



**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 #5

Subcommittee Draft Recommendations Review & Discussion

Webinar Date: June 9, 2017, 3:00 pm – 4:30 pm

June 9, 2017

# Webinar Agenda

- Welcome and Introductions
- Brief Progress Update
- Presentation of Recommendations, Comments and Proposed Changes
- Discussion
- Next Steps and Adjourn

## Subcommittee/CAG May Progress

- Minor edits to May 2<sup>nd</sup> meeting slide deck
- Shared with SC/CAG members for feedback
- Collected input and organized by recommendation area
- Proposed changes to recommendations based on meeting and off-line comments
- Matrix and Measures revisions to be discussed on 6/14/17 webinar

# Draft Recommendations Discussion

Jeanne Alicandro and Kate Breslin, Co-Chairs  
Chad Shearer and Suzanne Brundage, UHF

# Recommendation Considerations

- The role of “North Star” goals across all recommendations
- The intersection of children’s recommendations with existing VBP models and measures
- Recommendation Type
  - A **Standard** is required when it is crucial to the success of the VBP Roadmap that all MCOs and providers follow the same method.
  - A **Guideline** is sufficient when it is useful for providers and MCOs to have a starting point for the discussion, but MCOs and providers may deviate as local flexibility may contribute to the overall success of the VBP Roadmap.
  - A **Suggestion** is a recommendation directed at the state that is not directly related to MCO and provider standards and guidelines.

## 3 Categories of Recommendations

1. VBP Principles and Payment Models
2. Measures
3. Additional Work/Deliberation

# Recommendation Changes Summary

Based on feedback, 9 recommendations amended and 1 new recommendation since 5/2 meeting.

No.	Summary	Change/New
Payment 1	Slightly amended description to reflect holistic child needs including behavioral health.	Change
Payment 2	Slightly amended description and recommendation to clarify voluntary nature of PPCC for MCOs and providers.	Change
Payment 2.1	Change from standard to guideline and substantial recommendation revision reflecting MCO and provider flexibility necessary to define PPCC attribution	Change
Payment 2.2	Slightly amended description and recommendation to clarify importance of behavioral health and other enhancements included in the PPCC rate	Change
Payment 2.3	Single word added to recommendation to clarify that the quality withhold would be from the enhanced PPCC rate	Change
Payment 3	Major change to description and recommendation to reflect desire for pediatric payment goals to generally be consistent across VBP models	Change

## Recommendation Changes Summary (Continued)

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Measure 2	Emphasis added to recommendation type to recognize the Subcommittee/CAG strongly recommends a universal TCGP/IPC/PPCC measure set	Change
Measure 3	Emphasis added to recommendation type to recognize the Subcommittee/CAG strongly recommends that pediatric relevant Maternity measures be reflected in all other appropriate VBP model measure sets	Change
Measures 5	Added description and recommendation to recognize consensus among Subcommittee/CAG that developmental screening should become a level 1 VBP measure in the TCGP/IPC/PPCC measure set as soon as feasible (ideally measurement year 2019).	New
Additional Work 1	Major revisions to description and recommendation to reflect heterogeneity of the complex children population and potential solutions to be considered by future workgroup(s) focused on complex children and families.	Change



# Principles & Payment Models Recommendation #1

- **Type** – Suggestion
- **Description** – Children are not “little adults.” Focusing on the healthy growth and development of children will improve their quality of life. Children require a VBP approach that acknowledges the specific needs attendant to each developmental stage and the unique opportunity to improve health and life trajectories, as well as the importance of responding to immediate health needs. Support and recognition of families and caregivers is central to improving children’s lives.
- **Draft Recommendation 1**– The State should adopt the Matrix and it’s “North Star” goals as the guiding framework which recognizes the unique needs of children at different developmental stages, and the overarching role of primary care in both the delivery of healthcare services to children and the promotion of overall child well-being. Adoption of current and future payment models should be guided by this framework and the American Academy of Pediatrics Bright Futures Guidelines.

## Input/Considerations

- As written, the recommendation is too medically oriented.

