

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



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Dear Dr Conway:

On behalf of the American Academy of Pediatrics, a nonprofit professional organization of 66,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, thank you for the opportunity to respond to the Center for Medicare and Medicaid Innovation's Request for Information on Pediatric Alternative Payment Model Concepts.

Children are cared for in a constantly evolving health care system. The foundation of the pediatric practice is the family-centered medical home, a concept first described by pediatricians in the 1960's. In a family centered medical home, the pediatric care team works in partnership with a child and a child's family to assure that all the medical and non-medical needs are met. Partnerships can help the family/patient access, coordinate and understand services that are important for the overall health of the children and family including specialty care, educational services, out-of-home care, family support and other public and private community services.

Most innovation related to the implementation of value-based payment models has focused in adult populations. Children's care is often financed by Medicaid, which while chronically underfunded, provides flexibility and opportunity for innovation through its federated nature. Inherent differences exist between adults and children, which necessitate special consideration when implementing value-based payment models in pediatric populations. Integration of health care, health-related social services and educational services require robust infrastructure, including but not limited to HIT/HIE, aligned quality measures, and coordinated care. These infrastructure items are suboptimal at present. The timeline for return on investment is longer in pediatrics, and cost savings may not be realized in the health care realm. Therefore, the "value equation" may be more complex.

The AAP is in support of CMMI's efforts to test pediatric alternative payment model concepts, including the integration of health care and health-related social services. Thank you for the opportunity to comment and for your attention to the views of the American Academy of Pediatrics. If you have any questions regarding this or other system reform matters, please contact Anne R. Edwards, MD, FAAP at aedwards@aap.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Fernando Stein".

Fernando Stein, MD, FAAP
President

AAP Comments: Pediatric Alternative Payment Model Concepts

Children as a Unique Population

Children differ from adults and payment models that are tested should take these differences into account. Stille et al¹ described unique differences between children and adults: development, dependency, differential epidemiology, demographics, and dollars. 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. From a differential epidemiologic perspective, children, in general, are healthier than adults, and the goal of pediatrics is to optimize that health. While certain chronic conditions, e.g. asthma, obesity, affect larger numbers of children, a significant number of relatively rare chronic diseases exist in the pediatric population, and an increasing number of children are medically complex. Considering demographics, children have disproportionately higher rates of poverty and ethnic/racial diversity than in adult populations. From a dollar standpoint, the overall cost of pediatrics is low while the return on investment is realized over a lifetime.

Medicaid and CHIP present distinct opportunities to build new payment and delivery system models that take into consideration all the health care needs of children—and to incorporate social service, education, public health, human service, and other programs that address socioeconomic factors influencing child and family health. As alternate payment models are developed, key elements should be considered.

Pediatric Practices

Pediatric practices may be in varying stages of transformation based on past support for infrastructure change and current capacity. This should be considered as new payment models are implemented. Medicaid is also in a unique position to identify opportunities and supports that children need and build them into payment and delivery system models that ensure they are provided. 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. Prior state innovations through Section 1115 waivers, Delivery System Reform Incentive Payment (DSRIP) initiatives, and others² mainly focused on adult populations and should be evaluated in a systematic manner, with the input of pediatric primary, specialty, and subspecialty care, to determine their applicability toward building a new payment model specific to pediatrics.

Infrastructure Needs

System-level infrastructures will require enhancement to effectively integrate health care and health-related social services. To do this, health information technology will need further support, especially to address interoperability and data sharing needs between sectors. Enrollment processes that are streamlined and connected will improve patient and family experience. Quality measures should align not only across health entities but also across sectors. To implement a value-based payment model that supports integration and accountability for a population, multi-payer models should be encouraged and supported. Payment models which promote different care models within a practice lead to administrative burden and potential disparate care for families based on insurance. Such payment models will need to

¹ Stille C, et al The Family-Centered Medical Home: Specific Considerations for Child Health Research and Policy. The Family-Centered Medical Home: Specific Considerations for Child Health Research and Policy. *Academic Pediatrics*. 2010;10(4):211-217.

