NEW YORK STATE | Department of Health | Medicaid Redesign Team

Value Based Payment Advisory Group - Children's Health Subcommittee / Clinical Advisory Group (CAG)

Children's Health VBP Advisory Group Meeting 1

Meeting Date: October 20, 2016, 10:30 am – 1:30 pm

Agenda

1. Welcome and Introductions
2. The Role of the Subcommittee / CAG
3. Overview of Children's MRT and VBP
4. Review of Existing Data
5. Identification and Prioritization of Key Principles for Children's VBP (Discussion)
6. Preview and Next Steps

Welcome & Introductions

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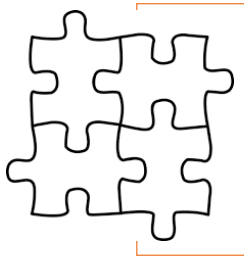
Now let us have the group's members introduce themselves!

2. Role of the Subcommittee / CAG

Opening Platform to Inform Our Work

- **Children Are Not Just Mini Adults!**



Early childhood development, social determinants of health, parental health, and clinical care all play a part in children's wellbeing

Ensuring that all children have access to high quality primary health care is important

Early Interventions can have profound, long-term positive effects on children's lifetime outcomes

Value from improving child outcomes will accrue over a longer time frame and to society at large

Cross-system collaboration is important as children follow their developmental trajectory

Children's Health VBP Subcommittee / Clinical Advisory Group (CAG) Composition: A Dual Approach

Subcommittee

Focus: to create recommendations to the State on VBP design

A geographically diverse group of leading experts and key stakeholders throughout NYS healthcare delivery system.

CAG

Focus: to develop quality measures for VBP Arrangements

- Clinical Experts
- Providers
- Universities
- Health Plans
- State Agencies
- Medical Societies
- Medical Centers

Comprehensive Stakeholder Engagement

Children's Health VBP Subcommittee / Clinical Advisory Group: Objectives

- Understand the State's vision for the Roadmap to Value Based Payment
- Review VBP arrangements for children's services
- Develop a plain language ***value statement*** for the health and well-being of New York's child and adolescent Medicaid beneficiaries
- Make recommendations to the State that reflect the ***value statement*** on:
  - Overall design for children's VBP, including populations / subpopulations
  - Pertinent quality measures for children's VBP arrangements
  - Data and other support required for providers to be successful
  - Implementation details related to VBP

Tentative Meeting Schedule

Meeting #1
October 20 - Albany

- Introductions and Explanation of Roles
- Overview of VBP and Children's MRT
- Review of Children's Medicaid Data and population distinctions
- Identification and Prioritization of Key Principles for Children's VBP

Meeting #2
November 18 - NYC

- Recap of Meeting #1
- Children's VBP Design
- Model Options for Children's VBP
- Group to discuss Model Recommendations
- Group to discuss Key Implementation Considerations
- Preview of Quality Measures

Meeting #3
December 12 - Albany

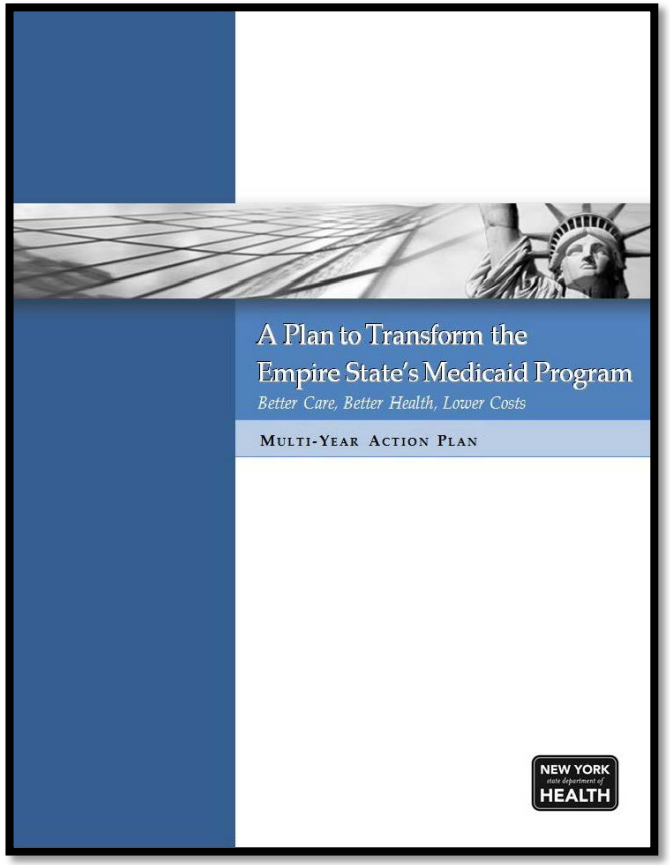
- Recap of Meetings #1 & 2
- Quality Measures Overview
- Detailed Measure Review and Discussion
  - Pediatric Health
  - Pediatric BH
  - Other (e.g. life outcomes; school readiness
- Quality Measure Selection and Recap
- Connection to Principles of Children's VBP

