

The Role of Title V Programs and Value-Based Purchasing for Children and Youth With Special Health Care Needs

The Catalyst Center
and
The American Academy of Pediatrics

December 6, 2017



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During the webinar:

- Submit questions via chat box
- We'll answer as many questions as we can during the Q&A at the end of the webinar
- Webinar will be recorded
- Keep lines muted



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- The Catalyst Center, the National Center for Health Insurance and Financing for Children and Youth with Special Health Care Needs, is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U41MC13618, \$473,000.
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- LCDR Leticia Manning, MPH, MCHB/HRSA Project Officer



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Welcome and introductions by LCDR Leticia Manning, MPH; MCHB/HRSA Project Officer

- Webinar speakers
 - Meg Comeau, MHA
 - Lou Terranova, MHA
 - Stacy Collins, MSW
 - Alison Martin, PhD
 - Jennie Munthali, MPH



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The Catalyst Center: an overview

- **The National Center** on health insurance coverage and financing policy for children and youth with special health care needs
- **We provide** technical assistance, conduct research and policy analysis, create resources, and promote partnerships to improve financing of health care and promote access to care and health equity



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American Academy of Pediatrics: an overview

- AAP mission is to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents and young adults.
- The AAP Division of Health Care Finance develops resources for member education and advocacy on coding, child health finance, including insurance, managed care and evolving payment models, and medical liability



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The Role of Title V Programs and Value-Based Purchasing for Children and Youth With Special Health Care Needs (CYSHCN)

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1. How have Title V programs been involved with value-based purchasing?
2. Lessons learned to date?
3. Where are future opportunities for collaboration?



Services for CYSHCN funded through Title V

- Wrap-around services and supports
- Care coordination
- Other services not covered by Medicaid or private insurance
- Some clinical services (payor of last resort)
- Medical home development



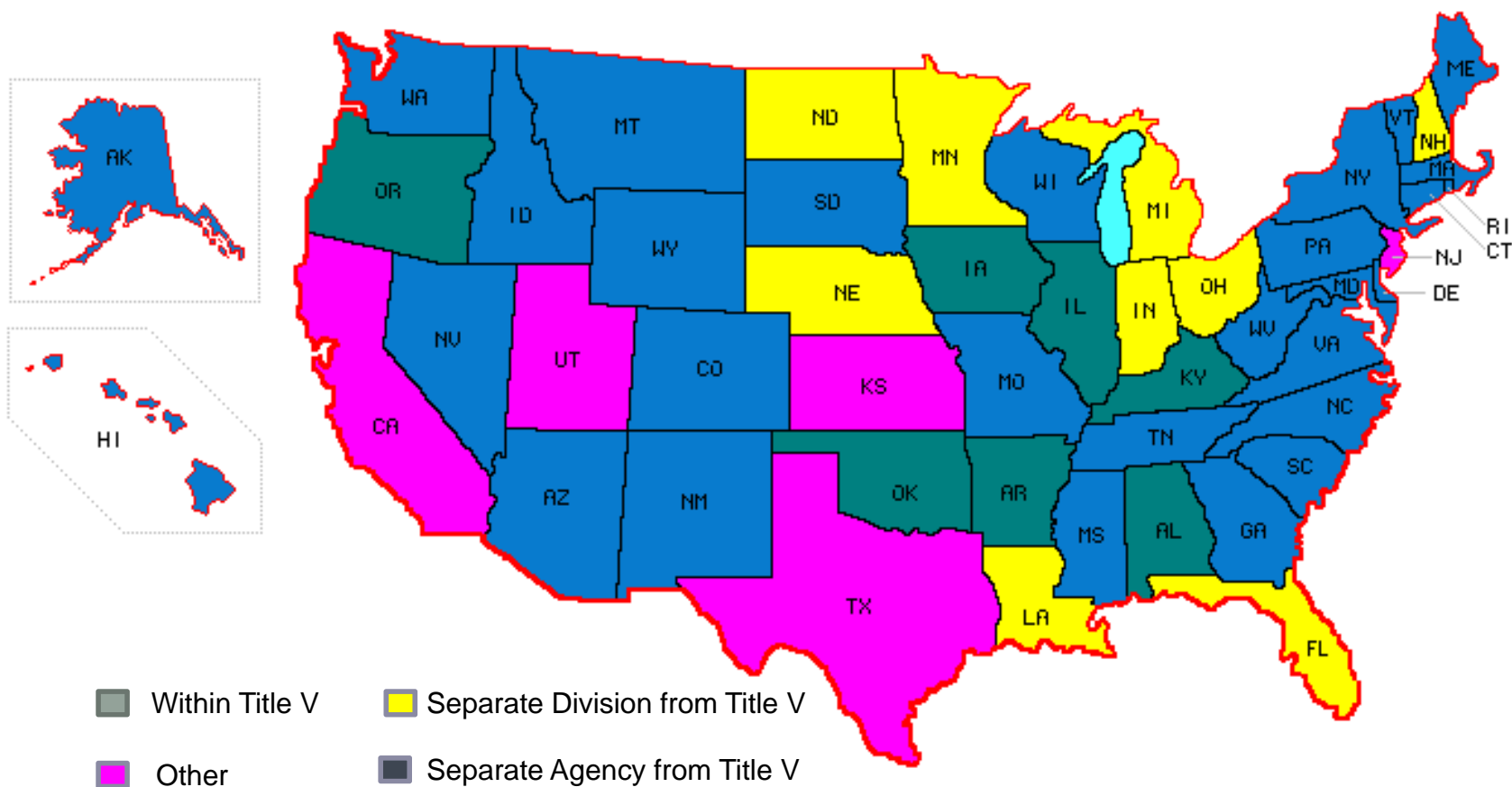
MCHB Quality Indicators

Core System Outcomes for CYSHCN:

- Family Professional Partnerships
- Medical Home
- Insurance and Financing
- Early and Continuous Screening and Referral
- Easy to Use Services and Supports
- Transition to Adulthood



Location of Title V CYSHCN Programs



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National Title V Children and Youth with Special Health Care Needs Program Profile

EXECUTIVE SUMMARY

Children and youth with special health care needs (CYSHCN) are a diverse group, ranging from children with chronic conditions to those with more medically complex health issues, to children with behavioral or emotional conditions. Within each state and territory in the U.S., the Title V Maternal and Child Health (MCH) and CYSHCN programs are charged with providing family-centered, community-based coordinated care. Although several state programs provide services for CYSHCN, the Title V CYSHCN programs are valued for their expertise in reaching CYSHCN populations, strong connections to networks of pediatric specialists, and high-quality data on the service needs of CYSHCN and their families.

