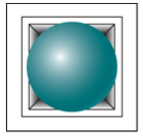
Designing Value-Based Payment (VBP) Innovations for Pediatric-to-Adult Transitional Care: Lessons from the Field

A webinar featuring Medicaid MCO Leaders from Florida Department of Health's Children's Medical Services, operated by Sunshine Health, and Texas' AmeriGroup STAR Kids Plan

January 26, 2022



The National Alliance To Advance Adolescent Health

got transition

Disclosures

- Peggy McManus, Annie Schmidt, and Patience White, from The National Alliance, have no financial relationships to disclose or Conflicts of Interest (COIs) to resolve. Our VBP work is supported by the Lucile Packard Foundation for Children's Health. The National Alliance to Advance Adolescent Health operates Got Transition, the federally funded national health care transition resource center.
- Rae Wilkerson, from Florida Department of Health's (DOH) Children's Medical Services Health Plan, operated by Sunshine Health, and Aron Head, from AmeriGroup have no financial relationships to disclose or COI to resolve.

Presentation Objectives

- Share a step-by-step approach for designing VBP initiatives from The National Alliance's new *Guide for Designing a Value-Based Payment Initiative for Pediatric-to-Adult Transitional Care*
- Gain insight into critical questions and decisions from senior officials in two large Medicaid MCOs in the process of designing a VBP pilot
- Provide opportunity for audience exchange

Why Payers Care about HCT

- "HCT aligns with achieving the triple aim of better patient experience, improved population health, and smarter spending."
- "Poor care coordination and other inefficiencies occurring during the transition period will likely lead to increased health care costs over time."
- "Value-based payment models are a natural lever to help MCOs develop solutions to the challenge of transitioning youth and young adults from pediatric to adult services…for example, it's much easier to include a service that wouldn't be paid for under traditional Medicaid."

--From key informant interviews with state Medicaid officials conducted by The National Alliance in 2021

Making the HCT Case

- Transition-aged youth and young adults, ages 12 through 25, represent **20%** of the United States population
  - An estimated **25-35%** have one more chronic conditions
  - An estimated **6.3%** have a disability
- Most do **not** receive transition preparation from their health care providers in the US
  - The 2019/2020 National Survey of Children's Health shows the percentage **not** receiving HCT preparation:
    - Youth with chronic conditions: **77%**
    - Youth without chronic conditions: **82%**

Making the HCT Case *(continued)*

- Professional recommendations from **AAP, AAFP, and ACP** call for a planned, longitudinal approach to HCT:
  - Between ages **12-26**
  - Transition = **planning, transfer, and integration into adult care**
  - Recommended improvement approach is Got Transition's **Six Core Elements of HCT**, with customizable, free, and ready-to-use tools
- **Special populations** require additional attention:
  - Those with intellectual/developmental disabilities, with mental/behavioral health conditions, with medical complexity, and with social complexity
- **Payment innovations needed** to develop HCT infrastructure in pediatric and adult care settings and improve HCT performance

New HCT VBP Guide

- Provides **step-by-step** approach for payers, MCOs, and pediatric and adult health systems interested in pursuing VBP initiatives
- Based on 2 years of TA offered to state Medicaid agencies (**TX, NY, OR, CO**), Medicaid MCOs (**DC's HSCSN; FL DOH's Children's Medical Services Health Plan, operated by Sunshine Health; TX AmeriGroup**), large integrated care system (**Intermountain**), and public health/Title V programs (**FL, OR, RI**)
- The new Guide features examples from 4 Medicaid MCOs; two of whom (**FL DOH's Children's Medical Services Health Plan/Sunshine Health and TX AmeriGroup**) are here today to tell you more