By the end of 2016, the recommendations put forth by the Subcommittee / CAG will be submitted and written into the recommendation report.

3. Overview of Children's MRT and VBP

Overview of Medicaid Redesign Team (MRT)

- In 2011, Governor Cuomo created the Medicaid Redesign Team (MRT).
  - Made up of 27 stakeholders representing every sector of healthcare delivery system
  - Developed a series of recommendations to lower immediate spending and propose reforms
  - Major reforms included cost control; global spending cap; care management for all, Patient Centered Medical Homes (PCMH), and Health Homes (HH)
- Part of the MRT plan was to obtain a 1115 Waiver which would reinvest MRT generated federal savings back into New York's health care delivery system
- In April 2014, New York State and CMS finalized agreement Waiver Amendment
  - Allows the State to reinvest $8 billion of $17.1 billion in Federal savings generated by MRT reforms
  - $6.4 billion is designated for Delivery System Reform Incentive Payment Program (DSRIP)



Delivery Reform and Payment Reform: Two Sides of the Same Coin

- A thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well
- Many of NYS system's problems (fragmentation, high re-admission rates) are rooted in how the State pays for services
  - Fee-for-Service (FFS) pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care
  - Current payment systems do not adequately incentivize prevention, coordination, or integration

Overview of Value Based Payments (VBP)

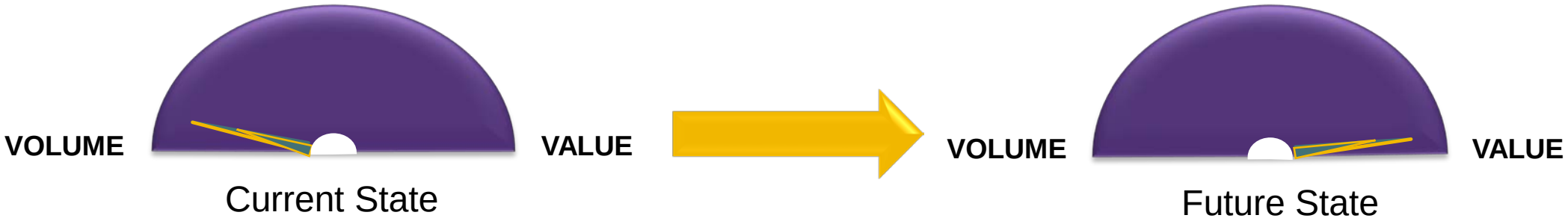
- A Five-Year Roadmap outlining New York State's plan for Medicaid Payment Reform (MRT) was required by the MRT Waiver
- By DSRIP Year 5 (2019), all Managed Care Organizations (MCOs) must employ non fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the Special Terms and Conditions of the waiver)
- The State and CMS have committed to the Roadmap
- Core Stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap
- If Roadmap goals are not met, overall DSRIP dollars from CMS to NYS will be significantly reduced

Reforming the Payment System and Moving from Volume to Value

Value Based Payments (VBP)

An approach to Medicaid reimbursement that rewards value over volume	An approach to incentivize providers through shared savings and financial risk	A method to directly tie payment to providers with quality of care and health outcomes	A component of DSRIP that is key to the sustainability of the program

- VBP arrangements are not intended primarily to save money for the State, but to allow providers to increase their margins by realizing value.



Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. NYSDOH DSRIP Website. Published March 2016.

