Alternative Payment Models to Support Child Health & Development: How to Design and Implement New Models

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Key Findings

- While children have a broad set of health, social, and developmental needs, financing for services to meet those needs remains siloed. Such separation discourages coordination across health care and social services, and these rigid funding streams prevent stakeholders from customizing resources to the needs of their community's children and families.

- There are opportunities to provide greater local flexibility for child-focused alternative payment models (APMs). While implementation of such models has been limited to date, the willingness of health care payers to use these new payment models for many populations and conditions signals the potential of applying APMs to children and families' health, social, and developmental needs.

- Organizations seeking to design and implement one of these new APMs will need to consider multiple technical questions, which will vary based on the needs of children and families in the local area, organizational goals, and the capabilities and resources of the organizations implementing the models.

- Implementing new child-focused APMs will require overcoming challenges such as legal and regulatory restrictions on financing streams (requiring combining and coordinating funds from different sources, often referred to as "blending and braiding"); collaborating across sectors that often have very different cultures and histories; and sharing different types and sources of data (to which different privacy regulations may frequently apply). However, there are examples of organizations that have overcome these challenges, as this brief sets forth below.

Many American children have unmet health, social, and developmental needs. These may be related to limited or uneven access to health care and social services, adverse childhood experiences, or disrupted familial relationships. Left unaddressed, these contribute to poor health and developmental outcomes, including the development of significant psychiatric disorders and chronic conditions (e.g., heart disease, diabetes) in later childhood or adulthood.[1–4]

One key reason children are not having all of their needs met is due to the fragmented and siloed financing and delivery systems for education, health care, and social services for children. Several groups have attempted to address this problem by stitching together a set of services from various systems, but such approaches often result in a disjointed experience for children and families and greatly diminish their positive impact on outcomes.

In addition, complicated sets of services provided through disparate delivery and payment systems are highly vulnerable to disruption. During the COVID-19 pandemic, many children are experiencing disruptions in access to educational, behavioral health, and other services as a result of steps taken to control the pandemic (e.g., physical distancing, school closures, etc.)[5]

Alternative payment models (APMs) are a promising tool for addressing the disjointed system and improving children's health, social, and developmental needs. Designed as an alternative to conventional fee-for-service payment in health care, APMs can support coordination across health care organizations and providers, reward high-quality care and outcomes, and give organizations flexibility to provide traditionally unreimbursed services (health care or other) that address major areas of need. The focus on coordination, flexibility, and accountability means that APMs can move beyond simply providing and paying for health care, and they can bring together organizations from a variety of sectors to address the full spectrum of children's health and developmental needs.[6,7] Additionally, APMs may allow organizations to be more resilient, as well as more capable of sustaining the delivery of services during public health emergencies (like COVID-19) or other times of uncertainty.

This brief offers guidance on the design and implementation of child-focused APMs, particularly for stakeholders who may have limited experience with APMs. Specifically, the brief outlines the key design components for new models and key strategies to overcome potential implementation challenges. The descriptions of key components, challenges, and strategies covered in this brief were informed by a review of the literature on child-health-focused APMs and proceedings from a convening of experts with experience designing and implementing innovative care delivery and payment models for children.

## Promise of Alternative Payment Models for Children's Health

While the number of child-focused APMs is limited (Figure 1), there are multiple existing models that reward improvements in health care quality, costs, and outcomes for children. For example, an Arkansas model bundled payment for perinatal services, and it increased prevention screenings, decreased emergency department visits among pregnant women, and demonstrated other improvements in quality of care.[8] In Ohio, Partners for Kids (PFK), a Medicaid accountable care organization (ACO) associated with Nationwide Children's Hospital, showed reductions in the growth of health care costs compared to fee-for-service Medicaid, reductions in the number of diabetes-related hospital admissions for children, and improvements in pediatric acute care quality.[9] To support more efficient and effective care delivery to nearly 300,000 low-income, Medicaid insured

children,[10] PFK receives a monthly age- and gender-adjusted payment from Ohio's Medicaid managed care plans. The payments are used to cover the costs of caring for the children attributed to the ACO, and PFK is held accountable for meeting specific cost and care quality benchmarks.[9]

Given the promise of child-focused APMs, state and federal policymakers are signaling increased interest in and encouraging greater implementation of child-focused APMs. State policymakers see APMs as a way to better meet the needs of children in their state, particularly those covered by Medicaid, *and* control the increasing pressure of health care costs on state budgets.[11,12] At the federal level, the Center for Medicare and Medicaid Innovation is supporting the implementation of child-focused Medicaid APMs through the Integrated Care for Kids (InCK) Model.[13] This model, to be tested in seven states, is designed to enable identification of children's physical, behavioral, and other health-related needs and connect children and their families to necessary health, social, and other service providers.

