



Achieving Payment Reform through Medicaid and Stakeholder Collaboration: A Guide for Action

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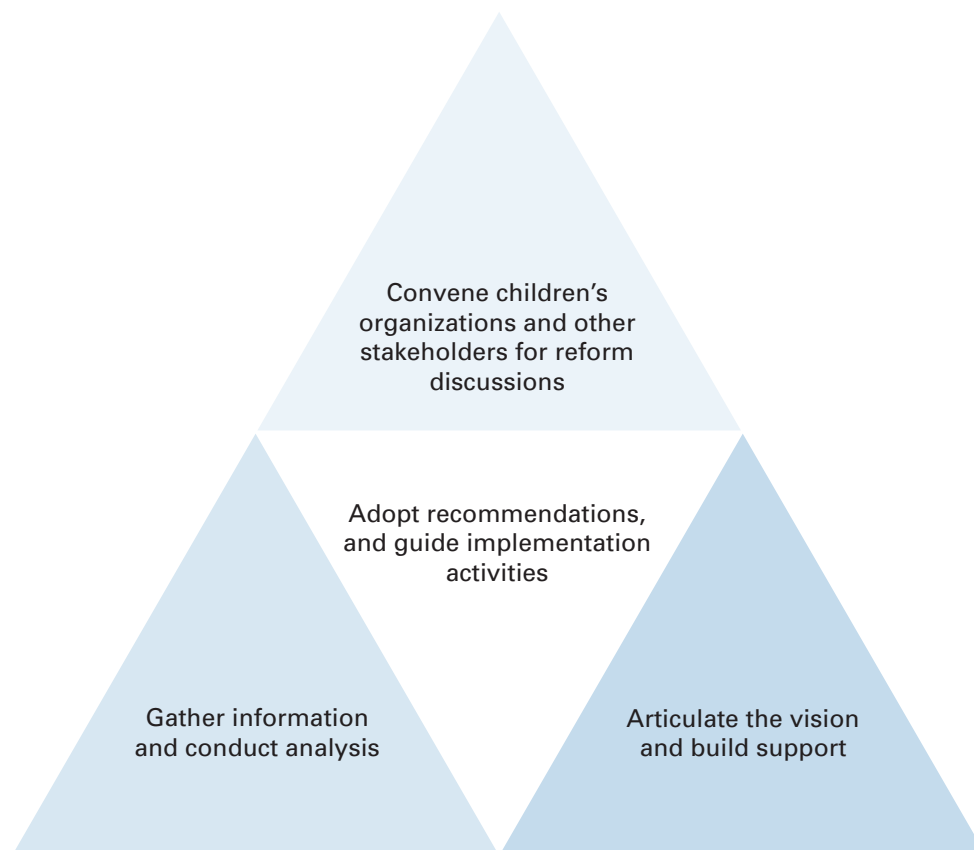
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Introduction

Payment reform can be a powerful force for improving children’s health. But effectively harnessing its potential depends, in large part, on Medicaid agencies and non-governmental organizations (NGOs) working together. This guide describes activities that stakeholders and Medicaid policymakers can jointly undertake to support payment reform for children. The information builds on the Payment Reform Engagement Framework that was introduced in this paper’s companion document, [“Achieving Payment Reform for Children through Medicaid and Stakeholder Collaboration,”](#) also published by United Hospital Fund.

Figure 1. Payment Reform Engagement Framework



Where to Begin?

It can be difficult for stakeholders to assess whether the time is right to employ the strategies included in this framework. That decision will often depend on how engaged the state’s Medicaid program already is in payment reform and the extent of “change fatigue” among key players. If a state is already moving toward payment reform for its Medicaid beneficiaries, and children’s organizations seem hungry for a reform effort focused on children, then it may be reasonable to pursue any or all of the contribution areas outlined in the accompanying context document—pending available resources, of course. If a state has not expressed interest in payment reform, or stakeholders have recently been through another large transformation effort, it may be wise to move more slowly. Beginning with data

collection and analysis is never a bad option and will provide a solid foundation on which to build discussions about payment reform when the moment is ripe.

Gather Information and Conduct Analysis

All payment reform efforts should be informed by substantial information about the needs of the relevant population, the structure of services available for that population, and opportunities to improve its care. Information-gathering and analysis help build a case for the “why” of child-centered reform efforts and drive meaningful conversation among stakeholders about what needs to be changed or improved in children’s health care. This aspect of the engagement framework covers a broad range of issues, but, at a minimum, stakeholders should strive to collect information in four categories:

- Medicaid delivery system and payment structure
- Medicaid utilization and expenditures
- Child health care quality
- Public health/population health

Data should be analyzed in the greatest demographic detail possible, including geography, age, race/ethnicity, etc.

This information rarely exists in one place, nor is it usually owned by one entity. Sometimes the mere process of collecting such information can raise important issues about who has access to data, the willingness of stakeholders around the state to share data across parties, and power dynamics between those who can access and interpret this information and those who cannot. If those dynamics are likely to emerge, stakeholders may want to first develop a process for information-sharing and consensus-building before attempting to collect and analyze data. Leveraging existing academic or NGO-based researchers familiar with the state Medicaid program’s structure, claims, and quality data could greatly streamline the information-gathering and analysis effort.

Data Collection: Sources and Analytic Approaches

Medicaid Delivery System and Payment Structure

Building on the pre-work noted in the accompanying document—a general familiarity with various approaches to reform—it is important to understand the scope of Medicaid coverage for children, how the program pays for children’s services, and what that looks like in practice in the delivery system. At minimum, the following questions should be asked and (to the extent possible) answered to provide context for the utilization and expenditure analysis that comes next. The illustrations below draw upon national data, but state-level data is always preferable and is generally available from the same cited sources.