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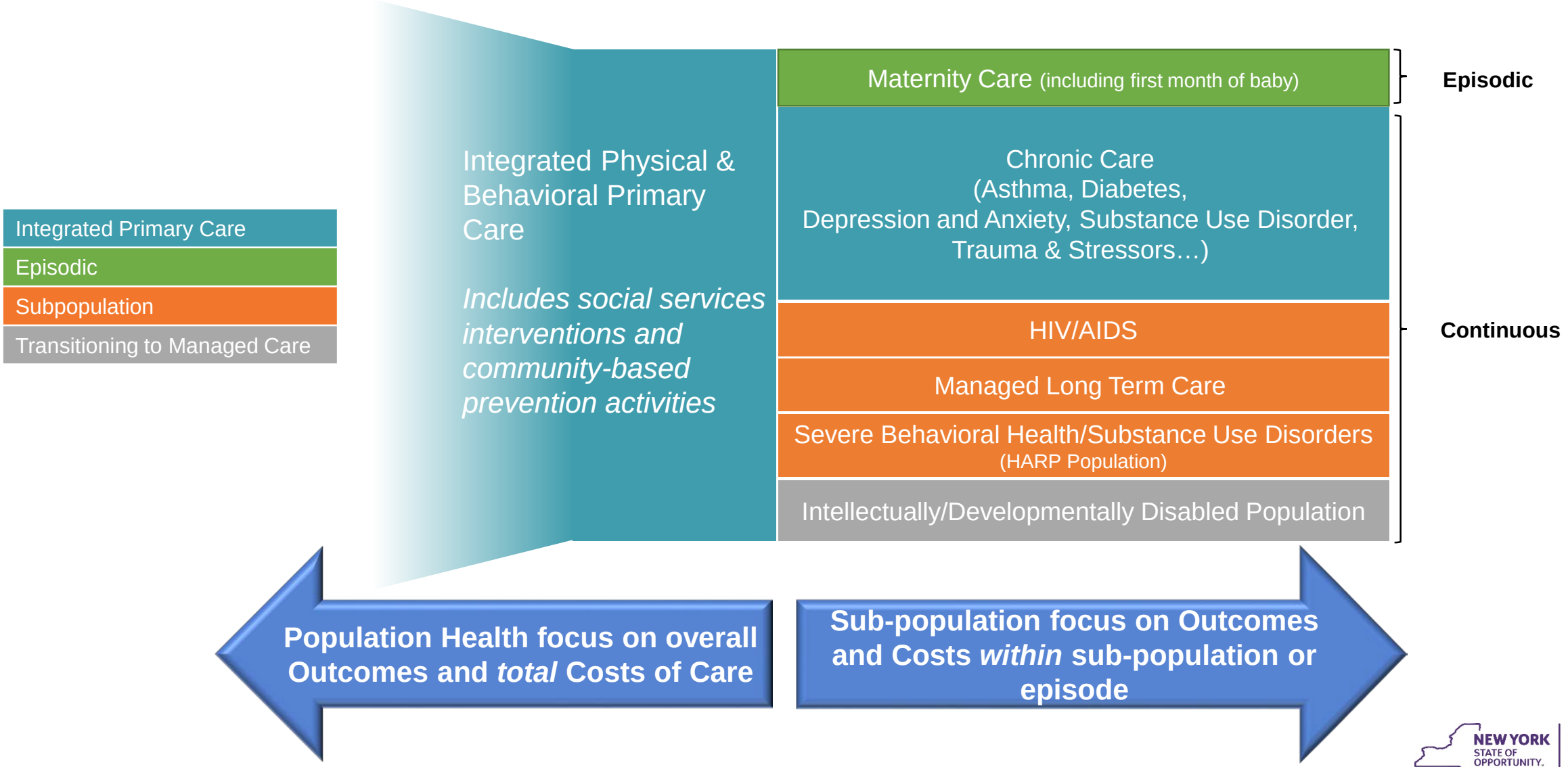
How an Integrated Delivery System should Function



MCOs and Contractors can Choose Different Levels of Value Based Payments

In addition to choosing which integrated services to focus on, the MCOs and contractors can choose different levels of VBP:

Level 0 VBP*	Level 1 VBP	Level 2 VBP	Level 3 VBP (feasible after experience with Level 2; requires mature contractors)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/IPC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)
FFS Payments	FFS Payments	FFS Payments	Prospective total budget payments
No Risk Sharing	↑ Upside Risk Only	↑↓ Upside & Downside Risk	↑↓ Upside & Downside Risk