Title V CYSHCN programs and their leadership face strategic decisions about their roles and responsibilities due to recent programmatic and policy influences. With the advent of new health care delivery models and other changes resulting from the Affordable Care Act (ACA), many state Title V CYSHCN programs are moving away from their more traditional role of providing direct health care services to the provision of wrap-around services and supports, and some payment for services not covered by Medicaid or private insurance, among other activities. The recent transformation of the Title V Block Grant and its new performance measurement system has led to restructuring and reframing of CYSHCN programs. Furthermore, some state Title V CYSHCN programs are assuming new roles in standards setting as the CYSHCN in their programs are moved into managed care arrangements.

The need for state Title V CYSHCN directors to network and consult with fellow state directors and reach out to CYSHCN experts has never been greater. In 2015-16, the Association of Maternal & Child Health Programs (AMCHP) fielded a CYSHCN Profile survey to gain insight into Title V CYSHCN programs across the U.S., including program structure and strengths, roles in systems of care, CYSHCN program partnerships, financing of care for CYSHCN populations and emerging issues for CYSHCN programs.

Profile Results

Forty-eight (48) state and territorial (hereafter referred to as "state") CYSHCN programs, including the District of Columbia, responded to the profile survey.¹ In the majority of states, the CYSHCN program is located within the Title V Maternal and Child Health program. The role of the CYSHCN program varies, with a smaller number continuing to provide direct services to children who do not have access to specialty care, and the majority transitioning to a focus on support services and systems development efforts.

Two major roles for CYSHCN programs are supporting medical home development and support services for transitioning CYSHCN to adult health care systems. In general, state CYSHCN programs do not have sole oversight related to medical home development efforts. In the areas of using payment policy to create **incentives** for and improve access to medical homes, providing **financial support** for care coordination, adopting **criteria and requirements** for established medical home models, and implementing processes to identify clinical practices that meet these standards, the majority of CYSHCN programs are aware of activities taking place in their states but are not leading the efforts. In the areas of developing **partnerships** to advance the importance of medical home, providing **expertise** on the unique needs of CYSHCN, assuring that medical home efforts are **linked** with other state activities, and offering **technical assistance** to support the development of medical homes, the majority of CYSHCN programs share oversight and responsibility.

In the area of transition to adulthood for adolescents and young adults, state CYSHCN programs are much more likely to have a leadership role within their states. The majority of CYSHCN programs report that they either share oversight and responsibility or have sole responsibility for:

- Overseeing the development of transition **policies**
- Educating staff about **best practices** in transition services

¹ While the survey response group includes both state and jurisdictional CYSHCN programs, the term "state" is used broadly throughout the report.



National Title V Children and Youth with Special Health Care Needs Program Profile

http://www.amchp.org/programsandtopics/CYSHCN/Documents/CYSHCN-Profile-2017_FINAL.pdf