Stakeholder groups, including state Medicaid agencies, private payers, health care systems and providers, as well as child and family-focused community-based organizations, may wish to capitalize on the heightened interest among policy makers by designing and implementing APMs that can address the needs of children and families in their own communities. Guidance on how to design and implement these new payment models follows.

Figure 1. Number of states participating in child-focused APMs.
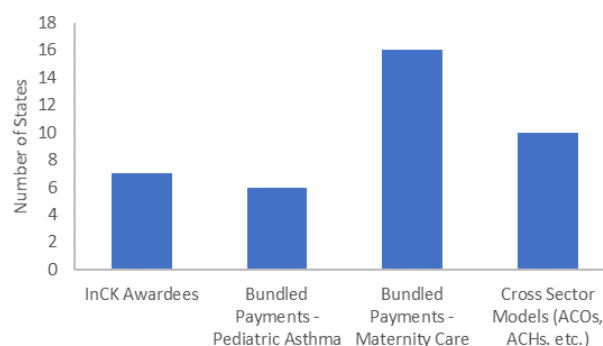
Notes: Models identified through a review of the literature, review of state Medicaid and health department websites, and expert feedback. InCK = Integrated Care for Kids Model; ACOs = child-focused Accountable Care Organizations; ACHs = Accountable Communities of Health that include children.

Table 1. Design Considerations for an Alternative Payment Model for Children

Model Component	Questions to Consider When Designing a Payment Model	Illustrative Examples of the Payment Model Component
Model Goals	• Who will be served by the model? • What needs will be addressed by the model? • What outcomes will the model aim to affect?	*Example Goal:* • Improve children's developmental outcomes and family functioning by integrating the delivery of health care and social services
Accountable Entity	• What organization will be accountable for the quality, costs, and outcomes of the model? • If multiple organizations coordinate to offer services, what arrangements will need to be in place between organizations to ensure accountability?	*Example Accountable Entities:* • A community-based organization with experience receiving and distributing funds to partner service organizations (e.g., United Way) • A local hospital system with an established billing and data infrastructure and experience partnering with community-based organizations
Attributed Population and Model Duration	• What children and family members will be attributed to the model? • How will attribution be operationalized (e.g., specific event or condition, defined geographic area)? What, if any, exclusions will apply? • How will the child's family be included in the model? • What will be the risk stratification method? • How long will children and their families be included in the model? What are the specific touchpoints for needs assessments and service delivery?	*Example Populations:* • Children who are admitted to the emergency department (ED) with an asthma exacerbation. Episode starts at ED admission and ends at follow-up visit with a primary care provider. • Geographic attribution with all children (0-18 years old) and their families residing in a single county included in the model
Services	• Which services should be prioritized for inclusion in the model? • Who is going to deliver these services?	*Example Services:* • Bundled community services including those delivered by social service agencies (e.g., family well-being assessments), school systems (e.g., after school learning programs), and community centers (e.g., parenting classes) • Health care services for a particular condition (e.g., asthma) or particular life stage or event (e.g., maternity or well-child - related services)
Payer	• Who is the payer for this model (e.g., private insurer, Medicaid, philanthropy)? Are there restrictions on the services this payer can support? • Are funds from other payers or other funding sources needed to pay for services not covered by the payer?	*Example Payers:* • Medicaid as the primary payer with supplemental funds from other state agencies (e.g., housing and education) used for services not covered by Medicaid • Commercial insurance as the primary payer with supplemental funds from private organizations
Payment Approach	• How will the accountable entity be paid for services (e.g., capitated monthly rate, bundled payment, etc.)? • *Quality Incentives:* How will the accountable entity be rewarded for delivering high-quality services and improving outcomes? • *Financial Incentives:* What are the financial incentives tied to the model (e.g., shared savings, bonus payments)? If multiple organizations are a part of the accountable entity, when and how will financial rewards be dispersed?	*Example Payment Approaches:* • Accountable entity bills for individual services and has a shared savings and losses agreement with the payer • Accountable entity receives bonus payment for achieving quality benchmarks and is eligible to share in a portion of shared savings • Accountable entity receives an age, gender, and health-status-adjusted capitated fee for each child enrolled in the model
Quality Measurement Approach	• What quality measures will be used in the model? At what level should these measures be specified (e.g., provider, population)? • What are the performance periods for measurement? How will quality data be shared with the accountable entity and service providers?	*Example Quality Measures:* • Use existing quality measures (e.g., Medicaid Child Core Set) relevant to the model's goals and attributed population • Collaborate with measure developers to develop and test new measures as part of the model's quality improvement strategy

