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April 7, 2017

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Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Blvd.  
Baltimore, MD 21244  
Submitted electronically to: [HealthyChildrenandYouth@cms.hhs.gov](mailto:HealthyChildrenandYouth@cms.hhs.gov)

Re: Request for Information on Pediatric Alternative Payment Model Concepts

Dear Dr. Conway,

We appreciate the opportunity to provide feedback on the Request for Information (RFI) on Pediatric Alternative Payment Model Concepts.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. The Center for Consumer Engagement in Health Innovation focuses on health system transformation and bringing the consumer experience to the forefront of health. The Center works directly with consumer advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers, particularly those that are most vulnerable.

We welcome CMS's effort to make a deeper financial investment in pilots for innovative approaches to children's health. This is an area of tremendous importance as care provided early on can change the trajectory of a child's life. Medicaid and the Children's Health Insurance Program (CHIP) cover more than 45 million children. Kids are not little adults; since they are constantly growing and changing, so are their physical and behavioral health care needs. Therefore, it is important to design care models that focus on the specific needs of children and youth, rather than relying on systems designed for adults. It is further necessary to ensure that models take into account the impact of multigenerational health needs and not address children in isolation.

Any pediatric integrated care system must prioritize and reward prevention. The majority of children's health care is prevention-oriented – yet its return on investment is long-term and difficult to measure. As noted in the RFI, outcomes are more likely to be determined by a child's environment and access to health-adjacent services such as healthy housing, food access and robust education. A final consideration is that children's developmental needs change across the lifecourse and may require different systems approaches with different metrics and cost-savings approaches. Any innovation or systems approach must not consider a child in isolation but rather take into consideration a multitude of factors that influence a child's health opportunity. Only through high-level coordination across social service sectors and

seamless local-level implementation can children be assured the greatest opportunity to develop into strong, productive adults.

## General Comments

### **Ensure Comprehensive Coverage Through Medicaid**

We urge CMS to work to ensure that Medicaid financing meets the needs of children, families and state budgets. Medicaid is a multi-generational program set up to protect our most vulnerable consumers at any stage in their lives. [Studies show](#) that children who have access to continuous health services lead healthier, more productive lives over the long term.<sup>1</sup> Medicaid and the Children's Health Insurance Program (CHIP) provide health insurance coverage to millions of children and maintaining this coverage is a vital first step in advancing any innovative payment and care delivery models for children. Under the current Medicaid program, children have special protections to make sure they have access to the health care they need. These protections include no cost-sharing and access to comprehensive benefits, including Early Periodic Screening, Diagnosis and Treatment (EPSDT), which provides the full range of services children need to help them develop and grow. Any successful innovations, including innovations to pediatric care, rely on a strong Medicaid program, so ensuring the continued state-federal partnership is a necessary first step in improving outcomes and lowering costs. Alongside Medicaid, the Children's Health Insurance Program (CHIP) plays an important role in securing coverage for children in families where coverage is just out of reach. CHIP also directs resources to outreach and enrollment and to pediatric quality research and implementation. Together, Medicaid and CHIP serve as the backbone of care innovation for children.

Pediatric alternative payment models (APM) should meet key principles to ensure that children have access to high quality care and health opportunity at a lower cost. Below we outline principles for pediatric APM approaches to innovation:

### Principles for Pediatric Alternative Payment Models

#### **1. Include A Two (Or More) Generation Approach**

We urge CMS to consider developing pediatric payment and delivery system reform models that address the needs of two or more generations so that these models best address the needs of children and their families. Studies show that toxic stress and adverse childhood experiences have lifelong effects including increased risk for cardiovascular disease, various forms of cancer and depression.<sup>2</sup> Ultimately, exposure to high levels of stress reduces a child's ability to build resilience – or the ability to overcome hardship. Building resilience is not unique to children, but it is particularly important for children to thrive and become healthy adults. Although the causal relationship between economic hardship and adversity is not fully understood, there is a strong relationship. Poor children are more likely to experience adversity than higher income children. There is also a distinct relationship between race and ethnicity and adversity. Black and Hispanic children are more likely to experience adversity than their white peers, and these disparities persist at the highest income levels.<sup>3</sup>

Given the significant impact of adversity on the healthy development and long-term health outcomes of both parents and children, good science and common sense would dictate that any pediatric payment and service delivery models should aim to have positive impacts on both parent and child. Despite the

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<sup>1</sup> Chester, Alisa and Alker, Joan. (2015). Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid. Georgetown Center for Children and Families. Retrieved from [http://ccf.georgetown.edu/wp-content/uploads/2015/08/Medicaid-at-50\\_final.pdf](http://ccf.georgetown.edu/wp-content/uploads/2015/08/Medicaid-at-50_final.pdf).