VBP Initiatives in Selected Medicaid MCOs

Health Plan	Pilot Population	HCT Activities Addressed	Pilot Duration & Start Date	Payment Methods	Quality Measures
DC Health Services for Children with Special Needs	Medicaid-insured SSI Enrollees with Intellectual and Developmental Disabilities	Transfer and integration into adult care	18 months Fall 2021	• Enhanced FFS • P4P • Recognizing selected HCT CPT codes	• Enrollee HCT Feedback Survey • Clinician HCT Feedback Survey
Florida DOH Children's Medical Services Health Plan, operated by Sunshine Health	Selected Title XIX Children's Medical Services Health Plan Medicaid Enrollees	Transfer and integration into adult care	12 months Early 2022	• Enhanced FFS • Enrollee gift card • Recognizing selected HCT CPT codes	• Enrollee HCT Feedback Survey • Pre/post Current Assessment of HCT Activities
Texas AmeriGroup	Selected Texas Medicaid Waiver Enrollees (STAR Kids)	Transfer and integration into adult care	18 months Early 2022	• PMPM	• Enrollee HCT Feedback Survey
Utah Intermountain/ Select Health (SH)	SH ACO Medicaid-Insured and SH Commercial Insured Youth with Congenital Heart Disease	Transition preparation and transfer	12-24 months Winter 2021	• Recognizing selected HCT CPT codes	• Enrollee HCT Feedback Survey • Enrollee completion of 1 or 2 visits in adult clinic

Step 1. Defining the HCT Intervention VBP Pilot

Key Question: What components of the HCT process do you want to focus on and over what period of time?

- Transition planning, transfer, and/or integration into adult care?
- Timing depends on HCT intervention selected; if transfer only, likely need 18-24 months; if all 3 chosen, longer
- Transfer pilots typically involve:
  - final pediatric visit
  - preparation & sharing of medical summary with patient & identified new adult practice
  - communication between sites & patient in advance of initial adult visit/joint telehealth visit
  - initial adult visit, & updating of medical summary

Step 1 Example: Intermountain

- Transition planning and transfer for youth/young adults (Y/YA) with congenital heart disease (CHD), ages 12-21; pilot duration:12-24 months
- Planning Steps:
  1. Pediatric cardiology nurses identify appropriate patients during standard pre-clinic screening and add patient to a Redcap registry
  2. Y/YA/Family receive education packet & cardiology passport/medical summary and complete readiness assessment to be discussed with pediatric cardiologist.
  3. EHR capacity updated to track readiness assessments and template available for education topics discussed

Step 1 Example *(continued)*

- Transfer Steps:
  1. Pediatric cardiologist places "Cardiology Transition Clinic" order when the YA is ready to transfer care and recommends adult cardiology provider and follow-up plan
  2. YA scheduled for 1-hour virtual transition visit with physician assistant who goes over education received, repeats knowledge assessment, discusses any knowledge gaps, completes final readiness assessment and passport, and places in the chart
  3. Adult provider chosen and 1st appointment scheduled. Redcap registry is completed, and YA is removed from pediatric cardiology transition education list
  4. Records available in EHR for when the YA goes to first adult cardiology visit

Step 2. Identifying Transition-Aged Populations for a VBP Initiative

Key Question: What population to start with?

- With chronic conditions (e.g., those with ID/DD, CHD) or
- In special program eligibility groups (e.g., receiving SSI or in state Title V special-needs programs)
- In particular age groups, such as:
  - All transition-aged Y/YA, ages 14-25, to create a population-based longitudinal approach to HCT
  - 17-19 year olds to allow for preparation, transfer, and integration
  - 21 and older still in pediatric care who need expedited attention
- Start pilot with population regularly using care

Step 2 Example: Y/YA with ID/DD

- Initial data to collect:
  - Total # of Y/YA with ID/DD, by individual years (ages 16, 17, 18, 19, 20, 21, 22, 23, 24, 25)
  - Of these Y/YA:
    - % with a pediatric PCP, with an adult PCP, with no identified PCP
    - % with a gap in ambulatory care in past year (>12 months, >24 months, or more)
    - % with an ED visit (not including urgent care) in past year (1, 2, or more)
    - % with an inpatient hospital admission in past year (1, 2, or more)

Step 2 Example *(continued)*

- Measurement ideas using these data:
  - Increase by x% the number of YA, ages 22-26, being seen by adult PCPs
  - Increase by x% the number of transition-aged Y/YA who transfer and have their initial adult PCP visit within 6 months of last pediatric visit
  - Increase by x% the number of 16-21 year olds with a pediatric PCP with access to their current medical summary; and/or with documentation in their medical record about anticipatory guidance on transition preparation

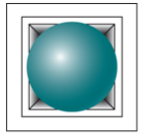
Step 3. Selecting Accountable Pediatric and Adult Care Sites

Key Question: Should the VBP pilot focus on primary, specialty, or behavioral health care?

- No right answer, often payers and MCOs chose **primary care**
- Goal - all sites should have a systematic HCT process

Key Question: Ways to find interested adult sites?