## Proposal

- **Description** – Children are not “little adults.” Focusing on the healthy growth and holistic development of children will improve their quality of life. Children require a VBP approach that acknowledges the specific needs attendant to each developmental stage and the unique opportunity to improve health and life trajectories, as well as the importance of responding to immediate physical and behavioral health needs. Support and recognition of families and caregivers is central to improving children’s lives.

## Principles & Payment Models Recommendation #2

- **Type** – Suggestion
- **Description** – The vast majority of children are low-cost and not ideally served by VBP models that rely on shared savings/risk. Additional investment in child primary care services is necessary to maximally contribute to the Matrix goals. A wholly separate VBP model should be available to MCOs and providers that voluntarily wish to develop unique VBP contracts for the pediatric population.
- **Draft Recommendation 2** – The State should consider creating an additional on-menu option in the VBP Roadmap that allows MCOs and providers to enter into pediatric primary care capitation (PPCC) arrangements consistent with the sub-recommendations that follow. The model would be deemed a Level 3 VBP arrangement under the Roadmap.

# Input/Considerations

- Clarify that the new PPCC model is optional for providers/plans, not mandatory
- Consider whether or not there is meaningful incentive for providers/plans to adopt PPCC model
- There should be an opportunity for large behavioral health organizations to directly contract in VBP arrangements with MCOs rather than subcontracting to primary care
  - PPCC is only designed to include behavioral health expenses to the extent they are integrated in the primary care practice. Nothing in PPCC precludes large behavioral health organization from directly contracting with MCOs in a VBP arrangement covering behavioral health services, it is merely assumed that these organizations are likely not suited to enter PPCC arrangements focused on the core primary medical care needs for pediatric populations.

# Proposal

- **Description** – The vast majority of children are low-cost and ~~not ideally served~~ **therefore may be better served** by VBP models that **do not** rely on shared savings/risk. Additional investment in child primary care services is necessary to maximally contribute to the Matrix goals. A wholly separate VBP model should be available to MCOs and providers that voluntarily wish to develop unique VBP contracts for the pediatric population.
- **Draft Recommendation 2**– The State should consider creating an additional on-menu option in the VBP Roadmap that allows **(but does not require)** MCOs and providers to enter into pediatric primary care capitation (PPCC) arrangements consistent with the sub-recommendations that follow. The model would be deemed a Level 3 VBP arrangement under the Roadmap.

## Principles & Payment Models Recommendation #2.1

- **Type** – Standard
- **Description** – PPCC arrangements are not ideal for medically and behaviorally complex children because they are insufficient to address the specialized needs and service utilization of these children.
- **Draft Recommendation 2.1** – MCOs and providers should be allowed to enter into PPCC arrangements only for children who are in the bottom 80<sup>th</sup> percentile of the MCO's overall cost/utilization distribution among all its child members.

# Input/Considerations

- Commenters had varying opinions on the appropriate attachment point and pediatric population subsets that should be included/excluded from PPCC VBP arrangements.

# Proposal

- **Type – Standard Guideline**
- **Description** – PPCC arrangements are not ideal for medically and behaviorally complex children because they are insufficient to address the specialized needs and service utilization of these children.
- **Draft Recommendation 2.1** – MCOs and providers should be allowed to enter into PPCC arrangements only for children who are in the bottom ~~80<sup>th</sup>~~ 90<sup>th</sup> percentile of the MCO's overall cost/utilization distribution among its child members. Plans and providers should be granted discretion in determining the attributed child population below the 90<sup>th</sup> percentile, particularly taking into account the share of members that would be considered part of a complex population that should be excluded from the PPCC arrangement. The attributed population methodology should be subject to State review and approval.

## Principles & Payment Models Recommendation #2.2

- **Type** – Guideline
- **Description** – The capitation rate in PPCC agreements must reflect the role of providers in screening and coordinating care for social and developmental threats to health, in addition to medical needs. The capitation should include enhancements sufficient to support all necessary screenings, risk-adjusted care coordination, and new workflows to address developmental needs and social determinants. The enhanced rate should incorporate behavioral health services for primary care practices with co-located and operational integrated behavioral healthcare. The capitation rate should exclude services where there may be a serious concern for underutilization.
- **Draft Recommendation 2.2** – The capitation rate should include nearly all primary care service needs for children. MCOs and providers can agree to exclude services where there are underutilization concerns (e.g., vaccinations, developmental screenings). Parties may also agree to exclude pediatric services provided by some, but not all providers that are party to the PPCC arrangement (e.g., suturing).



