Value-Based Payment Opportunities for Pediatric-to-Adult Transitional Care in Texas

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Peggy McManus, MHS, The National Alliance to Advance Adolescent Health/Got Transition®
Patience White, MD, MA, The National Alliance to Advance Adolescent Health/Got Transition®
Annie Schmidt, MPH, The National Alliance to Advance Adolescent Health/Got Transition®
Disclosures

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Presentation Topics

• Recognition of Texas leadership in Medicaid managed care and transition
• Background on health care transition (HCT)
• Review of options for designing a VBP transition pilot for STAR Kids population
  • Transition services overview
  • VBP options
  • Quality measurement options
  • DC VBP pilot example
  • Consideration of TX next steps for VBP pilot
• Q & A
Texas Recognition

• One of two states that have established detailed Medicaid managed care contract provisions for transitional care.

• STAR Kids MCAC Report (Jan 2020) recommends payment improvements and VBP transition pilots.

• Texas Department of State Health Services (Title V program) selected transition as a statewide public health priority.

• Baylor’s annual transition conference is the main transition conference in the country, bringing together US and international experts.
Receipt Of Transition Planning Guidance From Health Care Providers (HCPs) in Texas

National Survey of Children’s Health, 2018-2019:

• 18.6% of TX youth with special health care needs (YSHCN) received transition planning guidance from HCPs
• 12.8% of TX youth without special needs received transition planning guidance HCPs
• National Transition Performance Measure based on 1) youth had time alone with HCP during last preventive (medical care) visit, 2) HCP actively worked with youth to gain self-care skills or understand changes in health care at age 18, and 3) HCP discussed eventual (when this youth will) shift to an HCP who cares for adults
Outcome Evidence for Structured Transition Process

- Systematic reviews of HCT evaluation studies between 1995-2016* and May 2016-Dec 2018**
- With a **structured** transition process, statistically significant positive outcomes for YSHCN:
  - **Population health**: increased adherence to care, self-care skills, quality of life, self-reported health
  - **Experience of care**: increased satisfaction, reduction in barriers to care
  - **Utilization**: decrease in time between last pediatric and first adult visit, increase in adult ambulatory visits, decrease in hospital admissions and length of stay
- Of note: no evaluation studies on costs of HCT

**Sources**

Pediatric-to-Adult Health Care Transition

**Definition:** HCT is the process of moving from a child to an adult model of health care with or without a transfer to a new clinician

**Transition Goals for Youth/Young Adults and Clinicians:**
- To improve the ability of youth and young adults to manage their own health and effectively use health services
- To have an organized clinical process in pediatric and adult practices to facilitate transition preparation, transfer of care, and integration into adult-centered care

- Reaffirms that TRANSITION ≠ TRANSFER or PLANNING alone
- TRANSITION = planning, transfer and integration into adult care
Medical Professional Societies’ Guidance

• 2011 joint AAP/AAFP/ACP Report Clinical Report on Health Care Transition*

• AAP/AAFP/ACP updated CR in 2018 with guidance on evidence informed processes**

• Targets all youth, beginning at age 12 and continuing into young adulthood

• Application to primary and specialty practices

• Extends through transfer of care to adult medical home and adult specialists

• **Recommendation:** Focus on all three aspects of transition: planning, transfer and integration into adult care using a QI approach called the Six Core Elements of HCT

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The Case for VBP for Health Care Transition

• A structured HCT process is associated with improvements in health, utilization, and consumer experience among YSHCN.

• The period after transfer is an especially vulnerable time for YSHCN, and adverse events are common.

• Many of these problems can be attributed to:
  o Disconnection between pediatric and adult systems
  o Lack of physician availability to accept young adults with complex medical conditions
  o Inadequate transition preparation
  o Lack of financial incentives and infrastructure supports for both pediatric and adult practices

• The number of transition-aged YSHCN has been increasing dramatically over the last several decades.

• There is a need for innovation among payers and MCOs in VBP for transitional care.
VBP Recommendations for Pediatric and Adult Health Care Systems

• Recommendations informed by:
  • 65 key interviews with senior officials from CMS, state Medicaid agencies, commercial payers, health plans, researchers, advocacy groups, and clinical leaders

• Day-long leadership roundtable with 24 participants (May 2018), including payers, accountable care organizations, children’s hospitals, pediatric and adult professional association officials, consultants/researchers, and foundation, federal, and advocacy leaders.

