

Value-Based Payment to Support Children's Health and Wellness: Shifting the Focus from Short-Term to Life Course Impact

EXECUTIVE SUMMARY

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Health care payers, providers, and policymakers are increasingly pursuing value-based payment (VBP) to improve the quality of care and population health while controlling rising health care costs.¹ VBP models include a range of provider payment arrangements that move away from fee-for-service (which pays providers based on the volume of services they provide) to explicitly incentivize value and high-quality care.² When implemented in Medicaid, VBP programs often include children and adults in the same model, though these models may not fully account for children’s distinct health needs.^{3,4,5} Of particular concern, cost-saving incentives built into many VBP programs may drive care delivery reforms for adults with complex health and social needs while not adequately incentivizing a focus on pediatric populations that tend to be healthier and have lower health care costs. Childhood is an important period of rapid development, and investing in childhood health has the potential to impact health and social outcomes later in life and generate societal savings in the long run.^{6,7} With 38 percent of children in the United States covered by Medicaid, there is a particular opportunity for states to leverage and adapt VBP models to ensure an appropriate focus on improving children’s health.

In 2018, Massachusetts established the MassHealth Accountable Care Organization Program (ACO Program), a VBP effort supporting the state’s commitment to improving the quality and member experience of care. The program integrates the full spectrum of health services—including behavioral health (i.e., mental health and substance use disorder services). MassHealth defines accountable care organizations (ACOs) as “networks of physicians, hospitals, and other community-based health care providers” that are financially accountable for the cost and quality of care for MassHealth members.⁸ As with many VBP programs across the country, the MassHealth ACO Program is designed to serve both children and adults. As of April 2019, approximately 50 percent of MassHealth members eligible for ACO enrollment were children.⁹ Many Medicaid ACOs in the state provide care to both children and adults, and one ACO—Boston Children’s Accountable Care Organization—serves only a pediatric population.

As MassHealth and other stakeholders assess the early impacts of ACOs and plan for the evolution of the ACO Program, there may be ways to adapt the ACO model to better account for the distinct health and social needs of the pediatric population. MassHealth has identified investing in pediatric care as an explicit goal in planning for the future of the ACO Program and is engaging stakeholders on this issue, including the Child and Adolescent Health Initiative (CAHI), a multi-sector workgroup supported by the Massachusetts Chapter of the American Academy of Pediatrics and aimed at identifying opportunities to better serve children in Medicaid. CAHI recently released a report outlining recommendations to strengthen the support for pediatric care in MassHealth.^{10,11}

1 Institute for Healthcare Improvement. “IHI Triple Aim Initiative, Better Care for Individuals, Better Health for Populations, and Lower Per Capita Costs.” Available at: www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx.

2 Health Care Payment Learning & Action Network. “Alternative Payment Model: APM Framework.” 2017. Available at: <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.

3 C.A. Wong, J.M. Perrin, M. McClellan. “Making the Case for Value-Based Payment Reform in Children’s Health Care.” *JAMA Pediatrics*, 172, No.6 (2018): 513–514. Available at: <https://doi.org/10.1001/jamapediatrics.2018.0129>.

4 J.L. Raphael and A.P. Giardino. “Accounting for Kids in Accountable Care: A Policy Perspective.” *Clinical Pediatrics*, 52, No. 8, (2013): 695–698. Available at: <https://doi.org/10.1177/0009922813482181>.

5 P. Flanagan, P.M. Tighe, and J. Perrin. “The Value Proposition for Pediatric Care.” *JAMA Pediatrics*, 173, No. 12 (2019):1125–1126. Available at: <https://doi.org/10.1001/jamapediatrics.2019.3486>.

6 Center on the Developing Child. Harvard University. “In Brief: The Foundations of Life Long Health.” Available at: <https://46y5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2015/05/inbrief-programs-update-1.pdf>.

7 A. Chester and J. Alker. *Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid*. Georgetown University Health Policy Institute, Center for Children and Families, July 2015. Available at: https://ccf.georgetown.edu/wp-content/uploads/2015/08/Medicaid-at-50_final.pdf.

8 MassHealth, Executive Office of Health and Human Services. “MassHealth Partners with 17 Health Care Organizations to Improve Health Care Outcomes for Members.” August 17, 2017. Available at: www.mass.gov/news/masshealth-partners-with-17-health-care-organizations-to-improve-health-care-outcomes-for.

9 R.W. Seifert and C. Torri. *What to Know About ACOs: The Latest on MassHealth Accountable Care Organizations*. Blue Cross Blue Shield of Massachusetts Foundation. September 2019. Available at: www.blucrossmafoundation.org/publication/what-know-about-acos-latest-masshealth-accountable-care-organizations.

