Alternative Payment Model Framework for HealthySteps

HealthySteps National Office Policy and Finance Team

Overview

What is an Alternative Payment Model (APM)?

As health care financing trends move from paying for volume to paying for value, states and health plans continue to move away from traditional fee for service payment mechanisms, particularly for adult-focused chronic conditions, and are now considering how to structure APM arrangements in pediatric settings.[1] Generally, the goals of APMs include both increasing the quality of care and reducing the cost of services.[2] Given that children, especially those ages birth to three, are traditionally a low-cost population, payers have struggled to identify how to design and implement APMs for children's primary care.[3]

Why develop an APM for Early Childhood Pediatrics?

Pediatric primary care is the only system in the entire country that reaches nearly all young children and their families.[4] No other system has the same consistent and positive connection to families, their young children, and their communities. Comprehensive pediatric primary care requires providing services to young children *and* their caregivers. While this may initially appear to be outside the scope of pediatrics, one need only consider a visit focused on sleep training of an infant to reflect upon the ideal focus of the intervention as the dyad/family, not just the child. Pediatric practices should provide promotion, prevention and early intervention services to the child, caregiver, and the family, mitigating the need for more intensive and costly interventions later in life. These *family-oriented* (dyadic) services are the bedrock of high quality pediatric primary care. Though this type of enhanced pediatric primary care is the gold standard, these services are difficult to financially sustain given the structure of the current payment system.

A pediatric-focused APM can help to increase focus on the early years and incent providers to address child and caregiver needs that go beyond physical health, within a universally accessed setting. By providing an array of preventive services for both children and their caregivers (e.g., preventive behavioral health, universal screening for child and caregiver concerns and team-based care) there is a unique opportunity for payers to fund holistic supports to caregivers in the context of their young children's pediatric visits, and to drive cost savings.[5] Given the frequency of primary care use by young children - 13 well-child visits in the first three years of life – an APM that includes services to caregivers will encourage primary care providers to deliver preventive high-quality services, including integrated behavioral health services and health-related social needs supports. Providing these interventions in the context of pediatric primary care has the potential to drive significant improvements in health and to impact total cost of care for the family unit, bringing an innovative dyadic promotion and prevention-oriented approach that distinguishes itself from traditional pediatrics.

Why is an APM for Pediatrics More Important Today than Ever Before?

A well-designed APM should aim to achieve 'value-based care' and the quadruple aim of improved patient experience of care, improved health of the population, improved clinical experience, and reduced cost of care.[6] As the COVID-19 pandemic continues to unfold, there are many unknowns about the long-term impacts on the

physical and mental health of children and adults. Data already show declines in children's and caregiver's well-being. A recently released report in the Journal of Pediatrics states, "COVID-19 has had a substantial impact on the well-being of parents and children. As policymakers consider additional measures to mitigate the health and economic effects of the pandemic, they should consider the unique needs of families with children." According to the authors, since March 2020, "27% of parents reported worsening mental health for themselves, and 14% reported worsening behavioral health for their children."[7] Such increased physical and behavioral health needs, paired with ongoing or new family needs including sudden job loss and food and housing insecurities, have the potential to add significant costs to state Medicaid and cross-system partner agencies. An APM could serve to incent providers to offer critical comprehensive services to children and caregivers in the pediatric primary care setting, addressing needs in a timely manner, while bending the cost curve in an era when health expenditures are on the rise.

Leveraging HealthySteps for a Pediatric-Focused APM

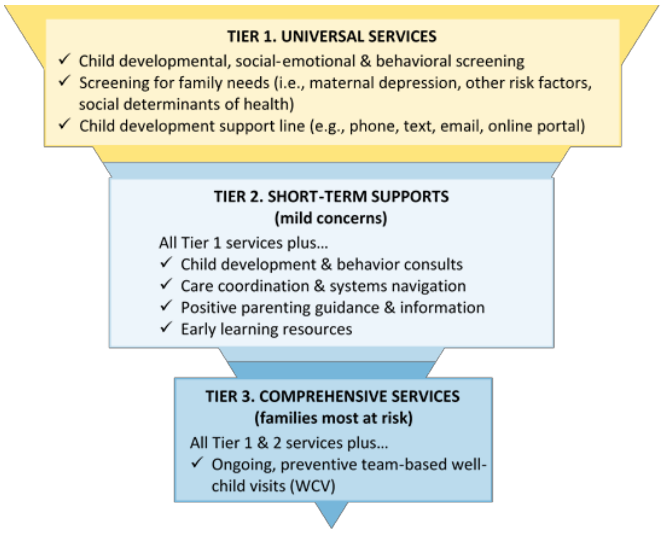
HealthySteps, a program of ZERO TO THREE, is an evidence-based pediatric primary care program that operationalizes prevention-oriented comprehensive pediatric primary care services to children and their families in the earliest years of life. The evidence-based model, paired with fidelity monitoring, makes HealthySteps well-positioned for an APM. This framework was developed by the HealthySteps National Office to support states, health plans, health systems, and providers in developing an APM that supports a payment and measurement structure based on the dyadic HealthySteps model. The framework was informed by subject matter expert input, national publications, and HealthySteps state-specific policy and sustainability work.

