



CMMI RFI RESPONSES: SOME COMMON THEMES

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Abstract. The Center for Medicare and Medicaid Innovation (CMMI) issued a Request for Information (RFI) on a variety of questions around “a pediatric alternative payment model that encourage[s] pediatric Medicaid and CHIP providers to collaborate with health-related social service providers and share accountability for outcomes for children and youth.” In addition to providing their own responses, the Health Equity and Young Children Initiative and Mental Health America secured responses from fourteen other child health organizations to review and produce a document excerpting from those responses around eight themes that were broadly shared across the respondents:

- *Regardless of the pediatric payment model, payments to providers must incent and support practices, particularly primary care practices, to be more holistic and preventive in their responses, including two- and sometimes multi-generation approaches to strengthening families and improving child development.*
- *The greatest potential for improving health and achieving the Triple Aim is with children (young children in particular) by addressing social, environmental, and behavioral as well as bio-medical determinants of health, often even before children manifest specific health conditions and delays.*
- *Primary child health practitioners can and should refer and connect children and their families to health-related social services (through care coordination and community health approaches), but this also necessitates the availability of supports and resources at the community level to meet identified family needs and priorities.*
- *An array of models has demonstrated efficacy in improving children’s health trajectories. These models are worthy of diffusion and scaling, but are not recognized and adequately supported in existing alternative payment models, which provide incentives primarily directed to adult and high-cost chronic or complex care populations.*
- *Promoting innovation and diffusion can be achieved through fee-for-service models or direct financing of innovation as well as through alternative payment models. To be achieved through alternative payment models, the emphasis must be on value and not immediate health care cost offsets. This requires quantifying “value” in terms of its long-term benefits, including but potentially extending beyond health conditions and their costs (to such areas as special education, behavioral health, and even justice system costs).*
- *Metrics are needed around healthy child development that include child, and at least for young children, family conditions related to physical, cognitive, social, and emotional development. CMS and CMMI have an opportunity to advance such metrics development and the quantification of their impacts from a value-based care perspective.*
- *Some shared savings are possible with the child population, particularly for children with existing diagnosed health conditions (e.g. asthma, prematurity), often by either “demedicalizing” responses or improving family agency in responding to ongoing child health needs. Such shared savings, however, are very modest and not sufficient to produce the types of practice changes necessary to achieve the greatest promise for value-based care in pediatrics.*
- *There is value in promoting further innovation at the practice level even beyond an overall payment model or system, in order to continually improve practice. CMMI can play a vital role in financing such innovation, as well as in focusing upon alternative payment models.*

OVERVIEW

The Health Equity and Young Children Initiative (HEYC) and Mental Health America (MHA) coordinated in developing two responses to the Center for Medicare and Medicaid Innovation's (CMMI) Request for Information (RFI) on Pediatric Alternative Payment Model Concepts (see insert). The Health Equity and Young Children Initiative's responses provided an overarching perspective on responding specifically to very young children and their healthy development, while Mental Health America's responses covered the full childhood period but focused more specifically on payment model considerations under an accountable care structure. Both sought advice and contributions from experts in the field and secured co-signatories, including each other's. In this process, HEYC and MHA identified other organizations that were developing their own responses to the RFI.

Excerpt from CMS-CMMI Request for Information

CMS is considering a pediatric alternative payment model that encourage[s] pediatric Medicaid and CHIP providers to collaborate with health-related social service providers and share accountability for outcomes for children and youth. Such an integrated service delivery model could present several benefits:

1. Comprehensive, universal screening of beneficiaries across sites could increase identification of health care needs at an earlier stage than currently experienced;
2. Alignment around eligibility and enrollment requirements could reduce service interruptions and churn, resulting in administrative cost savings;
3. Children and youth would receive streamlined, coordinated care across health care and health-related social services providers resulting in improvement in health and wellness and reduced total cost of care and service delivery; and,
4. Health care and health-related social service partners would be encouraged to develop the infrastructure needed to support sharing in accountability and cost savings.

The CMMI RFI enumerated an important, extensive and detailed list of questions around which it was seeking guidance, ones which have implications to many aspects of future work in pediatric transformations to improve child health. In addition to sharing their own responses, HEYC and MHA sought and secured the responses of fourteen other organizations with expertise in child health.

This report is an effort to summarize some common themes across these responses and identify particular insights. While the Center for Medicare and Medicaid Services (CMS) and CMMI will be making use of these responses in their own work and leadership around health improvement, the responses also deserve further discussion by the field as a whole. Such dialogues can inform future philanthropic, community, practice transformation, and policy actions in the field that, hopefully, will be synergistic with actions taken by CMS and CMMI.

The following is an introductory enumeration of common themes from these responses, along with selected excerpts from specific responses that articulate these themes. They are not designed to be inclusive of all the themes that might have been gathered or all the insights provided, but were produced to further dialogue specifically around advances that could be undertaken, with the particular emphasis upon the role the primary child health practitioner can play to advance child health.

COMMON THEMES

Regardless of the pediatric payment model, payments to providers must incent and support practices, particularly primary care practices, to be more holistic and preventive in their responses, including a two- and sometime multi-generation approach to strengthening families and improving child development.

