

Center for Medicare and Medicaid Innovation
Request for Information on Pediatric Alternative Payment Model Concepts

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS

ACTION: Request for Information (RFI)

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is seeking input on a draft pediatric care model concept, including:

- Integrated Pediatric Health Care and Health-Related Social Service Delivery Model (general)
- Operation of Integrated Service Model
- Integrated Pediatric Service Model Payment and Incentive Arrangements
- Pediatric measures
- Other comments

DATES: *Comment Date:* To be assured consideration, comments must be received by April 7, 2017

ADDRESSES: Comments should be submitted electronically to: HealthyChildrenandYouth@cms.hhs.gov

FOR FURTHER INFORMATION CONTACT: HealthyChildrenandYouth@cms.hhs.gov with “RFI” in the subject line.

BACKGROUND

Section 1115A of the Social Security Act, as enacted by section 3021 of the Affordable Care Act authorizes the Center for Medicare and Medicaid Innovation (Innovation Center) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) beneficiaries.

CMS is exploring the development of a new pediatric health care payment and service delivery model. We are issuing this Request for Information (RFI) to obtain input on the design of a draft model concept focused on improving the health of children and youth covered by Medicaid and CHIP through state-driven integration of health care and health-related social services with shared accountability and cost savings. The aim of this model is to facilitate strategies for timely and appropriate delivery of family-centered, community-based, linguistically and culturally appropriate, cost-effective, and integrated services to all children and youth covered by Medicaid and CHIP with an emphasis on those with or at-risk for developmental, social, emotional, or behavioral health challenges, intellectual or physical developmental delays or disabilities, and/or those with complex and/or chronic health conditions (also known as “high-need, high-risk beneficiaries”).

An individual’s health needs extend beyond preventive and therapeutic health care services to include access to health-related social supports, and this is especially true during childhood when factors such as sound nutrition, safe living environments, responsive adult caregivers, and nurturing social relationships are critical for healthy growth and development. As a result, inadequate or inconsistent access to these factors can have near and long-term physical and psychological impacts whose effects extend throughout the life course as children become adults. Children and youth covered by Medicaid and CHIP may be exposed to such unfavorable social conditions and adverse childhood experiences, which could go unrecognized or unaddressed as a result of limited support for providers to address them alone. A number of federally-funded programs play a role in addressing threats to children’s health, including Medicaid and CHIP, Healthy Start, Head Start, Child Welfare, the Indian Health Service (IHS) and more. However, many vulnerable children are not able to access the optimal combination of these programs and services. Pediatric beneficiaries can often receive the wrong care at the wrong time because of late presentations

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of neglected illnesses or challenges, often including under- or untreated behavioral and mental health issues.

CMS continues to work with state Medicaid programs and providers to focus on paying for value instead of volume in the Medicaid and CHIP programs. Lessons are emerging from state and tribal programs and use Medicaid Health Homes, accountable care organizations, community health teams, care management programs, and other services and models which promote shared accountability, patient centeredness, and service integration. To date, these and other innovations have focused primarily on the adult Medicaid population. In order to meet the diverse needs of pediatric beneficiaries and address the specific challenges to (and cost-saving potential of) accessing needed health and health-related social services, CMS is considering a pediatric alternative payment model. We wish to explore models that encourage pediatric Medicaid and CHIP providers to collaborate with health-related social service providers (e.g., early childhood development programs, child welfare services, crisis intervention programs, behavioral health providers, and home and community based service providers) at the state, tribal and local levels, and share accountability for outcomes for children and youth covered by Medicaid, and CHIP. Such an integrated service delivery model could present several benefits:

1. Comprehensive, universal screening of pediatric Medicaid and CHIP beneficiaries (in addition to services currently covered in Early Periodic Screening, Diagnosis and Treatment (EPSDT)) across model participants' clinical and partnering health-related social service sites could increase identification of health care needs (such as behavioral health) and community-based and other health-related social services supports among children, youth, and their families (such as respite care) at an earlier stage than what is currently commonly experienced;
2. Alignment around eligibility and enrollment requirements among Medicaid, CHIP, IHS, and health-related social service providers could reduce service interruptions and churn (or briefly losing and re-gaining eligibility), resulting in administrative cost savings;
3. Children and youth would stand to receive streamlined, coordinated care across health care and health-related social services providers with families at the center of decision-making, potentially 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;

We recognize that a number of state Medicaid programs have unique accountable care organization (ACO) models, most of which focus on the adult Medicaid population. CMS seeks input on the impediments to extending and enhancing ACOs or similar integrated service model concepts to the pediatric population in states and tribes. Additionally, we are interested in the flexibilities (e.g. streamlining and coordination of existing Medicaid and CHIP state plan and waiver authorities) and supports (e.g. infrastructure, training, data analytics models, etc.) states, tribes and providers may need to offer such a model to all or some subset(s) of a state's and tribe's pediatric population. In addition, CMS seeks comment on models for states and providers to coordinate Medicaid and CHIP authorities and waivers with other health-related social services for children and youth, including models supported by the provision of incentive payments and sharing in cost savings.