² Bachrach D, Guyer J, Levin A. Issue Brief: Medicaid Coverage of Social Interventions: A Road Map for States. Milbank Memorial Fund. July 2016. <https://www.milbank.org/publications/medicaid-coverage-social-interventions-road-map-states/>. Accessed March 15, 2017.

invest in infrastructure as incentives alone will work slowly. Medicaid/CHIP programs are well prepared to lead these efforts. 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.

Return on Investment

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). Much 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.³

Additional opportunities for return on investment in pediatrics exist, such as:

- Integrated health systems might better address adverse childhood events (ACE's) resulting in decreased chronic illness burden, including mental health issues, as children reach adulthood.
- Early developmental screening, including social emotional screening with appropriate follow up and intervention can limit development of expensive adolescent mental health and substance abuse issues.
- High rates of immunization among children save substantial dollars each year, and models should continue to promote and support high rates of immunization.

Having shared accountability for a population of children and making efforts to coordinate care, to reduce duplication, and to provide timely and effective care for children will lead to a healthier cohort of adults.⁴

SECTION I: INTEGRATED PEDIATRIC HEALTH CARE AND HEALTH-RELATED SOCIAL SERVICE DELIVERY MODEL

Question 1: What is the level of interest of states and tribes for a child and youth-focused care delivery model that combines and coordinates health care and health-related social services? Please comments on challenges and opportunities in service delivery for all pediatric beneficiaries and for those with higher needs and the level and range of technical assistance entities might require to support an effective model.

The Academy believes that greater integration between health care and health-related social services is highly desirable, as the fundamental determinants of children's health and well-being, and subsequently the health and well-being of the adults they will become, are rooted in social, environmental, and behavioral factors that lie beyond the purview of the health care system.⁵

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. These problems include infant mortality;

³ Wagnerman, K, Chester, A., et al. Medicaid is a Smart Investment in Children. *Georgetown University Health Policy Institute Center for Families and Children*

⁴ Belli PC, Bustreo F, Preker A. Investing in children's health: what are the economic benefits? *Bulletin of the World Health Organization*. 2005;83: 777-784.

⁵ AAP Council on Community Pediatrics and Committee on Native American Child Health. Health Equity and Children's Rights. *Pediatrics*. 2010;125(4):838-849. <http://pediatrics.aappublications.org/content/125/4/838>. Accessed March 17, 2017.

preventable infectious diseases; dental caries; sedentary lifestyles; chronic health care needs; obesity, metabolic syndrome, and other historically adult-onset chronic diseases; high levels of intentional and unintentional injuries; exposure to violence in all forms; risks of neurodevelopmental disabilities and illnesses from exposure to environmental tobacco smoke, lead, and other environmental hazards; substance abuse; mental health conditions; poor school readiness; family dysfunction; sexual health, unwanted pregnancies, and sexually transmitted diseases; relatively low rates of breastfeeding; social, medical, behavioral, economic, and environmental effects of disasters; and inequitable access to medical homes and basic material resources and poverty.⁶

Poverty is an important social determinant of health and contributes to child health disparities. Children who experience poverty, particularly during early life or for an extended period, are at risk of a host of adverse health and developmental outcomes through their life course.⁷

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.⁸

An integrated pediatric health care and health-related social service delivery model should be grounded in the patient- and family-centered medical home approach to care, with a particularly strong emphasis on family engagement and family-centered care. Family-centered care has been shown to improve patient and family outcomes, increase family and professional satisfaction, decrease health care costs, and improve effective use of health care resources.⁹

A model of care that coordinates health care and health related social services is particularly important for families of children and youth with special health care needs (CYSHCN), including the growing population of children diagnosed with mental health conditions, as they require a greater number of services, and outcomes are substantially improved when these services are integrated within primary care.

Question 2: Where pediatric health care providers have partnered, and aligned with health-related social service providers, what types of health care and health-related social services were included beyond the Medicaid mandatory benefits. Additionally, what program integrity strategies were employed where these partnerships exist?