Traditionally, pediatric practices have focused exclusively on children's health care needs. However, it is well-documented that a child's health is mediated by his/her caregivers' health, making two-generation approaches critical. The pediatrician's office is a powerful access point for children *and families*, particularly for low-income, high-need populations. ... By leveraging the positive relationships that most parents have with their children's pediatricians, as well as the universal, non-stigmatizing pediatric primary care setting, pediatric practices can go beyond mandatory Medicaid requirements and serve as early childhood systems navigators to impact both the bio-determinants (genetics and biological functions) and social determinants (family stability, poverty, safe housing, accessible outdoor play space, etc.) of health. – Robert Wood Johnson Foundation

The P.A.R.E.N.T.S. Science (Protective factor, Adverse childhood experiences, Resiliency, Epigenetics, Neurobiology, Toxic stress, and Social determinants of health) points to the first years of life as critical and foundational to healthy development – physical, social, emotional, language, and cognitive. This is a period where the roles of parents and caregivers are most foundational to healthy development. ... The key to success in working with families is to truly engage them and recognize their expertise regarding their child and the child's environment and to foster their own agency in nurturing their child. This involves family-centric and often family-driven responses to meeting child health needs, particularly around social determinants of health, starting with the contact families have with their primary care practitioner's office. – Health Equity and Young Children Initiative

Recent discussions with states and health plans seeking to identify innovative strategies designed to support high-risk, low-income families have indicated a number of opportunities to improve care for pediatric beneficiaries. CMS could consider the following topics of interest/technical assistance needs to support an effective model and prompt cross-sector efforts for this population: (1) Facilitate community and social services linkages to medical practices: Identify how to link community-based resources to medical practices to address upstream prevention; (2) Test innovative high-risk family-centered clinical models and interventions: Build out new care models and better understand what the health and social services systems need to do differently to support high-risk families; (3) Emphasize two-generation approaches: Recognize family relationships and treat the children and parents as a unit; (4) Identify and share information around basic metrics: Identify assessment tools and share information around metrics to determine common measurements that should be tracked. – Center for Health Care Strategies

The many opportunities in service delivery for all pediatric beneficiaries and for those with higher needs include (1) reducing intergenerational transmission of trauma, (2) coaching parents on positive parent-child interactions, (3) addressing two-generational health challenges, (4) directly promoting early learning and literacy, and (5) connecting to more intensive services and community resources to address social determinants of health. We believe the most effective pediatric primary care model would incorporate all five of these elements. – United Hospital Fund

Strengthening primary care is critical to driving greater value for patients, payers, and communities. Transformation cannot be overly complex and burdensome to operationalize. However, there is not a one-size-fits-all solution, as patient panels, populations, and primary care practices vary. There is an emerging consensus that strengthening primary care is imperative to improving individual and population health outcomes, as well as to restraining the growth of health care spending. ... The AAFP only supports patient-centered advanced primary care models that promote comprehensive, longitudinal care across settings and hold clinicians appropriately accountable for outcomes and costs. To support the development and implementation of APMs that accomplish these objectives, the AAFP has developed a set of principles to support patient-centered APMs: (1) Must Provide Longitudinal, Comprehensive Care; (2) Must Improve Quality, Access, and Health

Outcomes; (3) Should Coordinate with the Primary Care Team; (4) Should Promote Evidence-based Care; (5) Should be Multi-payer in Design. – American Academy of Family Physicians

The greatest potential for improving health and achieving the Triple Aim is with children (young children in particular) by addressing social, environmental, and behavioral as well as bio-medical determinants of health, often even before children manifest specific health conditions and concerns.

Children differ from adults and payment models that are tested should take these differences into account. ... Children have an upward developmental trajectory, with need and abilities changing over time; they require “habilitative” rather than “rehabilitative” support. Young children are dependent on families/caregivers to care for them and as such, these individuals are integral partners of the healthcare team and health outcomes for children. ... Medicaid’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program (with its inherent focus on preventive care), coverage of preventive services *recommended* by a physician and backed by the interdisciplinary Bright Futures guidelines, coverage of care coordination, and health homes all provide a strong base for future payment models. ... Families need to continuously be engaged in any transformation - understanding the many problems that families experience can best guide change and greater efficiency across systems. Without family engagement and enrollment, optimal health outcomes will not be realized. – American Academy of Pediatrics

The first one thousand days of a child’s life are a period of incredible growth, providing families and other caregivers with critical opportunities to promote healthy long-term development. Birth to five years offers the most promising opportunity to impact the trajectory of a child’s life and bend the cost curve, especially for children whose parents experienced adverse childhood experiences. Early investments during this time result in improved outcomes, significant cost avoidance, and societal gains. General interventions in the first five years of life can increase children’s cognitive and social-emotional development, increase educational achievement and graduation rates, and increase parental involvement. These upstream investments can also mitigate both juvenile and adult crimes, cases of abuse and neglect, intimate partner violence, welfare dependency and the need for special education. – Robert Wood Johnson Foundation

Focusing interventions on the birth to three age range offers the most promising opportunity to impact the trajectory of a child’s life and bend the overall cost curve. The first one thousand days of a child’s life are a period of incredible growth and laying down brain architecture, providing families and other caregivers with a critical opportunity to promote healthy long term development. Early investments during this time result in the most significant improved outcomes, cost avoidance, and societal gains (see Heckman’s curve below). General interventions in the first three years of life can increase children’s cognitive and social-emotional development, educational achievement and graduation rates and parental involvement. These upstream investments can also mitigate both juvenile and adult crimes, cases of abuse and neglect, intimate partner violence, welfare dependency and the need for special education. As research continues to demonstrate the importance of preventing, and ameliorating the effects of, adverse childhood events (ACEs), it is essential to provide children and families comprehensive services from birth. – Zero to Three

Focus specific attention on the earliest years – Children birth to three, particularly those vulnerable due to developmental delays and environmental circumstances (but not necessarily diagnosable with a specific health condition), offer the opportunity for the greatest impact in improving health over the life course (and achieving the triple aim). – Health Equity and Young Children Initiative

[A] pediatric model test should not focus solely on high-cost users. It is critical that it focus more broadly on testing approaches to optimize health for the entire population, including approaches that seek to prevent socially vulnerable children from becoming high-cost adults. We believe that there is great potential for improved outcomes and/or savings associated with targeting vulnerable children at risk for adverse developmental, behavioral, and medical problems but not yet manifesting delays, diseases, or disorders. We base this belief on research documenting the efficacy and availability of such interventions. – Nemours