# Input/Considerations

- Include specific mention of behavioral health needs
- Clarify whether the enhanced capitation rate in PPCC agreements is inclusive of co-located and operational integrated behavioral health care, or if the recommendation is to have a separate rate enhancement specifically for integrated behavioral health care.
- Amend language to “The capitation rate should include nearly all primary care and health-supportive service needs for children”.
  - Concern that this language is too broad – propose using the specific language in the recommendation description
- Why “exclude services where they maybe a concern for underutilization (vaccines, developmental screenings)” if the likely goal is to increase utilization of these?
  - Fee-for-service encourages service utilization. It is an effective payment method for health services that you want to encourage – particularly immunizations.

# Proposal

- **Description** – The capitation rate in PPCC agreements must reflect the role of providers in screening and coordinating care for social, **behavioral** and developmental threats to health, in addition to medical needs.
- **Draft Recommendation 2.2** – The **risk-adjusted primary care** capitation should include enhancements sufficient to support all necessary screenings, risk-adjusted care coordination, and new workflows to address developmental **and behavioral health** needs and social determinants. **An additional enhancement should be provided to** ~~The enhanced rate should incorporate behavioral health services for primary care practices with co-located and operational integrated behavioral health care.~~ **While** the capitation rate should include nearly all primary care service needs for children, **including the previously described enhancements**, MCOs and providers can agree to exclude services where there are underutilization concerns (e.g. **vaccine costs** ~~vaccinations, developmental screenings~~). Parties may also agree to exclude pediatric services provided by some, but not all, providers that are party to the PPCC arrangement (e.g., suturing).

## Principles & Payment Models Recommendation #2.3

- **Type** – Standard/Guideline
- **Description** – In a PPCC model, providers are paid a per-member / per-month payment for an attributed population of children. In order to ensure providers do not unduly limit child health utilization or reduce the quality of care provided under this model, a percentage withhold and periodic improvement/performance payment based on agreed to measures is necessary.
- **Draft Recommendation 2.3** –
  - Standard – MCOs shall implement a withhold from the PPCC rate to be disbursed at least annually based on both improvement and high performance on all Category 1 P4P measures, and complete and accurate reporting of all Category 1 P4R measures.
  - Guideline – MCOs and providers shall agree upon a percentage withhold and the weighting by which performance payments from the withhold are disbursed based on improvement and high performance. In weighting, MCOs and providers should take into account measures of particular relevance to the population being served, and current provider performance on those measures.

# Input/Considerations

- Concern that starting with a quality withhold in first year will be too challenging for primary care providers, consider a first year of bonus potential only with year two having downside risk.
- As written, it appears primary care providers will need to work harder to achieve current PMPM.
  - This was not the intention. The withhold should only be based on the *enhanced* PPCC rate.

# Proposal

- **Description** – In a PPCC model, providers are paid a per-member / per-month payment for an attributed population of children. In order to ensure providers do not unduly limit child health utilization or reduce the quality of care provided under this model, a percentage withhold and periodic improvement/performance payment based on agreed to measures is necessary.
- **Draft Recommendation 2.3–**
  - Standard – MCOs shall implement a withhold from the enhanced PPCC rate to be disbursed at least annually based on both improvement and high performance on all Category 1 P4P measures, and complete and accurate reporting of all Category 1 P4R measures.
  - Guideline – MCOs and providers shall agree upon a percentage withhold and the weighting by which performance payments from the withhold are disbursed based on improvement and high performance. In weighting, MCOs and providers should take into account measures of particular relevance to the population being served, and current provider performance on those measures.

