



# Reforming Payment for Children's Long-Term Health

Lessons from New York's  
Children's Value-Based Payment Effort

Suzanne C. Brundage

*Director, Children's Health Initiative, United Hospital Fund*

Chad Shearer

*Senior Vice President for Policy and Program, United Hospital Fund*

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**The  
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**United Hospital Fund**

*Improving Health Care for Every New Yorker*



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The mission of the Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.



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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. For more on our initiatives and programs, please visit our website at [www.uhfnyc.org](http://www.uhfnyc.org) and follow us on Twitter, @UnitedHospFund.

## Foreword

To improve health care quality and rein in growing health care costs, policymakers have increasingly been developing and testing models that pay providers based on value, rather than volume, of care. While many models have been successful, they have by and large been developed with adults in mind and tend not to account for the unique features of children's health care, such as dependencies on adults for care and developmental stages. By not considering children, these value-based payment (VBP) models miss the opportunity to intervene early in the life course, prevent long-term health issues, and ultimately curb costs. State Medicaid programs particularly stand to benefit from developing VBP models that focus on children's health care, as they cover approximately 40 percent of U.S. children.

Recognizing this opportunity, New York set out to develop a VBP model in its Medicaid program that uniquely responds to the needs of children. United Hospital Fund (UHF) partnered with New York's Medicaid program in a multi-step process to design an alternative payment model to promote high-quality care for children. The Commonwealth Fund commissioned UHF to draft a case study of this significant and collaborative effort. As is evident from the pages that follow, UHF and the State have made the case for a separate children's value-based payment model, launched a State-sponsored subcommittee to assess proposed payment models and quality measures, achieved consensus among subcommittee members on the goals and features of a potential pediatric primary care capitation model, and recommended the model for pilot contracting between managed care plans and pediatric providers. They found that engaging stakeholders with appropriate depth and breadth of expertise, using data to identify and define the target subpopulation, and agreeing on a set of guiding principles were critical to their success.

This work builds on The Commonwealth Fund's longstanding legacy and commitment to promoting a high-performing health system for children, one of society's most vulnerable populations. As states increasingly turn to VBP to promote high-quality, patient-centered care, as well as to rein in increasing cost growth in the Medicaid program, they will need to account for the unique needs of children. It is our belief that the lessons from New York provide a model that will inspire other states to develop VBP models that aim to improve children's health.

**MELINDA K. ABRAMS, MS**  
Senior Vice President  
The Commonwealth Fund

**LAURIE ZEPHYRIN, MD, MBA, MPH**  
Vice President  
The Commonwealth Fund

## Preface

What should value-based payment for children's health services look like?

In 2016, United Hospital Fund and the Schuyler Center for Analysis and Advocacy started contemplating this challenging and complex question. Our attempts to answer it became part of a multi-year effort to create a child-centered Medicaid payment approach in New York State. In close partnership with the New York Medicaid program and colleagues in other states asking similar questions, our staff and partners learned a lot about the challenges and opportunities of using value-based payment to improve children's health and well-being.

We conducted interviews, consulted with colleagues involved in New York's efforts, examined experiences in other states, and helped the state navigate its relationships with stakeholders. Earlier this year, we released a report, *Achieving Payment Reform for Children through Medicaid and Stakeholder Collaboration*, and an accompanying guide for action that chronicle some of this work. And now, in the pages that follow, we provide a case study of New York State's initiative to make a child-specific value-based payment model a reality. It contains some important lessons that could be useful to numerous stakeholders and to other states seeking to improve outcomes for children's health.

This report also makes it clear that although this work is challenging, it is critically important. And it shows that even though the process is still ongoing, we have seen notable progress to date—not least a strengthened commitment in New York's Medicaid program to serve its youngest beneficiaries.

United Hospital Fund is grateful for the Commonwealth Fund's support and is proud to be involved with this effort. We remain committed to working with New York State and our partners to make children's health care as effective as it can be.

**ANTHONY SHIH, MD**  
President  
United Hospital Fund

## Overview: New York’s Value-Based Payment for Children’s Health Services

**Important Feature:** Responding to provider and advocate requests, the New York Medicaid program has designed a value-based payment (VBP) approach specific to children’s health services and is actively seeking opportunities to pilot it with managed care plans and primary care providers. The proposed payment model is intended to give primary care providers increased resources and flexibility to invest in strategies, such as social needs screening, that promote optimal child health and can potentially reduce long-term health care costs.

**Population of Focus:** The proposed children’s VBP model is intended to improve care for the vast majority of Medicaid child beneficiaries. This includes approximately 90 percent of New York’s Medicaid child enrollment. The model is not intended for children with complex chronic conditions, medical fragility, severe intellectual or developmental disabilities, or those still served through the traditional fee-for-service system.

**Why It’s Important:** Value-based payment approaches for children’s primary health care services are urgently needed to improve quality of care; incentivize the use of health promotion services (especially in early childhood) that can prevent costly, future health conditions; and overcome chronic fragmentation in care. As Medicaid programs embrace VBP, payment model architects must be mindful that children are not “little adults” and that payment models must account for key differences between adult and child beneficiaries. On average, when compared to adults, child Medicaid beneficiaries have lower acute health care utilization, lower costs, and greater use of preventive services. Their health needs also change across developmental stages and are partially dependent on their parents.

**Benefits:** The focus on VBP for children has prompted New York to adopt children’s health care quality measures in value-based payment. The State’s focus on VBP has led to an iterative process of testing the proposed payment incentives with emerging delivery models for children’s primary care. Finally, it has facilitated exploration and emerging implementation of additional Medicaid projects and pilots to promote early childhood health and development to achieve long-term benefits and savings.

