is no single model that is likely to be effective in all settings. Developing effective models, based upon achieving the trip aim; diffusion them to move from exemplary to more routine practice; documenting their long-term as well as short-term impacts on health care costs; and determining how to incorporate them into Medicaid and CHIP payment systems are the goals for this Federal Opportunity Announcement.

4. Program and Initiative Requirements

This solicitation will offer direct funding to applicants for the purpose of improving primary care practices for young children (birth to five, or a subset of those years). Funding is available for start-up, implementation costs, and evaluation and continuous improvement approaches. All applicants must include in their proposals how their programs or initiatives are designed to improve the quality of health

services, child (and family) health outcomes, and result in health cost savings over the long-term – and provide ways to assess their effectiveness in achieving these.

The purpose is to improve healthy child development for young children enrolled in Medicaid and/or Children’s Health Insurance Program (CHIP) who are at-risk of early childhood adversity or other social determinants impacting health or experiencing early but otherwise unaddressed developmental issues and concerns. There are several reasons for inviting cooperative agreements to extend the knowledge base in the field and promote innovations and their diffusions which can meet the triple aim.

Developing innovative programs to address identified concerns that involve changes to primary care practice to achieve. While there are different exemplary programs that can be drawn upon, there also is need to continue to develop primary care practices which respond to different populations, types of clinical practices, communities, and family and child risk factors. As a first example, there could be further efforts to develop practices which work with families to develop their children’s eating and exercise patterns early in life. While obesity is more prevalent among older than younger children, it has its roots in the earliest years and the patterns of behavior developed there. As a second example, there could be further efforts to construct community utilities within poor and disinvested neighborhoods to better ensure that resources can be identified which can enable families to strengthen protective factors, particularly around peer support and mutual assistance. As a third example, there could be further efforts to respond more effectively to particular refugee populations by training and supporting primary health practitioners in understanding the population’s beliefs regarding both child development and medicine and clinical care, and establishing outreach and care coordination approaches which are culturally and linguistically responsive to the population. As a fourth example, the development of group well-child visits affords the opportunity to provide more extensive anticipatory guidance and to initiate peer support and mutual assistance which also can improve healthy child development by establishing an additional venue for social support. In each of these examples, the goal is to develop new efficacious models that can then be shared for subsequent diffusion to others addressing similar concerns in their practices and communities.

Expanding and diffusing efficacious models to broader application, with an eye to becoming standard and routine practice through developing training and technical assistance and payment and monitoring systems to support them. While there are different exemplary programs that have demonstrated their efficacy in impacting social determinants affecting child health and improving child health trajectories, these often operate as small-scale programs and diffusion and scale up to become standard practice has been limited. Strategies to diffuse and scale up such models require attention to fidelity of replication and to creating payment and monitoring systems within Medicaid and CHIP which support these models.

Developing reliable and valid estimates of program and initiative impacts on health outcomes and health costs. While primary, preventive, and developmental health services often have demonstrated a positive impact upon the trajectory of children’s health, most have not yet been examined in terms of their costs and benefits over the long-term. Young children are not drivers of health costs and, while the majority of enrollees on Medicaid and CHIP, account for only a small share of the costs. At the same time, young

children are developing health behaviors and conditions that have major cost implications for the future – not only in health costs, but in educational, social, and justice system costs as well. While the time frame for this solicitation is not sufficient to track young child outcomes over the long-term, this does not mean that reliable and valid estimates cannot be regarding the future cost implications for raising health trajectories and reducing the prevalence of future health conditions and the costs for their health management and treatment. While some programs and initiatives may achieve shorter-term savings through de-medicalizing service interventions and improving the management of existing child health conditions by identifying and responding to them early, the greatest gains in reducing per capita health costs are expected to be over the longer-term. All funded models will be required to track proximate impacts upon child health, while working with CMMI to develop longer-term (e.g. 10 to 30 year) projections on resulting future health conditions and the projected health system costs for addressing them. This may include both overall costs and costs specific to Medicaid, based upon estimates of projected economic conditions as adults and their resultant likelihood of needing to rely upon Medicaid for their care.

Explore family health impacts through two generation health strategies that seek to improve both young child and parent health through greater bonding, attachment, and nurturing. Parental stress, and more specifically parental and maternal depression, are recognized as having adverse impacts upon children’s own healthy mental development. Two-generation approaches, e.g. dyadic or group therapeutic interventions, which seek to strengthen nurturing and bonding between parent and child, can produce impacts both upon healthy child growth and development and parental health. They also may be eligible for funding through both the child’s and the parent’s Medicaid coverage and there are opportunities to explore through innovative practice how family pediatrics can produce dual benefits in child and adult health and to assess its overall impacts upon health care costs accordingly.

These reasons are provided to show the range of innovations which will be considered in this solicitation – but they are not necessarily inclusive of the innovations which will be considered under this solicitation.

In supporting innovations in this solicitation, CMMI will be looking for champions in child health with the passion and ideas to improve healthy child development from the entry point of the primary care practitioner’s contact with the young child and family through well-child visits. The goal of innovations is to learn by doing, and CMMI does not expect all innovations to be successful and would expect that innovations themselves may change through the process of testing and experience. In supporting the diffusion of exemplary and efficacious models, CMMI will be looking for champions and early adopters who have a strong focus upon designing structures, protocols, and processes that can ensure the fidelity of replication of impacts of those models, moving from efficacy to effectiveness.

IV APPLICATION AND SUBMISSION INFORMATION

2. Project Narrative

The application must address the following in the narrative.

- 1.1 *Innovation or model approach.* The application must describe the specific innovation being developed or diffused and how it differs from routine or standard practice. The innovation or model approach may be in terms of a new intervention or the adaptation, diffusion, or scaling up of an existing approach. The latter may include innovations related to payment models and monitoring models.
- 1.2 *Opportunity for learning and impact and evidence base.* The application must describe the reasons for believing that the approach has the potential to produce better outcomes and results for the population for which it designed, including what evidence base exists both for showing that there is need for innovation in this area (that current practice is not producing the best results) and that the approach itself has some potential to address some of these reasons. The application must describe how the innovation and the findings from that innovation will advance the field of knowledge and practice in responding to bio-medical and/or social determinants of young child health through actions initiated by primary care practitioners.
- 1.3 *Innovation team responsible for design and implementation and implementation strategy.* The application must describe the team which will be responsible for the design and implementation of the innovation, and the strengths members of the team bring to the process of innovation, in terms of developing innovative ideas and approaches, testing and learning from initial implementation efforts through interactive evaluation activities appropriate for the testing, and documenting lessons learned and contributing to further development and diffusion of approaches that have been developed that achieve better results.
- 1.4 *Evaluation and improvement plan.* The application must describe how data and information will be collected and analyzed with appropriate rigor to be able to learn from and adapt approaches in order to achieve the goals for the approach. This solicitation emphasizes a continuous learning approach to innovation and diffusion that employs continuous evaluations to inform implementation and expansion.
- 1.5 *Impact estimation.* The application must develop metrics related to measuring child (and, in some instances, parent/family) health impacts, with as much rigor and the ability to attribute causality (through establishing a counterfactual) as is feasible given the innovation approach. The application must identify proximate metrics related to the specific innovation approach, and agree to seek to estimate longer-term health outcomes associated with these proximate impacts, including estimates of long-term costs and benefits to Medicaid and CHIP.
- 1.6 *Diffusion or sustainability strategy.* When the approach is designed to diffuse and scale up innovations, the application must describe the strategies for achieving these ends, including the establishment of payment and monitoring systems within Medicaid and CHIP.