Don't Forget the Kids: Care Transformations That Meet the Needs of Children

Cindy Mann, JD; Jennifer Eder, MPH

From Manatt Health (C Mann and J Eder), Washington, DC
Address correspondence to Cindy Mann, JD, Manatt Health, 1050 Connecticut Ave, NW, Washington, DC 20036 (e-mail: cmann@manatt.com).
Received for publication May 24, 2019; accepted June 15, 2019.

ACADEMIC PEDIATRICS 2019;19:865–867

THERE'S LITTLE DISPUTE that children's physical and behavioral health needs are distinct from those of adults especially since they are heavily influenced by stages of development and family, social, and educational environments.[1] And yet, delivery and payment systems for children generally rely on systems designed for adults. Reforms are well underway across the country, but to date, not surprisingly, delivery system and payment reform has largely followed the money by focusing on high-cost adults. Children, as a group, are less costly, and because the majority of children's health care is prevention oriented, the return on investment can be long term and difficult to measure. Furthermore, the cost savings for children realized through reform often accrue to other sectors, such as education or child welfare. A variety of federal, state, and local services exist to help children grow and thrive, but even when information sharing and coordination of services are in place, combined – or aligned – budgeting is rare. Having payment and delivery systems that align with children's particular social, emotional, developmental, physical, and behavioral health needs is important for all children, and particularly for children with special health care needs. While there are signs of improvement in the delivery of integrated care to children, wider adoption of promising models and new approaches to financing and sustainability are needed to make large-scale transformation. This commentary discusses the status of practice transformation for children, focusing on 3 areas that a review of the evidence suggests targeted attention.

A central transformation strategy that can establish the infrastructure for appropriate interventions is to scale the medical home concept and expand it to address social determinants of health (SDOH) while assuring critical specialty capacity. The medical home model permits a holistic approach to children's health, and a team-based approach to providing care to the child and, as appropriate, to the family. The new generation of pediatric medical homes encompasses screening and treatment for physical and emotional developmental issues as well as interventions aimed at addressing health-related social needs such as unstable or unsafe housing, transportation, food security, and trauma. Young children are particularly sensitive to SDOH, and early investments result in improved health outcomes, cost savings, and societal gains.[2]

Experimentation in this area is deepening, but mostly for adults. However, several innovative pediatric models exist. For example:

- The Help Me Grow system, a medical home model which was first launched in Connecticut in 1997 and has since been expanded to 28 states, helps states and communities leverage existing resources to ensure children at risk for developmental and behavioral problems are identified through a screening strategy and linked to clinical interventions to address conditions like developmental delays, as well as health-related services to address SDOH.[3]
- The Partners for Kids pediatric accountable care organization at Nationwide Children's Hospital in Ohio partners with existing community services to address SDOH. A cost analysis from 2008 to 2013 found that Partners for Kids' per member per month costs were consistently lower than other Ohio Medicaid managed care organizations (MCOs) as well as the state's Medicaid fee-for-service program.[4] Savings are reinvested into child health programs, such as school-based asthma therapy and increased access to long-acting reversible contraceptives in rural communities.
- Oregon, which has been a leader in encouraging SDOH interventions in its MCOs called Coordinated Care Organizations (CCO), is poised to integrate additional SDOH interventions into its next round of CCO contracts. The new contracts will require CCOs to spend a portion of their net income or reserves on addressing SDOH, such as transportation supports for families with young children.[5] Complementing this strategy, Oregon Governor Kate Brown has proposed

a universal home visiting program to increase school readiness and an investment in substance use disorder treatment that focuses on both parents and children to reduce exposure to adverse childhood experiences.[6]

A second important transformation strategy is to incorporate 2-generational approaches into the pediatric delivery and payment system. Evidence is increasingly pointing to the important role that parental health has on the health of their children.[7] When adults strengthen caregiver skills and are screened and treated for maternal depression or a substance use disorder, children's health outcomes improve.[8,9] Home visiting programs like the Nurse-Family Partnership, and parenting programs, such as HealthySteps and the Triple P-Positive Parenting Program, address the health needs of both children and their parents by encouraging positive parenting, preventing child abuse, promoting child development, and screening for developmental delays and behavioral health conditions.[10–12]

Many of these approaches can be financed in part or in whole through Medicaid. The Centers for Medicare and Medicaid Services clarified in 2016 that maternal depression screening may be paid for as a Medicaid service for the child as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.[13] Maternal depression treatment services directed at the child and mother together can also be claimed as a direct service for the child, regardless of whether the mother is Medicaid eligible. While pediatric offices offer a powerful access point for addressing both children and their caregivers, a 2-generational approach would require significant retooling of the way care is delivered for many practices.