**Challenges:** Value-based payment models are often designed to incentivize cost-containment strategies. While children’s health care presents some opportunities

for short-term savings—such as preventing avoidable emergency department visits for asthma—most children are generally low-cost and in relatively good health. The goal of most pediatric primary care services is to promote a child’s development and prevent disease. The savings from pursuing this goal generally accrue over periods that are longer than current VBP contracts. As a result, improvements in child outcomes are likely to be detected in education, child welfare systems, and other sectors before becoming apparent in health care. While New York has broadly designed a VBP payment model that accounts for these realities, it still needs to be refined and piloted with pediatric primary care practices.

## **Key Takeaways**

- The goals and design of value-based payment should reflect unique child health needs.
- The value proposition for children’s health services stems from promoting optimal child health across the life course, which will lead to lower long-term health care costs and utilization (principally by preventing chronic conditions in adulthood), and producing savings and better outcomes for non-health sectors by improving child development. This stands in contrast to adult health care, where the value proposition typically comes from reducing costs over a one-to-two-year timeframe while maintaining or improving quality through more efficient care and better disease management.
- To generate that value, payment models must support high-quality pediatric primary care by incentivizing improvements in quality, encouraging less fragmentation in service delivery, and fostering the adoption of relatively low-cost health and development promotion services that improve outcomes over the life of a child.
- Because the development of VBP models for children’s health services is still in a relatively early stage, payment model design should include input from children’s health stakeholders. New payment models should also be tested in combination with innovative primary care models to ensure the incentive structures are appropriate.

## Introduction

Over the last decade, value-based payment (VBP) has emerged as a promising tool for combating two of the United States' most vexing health care challenges: inefficient, costly care and relatively poor health outcomes compared to other industrialized nations. As the failures of the dominant, fee-for-service payment model have become clear—most notably, its role in incentivizing volume of services—many state Medicaid programs are embracing VBP approaches that reward providers for efficient, high-quality care.

VBP models are typically based on the premise that there are significant opportunities to lower costs while simultaneously maintaining or improving the quality of care. These models encourage providers to pursue new care strategies (such as managing chronic diseases, addressing misuse or overuse of services, and increasing preventive care) that can yield savings in a one-two year timeframe and can be reinvested in additional value-added services. However, when developing VBP models for children, a different approach is needed: one that focuses on managing long-term costs by improving quality and promoting health and well-being over a child's developmental stages.

Most VBP demonstrations have focused on adult populations. Relatively recent reviews of state and national VBP approaches have found few payment approaches that account for the specific needs of children as a population.<sup>1</sup> The lack of a child focus in payment reform is concerning because children comprise nearly 40 percent of the Medicaid population nationally, and new payment approaches are needed to drive improvements in care and outcomes for these children. The tide may be turning, however: The Center for Medicare and Medicaid Innovation released in early 2019 a notice of funding opportunity for a new Integrated Care for Kids demonstration project. The explicit purpose is to test alternative payment models and new service delivery models that improve the health and well-being of children, including children considered generally well and those with complex physical and behavioral health conditions.

This case study discusses New York's pursuit of child-centered VBP approaches in Medicaid, which could be a model for other states and stakeholders pursuing efforts to promote high-quality health care for children, and especially for those states participating in the federal Integrated Care for Kids demonstration project. New York's effort began in 2016 with a process to design an option specifically for child-serving primary care providers. This case study highlights the development of children's quality measures for VBP and the opportunities and challenges associated with full-scale adoption of a child-specific VBP model.

1 The approaches that exist tend to be focused on specific childhood illnesses, such as episode-based payments for childhood asthma. A few pediatric-ACO models are being used by children's hospitals, which tend to focus on the needs of children who are sicker than the general population. <https://pediatrics.aappublications.org/content/139/2/e20161840>; <https://uhfnyc.org/publications/publication/value-based-payment-models-for-medicaid-child-health-services/>

## The Push for Child-Centered VBP in New York

In 2015, New York set a goal: make at least 80 percent of Medicaid managed care payments to providers value-based by 2020. In its CMS-approved, annually updated “VBP Roadmap,” the Medicaid program laid out four types of VBP arrangements<sup>2</sup> managed care plans may use with providers. Each arrangement has varying levels of risk bearing, beginning with shared savings only and advancing toward large percentages of downside risk being shared between managed care plans and providers. Because the VBP Roadmap is meant to guide how Medicaid Managed Care plans contract with providers, individuals still in the traditional Medicaid fee-for-service system are excluded from value-based payment.

Consistent with New York’s longstanding practice of using stakeholder groups to inform Medicaid policy, the state established several clinical advisory groups to help design payment arrangements for subpopulations and health conditions deemed “most relevant to NYS Medicaid.” Clinical advisory groups were established for the following topics: maternity care, chronic heart and pulmonary diseases, behavioral health, HIV/AIDS, Managed Long-Term Care (MLTC), and intellectual/developmental disabilities.

An explicit focus on child Medicaid beneficiaries was left out of these discussions (except for instances of some overlap with the maternity clinical advisory group).

2 The four VBP arrangement types are Total Care for the General Population, Total Care for Special Needs Subpopulation, Integrated Primary Care episode, and Maternity Care episode.

### Timeline of New York VBP Reforms

**2011:** Governor Cuomo created the Medicaid Redesign Team (MRT), which developed a series of recommendations to lower immediate spending and proposed future reforms.

**2014:** As part of the MRT plan, New York obtained a 1115 Waiver, which would reinvest MRT-generated federal savings back into redesigning New York’s health care delivery system (known as the Delivery System Reform Incentive Payment, or DSRIP, program).