Three elements of HealthySteps make it well-positioned for an APM: 1) a clear set of eight core components organized into three risk-stratified service delivery tiers that are responsive to each family's needs, 2) a robust evidence-base with demonstrated dyadic outcomes, and 3) quantifiable, annualized cost savings to state Medicaid agencies. Additionally, National Office fidelity monitoring ensures that all eight core components of the model are delivered as intended within three years of initial model implementation.

HealthySteps Evidence Base:

While HealthySteps has compelling outcomes across several areas of interest to payers, the following key findings can help inform the APM design:

- Children who participate in HealthySteps are more likely to attend recommended well-child visits and receive timely screenings and vaccinations and have fewer injury-related emergency department visits.
- Their parents are more likely to: receive information on community resources and services; provide infants with age-appropriate nutrition; sustain breastfeeding for longer;



adhere to child safety guidelines; use positive parenting strategies; and engage in early literacy-enhancing practices with their children.
- Families report higher levels of satisfaction with their pediatric care than other parents.
- Physicians report improved provider experiences, including that HealthySteps fosters a team-based approach to care and enhances their ability to effectively meet the needs of the children and families they serve.

HealthySteps Annualized Cost Savings:

The HealthySteps National Office and Manatt Health partnered to develop a return on investment (ROI) model that calculates annualized cost savings to state Medicaid agencies based on dyadic HealthySteps services. Cost-savings are attributed to the following child- and adult-focused interventions:

Child-Focused Interventions	Adult-Focused Interventions
1. Improving well-child visit and immunization rates ➢ Savings via averted outpatient/ED visits due to influenza immunization 2. Promoting earlier access to dental health care ➢ Savings per child via lower dental spending from being an "early starter" 3. Encouraging appropriate use of care for ambulatory sensitive conditions ➢ Savings per visit converted from ED to office/FQHC-based	1. Providing screening and referrals to care for postpartum maternal depression ➢ Savings per mother-child dyad affected by postpartum depression 2. Increasing support for continued breastfeeding ➢ Savings per averted outpatient/ED visits due to reductions in ear infections related to increased breastfeeding support 3. Providing counseling and referrals to support services for intimate partner violence ➢ Savings per improvement in severe intimate partner violence cases 4. Providing family planning consultations and referrals for families at risk of unhealthy birth spacing ➢ Savings per unintended pregnancy/birth averted, maternity through month 60 5. Providing counseling and referrals for smoking cessation services ➢ Combined child and adult medical cost savings over three years per individual who quit smoking

These cost savings data can help inform APM calculations. In addition to the short-term cost-savings demonstrated in the Manatt Health model, evidence suggests that investments made in the earliest years of life generate robust returns on investment and these early childhood investments have been shown to yield greater returns when evaluated over a longer period, even beyond the health sector.[8] Long-term cost savings are attributable to reductions in the need for developmental and special education services, prevention of chronic disease, reduced juvenile justice involvement, and positive outcomes such as higher educational attainment.

HealthySteps APM Design Considerations

The overarching goal of this framework is to define an APM that accurately reflects the level of enhanced, comprehensive care being provided by pediatric primary care practices that implement HealthySteps. Important components for consideration when designing an APM for young children are outlined below.

Key Considerations:

Who Will This Framework Serve?

This framework is designed to apply to all children ages birth to three in a primary care practice and their caregivers. Within the HealthySteps model, children/families are risk-stratified based on their needs. Children with significant medical complexity and/or special health care needs are not included in this proposed APM framework; however, it could be customized to develop an APM for a specific population such as children with special health care needs. This framework is also designed to be implemented in practices that employ a licensed behavioral health clinician as their HealthySteps Specialist (e.g., licensed clinical social worker, child psychologist, etc.), allowing for the delivery of short-term behavioral health interventions to children and caregivers in the primary care setting as needs are identified.

