Housekeeping

- WebEx Chat Functionality for Q&A
- Slides and a recording will be posted and made available soon
- Reminder: Information and timelines are current as of the date of the presentation.
Agenda

- Recap from Part I
- Children’s Quality Measures in Value-Based Payment
- Payment Models for Children’s VBP
- Putting It All Together
McSilver Institute for Poverty Policy and Research

The McSilver Institute for Poverty Policy and Research at New York University Silver School of Social Work is committed to creating new knowledge about the root causes of poverty, developing evidence-based interventions to address its consequences, and rapidly translating research findings into action.

The McSilver Institute employs collaborative research methods via partnerships with policymakers, service organizations, consumers and community stakeholders.

The McSilver Institute’s research efforts are guided by a recognition of the interrelatedness of race and poverty.
United Hospital Fund

Mission: United Hospital Fund works to build a more effective health care system for every New Yorker. An independent, nonprofit organization, we analyze public policy to inform decision-makers, find common ground among diverse stakeholders, and develop and support innovative programs that improve the quality, accessibility, affordability, and experience of patient care.

Children’s Health Initiative and Medicaid Institute Publications

- Seizing the Moment: Strengthening Children’s Primary Care in New York (Jan 2016)
- You Get What You Pay for: Measuring Quality in Value-Based Payment for Children’s Health Care (June 2016)
- Understanding Medicaid Utilization for Children in New York State (July 2016)
- Value-Based Payment Models for Medicaid Child Health Services (July 2016)
Recap
Value-Based Payment for Children — Setting the Stage

- ‘Value’ for children is different from adults
- Compared to adults, children are generally a low-cost, low-utilization population and have more contact with primary care.
- A very small subset of children with heterogeneous needs account for a large proportion of expenditures.
- The external environment – primarily Social Determinants of Health -- disproportionately impacts young children, with long-term implications for health care and other public sectors
- These characteristics will need to be considered as New York Medicaid pursues value-based payment for children
Key Questions from Part 1

- How to address the unique needs of medically complex children in VBP?
- What additional services are necessary and feasible in VBP for children, especially in early childhood?
- Are there lessons from other states that can be informative for New York?
- How do we ensure VBP is a positive incentive for providers, not a deterrent?
Measuring Quality in VBP
Value is Quality and Payment

- VBP is an umbrella term for different ways insurers pay providers
- Typically, goal is to maintain or improve quality while containing cost
- But can also think about it as an equation, where value is increased through large focus on improving quality and outcomes

\[ \text{Value} = \frac{\text{Quality}^*}{\text{Payment}} \]

* A composite of patient outcomes, safety, and experiences
Children’s Quality Measures in VBP

- Few national standards or models for guiding selection of child-focused cost and quality goals specifically in the context of VBP
- Quality measure development for children’s health services has lagged behind adults: “many important priorities for quality measurement and improvement do not yet have metrics available to address them.”
- 2015 survey of 12 pediatric accountable care arrangements:
  - Quality component of arrangements “underdeveloped”
  - None of the ACOs were required to perform well on quality measures as a prerequisite for receiving shared savings
  - Authors concluded that many pediatric accountable care structures have “failed to identify” how VBP can result in health improvements for children

Initial Observations

- The impact of prevention can be hard to measure.
- Many notable benefits from pediatric prevention efforts accrue to sectors outside the health care system.
- Standards for appropriate and high-quality care can differ across developmental stages.
- Proportionally, there are fewer high-cost, high-need patients among children than adults—but those children have specific care needs that should be safeguarded in VBP arrangements.

Sources: United Hospital Fund, You Get What You Pay For: Measuring Quality in Children’s Value-Based Payment
Who Is Focused on Kids and VBP?

- Oregon Health Authority
- Partners for Kids and Nationwide Children’s Hospital (Ohio)
- Colorado Pediatric Collaborative

Source: United Hospital Fund, You Get What You Pay For: Measuring Quality in Children’s Value-Based Payment
What Are They Measuring?

