Dear Administrator Verma:

Thank you for the opportunity to provide input on Pediatric Alternative Payment Model concepts and approaches to improve pediatric care. As the Robert Wood Johnson Foundation (RWJF) works to build a Culture of Health together with partners across the country, we recognize that promoting healthy development for children and their families is critical. We believe that it is essential to provide families, especially young children, with integrated, high value, health care, and social services. Exploring new payment and delivery system models that can provide this type of high quality care can ensure lifelong benefits, especially for the most vulnerable populations, and improve the nation’s health.

Here are RWJF’s responses to specific questions included in the Center for Medicare and Medicaid Services (CMS) Request for Information (RFI). They are based on input from several of the Foundation’s grantees and programs that work directly with states, tribes, and other community-based organizations: Manatt Health, ReThink Health, Data Across Sectors for Health (DASH), Safety Net Action Center (SNAC), Center for Healthcare Strategies, Altarum Institute, Zero To Three, Medical Legal Partnership, and researchers at the University of North Carolina.

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

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 comment on challenges and opportunities in service delivery for all pediatric beneficiaries and for those with higher needs (i.e., those at-risk for developmental, social, emotional, behavioral, or mental health problems, and those with
complex and/or chronic health conditions) and the level and range of technical assistance entities might require to support an effective model.

We have reason to believe that the level of interest would be high for exploring these models. For example, in spring, 2015, the DASH program, which works at the community level on developing infrastructure to support collaboration of health care and other sectors, released a Request for Proposals (RFP) for community collaborations seeking to invest in multi-sector data sharing infrastructure to improve community health. DASH received 407 applications for 10 awards. Communities from every state (except South Dakota) were among the applicants. Among DASH’s 10 grantees, two specifically focus on children. One of those is a city health department-led effort. The other is a tribal government-led effort.

In addition, recent discussions with states and health plans seeking to identify innovative strategies designed to support high-risk, low-income families have identified a number of opportunities to improve care for pediatric beneficiaries. Of course, all of these conversations elicits challenges and opportunities with this work. We would encourage CMS to consider the following topics of interest/technical assistance needs to support an effective model and prompt cross-sector efforts for this population:

- **Facilitate community and social services linkages to medical practices:** identify how to link community-based resources to medical practices to address upstream prevention. Health-related services should be defined as broadly as feasible in identifying ways to align such services with health care. Under a grant from the Robert Wood Johnson Foundation, the Altarum Institute developed a framework for thinking about the this type of investing in non-clinical prevention in order to help guide the implementation, evaluation, and alignment of services;

- **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;

- **Emphasize two-generation approaches:** recognize family relationships and treat the children and parents as a unit; and

- **Identify and share information around basic metrics:** identify assessment tools and share information around metrics to determine common measurements that should be tracked.

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 (including EPSDT; please be specific about what pediatric populations were targeted)? For example, in the case of oral health, what services have partners included beyond the Medicaid mandatory benefits? What health and health-related social services outcomes have been achieved and over what timeframe (including the time to “ramp up”)? Additionally, what program integrity strategies were employed where these partnerships exist?

Children and families’ needs cross many different domains and sectors. Health care practices are uniquely positioned to partner, align, and coordinate with health-related social services to
maximize benefits for children and families. 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.

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 (see American Academy of Pediatric’s Bright Futures Guidelines). The pediatrician’s office is a powerful access point for children and families, particularly for low-income, high-need populations. Decades of research show positive impacts across metrics as varied as: well-child visit adherence and immunization rates; injuries and emergency department visits; parenting knowledge and skills, including early literacy habits; parent and child connections to resources and services; and parental satisfaction with the pediatric practice.1,2,3

We are also learning through our work about the critical importance of providing trauma-informed care. So many children and families experience trauma that is at the root of their health and social needs. Health care entities have an opportunity to provide care that recognizes and seeks to address the trauma that these families have experienced, including providing the care and attention necessary for healing.

The DASH program had two pediatric projects that included the following partners: primary care, public health (conducting home inspections for lead hazards and remediation when indicated), schools, Head Start, homeless services, home health, housing, mental health, substance use disorders, child care, child supports, courts, education, employment and training, financial services, food distribution, and fuel and energy assistance. These projects are at the beginning stages so we do not yet have outcomes to share. However, we are happy to provide additional information as it is developed upon request.

In addition, CMS may also consider the role of legal professionals as part of the health and health care team. Social determinants of health, such as unsafe housing, difficulties in school, and unlawful denial of public benefits, may require the services of legal professionals, such as attorneys and paralegals. The integration of legal services into health care began in pediatric practice in the early 1990s. Currently, there are 45 medical-legal partnerships in children’s hospitals and over one hundred in health centers, many of which serve children. Adding legal services to pediatric health care ensures that, when social determinants of health are identified, legal professionals are ready and able to treat those social needs with legal remedies. Medical Legal Partnerships (MLP) can save money for patients and health systems. For example, the Health Law Partnership (HeLP), an MLP for children in Atlanta, Georgia, recovered $501,209 in benefits for patients with asthma over a seven-year period.4

Lastly, we are developing a program to learn more about the connections between health care and community-based social services that already exist and issued our own request for
information on this topic. We would be pleased to provide CMS with additional information once we have it.

SECTION II: OPERATION OF INTEGRATED SERVICE MODEL

3. What infrastructure development (electronic medical records [EMRs], health information exchanges [HIE], and information technology [IT] systems, contracts/agreements, training programs, or other processes) has been needed to integrate services across Medicaid enrolled providers and health-related social service providers? Please include specific details of stakeholder engagement and collaboration, timeline, and costs to operationalize integrated services and how could that experience be improved through a potential model?