A third area of focus for transforming the pediatric health care system is to tailor financing and payment models to the pediatric population. As noted, when investments are made in Medicaid on behalf of children, health care savings are likely to accrue but often over a long horizon and much of the savings will be realized by service/education programs outside of the traditional health care arena (this is often referred to as the "wrong pockets" issue). A health plan can be incentivized to invest in SDOH for high-need adults through a more mainstream managed care financing reform, such as through shared savings or a global budget. But for children, those types of incentives are less effective because of timing and the "wrong pockets" issue. A cross-sector investment strategy – likely requiring state engagement – is required to complement other financing strategies.[14]

Cross-sector investment strategies also require a broader view of the goals and therefore the metrics used to move pediatric delivery reform forward. To date, quality metrics have focused on ensuring the delivery of basic pediatric care, for example, by measuring immunization rates and asthma medication adherence. To incentivize health systems to take a population-based approach and coordinate with early childhood sector partners, some states are considering measures such as school readiness. Only 48% of children in low-income families in the United States are ready for kindergarten by age 5, compared to nearly 75% of children in middle- to high-income families.[15] Oregon and New York have both formed workgroups to recommend Medicaid quality measures around school readiness.[16,17]

The same "wrong pockets" issue that needs to be addressed at the state level arises at the federal level. Largely operating out of the public view is the federal budget neutrality "rule" governing Medicaid waivers that drives significant financing at the federal level. This rule requires that new federal Medicaid investments through waiver authority must not only be budget neutral to the federal government but also budget neutral to Medicaid. That is, investments must be offset by federal Medicaid savings. These rules, which are neither in statute nor regulation, could be revised to allow investments in Medicaid to be offset by projected savings in other federal expenditures, such as juvenile justice, early intervention and childhood education, child welfare, and K-12 education.

Two emerging models – 1 at the federal level and 1 at the state level – have the potential to move pediatric delivery and payment transformation forward. At the federal level, the new Center for Medicare and Medicaid Innovation (CMMI) Integrated Care for Kids model is the first CMMI initiative to specifically focus on child- and family-centered delivery and payment reforms. The model aims to integrate care across behavioral, physical, and other health-related social services and community-based child providers, while also sharing accountability for cost and outcomes.[18] CMMI plans to award grants to up to 8 states.

At the state level, North Carolina's new managed care delivery system is seeking to achieve major transformation in care delivery and financing with a focus on children through, among other initiatives, advanced medical homes, enhanced care management, and new "healthy opportunity" regional pilots. Seeded with a new federal and state investment of up to $650 million, the pilots will work with the MCOs and care managers to provide SDOH services that go beyond referrals to address food, housing, and transportation needs as well as interpersonal violence and toxic stress.[19] Pilot services will be targeted to Medicaid child and adult enrollees who meet certain physical/behavioral need-based criteria and social risk factors. Qualifying criteria for children include, but are not limited to, a positive maternal depression screen at an infant well-visit, adverse childhood experiences, or enrollment in foster care. Over time, payment for these SDOH services will increasingly be linked to outcomes.

CONCLUSIONS AND RECOMMENDATIONS

As the source of health coverage for nearly 4 out of 10 children in the United States, including 8 out of 10 of all low-income children, Medicaid is the key platform upon which to transform children's coverage.[20] But because children are not little adults, we cannot rely on payment and delivery reforms that have been designed for adults. The development and implementation of integrated care

delivery and financing models must thoughtfully and intentionally account for children's physical, mental, social, and emotional health in order to see true transformation in children's health and well-being.

Emerging (and some longstanding) models provide a helpful roadmap for further transformation. The following recommendations build on promising strategies, but these strategies must be brought to scale to have the necessary impact.

- Broaden the concept of medical homes to include interventions aimed at addressing nonmedical but health-related needs,
- Incorporate 2-generational approaches into the care delivery model, and
- Identify funding sources to support investments in children's wellbeing that are not dependent on an immediate "return on investment."

It's all doable, if we don't forget the kids.