How to Design Child-Focused APMs

Those designing APMs must first resolve several key model components (outlined in Table 1). Decisions include identifying the goals of the model, the organization(s) held accountable for outcomes, the children and families attributed to the model, the services included, the entity or entities that the payers for the model, the payment approach used, and the way quality will be measured.

Model Goals

As APMs are tools that could be applied toward multiple facets of health and development, APM designers should start by identifying the specific goals they want to accomplish through the payment model. Whether broad or narrow, **the APM's goals help provide a clear purpose for the model and drive decisions on the other model components** in Table 1. Designers need to consider several factors to set appropriate and feasible goals, including the needs of the children, families, and communities the model will serve; the resources available to the model implementers; and the level of buy-in from other stakeholder groups (e.g., local community and potential partner organizations). APM designers should involve key stakeholders in the goal determination process to obtain buy-in and ensure the goals are aligned with the needs and capabilities of the groups participating in or implementing the model.

Goals are likely to vary among APMs. For an APM that serves a population of children with behavioral health issues, the goals may include increasing access to behavioral health and supportive services for children with specific diagnoses, such as anxiety and depression, and reducing the impact of behavioral health issues on education-related outcomes, such as school absenteeism. By contrast, the goals of an APM addressing social drivers of health may be to increase access to supportive services, such as transportation and food banks, and to improve health and social well-being outcomes, such as employment and health care utilization rates.

Accountable Entity

APMs will need to **identify an accountable entity, which is the organization that will be held accountable for the quality, costs, and outcomes of the services delivered under the model**. In deciding which organization is best suited for this role, APM designers should consider the types of organizations currently providing medical, social, and developmental services to children and families in their local area; those organizations' available resources and ability to assume financial

risk; and the relationships among those organizations.

The accountable entity may be one specific organization, such as a hospital receiving a bundled payment for a child's heart surgery and rehabilitation, or a legal entity that represents a coalition of organizations. The coalition approach may work best when it is difficult to identify a single existing organization that possesses all the capabilities, resources, and relationships required to be successful in executing the components of the model. To implement the coalition approach, a group of participating organizations may come together to form a new legal entity that serves as the accountable entity – for example, an accountable care organization composed of multiple independent pediatric primary care practices. Alternatively, organizations may adopt a legal agreement spelling out how they will share resources, capabilities, and accountability inside the coalition.

While many types of organizations may function as an accountable entity, most child-focused APMs to date have selected a health care organization in this role. This choice may stem from the fact that many early models focused on specific medical conditions, such as asthma. In addition, the health care organizations serving as accountable entities generally have the infrastructure and resources to manage and coordinate services and have more mature financial capabilities, which can allow them to manage financial risk or distribute funding to the partners in the model.

With the move to child-focused models with broader goals outside of health care – such as improving health and social well-being for children covered by Medicaid – it will be important to identify an organization or coalition of organizations that can effectively integrate services across health care and social services, which have traditionally operated separately.

Attributed Population

An APM designer should **draw on the APM's goals to determine which children and families should be served by the model, and for whose care or outcomes the accountable entity should in fact be held accountable**. There also must be means of identifying this population and determining when a relationship begins between attributed children and families and participating health care or social service providers. For example, an APM focused on high-risk childhood asthma could use a health care claim of a recent emergency department visit for asthma as a trigger for children to become part of the APM. Similarly,

the APM could use health care claims data to gauge impact and outcomes, such as reductions in emergency department visits for asthma.