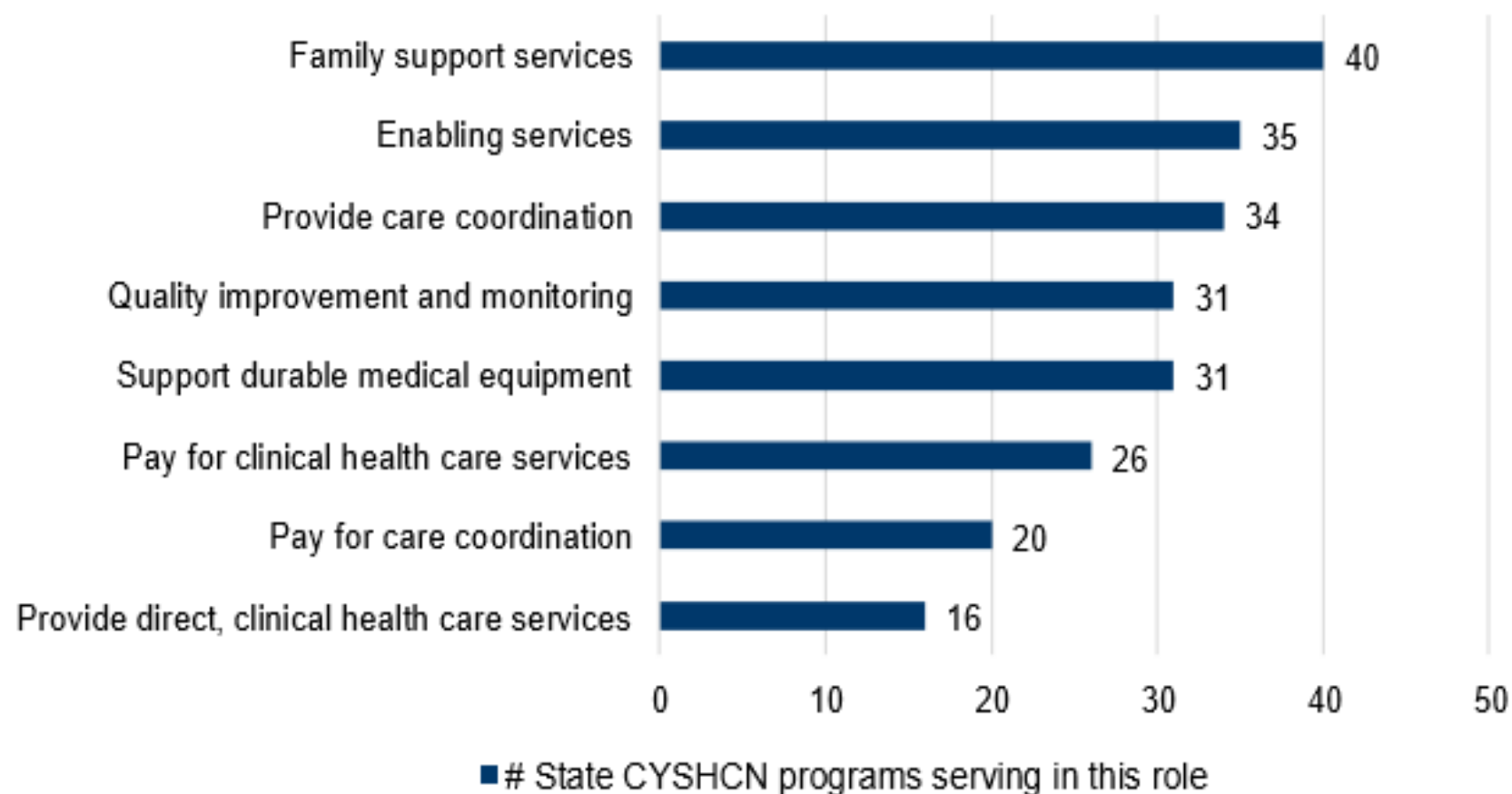
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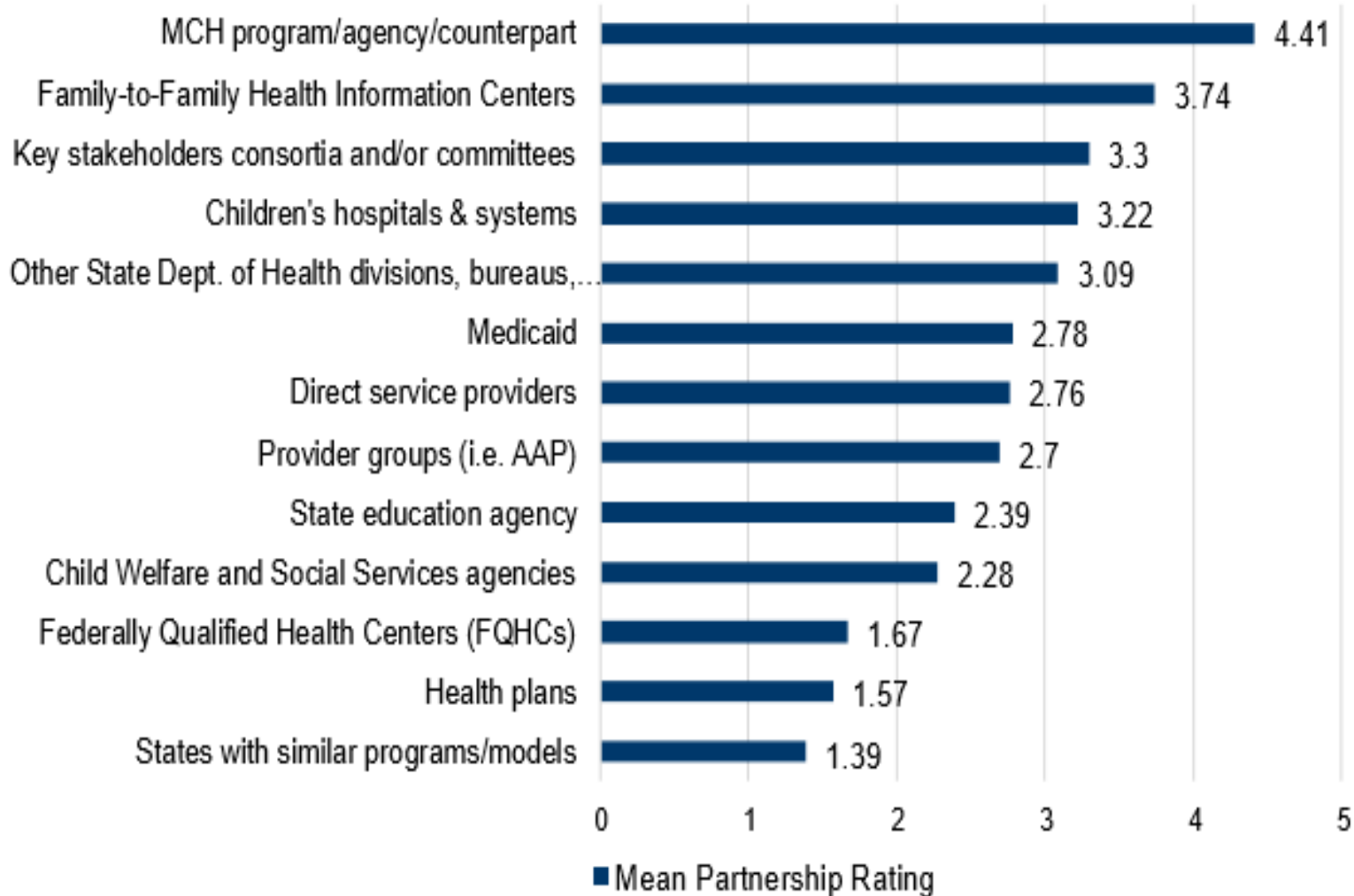