- **How many children are enrolled in Medicaid and how much do they cost?**
 - Nationwide, non-disabled children make up approximately half of all Medicaid enrollees. Individual state proportions of children enrolled vary substantially.¹

¹ Kaiser Family Foundation, State Health Facts. *Full-Benefit Medicaid Enrollees by Enrollment Group, 2014*. <https://www.kff.org/medicaid/state-indicator/distribution-of-full-benefit-medic-aid-enrollees-by-enrollment-group>

- In 2014, average annual per-enrollee spending for children without disabilities was \$2,602 on a national level; this is 34 percent less than the \$3,955 spent for adults without disabilities² and almost 60 percent less than the \$6,396 average spending amount for all Medicaid enrollees (including individuals with disabilities and seniors).³
- State-level data likely provide the opportunity to further disaggregate enrollment and per-enrollee spending by detailed eligibility categories, age groups, and/or expenditure distribution.
- **What is the general structure of the Medicaid payment system?**
 - Managed Care: State contracts with one or more health plans, which in turn contract with providers.
 - Fee for Service: State pays participating providers directly on a per-service basis.
 - Hybrid: Some populations or services are in managed care while others remain on a fee-for-service basis, and/or the state contracts with aggregated providers without a health plan intermediary. In hybrid structures, it is important to understand the distribution of child expenditures across the different aspects of the system.
- **Where and from whom do children receive their care?**
 - Primary care: Proportion of services provided in physician offices (by practice size if possible), federally qualified health centers, hospital outpatient departments/clinics, urgent care, school-based providers (where applicable), etc. This is important for getting the right provider stakeholders at the table and for helping create the portrait of children's health described below.
 - Specialty care: What types of specialty providers are children visiting (e.g., behavioral health; ear, nose and throat/allergy; etc.)? This is especially important for ensuring that the most appropriate provider stakeholders are engaged in payment reform discussions.
 - Hospital care: What is the hospital landscape in the state? Do a few major children's hospitals or academic medical centers handle most tertiary care for children? Do those same hospitals have large pediatric primary care networks? This is especially important for determining whether there are existing integrated delivery systems that could meet most child needs, or if ambulatory care remains generally independent from bigger hospital systems.

Medicaid Utilization and Expenditures

With a broad understanding of the population, payment system, and provider landscape in hand, an analysis of Medicaid service utilization and expenditures for children is vital for painting a comprehensive portrait of children's health in the state (see section below for more details). Detailed analysis of Medicaid claims is likely necessary to supplement any publicly available aggregate information already published by a state. The Medicaid agency proper or a non-governmental organization with access to the state's Medicaid claims data are likely sources for such detailed analyses. A full investigation in all areas may not be possible—depending on the detail of the Medicaid claims data available—but to fully understand the unique payment reform opportunities and challenges for children, all children should be compared to non-disabled adults under age 65.

² CMS labels these categories of eligibility as non-disabled children and non-disabled adults.

³ Kaiser Family Foundation, State Health Facts. *Medicaid Spending Per Full-Benefit Enrollee, 2014*. <https://www.kff.org/medicaid/state-indicator/medicaid-spending-per-full-benefit-enrollee>

Child Health Care Quality

The Centers for Medicare & Medicaid Services (CMS) has information on how state-specific Medicaid programs are performing against many of its Child Core Set measures. This information offers a useful, state-by-state comparison of how Medicaid programs are performing—areas in which they are doing well and those in which they are not—compared to their peers in other states.⁴ Additional detail on the core set measures may be available directly from the state or managed care plans. Some states also use their Medicaid claims or hospital discharge databases to report on the Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs), a set of measures that assess “problems that pediatric patients experience as a result of exposure to the health care system and that may be amenable to prevention by changes at the system or provider level.”⁵

Public Health/Population Health

Using quality data to identify payment reform opportunities is critical, but it is important to remember that state health care quality data alone do not tell the whole story about how children are faring. Other possible, state-specific data sources contain information from child-serving programs and surveys outside of Medicaid. Examples may include, but are not limited to, Maternal and Child Health Program performance measures, Early Intervention program metrics, and state or local children’s surveys. This state-specific information, combined with state-level indicators from broader public health data sources, can offer a more comprehensive view of child health than Medicaid claims and quality data alone. The Census Bureau’s National Survey of Children’s Health provides the most comprehensive state-level data on children’s health indicators for children of all ages among national surveys.⁶ The Centers for Disease Control and Prevention (CDC) also houses many potential public health resources for investigation, including the National Health Interview Survey, the National Health and Nutrition Examination Survey, the National Ambulatory Medical Care Survey, the National Hospital Ambulatory Medical Care Survey, Youth Risk Behavior Surveillance System, and the Pregnancy Risk Assessment Monitoring System.⁷ The March of Dimes PeriStats and the Annie E. Casey Foundation’s Kids Count Data Center compile information from many of these sources, supplemented with additional census and other data, providing a comprehensive view of child well-being in each state and nationwide.

⁴ Data.Medicare.Gov. 2016 *Child Health Care Quality Measures*. <https://data.medicare.gov/Quality/2016-Child-Health-Care-Quality-Measures/wnw8-atzy>

⁵ Agency for Healthcare Research and Quality. *Pediatric Quality Indicators Overview*. http://www.qualityindicators.ahrq.gov/modules/pdi_overview.aspx; See also <https://health.data.ny.gov/Health/Medicaid-Inpatient-Prevention-Quality-Indicators-P/64yg-akce>

⁶ Data Resource Center for Child & Adolescent Health. 2016 and 2017. “The National Survey of Children’s Health.” Available at: <http://www.childhealthdata.org/learn/NSCH>

⁷ Data sets are available, in order of listing, at: <https://www.cdc.gov/nchs/nhis/index.htm>; <https://www.cdc.gov/nchs/nhanes/>; <https://www.cdc.gov/nchs/dhcs/index.htm>; <https://www.cdc.gov/healthyyouth/data/yrbs/index.htm>; <https://www.cdc.gov/prams/index.htm>

Data for Strategy Versus Implementation

Aggregate claims, quality, and public health data, which are valuable for providing a broad picture of children’s health in a state and telling a narrative about how children and adolescents are faring, can help shape the state’s strategy. It is important to remember that aggregate data generally do not contain the level of detail that is necessary to define and measure accountability in payment reform; that likely requires more granular data analysis at the individual contractor level.

Painting a Portrait of Children's Health

There are many ways to use claims, quality, and public health data to paint a picture of children's health that can support a payment reform conversation. Table 1 below includes examples of the specific data analyses (the individual brush strokes) that, when put together, form a more complete portrait. The table also provides a docent-like guide of what to look for in the individual data analyses. The overall goal of the data analysis is to help identify areas for improvement and areas where existing high performance can be leveraged as a jumping-off point for achieving better outcomes.