While it is important for children of every age to be included in integrated care models, UHF believes it is especially important for children ages five and under to be included in such models. Adversity, including that caused by unmet social needs during the first five years of life, has the potential to disrupt healthy development and interfere with the foundation

of all lifelong health and learning. Research has shown that early childhood interventions can lead to lower medical spending in the long run and improved lifelong health. In addition, children enrolled in Medicaid and their families typically have the greatest access to primary care providers in the child's first five years of life, as nearly all such children make frequent visits to pediatricians. The large body of supporting evidence is provided in our 2016 paper entitled "Seizing the Moment: Strengthening Children's Primary Care in New York." – United Hospital Fund

Medicaid and CHIP beneficiary populations/participants that offer the greatest opportunity for generating savings and/or improving outcomes from integrated health care and health-related social services systems include: (1) Children with complex medical conditions as their medical issues are often intertwined with social complexity. This is a high cost, high need population where intensive care management and integration with social services can reduce hospital days and ED visits which will significantly lower the total cost of care. Complex care clinic physicians report the integration of behavioral and mental health services with physical health services should be a priority for these children; (2) Children at social risk. This includes those experiencing poverty and exposure to childhood adverse events as well as immigrant and minority children. Interventions for these children particularly those ages 0 to 5 years can greatly reduce downstream medical and social costs and ensure increased productivity; (3) Youth with medical complexity who are transitioning to adulthood. Early intervention starting at 12 can help youth develop autonomy in medical care and encourage effective self-management of the medical condition. Strong linkages with providers and community organizations who care for physically and cognitively impaired adults can reduce patient costs. – Children's Hospital Association

Pediatric primary care is a nearly-universal, de-stigmatized point of connection for families with young children. ... Healthcare providers are in a unique position to strengthen health and well-being by addressing the intersection of physical and socioemotional health and development with a focus on the earliest relationships. ... [A] vision of success ... for optimizing relational health and socioemotional development in the pediatric setting ... is captured in the following general principles: (1) All families can benefit and deserve enhanced socioemotional functioning; (2) Approaches should be widely available to all families, not limited to "at-risk" groups; (3) The caregiver-child bond may be viewed as a stepladder to help enhance socioemotional functioning [and the] goal of any approach should be to meet families where they are and help them move higher up the ladder; (4) Optimize interactions and access to resources for all families before, during, after, and in between pediatric well-child visits; (5) Identify families where socioemotional development is at risk. Connect these families to resources that match their risk and needs. ... There is an overall lack of standardized measurement of the caregiver-child bond, which may be a reflection of the few existing standardized tools that measure it. ... [Therefore, there is a need to] Identify and Implement Standardized Socioemotional Outcome Measurement within Primary Care Assessments – Create a measure of the caregiver-child bond that can be implemented in pediatric care. – National Institute for Children's Health Quality

Primary child health practitioners can and should refer and connect children and their families to health-related social services (through care coordination and community health approaches), but this also necessitates the availability of supports and resources at the community level to meet identified family needs and priorities.

Increasingly, the major threats to the healthy development of America's children stem from problems that cannot be addressed adequately by the practice model alone. ... The AAP recommends that its members work to link families to services as early as possible. The AAP recommends that pediatricians and other health care providers use validated screening tools and work together with public health departments, school districts, child welfare agencies, community and children's hospitals, and colleagues in related professions to identify and decrease barriers to the health and well-being of children in the communities they serve. Home visiting as well as evidence-based early literacy programs and healthy early child development and effective parenting programs in the office should be promoted and supported through payment. For coordinated delivery systems to realize success, payment and financing systems must be appropriately aligned and recognize clinicians who provide population-based prevention. ... [C]are coordination is integral. Pediatric trained case managers are best equipped to address pediatric cases as opposed to generic or adult oriented care managers. APMs may also begin to fill gaps in existing payment structures. To support pediatrician's facilitation of care coordination, any payment model must provide adequate incentives to cover the financial costs for care coordination. ... Appropriate payment for these services under a fee-for-service or an alternative payment model is essential to encourage collaborative services. – American Academy of Pediatrics

We also find that the type of care coordination we provide (i.e., from a family-centric and holistic perspective of identifying and responding to what families see as their needs and opportunities) is, for most families we serve, the only care coordination they experience that engages them as partners. Even in the relatively uncommon instances in which there are other engaged care coordinators or case managers, they typically operate from a categorical perspective that is limited in its focus upon specific presenting issues. Particularly with very young children, who are not yet in school and are not experiencing extreme conditions, there are generally few points of contact for screening and care coordination beyond the child health provider's office. For example, home visiting, Early Head Start, and Part C serve only a small fraction of young children, and less than one in five very young children (i.e., under 3 years) is in a formal child care setting. ... We support the wisdom of preferentially considering the primary care practice as a "health neighborhood" as opposed to a medical home, since the latter terminology implies that the programs, services, and interventions necessary to support families to promote their children's optimal healthy development necessarily reside within the child health sector. – Help Me Grow

Based on our experiences, we can attest to the importance of integrating health care and social services. As a foundational element, we believe that the concept of a medical home is critical. The medical home provides a core foundation that can serve as a hub for connections to other services. To determine which services a child and family need, we support a screening strategy for children and families in the context of a comprehensive approach to early detection, referral and linkage to programs and services. We recommend that a pediatric model embrace approaches such as *Help Me Grow*, that place early detection activities for vulnerable children within the context of a comprehensive, integrated process of developmental promotion, early detection, referral and linkage to intervention. As part of a two-generation approach, we also recommend inclusion of maternal depression screening. – Nemours

[I]t makes sense to clarify the definition of "health-related social services" we feel is most responsive to child and family needs. Our view is that social services should not be defined as a narrow set of agency-provided services available only to a defined set of individuals who meet diagnostic eligibility criteria. Our experience, and that of partners concerned with pediatric medical home implementation across Massachusetts, is that the social needs of families reflect hardship in multiple areas, including employment, housing, food access, child care, education, transportation, medical care and legal aid. Social services for families must also acknowledge and respond to the stress experienced when families are grappling with hardship on one or more often many of these fronts. This implies solutions that are family-centered, flexible, culturally and linguistically competent, and holistic. It implies system capacity to meet families where they are, rather than fit them into predefined service options and to do so with the compassion required to minimize, rather than exacerbate, stress. ... [W]e need a system that responds to the real needs of families, including their needs for primary and preventive care for children at risk and intervention for very young children with early signs of mental health need or with family circumstances that call for intervention. – Massachusetts Partnership for Early Childhood Mental Health