- Look at existing pediatric pilot referral sites for adult care
- Geo-map where pilot population lives
- Look at PCPs used by parents of pilot population
- Look for adult clinicians who have completed training in past 10 years (often their practices are not full)



Step 4. Choosing VBP And FFS Options

Key Question: What VBP options can be considered?

- **Enhanced FFS** – eg, pay higher E/M codes to incentivize adult PCPs to accept certain volume of YAs
- **Infrastructure Investment** – eg, pay upfront costs to improve EMR functionality on HCT
- **Pay for Performance** – eg, reward both pediatric and adult PCPs with certain utilization targets are achieved (last peds visit and initial adult visit made)
- **Direct Payment to Consumers** – eg, offer gift card if last peds visit and initial adult visit completed
- **PMPM** – eg, create risk-adjusted PMPM for year before and after transfer to cover added costs associated with preparing youth for transfer and integrating into adult care

Step 4. Choosing VBP And FFS Options

Key Question: What FFS options can be considered?

HCT Service	CPT Coding Options
Annual transition readiness assessment	Health risk assessment (CPT 96160)
Self-care skill-building as part of routine preventive and chronic care	E/M codes can be used for patients with chronic conditions (99202-5, 99211-5). For those without chronic condition, no options exist.
Preparation/update of medical summary and emergency care plan	Care plan oversight (99339, 99340), non-face-to-face prolonged services (99358, 99359), or care management services (99490, 99439, 99491, 99487, 99489, G2064, G2025)
Communication/consultation between pediatric and adult clinicians	Interprofessional telephone/internet/EHR consultation (99446-99449, 99451, 99452)

Step 5. Choosing Quality Metrics

Key Question: What HCT measure options could be considered?

- Consider different utilization measures important to HCT:
  - % of individuals, ages 18 and older, who made their initial adult primary care visit within 6 months of the last pediatric visit
  - % of pediatric practices transferring their patient with summary of care record using certified EHR technology and completing electronic exchange of summary of care record to new adult practice
  - % of adult practices receiving summary of care record referral and who conducts clinical information reconciliation for medication, medication allergy, and current problem list

Step 5 Example: Florida DOH's Children's Medical Services Health Plan, operated by Sunshine Health

Sample Health Care Transition Feedback Survey for Youth/Young Adults

This is a survey about what it was like for you to move from pediatric to adult health care. Your answers will help us improve our health care transition process. Your name will not be linked to your answers.

DID YOUR PAST DOCTOR OR OTHER HEALTH CARE PROVIDER... *Please check the answer that best fits at this time.*	YES	NO
Explain the transition process in a way that you could understand?	☐	☐
Give you guidance about the age you would need to move to a new adult doctor or other health care provider?	☐	☐
Give you a chance to speak with them alone during visits?	☐	☐
Explain the changes that happen in health care starting at age 18 (e.g., changes in privacy, consent, access to health records, or making decisions)?	☐	☐
Help you gain skills to manage your own health and health care (e.g., understanding current health needs, knowing what to do in a medical emergency, taking medicines)?	☐	☐
Help you make a plan to meet your transition and health goals?	☐	☐
Create and share your medical summary with you?	☐	☐
Explain how to reach the office online or by phone for medical information, test results, medical records, or appointment information?	☐	☐
Advise you to keep your emergency contact and medical information with you at all times (e.g., in your phone or wallet)?	☐	☐
Help you find a new adult doctor or other health care provider to move to?	☐	☐
Talk to you about the need to have health insurance as you become an adult?	☐	☐

Overall, how ready did you feel to move to an adult doctor or other health care provider?

☐ Very ☐ Somewhat ☐ Not at all

Do you have any ideas for your past doctor or other health care provider about making the move to adult health care easier?

Step 6. Getting Started

What are the initial steps to launch a pilot?