Table 1.

Analysis Type	Potential Analytic Approach	Data Examples	Sample Research Questions (not mutually exclusive for each analysis type)
Child demographics	Develop cohorts of children by different types of demographic groups that can be used for all subsequent analyses. Think specifically about the types of demographic categories that may reveal differences in health care utilization, costs, or needs.	<ul style="list-style-type: none"> Age groups (e.g., 0-1, 1-5, 6-12, 13-18, 19-21, 21-64). Race/ethnicity. Geography (e.g., county, zip code). Medicaid eligibility category. 	<ul style="list-style-type: none"> How have the demographics of children in Medicaid changed over time? How do the demographics of children in Medicaid compare to adult Medicaid beneficiaries?
Health care utilization	Understand which types of health care services and prescription drugs are provided to children across demographic categories, by which types of providers, and how often different groups of children receive those services and drugs. Consider using broad categories of service initially, followed by a deeper dive on specific evidence-based or recommended services (e.g., well-child visits).	<ul style="list-style-type: none"> Inpatient (IP) stays per 1,000 children. Emergency department (ED) visits per 1,000 children. Children with at least one outpatient primary care (PC) visit (evaluation and management or preventive care claim). Top 10-20 drugs prescribed to children. Children receiving special services and supports through health homes, case management, etc. 	<ul style="list-style-type: none"> How does utilization of services and medication differ at different ages (for example, you may find more primary care services at age 0-5, but more ED visits for children aged 12-21)? Is there variation in utilization across service categories by race/ethnicity, geography, Medicaid eligibility category, etc.? Are there indicators of inappropriate or unusual service utilization (e.g., high rates of antipsychotic prescribing for young children)?
Diagnoses driving utilization	Identify the diagnoses underlying service utilization of prescription drugs by different demographic cohorts. To the extent possible, use secondary diagnoses to assess common comorbidities. Future analysis may include analyzing health care utilization patterns and needs based on specific diagnoses (for example, long-term service utilization of children with mental health diagnoses).	<ul style="list-style-type: none"> Top 5-10 primary diagnosis categories for each major utilization category (IP, ED, PC). Common secondary diagnoses for top primary diagnosis categories. Health care utilization of children with and without specific diagnoses (e.g., behavioral health, developmental disability, complex chronic conditions). 	<ul style="list-style-type: none"> Which diagnoses are most associated with IP and ED services across demographic categories (e.g., asthma, behavioral health)? Are there common secondary diagnoses that may be driving service utilization (e.g. anxiety or depression as a comorbidity with physical health conditions)? Does any category of service utilization seem too low or too high for the population? Do any of the diagnoses driving high utilization seem ripe for prevention interventions?

Expenditures	Assess total and average per-child costs across demographic groups, broad categories of service, and cohorts of children with and without specific diagnoses. Break down the distribution of expenditures across the child population (e.g., by deciles or quintiles) for additional analysis.	<ul style="list-style-type: none"> • Total and per-enrollee expenditures on IP, ED, specialty care, and PC. • Total and per-enrollee expenditures for children with and without specific diagnoses. • The percent of children that account for the top 10% of total expenditures. 	<ul style="list-style-type: none"> • What are the total child expenditures, and how do these compare to adult expenditures? (Note: total expenditures may be masked by capitation payments to managed care plans). • How do expenditures for children differ by age, eligibility category, or diagnoses cohorts? • What is the size and profile of children in the highest expenditure category (e.g., top 1% or 10%)?
Population segments	Using the above analyses, further segment the child population into potentially useful comparison cohorts and reassess utilization and expenditures for those cohorts. Define natural break points in the data for future discussions around segmented payment reform goals for distinct child populations.	<ul style="list-style-type: none"> • Comparison of children in top X percent of expenditures or utilization versus all others. • Comparison of 'well-child' population (not in high expenditure or specific diagnoses cohorts) versus all others. • Comparison of children involved in multiple systems (e.g., foster care, juvenile justice system, special education) vs. all others. 	<ul style="list-style-type: none"> • What patterns emerge for each population segment you have created? • Are these patterns distinct enough that they might warrant separate payment reform strategies for each population segment? • What are the total expenditures for the 'well-child' population?
Disparities in utilization and quality, and identification of prevention opportunities	Use all the analyses above to assess disparities in utilization and quality of care across cohorts, employing widely available claims data "groupers" and additional quality measure sets. If possible, identify patterns of preventable utilization or poor quality that could be improved over time through 'upstream' investments.	<ul style="list-style-type: none"> • AHRQ Pediatric Quality Indicators (ambulatory care sensitive hospital admissions). • Potentially preventable IP/ED utilization and/or potentially avoidable complications (3M, HCl3). • CMS Child Core Set or HEDIS measures by cohort and demographics. 	<ul style="list-style-type: none"> • What variations in utilization or quality are apparent, and what might be causing these disparities (e.g., insufficient provider supply, low access to preventive care)? • In what areas is there strong performance, and how can these strengths be built upon? • What are opportunities to strengthen health promotion or prevention to avoid future utilization or expenditures?

While health care utilization, quality, and health outcomes are important, they present an incomplete picture of how children are faring in a state. Data from other sectors, especially education indicators, can be a good companion to more traditional health care data when painting a portrait of children's health. This data may also be helpful when trying to illuminate the ways children's health and well-being could be improved through greater health promotion and prevention investments. The potential to harness payment reform to prevent poor future outcomes and costs is often more difficult to promote because the pay-off from prevention interventions is usually long in the future, while the required investment may increase costs in the short run. Bolstering the perceived value of specific prevention opportunities with estimates of long-term health and cost savings outcomes from health services research literature is one way to help make the case. The rationale should not ignore the fact that child health improvements can generate savings outside the health care system as well. While research on specific savings is limited, even theoretical examples about how small percentage

reductions in costs to the child welfare, juvenile justice, or special education systems can result in tens or hundreds of millions of dollars saved may pique interest in child health improvement for those not inherently receptive to the obvious altruistic reasoning.