Consider both vulnerable rural and urban geographies for emphasis from a public health and community-building framework – Place matters and is particularly important to young children and their families, in terms of safe and supportive places and opportunities for interaction and exploring the world around the immediate home. ... This requires, particularly from a population health perspective, focusing attention on community-building strategies in neighborhoods – both rural and urban – where young children and their families face additional physical and environmental barriers to providing a safe and supportive environment. ... Addressing the health needs of young children in vulnerable neighborhoods involves building supports that extend beyond providing services and measuring results on a patient-specific basis or even across health system enrollees. If PAP models are to address social determinants of health on a population level, resources may need to be directed to such population-health strategies. This, in turn, requires investing in actions that are generally different from those provided by the child health and health-related services providers. Medical providers, especially public hospitals and federally qualified health centers (FQHCs) often have significant footprints in vulnerable neighborhoods and can serve as loci for community-building around healthy child development, although there currently are few funding streams or directives for enabling [supporting] them to do so. – Health Equity and Young Children Initiative

Bundled payments offer a promising approach to delivering clinical and health-related services through an integrated, primary-care based approach. For young children covered by Medicaid and CHIP, it will be important to incorporate both developmental and social services into the bundled payment model, as these domains are highly inter-related, as well as to consider the needs of both babies/toddlers and their families jointly. HealthySteps provides a clear and compelling model for how this could work: the bundle could include: joint well-child visits with the HSS and pediatrician; a schedule of screenings for children and parents (such as developmental, psychosocial and behavioral, maternal depression, intimate

partner violence, and substance abuse screenings); a set number of home visits (if desired); referral and systems navigation; early literacy and learning services (such as Reach Out and Read); and care coordination support. CMS should encourage a robust bundled payment study on preventive behavioral health services within the pediatric setting for infants and toddlers to support broader adoption of this approach. – Zero to Three

An array of models has demonstrated efficacy in improving children’s health trajectories. These models are worthy of diffusion and scaling, but are not recognized or adequately supported in existing alternative payment models, which provide incentives primarily directed to adult and high-cost chronic or complex care populations.

Exemplary programs (Help Me Grow, Child First, Project DULCE, Medical-Legal Partnerships, SEEK, MyChild, Healthy Steps for Young Children, Centering Health Care, etc.) have shown the potential for primary child health practitioners to strengthen families and promote healthy child development in the early years, by responding more preventively and developmentally to children’s needs, strengthening protective factors, and addressing social determinants of health. ... The challenge these programs face is securing sustainable financing that is aligned with what they actually do to produce better results. – Health Equity and Young Children Initiative

Parents play a crucial role in the upbringing of their children, impacting their well-being and long-term health trajectory. Fostering strong, positive relationships between parents and children during the early years of child development can increase a child’s physical and emotional health, helping them to become successful adults that can contribute and integrate successfully into society. We recommend promotion of evidence-based parenting programs. What follows are examples of effective programs to build the skills of parents from a strengths-based perspective, which creates a positive context for healthy childhood development: [Home visiting, Nurse-Family Partnership, Healthy Steps for Young Children, Triple P-Positive Parenting Program] -- Nemours

HealthySteps, which is an evidence-based, interdisciplinary primary care program, provides a clear model for how pediatric health care providers can partner, align, and coordinate with health-related social services to maximize benefits and outcomes for children and families. The model, which is operational in 118 sites nationwide, embeds a developmental specialist known as a HealthySteps Specialist (HSS) within the pediatric care team. ... Through screening, referral and follow up, HealthySteps identifies resources to address social determinants of health for vulnerable Medicaid and CHIP beneficiaries. ... Over 20 peer-reviewed papers—including a randomized controlled trial with a number of successful studies tied to it—have shown significant impact on children and families as a result of the model. HealthySteps has proven positive impacts on the following: Greater adherence to well-child visit; Increased vaccination rates; Increased home safety; Decreased injuries; Less use of emergency department for non-urgent needs; Increased age-appropriate nutrition; Increased continuity of preventive care; Increased exposure to early learning resources; and Improved literacy. – Zero to Three

Our comments are informed by our experience in implementing Project DULCE – a pediatric intervention designed to prevent and mitigate toxic stress by bolstering protective factors for families, addressing health-related social needs (HRSN) and enhancing the clinic-community connection to better support families. ... A number of evidence-based interventions, including Help Me Grow, Child First, Healthy Steps, CenteringParenting, SEEK (Safe Environment for Every Kid) and Project DULCE leverage pediatric primary care effectively to improve health outcomes for children. ... Data published in the journal *Pediatrics* (July 2015) indicate that intervention infants were more likely to have completed their 6-month immunization schedule by age 7 months (77% vs 63%) and by 8 months (88% vs 77%). Intervention infants were also more likely to have 5 or more routine preventive care visits by age 1 year (78% vs 67%) and were less likely to have visited the emergency department by age 6 months (37% vs 49.7%). The DULCE intervention accelerated access to concrete resources and led to improvements in preventive health care delivery and utilization among low-income families. A paper published recently in the journal *Zero-To-Three* offers additional case examples of DULCE’s ability to address maternal depression and other pressing family needs. These results were achieved at modest cost, offering promise that DULCE is a replicable, universal and cost-effective approach that can be widely used in pediatric care settings to address toxic stress in low-income neighborhoods. – Center for the Study of Social Policy

Promoting innovation and diffusion can be achieved through fee-for-service models or direct financing of innovation as well as through alternative payment models. To be achieved through alternative payment models, the emphasis must be on value and not just immediate health care cost offsets. This requires quantifying “value” in terms of its long-term benefits, including but potentially extending beyond health conditions and their costs (to such areas as special education, behavioral health, and even justice system costs).