**Level 0 is not considered to be a sufficient move away from traditional fee-for-service incentives to be counted as value based payment in the terms of the NYS VBP Roadmap.*

VBP Arrangements

- Arrangement Types*
  - Total Care General Population (TCGP)
  - Integrated Primary Care (includes Chronic Bundle) (IPC)
  - Maternity Bundle - episodic
  - Health and Recovery Plans (HARP)
  - HIV/AIDS
  - Managed Long Term Care (MLTC)

    **Arrangements do not yet include Dually Eligible members*

- Two VBP implementation subcommittees were created to focus on:
  - Social Determinants of Health (SDH) and CBOs
  - Advocacy and Engagement

The full recommendations that came from these Subcommittees are available in the DOH VBP Resource Library: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/index.htm

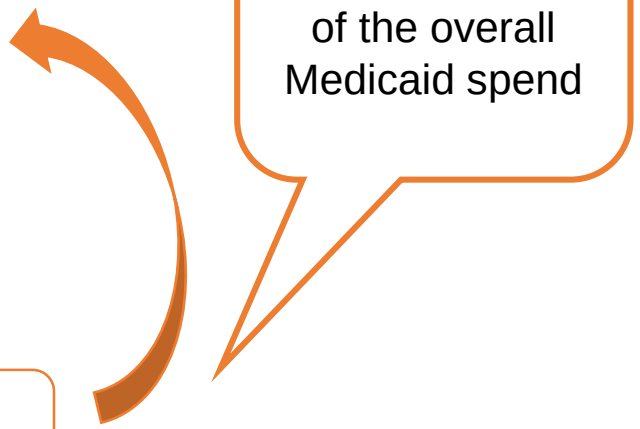
Important Platform of Managed Care

- Managed care is the vehicle for VBP

The **State** will adjust MCO premiums based on value delivered to their total membership per VBP arrangement type (whether actually contracted or not) and on meeting yearly targets to move to 80-90% VBP.

MCOs will subsequently drive providers to improve this value of care. VBP arrangements and insight in the potential performance of providers will be actionable entry point for MCOs

Providers: Deliver better quality and efficient care for Medicaid beneficiaries, allowing for further re-investment into the delivery system



- Populations transitioning to managed care will need an approach to VBP to be developed in a commensurate timeline
  - Contract and reward high value care, and incentivize improvement

Medicaid Redesign Team (MRT)'s Vision, Goals and Principles for Transforming the Delivery of Heath Care for Children

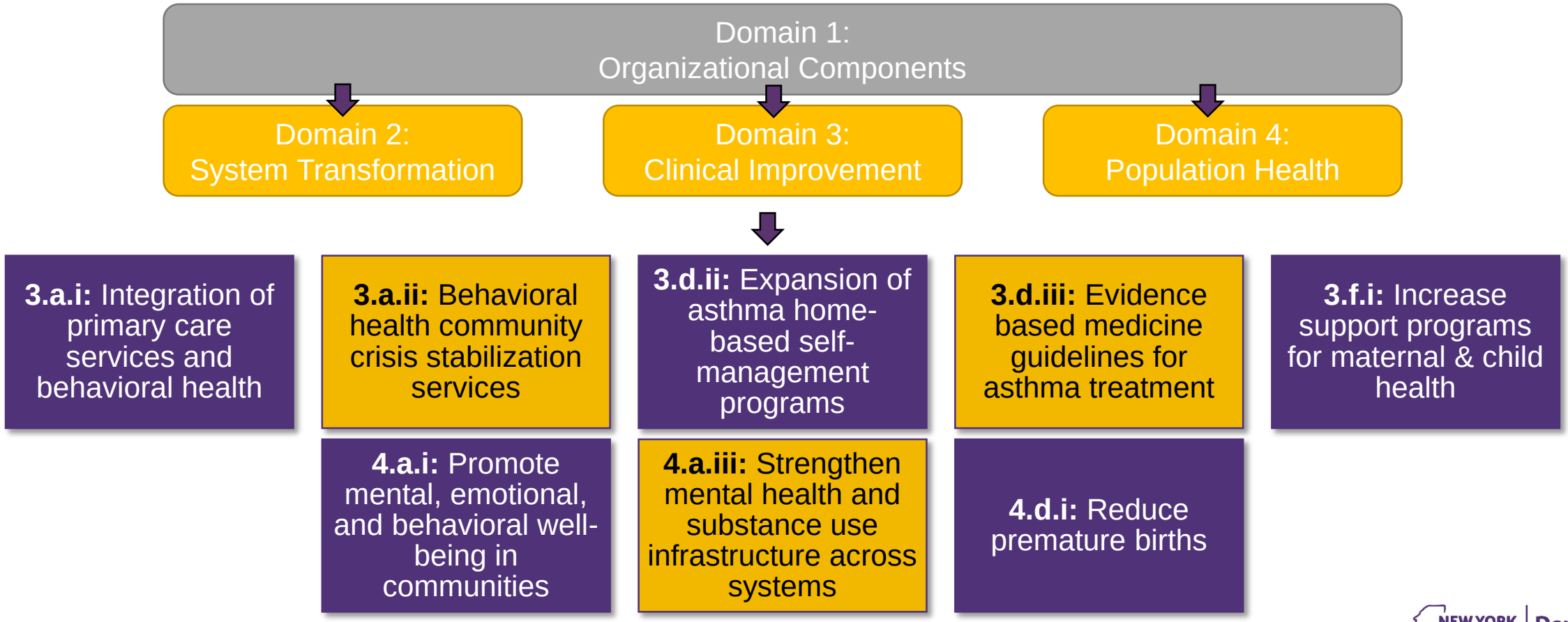
- ✓Keep children on their developmental trajectory
- ✓Focus on recovery and building resilience
- ✓Identify needs early and intervene
- ✓Maintain child at home with support and services
- ✓Maintain the child in the community in least restrictive settings
- ✓Prevent escalation and longer term need for higher end services
- ✓Maintain accountability for outcomes and quality
- ✓Maintain access to services for children without Medicaid as a "Household of One"