Articulate the Vision and Build Support

Articulating the vision and building support are important for raising awareness of how value-based payment approaches can improve child outcomes in the state. These activities also help clarify that the goals and strategy of payment reform efforts may need to look different for child and adolescent Medicaid beneficiaries than for adult beneficiaries. This contribution to the dialogue is important whether or not a payment reform strategy has already been initiated. If such efforts are underway, child-focused stakeholders can help the state clarify and articulate why a focus on children's unique needs is an important strategic goal and can build support among other stakeholders. If the state is not yet engaging in payment reform, this is the opportunity to make the case.

Make the Case

Identify the rationale for why a special focus on the unique needs of children and adolescents is a strategic opportunity. Even if the state Medicaid program is inclined to entertain child-centered payment reform, the Medicaid agency may need assistance articulating the precise rationale for such efforts. Clarity is important for building support from other government agencies, the governor's office, the state legislature, and stakeholders that will be affected by the reform effort. The following common arguments may be persuasive:

1. Designed *without* children in mind, the State's payment reform approach may lead to unintended incentives that could harm children's health. Payment reform efforts that fail to include quality measures appropriate for children⁸ while simultaneously encouraging providers to reduce costs could result in some providers skimping on care for children. This is a particular concern in relation to vulnerable populations, like children in foster care, that may already be under-served by the health care system.
2. Designed correctly, payment reform is an opportunity to address quality concerns, including disparities in care.
3. Improving health care for children, particularly through greater use of preventive interventions, is an opportunity to deter development of health care "super utilizers" of the future.
4. Inclusion of children's health services or engagement by child-serving health providers is necessary to achieve overall payment reform goals. For example, the state may have set a goal for the number of beneficiaries accounted for under value-based payment arrangements or for the percentage of Medicaid expenditures that count as value-based payment. The large share of children in the Medicaid program makes that goal easier to attain and thus works to the state's advantage.

⁸ One review of pediatric Accountable Care Organizations found that at most institutions, "the measurement and improvement of quality in the pediatric accountable care organization was not well conceptualized beyond cost and utilization." Makni N, A Rothenburger, and K Kelleher. 2015. Survey of twelve children's hospital-based accountable care organizations. *Journal of Health Care Management* 4(2): 64-73.

5. Payment reform is an opportunity to align the Medicaid program with other state reform efforts. For example, in 2011 Oregon's early learning system was undergoing a shift toward greater accountability for outcomes. This opened a window for the children's health community in Oregon to focus one dimension of the state's health care payment reform efforts on aligning incentives to achieve school readiness. Similar opportunities may be available to states in other areas in which good health and development are determinants of success, including in juvenile justice reforms.
6. Child-centered payment reform is an opportunity for the state to tell a positive story to the public—demonstrating, perhaps, a focus on children, or a role as innovative leader among states.

Stakeholders can prioritize these arguments or develop new ones by using key informant interviews or reviewing statements on record to ascertain what matters most to the policymakers and influencers in their state.

Assess Readiness for Change

Gauge the scope of system change that stakeholders—service providers, health plans, governmental partners, families, and others—are willing to accept. Assessing readiness for change among stakeholders is useful for calibrating the vision of reform, the scope of data collection and analysis needed for the effort, and the breadth of stakeholder involvement. In some states, an effort to link health care quality measures to existing payment approaches will be a significant enough change for many stakeholders. Other states already familiar with paying for performance may aim for system changes that extend beyond the traditional medical system to include payment incentives for working on social determinants of health or cross-sector collaboration.

Figure 2 lists some of the factors that may indicate stakeholders will be ready to pursue ambitious system reform. Equally important to understand are the opportunities and limitations the Medicaid agency may face in pursuing system reform. Figure 3 lists some of the primary factors influencing a Medicaid program's ability to engage in system reform. Figure 4 illustrates possible degrees of system change given these considerations.

Figure 2. Factors Contributing to Stakeholder Readiness for System Reform⁹

- High degree of collaboration within the health care community (e.g., between primary care and specialists, or providers and plans) and across sectors.
- Strong culture and infrastructure for data collection and sharing.
- Sufficient bandwidth for stakeholders to engage in reform efforts.
- Broad familiarity across stakeholders of system reform topics (e.g., the role non-health care factors play in influencing a child's health and developmental trajectory).
- Recognition by public and private leaders that the status quo is not adequate to achieve desired outcomes.

⁹ This checklist was partially informed by UCLA's Alcohol and Drug Policy Institute, "Health Care Reform Readiness Assessment", accessible at: <http://www.uclaisap.org/integration/assets/documents/health%20care%20reform/General/Healthcare%20Reform%20Readiness%20Assessment.pdf>

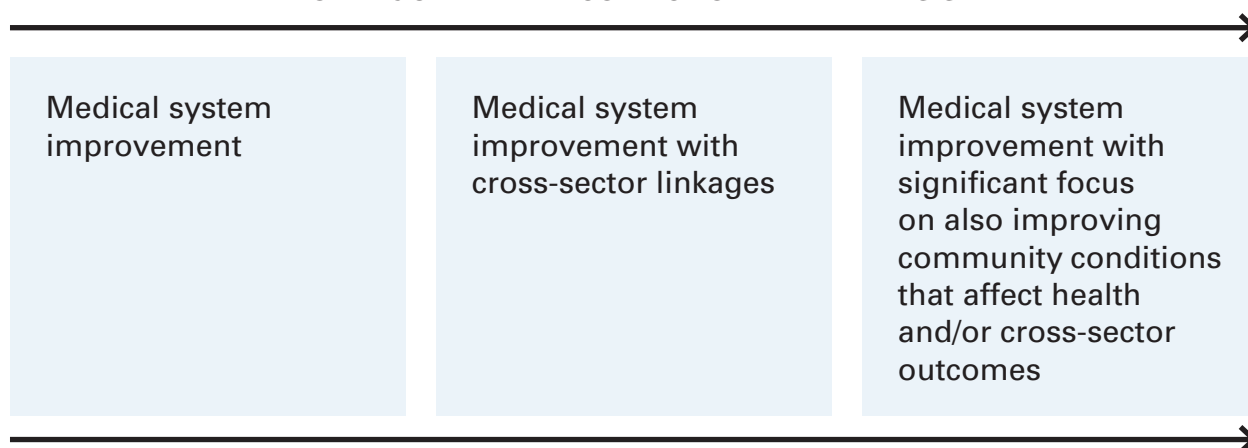
Figure 3. Factors Influencing State Medicaid Reform Processes