APM designers often have to limit the population involved in the model based on data availability. Models for children with specific conditions, such as asthma, often can use health care claims data to identify and assess the attributed population. However, APMs seeking to include all children and their families in a specific geographic region and provide broad access to health and social services may face data challenges. To identify children needing services in a specific geographic region, APM designers would need enrollment data for Medicaid, early childhood education, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to flag children who could participate in the model. The model designers must then ensure they have access to data that could be used to gauge health and developmental outcomes for those children.

Model Duration

Another key decision for APM designers is **how long the attributed population will be part of the model, which requires considering how much time is required to achieve the model's goals.** Models focused on a specific episode of care or stage of life are likely to be shorter in duration, and will end when a specific event occurs (e.g., delivery of a baby) or a new stage of life begins (e.g., a child starts elementary school). Models focused on longer-term outcomes, such as improving third grade reading achievement or increasing high school graduation rates, will need to be longer in duration to achieve the model's goal.

Data challenges should also be considered when determining the model's duration. The siloed nature of data systems and limitations in linking data can make it difficult, if not impossible, to access data on children and families over time, across service sectors, and linked between family members. For example, models seeking to include mothers and children from conception to one year of age are frequently stymied by challenges in linking the mother's health records to the infant's health records. APM designers must then choose either a prenatal bundled payment model that is centered around the mother and the length of the mother's pregnancy or a well-baby bundle centered around the child and its first year of life.

Services Included in the Model

When deciding which services should be part of the APM, **model designers should be guided by the model's goals, the needs of the attributed children and families, the availability of services in the local community, and the available resources and financing for the model**.

For new models, it may be most feasible to start with a core set of services that (1) most directly relate to the model goals, (2) meet the highest priority needs of the attributed population, and (3) can be feasibly delivered with available partners and resources. For example, an APM may center around a core set of services focused on primary care. The core set may include regular clinic appointments and home visits, which can be used to identify other non-medical needs and help connect individuals to services related to housing, nutrition, parental support, or other areas of need.

An advantage of APMs is that they give service providers flexibility in return for accountability. Therefore, an APM designer may seek to support a broad range of services in the model given the role social, educational, and other non-medical factors play in influencing children's health and development. Beyond medical services, new models can consider including services from educational providers (e.g., after-school learning programs), social services organizations (e.g., parenting classes), or other relevant sectors.

Combining a broad range of services under one model allows local service providers to identify the most important needs for their local population and address them through services that, in the absence of the payment model, are likely to be under-resourced, such as housing and nutrition services. The payers financing the model may be more willing to fund a broader range of services than they typically would, given the overall accountability of the entity receiving the funds for total expenditures and for achieving specified results for children's health and development. However, as described later in the brief, there are often legislative, regulatory, or other restrictions on whether a health care payer can support social and developmental services, which will limit what services can be included in the model.

Payment Approach

APM designers have used multiple different payment approaches to determine how to pay for services and how to tie payments to quality, costs, and outcomes. (Table 2 provides an overview of common APM payment approaches.) **Model designers should consider which of these approaches align with the focus of the model and provide sufficient financial support to the APM's service providers.** They should also tailor

Table 2. Overview of APM Payment Approaches

	Care Coordination Payments	Bundled/ Episode-Based Payments	Accountable Care Organization	Accountable Community for Health
Purpose	Support the development of infrastructure & processes needed to eventually transition to more advanced APM	Improve delivery of services for a specified episode of time around a health care procedure, health condition (e.g., asthma), or life event (e.g., maternity care, newborn care)	Support collaboration among clinicians that will be accountable for a defined clinical population	Support collaboration across sectors to deliver services to a defined geographic community
Participants	Traditionally, health care organizations and clinicians	Traditionally, health care organizations and clinicians	Traditionally, health care organizations and clinicians, but growing involvement of other sectors	Traditionally, organizations from multiple sectors (e.g., health care, social services, education)
Quality & Financial Incentives	Per Member Per Month (PMPM) payments for services such as enhanced care coordination, in addition to traditional FFS payments.	Providers paid a target amount for a set of services related to a defined episode of care. Providers retain savings if they spend less than the target payment and meet quality benchmarks or are responsible for costs that exceed the payment amount.	Providers share savings if ACO costs are below pre-defined benchmark costs for the population and they meet quality targets; advanced versions share losses if ACO costs are higher than the benchmark.	Payment structures vary. Existing models often funded through public health care payers, state/local agencies, and/or grants. Providers can be required to report quality metrics, and may receive additional payments for meeting quality goals. Model savings are reinvested in the model to sustain and expand service delivery.