The Academy applauds CMMI for exploring ways to integrate social services. For children, the social

⁶ AAP Council on Community Pediatrics. Community Pediatrics: Navigating the Intersection of Medicine, Public Health, and Social Determinants of Children's Health. *Pediatrics*. 2013;131(3):623-628.

<http://pediatrics.aappublications.org/content/131/3/623>. Accessed March 17, 2017.

⁷ AAP Council on Community Pediatrics. Poverty and Child Health in the United States. *Pediatrics*. 2016; 137(4):e20160339. <http://pediatrics.aappublications.org/content/137/4/e20160339>. Accessed March 17, 2017.

⁸ AAP Council on Community Pediatrics. Community Pediatrics: Navigating the Intersection of Medicine, Public Health, and Social Determinants of Children's Health. *Pediatrics*. 2013;131(3):623-628.

<http://pediatrics.aappublications.org/content/131/3/623>. Accessed March 17, 2017.

⁹ AAP Committee on Hospital Care. Family Centered Care and the Pediatrician's Role. *Pediatrics*. 2003;112(3):691-696. <http://pediatrics.aappublications.org/content/112/3/691>. Accessed March 17, 2017.

services that are “health-related” are much broader than those described in the RFI (e.g. early education and home visiting which may begin prenatally). Without embracing a broader set of social services, obtaining input from patients and families about what is important to them, and incorporating requirements and financing to facilitate the interaction between health and social services, the impact of innovative services delivery on children’s health will be limited.

Question 3: What policies or standards should CMS consider adopting to ensure that children, youth, and their families and providers in rural and underserved communities such as tribal reservations have an opportunity to participate? How might pediatric care delivered at Rural Health Clinics best be included as part of a new care delivery model for children and youth?

In rural/underserved communities, barriers include lack of services and transportation. States may consider implementing and supporting telehealth, tementoring and workforce training as models of care for children and youth. Enhanced payment to dentists, mental health clinicians and subspecialists in rural areas may increase participation.

An additional challenge in rural communities is the lower number of covered individuals and the volume of services. It is may not be possible to accrue required cost savings. Also, a small number of unexpected high utilizers or catastrophic incidents can mask any savings. Many key pediatric subspecialists may be hours or states away to support CYSHCN, and narrow networks may lack critical services for these children. Rural communities must not be held to the same levels as other, more populous systems.

SECTION II: OPERATION OF INTEGRATED SERVICE MODEL

Question 3: What infrastructure development (EMR, HIE, IT systems, contracts/agreements, training programs, or other process) has been needed to integrate services across Medicaid enrolled providers and health-related social service providers?

The AAP’s position on Electronic Health Records (EHRs) has been as follows:

- EHRs have the potential to provide value to the care of children.
- EHRs are necessary to facilitate the Medical Home – a core pediatric concept.
- EHRs are far from perfect and provide significant problems and challenges.
- EHRs must be improved in collaboration with government, vendors, stakeholders, patient advocates, and privacy experts to improve care to children.

An interoperable health information technology system (or well-functioning health information exchange) is needed to effectively integrate health care and health-related social services. Currently, there are deficiencies not only in the pediatric functionality of Electronic Health Records (EHRs), but also in the ability to exchange health information efficiently.

The AAP has been involved in programmatic activities aimed to improve pediatric functionality in EHRs over the course of the last decade, including working with the Agency for Healthcare Research and Quality as a subcontractor to develop the Model EHR Format and the more recent Model EHR Enhancement. The Academy believes the model EHR Format for children could serve as a framework upon which specifications for an integrated health information infrastructure is built.

Data from the Office of the National Coordinator for Health Information Technology suggest that participation rates in the Medicaid EHR incentive program are quite low (17.2% nationally) and lag other physician groups. This data further suggests that pediatricians are falling behind the attestation of

Meaningful Use signaling the lack of engagement in the program. This poses another challenge in the goal of health information exchange between health care and health-related social services.