Factors Influencing State Medicaid Reform Processes

- Federal Medicaid matching funds are in general limited to payment for clinical services (i.e., care provided by a licensed medical professional or facility), prescription drugs, certain durable medical equipment (like wheelchairs), and transportation to and from medical appointments. Proposed payment changes that include other services may not qualify for the federal match, thus greatly increasing the cost of making that change.
- States may apply to the federal government for waivers of federal matching fund rules to test a proposed change, such as offering an alternative benefit package to a subset of Medicaid enrollees (“statewideness” waivers), or to expand coverage to a non-clinical service. The waiver application process can, however, be cumbersome and time-consuming for the state, and federal approval is not assured. Waivers also require the state to document that the implementation of the change will not result in an increase in federal expenditures beyond what they would have been in the absence of the waiver (“budget neutrality”); the state is at risk for any expenditures above that amount.
- Most state Medicaid programs contract with managed care organizations (MCOs) to administer services for enrollees. Compared to states operating a traditional fee-for-service system, MCOs have greater flexibility in financing services, particularly “value-added” health services that are not covered in the state plan. This increased flexibility, along with the need to build support for reform among MCO leaders, needs to be taken into account early in any reform process.
- A shortage of qualified providers may make reform difficult. For example, a dearth of existing child behavioral health providers could mean that adopting payment incentives to link to those services has limited impact, at least in the short term.
- The extent to which a state has taken maximum advantage of existing federal Medicaid authority to spread population health management tools — such as case management, targeted case management, and health homes — may increase the likelihood that providers have the tools necessary to be successful under value-based payment.

Figure 4. Payment Reform Spurs a Range of System Changes

BREADTH AND DEPTH OF REQUIRED DATA COLLECTION AND ANALYSIS



Set Initial Expectations

It is important to define success for children's value-based payment early in the effort. Success can be considered in three domains:

- **Efficiency:** Providing more efficient care through better resource utilization—particularly by decreasing unnecessary and potentially harmful health care interventions—is a core aim of value-based payment. While children's health may present fewer areas in which to improve efficiency and generate savings—compared to adult health care services—variation in care for common, high-cost, pediatric conditions (such as prematurity) suggests that cost savings are possible.¹⁰ Any cost savings projections should include the timeline in which they are likely to be achieved and address whether those savings would accrue to the initial investor (i.e., the health care system) or to other sectors, like education.
- **Quality:** Because opportunities for cost savings are more limited in children's health care, improving quality of care or outcomes through improved payment strategies is a promising way of defining success.
- **Alternative perks:** While improving quality and efficiency are the two traditional justifications for pursuing alternative payment models, the shift to these models may also bring about additional benefits, including diffusion of innovations, strengthened systems, opportunities to invest in longer-term preventive efforts, provider satisfaction, and potential savings to sectors beyond health care.

Convene Children's Organizations and Other Stakeholders for Reform Discussions

Offering to convene stakeholders to develop payment reform recommendations for the state is an effective way for children's organizations to partner with Medicaid agencies. The purpose of such convenings is to ensure that the many parties with a stake in children's health transformation have an opportunity to deliberate together, hear one another's perspectives, identify common goals for transformation activities, and provide concrete information or policy options to the state Medicaid program.

Convenings may take the form of stand-alone activities or be integrated into broader state processes looking at payment reform for all Medicaid beneficiaries. There are benefits and drawbacks to each approach. A stand-alone effort will focus attention specifically on children's needs and may be able to accommodate more children's experts and practitioners at the table. But such an approach runs the risk of creating silos—between child health and maternal health considerations, for example—and may not be well tolerated by some stakeholders.

The subsections below present convening activities for a stand-alone process, but many of the key activities and tactics can be integrated into other existing processes.

¹⁰ Chua K-P, RM Conti, and GL Freed. March 20, 2018. Appropriately framing child health care spending: A prerequisite for value improvement. *JAMA*. 319(11): 1087–1088. <https://jamanetwork.com/journals/jama/article-abstract/2673897>

Identify a Clear Charge

Explicit agreement between the state Medicaid program and children's organizations about the deliverable the Medicaid program is seeking—including the scope, format, and timeline for the product—is essential. Most often, the deliverable will be a set of recommendations on a topic within payment reform, but the deliverable can also include foundational materials such as background information or guiding principles for the state.

Defining A Stakeholder Charge

Stakeholder responsibilities might include:

- Reviewing or recommending child-appropriate quality measures (see Appendix A for additional detail).
- Setting targets or goals for improvements in children's health or child-serving health care to help guide the State's overall strategy and evaluation of its efforts.
- Establishing child- and family-centered principles to guide payment reform.
- Developing goals or strategies for reducing disparities in child outcomes.
- Reviewing and recommending specific payment models.
- Identifying potential drawbacks of new payment models or incentive structures.
- Identifying infrastructure needs required for stakeholder success under payment reform.
- Soliciting family or community input on proposed payment reform changes.
- Providing an assessment of children's population health needs.

Set the Table for Productive Discussions

Successfully convening stakeholders on behalf of a state Medicaid program requires attention to detail and sensitivity to the needs of both the state and those who have been invited to participate in the process. Details to focus on include:

• Roles and Responsibilities

- **Facilitator:** Determine which individual or organization will act as a neutral facilitator of the convening process, handle meeting logistics, and ultimately be responsible for delivering a final product to the Medicaid program on time.
- **Medicaid agency participation:** Agree upon how the state Medicaid program will be involved. Is it an active participant in deliberations, an observer, or not a participant? Ideally, Medicaid staff would be active participants providing important context on policy and operational realities but would make clear that they are assuming a supporting role that is not intended to influence group deliberations.
- **Non-governmental leadership:** In addition to a neutral facilitator, the process may warrant respected chairs or vice-chairs drawn from agencies outside of government, or outside the health department if it is a cross-sector effort, to help lead deliberations.