Given that a primary goal in delivery system reform to date has been to generate quick cost-savings, improving children’s health has not been a focus. Importantly, in order to advance pediatric care, there must be the recognition that improvements in child health and costs will be longer-term and across sectors, including early childhood and education. ... In the short run, more resources will be needed to change the way our pediatric health care system delivers care to incorporate a more holistic approach to health. – Georgetown Center for Children and Families

[W]e believe that the greatest potential for improved outcomes and/or savings is associated with targeting vulnerable children who are at risk for adverse developmental, behavioral, and medical problems but are not yet manifesting delays, diseases, or disorders. ... [T]he major savings that can be achieved are long-term and life course in nature. Future value-based, population health financing systems need to find some way of recognizing and ascribing value to improvements in healthy child development in contracts and grants that promote such actions. CMMI can play a particularly important role in supporting the development of value models based upon intermediate impacts that correspond to improving trajectories of health and reward such short-term outcomes in the context of their contributions to managing long-term risk. – Help Me Grow

The return on investment for pediatric care varies significantly than for adult-focused care. While some short-term savings may be recognized in pediatric patients, e.g. ED utilization related to specific conditions (e.g. asthma) or utilization (e.g. inappropriate use of medication, radiologic testing), [m]uch of the return on investment occurs over a longer life course. In addition, these cost savings may not be fully realized in the health care sector, but rather, for example, in the education sector as healthy children realize an increased ability to learn resulting in improved academic achievement and lesser need for special education, or in the workforce as healthier children lead to more productive parents/caregivers. ... *Pediatric ACOs: Insight from Early Adopters* identifies several factors vital for pediatric ACOs to effectively care for and sustain an APM for pediatrics.

- To support clinical transformation, adequate capital is necessary not only for initial financing but to support infrastructure, staffing, data collection and management and linkages with key groups.
- Pediatric leadership is critical throughout the design, implementation and on-going management process.
- Use of pediatric trained care coordinators and case managers are necessary to support the pediatric medical home.
- The ACO framework should include: ... endorsement of integration of oral and behavior health as well as attention to social determinants in the practice. ... quality measures need to assess the long-term savings along with life-course measures that are specific to the pediatric population that are utilized by all payers. ...
- A guiding principle ... is to ensure that there is sufficient funding to cover the total costs for:
 - Episodic encounters common to pediatrics (i.e., wellness, preventive and problem oriented medical, oral health, mental and behavioral health services as well as nonface to face care).
 - Specific pediatric medical home functions including but not limited to care management, care coordination, patient and family education, counseling and consultative services, community integration services, anticipatory guidance and transition planning.
 - Identification of patient characteristics that necessitate higher utilization of medical services and medical home services as noted above. ...
 - Maintenance of health information technology and its application to quality improvement activities and population health.
- Pediatric payment systems based on value or return on investment needs to account for the long term investment opportunity as well as the thin margins for short-term savings inherent in pediatric care delivery systems. – American Academy of Pediatrics

Payers are often myopically focused on annual cost savings, which ignores critical long term cost-savings and societal gains. It is essential to incent payers to shift their focus and consider long term cost-savings across systems that can be realized

through powerful primary care interventions from the earliest years of life. Too often, cost-saving analyses focus solely on chronic conditions and ignore interventions that address the holistic needs of children and families, particularly in infants and toddlers. ... One common challenge is that the payer or system making the initial investment may not be the one to recoup savings downstream. The “wrong pockets problem” will continue to deter upfront investments. It is critical to shift current thinking around cost savings to look across systems and beyond short term savings. ... there are several concrete steps that CMS can encourage states and other payers to take that will facilitate the delivery of integrated social services to Medicaid and CHIP children, including: Allowing providers to bill for interventions that address social determinants of health (including referral, follow-up and case management time); Allowing pediatric providers to bill for services for parents (e.g., inter-birth spacing counseling) within the pediatric setting as well as dyadic and two-generation treatments; Allowing pediatric providers to bill for a child’s service based on a related parental diagnosis (e.g., for a child’s therapeutic services to address issues related to maternal depression); Allowing providers to bill for prevention, with the goal of preventing future diagnoses (including behavioral health preventive services for infants and toddlers); Adopting the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)* as the standard for behavioral health diagnostic assessments for all children under 5 years of age; Easing same day billing restrictions at Federally Qualified Health Centers to allow for flexibilities for linked parent/child encounters; and Sufficiently reimbursing appropriate validated screening tools, including the frequency with which they should be administered. – Zero to Three

Current per capita expenditures on primary child health care are small and, except in select cases, not subject to securing immediate savings and improving health care quality and population health. In fact, improving child health trajectories generally requires increased investments, with longer-term benefits in population health that are only partially reflected in medical conditions and costs and that occur well beyond any contractual period for current or alternative payment structures. ... Funders (particularly Medicaid and CHIP) must build into either fee-for-service or ACO and MCO contracts incentives and spending requirements and expectations for expanding the impact of primary young child care. This requires that funders recognize, require, and incent additional investments in these earliest years based upon measures of health quality and population health, including family measures – with a goal of promoting innovations and providing additional in-service training and essential tools and educational materials that will be used in the primary care child health practitioner’s office to help strengthen families. – Health Equity and Young Children Initiative

Payment should be designed around a series of measures that track development from the prenatal period through young adulthood and for which there is evidence of predicted later savings to CMS. ... CMS should ensure that sites are reimbursed an amount that is approximately equal to the predicted long-term savings the pilot site creates for CMS. ... Ultimately, it is essential that the system be structured so that practices and communities recognize that their primary role is to improve child health trajectories, primarily through responding more preventively, holistically, ecologically, and developmentally. ... APMs can contribute most when they foster this innovation and diffusion – and incent, above all, practitioners to increase their efforts in this area, while recognizing those practitioners are not accountants, econometricians, or bio-statisticians. The emphasis of any alternative payment system must be to promote actions at the practice and community levels that align with the science of healthy child development, moving beyond bio-medical responses to disease and injury to strengthening child and family agency in healthy development. – Mental Health America