Schools and other community services, including public health, lack robust pediatric-friendly IT systems. Interoperability between these IT systems and EHRs remains a challenge. Data-sharing is complicated by varied privacy requirements between the sectors.

The Academy supports the overarching goal of interoperability and the role it plays in the provision of safe, high quality healthcare. Unless true incentives for health information exchange are created, we believe interoperability will remain elusive.

SECTION II: OPERATION OF INTEGRATED SERVICE MODEL

Question 1: To what extent is service integration occurring for children and families at the state, tribal, and local levels, including all sectors of government, non-profit and private endeavors? What challenges are associated with operating with multiple state agencies?

Some of the challenges include data sharing, no ability or requirement for “braided” or blended funding, changing and tightening of admission criteria to programs (e.g. Early Intervention) and varied measures between sectors. To fully support an operation of a truly integrated service model, these challenges will need to be further addressed.

Question 4: Where streamlining of eligibility and/or alignment of program requirements has been achieved among Medicaid/CHIP and health related social service programs, how has this been accomplished?

Opportunities exist to remove further barriers to eligibility determinations and enrollment, not just for Medicaid/CHIP, but for the many programs that address other social determinants of health children face. As an example, in 2015 CMS gave states the option of using Supplemental Nutrition Assistance Program (SNAP) eligibility determinations to identify individuals who are income eligible for Medicaid but not yet enrolled.¹⁰ Similar streamlined enrollment procedures should be created in a bidirectional manner for other health and social service programs, so that those individuals and families found eligible for one health or social service program can also be more readily enrolled in others for which they are eligible. This would help complete the “no wrong door” approach to health coverage, where families are screened for programs no matter where they initially “touch” the application process.

To do so, Medicaid and other social service programs will need financial and infrastructure support to allow for more streamlined processes to identify and enroll eligible individuals into appropriate programs.

Question 8: What role do models of care such as ACOs play in the pediatric environment? Are pediatric ACOs commonly understood to represent payment arrangements, care delivery models, or both? How are pediatric ACOs the same or different from adult-focused ACOs? What opportunities do pediatric ACOs have for integration with community and health services systems?

¹⁰ Letter: Policy Options for Using SNAP to Determine Medicaid Eligibility and an Update on Targeted Enrollment Strategies. Centers for Medicare and Medicaid Services. August 2015. <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-15-001.pdf>. Accessed March 17, 2017.

Are states interested in having MCOs be part of an ACO, the ACO itself, or not involved? What responsibilities might MCOs have relative to ACOs and vice versa?

As models of care delivery and financing, ACOs are relatively new and evolving and there are no prescribed configurations regarding providers and payers (including MCOs), especially in pediatrics. Opportunities exist to build off nascent state Medicaid initiatives (albeit mainly adult) on accountable care organizations (ACOs),^{11,12} incorporation of social determinants of health,^{13,14} and value based purchasing^{15,16} to build a payment model that is specifically child focused. In addition, Medicaid and CHIP have the benefit of being statewide programs and can use state tools to conduct geospatial analysis and community needs assessments to guide place-based approaches to addressing social determinants of health in the community.^{17,18}

For ACOs or any other type of Alternative Payment Model (APM), it is vital to recognize the distinctions between pediatric and adult population health. Compared to adults, children have higher rates of poverty which influences the prevalence and severity of disease and access and response to treatment.¹⁹ Children have prevalent chronic conditions such as asthma, obesity, neurodevelopmental conditions, and behavioral and mental health conditions,²⁰ but are generally healthier overall, with 31.6% of physician office visits in children 0-21 years of age for preventive care, while 16.8% of visits relate to chronic conditions, as opposed to 45.1% of visits for chronic condition management in adult populations.²¹ For the pediatric population, often it is not the patient but the adult parent or caregiver that strongly influences the health and well-being of children. For these reasons, the Academy believes there are inherent risks to bundling the care of adults and children into one health care delivery and financing system, and recommends that alternative payment models be implemented in pediatric-only populations, taking the unique characteristics of this group into account.

