Massa, Cody

From: Gretchen Beesing <GretchenB@catalystmiami.org>
Sent: Friday, June 3, 2022 3:29 PM
To: solicitation.questions
Cc: Natalie Castellanos
Subject: Response to RFI 014-21/22
Attachments: PopulationHealthOutcomes for Children_6-2022.pdf

Dear Cody Massa,
Attached please find our response to the RFI regarding re-procurement of the statewide Medicaid Managed Care program.

Please note that the following organizations endorse our response to the RFI:

Florida Policy Institute
Florida Voices for Health
Center for Independent Living of South Florida
United Way of Florida
Heart of Florida United Way
United Way of St. Johns County
United Way Emerald Coast
United Way Miami
United Way Suncoast

Thank you!
Gretchen

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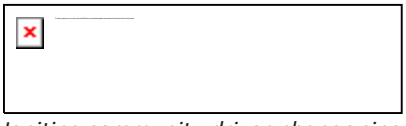

RESPONSE TO RFI 014-21/22
STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
REQUEST FOR INFORMATION

June 3, 2022

Cody Massa
Procurement Officer
solicitation.questions@ahca.myflorida.com

Early Child Development and Long-term Population Health

RFI response submitted by:
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This response to the SMMC RFI for innovative ideas and best practices focuses on the following domains:

- Align quality metrics and outcomes with the Florida State Health Improvement Plan.
- Utilize value-based payment designs to simultaneously increase quality and reduce costs.
- Improve mental health outcomes for children and adolescents.

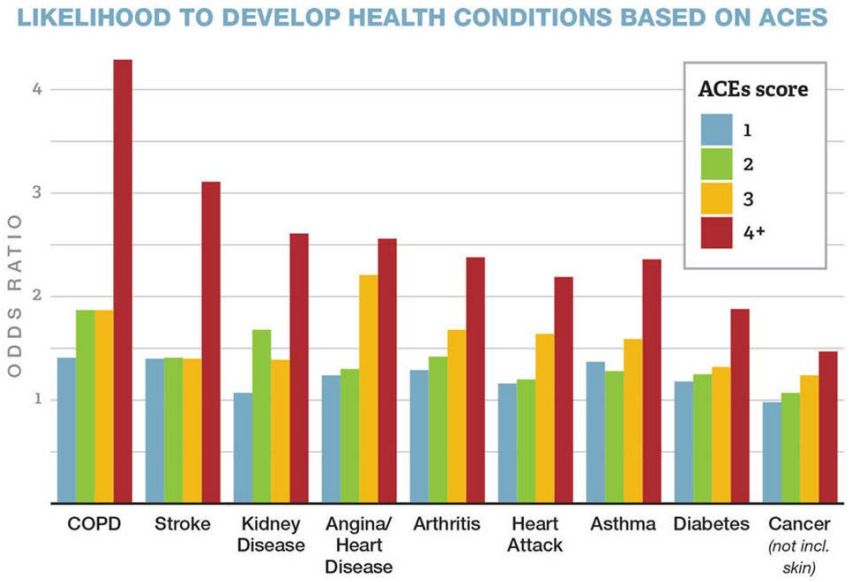
Key Ideas

- **The health and well-being of children is critical to our state, now and in the future (because childhood experiences predicts adult health).**
- **Child health is largely determined by where children live, play, and go to school, and by the health and well-being of their families and their communities.**
- **Improvements in the health of children are more effective at the population level than at the individual child level.**
- **Medicaid is one of the largest investments in children in the state budget, and with the next SMMC procurement there is an opportunity to align health care financing with other state and private efforts to improve outcomes for children.**

- **The Florida SMMC Program can improve the health and well-being of children—and long-term outcomes of adults in our state—by including population-level health outcomes in contracts with managed care organizations.**