[T]rue impact of preventive interventions is often not realized for many years to come and can often manifest in avoided costs and better outcomes for individuals. While it is important to show progress along the way, for a pediatric model, CMS should include a medium-term and long-term period for the Return on Investment and should track savings in the health care sector and other sectors (such as juvenile justice, education, etc.) and should account for cost savings for the parent-child dyad, as opposed to just the child. – Nemours

One significant challenge with APMs is that they reward near term (1-2 year) ROI. However, many promising pediatric interventions (particularly those that move upstream) create a longer term ROI that yield health and budgetary benefits much further down the line. – Center for Health Care Strategies

Early childhood programs have two distinct investment challenges. First, future savings associated with reduced prevalence of physical and behavioral health challenges are only likely to emerge after multiple years. This is different from many investments in adult primary care, which are predicated on achieving savings within a year of implementation, as in the Medicare Shared Savings Program. Second, when returns do materialize, the savings are often spread across multiple systems, including education, child welfare, and health. The dominant payers for pediatric primary care are public programs—Medicaid and Child Health Plus—that will have to adopt a long-term investment approach and concede that, in

the interest of improving the outcomes for a future generation, savings will likely accrue to public systems beyond health care. – United Hospital Fund

In the pediatric population, cost savings need to be measured over a lifetime, rather than over a few months or a few years. Children are usually born healthy. Our job in a Medical Home Pediatric Care model is to ensure they remain healthy for the first 20 years and are equipped to carry this health trajectory into adulthood. Our task on Day 1 of the newborn's life is to identify the high need, high risk baby and family to ascertain the newborn with or at risk for developmental, social, emotional, or behavioral health challenges, intellectual or physical developmental delays or disabilities, and those with complex and/or chronic health conditions. ... All children are particularly susceptible to the conditions of their environments, requiring an emphasis on the social determinants of health and adverse childhood experiences, which have a measurable impact on current and future health care needs. Since outcomes occur over a lifetime, we must view pediatric costs as the Lifetime Costs of Care rather than the limited Total Cost of Care perspective. – Washington Chapter of the American Academy of Pediatrics

Metrics are needed around healthy child development that include child, and at least for young children, family conditions related to physical, cognitive, social, and emotional development. CMS and CMMI have an opportunity to advance such metrics development and the quantification of their impacts from a value-based care perspective.

[R]esearch has proven the impact of strengthening families' protective factors on children's healthy development. We have embraced such protective factors as and operationalized these factors as important, short-term proximate measures to document the efficacy of interventions. ... We embrace the use of proximate measures to expand our capacity to measure the impact of developmental interventions such as *Help Me Grow*. Our work has focused, albeit not exclusively, on the strengthening of protective factors to enhance the capacity of families to support their children's healthy development. For example, a specific measure of parents' knowledge of parenting and child development is the proportion of parents reporting that they feel confident in understanding developmental milestones. We have similarly developed strategies to measure the impact of our interventions on such critical factors as parental resilience, social connections, concrete support in times of need, and families' capacity to promote their children's social and emotional competence. – Help Me Grow

RWJF has supported a body of work to consider how we re-orient our system of measurement so that it focuses more on what people and their families want from their health and health care systems, rather than what providers, payers, and researchers are looking to measure, which in turn, often drives accountability measurement programs today. For example, we encourage CMS to move toward measures that are patient-driven, reflect the context of the patient's life, and look beyond the health care system and consider social needs as well, like kindergarten readiness and school absenteeism. Additionally, measures that consider family involvement should be considered, such as family participation in care; parent depression; and parent substance use. – Robert Wood Johnson Foundation

The AAP highlights the following considerations for CMMI when developing pediatric payment models:

- While the gold standard for measures is those that have a strong evidence base. The inclusion of measures that are meaningful to child health and development may be evidence informed rather than evidence based.
- Identify measures for payment for pediatricians that can also be used to improve care quality.
- Consider the evolution of measures that will change over time once care gaps are minimized and care is improved.
- Examine the broad range and complexity of measures for pediatrics that include type of care (prevention/wellness, acute care, subspecialty care, mental/behavioral health, etc), sites of care (inpatient, outpatient, school-based, etc.), healthy behaviors, overuse and appropriate treatment, person and family centered care, and family and community engagement. Many of these measures will need to be developed for new models, especially related to person and family centered care as well as family and community engagement. ... Pediatric risk adjustment models need to include measures of parental well-being - e.g. maternal depression, poverty, homelessness and substance use. – American Academy of Pediatrics

To promote a more holistic approach to pediatric care, metrics should consider the whole family. CMS should consider adopting metrics around maternal depression screening in the pediatric and family medicine setting, as well as screening

and referral for social determinants of health. By promoting these metrics, CMS is highlighting that delivering these critical screenings is the new standard of care. ... One specific metric CMS could adopt is the percentage of children with qualifying developmental screenings referred to Early Intervention services. This could help minimize the duplication of screenings across systems and help to facilitate the connection of children with, or at risk of, a developmental delay to necessary Early Intervention services. – Zero to Three

Safety, stability and nurturing in the home environment can be measured, charted, and used to inform practice as well as to assess population needs and practice impact. There is a pressing need to develop (validated) tools for the field in this area, ideally open source. ... Such metrics also represent a good proximate indicator, on a population basis, for a child's development across the domains of school readiness (physical development, general cognition, language and literacy, social and emotional development, and approaches to learning). ... Recent research is persuasive that maternal depression impacts caregiving and children's healthy development, as does parental addiction. Stress is one of the recognized social determinants of health, and parental stress can impact children in multiple and profound ways, contributing to their children's levels of stress and bio-medical response. – Health Equity and Young Children Initiative