## Principles & Payment Models Recommendation #2.4

- **Type** – Suggestion
- **Description** – While PPCC is not an entirely new payment approach to some MCOs and providers, it is not widespread as described in these recommendations. It also may introduce currently unforeseeable impacts as it intersects with TCGP/IPC arrangements or where individual providers are pursuing a multitude of Medicaid and commercial VBP approaches for pediatric populations.
- **Draft Recommendation 2.4** – The state should consider offering pilot opportunities for the PPCC VBP model similar to the pilots offered for the existing VBP Roadmap models.

# Input/Considerations

- No comments or recommended changes

## Principles & Payment Models Recommendation #3

- **Type** – Guideline for TCGP and IPC Arrangements
- **Description** – Not all children will be served through a PPCC arrangement. Many will be covered by broader TCGP or IPC arrangements that include shared savings/risk that are not generally appropriate for the PPCC target population as previously defined. In TCGP or IPC arrangements with large pediatric populations with substantial avoidable hospital utilization it may be appropriate for shared savings/risk to apply to the child population for a limited time period to reduce avoidable utilization.
- **Draft Recommendation 3** – MCOs and providers in TCGP and IPC arrangements should consider excluding PPCC eligible populations from shared savings/risk calculations in order to ensure that pediatric primary care providers are not penalized for appropriate additional investments in child services that are unlikely to generate one-year savings opportunities.



## Input/Considerations

- Concern that the recommendation to consider excluding PPCC-eligible children from shared savings/risk calculations will undermine other VBP efforts and be administratively burden – suggest clarifying that this exclusion is optional.
- Request that VBP providers who include children in other VBP payment models may also receive the PPCC enhanced funding for pediatric care.

## Proposal

- **Description** – Not all children will be served through a PPCC arrangement. Many will be covered by broader TCGP or IPC arrangements that include shared savings/risk ~~that are not generally appropriate for the PPCC target population as previously defined. In TCGP or IPC arrangements with large pediatric populations with substantial avoidable hospital utilization it may be appropriate for shared savings/risk to apply to the child population for a limited time period to reduce avoidable utilization.~~ In those arrangements pediatric providers should not be disadvantaged because low-cost children generally do not generate savings. Pediatric providers should also receive any pediatric enhancements envisioned under PPCC.

## Proposal Continued

- **Draft Recommendation 3** – MCOs and providers in TCGP and IPC arrangements should consider ~~excluding PPCC-eligible populations from shared savings/risk calculations~~ appropriate children’s utilization and cost (including any potential additional enhancements added to MCO rates via a PPCC related increase) in determining baseline pediatric spending targets in these shared savings/risk arrangements. The state should review this methodology as part of the VBP contract review process in order to ensure that pediatric primary care providers are not penalized for appropriate additional investments in child services that are unlikely to generate one-year savings opportunities.

# Measures Recommendation #1

- **Type** – Suggestion
- **Description** – Standard health measures alone are insufficient to fully assess outcomes of high-value well-child care. Cross-sector measures of child development and well-being may be good proxy measures. While it is not currently feasible or appropriate to hold providers accountable for such cross-sector measures of appropriate child development, the State should not lose sight of these larger goals as it advances VBP for children.
- **Draft Recommendation 1** – The state should adopt the “North Star” goals and key indicators at each developmental stage, and the American Academy of Pediatrics Bright Futures Guidelines as the guiding framework by which the success of VBP for children is measured, and for consideration of all future children’s measure development and implementation for VBP purposes and beyond.

# Input/Considerations

- No comments or recommended changes.

## Measures Recommendation #2

- **Type** – Suggestion
- **Description** – Many children will be covered by TCGP/IPC arrangements regardless of the availability of the PPCC VBP model. The current TCGP/IPC measure set does not include sufficient pediatric focused measures to ensure providers are striving to improve and achieve high performance for children under those VBP models.
- **Draft Recommendation 2** – Measures developed for the PPCC model should be integrated with existing measures to create a universal TCGP/IPC/PPCC measure set for 2018 and beyond. PPCC measures in this universal set should be updated at least annually consistent with the processes used to update TCGP/IPC measures.

## Input/Considerations

- Request for this recommendation to receive a classification stronger than a “suggestion”
  - NYSDOH use of “guidelines” and “standards” is reserved for recommendations directed at MCOs and providers. All recommendations directed to the State are classified by default as a “suggestion.”