¹¹ The Rise and Future of Medicaid ACOs. Leavitt Partners. September 2015.

<http://leavittpartners.com/2015/09/the-rise-and-future-of-medicaid-acos/>. Accessed March 17, 2017.

¹² Medicaid Accountable Care Organizations: State Update. Center for Health Care Strategies, Inc. January 2017.

<http://www.chcs.org/resource/medicaid-accountable-care-organizations-state-update/>. Accessed March 17, 2017.

¹³ Bachrach D, Guyer J, Levin A. Issue Brief: Medicaid Coverage of Social Interventions: A Road Map for States.

Milbank Memorial Fund. July 2016. <https://www.milbank.org/publications/medicaid-coverage-social-interventions-road-map-states/>. Accessed March 17, 2017.

¹⁴ Spencer A, Freda B, McGinnis T, et al. Measuring Social Determinants of Health among Medicaid Beneficiaries: Early State Lessons. Center for Health Care Strategies, Inc. December 2016.

<http://www.chcs.org/resource/measuring-social-determinants-health-among-medicaid-beneficiaries-early-state-lessons/>. Accessed March 17, 2017.

¹⁵ Leddy T, McGinnis T, Howe G. Value-Based Payments in Medicaid Managed Care: An Overview of State Approaches. Centers for Health Care Strategies, Inc. February 2016. <http://www.chcs.org/resource/value-based-payments-in-medicaid-managed-care-an-overview-of-state-approaches/>. Accessed March 17, 2017.

¹⁶ Value-Based Payment Models for Medicaid Child Health Services. Bailit Health. July 2016.

<http://www.uhfnyc.org/publications/881145>. Accessed March 17, 2017.

¹⁷ Heiman HJ, Artiga S. Issue Brief: Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. The Henry J. Kaiser Family Foundation. November 2015.

<http://files.kff.org/attachment/issue-brief-beyond-health-care>. Accessed March 15, 2017.

¹⁸ Stille C, Turchi RM, Antonelli R, et al. The Family-Centered Medical Home: Specific Considerations for Child Health Research and Policy. *Academic Pediatrics*. 2010;10(4):211-217.

¹⁹ AAP Council on Community Pediatrics. Poverty and Child Health in the United States. *Pediatrics*. 2016; 137(4):e20160339. <http://pediatrics.aappublications.org/content/137/4/e20160339>. Accessed March 17, 2017.

²⁰ Van Cleave, et al. Dynamics of obesity and chronic health conditions among children and Youth. *JAMA*. 2010;303(7):623-630.

²¹ AAP analysis of data from the 2011-2013 *National Ambulatory Medical Care Survey*.

The AAP collaborated with Leavitt Partners to explore existing pediatric ACO models and characterize key components, which were published in 2017. *Pediatric ACOs: Insight from Early Adopters* identifies several factors vital for pediatric ACOs to effectively care for and sustain an APM for pediatrics.²²

- 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:
 - care strategies proven to be effective for pediatric populations, such as care management.
 - description of proper referral pattern to aid primary care providers and specialists to understand their roles in population management.
 - endorsement of integration of oral and behavior health as well as attention to social determinants in the practice.
 - integrated data collection. All pediatric ACOs in the report noted difficulties in obtaining adequate data for quality measurement, with their Medicaid programs. These problems reflect limited data management capacity in many Medicaid agencies and they also reflect, in part, the use of managed care intermediaries who have limited incentive to provide needed data. The diverse formats and sources of claims make analysis difficult and that inadequate data create significant barriers effect change in an APM environment.
 - 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.
 - new technologies as well as HIT and EHR must have pediatric specific components and standards.

Question 9: What other models of care besides ACOs and MCOs could be useful to implement to improve the quality and reduce the cost of care for the pediatric population?