Most Common Areas of Measurement (3 out of 3)

- Incidence of well care visits, child and/or adolescent ★ #
- Hospital utilization: ED utilization, avoiding inpatient admissions #

Common Areas of Measurement (2 out of 3)

- Child or adolescent immunization status ★ #
- Pregnancy-related measures, including contraceptive use, timeliness and frequency of pre-natal and post-partum care ★ #
- Ambulatory: appropriate pharyngitis/URI treatment ★
- Asthma or diabetes ★ #
- Behavioral health ★ #

★ = NY QARR Measure
# = NY DSRIP Measure

Measures Unique to Each Case Study

Preventive Care
- Incidence of developmental screening, first 36 months
- Incidence of screening for alcohol, tobacco, substance abuse, among adolescents ★
- Dental care ★

Birth Outcomes
- Infant mortality rate, incidence of prematurity or low birth weight, NICU days ★ #

Management of Chronic Conditions
- Receiving high-risk care coordination


★ = NY QARR Measure
# = NY DSRIP Measure
Measures Unique to Each Case Study

Other

- Enrolled in a patient-centered primary care medical home
- Generic Rx dispensing rate
- Child and adolescent access to primary care #
- Measuring access to preventive services embedded in schools

★ = NY QARR Measure
# = NY DSRIP Measure

What’s Next?

Colorado Pediatric Collaborative:
- Limited opportunity to accrue savings, need to transition quickly to “next version” of VBP—developing strategies to improve the long-term health of the population by working with families and education system

Partners for Kids and Nationwide Children’s Hospital:
- Move from process outcomes (e.g. delivery of prevention services) to outcome measures
- Improve primary care quality and population health efforts while decreasing costs in subspecialty pediatrics

Oregon Health Authority:
- Development of a joint accountability measure on “Kindergarten Readiness”
Kindergarten Readiness Example

Health Care Components
- Well-child check completed in past year
- Vision is normal or corrected
- Hearing is normal or addressed
- Immunizations are up to date
- Dental exam shows no active decay
- Children with a special health care need have a cross-system, family-centered, actionable shared care plan in place
- Family is screened for food insecurity/hunger
- Developmental screening has been completed in past year

Family Components
- Parent/caregiver assessed for depression in past year
- Parent/caregiver assessed for substance use disorder in past year
- Parent/caregiver assessed for domestic violence in past year

Kindergarten Assessment Components
- Children have behavior that facilitates learning
- Children have literacy skills
- Children have numeracy skills

Source: United Hospital Fund, You Get What You Pay For: Measuring Quality in Children’s Value-Based Payment
**New York Measures Today**

- New York generally performs well on the child core set, compared to other state Medicaid programs
- Areas for opportunity and improvement remain
- A desire to push the envelope and develop measures that go beyond service utilization

<table>
<thead>
<tr>
<th>Measure</th>
<th>Median of Reporting States</th>
<th>New York Performance</th>
<th>New York Quartile Ranking</th>
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</thead>
<tbody>
<tr>
<td>Six or More Well-Child Visits in the First 15 Months</td>
<td>62.1</td>
<td>68.5</td>
<td>Next to Top</td>
</tr>
<tr>
<td>One or More Well-Child Visits in Years 3–6</td>
<td>67.4</td>
<td>83.1</td>
<td>Top</td>
</tr>
<tr>
<td>One or More Well-Care Visits in Years 12–21</td>
<td>43.5</td>
<td>63.9</td>
<td>Top</td>
</tr>
<tr>
<td>Follow-up After Mental Illness Hospitalization Within 7 Days; Ages 6–20 Years</td>
<td>43.9</td>
<td>70.4</td>
<td>Top</td>
</tr>
<tr>
<td>Follow-up After Mental Illness Hospitalization Within 30 Days; Ages 6–20 Years</td>
<td>65.2</td>
<td>84.5</td>
<td>Top</td>
</tr>
<tr>
<td>ED Visits per 1,000 Enrollees; Ages 0–19 Years (lower is better)</td>
<td>45.7</td>
<td>40.5</td>
<td>Next to top</td>
</tr>
<tr>
<td>Asthma Medication Management; Ages 5–20 Years</td>
<td>31.2</td>
<td>28.6</td>
<td>Next to bottom</td>
</tr>
</tbody>
</table>
Bailit Health Recommendations

1. regular access to a primary care team
2. regular developmental screens and preventive care
3. regular screens for socioeconomic determinants of health, with resource referral when needed
4. access to coordinated specialty care, when needed
5. family involvement in care
6. seamless integration of behavioral health and primary care
7. health is well-managed and the child is emotionally well
8. the child is able to appropriately and effectively function – e.g. at developmental milestones, performing activities of daily living, attending school, and achieving academically

Source: United Hospital Fund, Value-Based Payment Models for Medicaid Child Health Services (Bailit Health)
NY Takeaways

1. Government and public programs, particularly Medicaid, will likely have to lead the way in development of new measures for children.
3. Establishing VBP measures for medically complex children is going to be methodologically complex.
4. VBP measures could encourage integration of BH, oral health, and social determinants of health services into primary care.