Children and Behavioral Health Initiatives in the MRT

- Expansion of Co-located BH and Primary Care (PC)
- Expansion of Health Homes (HH) to Children
- Expansion of Home and Community Based Services for children
- Children's Workgroup
- HH Children's Workgroup

PPS DSRIP Projects that Impact Children Healthcare

DSRIP Project Organization



Source: New York State DSRIP Project Toolkit. NYSDOH DSRIP Website.

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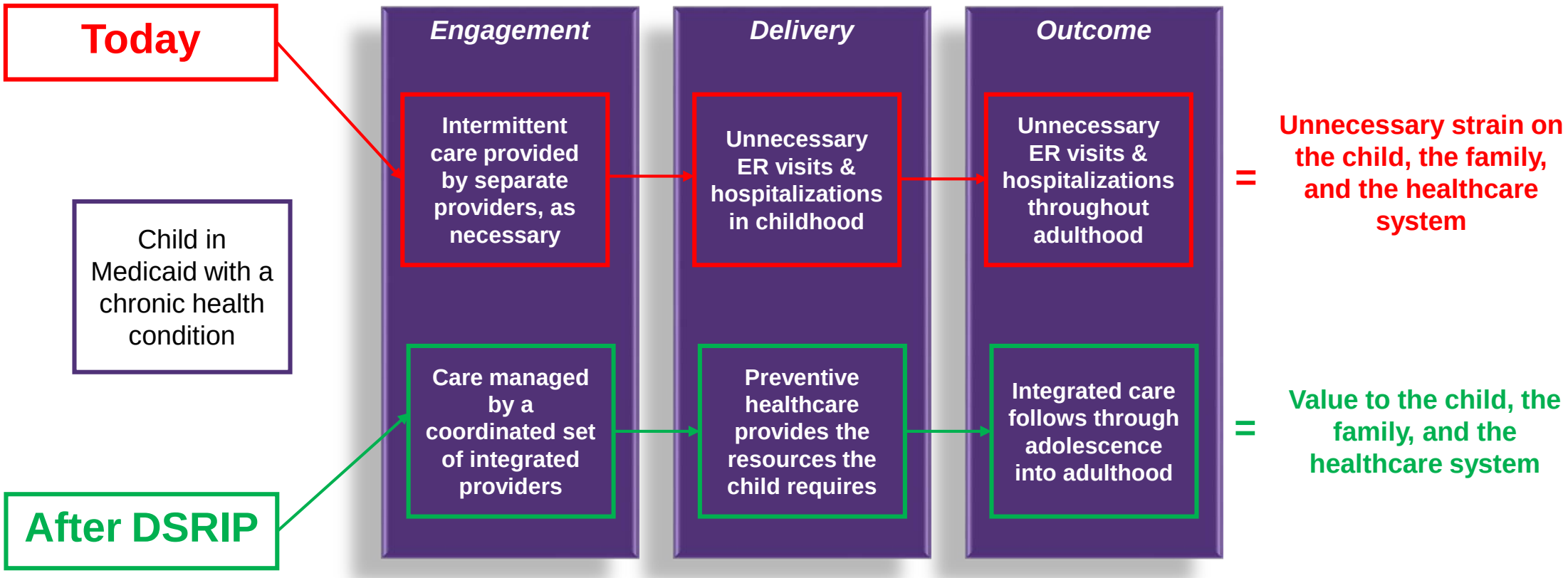
DSRIP Health Outcomes for Children: An Example