## Prioritized VBP Recommendations

<table>
<thead>
<tr>
<th>Payment Strategy</th>
<th>Overall</th>
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<tbody>
<tr>
<td>Enhanced fee-for-service (FFS)</td>
<td>1.89</td>
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<tr>
<td>Infrastructure investment</td>
<td>2.62</td>
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<tr>
<td>Pay-for-performance (P4P)</td>
<td>3.09</td>
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<tr>
<td>Direct payment to consumers</td>
<td>4.11</td>
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<tr>
<td>Episode of care/bundled payment</td>
<td>4.43</td>
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<tr>
<td>Per member per month (PMPM)</td>
<td>4.45</td>
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</tbody>
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* Lower scores = higher priority
VBP Options and Examples

**Enhanced fee for service (FFS) payments**
Built on FFS/relative value unit structure, with payments positively adjusted for selected codes and linked to quality metrics. *Examples:*

- Use higher fees for Evaluation & Management (E&M) services to incentivize adult practices to accept a certain volume of young adults with chronic conditions.
- Pay a higher fee for care plan oversight services or for prolonged services (non-face-to-face) to incentivize preparation of medical summary/emergency care plan.

**Infrastructure investments**
Upfront or one-time only investments to generate practice/system changes. *Examples:*

- Upgrade electronic medical records (EMRs) to incorporate recommended HCT clinical processes in pediatric and adult practices.
- Support training and quality improvement (QI) to implement recommended HCT clinic processes into routine care.
VBP Options and Examples

Pay-for-performance (P4P) payments
Rewards providers based on performance on selected quality metrics. Examples:
• Create incentives for shared pediatric and adult accountability for transfer of YAs with evidence of reduced preventable ER/hospital visits during time between last pediatric visit and initial adult visit.
• Structure bonus if specific transfer services are completed: last pediatric visit, preparation and exchange of comprehensive medical summary and emergency care plan, joint telehealth visit with pediatric/adult providers and young adult/caregiver, and initial adult visit.

Direct payments to consumers
Offer gift card to consumers to attend visits/adhere to care. This option can be used with other VBP options; on its own, it would not influence availability of structured HCT process. Example:
• Provide gift card to young adult if last pediatric visit made, participation in joint telehealth visit, and initial adult visit made.
VBP Options and Examples

**Episode of care/bundled payments**
Payment linked to provision of a defined set of services. *Examples:*
- Create transfer episode of care covering year before and after transfer with pediatric and adult accountable providers, rewarded based on average per episode cost compared to peers or based on a bundled target amount minus actual medical expense, with savings/loss calculated along with quality adjustment for accountable providers.
- Create ambulatory HCT code (HCPCS) for use by pediatric and adult clinicians. Bundled activities could include last pediatric & initial adult office visit, joint telehealth visit, preparation/exchange of transfer package. This could be modeled after the hospital to home transition code and aligned with specific quality measures.

**Per member per month (PMPM) payments**
Monthly amount paid to provider/system for all or selected patients under their care. *Examples:*
- (Pediatric) Create risk-adjusted monthly capitation for defined period prior to transfer for added costs associated with preparing youth for transfer to adult care and aligned with quality measures, such as consumer experience with HCT process.
- (Adult) Create risk-adjusted monthly capitation for defined period following transfer for added costs associated with integrating and retaining YA in adult care and aligned with quality measures, such as reduced preventable hospitalizations.
DC VBP HCT Pilot

• Funded by the WITH Foundation to The National Alliance to Advance Adolescent Health

• Starting date of January 2021 (delayed due to COVID-19)

• 1st of its kind: Involves Medicaid specialty MCO, children’s hospital, and 2 FQHCs serving as adult receiving sites

• Population of interest is 18-25 year-olds with intellectual and developmental disabilities

• Length of pilot: 9 months (originally 18 months)

• HCT Training/QI support to MCO and participating pediatric and adult sites
HCT Elements in DC Pilot

- Preparation of HCT “Change” Package, focused on transfer, customized from the Six Core Elements:
  - 1 final peds visit, 1 joint telehealth visit, and 1 initial adult visit
  - Transition readiness assessment
  - Medical summary/emergency care plan
  - Plan of care
  - MCO providing care coordination support to young adults/caregivers
DC VBP Pilot

1. MCO to recognize selected HCT-related CPT codes and modifiers to encourage preparation of medical summary and participation in joint telehealth visit.

2. Joint visit will be billed as 2 E&M visits for single patient on same day using a telehealth modifier and modifier 77.