The following general principles are applicable for any payment and care delivery model serving children, (i.e., ACOs, MCOs and APMs)

- A guiding principle for any type of pediatric APM 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 non-face 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. APMs lacking an adequate risk adjustment tool may end up penalizing practices that take on a proportionally higher

²² Perrin, JM, et al. Pediatric Accountable Care Organizations: Insight from Early Adopters. *Pediatrics*. 2017;139(2):e20161840. <http://pediatrics.aappublications.org/content/139/2/e20161840>. Accessed March 17, 2017.

rate of complex patients, including children with medical and social complexity. Risk adjusted payments must account for the medical and social severity and acuity of the patient panel

- 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.
- All APMs providing pediatric care should be designed with the input of primary care and medical and surgical specialty pediatricians having relevant experience in practice and financing.

SECTION III: INTEGRATED PEDIATRIC SERVICE MODEL PAYMENT AND INCENTIVE ARRANGEMENTS

Question 2: How could health care providers be encouraged to provide collaborative services with health-related social service providers for a designated pediatric population’s health and social needs?

The unique nature of pediatric care has driven pediatricians to incorporate care coordination within the practice setting, not only for children with complex medical needs, but for all children with a short term need for coordinated services among social and community services to address familial, and social needs.

For any APM and population health model, care coordination is integral. Pediatric trained case managers are best equipped to address pediatric cases as opposed to generic or adult oriented care managers.²³ 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. Currently, payers are not uniform in benefits coverage and payment for non-face to face services such as care coordination, telehealth, and consultation services. Appropriate payment for these services under a fee-for-service or an alternative payment model is essential to encourage collaborative services.

a. What payment models should CMS consider?

When designing a value based payment model for pediatrics, it is critical to note that Medicaid fee schedules and capitated payments to primary care, specialty, and subspecialty providers are significantly lower than payments for comparable services from Medicare and private insurance companies in most states. Low Medicaid payment is the primary reason that physicians limit participation in the program, with resulting barriers to patient access for primary and subspecialty health care services.²⁴ Furthermore, payment in the medical home context must be sufficient to enable pediatric primary and medical subspecialty care practices to support the services of a comprehensive care team, which may include nurses, care coordinators, mental health professionals, social workers, psychologists, dieticians, pharmacists, and administrative professionals. Financing mechanisms must be developed to allow pediatricians to be paid prospectively to acquire and maintain necessary health information technology and other practice infrastructure supports, including after-hours phone triage services, care coordinators,

²³ Perrin, JM, et al. Pediatric Accountable Care Organizations: Insight from Early Adopters. *Pediatrics*. 2017;139(2): e20161840. <http://pediatrics.aappublications.org/content/139/2/e20161840>. Accessed March 17, 2017.

²⁴ AAP Committee on Child Health Financing. Medicaid Policy Statement. *Pediatrics*. 2013;131(4). <http://pediatrics.aappublications.org/content/early/2013/03/27/peds.2013-0419>. Accessed March 17, 2017.

etc. Publication of the RUC-recommended values for pediatric services is a necessary piece to ensuring that value-based payment models are calculated in a fair manner.

The overall objective of pediatric health care is to support the healthy growth and development of children so they reach adulthood with their full potential. APM models and return on investment (ROI) measures need to incorporate the value of pediatrics that includes the long-term clinical, financial, and societal outcomes. Payer models of ROI not only should consider short-term cost savings (e.g., preventable admissions for asthma), but also long-term reduction of mortality and improvement of quality of life through preventive screening services, anticipatory guidance, and counseling. Early childhood health interventions have also been shown to have positive financial ROI and societal outcomes in non-medical arenas, such as literacy, crime, and income.²⁵

b. Specific approaches to attribution and risk-adjustment to be considered?

As stated, pediatric population health is much different from adults and any risk adjustment methodology needs to account for these differences. The dependent nature of children on adult caregivers requires consideration of the caregiver's role as a variable in any predictive measures. The education, income level, and mental health status of the parent (e.g. maternal depression and substance use) need to be recognized as impacting a child's health status. Pediatric risk adjustment models need to include measures of parental well-being - e.g. maternal depression, poverty, homelessness and substance use. Such considerations are not required in risk adjustment models for the adult patient.