- **Workgroup Membership¹¹**

- The convening process should include representatives from all stakeholder groups necessary to inform the state's approach, including the parties most likely to be affected by payment reform, and should reflect the scope of system change that payment reform is expected to create.
- Consider including the following stakeholder groups: experts from non-Medicaid governmental agencies responsible for children's mental health, public health, child welfare, education, and juvenile justice; providers in family medicine, pediatrics, and women's health; managed care plans; community organizations working on social determinants of health; experts in particularly challenging dimensions of children's health, (e.g., transitions in care, children with complex medical needs); academics; local or national foundation representatives; consumer groups; and family representatives.
- Getting people to the table is likely to be easier if it is clear the group is being convened at the request of the state Medicaid program and has a concrete charge from the state.

- **Culture and Ground Rules**

- Convening stakeholders for deliberations is only fruitful if stakeholders feel comfortable sharing their ideas and brainstorming with one another. Setting the right tone, providing ground rules for discussion, encouraging open communication inside and outside of the convening, and being transparent about decision-making can help establish such an environment.

Build Common Knowledge

Typically, any broad convening effort will include stakeholders with diverse expertise and varying degrees of knowledge about payment reform. Conveners can help level the playing field among participants by regularly educating stakeholders, both inside and outside formal convening sessions, on topics such as the fundamentals of payment reform, updates on the state's current payment reform approach, data about children in the Medicaid program, and implications of payment reform for different players in the health care system. These informational sessions can be tailored to different audiences and offered through a variety of educational modalities (e.g., in-person presentations, webinars, etc.). Holding some sessions without government officials in the room may help some stakeholders feel more comfortable about sharing any gaps in knowledge on payment reform in general or specific reform efforts.

Gain Consensus on Goals

Clarity and consensus on overarching goals for children and adolescents that should drive payment and delivery system reform can help focus stakeholders when the details and complexities of payment reform threaten to derail the conversation. One approach to gaining consensus is to collectively develop a "North Star Framework" that identifies overarching goals and then drills down into the quality measures that best match them and the payment-amenable delivery system improvements that can help achieve them. (See Appendix B for an example.)

¹¹ This includes deciding whether the convening is a closed membership process or open to new entrants. Keep in mind that there may be state laws related to transparency of materials, and whether or how to involve the public.

Components could include:

- Statement of goals for children and adolescents—either health care-specific or speaking more broadly to child and adolescent well-being;
- Segmented goals for distinct child populations by developmental stage, geography, or health status (e.g., generally well children, those with special health care needs, and children with complex chronic conditions);
- Indicators of progress toward reaching these goals and/or reducing disparities in reaching these goals;
- Desired delivery system improvements that could be supported through payment reform, keeping in mind that not all desired changes are payment-amenable, and payment alone is usually insufficient to bring about desired system changes.

A useful byproduct that can often result from such deliberations is a mutual understanding among different parts of the health care system and different sectors of what each believes to be an important change for children.

Desired Goals vs. Existing Efforts

Compare the goals detailed in the North Star Framework with the state's payment reform approach, drawing upon the expertise of those with detailed knowledge of the Medicaid program—the mechanics of benefit coverage and provider payment, quality measures, etc.—to explore broad questions such as:

- In what ways does the State's payment approach, or potential payment approaches, support or conflict with the North Star Framework?
- In what ways could the payment approach be more supportive of the North Star Framework?
- What payment approach(es) would ideally support the North Star Framework?

More specific inquiries might include:

- Are any key strategies in the North Star Framework *discouraged* by specific payment models? If so, can those counter-productive incentives be removed?
- Which quality measures that align with the North Star Framework can be integrated into payment approaches, either as a minimum quality measure set or as high-performance measures that can be paid for on an incentive basis? (Appendix A provides additional detail.)
- What opportunities are there to define and test new performance or outcome measures that align with the North Star goals?
- Would removing barriers to data-sharing, provider access, or collaboration help providers, payers, and other stakeholders implement the strategies in the Framework?
- How could tying payment to certain evidence-based models or interventions help achieve the North Star goals?
- Would setting a state-level performance improvement target specific to children or adolescents help achieve the goals?
- Would cross-subsidization from other health care sectors or additional investment in children's health services be necessary?
- What would the ideal payment model look like?

Develop Specific Recommendations

Use insights and ideas from group deliberations to provide specific recommendations to the state Medicaid agency, in keeping with the initial charge to the group. Following are examples of how a group may move from discussion of North Star goals and strategies to specific recommendations. These do not constitute comprehensive payment strategies but could be *elements* of a payment strategy.

Example 1. Behavioral Health

Stakeholders observe high suspension rates of children in kindergarten and agree that this is an indicator of underinvestment in behavioral health preventive efforts, as well as an important population health measure for children. Depending on the state's approach, stakeholders might recommend:

- Linking a certain percentage of provider payments to adoption of, and fidelity to, evidence-based behavioral health prevention models.¹²
- Supporting information-sharing between educators and pediatric primary care providers through joint guidance from the state's education and health departments on data-sharing that satisfies both the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPPA), and exploring opportunities for shared accountability measures between health and education.¹³
- Development of a bundle of health care quality measures that are likely to drive school success among young children—such as newborn hearing, developmental screening, and vision—and rewarding high-performing and/or most improved health care systems. This could also include use of less traditional measures, such as those related to interventions on social determinants of health—as long as appropriate steps are taken to enable such cross-sector collaboration.¹⁴

Consensus-building Tools

Conscious efforts at consensus-building are often needed before a group of stakeholders can arrive at agreement on a set of recommendations. Helpful resources for building consensus can be found at:

The UK-based Seeds for Change organization: <https://www.seedsforchange.org.uk/consensus/>;

The Annie E. Casey Foundation's Results-Based Facilitation materials: <https://www.aecf.org/blog/new-leadership-video-improve-decisions-with-proposal-based-decision-making/>

¹² There is some precedence for this in Washington State with the Collaborative Care Model of behavioral health integration. See Bao Y, TG McGuire, Y-F Chan, AA Eggman, et al. January 2017. Value-based payment in implementing evidence-based care: The Mental Health Integration Program in Washington State. *American Journal of Managed Care* 23(1): 48-53. <https://www.ajmc.com/journals/issue/2017/2017-vol23-n1/value-based-payment-in-implementing-evidence-based-care-the-mental-health-integration-program-in-washington-state>

¹³ Medicaid value-based payment efforts in both Oregon, under the Oregon Health Authority, and Ohio, under the Governor's Office of Health Transformation, have included efforts to align the health and education sectors around goals such as improving kindergarten readiness and decreasing chronic absenteeism. An example of joint health and education guidance to facilitate data-sharing can be found in Ohio's toolkit to support school-based health care: <http://education.ohio.gov/getattachment/Administrators/School-Based-Health-Care-Support-Toolkit/Ohio-toolkit-Consent-form-and-service-agreement-templates.pdf.aspx?lang=en-US>

¹⁴ See pages 6 and 7 of <http://www.chcs.org/media/VBP-BH-Brief-061917.pdf> for discussion of how one of Arizona's Regional Behavioral Health Authorities included a social determinants of health measure among more traditional quality and utilization measures.