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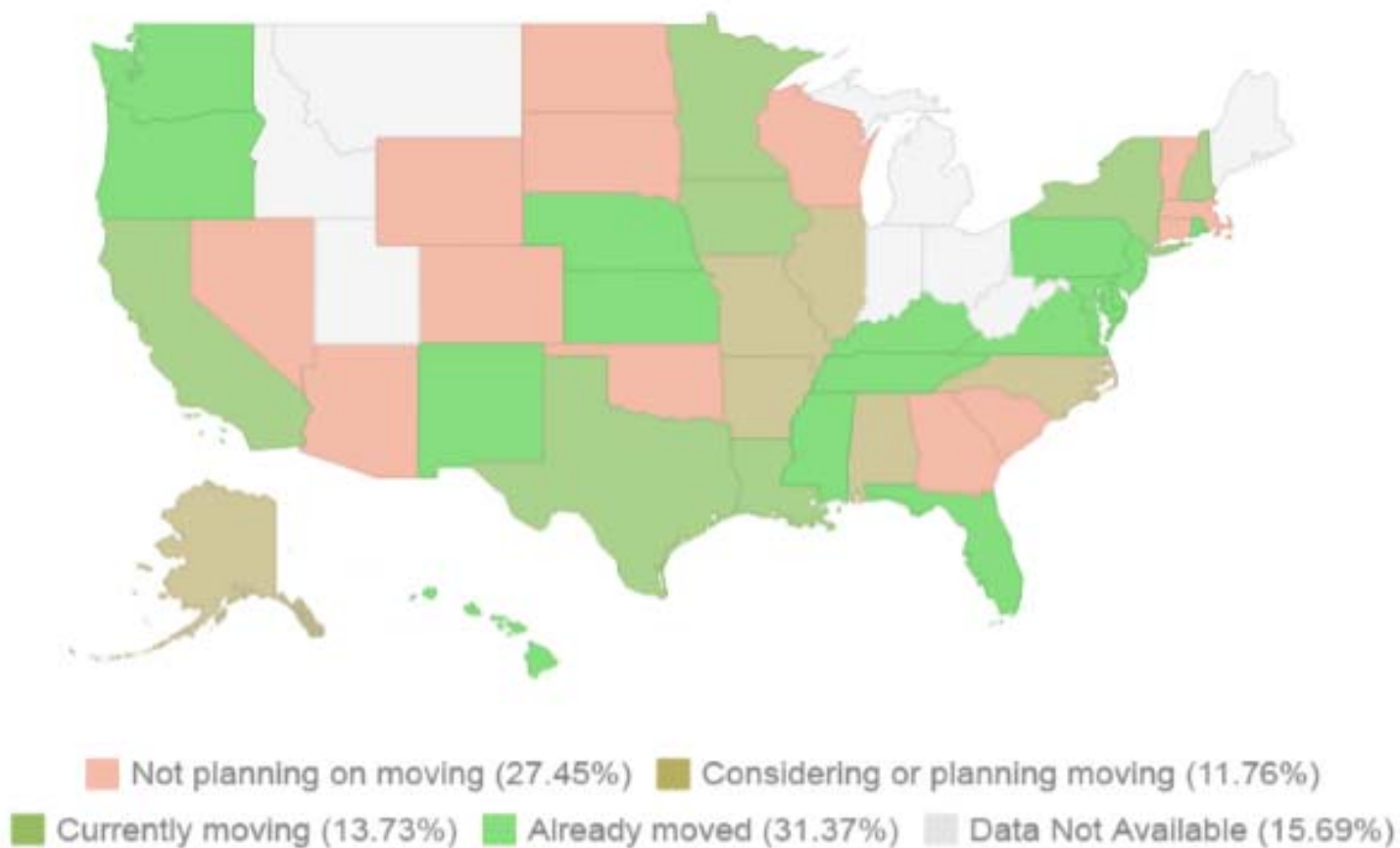
Role of State CYSHCN Programs



CYSHCN Program Collaborations with Key Stakeholders



State Positions on Medicaid Managed Care Agreements and CYSHCN



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Title V contributions to VBP development for CYSHCN

- Promote common performance measures (e.g., Standards for Systems of Care for CYSHCN) among public and private purchasers in VBP arrangements



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Title V contributions to VBP development for CYSHCN

- Serve as brokers across payers, purchasers, and providers to align payment and care delivery for CYSHCN
- Provide expertise: Care coordination; statewide reach; long-standing relationships with CYSHCN providers (specialists, children's hospitals, etc) and family advocates; experience in transition of CYSHCN into MCOs; understanding of community based resources



Title V innovations in VBP

- HRSA-MCHB D-70 grants: Testing multipayer health care financing and service delivery models to improve health system performance, increase quality, and decrease costs.



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State Examples

- Oregon



- Colorado



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Oregon's Title V CYSHCN Block Grant Priorities, Strategies, and Alternative Payment Methods

Alison J. Martin, PhD; Robert Nickel, MD, Marilyn Berardinelli
Oregon Center for Children and Youth with Special Health Needs
December 6, 2017



