Child Health and Development Institute of Connecticut, Inc.

Children's Fund of Connecticut

Connecticut Health Foundation

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To: Payment Reform Council

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Re: Bundling Payment for Pediatric Primary Care

The Connecticut Health Foundation and Child Health and Development Institute and Children's Fund of Connecticut are supporting the work of a pediatric primary care payment reform study group, with membership from providers, payers, state agencies, and health policy experts. Our two organizations embarked on this work with the recognition that alternative payment for pediatric primary care could support improved long term population health, improve health equity, and better embed health services within community systems dedicated to children's health and well being. Over the past year the study group formulated goals for pediatric primary care, identified the gaps in primary care capacity and capabilities, and crafted recommendations (included below) to guide the development of alternative payment to encourage a larger contribution from primary care.

We urge the Council to prioritize bundling preventive service payments for children's health and to consider payment for health outcomes achieved as a second step in reforming payment for pediatric primary care.

It is well documented that health promotion in the very earliest years can alter the life trajectory of vulnerable children.[1] Health promotion happens in families and communities, but pediatric primary care providers can make a strong contribution also. More than 90% of children use primary care services annually,[2] providing a venue to support families in promoting health, deliver health messages, identify health concerns, and connect patients to services that can address health risks early before they lead to larger problems, which are costly to manage and become lifelong chronic conditions. The American Academy of Pediatrics (AAP) and federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) schedules outline an array of primary care services that, when fully implemented, contribute to long term health outcomes.[3]

[1] https://developingchild.harvard.edu/resources/inbrief-the-foundations-of-lifelong-health/
[2] https://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2015_SHS_Table_C-8.pdf
[3] https://www.aap.org/en-us/documents/periodicity_schedule.pdf

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Noteworthy in these recommendations is the abundance of preventive visits in the early years of life. The AAP and EPSDT schedules call for 12 preventive care visits before the second birthday.[4] Preventive care topics for these visits include: physical growth monitoring, immunizations, sensory screening, developmental screening, lead screening, and anticipatory guidance to promote parenting skills, home and car safety and socio-emotional development. Not only are these visits universally reimbursed by public and private payers, but data show high adherence to the schedule.[5] Research has clearly shown the importance of the early years in determining lifelong outcomes, from development of resiliency to mitigate the effects of toxic stress to moving families out of poverty,[6] suggesting that pediatric primary care can make an enormous contribution to population health and health equity.

An effective pediatric primary care payment model, then, that recognizes the numerous opportunities for parent and child contact in the early years can maximize the contribution of pediatric primary care services to population health and other societal goals. Payment that allows health providers to collaborate with community supports, to spend time with families, use evidence-based innovations such as group well child visits and literacy promotion, and generally support caretakers in parenting, can go a long a way in supporting the health of future generations. Current fee-for-service payment forces pediatric providers to limit visit length so that they can conduct enough visits in a day to sustain their practices. They are also constrained in using social service and other providers, whose services are not reimbursed under traditional health insurance plans.

A further argument for bringing flexibility to the delivery of pediatric primary care through bundled payment is that there are so many opportunities in states and communities to promote health and development and to address child and family risks once they are identified. Federally mandated and funded early intervention services under the Individuals with Disabilities Education Act,[7] the Children and Youth with Special Health Care Needs program,[8] Head Start and Early Head Start,[9] and other block grant programs provide support for families with a variety of needs. Connecticut also has a *Help Me Grow* system, which ensures that children who do not qualify for publically funded programs are linked to community services that promote development and address social determinants of health and development. Primary care can ensure that families are connected to these services if supported by a payment model that recognizes expanded services in primary care within a system of services that includes community partners.

In summary, bundling payment for well visits for children can bring flexibility to practices to allow them to make a bigger contribution to health promotion and health equity with outcomes over the lifetime and in many sectors. Further, we believe that flexibility in payment can encourage practices to use community services better to address child and family health as well as increase their unique contribution to health. The innovations are out there to do this, and the measurements to ensure

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[4] ibid
[5] https://www.aap.org/en-us/Documents/practicet_Profile_Pediatric_Visits.pdf
[6] http://developingchild.harvard.edu
[7] https://www.gpo.gov/fdsys/pkg/PLAW-108publ446/html/PLAW-108publ446.htm
[8] https://mchb.hrsa.gov/maternal-child-health-topics/children-and-youth-special-health-needs
[9] https://www.acf.hhs.gov/ohs

quality and guard against under-provision of services are also available. Once primary care payment is reformed to provide flexibility in service delivery, we will see outcomes in a variety of sectors, such as improved kindergarten readiness, 3rd grade reading scores, and social competence. Large-scale studies have documented that young children's challenges in school are more the result of health and behavioral health challenges than cognitive ones,[10] suggesting that we can use educational system data to add payment for outcomes to the State's alternative payment methodology.

Please contact either one of us to discuss these issues further.

[10] Wertheimer R, Croan T, Moore KA, Hair EC. Attending kindergarten and already behind: a statistical portrait of vulnerable young children. Washington, DC: Child Trends;2003.

Recommendations for Reforming Payment in Pediatric Primary Care

The Pediatric Primary Care Payment Reform Study Group recognizes that physical, emotional and social factors affect children's lifelong health and well-being. Building on existing structures of primary care, changes to pediatric practice can advance long-term goals of improving population health, promoting health equity and reducing health disparities among children and adults in Connecticut, and better connecting health with other sectors to support life outcomes. These improvements, in turn, will have positive societal effects: an economy made stronger by a better educated, healthier workforce, and a populace with better prospects for social mobility.