Source: United Hospital Fund, You Get What You Pay For: Measuring Quality in Children’s Value-Based Payment
Output to Outcomes - Assessment Databases & EHR Report Project
Project Components

Goal: To help behavioral health providers improve quality of care while lowering healthcare costs.

1) Creating a comprehensive assessment database for practitioners and organization decision makers to identify clinical outcome and process measures – OTO

2) Developing a set of standardized reports to integrate within organizations’ electronic health records (EHRs)

3) Disseminating project tools through presentations and training opportunities
Guiding Principles: Data = Information

Data already exists... *the key is to identify it and use it to inform your processes*

- Choose and define the outcomes of focus
- Capture the data and understand it so that it informs:
  - The client
  - The program
  - The agency
  - The payer
  - Referral Sources
- “Data” must be accessible and actionable by everyone
Data-Driven Decision Making

Making decisions based on available data:

- What do we already track? What is required and necessary?
- What do we need to track? Requires thinking in advance how data may best inform what we need to know
- How should we track our progress? Implement standard performance-monitoring protocol
- What changes do we need to make? Be willing to adjust measurements intermittently – feedback loop
All levels of staff will use the best available data to make informed-decisions

- Clinical staff will collect, monitor, and review clinical outcome data to make treatment decisions

- Program directors will use outcome data, clinical, claims and payment data for each service and program to understand system level processes (e.g., client improvements, cost management, staff management, and services offered)

- Leadership will use data to better understand outcomes and services for each program and to make decisions
Example to Consider Across Levels

Individual-Level Approach

- How, agency-wide or as an individual clinician, do you treat a child who has or may have ADHD?

- How do you assess? How do you treat? How do you track progress over time?

- Is this consistent across all individuals receiving services for ADHD?

- What does this mean for care managers?
Example to Consider Across Levels (cont.)

Population-Level Approach

- How many children with ADHD do you provide services to? What demographic information are you capturing and considering? How as a larger group are they faring over time?

- Outcomes are aggregate individual level information used to identify areas of strength and opportunities for change at a program, agency, or system-wide level.
Output to Outcomes
An Assessment Resource for Providers
OUTPUT to OUTCOMES

ASSessment Resource for Clinics

Helping behavioral health agencies integrate outcome measures into their clinical treatment and services.

Search Now

WE'VE STREAMLINED THE PROCESS FOR YOU.
Find valid measure options for your clinical case work in less time.
How Providers Can Use the Database

- Providers can search and identify assessment tools to be used within their agency.

- Assessment tools range from daily living skills, to behavioral health, social, and employment.

- Many of the assessment tools within the database allow providers to measure and track progress.
Database Search Functionality

START YOUR SEARCH 😊

Choose an outcome category

Select a category ▼

or

Search by keyword

[Image of a computer screen displaying a database search interface]

United Hospital Fund

McSilver Institute for Poverty Policy and Research

NYU Silver
Standardized Reports

An EHR and Provider Collaboration & Pilot
In Depth Process

- Provider Driven – Focus Groups, with vendor guidance
- Calls
- Starting with information already in the EHR (mostly billing data)
  - Allows standardization
  - Lets agencies use the information they already have rather than collecting new information
- Diagnostic Categories, Service Type, Payer Mix
Report Features

- Payer Mix, Service Delivery, Diagnostic
- Each report will be available at the agency, program type, and individual program level
- Each report can be drilled down by diagnostic category and service type
- Standardized set of definitions
- Will be free of charge and available in perpetuity to ALL current and future NYS clients
Reports will allow organizations to:

- Get a sense of who they’re serving
- The types of services they are delivering
- The types of services individuals with specific diagnoses are receiving
- Breakdown of clients by Insurance Type