Data sharing is one of the critical ingredients for collaboration across entities and sectors. One of the significant challenges to this collaboration can be sharing data via the electronic medical record. In our work with DASH, we note that some communities are building a collaborative, longitudinal care record, accessed by providers of health care and/or social services agencies that have agreed to coordinate care. These may be based within a health system or hosted by a third party like a health information exchange. This approach may reduce barriers mentioned above to the point where providers can more readily realize a return on investment of time and effort, particularly with high-acuity patients, but it remains to be seen whether these systems can be sustained by participants.

Another issue that providers are beginning to work on is screening for social determinants of health and adverse childhood experiences. Providers are identifying potential screening tools, but often lack confidence in their ability to screen and in their capacity for addressing challenges that arise during the screening process. The National Association of Community Health Centers, along with multiple partners, developed a screening tool to assess patient social needs, called the Protocol for Responding To and Assessing Patients’ Assets, Risks and Experiences (PRAPARE). The PRAPARE tool aligns with federal initiatives that prioritize social determinants of health and is compatible with several electronic health record platforms. Although not specific to pediatrics, PRAPARE is now being used in health centers in 31 states. This use, coupled with the fact that one in 10 children receive care from health centers, demonstrates that an electronic social determinants of health assessment tool is poised to become a routine feature of pediatric practice for low-income children.

6. What are some obstacles that health care and social services providers as well as payers face when integrating services? How might these obstacles be overcome?

There are multiple obstacles, many of which CMS is likely already aware, including the following:

- Data sharing across sectors;
- Many providers addressing social determinants of health are not necessarily recognized as treatment providers, causing reimbursement challenges;
- Financial incentives are not aligned such that health care entities, including accountable care organizations, are not incentivized to support social services;
• Lack of provider time and training to address child and family social service needs; and
• Challenges in that return on investment for pediatric focused programs are often not seen for many years.

Different ways to address these obstacles may include supporting community data infrastructure; providing technical assistance to providers, including thinking about the entire health and health care team as part of training to provide integrated services; allowing providers to bill for interventions that address social determinants of health; and allowing pediatric providers to bill for two-generation services for parents. In addition, many promising pediatric interventions create a longer-term return on investment that yield health and budgetary benefits much further down the line. We encourage CMS to purposefully address these longer-term return on investment opportunities.

SECTION III: INTEGRATED PEDIATRIC SERVICE MODEL PAYMENT AND INCENTIVE

1b. What specific age ranges of CMS beneficiaries should be included in an integrated health care and health-related social service model to achieve the greatest impact on outcomes and cost savings for children and youth?

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.6

2b. What specific approaches to attribution and risk-adjustment should be considered in a care delivery model encompassing all children and youth in a population in order to support addressing the needs of high-risk, high-need individuals and avoid adverse selection pressures?

CMS might 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 has done for its affordable care organization programs.

3c. Based on the current experiences, please provide details on the data sharing models and infrastructure used to track outcomes and funding streams.
DASH has observed the development of the following data sharing models. These models relate to sharing data for purposes of care coordination and do not address tracking outcomes and funding streams.

- Developing and implementing a common, centrally hosted data system for screening and care coordination across providers. A drawback is that this may require double entry if it is not linked to existing electronic health records,
- Health information exchanges are increasingly building solutions to facilitate capture of social services provided to patients, as well as referrals between health care and social services providers. This is fundamentally limited by: 1) lack of standard electronic systems in use by social services providers, and 2) the technical capacity and market share of the health information exchange, and
- Public health as an intermediary – not necessarily in providing individual level data – but taking in granular environmental datasets and producing place based risk information that is useful for social services and health care providers.

5. In addition to Medicaid’s mandatory benefits (including services and supports required under the EPSDT benefit), what other services might be appropriate to incorporate in any new integrated service delivery model? a. While these are currently available to states and tribes, what barriers exist to states and tribes using more of these options?

- 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.

SECTION IV: PEDIATRIC MEASURES

1. What additional measures are appropriate for beneficiaries aged 0-18 years or 0-21 years? Are they indicative of both near-term health and well-being as well as predictive of long-term outcomes? We are interested in health care measures as well as measures reflecting overall health and well-being.

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. We are happy to provide CMS with additional information on our patient-centered measurement work when it is available.

SECTION V: OTHER COMMENTS

What are the critical success factors and barriers to effective partnership between states, tribes, communities, providers and others to achieve better health outcomes for children and youth?

In the absence of a payment or incentive structure that promotes shared accountability across multi-sector providers, the success factors for local partnerships rests heavily on the skill and persistence of local leaders in creating relationships through which partners can develop trust, articulate a shared vision, and build a shared vocabulary.

Overall, we are very pleased to see CMS exploring cross-sector strategies for family-centered, integrated services for all children, particularly at-risk, low-income children and families. The background section within the RFI reflects an understanding of the need to address social determinants of health across the lifespan and recognizes the short- and long-term impact of adverse childhood experiences. We also encourage CMS to include trauma-informed care as part of a pediatric care model concept to reduce the lasting effects that adverse childhood experiences can have on health, behaviors, and life potential.

As always, we are happy to furnish any additional information to CMS or answer any questions that have come up relevant to this response or otherwise. We look forward to partnering together to build a Culture of Health so that everyone has an equal opportunity to live the healthiest life possible.

Thank you,

Risa Lavizzo-Mourey, MD, MBA
President and CEO
1 Addressing Early Childhood Emotional and Behavioral Problems PEDIATRICS Volume 138, no. 6 December 2016 :e 20163023 Council on Early Childhood, Committee on psychosocial aspects of child and family health, Section on Developmental and Behavioral Pediatrics.

2 Promoting Optimal Child Development: Opportunities in Primary Care Background for expert meeting, 2016 National Institute for Children’s Health Quality.