<sup>2</sup> Shonkoff, JP. et al. (2012). The Lifelong Effects of Early Childhood Adversity and Toxic Stress. American Academy of Pediatrics. Retrieved from <http://pediatrics.aappublications.org/content/129/1/e232.full>.

<sup>3</sup> Slopen, N. et al. (2016). Racial disparities in child adversity in the U.S.: Interactions with Family Immigration History and Income. American Journal of Preventive Medicine. Retrieved from [http://scholar.harvard.edu/files/davidrwilliams/files/child\\_adversity.pdf](http://scholar.harvard.edu/files/davidrwilliams/files/child_adversity.pdf)

challenges of adversity, and resulting toxic stress, research indicates that interventions, such as those that promote a supportive, responsive relationship between parent and child, can reverse the damaging effects of toxic stress. For example, some counties in Washington state incorporated the Filming Interactions to Nurture Development (FIND) program, a video coaching program that helps support positive interaction between caregivers and parents, into their home- visiting programs. Evaluations found that participation was associated with positive outcomes including reductions in parenting stress, increased father involvement, and improvement in child behavior problems.<sup>4</sup>

Interventions that help adults build caregiver skills, relieve economic stress by focusing on job training and financial literacy, and support the health and nutritional needs of pregnant women have the ability to improve children's health outcomes.<sup>5</sup> However, there are several barriers to implementing multi-generational interventions through a pediatric alternative payment model. Parents and other adult caregivers often receive health care from different providers than the children they care for and in some cases are covered by different insurers. In implementing new pediatric alternative payment models, we encourage CMS to think about strategies for aligning with programs and models that also reach caregivers. For example, CMS could find ways to incorporate pediatric practices into existing models, such as the Comprehensive Primary Care Plus (CPC+) model, or explore ways to share "joint accountability" with adult primary care providers on certain targeted adult health measures.

## **2. Ensure Alternative Payment Models Are Tailored the Unique Needs of Children**

By and large, children are healthy, low-cost consumers. For most children and their families, health care is simply prevention; children follow a schedule of well-visits from birth into adolescence with few bumps in the road. Yet for children who do have health challenges, the journey can be complex involving multiple diagnoses, providers and coordination challenges. For example, children who face adversity are more likely to confront mental health challenges and chronic conditions like asthma. Children facing complex medical conditions such as cystic fibrosis or sickle cell have a range of ongoing needs that require pediatric appropriate case management. Due to the heterogeneity of children with special health care need, approaches to bringing down cost while increasing quality must be designed with these challenges in mind. In this effort, CMS should prioritize **risk adjustment** to protect children with special health care needs from cherry picking and **provider compensation designs** to ensure that payment incentives are aligned with chronic care needs and long terms goals including important preventive care such as vaccine administration.

We urge CMS to implement pediatric alternative payment models with these unique circumstances in mind. The goal of these models should be to improve care for children, particularly those with special health care needs, so it is important that payment structures are not designed in a way that would disincentivize providers from enrolling higher risk kids, increase out of pocket costs for families, or prevent children from accessing specialty providers they need to help them manage complex health conditions. Specifically, we ask CMS to consider recommendations advanced by the AAP on ACOs including<sup>6</sup> the need for a pediatric risk-adjustment methodology for special needs children and adequate reimbursement for additional effort required to care for this subpopulation. For example, children with special health care needs require intense care coordination and case management by pediatric-trained case management providers that are able to address the needs of both parent and child. Compensation systems must also recognize and adequately pay for other special elements of pediatric care, such as the administration of vaccines. Successful models include Rhode Island PCMH Kids Initiative that provides supplemental payments to practices that are working to transform into patient-centered medical homes.