3. Gift cards will be given to pilot members if all visits attended.

3. P4P for both pediatric and adult clinicians with evidence of pilot member’s attendance at last peds, joint visit, and initial adult visit and preparation and exchange of current medical information.

4. MCO is working with pediatric and adult sites on EMR functionality around medical summary and exchange of medical information during transfer process.
VBP Elements: DC Example

• **Quality Metrics:**
  
  • *Process:*
    
    • Measure receipt of recommended transition services through MCO registry, tracking receipt of Six Core Elements
  
  • *Utilization:*
    
    • 10% increase in ambulatory care use
    • 10% decrease in ED use
  
  • *Patient and clinician experience:*
    
    • HCT Feedback Surveys
Texas Considerations for Transition VBP Pilot

- Identification of interested MCO(s), preferably working with MCO that cares for enrollees in both STAR Kids and STAR Plus
- Identification of patient population and age group (e.g., 18-24)
- Selection of pediatric site(s) with sizeable pilot population
- Geomap the location of the pilot population to identify convenient adult practices
- Invite clinical leads from pediatric and adult sites to participate in the design and implementation of the pilot
Texas Considerations for Transition VBP Pilot

• Define set of HCT services (eg, last pediatric visit(s), joint telehealth visit, initial adult visit(s), preparation/exchange of medical summary and plan of care)

• Identify gaps in payment for these services and specific infrastructure needs, especially on adult side (eg, EMR functionality for HCT, training on pediatric complex conditions, care coordination)

• Examine health care utilization and cost patterns for this patient population to identify potential opportunities for quality and cost improvements (eg, high ED use, low preventive/primary care use)

• Use this information to select measures that will be part of the VBP structure – eg, potentially preventable ED visits, admissions or readmissions; well visits)
Texas Considerations for Transition-VBP Pilot

• What other measures should be considered –
  • Retention in care/reductions in loss to follow-up (for both pediatric and adult providers)
  • Timely exchange of updated medical summary/emergency care plan and plan of care
  • Transition questions in Medicaid survey of enrollees/caregivers (see Got Transition’s Feedback Survey*)
  • Evidence of transition registry in EMR documenting receipt of Six Core Elements or HCT in pilot

*Available at https://www.gottransition.org/six-core-elements/measurement.cfm
Selection of VBP method(s)

1. **Pay for performance** – Provide capitation distribution to accountable pediatric and adult providers based on performance on specific combination of measures.

2. **Bundled Payment** – Establish transfer episode of care payment for year before and after transfer with pediatric and adult accountable providers, rewarded based on average per episode cost compared to peers or based on bundled target amount minus actual medical expense, with savings/loss calculated along with a quality adjustment for accountable providers.
Texas Considerations for Transition VBP Pilot

3. **Bundled Payment (2)** – Create a new HCPCS code to cover set of transfer services for both pediatric and adult providers to bill, including last pediatric visit, joint telehealth visit, initial adult visit, and preparation/exchange of medical summary.

4. **Volume Performance Payment** – Incentivize adult primary care practices to accept a certain volume of young adults with complex chronic conditions, linked with a set of measures and supported with pediatric consultation. This could be set up in different ways:
   - using infrastructure payments
   - using risk-adjusted PMPM payments
   - using enhanced fees for selected E & M codes

5. **FFS Payment** – Recognize selected transition-related codes (see Got Transition’s Coding and Reimbursement Tip Sheet*)

*Available at https://www.gottransition.org/resource/2020-coding-tip-sheet*
Innovation Opportunity

• Texas Medicaid is uniquely positioned to become an early innovator in VBP for pediatric-to-adult transitional care.

• We are available to provide free, short-term TA to assist in planning a VBP pilot, helping to offer recommendations:
  • On the HCT “change” package for a pilot
  • Considering potential YSHCN pilot populations and practice sites
  • Identifying selection of VBP payment methods to incentivize success
  • Considering alternative ways to evaluate the pilot
  • Offering options for including pediatric-to-adult HCT language in MCO contract
Got Transition Resources

• 2020 Coding and Reimbursement Tip Sheet for Transition (with AAP) – 2021 version available in new year

• Recommendations for Value-Based Transition Payment for Pediatric and Adult Health Care Systems

• 2018 AAP/AAFP/ACP Clinical Report on HCT

• The Six Core Elements 3.0™ and new QI implementation guide

• Family Toolkit on Pediatric-to-Adult HCT

• Medicaid Managed Care Contract Language to Expand the Availability of Pediatric-to-Adult HCT

Resources are all available on Got Transition’s recently revamped website at www.GotTransition.org
Questions?