**2015:** As part of DSRIP, New York began an ambitious payment reform plan, working toward an 80 percent VBP goal by the end of the waiver period.

**June 2015:** New York published a multi-year VBP Roadmap, a living document that outlines the State’s payment reform goals and program requirements.

**October 2016:** Children’s Health VBP Subcommittee was created to review NY Medicaid’s VBP Roadmap and its “fit” with child health needs.

**August 2017:** First 1,000 Days on Medicaid initiative launched.

**September 2017:** Children’s Health Subcommittee submitted final VBP report and recommendations to NY Medicaid Program and VBP work group.

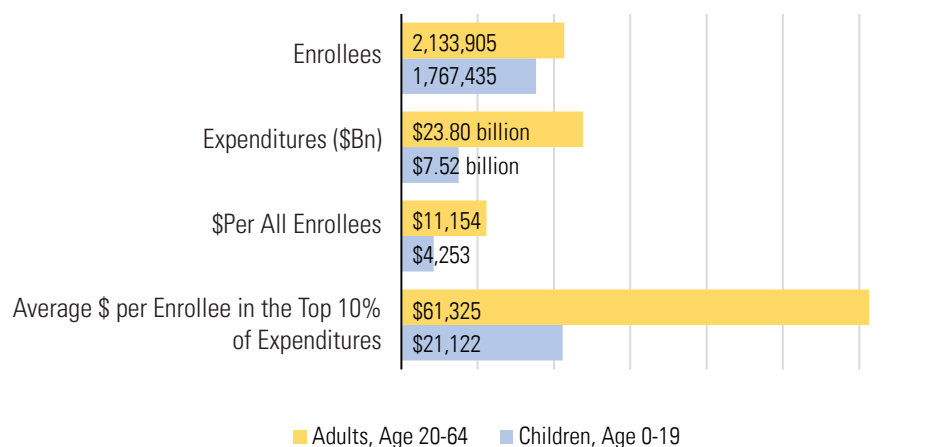
**April 2018:** First 1,000 Days on Medicaid was included in state budget, paving a path for newly established Preventive Pediatric Care Clinical Advisory Group to propose an enhanced model of pediatric primary care that could be supported by VBP.



This raised concerns for the New York children’s health community, which believed that an overarching approach might be insufficient for children. Advances in the care of children were certainly needed—and still are. Parts of the state, including New York City, have high rates of potentially preventable hospitalizations of children for chronic illnesses, such as asthma. While New York performs highly on most other children’s quality metrics, these measures are limited in what they capture. Broader population measures—e.g., obesity, childhood mental health—suggest much more can be done to promote the health and well-being of children. Family reports of fragmented pediatric services and provider concerns that essential but nontraditional services are not covered under existing payment approaches suggest that child health providers need payment flexibility in providing needed services in a way that meets evolving patient needs throughout childhood.

And yet, as advocates rightly noted, the devil is in the details. They argued that kids deserve “value” too but that the mechanics of common VBP approaches often foster strategies focused on high-cost or high-utilizing patients and provide little incentive to make substantial investments in preventive primary care. A work group established by the state to address social determinants of health (SDH) through VBP—an area of special interest to the state—also suggested a focus on children’s health services given the outsized role of SDH in children’s lives. The group called for the creation of a separate stakeholder group to advise the state on how to promote developmental health in the context of VBP. Some advocates felt that without an explicit focus on incentivizing improvements in the care of children and adolescents, their health care needs would largely be ignored in a new era dominated by VBP.

## 2014 New York Medicaid Expenditures for Continuously Enrolled Children and Adults

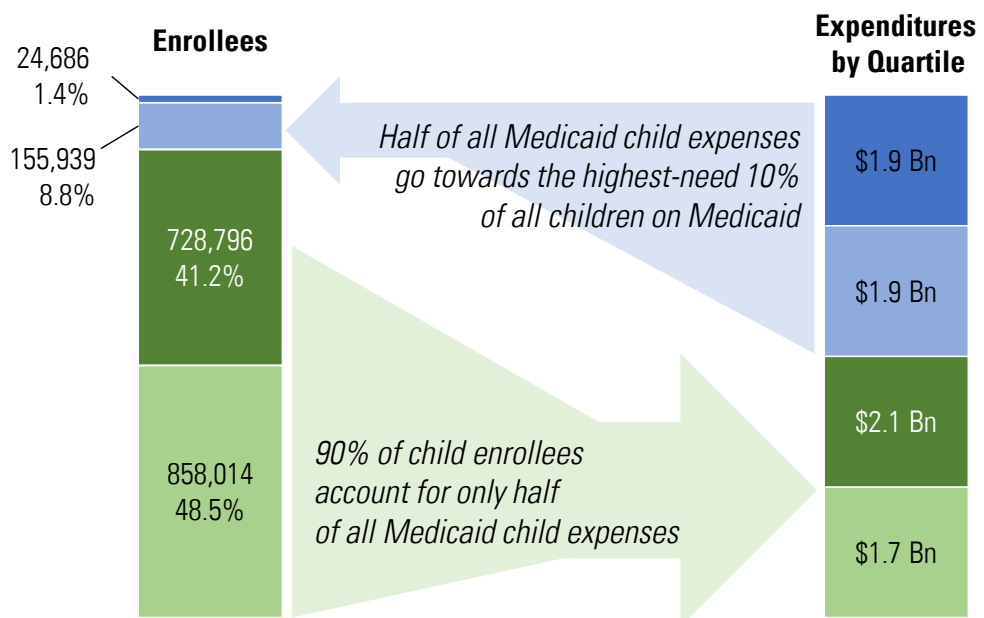


Data for children and adults continuously enrolled in Medicaid in 2014; analysis was performed by UHF in 2016 using Salient NYS Medicaid System. Source: Kennedy-Shaffer L and Shearer C. July 2016. *Understanding Medicaid Utilization for Children in New York State: A Chartbook*. UHF. <https://uhfnyc.org/publications/publication/understanding-medicaid-utilization-for-children-in-new-york-state/>