## Proposal

- **Type** – Suggestion (**Strongly Recommended**)

## Measures Recommendation #3

- **Type** – Suggestion
- **Description** – Maternal health has a major impact on child health, especially pre- and post-natal and during the first year of a child's life. Maternity costs are included in the TCGP VBP model and excluded from the IPC model. Births are likely to occur both under the maternity bundle and TCGP VBP models, but there are no maternity measures in the TCGP measure set. There are also a small number of additional pre- and post-natal measures identified as especially relevant to child health that are not included in the maternity bundle measure set.
- **Draft Recommendation 3\*** – Four specific measures in the current maternity bundle that are especially relevant for child health should be added to the TCGP measure set for 2018 and beyond. The maternity CAG should consider the addition of one new maternity bundle measure identified by the Children's CAG as particularly relevant to children's health. That measure should be added to the TCGP measure set for 2018 and beyond as adopted for the maternity bundle.

\* Recommendation subject to adjustment pending specific measures CAG discussion and additional clarification on maternity bundle and TCGP intersection.

## Input/Considerations

- Request for this recommendation to receive a classification stronger than a “suggestion”
  - NYSDOH use of “guidelines” and “standards” is reserved for recommendations directed at MCOs and providers. All recommendations directed to the State are classified by default as a “suggestion.”

## Proposal

- **Type** – Suggestion (**Strongly Recommended**)



## Measures Recommendation #4

- **Type** – Standard
- **Description** – The pediatric population is more diverse than the adult population and disparities in care are especially troubling for children. Tracking VBP measures for children with race-ethnicity breakdowns would provide a unique opportunity to assess disparities and identify future opportunities for improved equity through appropriate disparity reduction targets.
- **Draft Recommendation 4** – VBP arrangements, regardless of model, should require providers and MCOs to report and track performance on all pediatric VBP measures at the most detailed level of race/ethnicity breakdown possible.

# Input/Considerations

- No comments or recommended changes.

# Measures Recommendation #5



NEW

- **Type** – Suggestion
- **Description** – Developmental screening is widely recognized as an important clinical strategy for early identification of children experiencing developmental delays and challenges. When combined with access to appropriate interventions, developmental screening is a critical strategy for ensuring children are able to achieve their maximum potential. Developmental Screening in the First Three Years of Life (NQF #1448) is included in the CMS Child Core Set of quality measures, and currently 20 states annually report on developmental screening as part of that process. While acknowledging that there are concerns with developmental screening measure NQF# 1448, particularly the validity of using the billing code CPT 96110 to collect appropriate measurement data, the SC/CAG believes it is important to overcome these barriers in order to encourage developmental screening in clinical practice.
- **Draft Recommendation 5** - The State should expedite its efforts to work with providers and plans through its School Readiness VBP Pilot, New York’s Early Childhood Comprehensive Systems federal grant, and other related efforts, to refine its approach to using Developmental Screening in the First Three Years of Life (NQF #1448). The State should consider lessons learned from other states that have modified their billing policies for this measure, including Maine, Minnesota, and Connecticut. The goal of this work should be on reasonably resolving concerns related to NQF #1448’s measure specifications and updating related clinical guidance for providers and plans, in order to adopt a developmental screening measure as a Category 1 measure by Measurement Year 2019.

# Additional Work/Deliberation Recommendation #1

- **Type** – Suggestion
- **Description** – The Subcommittee discussed a number of options for addressing the unique needs of complex children through VBP and worked with a subset of members to brainstorm potential models. Given time and data constraints, and the recognition that many complex children are not yet in managed care and/or relevant services remain carved-out, additional deliberation is required.
- **Draft Recommendation 1** – The state should utilize this subcommittee, a subgroup thereof, or develop a new advisory group to make recommendations on payment models and measures for complex children. This process should specifically consider:
  - The definition of complex children for VBP purposes and the issue of small and unique complex population subsets and substantial regression to the mean.
  - Whether a complex family subpopulation that includes payment for children and their caretakers on Medicaid is viable and feasible.
  - What measures from the TCGP/IPC/PPCC measure set should apply to complex children and what additional measures are required.

