



**Child and Family Policy Center, Mental Health America, Help Me Grow National Center, and Center for the Study of Social Policy**

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**COMMENTARY –**

**Alternative Payment Models for Pediatrics: Operationalizing Value-Based Care Over the Life Course**

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**Abstract**

Sixteen organizations dedicated to advancing the health of children shared their responses to a March 2017 Request for Information from the Center for Medicare and Medicaid Innovation on developing alternative payment models for pediatrics. The authors of this commentary identified eight common themes from these responses, pointing to the need for much greater attention to defining value in terms of long-term healthy development for children. Doing so requires a fundamentally different approach than employed by current alternative payment models, developed largely with adults and chronic care and high cost populations in mind. In particular, contractors (including Medicaid) need to support increased investments in primary care and to develop metrics for assessing impact that go beyond immediate medical conditions and costs. Such an approach is consistent with the concept of “value-based care” and offers one of the most powerful opportunities to achieve the triple aim of improved health quality, improved population health, and reduced per capita health care costs.

**Commentary**

In March 2017, the Center for Medicare and Medicaid Innovation (CMMI) issued a Request for Information (RFI) 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.”<sup>1</sup> The authors solicited and obtained submissions from sixteen leading organizations dedicated to advancing the health of young children, including advocacy groups, think tanks, provider societies, health care systems, and the authors’ home institutions.<sup>2</sup> The authors individually analyzed the submissions and excerpted and organized key concepts from the responses under eight identified common themes:<sup>3</sup>

1. 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.
2. 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.
3. 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.
4. An array of models has demonstrated efficacy in improving children's health trajectories.<sup>4</sup> 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.
5. 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).
6. 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.
7. 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.
8. 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.

Taken together, these themes suggest the need for a fundamental departure from current alternative payment models based upon achieving short-term cost benefits. In the transition from volume to value, current alternative payment models seek to reduce costs through the contractor (which for children includes state Medicaid programs and their structuring of managed care contracts) providing incentives to the contractee (generally a managed or accountable care organization) based upon estimates of the total cost of care under the current payment system, and then sharing savings achieved by the contractee more efficiently managing health care expenditures. The savings must accrue during a contractual period, which is rarely more than a year or two, and within the medical care system.

This approach may be sufficient to achieve positive ends for chronic care and high-cost populations, as contractees often can employ additional care coordination and health maintenance services that reduce hospitalizations or other high medical costs and, therefore, meet the aims of better quality care and improved health maintenance, as well as reduced costs. (Contractees, of course, also may employ other means to reduce expenditures through prior authorizations, rate negotiations, and limitations on specific treatments, which may or may not achieve goals related to quality and outcomes.)

Such short-term gains, however, seldom exist for children, particularly those not already experiencing high-cost health conditions. Children are not high-cost users or drivers of health costs today. In the seminal article setting the stage for “value-based care,” Berwick and his colleagues emphasized that, while the end goal of health transformation should be achieving the triple aim of improved health quality, improved population health, and reduced per capita health care costs, this requires investing more, rather than less, in primary, preventive, and developmental care.<sup>5</sup> At no age is this truer than for children, whose health trajectories have health cost implications over decades and lifetimes.

Many of the responses to CMMI’s RFI cited specific programs and practices with proven success and value in improving child health trajectories. These often involved early childhood practices which expanded the primary practitioner’s role to identify and respond to social conditions and early developmental needs, as well as medical ones.<sup>6</sup> These programs and practices take on additional roles in improving the safety, stability, and nurturing in the home environment through care coordination, additional actions in strengthening parent and child bonding, earlier responses to developmental issues and delays, and linkages to community services. As a result, they have produced gains in family functioning (safety, stability, and nurturing) and in early childhood social, emotional, cognitive, and physical development.

Under current alternative payment models, these programs and practices do not receive additional funding beyond reimbursement for standard primary pediatric care, despite requiring additional investments and resources. Rather, they now are typically funded by foundation grants or as demonstration programs. They are not otherwise rewarded financially for demonstrating they have produced gains in children’s developmental trajectories. Moreover, gains in improved safety, stability, and nurturing in the home environment and enhanced social, emotional, cognitive and physical development are not part of the metrics for which providers are compensated for collecting.

Research is clear on the importance and value of a healthy start in life as foundational to lifelong health and social, psychological, educational, and economic well-being. The rates of return from effective investments in children’s safety, nurturing, and well-being in the earliest years are higher than virtually any other possible societal investments.<sup>7</sup> Moreover, when Medicaid and, therefore, government is the contractor, most of these economic benefits – in future health costs, in social welfare costs, in criminal justice costs, and in economic dependency costs – ultimately benefit the contractor. The value of practice changes that improve young children’s healthy development is likely to be far in excess of the investments needed to produce them.

To advance such practice change within alternative payment models, contractors must incent contractees to make increased, value-based payments to practices which can produce long-term gains, even when operating within overall contracts where contractees are otherwise expected to reduce annual expenditures or contain expenditure growth. Contractors and contractees must define and recognize such practices, the value they produce, and provide a differential payment that is sufficient to cover their costs. They must develop and apply new metrics to measure the impacts that produce long-term gain, including the new standards for primary pediatric care in the latest edition of *Bright Futures*.<sup>8</sup>

Ultimately, these common themes demonstrate the essence of value-based care for child health. Responses to the CMMI RFI show that leading children’s health organizations are aligned with and can contribute to advancing such payment transformation.

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<sup>1</sup> Request for Information on Pediatric Alternative Payment Model Concepts, Center for Medicare and Medicaid Innovation (May 5, 2017), <https://innovation.cms.gov/Files/x/pediatricapm-rfi.pdf>.

<sup>2</sup> 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.

<sup>3</sup> Bruner C, Counts, N. CMMI RFI Synthesis of Key Themes. Child and Family Policy Center, Des Moines, IA, 2017.

<sup>4</sup> Different respondents identified different specific program models, often presenting program research results. While not inclusive of all program models related to young children, the Health Equity and Young Children Initiative has worked with thirteen different specific programs and, with those programs, helped define their common core functions (practitioner anticipatory guidance, care coordination, and community linkages) as well as describe each program for its particular strengths. See: Bruner C, Dworkin P, Fine A, Hayes M, Johnson K, Sauia A, Schor E, Shaw J, Shah R. Transforming Young Child Primary Health Care Practice: Building Upon Evidence and Innovation. Health Equity and Young Children Initiative, Child and Family Policy Center, 2017. Others have described similar functions for working effectively with older children and adolescents.

<sup>5</sup> Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Affairs*. 2008 May 1;27(3):759-69.

<sup>6</sup> Bruner, Dworkin, Fine, Hayes, Johnson, Sauia, Schor, Shaw, Shah, *op.cit.*

<sup>7</sup> <https://heckmanequation.org>

<sup>8</sup> Hagan J, Shaw J, Duncan P. *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4<sup>th</sup> Edition. American Academy of Pediatrics, 2017.