REFERENCES

1. Tyler ET, Hulkower RL, Kaminski JW. Behavioral Health Integration in Pediatric Primary Care: Considerations and Opportunities for Policymakers, Planners, and Providers. Milbank Memorial Fund; March 2017. https://www.milbank.org/wp-content/uploads/2017/03/MMF_BHI_REPORT_FINAL.pdf. Accessed November 15, 2018.
2. Heckman J. Investing in Disadvantaged Young Children is Good Economics and Good Public Policy. Washington, D.C.: Testimony Before the United States Congress Joint Economic Committee; June 27, 2007.
3. Help Me Grow. https://helpmegrownational.org/what-is-help-me-grow/. Accessed November 15, 2018.
4. Nationwide Children's Hospital. Partners for Kids, Nationwide Children's Hospital Demonstrate Cost Savings and Quality as Pediatric ACO; February 17, 2015. https://www.nationwidechildrens.org/newsroom/news-releases/2015/02/partners-for-kids-nationwide-childrens-hospital-demonstrate-cost-savings-and-quality-as-pediatric. Accessed November 15, 2018.
5. Oregon Health Policy Board. CCC 2.0 Recommendations of the Oregon Health Policy Board. Oregon Health Authority; November 21, 2018. https://www.oregon.gov/oha/OHPB/CCODocuments/2018-OHA-CCO-2.0-Report.pdf. Accessed February 21, 2019.
6. Brown K, Edlund T. Health Care for All: Sustaining the Oregon Model of Health Care Coverage, Quality, and Cost Management. State of Oregon Office of the Governor; September 7, 2018. https://www.oregon.gov/gov/policy/documents/health%20care%20agenda-governor%20kate%20brown.pdf. Accessed January 5, 2019.
7. American Academy of Pediatrics. Bright Futures Guidelines; February 2017. https://brightfutures.aap.org/Pages/default.aspx. Accessed November 15, 2018.
8. Center on the Developing Child at Harvard University. From Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families; 2016. https://developingchild.harvard.edu/resources/from-best-practices-to-breakthrough-impacts/. Accessed November 15, 2018.
9. Guevara JP, Mandell D, Danagoulian S, et al. Parental depressive symptoms and children's school attendance and emergency department use: a nationally representative study. *Matern Child Health J*. 2013;17:1130–1137. https://doi.org/10.1007/s10995-012-1109-5.
10. Nurse-Family Partnership. https://www.nursefamilypartnership.org/. Accessed November 15, 2018.
11. Zero to Three. HealthySteps. https://www.healthysteps.org/. Accessed November 15, 2018.
12. Triple P: Positive Parenting Program. https://www.triplep-parenting.com/us/triple-p/. Accessed November 15, 2018.
13. Centers for Medicare and Medicaid Services. Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children. https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf. Accessed January 2, 2019.
14. Crumley D, Pierre-Wright M. For example, Massachusetts is risk adjusting its ACO payment methodology for housing stability and neighborhood stress score; see, Addressing Social Determinants of Health Through Medicaid Accountable Care Organizations. Center for Health Care Strategies; April 18, 2018. https://www.chcs.org/addressing-social-determinants-health-medicaid-accountable-care-organizations/. Accessed November 15, 2018.
15. Isaacs J. Starting School at a Disadvantage. Brookings Center on Children and Families; March 2012. https://www.brookings.edu/wp-content/uploads/2016/06/0319_school_disadvantage_isaacs.pdf. Accessed January 31, 2019.
16. Oregon Health Authority Office of Health Analytics. Health Aspects of Kindergarten Readiness Technical Workgroup. https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/KR-Health.aspx. Accessed January 31, 2019.
17. New York State Department of Health. First 1000 Days on Medicaid Initiative. https://www.health.ny.gov/health_care/medicaid/redesign/first_1000.htm. Accessed January 31, 2019.
18. Centers for Medicare and Medicaid Services. Integrated Care for Kids (InCK) Model; August 23, 2018. https://www.cms.gov/newsroom/fact-sheets/integrated-care-kids-inck-model. Accessed November 15, 2018.
19. Centers for Medicare & Medicaid Services. North Carolina Medicaid Reform Demonstration Waiver and Expenditure Authority and Special Terms and Conditions; October 19, 2018. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf. Accessed November 15, 2018.
20. U.S. Census Bureau. 2017 American Community Survey 1-Year Estimates: Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months of Age; 2017. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk. Accessed January 31, 2019.