The path to lifelong well-being – characterized by a variety of health and other developmental assets (e.g. supportive social relationships, healthy weight, reduced risk of chronic illness, and economic productivity) – begins in childhood. While health care is not the only sphere that can influence a child's life course, the regular, frequent, and near-universal engagement of children and families with pediatric primary care is an opportunity to better work within a comprehensive childhood to adolescent system to increase pediatrics' contributions and value.
Not all families have the same resources available to provide for their children early in life.[11] Acknowledging these disparities early on, through development of Family Protective Factors[12] and other pediatric-lead early intervention and health promotion mechanisms, can mitigate long-term impacts of childhood poverty and other social determinants of health.[13]

The transformation of pediatric practice – the services children, adolescents and their families receive, how care is delivered, and how effectiveness is measured – is critical to achieving goals of lifelong well-being for individuals and improved overall population health. The success of practice transformation will require reform in how primary care is paid for, to ensure providers have the flexibility to deliver new kinds of services that are integrated within the larger social context in which children and their families live and grow. With this perspective in mind, the Study Group offers the following recommendations for payment reform.

1. **Payment reforms in pediatrics should reward effective health promotion and prevention among all children, receiving care in all practice settings, and covered by all payers**. Primary care should enhance families' capacity to achieve such priorities as:

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[11] *Early Childhood is Critical to Health Equity* Report, Robert Wood Johnson Foundation, UCSF (May 2018)
[12] Strengthening Families, Center for the Study of Social Policy Protective Factors Framework Overview
[13] The Interdependence of Families, Communities, and Children's Health: Public Investments That Strengthen Families and Communities, and Promote Children's Healthy Development and Societal Prosperity. "[...] *therefore a crucial factor in optimizing health in this developmental period is building the capacities of families and communities, which includes access to community-based early childhood enrichment services (for example, early care and education, home visiting, and parent support programs."*

a. Promoting healthy weight (e.g. through lactation consultation, nutritional counseling, connecting families to community nutrition support such as WIC).
b. Promoting socio-emotional well-being among all children, and particularly children with social or medical complexity. This can be achieved through parent support and education interventions such as the Positive Parenting Program, strategies for enhancing family and child resiliency as used in the family protective factors framework, and greater integration of behavioral health services with primary care throughout childhood and adolescence.
c. Promoting developmental outcomes to ensure school readiness and success for all children, and particularly children who may have lower rates of success in school due to language, cultural and other barriers.

2. **Payment methods for pediatric primary care should motivate the restructuring of practices that can improve population health, health equity, health care quality, and address costs.** Payments should:
    a. Allow flexibility to support service innovations that would ordinarily not be covered within traditional fee-for-service payment, including two-generation approaches that involve parents/caregivers in care. New capabilities in a restructured practice might include:
        i. care coordination for children and families with medical or social complexity, or who are at risk of falling behind on health and related goals;
        ii. flexible office hours that include some weekend and evening hours;
        iii. alternative visit capabilities (such as e-consults, group visits and telehealth video-appointments);
        iv. embedded or easy access to behavioral health screening, follow up, and consultations;
        v. embedded or easy access to additional practitioners such as nutritional counselors and pharmacists;
        vi. transportation assistance;
    b. Reduce physician burden, optimize efficiency, and expand practice capabilities by accommodating innovative staffing using non-physician professionals and paraprofessionals;
    c. Ensure dollars are used to directly support changes at the individual practice site level;

d. Provide up-front funds, separate from payments for care and services, to support practices in developing infrastructure needed for practice innovations;
e. Support practices to report back to payers on the new capabilities, activities and outcomes new payment structures have enabled;
f. Ensure families directly experience and realize the benefits of practice innovation for their children's health and future well-being;
g. Support existing innovative primary care models and bring evidence-informed innovations to scale.

3. **Stakeholders in Connecticut should support efforts to improve measurement and supply data that connects effective pediatric primary care to adult health and well-being.** Focusing on both process and outcome measures (proximate and distal) will fortify the evidence base for primary care innovations. Over time, this will supply the Return on Investment (ROI) evidence that is needed to promote adoption of payment reform by different payer constituents (e.g., State Medicaid Agency, Health Insurers, Self-Funded Employer Sponsors, etc.).

4. **The participation of all payers in payment reform solutions for pediatric primary care is essential to success.**
   - Practice transformation to achieve significant contributions to population health and health equity requires pervasive change in the delivery of primary care services. Such change is only feasible if implemented across the entire practice population, not just for those insured by one plan only.
   - Participation by all payers mitigates the disincentive any single payer has to finance innovations that may yield its benefits (savings) to other payers later.

5. Payment methods need to recognize the variety of service sectors' overlapping encounters with and responsibilities for children. Cross-sector collaborations (e.g. medical, social service, education), financed through braided and/or blended funding, will allow for efficiency in service delivery, shared financing, accountability and, ultimately, support improved health and other benefits.

6. The benefits of improved pediatric primary care are considered a public good; they accrue across the lifespan, to many spheres of social policy, and to the state's economy in general. As with public education, which analogously spends on children to reap benefits across the population and over time, a public-sector role, in some form, is warranted.