Independent data analysis of New York Medicaid claims revealed substantial differences between adult and child beneficiaries and affirmed the need for a separate payment approach for children. Compared to adults, children in Medicaid are relatively low-cost, use fewer inpatient services, and experience less chronic disease. Further, analysis completed by national payment reform experts to inform New York’s VBP process concluded that, while adult VBP approaches may successfully incentivize better care for some common chronic conditions in children, children’s services, by and large, have a distinct value proposition that warrants a distinct payment approach. That approach should encourage high-value health promotion services and reward providers for achieving longer-term health savings. In pediatric care, value primarily comes from promoting healthy child development, as well as preventing future costly health conditions, particularly adult chronic diseases, that have an enormous human toll. Payment models must be structured to motivate and support primary care providers in achieving that goal.

In response to these discussions, the state established a Children’s Health Subcommittee/Clinical Advisory Group charged with assessing the “relative fit” of existing VBP arrangements for children and making recommendations to the state for needed improvements.

### 2014 New York Medicaid Expenditure Quartiles for Continuously Enrolled Children, Ages 0–20



Source: Kennedy-Shaffer L and Shearer C. July 2016. *Understanding Medicaid Utilization for Children in New York State: A Chartbook*. UHF. <https://uhfny.org/publications/publication/understanding-medicaid-utilization-for-children-in-new-york-state/>

## Stakeholder Concerns About VBP and Children

**Perverse incentives.** If not carefully designed, payment reforms can lead to perverse incentives, such as discouraging preventive care as a means of achieving cost-savings. Children’s advocates were concerned that, unless the state’s VBP approaches were examined through a child-specific lens, perverse incentives might emerge.

**Limited use of children’s quality measures.** The limited research available in 2015 suggested that children’s health quality measures were rarely included in VBP contracts, which further discourages a focus on improving quality and care for children.

**Lack of positive incentives.** Even if there were no detrimental effects on children’s care, it was unclear how the VBP arrangements included in the NYS VBP Roadmap—which focused on total care for the general population and integrated primary care with chronic condition bundles—would prompt delivery system changes in pediatric primary care. This lack of incentives limits opportunities to promote life-long health and development.

**Pediatric provider readiness.** Conducted in parallel with VBP efforts, New York’s Delivery System Reform Incentive Payment (DSRIP) program was preparing providers to engage in future VBP contracts by working toward a goal of cutting preventable hospital visits by 25 percent. Because so few children have preventable hospital visits, few provider systems focused their DSRIP projects on improving children’s health quality or transforming pediatric primary care. This lack of attention and readiness, combined with an unclear value proposition for pediatricians to join value-based contracts (i.e., less potential for savings), created doubt that pediatricians would engage. This was particularly challenging for the State since pediatrician participation was necessary for it to reach its goal of transitioning at least 80 percent of Medicaid managed care payments to VBP.

“The primary emphasis within DSRIP and VBP is achieving immediate or short-term cost savings/outcomes. Children are not, generally, high-cost users of health services today, though inattention to their developmental health could lead to future needs and costs. With regard to the SDH, evidence suggests that one of the most important things that can be done in the early years for positive health outcomes later is strengthening the stability, safety, and nurturing in the home environment. The task force should advise on how this can be accomplished in the context of VBP.”

—New York State Social Determinants of Health and Community Based Organizations Subcommittee’s recommendation that “the state should form a taskforce of experts and a process specifically focused on children and adolescents in the context of VBP”

## **Development of a VBP Model to Promote Children’s Health**

### **Stakeholder Engagement**

The Children’s Subcommittee launched in 2016 and met for nearly a year. From the outset, it was an inclusive body, comprising experts and providers from the fields of pediatrics, children’s behavioral health, managed care, child welfare, and children’s advocacy. While state Medicaid officials participated in meetings, discussions were facilitated by impartial consultants and the non-governmental chairs.

### **Data Review and Discussion**

The group began by reviewing data on children in New York Medicaid and comparisons to data on adults. It also examined how many children were enrolled in managed care and eligible to be attributed to VBP arrangements. The group concluded that while the models already included in the state’s VBP Roadmap could lead to small improvements for some children—particularly if more quality measures for children were incorporated—it seemed unlikely that any of the payment models would significantly advance children’s health. One work group participant commented that “children were being retrofitted into health care models designed for adults, rather than starting with children’s needs and designing from there.” The group decided to propose a new pediatric-specific VBP model for the state to pilot and evaluate.

### **Critical Payment Reform Design Questions**

- What is the attributed population?
- What are the policy goals for this population?
- How does payment reform relate to those goals?
- What principles should guide the proposed payment structure?
- Which quality measures should be used to reward performance and how?
- What services should be included/excluded in the model?