payment approaches to what the APM's accountability entity can absorb given its resources and experience with APM arrangements.

Additionally, designers may use a phased approach, such as beginning with simpler and focused payment strategies (e.g., payments for coordinating care) and, over time, transitioning to a more advanced payment approach that combines greater flexibility with accountability (e.g., global payments under which the accountable entity may receive a fixed amount for an attributed child or family and is at risk if expenditures exceed that amount). Phased approaches can be important, as it takes time for organizations to develop the infrastructure and processes needed to coordinate services, manage costs, and consistently meet quality and outcome goals.

Payers

An APM will look different depending on the payer or payers providing financial support for the model and setting quality, cost, and outcome goals. Payers often design the APMs they use, although some health care delivery or community organizations have designed APMs and then recruited payers to participate in the model. The most common APM payers to date are public or private health care insurers (e.g., Medicaid or commercial insurance companies), largely because APMs have traditionally focused on health care. However, some social or community organizations have started to be the payers for emerging child-focused APMs.

Because Medicaid is the payer for a significant portion of children's health care services in the United States, it will likely be a payer, or the lone payer, for many new child-focused APMs.[14] This reality can drive an APM's design since, by law and regulation, Medicaid funds may only be used to pay for specific approved services, most of which are focused on addressing medical needs.[14]

As a result, APM designers will need to collaborate with their state's Medicaid agency to determine whether the services offered through their model would qualify for coverage under their state's agreements with the Centers for Medicare and Medicaid Services (CMS). While there is overarching Medicaid law and regulation, states have differing flexibilities through negotiated waivers (where the federal government can waive rules that usually apply to Medicaid) and state plan amendments (changes that states make in program policies or operational approaches).

If some of the model's services are ineligible for payment with Medicaid funds, model designers can try to identify ways to supplement Medicaid payments with funds from other sources. These other sources may come from philanthropic

organizations, other state agencies (e.g., housing, education, criminal justice), or community organizations. This approach of combining funds from different sources – frequently called braiding and blending – is often used to fund programs that deliver services not traditionally covered by Medicaid or a given payer.[15–17]

Private health insurers may be interested in being the payer for a child-focused APM, or, alternatively, an APM designer may be interested in recruiting a private health insurer to serve in that role. **Private payers tend to have more flexibility than Medicaid in the services that they may cover, so there may be options for covering a larger range of services that address social and developmental needs.** However, private payers also have constraints, which vary based on the state and the type of health insurance they offer. For example, they have to (1) spend a set amount of their premiums on medical care (called the medical loss ratio); (2) provide actuarially sound products, under federal and state regulation; and (3) be competitively priced to succeed in their local market. These factors may limit the total amount of funding available for child-focused services. However, given that nearly half of children in the US are covered by commercial insurers, partnering with private health insurers to overcome these challenges will be important to ensuring APMs can be leveraged to improve the health and developmental well-being of children not covered by Medicaid.[18]

Quality Measurement

Quality measures are used to determine whether the APM is achieving its quality, cost, and outcome goals. Along with serving as accountability tools, quality measures help service-providing organizations conduct quality improvement activities and identify disparities in the quality of services delivered to, and outcomes experienced by, different segments of the population served by the APM.

When selecting quality measures for the APM, model designers can consider which measures would provide information about the outcomes of interest and/or processes influencing those outcomes.[6] Models may select measures from existing child-focused quality measure sets, including the Medicaid Child Core Set and the National Quality Forum's Pediatric Measures portfolio.[19,20] However, it should be noted that the majority of these measures are *process* measures focused on health care-related services (e.g., whether the populations in the model receive immunizations, screenings, and/or treatments).