- Blended or braided payment approaches that bring together Medicaid payment with non-Medicaid funding sources, allowing pediatric health systems to invest in services that are not solely funded by Medicaid—for example, training early education professionals in the identification of behavioral health problems in young children.

Example 2. Low Birthweight

Stakeholders identify a goal of improving birth outcomes for mothers and newborns based on data revealing a high percentage of low-birthweight babies in the Medicaid program. The group decides that the existing Medicaid payment approach could be strengthened by focusing on this goal. Depending on the State's approach, stakeholders could:

- Recommend new requirements that essential data, like Medicaid claims and vital statistics (e.g., birth certificate) information, be regularly shared in a timely manner with value-based payment contracting entities, to allow for planning of preventive interventions.
- Identify and recommend use of specific quality measures related to healthier pregnancies.
- Identify “perverse incentives”—those creating an effect opposite of what was intended—that may discourage high-impact strategies. These unintended consequences frequently pop up if changes to payment structures are not carefully considered. A common type to look out for is one that is meant to increase utilization of a preventive service but in practice would incentivize decreased service utilization because it would save providers money. For example, stakeholders may recognize that inclusion of 17P (progesterone shots to help prevent premature birth) in the state's maternity payment bundle could discourage its use because the treatment is expensive and providers could save money by not widely administering it. To counter this effect, stakeholders may recommend that the state Medicaid program remove provision of 17P from the maternity payment bundle and pay for it separately to encourage use.

Example 3. Missing Focus on Children

Stakeholders review an established state plan for payment reform and determine that the overarching goal is to reduce preventable hospital utilization. With few child-specific measures, they feel the plan

Evaluating recommendations

Whether a stakeholder group is assessing its own potential recommendations to the state or ideas brought forward by the Medicaid agency, each payment reform recommendation should be considered with the following in mind:

- A clear idea of how the recommendation will affect each player in the health care ecosystem or in other sectors and the likely impact it will have on operations.
- The extent to which the recommendation adheres to key principles or goals articulated by the group.
- The likelihood the recommendation will encourage efficient and/or high-quality care.
- The complexity of implementing proposed recommendations. Developing a new payment model is clearly a complex endeavor that could take several years to flesh out and test. In general, the more the payment approach requires new money, requires burdensome data collection for providers or plans, or increases financial risk for providers, the greater the complexity.
- Likely uptake of the proposed recommendation by the state, health care providers, managed care plans, and other parties.

pays insufficient attention to child health needs. Stakeholders could recommend:

- Development of additional goals specific to children and adolescents while still targeting preventable hospital utilization—decreasing neonatal intensive care unit stays, for example, or emergency department visits for asthma, or preventable psychiatric readmissions among children and adolescents. An alternative approach could be to establish a goal unrelated to health care utilization—ensuring that all children are optimally on developmental trajectory by a specific age, for example.
- Inclusion of child-specific measures in the quality scores for all payers and providers. This could include specific improvement targets, including disparity reduction.
- Reinvestment of a certain percentage of savings from value-based payment arrangements, particularly decreases in adult expenditures, in child and adolescent preventive investments.
- A review of chronic disease episode bundles, often designed for predominantly adult conditions like hypertension, with the goal of recommending child-specific conditions for inclusion.
- Creation of an alternative model that allows for flexibility in payment and encourages high-quality care without being dependent upon significant short-term savings from children's health care. Possibilities include piloting an improved model of care for vulnerable populations, such as children in foster care, to ensure that any payment models with targeted annual budgets can sufficiently cover the costs of caring well for a previously underserved population.

Adopt Recommendations and Guide the Implementation Process

Including stakeholder input in a Medicaid payment reform process is just the first step. Once recommendations are endorsed by the Medicaid program's leadership, those leaders may need to secure the support of the governor and state legislature and seek appropriate approval from the Centers for Medicare and Medicaid Services to move forward. The Medicaid program will then need to tend to the detailed work of reform implementation, including providing consumer notice and protections; providing plan and provider contracting guidance; working out the details of payment changes, including clear definitions of included and excluded populations and services; and designing pilots to test changes. During this process, children's organizations can still play a role.

Continue to Build Support

Build support to ensure that recommendations are adopted and the Medicaid program has the resources and tools necessary to succeed. Depending on the stakeholder organization, this can include:

- Presenting at legislative or administrative briefings to educate policymakers on the child-centered features of the payment reform approach.
- Providing budget advice to the Medicaid program for pilots or other accompanying delivery system reform efforts.
- Identifying health care providers or managed care plans that may want to pilot new payment reform approaches.
- Informing stakeholders of how they can weigh in on proposed changes.

Observe and Respond

Monitor implementation efforts and provide constructive feedback. Children's organizations are often well positioned to serve as on-the-ground "eyes and ears," providing Medicaid programs with real-time feedback on how reform efforts are affecting families and service providers. Information might include:

- Feedback from providers and plans on why they have or have not availed themselves of certain payment reform strategies (e.g., participation in pilot programs, adoption of specific voluntary payment models).
- Feedback from families on any barriers or challenges they are facing in receiving care, especially access to specialty care.
- Strategies for how to evaluate the effect of payment reform on key children's indicators and North Star goals.

Remain Involved

- Periodically reconvene stakeholders, including state representatives, to review progress and adjust reform plans. Stakeholders can continue to act in an advisory capacity to state policymakers as payment reform plans begin to be adopted. Areas of input might include an annual review of quality measures, periodic discussion of the major challenges and learning associated with reform, and progress updates on whether payment reform is helping achieve the overarching goals identified for the state's children and adolescents.