### **Defining the Population**

The group immediately encountered a series of important and vexing design questions. First was the matter of population. Did the group intend to design a model that could be used for all children enrolled in Medicaid managed care, or should it consider subsets of that population? Answering this question required a close examination of New York’s claims data for any significant differences within the children’s population. The group identified two subpopulations:

- Children who were “generally well”: 90 percent of child enrollees accounted for only half of all child health expenditures. Even within the children’s population,

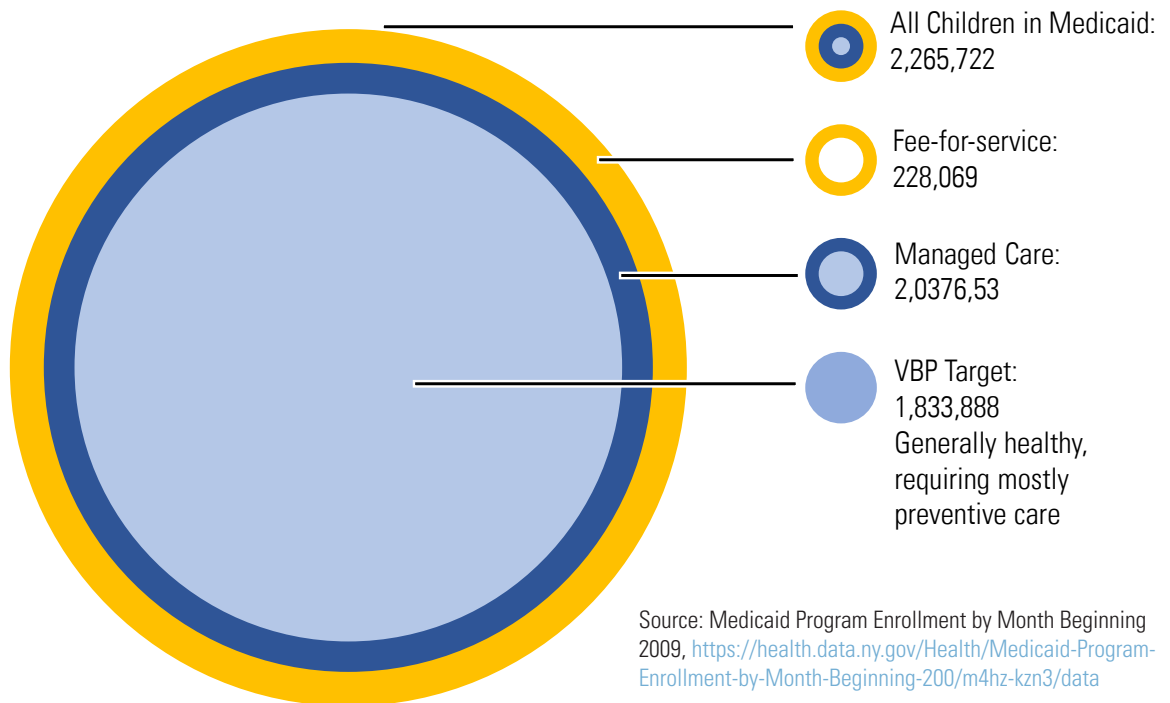
these children had incredibly low expenditures and low inpatient health care utilization but relatively high usage of primary care services (mainly well-child care visits). They were either considered healthy or had chronic conditions, like asthma or obesity, which can typically be managed by community providers.

- Children with physical or behavioral health “complexity”: 10 percent of child enrollees accounted for the remaining half of all child health expenditures. Their health conditions were very heterogenous. These children typically were medically fragile or had complex chronic conditions affecting multiple organ systems or severe disabilities. These conditions often create high-cost outliers. Given the structure of New York’s delivery system, which includes many academic medical systems, these children are often treated by a range of tertiary referral centers rather than a single children’s hospital or center of excellence. The unpredictability of these conditions and their rarity in any single provider system makes risk-bearing for this vulnerable group of children especially hard.

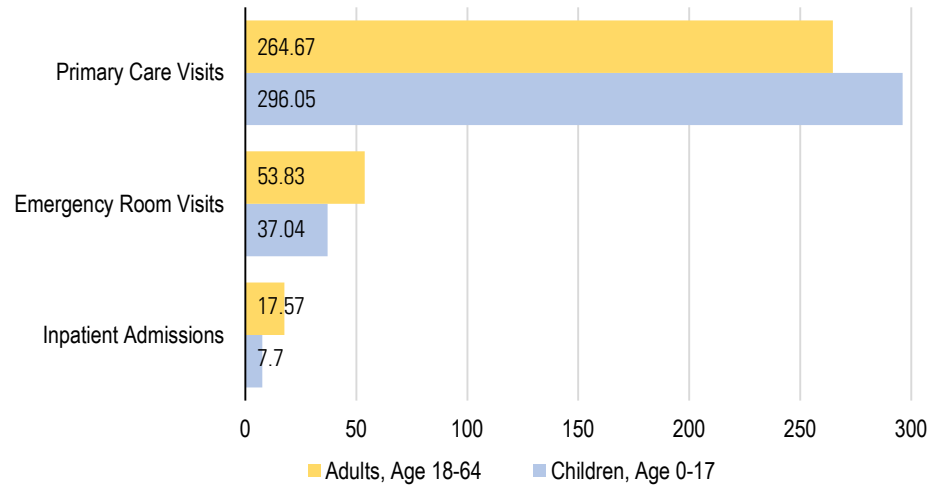
The group decided to focus its design efforts on the “generally well” 90 percent and deferred on making payment reform recommendations (including the option of not pursuing risk approaches at all) for the 10 percent of child enrollees that drive half of the child costs.

## 2017 New York Medicaid Children Average Monthly Enrollment and VBP Target Population

Age 0-20 Average Monthly Enrollment in 2017 in Medicaid Managed Care (MMC) vs. Fee-For-Service (FFS); VBP Target is 90% of MMC population.