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<sup>4</sup>Center on the Developing Child at Harvard University (2016). Filming Interactions to Nurture Development. Retrieved from: <http://developingchild.harvard.edu/innovation-application/innovation-in-action/find/>

<sup>5</sup>Center on the Developing Child at Harvard University. (2016). Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families. Retrieved from <http://www.developingchild.harvard.edu>.

<sup>6</sup>Accountable Care Organizations (ACOs) and Pediatrician: Evaluation and Engagement. American Academy of Pediatrics. Available at: [www.aap.org/enus/professional-resources/practice-support/Pages/Accountable-Care-Organizationsand-Pediatricians-Evaluation-and-Engagement.aspx](http://www.aap.org/enus/professional-resources/practice-support/Pages/Accountable-Care-Organizationsand-Pediatricians-Evaluation-and-Engagement.aspx)

Payments are intended to build capacity in practices to coordinate care, reporting metrics and reduce emergency room visits. In Arkansas, Medicaid provides some episodic based payments for attention-deficit/hyperactive disorder (ADHD), asthma and other disorders. These approaches accommodate for pediatric specific challenges.<sup>7</sup> We also ask that CMS consider including dental services within alternative payment models to promote innovations aimed at the prevention of oral disease<sup>8</sup>, which has had promising results in Oregon.<sup>9</sup>

Pediatric Alternative Payment Models must also recognize that unique position of pediatric providers. As mentioned previously, many pediatric providers are dealing with populations that are, by and large, quite healthy. These providers are unlikely to achieve significant cost savings in the short term or see significant improvements in traditional measures of health outcomes. We hope CMS will use this opportunity to test new models that amplify the importance of pediatric providers in emphasizing prevention and community linkages to address the social determinants of health. We suggest that CMS look at lessons learned from trying to incorporate other primary care providers into alternative payment models, such as the CPC+ model. For example, CMS could consider implementing bonus payments or care coordination fees rather than two-sided risk models.

Finally, we note that some of the savings from these models could be longer-term and lie outside of what is traditionally counted as a health care expenditure. Therefore, assessment of the scope of savings should look both longer and broader to detect improvements.

### **3. Ensure Robust Child and Family Engagement**

Strong consumer engagement mechanisms are necessary for successful payment and delivery reforms. Increasing evidence points to the importance of consumer empowerment and engagement as a means of quality improvement and cost savings.<sup>10</sup> Consumer and patient voices provide a vital perspective for ensuring new delivery models are patient-centered, culturally competent, and meet the specific needs of the community. This is particularly important in the case of pediatric alternative payment models, where integrating caregivers and family members and making linkages to community resources and other social services will be key to a successful model. As CMS considers next steps for advancing state based multi-payer reforms, we urge CMS to make consumer engagement at all levels an integral piece of pediatric alternative payment models.

We ask that CMS make consumer engagement a required element of any pediatric alternative payment models it develops. Engagement needs to be more than simply informing consumers or hosting focus groups. Children and their families should be engaged collaboratively to design important aspects of the delivery of care at the clinical, health care organizations, and state and federal policy-making levels. For example, in Massachusetts, Family Voices, a grassroots organization that advocates for children with special health care needs, was funded to provide family engagement support on the Massachusetts' Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant. This

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<sup>7</sup> Bailit Health. (2016). Value-Based Payment Models for Medicaid Child Health Services. Report to the Schuyler Center for Analysis and Advocacy and the United Hospital Fund. Retrieved from: <https://www.uhfnyc.org/assets/1503>

<sup>8</sup> Vujcic, Nasseh (2013) Accountable Care Organizations Present Key Opportunities for the Dental Profession. Retrieved from: file:///C:/Users/hhendrickson/Downloads/HPIBrief\_0413\_2.pdf

<sup>9</sup> Oregon's Health Authority (2017) Oregon's Health System Transformation: CCO Metrics 2016 Mid-Year Report. Retrieved from: [http://www.oregon.gov/oha/Metrics/Documents/2016\\_Mid-Year\\_Report.pdf](http://www.oregon.gov/oha/Metrics/Documents/2016_Mid-Year_Report.pdf)

