

VBP Models for Medicaid Child Health Services

Presentation to the NYS Medicaid VBP Children's Subcommittee
and Clinical Advisory Group

Marge Houy, Senior Consultant

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Agenda

1. Background
2. Research Approach and Key Findings
3. Proposed Payment Model
 - i. Payment for Children without Medical Complexity
 - ii. Payment for Children with Medical Complexity
4. Other Considerations
5. Policy Implications for Funding
6. Conclusion and Discussion

1. Background

- The Schuyler Center for Analysis and Advocacy and the United Hospital Fund invited Bailit Health to research and propose value-based payment models for Medicaid Child Health Services.
 - In recognition that NYS' Medicaid roadmap is moving towards value-based incentives
 - In recognition that there is a need for a different value proposition and payment model for pediatrics
 - Interest in helping inform policy discussions as changes to Medicaid payment models move forward

Introduction to Bailit Health

- Bailit Health's mission is to work with public agencies and private purchasers to improve health care system performance for all.
 - We work to facilitate change and to ensure insurer and provider performance accountability for delivering value
 - We believe delivery system transformation and payment reform are inextricably linked and are the foundation for system improvement
 - We have worked on payment reform issues throughout the United States

2. Research Approach and Key Findings

- Approach:
researched relevant literature, interviewed state and national experts, reviewed NYS Medicaid data

Interviewees

Richard Antonelli, M.D., The Boston's Children Hospital

George Askew, M.D., NYC Dept. of Health and M Hygiene

Susan Berman, M.D., American Academy of Pediatrics

Marc Berg, M.D., KPMG

Debbie Chang, MPH, Nemours Children's Health System

Suzanne Delbanco, Ph.D., Catalyst for Payment Reform

Steven Farmer, M.D., George Washington University

Eliot Fishman, Ph.D., CMS

Jason Helgerson, MPP, New York State DOH

Dana Hargunani, M.D., OHSU HealthCare

Mark Hudak, M.D., American Academy of Pediatrics

Kelly Kelleher, M.D., Nationwide Children's Hospital

Bruce Nash, M.D., Blue Cross Blue Shield of Mass.

Andrew Racine, M.D., Montefiore Health System

Shanna Shulman, Ph.D., Smith Family Foundation

Joseph Stankaitis, M.D., MPH., Monroe Plan

Peter Szilagyi, M.D., University of California, Los Angeles

Key Findings That Shaped Our Recommendations

1. The value proposition for pediatric care must recognize the long-term (and not just the immediate) impact of care provided
 - Adult value propositions focus on reducing IP and ED utilization
2. There are 3 subsets of children that must be considered:
 - Those with medical complexity needing tertiary care
 - Those with 1 or more chronic condition and/or a significant social need that can be managed by community pediatricians
 - Those who are generally healthy
3. Non-traditional services/delivery system flexibility needs funding
4. Pediatricians are in a unique position to identify SDOHs

Implications of Key Findings

A Medicaid child health payment model should support:

1. Clinical care management services, because of the high prevalence of chronic conditions
2. Accountability to measures specific to child health
3. Adoption of co-located/operationally integrated behavioral health services due to high rates of children/teens with BH needs
4. Actions a pediatric practice can realistically take to address SDOHs:
 - Screen
 - Provide interventions when services are in-practice
 - Establish robust linkages to community-based services
 - Actively manage the referral process to community-based services

Defining Value for Child Health Care

- We propose defining “value” as a mix of care processes and outcomes that together promote a child’s opportunity to develop physically and emotionally such that s/he can productively contribute to society throughout his/her life*:
 - regular access to a primary care team
 - regular developmental screening and other preventive care
 - regular screening for SDOH with resource referrals as appropriate
 - access to coordinated specialty care
 - family involvement in care
 - seamless integration of behavioral health and primary care
 - health is well-managed and the child is emotionally well
 - the child can appropriately/effectively function – at developmental milestones, performing ADLs, attending school, achieving academically

* Recommended by Shanna Shulman, PhD.

3. Payment for Children without Medical Complexity

Goal: adequately fund traditional and non-traditional services, provide service flexibility and incentivize QI

PMPM Capitation

Removes financial need to generate office visits
Liberates providers to provide new services, employ workforce resources creatively and use non-office visit modalities



PMPM Care Coord.