What Needs Are Addressed by the Framework?

Child well-being:

- Preventive health care
- Development
- Social-emotional and behavioral health
- Early learning
- Positive parenting
- Oral health
- Early nutrition

Caregiver well-being:

- Breastfeeding
- Maternal mental health
- Access to preventive health care
- Healthy birth spacing
- Tobacco use

Family well-being:

- Health related social needs influenced by social determinants of health (SDOH) (e.g., intimate partner violence, food insecurity, housing stability, transportation needs, and substance use)

What Outcome Areas Will the Framework Aim to Affect?

Improved health of the population:

- Well-child visit frequency
- Childhood immunization

- Developmental screening
- Social-emotional/behavioral screening
- Screening for social needs related to SDOH
- Closed-loop referrals
- Pediatric oral health
- Postpartum care
- Postpartum maternal depression

Improved patient experience of care:

- Patient satisfaction

Improved clinical experience:

- Provider satisfaction

Decreased total cost of care related to:

- Well-child visit and immunization rates
- Pediatric oral health
- Appropriate use of outpatient and emergency services
- Breastfeeding
- Postpartum maternal depression
- Intimate partner violence
- Healthy birth spacing
- Smoking cessation

HealthySteps APM Payment Approach

While there are many different approaches states and payers can consider when developing an APM for a pediatric primary care prevention program like HealthySteps, this framework recommends a specific payment structure which can be customized to align with site/state specific initiatives. The HealthySteps National Office recommends a phased approach that initially utilizes fee for service payments to allow time for data collection and infrastructure-building to help inform the structure of a long-term APM payment.

Phase I:

The payment structure proposed for Phase I includes support for initial costs incurred by a participating HealthySteps site, and fee for service payments to support key program elements that are not traditionally reimbursable through state Medicaid programs:

Initial payment: A one-time payment to HealthySteps sites to support infrastructure costs such as enhanced electronic health record capacity to track universal screenings and referral follow up and provide additional data supports and bolster practice transformation efforts – all necessary components to operationalize a new model of care.[*]

[*] This payment does not cover the cost of the one-time HealthySteps Institute for new sites and associated salary and fringe benefit costs of the HealthySteps Specialist(s).

Reimbursement for universal screenings: Separate payments to providers for each administered child, caregiver, and family-focused (health related social needs and SDOH) universal screening, all recommended by the AAP Bright Futures Guidelines.[9] Reimbursement for each screening is critical to ensure screenings are completed, child/family needs are addressed, and utilization data is collected to help inform a future capitated payment.

Separate reimbursement for dyadic prevention, short-term behavioral health interventions, and care coordination services using expanded billing/coding opportunities: Many of these services are not currently reimbursed by state Medicaid agencies and health plans without a patient diagnosis. Using innovative fee for service-based payment approaches to support the delivery of these services in pediatric primary care provides an opportunity to gather cost and utilization data to inform a more comprehensive payment in Phase II to more broadly encompass the dyad.

Examples of how payers can separately reimburse for dyadic prevention, short-term behavioral health interventions, and care coordination services include:

- Reimbursement for H0025 (preventative psychosocial intervention) to enable delivery and payment of behavioral health prevention education services. H0025 would allow behavioral health clinicians to provide behavioral health well-child visits aligned with medical well-child visits and would achieve parity for preventive/surveillance behavioral health services. H0025 could be used with a Z03.89 diagnosis deferred or alternatively a well-child visit code or behavioral health modifier to indicate a team-based well-child visit was conducted.

- Allow codes and established at-risk conditions to be used as the primary diagnosis for short-term behavioral health prevention services (e.g., family therapy CPT codes 90846 and 90847) targeting dyadic behavioral health services (including caregiver(s) and overall family well-being).

- Reimburse for 99484 when billed by a behavioral health provider for care coordination services using Z-codes as the primary diagnosis.

Phase II:

Fee for service-based payments made in Phase I would be used to inform a Phase II payment. Phase I payments would end once sufficient data is collected. Utilization data gathered on services provided and reimbursed in Phase I should be used to build a capitated payment. The *per member per month (PMPM)* payment should be *comprehensive, age-based, and risk-stratified (based on the HealthySteps model service tiers),* covering the provision of universal screenings by the practice and Tier 2 and Tier 3 services provided by the HealthySteps Specialist, including health promotion, interdisciplinary team-based well-child visits, care coordination, and preventive behavioral health services based on family needs.