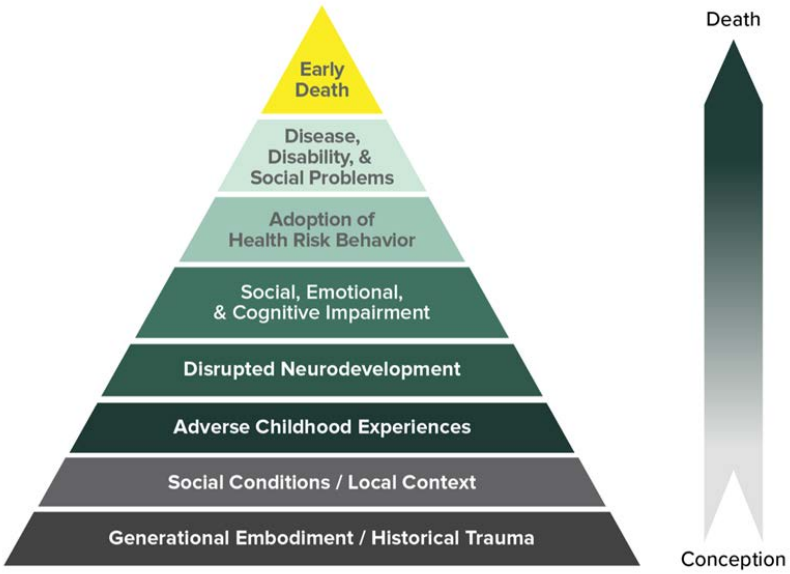
Background

A Robert Wood Johnson Foundation expert panel concluded a decade ago that investing in early childhood development is the best way to improve the health of all Americans.[1] The Centers for Disease Control has also long identified addressing adverse childhood events (ACEs), such as substance use and child neglect, as essential to reducing the burden of common ailments such as heart disease, stroke, and cancer among adults. As depicted in Figure 1 below, the larger the number of ACEs a child experiences, the great the likelihood of dying from one of the nine leading causes of death in the U.S.



This chart represents odds ratios, or how many times more likely an adult with ACEs is to experience a given health outcome compared to those without ACEs. For example, those with four or more ACEs are 4.3 times more likely to have chronic obstructive pulmonary disease (COPD), 2.4 times more likely to develop asthma, and 2.2 times more likely to have a heart attack than those without ACEs.

Research indicated that disrupted neurodevelopment in children is a critical step in the path from ACEs to adult mortality, and an area where intervention can substantially improve outcomes. Figure 2 shows the pathway by which conditions of childhood are linked to the health of adults decades later.



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

In one randomized controlled trial of two years of high-quality early child education among children at high risk of poor outcomes, for example, participants were much more likely than waitlist controls to enjoy economic security, achieve academic success, and avoid the criminal justice system in follow-up studies that extended to 40 years later.[2] Addressing social and community-based drivers of health (SDH) in the first five years of life is the best investment a society can make, according to a review of the research by Nobel Prize winner James Heckman.[8]

Roles of Healthcare Systems in Population Health

Despite recognition of the importance of SDH in early childhood for the health of people across the lifespan, the healthcare sector has had limited success in directly addressing these environmental drivers of health. One long-standing reason is that payment mechanisms discourage investing in disease prevention and health promotion. For example, under traditional fee-for-service payment arrangements, healthcare systems are economically most productive when children with asthma make frequent physician and emergency-department visits, are hospitalized, and are admitted to intensive care units. There is no financial incentive to work with families on asthma action plans, include school nurses in action plans, confirm children obtain needed medications and know how to use them, and ensure that children reside in allergen-free homes in neighborhoods with clean air. During the early stages of the COVID-19 pandemic, when children were not admitted to hospital except in extreme emergencies, administrators feared for the financial viability of their institutions because beds were empty and income streams stopped. Such is the economic logic of fee-for-service payment arrangements.

Adult healthcare systems are moving toward value-based payment mechanisms that reward healthcare organizations for improving outcomes and not merely providing discrete services for individual payments. Such financing arrangements have been more difficult to implement in

children, especially those covered by Medicaid.[3] Children are healthier, on average, than adults, so there are fewer opportunities for healthcare cost savings; benefits of improved child health and development accrue to other systems (education, juvenile justice, and adult healthcare) and are generally long-term (i.e., reduced adult morbidity decades later)[4]; children with medical complexity account for much of a healthcare system's costs because they their care is expensive. Perhaps most importantly, improving child health outcomes is generally beyond the capacity of individual clinicians, because they have limited ability to influence SDH. Pediatricians can screen for family concerns such as unemployment and homelessness, , for example, but this fails to address the underlying social and economic conditions at a population level.[5]

One exception is Partners for Kids, the accountable-care organization affiliated with Nationwide Children's Hospital in Columbus, Ohio, in which the healthcare organization collaborates with community partners on job training and improved housing in neighborhoods around the hospital.[6] In a per-member, per-month arrangement for approximately 300,000 children with Ohio Medicaid, Partners for Kids has demonstrated not just improved quality and decreased costs for children but also that health care institutions can work with other state and community organizations to address population-level drivers of health.[7] In another example, the Mailman Center for Child Development in the Department of Pediatrics at the University of Miami Miller School of Medicine partnered with leaders of community-based coalitions in two neighborhoods adjacent to the healthcare center. This decade-long collaboration was associated with population-level improvements in early childhood development, compared with control neighborhoods.[8]

What Can Florida Medicaid Do?