Key features: standardization of definitions and terms across organizations and vendors
## Sample Payer Mix Report

### Payer Mix by Program

<table>
<thead>
<tr>
<th>Program</th>
<th>Self Pay</th>
<th>Medicare FFS</th>
<th>Medicare and Medicaid</th>
<th>Medicaid FFS</th>
<th>Commercial Insurance</th>
<th>Commercial Managed Care</th>
<th>Medicaid Managed Care</th>
<th>Medicare Managed Care</th>
<th>Total Managed Care/Insurance</th>
<th>Third Party Payer</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program A</td>
<td>73</td>
<td>12.0%</td>
<td>60</td>
<td>9.9%</td>
<td>101</td>
<td>16.8%</td>
<td>211</td>
<td>34.8%</td>
<td>7</td>
<td>1.2%</td>
<td>72</td>
</tr>
<tr>
<td>Program B</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>1.2%</td>
<td>2</td>
<td>25.0%</td>
<td>5</td>
<td>62.5%</td>
<td>6</td>
<td>75.0%</td>
<td>0</td>
</tr>
<tr>
<td>Program C</td>
<td>16</td>
<td>2.5%</td>
<td>10</td>
<td>1.8%</td>
<td>138</td>
<td>25.4%</td>
<td>263</td>
<td>48.3%</td>
<td>11</td>
<td>2.0%</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>89</td>
<td>7.7%</td>
<td>71</td>
<td>6.1%</td>
<td>241</td>
<td>20.8%</td>
<td>479</td>
<td>41.3%</td>
<td>24</td>
<td>2.1%</td>
<td>97</td>
</tr>
</tbody>
</table>
Sample Service Delivery & Diagnostic Report

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Diagnostic Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ADHD + Disruptive, Impulse-Control and Conduct Disorders</td>
</tr>
<tr>
<td></td>
<td>Schizophrenia Spectrum and Other Psychotic Disorders</td>
</tr>
<tr>
<td></td>
<td>Bipolar and Related Disorders</td>
</tr>
<tr>
<td></td>
<td>Depressive Disorders</td>
</tr>
<tr>
<td></td>
<td>Anxiety Disorders</td>
</tr>
<tr>
<td></td>
<td>OCD and Related Disorders</td>
</tr>
<tr>
<td></td>
<td>Trauma- and Stressor-Related Disorders</td>
</tr>
<tr>
<td></td>
<td>Alcohol-Related Disorders</td>
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<tr>
<td></td>
<td>Opioid-Related Disorders</td>
</tr>
<tr>
<td></td>
<td>Other Substance-Related and Addictive Disorders</td>
</tr>
<tr>
<td></td>
<td>Personality Disorders</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
</tr>
</tbody>
</table>

- Follows the structure of the DSM V, please consult for more thorough definitions.
- The service-type options correspond with the program type
Payment Models for VBP
NY Medicaid VBP Roadmap

VBP Models

- Total Cost of Care for the General Population
- Partial Cost of Care for Integrated Primary Care and Chronic Care
- Maternity Bundle
- Total Cost of Care for Special Needs Subpopulations

Levels of Risk Assumed by Providers

1) Shared Savings – Upside Only
2) Shared Risk – Upside and Downside
3) Prospective Capitation or Bundle
Roadmap Questions and Next Steps

Questions – How will...?
- Quality measurement in VBP actually work
- Cost and quality be benchmarked
- Social determinants of health be included in VBP
- Community based organizations be included in VBP arrangements

Next Steps
- Up to 15 VBP pilots testing all types and levels of VBP arrangements
- Ongoing clinical advisory groups defining measures
- Children’s VBP Subcommittee and Clinical Advisory Group – Convening this fall “focused on children and adolescents in the context of VBP”
Current Approaches are Insufficient

"...interviewees recognized the importance of a healthy childhood to becoming a productive adult and the key role that pediatricians have in providing critical developmental screenings, preventive services, anticipatory guidance, and in managing acute and chronic health care issues...payment models undervalue pediatric care because of the long-term payoff that is not reflected in current fee-for-service rates.”