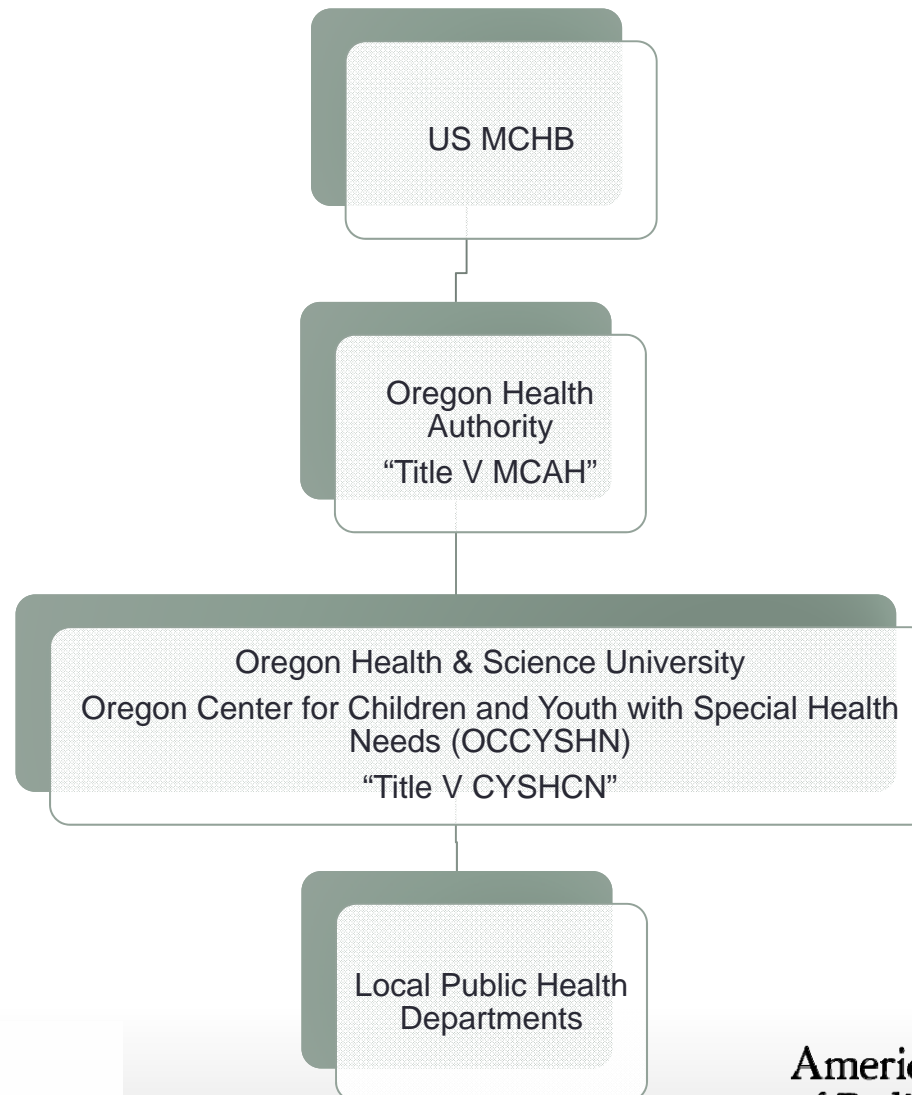
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Title V CYSHCN Funding in Oregon



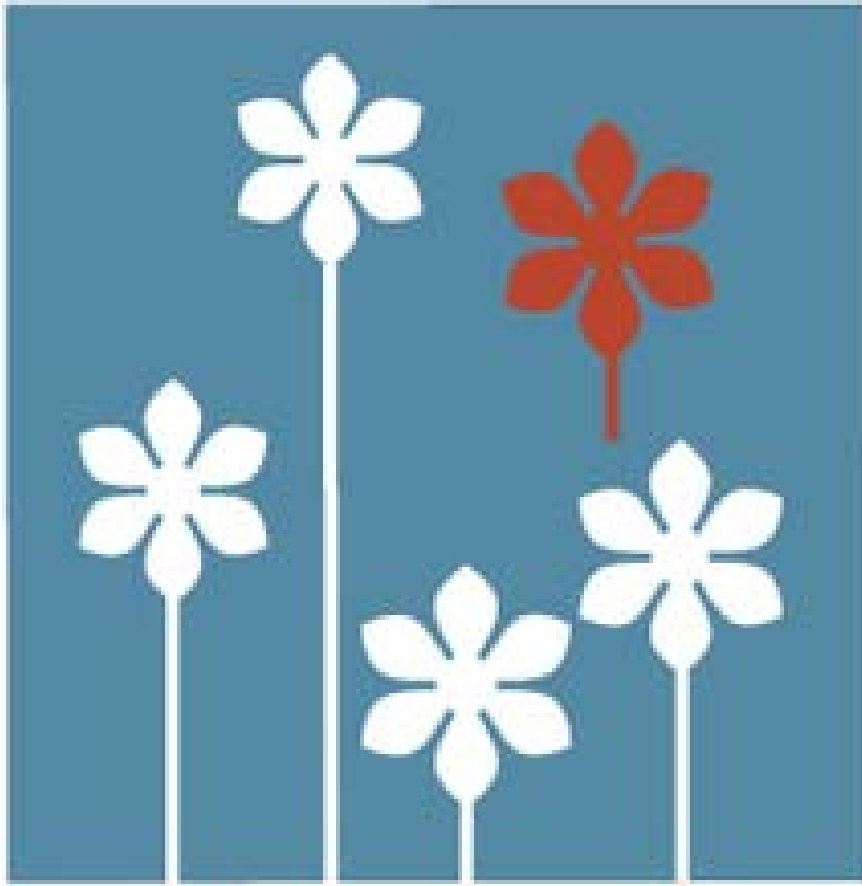
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Oregon CYSHCN



Population: Birth - 21 yrs

Data available: < 18 yrs

Prevalence: 18.5%

Insurance Type

Public only = 32%

Private only = 53%

Public & Private = 10%

Unknown = 4%

Uninsured = <1%

Source: National Survey of Children's Health, 2016



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OCCYSHN 2015-2020 Block Grant Priorities

National: Health Care Transition

National: Medical Home

State: Culturally and Linguistically Appropriate Services

Key Strategies

- Local public health staff convene cross-systems (interprofessional) child health teams to develop SPOC
- Regional teams engage in cross-systems QI to address system-level barriers



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Rationale for Strategies

- 2015 statewide needs assessment results
 - Care coordination not well implemented for CYSHCN
 - Care plans are under utilized
- Alignment of Title V Block Grant with ACA Implementation
- Oregon's Patient-Centered Primary Care Home (PCPCH) Program (a.k.a. "medical home")
 - Standards for care coordination
- Coordinated Care Organization (CCO) Metrics
 - Access to care
 - Satisfaction with care
 - Avoidable emergency department utilization
 - Developmental screening in the first 36 months of life



APMs Provide Necessary Infrastructure for Care Coordination

- Provide reimbursement to primary care for non-billable or non-reimbursable activities
- Provide an enhanced rate to PCPCH for CYSHCN that are identified as needing care coordination (e.g., CYSHCN with two or more systems involvement)
- Provide reimbursement for representatives of primary or specialty care to participate in team-based implementation of shared plans of care to facilitate cross-systems care coordination (CSCC)



Challenges: Lower health care costs may not result.