Coverage of Children Under Existing VBP Arrangements

- Currently, children are covered in 3 types of arrangements:
  - Total Care for the General Population (TCGP)
  - Integrated Primary Care (IPC)
  - Existing Subpopulation Arrangements
    -HIV/AIDS
    -I/DD (under development)

<u>Key to Consider:</u>

- Are there gaps in VBP coverage that should be addressed?
- Is the volume sufficient to support a specialized arrangements?
- What are the unintended consequences (if any) of a particular approach?

Coverage of Children Total Care for the General Population (TCGP)

- Larger providers that are focused on population health may be interested in TCGP arrangements that cover at least 10,000 members
  - Children are currently included in TCGP
  - Attribution follows PCP assignment (PCP may include pediatricians or family practice doctors)

- Quality measures for TCGP include a range of pediatric measures (see Appendix)

Coverage of Children in Integrated Primary Care (IPC)

IPC =

Preventive Care
(ages 0 -65)

Includes e.g.:
- Wellness visits
- Immunizations, vaccinations (Medicaid-covered)
- Screening
- Routine diagnostics

+

Routine Sick Care
(age range depends on condition)

Includes e.g.:

ages 0-65	Routine Sick Care
ages 2-65	Rhinitis/Sinusitis, Upper Respiratory Infection, Tonsillectomy

+

Chronic Care
(age range depends on condition)

Includes 14 chronic conditions:

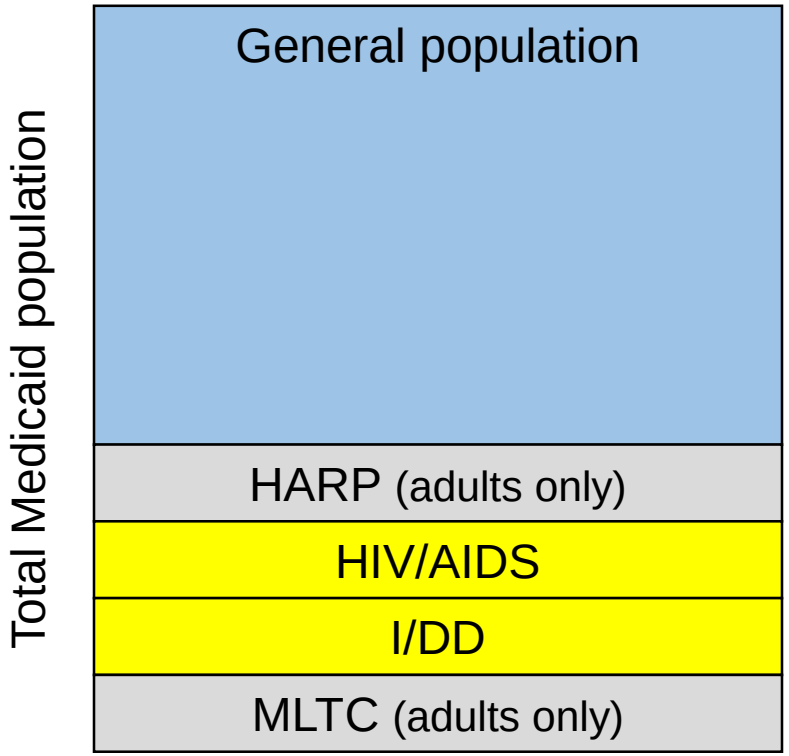
ages 2-65	Asthma
ages 5-65	Diabetes
ages 12-65	Lower Back Pain, Bipolar, Depression and Anxiety, Substance Use Disorder, Trauma and Stressors
ages 18-65	COPD, CHF, CAD, Arrhythmia, Heart Block/Conduction Disorders, Hypertension, Osteoarthritis and Gastro-Esophageal Reflux

Note: Patients that are attributed to subpopulations are excluded.