- Research doesn’t differentiate between delivery models (e.g., PCMH) and payment models (capitation, episodes, etc.)
- Pediatric Accountable Care Organizations and bundled payments initiatives to date have focused more on cost, than quality, and don’t include accountability for social determinants of health
- Current primary care payment models don’t reflect services necessary to generate real ‘value’ for children
Socioeconomic & Psychosocial Factors

1) screening for them;
2) providing interventions when appropriate services are available within the practice;
3) establishing robust linkages to community-based behavioral health, educational, and social service organizations that can address more directly the social determinants that are beyond the scope of a pediatric practice; and
4) making and closing referrals to such community-based organizations.

“There are *many* social determinants of health... we specifically suggest considering the following as a non-exclusive list of opportunities:

- Parental depression and stress
- Kindergarten readiness
- Environmental triggers of asthma, and
- Parental education and support regarding ACEs”
Potential Payment Models for Children

- **Primary care capitation**, increased from historical rates to encompass
  - American Academy of Pediatrics Bright Futures clinical guidelines
  - Child and parental screening for social determinants and other risk factors
  - Physician time for telephone interaction with patients
- + Care coordination payment for children with medical and social risk factors – especially for services associated with connecting families to a robust network of community based organizations that can help address social determinants
- + Performance incentive bonus for both excellence and improvement over time
Potential Payment Model for High-Need Children

- Children with medical complexity account for 40% of all hospitalizations for ambulatory-care sensitive conditions of children in Medicaid
- Payment for this small subpopulation in a total cost of care model provides financial flexibility and incentive to reduce unnecessary care
  - Requires a sufficiently large population
  - Can be shared savings or shared risk, but should never be full risk
  - Savings based on quality, not just cost
- + Care coordination payment that accounts for higher clinical credentials necessary to manage children with medical complexity
Issues Needing Focus

- Cross-subsidization
- Joint accountability
- Social needs risk adjustment
- Patient attribution

“Children served by Medicaid are subject to many more adverse social determinants of health and have worse health status than higher-income children, and yet are generally funded at lower levels than commercially insured children.”
What’s Next?
What's Next for Children in New York

- Children’s VBP Subcommittee and Clinical Advisory Group
- Ongoing system transformation timeline
  - Children’s Health Homes (December 1, 2016 -- statewide)
  - State Plan Amendment (SPA) Services: (January 1, 2017 – statewide)
  - Medicaid Managed Care and Children’s BH HCBS
    - July 1, 2017 – NYC, Long Island and Westchester Counties
    - January 1, 2018 – Rest-of-State
Next Steps for Providers

Step 1: Determine where you fit in

- **Define** the problems and goals that your organization is best suited to address in the new behavioral health care environment
- **Evaluate** the processes, resources, and talents that will be necessary to be a successful and valued partner.
- **Measure** your current effectiveness and efficiencies
- **Clearly articulate** how your agency will play a part in the triple aim of health care reform: Improving Care, Improving Health, Reducing Costs
Next Steps for Providers

Step 2: Determine What You Need
- Staffing and Training
- Organizational Structure
- Technology
- Processes

- Step 3: Develop a Plan (and stick with it!)
Questions to Ask

- What does VBP mean for your organization?
- Do you have resource/infrastructure/staff that can develop, implement, and monitor outcomes?
- Do you have a budget to support this?
- What are your options? Have you identified and explored them?
- When can we get started?
Resources

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Value-Based Payment Models for Medicaid Child Health Services (Bailit Health)
http://www.uhfnyc.org/publications/881145

You Get What You Pay for: Measuring Quality in Value-Based Payment for Children’s Health Care
http://www.uhfnyc.org/publications/881134

Seizing the Moment: Strengthening Children’s Primary Care in New York
http://www.uhfnyc.org/publications/881092

Understanding Medicaid Utilization for Children in New York State
http://www.uhfnyc.org/publications/881143

New York’s Value-Based Payment Roadmap (June 2016 Update):
Resources

McSilver Institute for Poverty Policy and Research
www.mcsilver.nyu.edu
mcsilver@nyu.edu

Community Technical Assistance Center (CTAC)
www.ctacny.org
ctac.info@nyu.edu

Children’s System Transition Timeline

Q&A from Children’s System Transformation Trainings
http://ctacny.org/sites/default/files/Kids%20Q%26A%20Augus%202016.pdf

Information about Children’s Health Homes (DOH)
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_homes_and_children.htm

SPA Provider Manual

CTAC Children’s System Resources
http://ctacny.org/systems-transformation