CMS seeks broad input from beneficiaries, consumers, and consumer organizations (including family members and youth); pediatric providers, including Indian health care providers, and behavioral health specialists and providers; pediatric dentists and other oral care providers for children and youth; child advocacy groups; elected officials, including Governors and legislators; tribal councils, state offices

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including Medicaid, departments of health, public health, and health-related social services agencies and providers; purchasers, health plans and managed care organizations; home and community-based service providers; Health IT and Health Information Exchange (HIE) vendors and associations; school administrators and local educational organization leaders; and other private and public stakeholders. Commenters are encouraged to provide the name of their organization and a contact person, mailing address, email address, and phone number. However, this information is not required as a condition of CMS' full consideration of the comments.

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

CMS is interested in learning about pediatric alternative payment models (APM) (APM defined here as a payment model other than traditional fee-for-service) that emphasize both quality and multi-disciplinary service delivery, with consideration of the unique needs of children and youth covered by Medicaid and CHIP and the potential impacts on their health and well-being. In the model concept being explored, CMS proposes that pediatric health care systems and providers work with their states and tribes to take on accountability for the health and wellness of children and youth, with the families at the center of care planning, potentially sharing that accountability with health-related social service provider partners.

QUESTIONS:

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.
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?
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 a part of a new care delivery model for children and youth?

SECTION II: OPERATION OF INTEGRATED SERVICE MODEL

CMS is exploring how the establishment of partnerships between child- and youth-focused health care and health-related social services providers might be structured and operate to integrate services.

Additionally, CMS understands that varying eligibility criteria and program requirements can be challenging for children, youth, families and providers to manage, resulting in both service gaps and implementation challenges, such as different case managers or navigators for each program. We are interested in innovative approaches to integrate child and youth services within these partnerships by lowering barriers to identifying, enrolling, and maintaining coverage.

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QUESTIONS

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 (e.g. State Medicaid agencies and health-related social services agencies)?
 - a. Please comment particularly on service integration with programs such as [Head Start](#); child welfare programs; Children’s Mental Health Initiative programs; [Healthy Transitions](#) grantees; [Safe Schools/Healthy Students](#); foster care programs; the [Maternal, Infant, and Early Childhood Home Visiting Program](#); [Individuals with Disabilities Education Act, Part C programs](#); [Healthy Start](#) projects; and other state, tribal, and federal programs.
2. Where pediatric health care providers have partnered with health-related social service providers, how have these partnerships operated and integrated service delivery?
 - a. Which health-related social service providers have been or should be included in a child- and youth-focused integrated service delivery model?
 - b. What potential exists for increased partnership for provision of home and community-based services?
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?
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? Please be specific about the role of Medicaid or other waivers, any administrative savings, reporting, tracking, and adherence to program integrity requirements in integrated services.
5. Where is there the most potential for improved outcomes and/or savings associated with future streamlining of eligibility and/or alignment of program requirements among Medicaid/CHIP and health-related social service programs?
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?
7. What lessons can a Medicaid managed care organization (MCO) or delivery system offer to inform this model concept? What challenges/barriers have managed care entities encountered?
8. What role do models of care such as ACOs play in the pediatric environment?
 - a. Are pediatric ACOs commonly understood to represent payment arrangements (i.e. shared savings), care delivery models (improved care coordination within and across care delivery sites), or both?
 - b. How are pediatric ACOs the same or different from adult-focused ACOs?
 - c. What opportunities do pediatric ACOs have for integration with community and health services systems?
 - d. 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?
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?