# Input/Considerations

- Acknowledge in the recommendation that behaviorally complex children and medically complex children have different needs and considerations.
- Acknowledge the importance of addressing family needs, particularly for children with medical and behavioral complexities.
- Acknowledge the difference between medically complex and medically fragile children and encourage the use of NYSDOH's existing "medically fragile children" definition.

# Proposal

- **Description** – The Subcommittee discussed a number of options for addressing the unique needs of **complex** children **and families** through VBP and worked with a subset of members to brainstorm potential models **for the behaviorally complex subpopulation**. Given time and data constraints, **the heterogeneity of subpopulations within the group of complex children and families (e.g., medically complex, medically fragile, behaviorally complex)**, and the recognition that ~~many complex~~ **some portion of these** children are not yet in managed care and/or relevant services remain carved-out, additional deliberation is required.

# Proposal Continued

- **Draft Recommendation 1** – The state should utilize this subcommittee, a subgroup thereof, or develop a new advisory group(s) to make recommendations on payment models and measures for complex children. This process should specifically consider:
  - The definition (s) of complex children for VBP purposes and the ~~issue of~~ feasibility of VBP models for small and unique complex population subsets (e.g., medically complex, medically fragile – as already defined by the state, and behaviorally complex) and substantial regression to the mean.
  - Whether a payment model for a behaviorally complex family subpopulation that includes children and their caretakers on Medicaid is viable and feasible, and should be piloted.
  - What measures from the TCGP/IPC/PPCC measure set should apply to complex children (and/or redefined subsets thereof) and what additional measures are required.
  - Whether centers of excellence for very small subsets of complex children (e.g., medically fragile) could be a viable strategy for achieving VBP goals without creating unnecessary risk for providers and MCOs.

## Additional Work/Deliberation Recommendation #2

- **Type** – Suggestion
- **Description** – Ongoing measure review, development, and implementation is required to continue to push the envelope for improvement and to ensure the measures being utilized are valid and appropriate. Outside of the current CAGs there is no obvious venue for this vital ongoing work.
- **Draft Recommendation 2**– The state should utilize the existing CAG expertise but consider a centralized and streamlined process for: 1) annual reconsideration of VBP measures; 2) inclusion of new measures; 3) encouraging further development of Category 1 P4R and Category 2 measures so that they can become P4P; and 4) developing additional measures that are important to VBP goals, but not currently feasible. This group or a subgroup thereof could be charged with refinement of the pediatric “North Star” goals and indicators and developing pathways for cross-sector measurement. The Oregon Metrics and Scoring Committee is an example the State should consider as a model.



# Input/Considerations

- No comments or recommended changes.

## Additional Work/Deliberation Recommendation #3

- **Type** – Suggestion
- **Description** – There are multiple efforts underway to transform the delivery system broadly and primary care specifically. None of those efforts specifically focus on the unique needs of pediatric patients or pediatric primary care practices.
- **Draft Recommendation 3** – The State should build on its early efforts (e.g., All Albany Kids Ready) to develop additional pilots, programs and/or technical assistance efforts that test, evaluate and spread optimum pediatric primary care delivery models that are focused on the “North Star” goals.

# Input/Considerations

- No comments or recommended changes.

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Measures 5	Added description and recommendation to recognize consensus among Subcommittee/CAG that developmental screening should become a level 1 VBP measure in the TCGP/IPC/PPCC measure set as soon as feasible (ideally measurement year 2019).	New
Additional Work 1	Major revisions to description and recommendation to reflect heterogeneity of the complex children population and potential solutions to be considered by future workgroup(s) focused on complex children and families.	Change

# Next Steps

Jeanne Alicandro and Kate Breslin, Co-Chairs  
Chad Shearer and Suzanne Brundage, UHF

# Timeline

Activity	Date
Quality measures webinar	June 14
Final recommendations, measure set, and matrix compiled and circulated to subcommittee for 7/10 meeting	July 7
Final subcommittee meeting	July 10, 11am – 3pm, Albany
Draft subcommittee report circulated	August
Final subcommittee report presented to VBP Workgroup	September