- Gain leadership buy-in
- Form a small improvement team with pediatric and adult clinicians, nursing/SW, IT, Y/YA/Family
- Decide on the HCT intervention for pilot and determine what Six Core Elements tools need to be customized and workflow established
- Elicit feedback on the HCT plan in advance of launch

Step 6. Getting Started *(continued)*

Pediatric HCT QI Activities	Timetable
Form HCT Team	Month 1
Project Start-Up	Month 2
Customize HCT Tools & Process from Six Core Elements Using QI Methods (for each core element, customize tool and complete PDSA cycle and share approach at regular QI meetings)	Months 2-3
Identify & Invite Interested YA Patients	Months 4-5
Start HCT Transfer Pilot	Months 6-15
Project Ending	Month 18

Step 6. Getting Started *(continued)*

Adult HCT QI Activities	Timetable
Form HCT Team	Month 1
Project Start-Up	Month 2
Customize HCT Tools & Process from Six Core Elements Using QI Methods (for each core element, customize tool and complete PDSA cycle and share at regular QI meetings)	Months 2-3
Learn about Number of YA Interested in Transferring	Months 4-5
Start HCT Transfer Pilot	Months 9-18
Project Ending	Month 18

MCO Questions

1. What factors did you take into consideration in deciding to pursue this VBP pilot?
2. Who were the key players involved in this senior leadership effort (eg, titles and mix of representatives) and how did you select the pediatric and adult sites for your pilot?
3. Why did you decide to focus on the transfer period for the pilot, and why did you choose the length of time you are planning for the pilot?
4. How did you decide on your specific payment strategies? And your measurement strategies?
5. What advice do you have for others interested in undertaking such a health care transition pilot?

Children's Medical Services Health Plan Operated by Sunshine Health

- Children's Medical Services (CMS) Health Plan, operated by Sunshine Health on behalf of the Florida Department of Health (DOH), is one of Florida's largest pediatric-only health plans with more than 25 years of clinical care experience, serving 91,000+ children and adolescents.
- CMS Health Plan provides integrated medical and behavioral health services for children and youth less than 21 years with serious, chronic conditions.
- Our goal is to provide child and family-centered care and solutions, helping children and families realize their full health and wellness potential, and providing an array of benefits and services that are easy to use and access.

Children's Medical Services Health Plan Operated by Sunshine Health

- Florida Department of Health (DOH) contracts with Sunshine Health to operate the Children's Medical Service (CMS) Health Plan.
- Sunshine Health is among the largest healthcare plans in Florida offering government-sponsored managed care through Medicaid, Long Term Care, the Health Insurance Marketplace and Medicare. Our specialty plans include the Child Welfare Specialty Plan serving children in or adopted from the state's Child Welfare system and the Serious Mental Illness Specialty Plan for people living with serious mental illness.

VBP Pilot - Factors and Considerations

- Built a strong working relationship with Florida Department of Health (DOH) Children's Medical Services (CMS) Health Plan.
- Identified health care transition (HCT) gaps occurring with membership, confirmed by physician feedback.
- Leveraged prior experience with transition-related work which created the foundation for program expansion into value-based initiatives.

Selection of Pediatric and Adult Sites

- Selected two large pediatric sites for HCT pilot based on:
  - *Engagement* – Enthusiastic leadership teams eager to participate in pilot.
  - *Reputation* – Well known and respected in community.
  - *Mature Infrastructure* – Advanced technologies and EHRs, mature policies and procedures, and established referral pathways.
- Selected two adult primary care sites – both federally qualified health centers (FQHCs), conveniently located to pediatric sites and CMS members.
- Scheduled subsequent joint meetings with senior leaders from Health Plan and both pediatric & adult teams to review and customize the HCT pilot.

Pilot Focus and Duration

- Empower CMS members who are transition-ready age to proactively manage their own health care.
- Support families with transition-age youth to effectively utilize services.
- Facilitate an organized transition process within the pilot partner groups to ensure transition policies are in place, readiness and planning are tracked, and transfer of care is successful.

Payment and Measurement Strategies

- Enhanced Fee for Service (FFS)
  - Streamlined program administration
  - Ease of use for physicians
  - Quick adoption
- Direct to consumer payment
  - Value-add component to members and families
  - Incentivized engagement
- Outcomes and Expectations:
  - Increased engagement in HCT-related activities by both member and physician
  - Increased member compliance and decreased missed appointments
  - Standardized processes around HCT documentation

Advice for Others

- Sponsorship from:
  - Regulatory partners
  - Health Plan leadership and key stakeholders
  - Physician group practices

- Success is determined by:
  - Allocation of appropriate resources
  - Proper planning and scope of work determination
  - Willingness to commit time and key staff

AmeriGroup

- Amerigroup has been helping Texas families get the health-care benefits they need since 1996. We have helped millions of Texans get and stay healthy.
- Amerigroup works with thousands of doctors, specialists, and hospitals throughout Texas, and we partner with many local community organizations. Our focus is to help members get the care and services needed.
- Amerigroup currently serves 1 million members across 230 Texas counties through its STAR, STAR Kids, STAR+PLUS and CHIP programs.