<sup>10</sup> See, e.g., Ahn S, Basu R, Smith ML, Jiang L, Lorig K, Whitlaw N, Ory MG. The impact of chronic disease self management programs: healthcare savings through a community-based intervention. *BMC Public Health*. 2013; 13:1141; Carman KL, Dardess P, Maurer M, Sofaer S, Adam K, Bechtel C, Sweeney J. Patient and family engagement: a framework for understanding the elements and developing interventions and policies. *Health Aff*. 2013; 32(2): 223-231. Greene J, Hibbard JH, Sacks R, Overton V, Parrotta CD. When patient activation levels change, health outcomes and costs change, too. *Health Aff*. 2015; 34(3): 431-437.

work included creating a family engagement guide and a tool kit to help pediatric practices form Patient and Family Advisory Councils (PFACs).<sup>11</sup>

We also encourage CMS to look at examples of how other health system transformation efforts, such as the dual eligible demonstration projects, have utilized consumer engagement. For example, Massachusetts established a statewide stakeholder Implementation Council with a requirement for 51 percent consumer and consumer advocate membership for its One Care demonstration for dually eligible individuals with disabilities, and built advocacy into its care model, such as through the inclusion of an independent long-term services and supports coordinator from community-based organizations.<sup>12</sup>

This engagement won't be successful without sufficient resources. Dedicated funding and training for consumer engagement activities is absolutely necessary for ensuring pediatric alternative payment models are patient-centered and designed to meet the health needs of the diverse populations these efforts will impact. Community Catalyst regularly speaks with consumer health advocates in 40 states across the country. These advocates are in direct contact with consumers in their state and, accordingly, are able to provide an accurate perspective on the issues consumers face in accessing health care on a daily basis. We've repeatedly heard from our advocates that one of the largest barriers they face to effective consumer engagement is a lack of resources.<sup>13</sup> The Massachusetts Implementation Council mentioned earlier is successful in part because of the associated resources provided. The state provides trainings and physical accommodations, as needed, to council members, pays stipends to consumer members for attending meetings and doing preparatory work, and provides reimbursement for travel expenses.<sup>14</sup>

#### **4. Addresses Health Equity**

Health disparities exist when certain populations and demographic groups suffer from illnesses or morbidities at rates disproportionately larger than the general population. Health care disparities, on the other hand, occur when certain groups have disproportionately poor access to affordable care, including a lack of insurance or the means to afford insurance or care, as well as poor access to providers (e.g. no local hospital) or transportation. These two forms of disparities are intrinsically linked and often align to create populations that have both poor health and less access to care that is affordable and of high quality. It is worth noting that health disparities exist in both medical and dental care.<sup>15</sup>

A pediatric alternative payment model that successfully begins to address health equity and influence the social determinants of health will require several components. We urge CMS to improve data collection and metrics on disparities. In order to effectively address health and care disparities, stakeholders must have reliable, evidence-based and consistent metrics for evaluating disparities and measuring progress towards greater equality. Data should be collected by gender, race, ethnicity, sexual orientation, gender identify, preferred languages and disability status. We further encourage CMS to consider incorporating socioeconomic risk adjustments in payment reform, ensuring that all providers are culturally competent, reallocating resources to address social determinants of health, and promoting a more diverse workforce by integrating trusted community-based providers such as Community Health Workers. We encourage CMS to look to existing models that aim to address the social determinants of health for vulnerable

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<sup>11</sup> Ananad, Shikah. (2015). NICHQ's CHIPRA Massachusetts Medical Home Initiative. Engaging Patients.Org. Retrieved from: <http://www.engagingpatients.org/?jqstories=nichqs-chipra-massachusetts-medical-home-initiative>

<sup>12</sup> Massachusetts Executive Office of Health and Human Services. Frequently Asked Questions about the Implementation Council. Retrieved from: <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/implementation-council-faq.pdf>