Coverage of Children in Existing Subpopulation Arrangements

- **HIV/AIDs** – Includes cohort of Medicaid members who are HIV-positive or have AIDS, regardless of age
  - Includes all care for the total subpopulation

- **Intellectually/Developmentally Disabled (I/DD)**
  - Under Development
  - I/DD advisory group convened; 4 meetings completed; quality measures in discussion



4. Review of Existing Data for Children's Health

Presentation by Chad Shearer from United Hospital Fund (UHF)

5. Identification and Prioritization of Key Principles for Children's VBP

➢ Many Factors Impact Children's Health

- ❖ Early Childhood Development
- ❖ Social Determinants of Health
- ❖ Parental Health and Wellbeing
- ❖ Experience in the Education System

➢ Early intervention with children can pay long-lasting, broad-based dividends

- ❖ Future benefits accrue not just to individuals or the healthcare system but to society more broadly
- ❖ Research has shown that preventing/reducing exposure to adverse life events improves the overall lifetime trajectory for children

➢ Children's Health Needs are Dynamic

- ❖ Health needs change as children age
- ❖ Some symptoms and conditions are not as prevalent in older children as they are in younger children (e.g. asthma / pulmonary conditions)
- ❖ Some physical and behavioral health conditions can present during adolescence

➢ Others?

- ❖ Group Discussion

Prioritization Discussion

The prioritization and categorization of our key principles will provide structure as we create recommendations.

What key principles are most critical to address first?
Do these key principles reflect the groups' *value statement*?

Examples of Specific VBP Questions to Consider

In some cases a key principle may link directly to a VBP design question. These will be explored during the next meeting. Examples include:

- Are there specific child and adolescent preventive services that should remain fee-for-service in order to incentivize volume?
- How can the most relevant SDH for children be encouraged through value based payment models?
- How the importance of family network to care outcomes be explicitly recognized in VBP?
- How can public investment from other systems (e.g. school) be factored into VBP arrangements?
- How can VBP address a longer timeframe for savings?

Starting Points for Quality Measurement

The quality measure selection process can begin using the following sources:

- Relevant DSRIP Domain 2 and 3 measures
- Relevant NYS Quality Assurance Reporting Requirements (QARR) measures
- Advanced Primary Care (APC) measure set (State Heath Innovation Plan – SHIP)
- Relevant measures from CMS measure sets
- National Quality Forum (NQF) measures
- National Committee for Quality Assurance (NCQA)

Key starting point: no reinventing of the wheel!

* Please refer to Appendix A for a listing of pediatric-specific quality measures

Source: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2016-child-core-set.pdf

7. Preview and Next Steps

Preview of Children's Health VBP Advisory Group Meeting #2

Topics covered	Featured Presenters	Date & Time	Location
• Children's VBP design • Model options for consideration • Develop model recommendations • Discuss key implementation considerations • Preview quality measures	• Michael Bailit, *Bailit Health* • Marc Berg, *KPMG*	November 18th	NYC - TBD

Recommended Reading

- VBP Roadmap (2016 update)
- Value-Based Payment Models for Medicaid Child Health Services (Bailit Health)
- Poverty and Child Health in the United States
- Effects of Social Needs Screening and In-Person Service Navigation on Child Health
- You Get What You Pay For: Measuring Quality in Value-Based Payment for Children's Health Care
- Understanding Medicaid Utilization for Children in New York State: Data Brief and Chartbook
- Shifting the Care and Payment Paradigm for Vulnerable Children
- Accounting for Kids in Accountable Care: A Policy Perspective
- Transformation of Child Health in the United States

Additional Information:

DOH Website:
http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/

Contact Us:
DSRIP Email:
dsrip@health.ny.gov

Appendix A – Sample Pediatric Quality Measures

Measures with a Pediatric focus in the IPC and Total Care for the General Population Measure set

All measures developed by the Advanced Primary Care (APC) Integrated Care Workgroup as part of the State Health Innovation Plan (SHIP) are included in this set