[W]e propose the following three-tiered measurement system that can target proper incentive payments while ensuring cost-neutrality for CMS: (1) measures that track relatively consistent, foundational constructs throughout each individual's cognitive, affective, and behavioral (CAB) development, along with key risk and protective factors that influence it (recognizing that, particularly for young children, healthy development is integrally tied to family safety, consistency, and nurturing); (2) measures that track points along an individual's developmental cascade, indicating how the first-tier measures affected age-appropriate developmental tasks (i.e. development prenatally to twenty-four months in attachment, bonding, and limitations on adversity and unmitigated stress; to kindergarten readiness at age five; to grade-level reading at age eight; to social, psychological, and cognitive development through high school); (3) measures that are reported to CMS to determine quality and payment, which may be selected from first- and second-tier measures. ... If a population-level approach [is] taken, the third-tier measures could also include measures of changes in community-wide risk and protective factors where feasible. – Mental Health America

A final category of *quality and outcomes measures* should include short-term, medium-term and long-term metrics and should address the health of the child, family and pregnant mother to track health before and during pregnancy and enhance outcomes for the child in the future. Examples of options for outcomes measures (to be selected by model participants include, based on the nature of the model) include: Prematurity rates, birth weight, infant mortality, preventive care (for pregnant mom and child), immunization rates, scores on validated screeners and questionnaires or assessments (e.g. SEEK, Ages and Stages, PEDS, and Strengths and Difficulties, Strengthening Families Five Protective Factors Assessment, literacy screenings), breastfeeding rates for new mothers, decreasing stress, trauma, drug usage in teenage women, tobacco usage in the home, increased use of safe sleep techniques; weight for children and adolescents; identifying screening and treating toxic stress; proportion of children ready for kindergarten, kindergarten attendance/school days missed, reading level by grade 3, proportion of adolescents that use alcohol or tobacco or that develop mental health conditions, rates of maternal depression, length of time in custody for adolescents, rates of food insecurity for families; rates of housing insecurity/ homelessness for families. – Nemours

CMS could consider incorporating social determinants of health factors (such as including homelessness and neighborhood stress scores) into its risk-adjustment model to help avoid adverse selection pressures, as Massachusetts is doing for its ACO programs. ... CMS could consider incorporating measures of health-related social needs, such as kindergarten readiness and school absenteeism. Additionally, measures that consider family involvement could be considered, such as family involvement in care; parent depression; and parent substance use. – Center for Health Care Strategies

Together with HRSA MCHB, NICHQ is leading the Early Childhood Comprehensive Systems Collaborative Improvement and Innovation Network (ECCS CoIIN). ... With input from experts, faculty, families as well as the states and place-based communities partnering on the ECCS CoIIN, we are currently developing indicators and measures to align with the six primary drivers in the initiative: (1) Early identification/prevention of developmental health needs, (2) Family engagement, (3) Addressing social determinants of health, (4) Systems promote developmental health & meet needs of children and families; (5) Systems are linked and coordinated, and (6) Advocacy & policy change. – National Institute for Children's Health Quality

[T]he New York Medicaid program’s Children and Adolescent Value-Based Payment Subcommittee/Clinical Advisory Group ... is keenly aware that the majority of health care measures in present day use insufficiently capture pediatric primary care’s ability to improve or maintain a child’s healthy developmental trajectory. The group is currently in the process of assessing measures that are most appropriate at different stages of childhood development and how to connect those measures with newly proposed and existing payment models. There is particular interest in the development of a kindergarten readiness measure that reflects the cumulative contributions of high quality primary care in the first five years of life, inclusive of physical and social-emotional health. ...There is also significant interest in the development of a “secure parent attachment” measure, particularly for use in the first year of life. – United Hospital Fund

The role of performance measurement is foundational to APMs. APMs ask systems and/or providers to accept accountability for costs, the quality of care and the outcomes. APMs, through their design and payment models, seek to incentivize improvements in these by sharing risk or rewarding high or improved performance. The selection of the performance measures, thus, can serve not only to assess, but also to drive improvement by motivating systems and individuals to improve the health and well-being of the population. Thus, it is critical that the measures align with the goals of the APM and how value is defined. Further, there will be a need for cascading, or shorter-term measures that inform the directional contribution to overarching measures so that providers can take appropriate action toward those goals. The design and functionality of the APM’s measurement system is critical to success, and it is sensitive to the design of the payment model. – Children’ Hospital Association

It is critical that the Advanced Payment Models of a Pediatric Care Payment Framework aligns payers and providers around shared goals to facilitate collaboration, integration, process improvement and accountability and, [f]ocuses on pediatric health measures (preventive, acute, chronic; behavioral; developmental); and health-related social measures (food insecurity, homelessness, ACE's, poverty, toxic stress). Washington Chapter of the American Academy of Pediatrics

Some shared savings are possible with the child population, particularly for children with existing diagnosed health conditions (e.g. asthma, prematurity), often by either “demedicalizing” responses or improving family agency in responding to ongoing child health needs. Such shared savings, however, are very modest and not sufficient to produce the types of practice changes necessary to achieve the greatest promise for value-based care in pediatrics.

Our research suggests the potential for some “real-time” cost savings associated with “demedicalizing” behavioral concerns and shifting referrals from pediatric subspecialists (e.g., developmental-behavioral pediatricians, neurologists) to community-based programs and services (e.g., parenting programs, family resource centers). – Help Me Grow

While most ... health savings are in the chronic care and adult health care system, there are areas within child health where knowledge and exemplary practices show demonstrable gains that could be identified in PAP contracting work as areas for expected and projected savings for reinvestment. While implementation may need to address political as well as practice transformation challenges, the science suggests these as areas where contractors should both expect savings and direct those savings for reinvestment: (1) prenatal care a birthing, (2) NICU patients and follow-up, and (3) asthma and hospitalizations. – Health Equity and Young Children Initiative

Although the greatest potential comes from promoting life-course health, there are areas for savings in pediatrics that can expedite the rate at which the model achieves cost-neutrality. A pediatric health home with stepped behavioral health services and integrated community-based supports for children and families that are commensurate with their risk of complex health needs can reduce costs in a five to seven-year timeframe. ... Across pediatrics, comorbid physical and behavioral health conditions increase costs, and there is strong evidence that an overall integrated family-focused early intervention and prevention model for behavioral health will reduce costs for otherwise high-need children. These short-term savings in high-need populations can help the model achieve cost-neutrality more quickly while the rest of the overall model reduces lifetime risk of health conditions across the attributed population. – Mental Health America

There is value in promoting further innovation at the practice level even beyond an overall payment model or system in order to continually improve practice. CMMI can play a vital role in financing such innovation, as well as focusing upon alternative payment models.