SECTION III: INTEGRATED PEDIATRIC SERVICE MODEL PAYMENT AND INCENTIVE ARRANGEMENTS

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CMS recognizes that accessing the optimal combination of child and youth services to meet each child's unique needs presents a significant challenge for vulnerable children and youth in need of services, as well as for their families. In the draft model concept, we seek to improve coordination and alignment across programs and systems by supporting the establishment of robust health care and health-related social service provider partnerships to improve health, wellness, and total cost of care with the potential for sharing in cost savings for successful performance. We are interested in input on innovative financial arrangements that combine or coordinate funding in an effort to integrate and streamline care for high-need and vulnerable children and adhere to current Medicaid and CHIP program integrity requirements. Since the Innovation Center seeks to test models that, when successful, can be scaled and spread, we seek comments on how current Medicaid and CHIP authorities and programs might be used to support reproducible state-based models to improve care for children and youth.

QUESTIONS

1. What Medicaid and CHIP beneficiary populations/participants offer the greatest opportunity for generating savings and/or improving outcomes for children and youth receiving services from integrated health care and health-related social services systems?
 - a. Are there specific high-need, high-risk populations that should be included in an integrated care model (including but not limited to children with or at risk for developmental, social, emotional, behavioral, or mental health problems including substance use disorder, and those with complex and/or chronic health conditions)?
 - b. 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?
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?
 - a. What payment models, such as shared savings arrangements, should CMS consider? Please be specific about the methodology for attribution and determining whether different providers have achieved savings. Please also comment on risk, upside (potential savings) and/or downside (potential costs), including appropriate "ramp-up" periods relative to the payment models.
 - b. 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?
 - c. Please be specific and explain the relative advantages and disadvantages of any such payment arrangements. We are particularly seeking comments on whether methodologies should be changed to account for smaller provider entities or rural providers who may have coverage responsibility for a small percentage of the providers' patients.
 - d. Are different payment models appropriate for different potential health care and health-related social service providers? Please be specific about which payment approaches would be appropriate for specific patient populations and service providers.
3. To what extent are financial incentives and funding streams currently aligned across health care and other health-related service providers serving children and families at the state, tribal and local levels, including through public and private endeavors?
 - a. Please comment on the challenges states, local government, or other private/public entities face in aligning on outcomes for children and youth across health care and health-related social service providers.

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- b. What factors are essential to the success of this alignment?
 - c. Based on the current experiences, please provide details on the data sharing models and infrastructure used to track outcomes and funding streams.
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?
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?
 - b. What benefit, if any, might come from combining a subset of authorities vs. using only one or two in isolation?
 - c. How could the Health Home model be further adapted to better meet the needs of a pediatric population? Are there particular "bundles" of services appropriate for a pediatric population or subset of children and youth covered by Medicaid and CHIP that include health/clinical and health-related services?
6. How might CMS, states and tribes, and health care and health-related social service providers calculate the savings in Medicare, Medicaid, and CHIP expenditures from an integrated pediatric service model?

SECTION IV: PEDIATRIC MEASURES

CMS has worked with stakeholders to develop a core set of child health care quality measures that can be used to assess the quality of health care provided to children enrolled in Medicaid and CHIP. States and tribes can use the child core set of measures to monitor and improve the quality of health care provided to Medicaid and CHIP enrollees; however, CMS notes that state and tribal reporting on the core set is voluntary. CMS is interested in learning from and, where appropriate, building upon its work on pediatric quality measures indicative of health outcomes. In particular, we are interested in short-to-medium term measures associated with both short- and long-term cost reductions and improved quality to both Medicaid and other public sector programs as healthy children become healthy adults. In addition, CMS is interested in learning how measures of health-related social needs might be incorporated in an integrated model to reflect a comprehensive picture of child and youth health.

QUESTIONS

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.
2. Are these measures currently collected, and at what level (provider, health plan, state, tribe or other)? Please be specific about data elements, data systems employed to collect the data elements, what private and/or public entities currently collect these elements, and any predictive validity evidence for long-term outcomes.

SECTION V: OTHER COMMENTS

1. 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?

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2. As we consider a model to improve care and health outcomes for children and youth, are there other ideas or concepts we should consider? Please be as specific as possible.

SPECIAL NOTE TO RESPONDENTS: Whenever possible, respondents are asked to draw their responses from objective, empirical, and actionable evidence and to cite this evidence within their responses.

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY. This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This RFI does not commit the Government to contract for any supplies or services or make a grant or cooperative agreement award. Further, CMS is not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement or program, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request.

Please note that CMS will not respond to questions about the policy issues raised in this RFI. CMS may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur costs for which payment would be required or sought. All submissions become Government property and will not be returned. CMS may publicly post the comments received, or a summary thereof.