10 Massachusetts Child and Adolescent Health Initiative. “Moving to the Vanguard on Pediatric Care: Child and Adolescent Health Initiative Recommendations for the MassHealth Section 1115 Waiver Renewal.” September 2020. Available at: <https://mcaap.org/2018/wp-content/uploads/Massachusetts-Child-and-Adolescent-Health-Initiative-Report-to-MassHealth-9-2020.pdf>.

11 While this report is more narrowly focused on VBP than is the CAHI report, findings from this environmental scan are well aligned with the workgroup report’s themes such as promoting family-centered care, addressing social needs and health equity, and increasing investment in pediatric care to address children’s distinct needs.

To inform Massachusetts policymaker and stakeholder efforts to better incorporate children's health needs into the payment models in the MassHealth ACO Program, the Massachusetts Medicaid Policy Institute (MMPI), a program of the Blue Cross Blue Shield of Massachusetts Foundation, enlisted the Center for Health Care Strategies (CHCS) to examine relevant lessons from states and providers across the country. This report does not recommend a new, pediatric-specific payment model for Massachusetts but rather shares examples and lessons from existing VBP models and child health initiatives. To inform this report, CHCS performed an environmental scan, including a search of peer-reviewed and gray literature and interviews with 18 subject matter experts; compiled information on VBP models across the country; identified key themes related to implementing VBP models for children; and identified a set of policy and program considerations to help Massachusetts design an approach to better meet children's needs.

The environmental scan found that few existing VBP models are specifically designed to serve pediatric populations, as many state-designed VBP arrangements, like those in Massachusetts, include both children and adults. Many existing pediatric-specific models are individually negotiated arrangements between pediatric providers and managed care organizations (MCOs), as opposed to statewide or state-defined arrangements. CHCS' research identified four main VBP approaches for delivering value-based care to the pediatric populations: (1) ACOs covering a broad range of services for children; (2) primary-care VBP models for children; (3) episode-of-care programs focused on specific pediatric conditions or procedures over a defined period of time; and (4) the Center for Medicare and Medicaid Innovation's Integrated Care for Kids Model, which aims to support states and local providers in improving child health, in part by creating pediatric VBP models.

Since Massachusetts has an existing ACO model, these approaches may not all be immediately applicable. However, insights from these models are helpful for understanding the challenges and opportunities in creating a VBP model focused on serving the pediatric population. Additionally, literature on the effectiveness of VBP models for pediatric populations is limited, and more research is needed to determine the extent to which VBP can result in quality improvement and cost savings for children's health services. These findings suggest there is great opportunity for Massachusetts to serve as a leader in this field, learning from the limited experience to date while testing new approaches that consider the health and social needs of children and their families.

Based on the research, CHCS identified seven key themes related to designing VBP models for children, most of which stem from the fundamental differences between pediatric and adult populations:

1. **There are limited opportunities for short-term, direct health care cost savings among pediatric populations compared to adult populations.** The pediatric population is generally healthier than the adult population, and health care spending is lower for child than adult populations. While there may be opportunities for short-term savings among some pediatric populations, VBP models that incentivize short-term savings may not optimally serve most pediatric patients.
2. **Investment in child well-being may support lifelong wellness and result in a long-term return on investment for society.** Despite the limited opportunities for short-term health care cost savings for children, there is significant opportunity for investments in pediatric care to support health and wellness across the life span. Investments in child health and well-being may yield a long-term return on investment for society, including in sectors outside health care.
3. **To promote long-term health and health equity, the health system needs to focus more on upstream prevention.** Multigenerational approaches to care, which focus on the health and social needs of the whole family, and coordination with sectors outside health care, such as social services, could have a major impact on children's short-term social and educational needs as well as their long-term health. An increased focus on upstream factors is also necessary for reducing entrenched health inequities.
4. **VBP models that emphasize investment in children's health and prospective payment offer the potential to better support child wellness.** Because pediatric providers cannot rely on short-term savings to offset the

costs associated with investing in new care models or quality improvement initiatives, models with upfront, flexible payment mechanisms and/or new funding streams may be particularly beneficial. Prospective payment models (offering predictable, upfront payments that are not dependent on specific services rendered) that include funding above baseline fee-for-service rates may allow providers more flexibility in how care is delivered, provide additional opportunity to invest in quality improvement, and potentially support long-term improvements in outcomes and cost savings, including in sectors outside health care.