## 2017 New York Medicaid Managed Care Enrolled Child and Adult Utilization Rate Comparison (per 1,000 Member Months)



Source: NYS DSRIP Public Facing Dashboards: C1, C3, and C5. <https://dsripdashboards.health.ny.gov/>

### Setting Goals to Guide Payment Reform

While the group knew a move away from fee-for-service for children was needed, it struggled to determine how to design a payment model that would incentivize higher-value pediatric primary care. Stakeholder engagement was critical to defining the goals that would guide payment reform design. A clarifying moment occurred in group deliberations when a member asked, “What is the goal we want pediatric providers to focus on? What’s the North Star? And does that change as children age?” This was a particularly important question because traditional metrics for evaluating the success of value-based payment arrangements—namely, the attainment of short-term cost savings and improvement on clinical quality measures—are hard to achieve in the children’s context. Up to this point, members had generally agreed on the role of pediatrics in optimizing health and developmental trajectories for children, but they had not yet discussed more specific goals that could guide payment and delivery system reform.

To bridge this gap, stakeholders worked together to develop a North Star Framework that had four parts:

1. Segmentation of the children’s population into developmental stages;
2. Plain language goals that articulated the group’s consensus on what high-value care would achieve for children at each stage;
3. Indicators that could potentially be used to determine whether the state was making progress toward that goal; and
4. The “high-value, often underutilized” pediatric primary care services that would contribute to that goal if appropriately incentivized.

After successfully generating consensus across the 80-person work group, the framework was universally adopted and ultimately recommended to the state as a guiding document not just for informing children’s payment reform, but all reforms for children.

## **Guiding Principles for Children’s Value-Based Payment**

*The Subcommittee developed a set of principles to guide children’s VBP design, including:*

1. Children are not “little adults.” Typical value-enhancing strategies and disease-oriented quality measures may miss key aspects of child well-being.
2. Maximizing the healthy growth and development of children today will reduce future health care needs and bring long-term value to Medicaid and other public systems. For these reasons, a longer timeframe for assessing cost savings must be considered.
3. Addressing social determinants of health and mitigating the effects of adverse childhood experiences are critical. Supporting systems of care and parents/caregivers is fundamental to addressing these issues.
4. Access to high-quality primary care is essential, and access to specialty care—especially for maternal and child behavioral health—should be integrated into primary care settings.
5. Current investment in children’s health may not be enough to fully meet the unique needs of children.

## Using Goals to Inform Payment Model Construction

The group reflected on how a payment model could be derived from the North Star Framework. There are two parts to a value-based payment model: the payment structure and quality performance measures.

Nationally validated quality measures were compared to the North Star Framework, and those that best matched elements of the framework—either the key indicators or the high-value strategies—were prioritized for inclusion in the VBP measure set.

The group identified four criteria for the payment structure based on its discussions of the North Star Framework:

1. Due to the low annual expenditures for the population, any new payment model would need to assume limited cost savings will be available.
2. The payment model should be a capitated arrangement to allow for more flexible funding of services, which would remove the harsh financial incentive to generate medical services. This would also liberate providers to offer some services that are not currently reimbursable under Medicaid but are listed in the North Star Framework as essential to improving health outcomes for children and use non-office-visit modalities like telephone-based consults.
3. The payment rate for pediatric primary care should be increased to sufficiently support traditional medical services and all necessary health screenings (including parental screenings, such as for maternal depression), risk-adjusted care coordination, and new workflows that address developmental and behavioral health needs and social determinants (in accordance with the most recent Bright Futures Guidelines).
4. The payment model should reward quality improvement and include quality measures appropriate to each developmental stage.



## Recommended Payment Model and Quality Measure Set

The group recommended that the state add a Pediatric Primary Care Capitation (PPCC) model to its list of allowable models that guide how Medicaid managed care plans pay providers. Because New York's Medicaid managed care plans have incentives and penalties for not reaching VBP contracting goals, the addition of the PPCC model would give plans another contracting option to help them reach their overall VBP goals. The recommended PPCC model has these features:

- **A capitated, voluntary payment arrangement** for child-serving pediatric and family medicine primary care providers. Providers would be paid on a per-member/per-month basis for all primary care attributed children.
- **A target population of the bottom 90th percentile of the Medicaid managed care plan's child members according to a cost/utilization distribution.** Plans and providers would be granted discretion in determining the attributed child population below the 90th percentile of members. The arrangement is not meant to include medically and behaviorally complex or fragile children; a separate model might better serve the needs of this population. The attributed population methodology would be subject to state review and approval.
- **A risk-adjusted payment rate that is higher than current payment rates** to sufficiently encourage adoption of all necessary health and developmental screenings (including parental screenings); care coordination for necessary medical and social services; and new workflows to integrate services for developmental and behavioral health and social determinants of health. An additional enhancement would be provided to primary care practices with co-located or operationally integrated behavioral health care for children and their parents. Medicaid managed care plans and providers can agree to exclude specific services, such as vaccinations, that are perhaps best incentivized through fee-for-service payment arrangements because high volume is desirable.
- **A payment adjustment based on quality performance.** Medicaid managed care plans must contract with providers using the VBP child quality measure set and guidelines annually provided by the state. Managed care plans should implement a payment withhold from the PPCC rate based on improvement and high performance on all required pay-for-performance measures and on complete and accurate reporting of all required pay-for-reporting measures. The withhold must be disbursed at least annually. MCOs and providers should have discretion to agree on the percentage of the withhold and relative weighting of the quality measures. The overall approach of using a percentage withhold based on total performance and provider improvement is intended to ensure that child health quality and access are not reduced under this model.