<sup>13</sup> Wiitala, K, Metzger, M, and Hwang, A. (2016). Consumer Engagement in Medicaid Accountable Care Organizations: A Review of Practices in Six States. Community Catalyst. Retrieved from: <http://www.communitycatalyst.org/resources/publications/document/ConsumerEngagementMedicaidACOs.pdf?1474915709>

<sup>14</sup> Dembner, A and Regan, C. (2013). A Seat at the Table: Consumer Engagement Strategies Essential to the Success of State Dual Eligible Demonstration Projects. Community Catalyst. Retrieved from: <http://www.communitycatalyst.org/docstore/publications/a-seat-at-the-table-duals-consumer-engagement.pdf>

<sup>15</sup> Centers for Disease Congtrol. (n.d.). Retrieved April 6, 2017, from [https://www.cdc.gov/oralhealth/oral\\_health\\_disparities/](https://www.cdc.gov/oralhealth/oral_health_disparities/)



children and children with special health care needs. For example the Collaborative Care Coordination and Consultative Model for Complex Kids (4c) program in Massachusetts provides children with complex medical conditions with a team of providers, including a nurse care coordinator and social worker, and a comprehensive care plan.

## **5. Streamlines Eligibility & Enrollment in Medicaid and Social Services**

A successful pediatric alternative payment model will require that patients have uninterrupted access to Medicaid coverage and seamless enrollment processes for other programs and social services that can improve their health. Well-coordinated care that improves health outcomes and lowers costs is far easier to provide when children aren't churning on and off of programs or constantly going through eligibility determinations for various services that are integral to their care plan. Research shows that people who churn on and off different sources of health coverage are less likely to have regular sources of care and more likely to experience treatment delays.<sup>16</sup>

We urge CMS not to impede eligibility and enrollment in Medicaid for low-income children and families. We are concerned by proposals to eliminate presumptive eligibility for parents; require burdensome steps for immigrant families to enroll in Medicaid; require states to redetermine eligibility for the expansion population every 6 months; and lower mandatory eligibility for kids to 100% FPL. Measures such as these make it harder for low-income children and families to enroll in coverage, increase churn, and fragment families across different coverage options. This goes against CMS's goal of aligning eligibility and enrollment and ensuring kids and families have seamless access to well-coordinated care.

We also urge CMS to work with other state and federal agencies to identify opportunities to streamline eligibility and enrollment between Medicaid and other social services, for example, combining program applications, using electronic data to auto-enroll individuals across programs, streamlining definitions and eligibility requirements, and aligning the timing of renewals or instituting automatic renewals. We also encourage CMS to explore policies that reduce churn in program, for example reducing reporting requirements and lengthening certification periods.

## **6. Uses Pediatric-Specific Quality Measures**

Pediatric quality research has lagged behind quality improvement efforts for adults. Over the past decade, key investments in pediatric quality measurement have led to improvements across states but more work is needed. As such, Medicaid and CHIP investments will continue to play an important role in advancing the pediatric quality measurement field. As CMS considers designing opportunities for states to innovate and advance pediatric integrated care, CMS should look to the CHIPRA quality work to inform how alternative payment models integrate and leverage pediatric quality measures to improve systems and health outcomes for children. In addition, CMS should review emerging pediatric Accountable Care Organizations' (ACO) key lessons in implementing and using pediatric quality measures.

Quality measures should draw upon multiple domains over the lifecycle of a child and should be diverse, capturing quality across structure, process and outcome. To date, the Child Core Set (CCS) focuses heavily on process measures and does not comprehensively capture health outcomes.<sup>17</sup> The Child Core Set should be reevaluated and revised regularly to build out the pediatric set and CMS should continue to add measures from the Pediatric Quality Measures Program (PQMP) that can help develop a comprehensive approach to pediatric quality measurement. Of note, the CHIPRA funded work (6 projects underway) expires September 2017. This funding should be extended in order to sustain and advance the pediatric quality measurement work.

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<sup>16</sup> Cardwell, Anita. (2016). Revisiting Churn: An Early Understanding of State-Level Health Coverage Transitions Under the ACA National Academy for State Health Policy. Retrieved from: <http://nashp.org/wp-content/uploads/2016/08/Churn-Brief.pdf>.