Because of developmental stages, the risk management model for pediatrics must be delineated among age groups. Additionally, the epidemiology of disease is quite different in pediatrics than for adults. Certain chronic conditions treated for adults (cardiac, pulmonary and renal conditions) that tend to replicate year after year are relatively uncommon for children. Whereas in pediatrics, children are more prone to unpredictable bouts of acute infections or injuries.

Lastly, it is important to note that most pediatric practices do not have sophisticated payment data or adequate sample size to perform their own actuarial calculations and compute risk adjustment which are necessary in negotiating any type of risk bearing payment model.

Concerning risk adjustment and attribution models for pediatric payment, it is recommended that APMs:

- Allow for exclusions of costs or risk adjustments, when appropriate. Medically complex children incur 14.2 times the costs of medical care that healthy children do.²⁶ Adjustment of risk for pediatric APMs might include risk adjustment/stratification or carveouts for prolonged hospital care (e.g., NICU stays for extreme prematurity) or specialized services (e.g., residential mental health or complex surgery).
- Sufficiently detail the methodology for payer computation of any provider-level metric, such that the provider can precisely reproduce the calculation, including the provision of raw data sources, where applicable. Quality measures should define terms such as "active patient" and "up to date" in unambiguous language¹; payment mechanisms that use undisclosed "proprietary criteria" are not acceptable. Methodology for patient attribution and provider cost attribution should be particularly clear and timely.

²⁵ 13% ROI Research Toolkit. Heckman. <https://heckmanequation.org/resource/13-roi-toolbox/>. Accessed March 17, 2017.

²⁶ Kuo DZ, Melguizo-Castro M, Goudie A, et al. Variation in Child Health Care Utilization by Medical Complexity. *Maternal and Child Health Journal*. 2015;19(1):40-48.

- Use sophisticated attribution methods drawing from multiple data sources. Single-source performance data may be incomplete and thus inaccurately represent physician performance. While “the responsible decision maker” is usually attributed to a physician, the treating facility or the health plan may have the largest impact on variable costs.^{27, 28}

c. Advantages and disadvantages of payment models

Regarding specific APM methods and pediatrics the following provides a pediatric perspective on APMs currently in place:

- Bundled payments: may be appropriate as a payment method when services and provider responsibilities are well defined and straightforward. However bundled payments are considered inappropriate when goals are complex and responsibilities overlap.
- Per member per month (PMPM) payments generally have been used to support care coordination. External funding of care coordination, rather than requiring a practice to support it with general revenues, leads to faster implementation.²⁹
- Pay for Performance: may be appropriate for some health care delivery efforts which might include those that reduce overutilization of interventions (e.g., unnecessary prescription of antibiotics and medical imaging) that are controlled by the physician, or improve access (e.g., paying bonuses for patients seen on weekends or after hours). Withhold payments are strongly discouraged. Withholding payments to practices is counter-intuitive to improving quality as they do not provide support to the practice to build capacity to achieve the desired standard.

d. Are different payment models appropriate for different providers, populations?

To reiterate, guiding principles for any type of pediatric APM must ensure 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 non-face 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. APMs lacking an adequate risk adjustment tool may end up penalizing practices that take on a proportionally higher rate of complex patients, including children with medical and social complexity. Risk adjusted payments must account for the medical and social severity and acuity of the patient panel
- Maintenance of health information technology and its application to quality improvement activities and population health.

Question 4: How could states and tribes and providers coordinate incentive payments, state and federal grant funding, and hospitals’ community benefit dollars be combined to support an integrated care delivery model?

²⁷ Accuracy of electronic quality reporting varies across quality measures. AHRQ, Research Activities. July 2013. <http://www.ahrq.gov/news/newsletters/research-activities/13jul/0713ra9.html>. Accessed March 17, 2017.

²⁸ Hirth RA, Turenne MN, Wheeler JR, et al. Provider monitoring and pay-for-performance when multiple providers affect outcomes: An application to renal dialysis. *Health Serv Res.* 2009;44(5 Pt 1):1585-602.