5. **Challenges in developing VBP models serving children may differ between pediatric-only providers and providers serving both children and adults.** Elements of VBP models designed to serve both adults and children, such as quality measures and risk adjustment, may need to be adapted to reflect the needs of pediatric-only populations.
6. **There is an opportunity to develop more meaningful and outcomes-based quality measures for children.** Existing quality metrics used to measure success in VBP programs may not be adequate to measure health outcomes for pediatric populations. While metrics focused on primary and preventive care are common, increased use of metrics focused on care for children with complex needs, on long-term health outcomes, and/or on health-related social needs (HRSN) may be helpful.
7. **VBP alone is not enough to address funding and data-sharing barriers to upstream interventions.** While VBP design elements such as increased investment, prospective payment, and new quality measures can support upstream interventions, VBP alone cannot address some of the entrenched barriers to multigenerational care models and tackling HRSN. Supporting child health and development may also require resources beyond what is currently feasible within the scope of a Medicaid VBP program, such as cross-agency collaboration within state government and addressing data-sharing challenges.

With these insights in mind, CHCS' analysis found several opportunities for Massachusetts to be a leader in better serving children within and alongside the framework of the existing ACO Program. Four policy and program considerations for the state are below.

1. **Define Massachusetts-specific pediatric care delivery priorities and accompanying quality measures, including those related to health equity.** MassHealth and its stakeholders should identify pediatric care delivery priorities to be supported through payment reform, including priorities related to advancing health equity in the pediatric population. This aligns with MassHealth's broader priorities in planning for the future of the ACO Program, since the state has identified overarching goals that include making reforms and investments in pediatric care and advancing health equity, particularly in the context of HRSN, maternal mortality, and justice-involved populations.¹² Stakeholders should also define a vision for developing longer-term, outcomes-based quality measures to support these child health goals.
2. **Explore a payment model for pediatric populations that emphasizes quality improvement and long-term return on investment.** MassHealth could consider adapting aspects of the MassHealth ACO payment model for pediatric providers to ensure that children's needs do not get overlooked within the broader ACO model. For instance, MassHealth could implement a new payment model or funding streams that incentivize quality improvement over short-term savings. This aligns with MassHealth's initial thinking about the future of the ACO Program, since MassHealth is considering a primary care capitation model, which would pay primary care practices a lump sum each month to care for each ACO enrollee.¹³ This kind of upfront payment could give pediatric providers the flexibility to invest in improvements in care delivery despite low expectations for short-term cost savings.

¹² MassHealth, Executive Office of Health and Human Services. "MassHealth 1115 Demonstration: Strategy for 2022 Extension." July 2021. Available at: www.mass.gov/doc/july-1115-demonstration-deck/download.

¹³ Ibid.

3. **Identify additional opportunities to incentivize, align, and sustain ACO approaches to integrating health and social services for pediatric populations.** Experiences from other states suggest that cost-savings incentives may result in ACOs focusing on addressing the health-related social needs of adults rather than those of children. MassHealth may consider opportunities to assess and guide ACOs to specifically invest in and support pediatric HRSN. This is consistent with the vision MassHealth recently laid out for the next iteration of the ACO Program, which suggests it plans to require ACOs to target a portion of Flexible Services programming to children and youth.¹⁴ MassHealth and its stakeholders may also consider how to further support cross-sector collaborations across domains such as health, education, child care, child welfare, and the justice system to better address HRSN—with an objective of eventually enhancing coordination of funding across different state agencies to address cross-sector goals.
4. **Identify and support provider practice changes to implement a multigenerational approach to pediatric care.** MassHealth and its stakeholders should identify practice changes to shift care delivery to a multigenerational care model with increased coordination between adult and pediatric providers, screening for family needs, family-centered care planning, home visiting, and coordinating or co-locating behavioral health and social services. MassHealth and its stakeholders can also consider how to support these practice changes through VBP incentives and technical assistance supports.^{15,16}

As MassHealth continues to build on and refine its ACO Program, it is working to ensure that children are adequately prioritized and that reform efforts recognize their particular health and social needs. Ultimately, adapting VBP for pediatric populations requires recognition that pediatric VBP models should not be focused on short-term savings but rather on improving quality of care to support child health and long-term population health outcomes. Developing VBP models with these elements in mind will require stakeholders to clearly define pediatric care priorities, implement incentives and supports that enable pediatric delivery system improvement, commit to cross-sector collaboration to address HRSN, and begin clearing the path for a multigenerational approach to health care.

¹⁴ Ibid.

¹⁵ Massachusetts Child and Adolescent Health Initiative, op. cit.

¹⁶ National Academies of Sciences, Engineering, and Medicine. *Vibrant and Healthy Kids: Aligning Science, Practice, and Policy to Advance Health Equity*. Washington, DC: The National Academies Press. 2019. Available at: <https://doi.org/10.17226/25466>.