Appendix A. Selecting Quality Measures

Stakeholders may be charged with selecting and prioritizing quality measures for inclusion in alternative payment models. One proposed process for reviewing and selecting quality measures:

Create an inventory of child-relevant quality measures that could be included in a payment model, providing, for example:

- The domain of care being measured (such as access or oral health).
- The quality measure name.
- A brief description of the measure, including its numerator and denominator.
- Whether the measure is endorsed by the National Quality Forum.
- Whether the measure is included in other state initiatives or in the CMS Child Core Set.
- Data collection methods (e.g., claims data, medical record review).

Next, assess the measures against criteria agreed upon by stakeholders. For example, New York's Subcommittee and Clinical Advisory Group for Children and Adolescent Value-Based Payment applied four principles to quality measure selection:

- The measure is relevant to one of the strategies or indicators identified to achieve a particular "North Star" goal.
- The measure is evidence-based (i.e., has been tested for validity and reliability and, preferably, is endorsed for use by the National Quality Forum).
- The measure should be feasible for providers to use and report with minimal additional burden (e.g., does not require expensive medical records review).
- The final recommended measure set should be parsimonious, with outcome measures having priority.

Consider dividing stakeholders into subgroups for this work, with a technical advisory group weighing in on what is feasible and best practice.

Then, select a subset of measures for recommendation. Stakeholders should consider the payment criteria for these measures. The two main options are "paying for reporting," through which providers are paid for having provided data on the quality measure, and "paying for performance," through which providers receive payment based on their performance on the measure. New quality measures are often introduced in a reporting-only manner. Stakeholders might also consider sorting recommended measures into mandatory or optional categories.

Finally, identify measurement gaps—areas of care without readily available quality measures—to encourage the state to foster development and testing of new measures in these areas.

Appendix B. Example of a “North Star” Framework to Guide VBP Deliberations

Value-Based Payment for Kids: Goals, Indicators, & High-Value Primary Care Strategies, by Age

Preterm to 1 Month	1 Month to 1 Year	1 Year to 5 Years
 Overarching “North Star” Goals		
Optimal birth outcomes for mother and child	Optimal physical health and a secure attachment with a primary caregiver	Optimal physical health and developmentally on track at school entry
 Key Indicators		
<ul style="list-style-type: none"> • Birthweight <2500 grams • Preterm births • Severe maternal morbidity 	<ul style="list-style-type: none"> • On-target developmental and social-emotional screens • Reported cases of abuse and neglect 	<ul style="list-style-type: none"> • On-target developmental and social-emotional screens • ED visits for unintentional injury • Expulsions/suspensions • Kindergarten readiness using standardized tool (aspirational) • Reported cases of abuse and neglect
 High Value, Often Underutilized Primary Care Strategies		
Early and regular prenatal care visits including: <ul style="list-style-type: none"> • Birth spacing/contraceptive use counseling • Breastfeeding encouragement • Care transition plan for use by obstetrician, newborn nursery, and primary care doctor • Screening/treatment for preterm birth risks and tobacco/substance use Co-located/integrated behavioral health services Screening/referrals for: <ul style="list-style-type: none"> • Adverse Childhood Experiences (ACEs) • Social determinants of health • Domestic violence/personal safety • Maternal depression Enhancing parental skills through evidence-based education/home visitation programs Seamless information exchange between women’s health and child health providers	Regular well-child visits including: <ul style="list-style-type: none"> • Developmental screenings in four domains: motor, language, cognitive, and social emotional • Weight/nutrition/physical activity counseling • Early Intervention referral Co-located/integrated behavioral health services Screening/referrals for: <ul style="list-style-type: none"> • ACEs • Social determinants of health • Domestic violence/personal safety • Maternal depression Enhancing parental skills through evidence-based education/home visitation programs Seamless information exchange between women’s health and child health providers (when mother is primary caregiver of child)	Regular well-child visits including: <ul style="list-style-type: none"> • Developmental screenings in four domains: motor, language, cognitive, and social emotional • Weight/nutrition/physical activity counseling • Early Intervention referral • Dental screening/treatment • Eye and hearing examination/referral • Vaccinations Co-located/integrated behavioral health services Screening/referrals for: <ul style="list-style-type: none"> • ACEs • Social determinants of health Enhancing parental skills through evidence-based educational programs Management/treatment of chronic conditions

Value-Based Payment for Kids: Goals, Indicators, & High-Value Primary Care Strategies, by Age

6 Years to 10 Years

11 Years to 14 Years

15 Years to 21 Years

Overarching “North Star” Goals

Staying healthy and strengthening social, emotional and intellectual skills

Staying healthy and coping effectively with challenges of early adolescence

Staying healthy and able to succeed in the world of work, school, and other adult responsibilities

Key Indicators

- Average daily school attendance
- Hospitalization for asthma
- Obesity
- Positive screens for depression/anxiety
- Grade progression
- Standard 3rd-grade reading scores

- Average daily school attendance
- Hospitalization for asthma
- Obesity
- Positive screens for depression/anxiety
- Tobacco/substance use

- Algebra 1 Regent passing
- Hospitalization for asthma
- Obesity
- Positive screens for depression/anxiety
- Tobacco/substance use
- Cohort graduation
- Post-secondary enrollment
- Pregnancy, ages 15-17

High Value, Often Underutilized Primary Care Strategies

Regular well-child visits including:

- Weight/nutrition/physical activity counseling
- Dental screening/treatment

Co-located/integrated behavioral health services Screening/referrals for:

- ACEs
- Social determinants of health
- Behavioral health risks

Enhancing parental skills through evidence-based educational programs

Management/treatment of chronic conditions

Regular adolescent visits including:

- Weight/nutrition/physical activity counseling
- Health care self-management/health literacy education
- Vaccinations

Co-located/integrated behavioral health services Screening/counseling/referrals for:

- ACEs
- Social determinants of health
- Behavioral health risks

Enhancing parental skills through evidence-based educational programs

Management/treatment of chronic conditions

Regular adolescent visits including:

- Weight/nutrition/physical activity counseling
- Health care self-management/health literacy education
- Vaccinations

Co-located/integrated behavioral health services Screening/counseling/referrals for:

- ACEs
- Social determinants of health
- Behavioral health risks

Management/treatment of chronic conditions