²⁹ Van Cleave J, Boudreau AA, Mcallister J, et al. Care coordination over time in medical homes for children with special health care needs. *Pediatrics.* 2015;135(6):1018-26.

A critical area for APMs to support an integrated care model is to remove obstacles and adequately fund integrated oral health and behavioral/mental health care in the primary pediatric care setting.

Comprehensive benefits coverage and effective financing systems for children's oral health and mental health in primary care are essential in building a successful comprehensive system of care. However, numerous challenges and barriers impact not only financing and service delivery systems but also children's access to oral health, and behavioral/mental health services. These issues include:

- Limitations on coverage for oral health and mental health services in public and private health insurance systems.
- Inadequate payment for oral health and behavioral/mental health services, including preventive services, to primary care clinicians and other key professionals.
- Payer billing and coding rules and regulations that impede the provision of oral health and behavioral/mental health services by primary care clinicians and other types of clinicians.
- Carve-outs in health plans that limit the ability of primary care clinicians to identify and treat oral health and behavioral/mental health conditions early and make direct referrals for appropriate services, thereby creating access barriers to services for children and their families.
- Lack of payment for case management and care coordination efforts.

Pediatric primary care offers a setting that encourages trusting, longitudinal relationships with the child and family often referred to as the 'primary care advantage.' The pediatric primary care advantage recognizes that pediatricians have unique opportunities to affect the overall health of children, including oral health and behavioral/mental health such as preventing problems by guiding parents in behavior management; identifying oral health and behavioral/mental health symptoms as they emerge, intervening early, before symptoms have evolved into disorders; providing treatment for more common mental health conditions; facilitating referral of children and their family members when specialty services are needed.

SECTION IV: PEDIATRIC MEASURES

Payers, plans, consumers, and physicians are utilizing quality measures in various forms to improve the overall quality of care, contain growing health care costs, and to differentiate themselves from competitors. The development and implementation of national pediatric measures have moved considerably slower than that of adults due to lack of evidence, risk adjustment, unreliable data sources, and small patient population for chronic pediatric conditions. Despite these challenges, there have been successful efforts to create a robust set of pediatric endorsed measures through many organizations including the National Committee for Quality Assurance, the Agency for Health Care Research and Quality, National Quality Forum, Children's Hospital Association, America's Health Insurance Plans, and the National Academy of Medicine.

The AAP is supportive of CMMI's interest in identifying measures that demonstrate improved quality as children transition to adulthood. While the AAP acknowledges the importance of seeking short- and long-term cost savings it is essential to note that measuring the value of children's healthcare is fundamentally different. Investments in child health have long term savings outcomes (healthy children mean healthier adults and thus less expensive consumers of healthcare).

Children with medical complexity highlight one specific area where innovative payment models have found success. There are several models around the country of integrated health systems that do a very good job of keeping children with medical complexity out of the hospital and healthy. Intermountain, Seattle Children's, Nationwide and Cincinnati Children's for example are some of the few that have good programs that cover all aspects of healthcare for these children.

The AAP is supportive of nationally standardized measures in pediatrics for widespread use and reporting; and has been working to identify a group of measures that are meaningful to the broad spectrum of child health and development. The AAP is interested in promoting measures that serve as indicators of success and can be used for payment while also identifying gaps in children's health. These gaps will provide direction to the application of quality improvement strategies, when needed. The AAP has a long history of partnership with the previously noted organizations including the CHIPRA Pediatric Quality Measures Program (PQMP). We encourage CMMI to leverage the experience and infrastructure of the PQMP to develop and test pediatric quality measures where gaps in care are identified.

The AAP recognizes that measures should be evidence based and consist of numerators and denominators when possible; however, understands linking quality improvement and pay for value do not require equally stringent specifications. When examining measures that are essential to child health and development, it is critical that CMMI understands the complexities of pediatric measure development and the dichotomy between a theoretical ideal and the practical reality. 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.
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