<sup>17</sup> National Quality Forum. (2016). Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP. Retrieved from: [http://www.qualityforum.org/Publications/2015/08/Strengthening\\_the\\_Core\\_Set\\_of\\_Healthcare\\_Quality\\_Measures\\_for\\_Children\\_Enrolled\\_in\\_Medicaid,\\_2015.aspx](http://www.qualityforum.org/Publications/2015/08/Strengthening_the_Core_Set_of_Healthcare_Quality_Measures_for_Children_Enrolled_in_Medicaid,_2015.aspx)

Three important themes emerge as CMS contemplates alternative payment model concepts for children and quality measurement:

*Pediatric quality measurement work should continue to be a priority for CMS:*

- Medicaid/CHIP leads pediatric quality measurement and plays an important role in developing and institutionalizing pediatric measures to improve health outcomes and reduce health disparities. Current Medicaid/CHIP metrics are an important starting point to ensure that pediatric integrated models of care support children with special health care needs. CMS should continue to invest and leverage state work to inform measurement development, revision and inclusion in the Child Core Set. Further, this work should inform and serve as a foundation for any alternative payment model.
- Despite progress, high priority gaps exist. As summarized in the National Quality Forum (NQF), metrics are needed for key areas of pediatric health and development. These include but are not limited to: pediatric care coordination for home and community based services; social services connections; cross-sector measures around accountability for education and criminal justice systems; access to trauma-informed care; exposure to Adverse Child Events (ACEs); out of pocket costs; patient reported outcomes; and duration of health insurance over a 12-month period.<sup>18</sup>
- Medicaid/CHIP programs in states are working to identify measures that align with the long-term needs of children and their well-being:
  - Any measurement approach should include short-term, intermediate and long-term goals that are monitored by Medicaid and made available to the public and to researchers.
  - Measures should ensure that children with special health care needs receive high quality care and are not harmed by incentives to reduce costs.
  - All data should stratify by race and ethnicity in order to more comprehensively understand how policies, programs and interventions affect populations.
- As CMS contemplates APM and/or invests in accelerator programs and other innovation programs as a pathway to increasing the quality of care for consumers at a lower cost, they should require grantees and programs to address the impact of quality measurement on pediatric populations. This is important to ensure that adult measures are not inappropriately being used to chart success for pediatric populations. The distinction is also important as we track and monitor alignment of the measures across the Child and Adult Core Sets, especially for high-impact conditions like reproductive and behavioral health—here a two-generation approach becomes increasingly relevant as we work to ensure long term health outcomes for children as they grow into adults.

*Pediatric quality measurement should be actionable and advance health outcomes for disproportionately affected populations:*

- CMS should work to include more family-focused metrics that capture patient experience, allowing providers to respond to these measures to improve care delivery. This is a gap at both the national and state levels—as recent as this week, researchers published findings in *Pediatrics* highlighting the need for continued monitoring of institutions’ engagement of families in the care process particularly around preventing mistakes and reporting concerns.<sup>19</sup>
- As noted by the American Academy of Pediatrics (AAP), the current set of measures relies on administrative data and/or calls for abstracted data from chart review.<sup>20</sup> This work is time

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<sup>18</sup> National Quality Forum. (2016). Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP. Retrieved from: [http://www.qualityforum.org/Publications/2015/08/Strengthening\\_the\\_Core\\_Set\\_of\\_Healthcare\\_Quality\\_Measures\\_for\\_Children\\_Enrolled\\_in\\_Medicaid,\\_2015.aspx](http://www.qualityforum.org/Publications/2015/08/Strengthening_the_Core_Set_of_Healthcare_Quality_Measures_for_Children_Enrolled_in_Medicaid,_2015.aspx)

<sup>19</sup> Toomey, Sarah L., et. al. (2017). Variation in Family Experience of Pediatric Inpatient Care As Measured by Child HCAHPS. American Academy of Pediatrics. Retrieved from: <http://pediatrics.aappublications.org/content/early/2017/03/20/peds.2016-3372>

<sup>20</sup> Adirim, Terry, et.al. A New Era in Quality Measurement: The Development and Application

consuming and requires resources and support to build out the electronic systems and processes needed to yield actionable results for providers and hold stakeholders accountable. CMS should identify resources and opportunities for states to more deeply engage and invest in institutions and providers to implement this work.