CYSHCN are a small group of children with idiosyncratic diagnoses. With children the goal we are looking for is maximizing the arc of development. Long term outcomes are not captured in APM. Children make up 12% of health care spending nationally. It's hard to generate shared savings with a small piece of the pie.

Dr. David Keller, University of Colorado School of Medicine

If lowering health care costs is not a compelling argument, what is?



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Possible VBP Entry Points in Oregon – Challenges

- Via insurers: Medicaid provides funds to Coordinated Care Organizations (CCOs) via global budgets. **How do we access private insurers?**
 - CCOs do have to test alternative payments.
 - **Stakeholders perceive “physician fatigue.”**
 - **CCOs operate relatively independently; how motivate to test?**
 - CCOs have incentive metrics.
 - **Are there enough CYSHCN to “move the needle”?**
 - **Will CCOs care? (CCOs need to meet 20 of 22 benchmarks to obtain their incentive.)**
- Primary care payment reform: Oregon is participating in CPC+.
 - **CPC+ is adult focused.**
 - **APMs make payment to medical home, not community based providers.**



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Proposed Health Care Transition Project

- Cross-systems care coordination *includes* transition planning
- Focus on children with medical complexity (Align with CMC CoIIN)
 - 16 to 17 year olds with orthopedic conditions or spinal cord injuries
- Case Rate #1: Pediatric provider
 - Transition readiness assessment
 - Transition goals developed as part of SPOC
 - Other activities
- Case Rate #2: Adult provider
 - Pediatric provider warm handoff
 - Follow up transition readiness assessment
 - Update of transition goals
 - Other activities
- Technical Assistance from Got Transition & Catalyst Center

**This project is
in its planning
stage.**



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Oregon Center for Children and Youth with Special Health Needs

Alison J. Martin, PhD
Assessment & Evaluation
Coordinator
503-494-5435
martial@ohsu.edu

Thank you!



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Colorado's Accountable Care Collaborative