Focus on children with medical and social risk factors
Manage specialty referrals, track testing, patient follow-up
Link children and families to needed community-based resources



Performance Bonus

Reward excellence and improvement over time
Use national measures
Approach 10% of compensation

Structure of Primary Care Capitation

- Rate based on historical costs, adjusted up, as necessary, to cover costs of:
 - Delivery of care consistent with Bright Futures guidelines
 - Screening for SDOH and other risk factors, including parental health
 - Physician time for telephone calls
 - Co-located and operationally integrated BH care, when offered
- PMPM should exclude vaccines, services not delivered by most pediatricians (e.g., suturing), and any services where underutilization is a concern.
 - Pay these services on a fee-for-service basis

Structure of Primary Care Capitation (cont'd)

- Rate should be adjusted down when practice has higher-than-expected utilization of ED, urgent care and physician specialist services.
 - Disincentive for dumping patients
 - Incentive to build PCMH infrastructure to provide 24/7 access to care team
 - Incentive to provide effective care management for high-risk patients
- Exclude children with complex health needs from the primary care capitation model.

Care Coordination Payment

- For many children services could be provided by social workers or community health workers, depending on needs.
- PMPM should be risk-adjusted for:
 - Clinical risks (e.g., chronic conditions, behavioral health diagnoses, foster care status)
 - Socioeconomic risk, using proxies in the short term (e.g., zip code, income, employment status, primary language, single parent, etc.)

Performance Bonus

- Must be significantly large to drive behavior change
 - Research suggests close to 10% of reimbursement
- Quality measures would ideally be adopted on a multi-payer basis.
- Measures could be used to promote joint accountability for parental health and specific SDOH (discussed later).

Payment for Children with Medical Complexity

Goal: reduce costs and improve care

Total Cost of Care

- Based on attributed population
- Shared savings and shared risk opportunities
- Provides financial flexibility
- Incentizes providers to reduce unnecessary care and find better ways to provide care



Care Coordination PMPM

- Support care managers with appropriate clinical credentials
- Should reflect level of intensity of services provided

Children with Medical Complexity (cont'd)

- Model characteristics:
 - Need sufficiently large population to ensure accurate assessment of financial performance
 - Model should evolve from shared savings to shared risk, but never full risk due to impact of high-cost outliers
 - Savings should be based on achieving performance levels on pre-negotiated measure set that is relevant to the targeted population

4. Other Considerations for Medicaid Payment for Child Health Services

- Episode-based payments
 - Consider exploring and testing for specialty care
 - Possibly a model for populations managed by specialists
 - Possible application with specialists who operate both within and outside of a total cost of care contract
- Accountability for social determinants of health
 - Select SDOH that can be influenced by health care providers and begin to integrate into payment models. Examples:
 - Parental depression and stress
 - Kindergarten readiness (e.g., pre-reading skills)
 - Environmental triggers for asthma
 - Parental education and support regarding ACEs

Other Considerations for Medicaid Payment for Child Health Services (cont'd)

- Joint accountability
 - Encourage coordination across siloed entities
 - Shared performance measures across health care providers and agencies addressing SDOH
 - Oregon is considering joint accountability across CCOs (MCO/ACO-type organizations) and regional early learning “hubs” for kindergarten readiness
 - Shared performance measures among adult and pediatric practices for parental activities that impact child health:
 - Tobacco use
 - Substance use
 - Nutrition

5. Policy Implications for Funding

- The recommended payment model assumes funding of some currently non-funded activities.
- Cross-subsidization will be necessary to maintain and invest in primary care for Medicaid children who face more adverse conditions and lower funding.
- Possible sources of funding include:
 - Savings generated through better care for children with medical complexity (reduced avoidable ED and IP services, inappropriate specialty referrals, duplication of testing)
 - Savings generated through better care for chronically ill and medically complex adults.

6. Conclusion

Our recommended model:

- removes the deleterious effects of fee-for-service payment
- promotes expanded funding for pediatric care in recognition of long-term impact on a child's adulthood of early childhood and adolescent events that are not identified and addressed
- promotes an engaged role for pediatricians to screen, identify, treat and/or refer regarding behavioral health needs and SDOH
- offers financial incentives to providers for high value care

Conclusion

- Our recommended model represents one possible approach.
- It is not the same as the proposed primary care bundle, but it certainly shares some common attributes.

Discussion