Primary Prevention Measure Relevant to Pediatric Population (0-65 age range)

Advanced Primary Care Measure set

No.	Measure	Reporting Source	State Recommended Category	P4R
1	Topical Fluoride for Children at Elevated Caries Risk, Dental Services	State	1	No
2	Childhood Immunization Status	VBP Contractor	1	No
3	Preventive Care and Screening: Influenza Immunization	VBP Contractor	1	Yes
4	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	VBP Contractor	1	Yes
5	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	VBP Contractor	1	Yes
6	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	VBP Contractor	1	Yes

Asthma measures (2-65 age range)

No.	Measure	Reporting Source	State Recommended Category	P4R
1	Lung Function/Spirometry Evaluation	State	1	Yes
2	Medication management	State	1	Yes
3	Potentially Avoidable Complications	State	1	No
4	Assessment of Asthma Control – Ambulatory Care Setting	State	2	Yes
5	Patient Self-Management and Action Plan	VBP Contractor	2*	Yes
6	PDI #14 Pediatric Admission Rate	State	3**	
7	PQI #15 Younger Adults Admission Rate	State	3**	
8	Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver (process)	VBP Contractor	2	Yes

* Measure managed by private registry that charges for use. Inclusion in this list does not imply endorsement by the State

** Incidence too low in Medicaid population for reliable measurement. PQIs are included in the Potentially Avoidable Complications (PAC) measure.

Diabetes Measures (5-65 age range)

Children's Health SC / CAG to recommend which of these measures are relevant for the pediatric population

No.	Measure	Reporting Source	State Recommended Category	P4R
1	Medical Attention for Nephropathy	State	1	No
2	Hemoglobin A1c (HbA1c) testing performed	State	1	No
3	Hemoglobin A1c (HbA1c) Poor Control (<8.0 or >9.0%)	State	1	Yes
4	Eye Exam (retinal) performed	State	1	No
5	Foot Exam	State	1	No
6	Composite measure: Comprehensive Diabetes Care (combination of Diabetes measures above)	State	1	No
7	Optimal Diabetes Care (Composite Measure)	State	3**	
8	Controlling Blood Pressure	State	1	No
9	Statin Therapy	State	1	No
10	Proportion of Days Covered (PDC): three rates by therapeutic category (RAS antagonists, diabetes medication or statins)	State	1	No
11	Angiotensin-Converting Enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) therapy	VBP Contractor	2	Yes

- Measures recommended by more than 1 CAG are not (see slide 4). For prevention measures see Appendix.

** Measure not in APC or QARR. Large overlap with existing measures.

*** Incidence too low to be reliable. Is also included in PAC measure.

Recommended Maternity Measures (Mother 60 days post partum; infant 30 days post partum)

Maternity – Category 1 Measures

The CAG recommends the following quality measures for use in the Maternity VBP Arrangement.

No.	Category 1 Measure	Reporting Source	State Recommended Category	P4R
1	Frequency of Ongoing Prenatal Care	State	1	No
2	Prenatal and Postpartum Care (PPC)	State	1	No
3	% of Vaginal Deliveries with Episiotomy	VBP Contractor	1	Yes
4	Vaginal Birth After Cesarean (VBAC) Delivery Rate	VBP Contractor	1	Yes
5	C-Section for Nulliparous Singleton Term Vertex (NSTV) (risk adjusted)	VBP Contractor	1	Yes
6	% of Early Elective Deliveries	VBP Contractor	1	Yes

Maternity – Category 2 Measures

The CAG recommends the following quality measures for use in the Maternity VBP Arrangement.

No.	Category 2 Measure	Reporting Source	State Recommended Category	P4R
7	Birth Trauma Rate – Injury to Neonate	State	1	No
8	Live Births Weighing Less than 2,500 Grams (risk adjusted)	VBP Contractor	1	Yes
9	% Preterm Births	VBP Contractor	1	Yes
10	Under 1500g Infant Not Delivered at Appropriate Level of Care	State	1	No
11	LARC Uptake	VBP Contractor	2	Yes
12	Neonatal Mortality Rate	VBP Contractor	3	N/A
13	Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Discharge	VBP Contractor	2	Yes
14	% of Babies Who Were Exclusively Fed with Breast Milk During Stay	VBP Contractor	1	Yes
15	Monitoring and Reporting of NICU Referral Rates	VBP Contractor	2	Yes