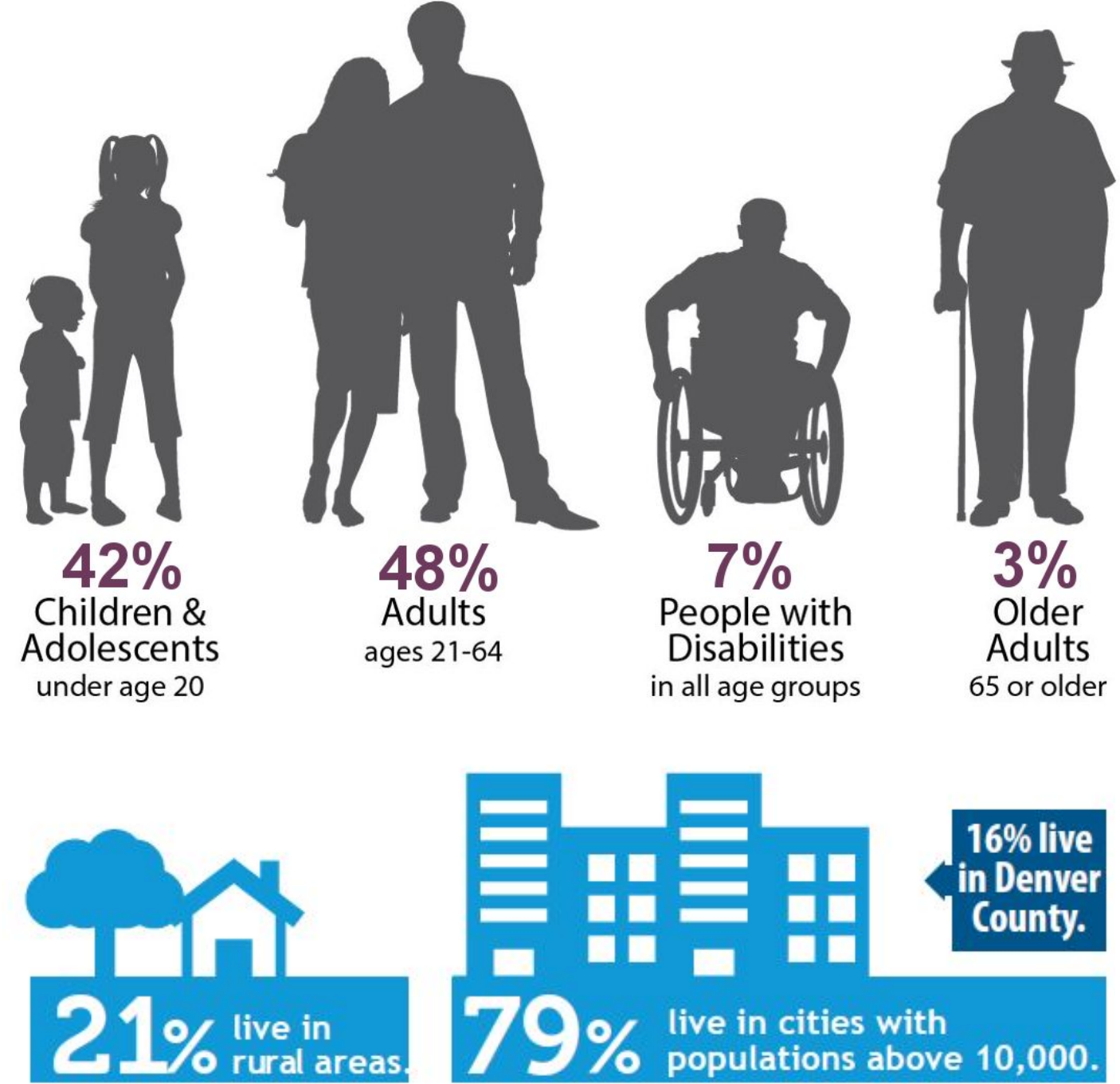


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Who We Serve

Fiscal Year 2015-16 Health First Colorado Caseload



75% of Medicaid adults work



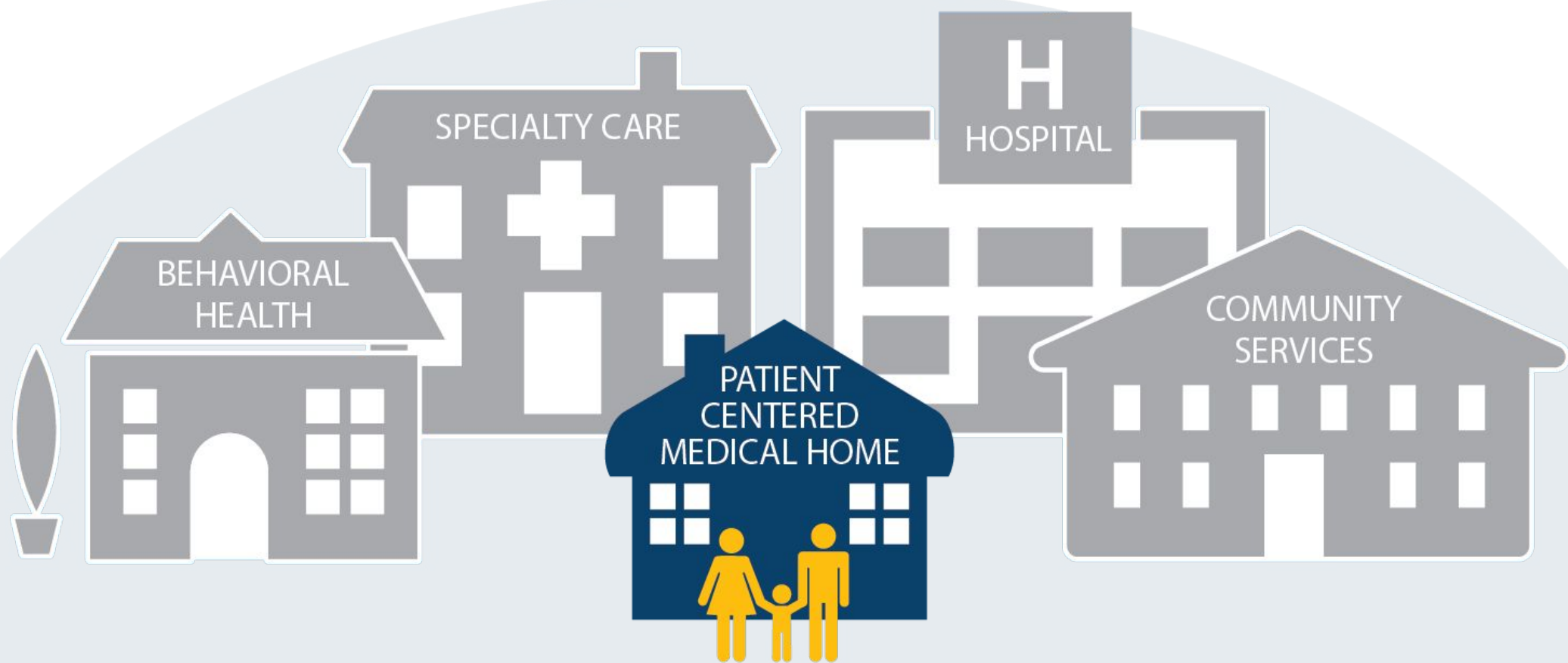
2016 Federal Poverty Levels by Family Size

	Family of 1	Family of 4
133%	\$15,804	\$32,328
*Some earning more may still qualify.		



Health First Colorado Delivery System: Accountable Care Collaborative

Care Coordination (RCCOs)



Data & Analytics (SDAC)

Impetus for the ACC

Created in response to:

- Unsuccessful attempt at capitated Managed Care in the state
- 85% in an unmanaged Fee-For-Service (FFS) system
- Highest caseload and expenditures in the state's history of Medicaid

How the Program Works



Better Health and Life Outcomes



Medical Home

Coordinated care means improved health outcomes and a better experience for providers and members as they interact with the system, and wiser use of state resources.



Regional Coordination

Improved health outcomes and smarter use of state resources requires regional and local coordination that recognizes the need for medical care, behavioral health care and community supports all working together.



Data

Members, providers and the system receive the data needed to make real-time decisions that improve care, increase coordinated services and improve overall efficiencies.

ACC Program Goals

- **Focal point of care or medical home for all members**
- **Coordinate** medical and non-medical care and services
- **Improve member and provider experiences**
- **Data** to support these goals, analyze progress, and move the program forward