VBP Pilot - Factors and Considerations

- The need to transition from pediatric to adult care is known element in the child's continuum of care.
- The STAR Kids program addresses this by addressing transition in service coordination activities beginning at age 15. This requirement addresses the member, but not the provider. There is little incentive for practitioners to commit time needed to ensure a soft landing in adult care from the pediatric experience.
- A more organized approach to transition is clearly needed. Such an approach must appropriately value the practitioner's time commitment to achieve desired outcome.

Key Players and Selection of Pediatric and Adult Sites

- Key Players
  - Executive Director, STAR Kids
  - Director, Network Management
  - Manager, Network Relations
  - Director, Quality Management
  - Director II, Product Development
  - Business Change Manager, Specialized Populations
  - National Alliance partners

- Concerning the selection of the provider, we looked at large panel multi-specialty providers already engaged in APM/quality efforts with us and who have demonstrated a strong desire to partner for improvement.

Pilot Focus and Duration

- We focused on this time period because we felt that it would provide the appropriate amount of time for a successful transition of care.
- Given the complexities associated with the transition, we wanted to ensure that the member had a holistic understanding of and played an integral role in continuing their care into adulthood.
- The transfer period also aligns with other transition age youth focused programing offered by Amerigroup TX that contributes to member success into adulthood.
- We decided the length of time needed for the pilot was 18 months to allow enough time to schedule the last pediatric visit, the joint visit and the initial adult visit.

Payment Strategy

AmeriGroup's VBP Methods and Amounts
PMPM for 18 months: 12 months for pediatric practices and 12 months for adult practices, with overlapping 6 month period to allow for completion of joint telehealth visits. This PMPM calculation includes enhanced fees for selected services and recognition of CPT HCT-related codes previously unrecognized.
Pediatric PCP: Estimated 12-month total = $700 or $58.33 PMPM (to be paid out between months 1-12 of pilot)
• 2 final office visits with established patients (virtual or in person) (CPT 99214) @ $100 X 2 = $200 • Preparation of medical summary and emergency care plan (CPT 99358/non-face-to-face prolonged services) @ $110 • Joint telehealth visit with adult PCP and transferring patient (CPT 99214 with modifiers 95 and 77) @ $100 • Interprofessional consultation with new adult PCP following initial visit, if needed (CPT 99449) @ $50 • Comprehensive care management (G2065) @ $20/month X 12 months = $240
Adult PCP: Estimated 12-month total = $600 or $50 PMPM (to be paid out between months 6-18 of the pilot)
• Joint telehealth visit with pediatric PCP and transferring patient (CPT 99214 with modifiers 95 and 77) @ $100 • 1 initial office visit with new patient (virtual or in person) (CPT 99214) @ $100 • Update of medical summary and emergency care plan (CPT 99358/non-face-to-face prolonged services) @ $110 • Interprofessional consultation with pediatric PCP following initial visit, if needed (CPT 99449) @ $50 • Comprehensive care management (G2065) @ $20/month X 12 months = $240

Advice for Others

- Co-opt the talents of your best leaders in your network team, quality management and elsewhere in your organization

- Partner with the National Alliance and lean heavily on all involved.

Useful Resources

- *A Guide for Designing a Value-Based Payment Initiative for Pediatric-to-Adult Transitional Care*
- *Recommendations for Value-Based Transition Payment for Pediatric and Adult Health Care Systems: A Leadership Roundtable Report*
- *Medicaid Managed Care Contract Language to Expand the Availability of Pediatric-to-Adult Transitional Care*
- *2021 Coding and Payment Tip Sheet for Transition from Pediatric to Adult Health Care*

For additional HCT resources, visit GotTransition.org.

Questions?

Contacts:

Peggy McManus at MMcManus@TheNationalAlliance.org

Annie Schmidt at ASchmidt@TheNationalAlliance.org

Patience White at PWhite@TheNationalAlliance.org

Rae Wilkerson at Rae.Wilkerson@sunshinehealth.com

Aron Head at aron.head@amerigroup.com