Ideally, future APMs could incorporate measures on a broader set of developmental *outcomes* such as kindergarten readiness, 3rd grade reading achievement, and high school graduation rates. Because these outcomes may only be discernible over time, and may in some instances be more difficult to measure, models may need to start with existing process measures.

Implementation Strategies for New Child-Focused APM

New APMs focused on child health and development must anticipate challenges during model implementation. These challenges are described below, along with promising strategies that may be used to overcome them.

Funding and Financing Challenges

One of the most common funding challenges is related to limitations on the use of Medicaid funds for services that are not considered directly related to health. Given the variability in how Medicaid is administered in each state, APM designers may consider working closely with the Medicaid agency or agencies in the state or states where the model will be implemented to understand the services those Medicaid programs can fund.

In states with Medicaid managed care, APM designers should explore the services that could be provided through managed care plans, as recent updates to Medicaid managed care regulations provide new mechanisms to offer critical health-related social supports.[21] These mechanisms include allowing payments for screenings related to social drivers of health and allowing managed care plans to pay for nontraditional services via the "in-lieu-of" and "value-added services" provisions of managed care regulations.[21]

As noted above, an additional strategy to address funding-related challenges is supplementing Medicaid or private insurer payments with funds from other sources. One approach is to "braid" together funds from different sources and use each source to fund specific services within the model. Under this approach, funds are tracked and reported separately to the different funding sources, with each "braid" of funding only supporting the services or population allowed by law, regulation, or policy. Another approach is to "blend" funds from different sources together so they create one funding stream that is used to pay for model services, in which funds are not tracked or reported separately.[16,22,23] However, many funds are not allowed to be blended due to law, regulation, or policies by the payer.

Table 3. Funding and Financing Challenges and Strategies
Challenges
• Legal and regulatory restrictions on the use of Medicaid funds for services and providers.
• Braiding and blending funds requires complicated accounting strategies and makes demonstrating return on investments difficult.
Strategies
• Leverage recent changes to Medicaid managed care regulations to expand service offerings.
• Identify braiding and blending best practices from other successful models and programs.

Implementing braiding and blending is often necessary, but can be challenging. Braiding funds often requires complex accounting and financial management strategies and can be complicated by variations in budgeting and reporting cycles across partners and payers. With multiple funding sources, it can be hard to link spending in one sector (e.g., education) to reductions in costs or improvements in outcomes in another (e.g., criminal justice).

Identifying best practices for braiding and blending funds would be beneficial for new APMs. Such best practices could be identified by reaching out to programs that have successfully used these approaches to deliver innovative services to children and their families. An example of such a program is Colorado's Trauma Informed System of Care (COACT Colorado), which has used braiding and blending to fund the delivery of services to children and families with complex needs.[24]

Organizational Commitment and Capacity

New models require relationships with new partners and changes in organizational culture and operations. As such, the model requires strong commitment from participating organizations, including the accountable entity, service providers (e.g., health care practices and community-based organizations), and payers (e.g., private insurers and state Medicaid agencies). This commitment can be difficult to secure and maintain as leadership, priorities, and resources change over time.

Early and continuous engagement among organizational leaders and staff is one strategy to overcome commitment-related challenges. Engaging partner organizations early in the design of a model is one way to ensure that they feel highly invested in the success of the model in the long term. Continuous engagement – especially with respect to regular communication of the model's

successes – is also important for maintaining commitment over time. Being able to demonstrate how each organization contributes to the model's success is particularly vital for ensuring that organizations are recognized for the important contributions they bring to the model and for the value their services have on the health and developmental outcomes of the children and families served.

There is also an overriding need to coordinate the different services delivered by various participating organizations. Yet the different cultures and limited history of collaboration across sectors can pose challenges in connecting children and their families with all the different types of services that they may need. In addition, a health care organization may not know or have ready connections with social services, and vice versa. Further, needs assessments, eligibility requirements, plans of care, and referral results may not be communicated between participating organizations.

To address these challenges, models can develop and implement common access points for screening individuals and referring them to appropriate services. This access point may be an online portal all organizations participating in the model can access. The portal can serve as the integration point for information about children and families' needs and their connections to model services. Learning networks can also be established to share best practices for communication processes and building capabilities (e.g., around maintaining data security and privacy).