Other potential payment options that could be implemented in Phase II include:

- *Performance incentive payments:* Incentives and rewards for high-performance on quality metrics as determined by the state and/or payer (recommended quality measures are outlined below).

- *Shared savings:* Practices can share in demonstrated cost-savings calculated using the Manatt Health short-term cost-savings model, matched against Medicaid claims data.

APM Quality Measurement

Measuring the quality of services delivered and their impact is critical to a successful APM.[3] Medicaid agencies and health plans already utilize nationally validated measures that can help assess the impact of HealthySteps related services – there may also be opportunities to utilize additional measures to fill gaps in national measures.

Relevant Nationally Validated Quality Measures:

Based on the data collected in Phase I, practices should be assessed on quality metrics tied to performance incentive bonus payments and eligibility for shared savings. Recommendations for nationally validated measures are below.

- Well-Child Visits in the First 15 Months of Life (Child Core Set/Scorecard)
- Developmental Screening in the First Three Years of Life (Child Core Set)
- Percentage of Eligibles Who Received Preventive Dental Services (Child Core Set/Scorecard)
- Childhood Immunization Status, age 2 (HEDIS/Child Core Set)
- Prenatal and Postpartum Care: Postpartum Care (HEDIS/Adult Core Set)
- Postpartum Depression Screening and Follow-up (HEDIS)
- Expanded Consumer Assessment of Healthcare Providers & Systems (CAHPS®) 3.0 Child Survey[10]
    - Experience Measures
        - ✓ Provider explained things in a way that was easy to understand
        - ✓ Provider listened carefully to enrollee
        - ✓ Provider showed respect for what enrollee had to say
        - ✓ Provider spent enough time with enrollee

Additionally, areas where there are gaps in available national measures, but where there are important quality outcomes associated with HealthySteps, are also provided for consideration.

- Child social-emotional/behavioral health screening and follow-up
- Screening for needs related to SDOH and follow-up
- Overall referral coordination and follow-up

APM Implementation Considerations

This APM framework reflects the enhanced preventive primary care services offered to children and their families in HealthySteps sites. There are many practice-specific, state-specific, and payer-specific factors that may impact APM design and payment amounts. Key practice characteristics and state/payer characteristics that should also be considered when implementing an APM to support HealthySteps service delivery include:

Practice Characteristics:

- *Available infrastructure:* Practices will need robust data tracking systems to capture quality metrics and child and family outcomes to participate in the APM. Medicaid agencies and other payers should consider ways to support practices in implementing needed technologies, including the initial practice payment in Phase I.

- *Practice structure:* Health systems that serve both children and adults may be able to more easily implement an APM that uses a dyadic approach, allowing more complete EMR documentation on the dyad since both child and adult are eligible patients.

- *Cross-sector partnership:* The quality measures utilized in this framework are all health care sector-specific metrics. Cross-sector partnerships that braid and blend funding and align financial incentives can impact longer-term outcomes and cost savings and will go beyond Medicaid-only metrics.[1] The potential for impact on child and caregiver outcomes may be much greater with a cross-sector, longitudinal approach.

State/Payer Characteristics:

- *State Medicaid expansion:* Does the state provide Medicaid coverage to caregivers past six weeks postpartum? If not, it may be difficult to justify dyadic savings and an APM given that the state and other insurers are not responsible for service delivery and total cost of care for caregivers under the Medicaid state benefit.

- *State Medicaid program design:* Does the state have Medicaid managed care? If yes, is there a behavioral health carve out? If the APM is implemented at the health plan level, cost savings will vary based on whether behavioral health services are carved-out.

- *Managed care enrollment:* Are both the child and the caregiver typically enrolled in the same health plan? Cost savings calculations must consider caregiver insurance status.

- *Accountability:* Based on state Medicaid program structure, accountability for cost and quality live in different places. In most cases, individual practices or health systems are accountable for the quality, costs, and outcomes of this APM model.

- *Accountable care organizations (ACOs):* Is there a Pediatric ACO program or similar entity active in the state? ACO involvement may impact the way a state or payer approaches total cost of care and accountability.

Conclusion

Now, more than ever, with the impacts of the COVID-19 pandemic and subsequent economic downturn, states and health plans have an opportunity to achieve the quadruple aim of improving outcomes for young children, caregivers, and their families, saving money, and increasing patient and provider satisfaction by creating a true population health focused APM for young children. By explicitly focusing on prevention, screening and follow-up, and trusted relationships, the HealthySteps model can help create the foundation for creating an innovative, dyadic and early childhood pediatric primary care APM.

Citations

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