- An overlooked challenge of metric development and implementation is data collection and public reporting. States and providers need additional capacity to collect data on patient experience (including adolescent and parent feedback), family coordination and community linkages (stratified by race and ethnicity). Quality reporting is also important. We suggest that CMS create incentives for public reporting so that quality measurements are playing their intended role of advancing policies and practices that improve care at all levels.
- In an effort to improve health outcomes, CMS must commit to supporting alignment efforts both within its own cross-agency work but also through incentives to state partners to align at the state, institution and practice levels. As highlighted by the NQF, alignment could be defined as leveraging the same measure across multiple programs, populations or age groups.<sup>21</sup> Providers and institutions are often reporting to multiple sources for different programs and insurance products. Incentives to align across Maternal and Child Health Services Block Grant, for example, is one ripe area of opportunity for harmonization.
- Finally, these alignment efforts must be flexible enough to ensure that quality metrics are appropriate for the specific populations served.

*Pediatric quality measurement should reflect social determinants of health:*

- As highlighted by a Bailit Health analysis, stakeholders engaged in advancing value-based approaches to pediatric care agree that quality measurement is an important part of any payment strategy and broadly should include preventive care including screening, mental health access to care and immunizations.<sup>22</sup> While new approaches to care need “ramp up” time, CMS should not silo the CCS work from innovation work. Rather, CSS should be the foundation of any quality work and build on the evidence that currently exists.
- A number of early adopters of pediatric focused Accountable Care Organizations (ACOs) exist and provide lessons in pediatric quality measurement that should be leveraged for APMs. Some recent findings<sup>23</sup> highlight the importance of:
  - Pediatric-specific measures that are more focused on health outcomes.
  - Inclusion of metrics – and a conceptual “rethinking” of social determinants of health. Cited metrics included school readiness at age 5; literacy at age 8 and school graduation. We would add other metrics that have cross-sector relevance including social/emotional health and chronic absenteeism.
  - New thinking is required on how we define and measure value in pediatric care. Recent feedback on emerging ACOs is that there needs to be deeper engagement and investment in alignment across sectors with a focus on long-term outcomes and a manageable number of metrics that all are driving us toward a common understanding of pediatric value.

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(<http://pediatrics.aappublications.org/content/pediatrics/early/2016/12/22/peds.2016-3442.full.pdf>)

<sup>21</sup> National Quality Forum. (2016). Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP. Retrieved from:

[http://www.qualityforum.org/Publications/2015/08/Strengthening\\_the\\_Core\\_Set\\_of\\_Healthcare\\_Quality\\_Measures\\_for\\_Children\\_Enrolled\\_in\\_Medicaid,\\_2015.aspx](http://www.qualityforum.org/Publications/2015/08/Strengthening_the_Core_Set_of_Healthcare_Quality_Measures_for_Children_Enrolled_in_Medicaid,_2015.aspx)

<sup>22</sup> Bailit Health. (2016). Value-Based Payment Models for Medicaid Child Health Services. Report to the Schuyler Center for Analysis and Advocacy and the United Hospital Fund. Retrieved from:

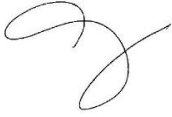
<https://www.uhfnyc.org/assets/1503>

<sup>23</sup> Perrin JM, Zimmerman E, Hertz A, et al. Pediatric Accountable Care Organizations: Insight From Early Adopters. *Pediatrics*. 2017; 139(2):e20161840



Thank you for the opportunity to comment on this important provision. Please do not hesitate to contact Ann Hwang at [ahwang@communitycatalyst.org](mailto:ahwang@communitycatalyst.org) and Eva Marie Stahl at [emstahl@communitycatalyst.org](mailto:emstahl@communitycatalyst.org) should you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to be 'AH', written in a cursive style.

Ann Hwang, MD  
Director, Center for Consumer Engagement in Health Innovation

A handwritten signature in black ink, appearing to be 'E Stahl', written in a cursive style.

Eva Marie Stahl, Ph.D.  
Project Director, Children's Health, Community Catalyst