We encourage CMS to explore ways to go beyond the payment models to support the integration of health-related social services. CMS can leverage the “flexible services” approach that states like Oregon and Massachusetts are using to these services, prioritizing the coverage of services that are not sufficiently covered via other programs targeted to meet the social needs of pediatric populations. Taking a “fee for service” approach to funding such services may be appropriate, particularly in initial phases or for models like shared savings/risk that do not provide the upfront funding needed to reimburse for health-related social services. – Robert Wood Johnson Foundation

[M]uch of the work to innovate and diffuse effective approaches occurs at the practice and community level (i.e., is “place-based”) and requires investment at that level with champions who can advance practice among their colleagues. We are particularly mindful of the importance of system building to support such community-based initiatives to achieve both scale and sustainability. – Help Me Grow

[M]ost practice innovations initially occur outside traditional payment systems – and then serve as models for incorporation into payment systems that support and move them toward more widespread and routine practice. The first stage in developing practice innovation therefore involves investing in practitioner champions who are motivated by improving child health trajectories – and not in devising new financing systems. ... While the emphasis of the RFI is upon pediatric alternative payment models, the RFI also seeks information on other ways to promote the triple aim within the pediatric population. Developing an FOA for young children that focuses upon practice transformation to respond to social as well as biomedical determinants of health would clearly advance the field, particularly as it could also be directed (both within CMMI and CMS and among the grantees) to developing effective innovations and determining how they can be incorporated into payment models to promote their expansion and sustainability. – Health Equity and Young Children Initiative

With regard to a pediatric payment model, we urge CMS to be flexible and not overly prescriptive. ... States, communities and providers need latitude to experiment with pediatric incentive models because there is limited experience in the pediatric field with value-based models. Different delivery models will require different incentives – for example, targeted models that are focused specifically on special populations (e.g. children with medical complexity) may not be best suited to the same payment model as a delivery model that tests an approach to improving health of a geographic population. Finally, as incentives are tested to align with value-based models, there will need to be a focus on practice transformation and culture change, which takes time. – Nemours

While there are a growing number of emerging models of more effective primary pediatric practice showing great potential for improving child health trajectories, much more needs to be learned through innovation and diffusion, even at this practice level, and even less is known about effective collaboration across sectors for CAB promotion. – Mental Health America

Organizations Sharing Comments and Statements Excerpted in this Summary:

Health Equity and Young Children Initiative
Mental Health America
American Academy of Pediatrics
American Academy of Family Physicians
Center for Health Care Strategies
Center for the Study of Social Policy
Children’s Hospital Association
Georgetown Center for Children and Families
Help Me Grow National Center
Massachusetts Partnership for Early Childhood Mental Health

National Institute for Children’s Health Quality
Nemours Health System
Robert Wood Johnson Foundation
United Hospital Fund
Washington Chapter of American Academy of Pediatrics
Zero to Three

Note: This synthesis and excerpting was developed by Charles Bruner from the Health Equity and Young Children Initiative and shared with all the organizations providing statements. It does not represent the full-range of comments and each statement deserves its own review.

June 21, 2017

CROSS-WALK OF CORE PRINCIPLES PRESENTED IN RESPONSES TO THE CMMI RFI

HEALTH EQUITY AND YOUNG CHILDREN

NEMOURS

HELP ME GROW

Focus specific attention on the earliest years	Emphasizing (but not limiting) a focus on the early years provides the opportunity to improve health across the life course. Young children are particularly sensitive to social determinants	Focus on [young] children at-risk for adverse health, developmental, and behavioral outcomes to maximize value and impact.
Emphasize the primary health practitioner’s role	There is no wrong door for improving child and family health; all community partners and members have a role to play	Strengthen the effectiveness of primary care child health services to make an optimal contribution to children’s healthy development.
Focus upon family strengthening and not just service integration	Improving child health necessitates two-generation approaches that focus on the family – from addressing basic needs to strengthening parenting to amplifying family representation in decision-making	Embrace evidence-based, strength-building, and health promoting frameworks (e.g., Strengthening Families Protective Factors Framework) in all programs, systems, and policy work.
Include metrics related to the safety, stability, and nurturing of the home environment	Optimizing health care goes beyond health care. It means attending to the whole child’s health, development and well-being	Promote the adoption of proximate measures/ mediating factors as valid means to evaluate the impact of community-oriented programming.
Consider both vulnerable urban and rural geographies for emphasis from a public health and community-building perspective	Public and private funds can catalyze key stakeholders at the community level to create shared ownership in a common destination	Support community-based efforts (i.e., community hubs) that promote the health and safety of children and their families in a variety of settings.
Develop payment structures to recognize and achieve long-term savings	Models to improve child health should have a longer ROI timeframe	Encourage the formal financial scoring of interventions over years to decades (i.e., “dynamic scoring”) to capture ROI.
Capitalize on opportunities to reinvest shared savings achieved through alternative payment models		Employ such strategies as de-medicalization, mid-level developmental assessment, and linkage to community-based programs and services to demonstrate real time cost-effectiveness.
Invest directly in practice champions to foster continuing innovation and diffusion	Onerous requirements and rigidity stifle innovation; initiatives to improve pediatric health should foster conditions for local innovation, allow flexibility and reduce burdensome reporting requirements.	Embed developmental surveillance and screening into the full spectrum of services. Ensure that early detection leads to assessment and intervention. Encourage the design and dissemination of new roles for such staff as community health workers, home visitors, and care coordinators to support families’ promotion of children’s healthy development.

Note: Three responses to the RFI started with an outline of core principles to promote pediatric practice transformation to improve child health trajectories. This table provides a side-by-side comparison of principles in common.