Email us:

• Peggy McManus, MHS at mmcmanus@thenationalalliance.org
• Patience White, MD, MA at pwhite@thenationalalliance.org
• Annie Schmidt, MPH at aschmidt@thenationalalliance.org

Visit our websites:

• www.GotTransition.org
• www.TheNationalAlliance.org
Sample Content for Joint HCT Telehealth/Face to Face Visit

This tip sheet includes suggestions of the timing and content to be covered during a joint HCT telehealth or Face to face visit to be conducted in advance of the young adult’s initial adult care visit. Before the joint visit:

The adult clinician should share the welcome letter and practice FAQs with the young adult (e.g. see: https://www.gottransition.org/6ce/integrating-welcome-orientation)

The pediatric clinician should share the medical summary and emergency care plan with the young adult (e.g. see https://www.gottransition.org/6ce/leaving-medical-summary-emergency-plan)

Who:

Young Adult

Pediatric and Adult Clinicians (e.g. physician/nurse/social workers/care manager, other key team members as needed)

Parent/caregiver may be present, if appropriate

Goals:

Provide young adult opportunity to meet and engage with new adult clinician(s)

Ensure a warm handoff between pediatric and adult clinicians

Give young adult opportunity to ask questions about the transfer into adult care

Clarify next steps for the first adult clinician visit (e.g., appointment time, location)
**Timing:**

The length of the telehealth visit generally should be determined by the complexity of the young adult’s medical and social issues that need to be reviewed.

The clinicians and the family can decide if the young adult and family want to be present for the whole telehealth/face to face visit (including both segments—see below) or if the clinicians want some time to discuss the technical aspects of the young adult’s condition and the young adult or the clinicians do not feel the young adult wants/needs to be present.

For joint telehealth/face to face visits a 30-minute visit could be planned with the young adult/family and clinicians together or the time could be divided into the first segment lasting 10-15 minutes and the second lasting 15-20 minutes.

**Content/Agenda:**

**Option one:** the young adult and the clinicians are present for both segments outlined below and if further discussion of technical aspects of the young adults condition need to be discussed between the pediatric and adult clinician, it could occur on a call between clinicians at a different time.

or

**Option two:** *Initial segment* with the pediatric and adult clinicians and HSCSN care manager, without the young adult/caregiver present to provide an opportunity for clinicians to share and ask questions, such as:

Any key aspects of the care of the young adult not conveyed in the medical summary prepared by the pediatric clinician (e.g. social complexities facing the young adult)

Questions about the young adult’s chronic medical/behavioral health conditions from the adult clinician (e.g. other medical and community referrals needed, equipment needs/referrals, reauthorization for care required in the home)
Clarification about how the new adult clinician can reach/consult the pediatric clinician, if needed

**Second segment** with the young adult/caregiver joins the call with the HSCSN care manager pediatric and adult clinicians:

Led by the pediatric clinician and/or the care manager:

**Introductions**

Ask if young adult has anything they want the new provider to know about them that might make the initial visits more comfortable (e.g., non-medical information)

Assure the young adult that they can contact their pediatric clinician for questions such as medication renewals until they have had their first adult visit when the adult provider will take over the responsibility of answering questions such as renewal of medications.

Ongoing issues that the pediatric clinician suggests that the adult clinician needs to address in the first visit

Led by the Adult Clinician:

Let the young adult know that their medical summary and emergency care plan (and decision-making support info, if needed) was received

Speak to the adult provider’s experience with caring for other individuals with similar conditions.

Give first adult visit overview: what to expect (e.g. logistics, what they need to bring to the appointment—see practice example below)

Ask if the young adult has any questions about the new practice before their first visit

**Practice example** of an adult nurse practitioner’s script for information about the first adult visit in a joint telehealth/face to face visit:

Introduction to me and my role in the center/the goal of these calls and the transition pathway

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Practice differences between pediatric and adult practices e.g. utilization of NPs for clinic visits, who to call for refills, how to communicate with providers during and after business hours,

**What to know for first visit** - records accessed electronically but bring imaging on disk to appointment; expect to provide history of and past treatments; prepare for provider to speak to adolescent with or without parent present for some of visit

**Where to go:** clinic location, traffic issues, arrive early, late policy, etc.