Many secondary design issues were left for the state to decide, including which providers would qualify for the model, exactly which services would be excluded from the capitation and left as fee-for-service, how to establish safeguards to ensure providers are using enhanced capitated funds for the intended services, and how to establish the risk-adjustment methodology.

## **Quality Measure Selection Principles**

The Subcommittee prioritized measures that were:

- Relevant to the ‘North Star’ goals
- Valid and reliable
- Endorsed for use by the National Quality Forum
- Feasible for providers to use and report with minimal burden
- Parsimonious
- Outcome-based

New York’s VBP Measure Sets are classified based on an assessment of clinical relevance, reliability, validity, and feasibility. Category 1 measures have been deemed by the state to be acceptable for immediate use and are to be reported by VBP contractors to managed care organizations. Category 2 measures are considered clinically relevant, valid, and reliable, but not available for widespread use due to implementation concerns. Because these measures are still considered important to children’s health care, the state encourages managed care plans and providers to test Category 2 measures and develop strategies to overcome feasibility concerns before they are used widely.

The group recommended that the measures in both categories also apply to the state’s existing VBP models to ensure all children attributed to any VBP model have the same quality assurances.

In addition, the group recommended that the state pursue and/or support development of “aspirational” measures that would better match the North Star Framework’s goals and strategies. For example, the group felt that parent-child attachment in the first year of life and a child being on developmental trajectory by kindergarten entry are both important outcomes of pediatric primary care but not currently measurable (at least in a health care context). Even some of the validated national measures deemed critically important could not be put forward as mandatory in the VBP context due to data collection feasibility concerns. Most

troubling to the group was the inability to make developmental and maternal depression screening mandatory, as part of the state’s current measurement infrastructure limits the reliable collection of these screening measures. The group recommended that the state prioritize resolving these concerns, so developmental and maternal depression screening measures can be adopted into the VBP measure set in the near future.

## New York’s 2019 VBP Quality Measure Set for Children

Recommended Children’s VBP Measures (Category 1)	Classification
Pediatric Quality Indicator Asthma Admission Rate, Ages 2 Through 17 Years (PDI #14)	P4R
Adolescent Well-Care Visits	P4R
Adolescent preventive care – assessment and counseling of adolescents on sexual activity, tobacco use, alcohol and drug use, depression	P4R
Annual dental visit	P4R
Asthma Medication Ratio	P4P
Childhood Immunization Status, Combination 3	P4P
Follow-up care for children prescribed ADHD medication	P4R
Immunizations for adolescents, Combination 2	P4P
Medication management for people with asthma (NQF 1799)	P4P
Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	P4R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	P4P
Well child visits in the first 15 months of life	P4P
Well child visits in the third, fourth, fifth, and sixth year of life	P4R

Recommended Measures for Feasibility Testing by New York (Category 2)	Classification
Developmental Screening in the First Three Years of Life (NQF 1448)	P4R
Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (NQF 2605)	P4R
Follow-up After Emergency Department Visit for Mental Illness (NQF 2605)	P4R
Maternal Depression Screening (NQF 1401)	P4R
Screening for Reduced Visual Acuity and Referral in Children (NQF 2721)	P4R
Topical Fluoride for Children at Elevated Caries Risk, Dental Services (NQF 2528)	P4R
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (NQF 2801)	P4R

Note: “P4R” stands for “pay for reporting” and “P4P” stands for “pay for performance.” The Children’s VBP Measure Set is reviewed and updated annually.

## Results to Date

In August 2017, the group submitted its final report and recommendations to the Medicaid program and its VBP work group. One year later, the state is still working toward including a child-centered approach in its VBP Roadmap. Even though the process is ongoing, it has led to significant advancements in VBP for children and adolescents and has also bolstered Medicaid's commitment to its youngest beneficiaries. Among the improvements to date:

**Increased attention to quality.** Hearing the subcommittee's concerns that children's needs were not adequately reflected in existing VBP quality measure sets, the state adopted the recommended child quality measure set for all Medicaid VBP contracts beginning in plan year 2018. The state also subsequently required that child-specific measures be used in the Total Care for General Population measure set whenever children are attributed to that model.

**Agreement on payment principles.** Upon receiving the subcommittee's recommendations, the state determined it needed additional time to further develop the proposed payment model but agreed on high-level principles, especially the need to sustainably support an enhanced model of pediatric primary care through VBP. In general, the state has committed to stakeholders that it agrees a future child-centered payment approach should:

- Take the shape of a population-based arrangement;
- Account for the unique nature of children, including recognition that, for a generally healthy population, savings will need to be realized over the long-term;
- Have a lower risk-threshold, possibly including not tying performance to an efficiency measure;
- Include a capitation option to allow for flexibility in payment; and,
- Carefully consider the appropriateness of including children with complex medical needs.

**Commitment to piloting a children's specific payment model.** In its annual update to CMS, the New York Medicaid program committed to testing the children's payment model consistent with the work group's recommendations. The State specified that the model must "account for a relatively healthy pediatric population, where savings can generally only be realized over the long term." It also stipulated that the model should reflect the principles outlined by stakeholders. This includes recognizing the unique needs of children at different developmental stages; the overarching role of primary care in the delivery of health care services to children and promotion of overall child well-being; and the role of caregivers and non-medical factors that shape children's long-term health.

## First 1,000 Days on Medicaid Initiative

The First 1,000 Days on Medicaid initiative is a 10-point action plan aimed at promoting the health and development of Medicaid beneficiaries between the ages of 0 and 3. The plan was developed by over 200 experts and practitioners across New York in the fields of child health, mental health, child care, education, human services, and advocacy. It was included in Governor Cuomo's 2018 State of the State and adopted by the state legislature.