One example of a portal in development is North Carolina's "NCCare360" platform, which will link health care and social services providers.[25]

Table 4. Organizational Commitment and Capacity Challenges and Strategies
Challenges
• New models require a change in culture, the development of new relationships, and the establishment of trust with partners, all of which take time.
• It is difficult to connect individuals with appropriate services as the various access points and eligibility requirements vary from program to program.
Strategies
• Engage organizational leaders and staff early in the design process and regularly communicate model success to participating organizations.
• Develop a universal access point to screen and refer individuals to appropriate services.
• Establish learning networks for sharing best practices related key capacity areas (e.g., communication, data sharing, and privacy protections).

Data and Technology Challenges

Data challenges include difficulties in collecting, analyzing, and sharing data about the children and families served by the model. For example, data about children's social needs are rarely collected in electronic health records (EHRs) — and if data are collected, it is done inconsistently across different EHR platforms. As a result, it can be difficult to identify through EHRs the full suite of services that a child and family may need. Current data sources are also limited in their ability to link data between a child, parent or caregiver, and family.

New APMs would benefit from identifying and implementing data tools that consistently collect data on the needs of children and families who are served by the model. Such tools may include traditional intake and health assessment tools for the collection of data on medical needs and tools designed specifically for the collection of data on other types of needs, such as the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) toolkit.[26] Additionally, these tools may also be adapted to collect family-related needs and help link data pertaining to children with data pertaining to their parents or other family members.

Confusion around different data sharing regulations, such as those created under the Health Insurance Portability and Accountability Act [HIPAA] and the Family Educational Rights and Privacy Act [FERPA], frequently inhibits data sharing among sectors, and also hinders coordination across health care and social services providers within a given model. APM designers would benefit from a template for a data sharing agreement that addresses HIPAA and FERPA- related concerns. Such an agreement would help with data sharing and improve coordination across service providers.

Conclusion

Implementation of alternative payment models is a promising approach to addressing the health and developmental needs of children. These models can bring together services from sectors previously siloed from one another, and offer a coordinated set of services specifically designed to meet the needs of children and their families. Additionally, such models can be more resilient during times of emergency (such as COVID-19) and ensure the consistent delivery of services and supports to children, especially vulnerable groups of children.

Thoughtful attention to the key components of models described in this brief is required if they are to be successful in meeting the needs of the children that they serve, enabling effective cooperation and coordination across sectors, and achieving financial sustainability. Anticipating and addressing the many challenges that can impede implementation will require strong collaboration across stakeholder groups. While the work of model design and implementation can be challenging, the results will be worthwhile, helping to achieve meaningful improvements in child health and developmental outcomes.

Table 5. Data and Technology Challenges and Strategies
Challenges
• Inconsistent approaches to collecting data, especially social needs data, inhibits data availability and sharing.
• Inability to link child, parent/caregiver, and family-related data limits ability to identify and address the full spectrum of a child and its family's needs.
• Lack of clarity regarding data sharing regulations (e.g., HIPAA and FERPA) limits organizations' willingness and ability to share data that could inform service design and delivery.
Strategies
• Identify and implement a shared data collection tool that captures data related to a wide variety of needs (e.g., health, social).
• Develop a model data sharing agreement addressing HIPAA and FERPA concerns and implement across organizations participating in the model.

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About the Duke Margolis Center for Health Policy

The Robert J. Margolis, MD, Center for Health Policy at Duke University is both an academic research center and a policy laboratory. Its mission is to improve health and the value of health care through practical, innovative, and evidence-based policy solutions. To learn more, please visit healthpolicy.duke.edu.

About the UCLA Center for Healthier Children, Families & Communities

The Center for Healthier Children, Families & Communities is a multidisciplinary, community-focused research, policy, and training center at UCLA. Established in 1996, we are joint effort of the David Geffen School of Medicine Department of Pediatrics and the UCLA Fielding School of Public Health.

About Mental Health America

MHA – founded in 1909 – is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the overall mental health of all Americans. Our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention services for all, early identification and intervention for those at risk, integrated care, services, and supports for those who need it, with recovery as the goal.

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