Medicaid policy in our state has the potential to make such examples as Partners for Kids the norm: healthcare systems could aim to improve child health and development, rather than depend on children being sick for their financial viability. Medicaid is an especially powerful lever, as more than 40% of Florida's children are enrolled in Medicaid,[9] and they represent the children most affected by SDH and ACEs. As noted above, the transition to value-based care can be difficult in Medicaid populations, though states such as Ohio have successfully moved most children in Medicaid to such payment arrangements. The danger in this shift to per-member-per-month payment schemes is that managed care organizations (MCOs) and healthcare providers are financially motivated to not provide medical care. To avoid such an outcome, state Medicaid agencies such as AHCA carefully monitor healthcare measures, such as the Healthcare Effectiveness Data and Information Set and the Medicaid Core Set. Financial penalties for failing to provide high-quality care can mitigate incentives to limit healthcare services. Although useful for ensuring needed care, such as immunizations and well-child care visits, such process measures do not address the deeper elements of child health and well-being.

We recommend that AHCA consider providing financial incentives to MCOs and healthcare providers to improve child development at a population level. For example,

what if SMMC contracts included additional payments (or forgiveness re liquidated damages) to MCOs if an objective measure of kindergarten readiness (age 5 years) or reading levels (age 8 years) improved each year? Rewarding MCOs for focusing on early child development would align the vast resources of the healthcare system with other state and private investments in children to disrupt the mechanism by which SDH lead to poor outcomes. Most MCOs already recognize addressing SDH is essential to reducing their members' healthcare costs, and offer a variety of enhanced or in-lieu-of benefits to support families and prevent illness. Providing MCO financial incentives for early child outcomes would more directly reward their efforts to mitigate SDH, and even prompt them to work with partners to address socioeconomic and political issues underlying community-level health disparities.

What might MCOs actually do to invest in early childhood development? They could work with clinicians to ensure evidence-based activities, such as Healthy Steps[10] and Reach Out and Read,[11] were as routine as vaccinations in pediatric offices. Parenting interventions, such as the Incredible Years[12] and Parent Child Interaction Therapy,[13] would be essential benefits, and there would be seamless referrals to child-development programs, such as Part C Early Intervention and Part B Special Education. Home visits by nurses and parent mentors would be financially rewarded. Care coordinators would routinely link families to mechanisms for financial self-sufficiency such as job training and tax benefits such as the child tax credit and the earned income tax credits. More generally, MCOs would have strong incentives to partner with community organizations to address poverty, homelessness, and other SDH.

Data to measure child development are already available at the population level, and outcomes could be aligned with Florida's State Health Improvement Program. Currently Florida, state law requires that a child-development screening instrument, the Florida Kindergarten Readiness Screener, be administered to all public-school kindergarten students within the first 30 days of each school year.[14] Population-level data for this and similar measures are publicly available by zip code, and could be used to measure improvement in geographic areas where each MCO has enrollees. By using population-level data, rather than outcomes for individual children, MCOs would be incentivized to collaborate with community partners to address underlying SDH. By rewarding annual improvements rather than high levels of kindergarten readiness, MCOs would be incentivized to invest in neighborhoods with the greatest potential for change.

There are challenges to such a novel approach to healthcare financing. A first step would be convening MCOs and community partners to assure alignment of goals and incentives. A successful regional pilot program would start with transparent and meaningful engagement of families (healthcare plan members), community and political leaders, local anchor organizations, and representatives from other systems that impact child development, such as education, housing, employment, public safety, and community planning. Fortunately, many communities already have children's service councils that serve to coordinate activities on behalf of children and families. One key issue would be careful analysis of the specific measure (e.g., kindergarten readiness or 3rd-grade reading scores) to ensure agreement that it is a reliable and meaningful way to gauge outcomes. Another issue would be how to apportion MCO

responsibility (e.g., number of enrollees in a defined geographic area); with multiple MCOs in a given neighborhood, a mechanism would be needed for identifying who gets the credit.

Medicaid financing is one of the most powerful mechanisms that state and federal governments have to improve child health and well-being, especially among children who face challenges because of poverty and other SDH. As healthcare systems transition to value-based arrangements, health-policy leaders at AHCA have the opportunity to align financial incentives that promote child development and have the potential for enormous long-term impact. The next SMMC procurement is an opportunity to explore how best to align healthcare payment arrangements with outcomes that matter most to children, families, and broader society.

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