### **Braided funding for early childhood mental health consultations**

to unite several state agencies to co-fund training for early childhood teachers on how to support healthy development and identify behavioral problems

### **Requiring managed care plans to have a child-specific quality agenda**

to develop performance improvement programs on common, child-health quality measures

### **Statewide home visiting**

to expand home visiting programs that have demonstrated improved outcomes

### **Developmental inventory upon kindergarten entry**

to create a standard measurement tool(s) for use at that milestone

### **Preventive Pediatric Care Clinical Advisory Group**

to guide pediatricians and family physicians on prevention, health promotion, and addressing poverty-related risks (*see box below for detail on group's recommendations*)

### **Peer family navigators in multiple settings**

to launch pilot projects in homeless shelters, drug treatment programs, and other settings to help hard-to-reach families access resources

### **Expansion of "Centering Pregnancy"**

to spread this successful model of group prenatal care for mothers in communities with the poorest birth outcomes

### **Parent/caregiver diagnosis**

#### **as eligibility criterion for dyadic therapy**

to allow children's Medicaid enrollment to cover a proven parent/child therapy model based solely on a parent's mood, anxiety, or substance use disorder diagnosis

### **Early literacy through local strategies**

to improve early language development by expanding "Reach Out and Read" in pediatric primary care

### **Data system development for cross-sector referrals**

to develop a screening and referral data system that connects families to nearby health and social services.

The Preventive Pediatric Care Clinical Advisory Group has recommended the following to enhance the pediatric patient-centered medical home:

**Higher standards** for comprehensive, well-child care that include the integration of at least one evidence-based universal primary prevention intervention to support optimal growth and development

**Care coordination/case management** capacity for navigating across medical services and social determinants of health to include other supporting roles, such as community health workers and peer navigators, and to engage with faith-based organizations

**Integrated behavioral health care** that is sensitive to the relationship between the health care practitioner and family, culturally sensitive, age-appropriate, and two-generational

One issue the State would like to resolve before proceeding with VBP model design and piloting is how to set the benchmark cost. The Subcommittee called for an enhanced payment rate (compared to historic expenditures) that would support a model of advanced pediatric primary care—however, details of what that primary care model would look like, and what it would cost, were not part of the recommendations. Before moving forward with payment reform, the State elected to let a clinical advisory group—working in parallel to develop a model for advanced pediatric primary care—complete its work (see box on First 1,000 Days on Medicaid, page 17). Design of the advanced pediatric primary care model is nearly complete, and the New York Medicaid program is seeking opportunities to pilot it with the purpose of testing a child-centered VBP model.

**Greater focus on role of Medicaid in early childhood.** Perhaps one of the most significant and unexpected results from the VBP process is the emergence of New York’s First 1,000 Days on Medicaid initiative. This initiative includes 10 reform proposals to use the leverage of Medicaid to enhance cognitive, physical, and social-emotional development of children ages 0 to 3. A central feature of New York’s First 1,000 Days on Medicaid initiative was the establishment of a Preventive Pediatric Care Clinical Advisory Group, which recommended several enhancements to the pediatric patient-centered medical home (see box on page 17).

## Lessons for Other States

The New York experience highlights the importance, as well as the complexity, of designing child-centered VBP. All state Medicaid agencies encouraging a transition to VBP should assess whether their current state-based payment models adequately address the needs of children. If the answer is no, then a child-focused process is warranted. Some lessons from New York’s experience that are worth considering:

- **Create a multi-stakeholder process to genuinely engage the children’s health community.** Include families, providers, managed care plans, and advocates. Not only are these stakeholders likely to be affected by proposed payment reforms, they are also likely to have unique insight into what the goals of payment reform should be and what payment structures will need to change to reach that desired goal. Medicaid staff and payment experts, who will ultimately need to perform much of the detailed design work, should be engaged partners throughout the process but not dominate group deliberations.

- **Review data to better understand child health needs and utilization in the state and to assess which part of the child population to focus on.** Include an assessment of children’s health care utilization, expenditures, and health needs. Identify whether service use and needs differ substantially between subpopulations of children.
- **Be honest about the amount of savings payment reform will likely generate, how long it will take, and who will benefit.** Realism about these limitations and challenges will help manage expectations.
- **Identify or define the model(s) of children’s health care services meant to be supported by payment reform.** Payment reform is ultimately a tool to support or encourage improvements in how health care services are delivered. Stakeholders should identify what they want the delivery system for children to look like. If great models already exist, stakeholders should design payment with the intention of supporting these models. If good models do not exist, stakeholders will need to define what those models would look like before developing a payment model to support them.
- **Carefully select quality measures.** Quality measurement is an essential component of VBP. Tying payment to performance on quality measures is an incredibly effective way to focus provider attention on improvements in these specific measurement areas, and stakeholders should thus carefully select and prioritize measures that are deemed most important to child health. Quality measurement can also ensure that the quality of, and access to, care are not harmed when a new payment model—possibly with hidden unintended incentives—is introduced.
- **Test proposed payment models through small pilots.** Initiate a pilot with one community or one payer and a few primary care practices. Starting small will allow the state to evaluate, and if necessary refine, the payment model before introducing it broadly.

Finally, regardless of whether or what child-centered policies emerge in a state’s payment reform process, Medicaid can and should use all its available levers to promote child health. In the early childhood years especially, Medicaid’s access to children and families is relatively unmatched, particularly in states with nearly universal health coverage for children and pregnant women. Payment reform is but one approach to improve health and health care for these families.