ACC Strategies

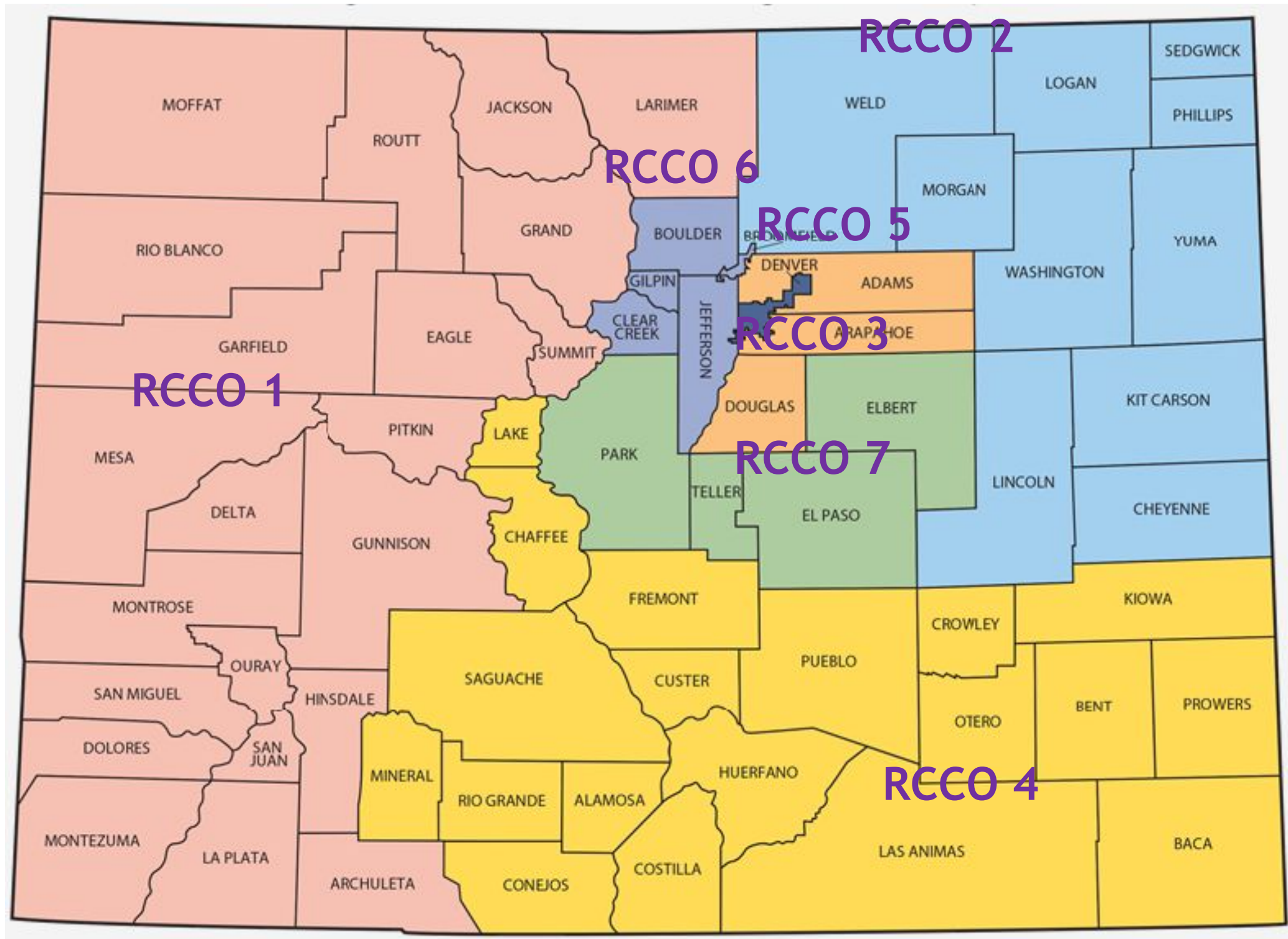
- Every member has a **Primary Care Medical Provider (PCMP)**
- All ACC members and PCMPs belong to a local **Regional Care Collaborative Organization (RCCO)**
- Increased access to data through the **Statewide Data and Analytics Contractor (SDAC)**
- Gradual introduction of payment strategies to reward outcomes instead of volume



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Regional Approach



Regional Care Collaborative Organizations (RCCOs)

- Ensure a medical home for every member
- Develop and manage a network
- Support providers
- Ensure medical management and care coordination
- Report on progress and outcomes
- Accountable for health outcomes and costs



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Paying for Value

- Key Performance Indicators
 - Well-child check (ages 3-9)
 - Emergency room visits
 - Postpartum care
- Pay-For-Performance Pool
 - payer support for SIM and CPC plus SIM practices
 - Participation in SIM
- Enhanced Primary Care Medical Provider
 - PCMPs meeting 5 of 9 enhanced medical home factors are eligible to receive an additional \$.50 PMPM

Accountable Care Collaborative

Phase II Key Concepts

To improve
health and life
outcomes for
Members

To use state
resources
wisely

- Single regional administrative entity for physical health care and behavioral health services
- Strengthen coordination of services by advancing health neighborhood
- Population health management approach
- Payment for integrated care and value
- Greater accountability and transparency

Colorado's Title V Support for Children with Special Health Care Needs



Three Strategic Priorities

Care
Coordination

Access to
Specialty care

Medical Home



Title V Care Coordination

- Approximately 1,100 care coordination clients annually (with additional 2,000 information and referral contacts)
- Target population CYSHCN birth - 21; funded through state general fund and Title V Block Grant
- Administered by Department of Public Health and Environment through contracts with local public health agencies
- Ratio of Care Coordinator to clients 1:50



Identified Strengths to Leverage



- Title V has an existing statewide infrastructure for providing care coordination services for CYSHCN
- Title V has specific focus and expertise in serving children and youth
- RCCOs are responsible for assuring that their members have access to care coordination services
- RCCO contracts are up for re-bid. Opportunity to influence care coordination standards

Identified Challenges to Address

- RCCO care coordination varies
- No standardized approach to identifying CYSHCN enrolled in the RCCOs
- Limited quality standards/expectations
- RCCOs have large staff to client ratios
- RCCOs and Title V understanding of roles varies across the state
- No standardized technology solution to support a shared plan of care



Successes to Date

- Established and/or **strengthened relationships** between key state and local partners
- **Identified over 40** potential programmatic and cross-agency **policy/systems change opportunities**
- **Prioritized areas of focus:** data sharing and analysis; developing pathways for interagency communication; and standardized processes for interagency case conferences and shared plans of care
- **State and local action plans** for prioritized policy/systems change opportunities



Future Opportunities

- Identify and promote key performance indicator for CYSHCN in ACC 2.0
- Promote RCCO and practice awareness and understanding of community based resources
- Remove barriers to regional and/or local data sharing agreements between local public health agencies and the RCCOs to facilitate shared plans of care for CYSHCN
- Promote care coordination standards in the implementation of ACC 2.0 (July 2018)



Contact Information

Jennie Munthali
CYSHCN Section Manager
CO Dep't of Public Health and Environment
jennie.munthali@state.co.us



Questions and Discussion



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**For more information,
please contact us at:**

The Catalyst Center
Center for Advancing Health Policy and Practice

Boston University School of Social Work

302-329-9261

www.catalystctr.org



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