

Value-Based Payment for Children's Health Care

Policy Paper

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Introduction

Washington State is on the forefront of the national value-based payment (VBP) movement. Through Healthier Washington the state has set a goal to move 90 percent of state-financed health care to VBP by 2021. To attain that target, VBP models will need to be implemented with pediatricians, family physicians, and advanced practice providers who care for children.

Heretofore, VBP models in the U.S. have generally been focused on strategies for near-term savings in adult populations. These VBP models are successful at getting providers to focus on reducing hospital admissions and readmissions to realize quick cost savings. Avoided hospital admissions and readmissions will not generate near-term savings in pediatric care, however, as children are rarely hospitalized. Unique, child-focused VBP models are needed because of the differences between adults and children in terms of disease burden and health care needs.

The “value” in VBP models for children is not in improved management of chronic conditions. Rather, “value” for children entails addressing issues affecting children that will impact them into and throughout their adult lives. These issues include the social determinants of health (SDOH), Adverse Childhood Events (ACEs), and other multi-generational factors that impact childhood development and long-term outcomes in health, education and economic productivity. VBP models for children’s health care

need to value the role child-focused primary care can have on future health care costs.

This policy brief sets forth our recommendations for pediatric-focused VBP models. The recommendations were informed by a 2016 United Hospital Fund report on pediatric VBP authored by Bailit Health.¹

The science is clear that an individual’s health trajectory is affected during early childhood and providers need to be incentivized to screen for social determinants of health, provide interventions, such as parental education, support and some behavioral health services, and create strong linkages to community organizations that support families with complex issues. Therefore the primary care payment model includes integrated behavioral health services in the capitation payment, fee-for-service payment for SDOH screening, and coordination with community organizations in the care coordination payment.

¹ Bailit, M. and Houy, M. “Value-Based Payment Models for Medicaid Child Health Services.” United Hospital Fund and the Schuler Center for Analysis and Advocacy. July 12, 2016. See www.bailit-health.com/articles/2016-0713-Bailit-vbf-final.pdf. (Last accessed September 13, 2017.)

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Recommendations

We recommend two separate VBP models to accommodate two distinct subpopulations within the overall population of children – children who are generally healthy, and children with medical complexities. Each payment model is discussed below.

1. Primary Care Payment for Healthy Children

We recommend a primary care capitation model for pediatric primary care providers that serve generally healthy children. This model has three elements: (1) a capitation payment; (2) care coordination fees; and (3) performance bonus opportunities. The goal of this model is not to place financial risk on the clinician, but to adequately fund traditional and non-traditional services (some of which are not currently funded), provide delivery service flexibility, and provide incentives to continually improve the quality of care provided. The following narrative describes the payment model in greater detail:

Capitation

Most services that are provided by a pediatric primary care provider for children *without* complex health needs should be paid for prospectively on a per-patient-per-month basis. The capitation rate should be based on historical costs that are adjusted upwards, as necessary for providers to deliver care consistent with the Bright Futures guidelines² and to account for physician and advanced practice provider

time for telephone calls with families, schools, etc. Recognizing the need for support for behavioral health, the capitation rate should incorporate the cost of providing behavioral health services for primary care practices with co-located and operationally integrated behavioral health care. Children with complex health needs should be excluded from primary care capitation.

There are some services that should remain outside of the capitation rate in order to incentivize the delivery of the service. The capitation rate should specifically exclude vaccine costs, for example, and pay for those on a fee-for-service basis. Additionally, screening for social determinants of health, including parental depression, should be paid on a fee-for-service basis, outside of the capitation payment. Finally, certain services that are delivered by some, but not most practices (e.g., suturing), should also be outside of the capitation payment.

The rate should be adjusted downward for a given practice if experience shows the practice to be making higher-than-expected use of emergency department, urgent care, and physician specialist services.

Care Coordination Payment

The primary care capitation payment should be complemented with a care coordination payment, paid on a per-patient-per-month basis. The care coordination payment should fund care coordination for children within the practice with medical and social risk factors.³ The payment should

2 <https://brightfutures.aap.org/clinical-practice/Pages/default.aspx> (last accessed September 12, 2017).

3 R. Antonelli, J. McAllister, J. Popp. “Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary

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cover care coordination activities such as coordinating specialist referrals, tracking tests and performing patient follow-up, as well as care coordination services associated with connecting families to a robust network of community-based agencies that can help with addressing social determinants. For many children and families, the care coordinators could be social workers or community health workers. For ease of administration, the PCP capitation payment and the care coordination payment could be combined into a single payment stream.

The capitation and care coordination payment(s) should be risk-adjusted. Those criteria should include clinical risk (e.g., chronic condition, behavioral health diagnosis, foster care status) and ideally, socioeconomic risk. Because there are no well-established means for adjusting care coordination payments for socioeconomic risk, proxies may be necessary in the short-term.

Performance Bonus Opportunity

The final pediatric primary care payment component is a performance incentive bonus. It is important that there be an explicit incentive and reward for the delivery of high quality and efficient care. Research suggests that potential rewards should approach 10% of compensation to provide sufficient motivation.⁴ Both excellence and improvement over time should be rewarded. Performance measures should be evidence-based and drawn from national measure sets.

2. Payment for Children with Medical Complexity

The care for children with medical complexity – estimated to be no more than 5% of the pediatric population, most of whom are supported by care teams at tertiary referral centers – should be paid using a **total cost of care model**, unless the provider organization is already contracting on a total cost of care basis for its total patient population. Doing so provides financial flexibility for the attributed provider as with primary care capitation, but to a far greater degree because the “budget” is so much larger. It also provides a financial incentive to reduce unnecessary care and to find better ways to meet patient and family needs.

The total cost of care model for children with medical complexity should have the following characteristics:

- a. There should be a sufficiently large population to ensure an accurate assessment of financial performance.
- b. The total cost of care model should evolve from shared savings to shared risk, but should not be full risk due to the impact of high cost outliers.
- c. Eligibility for distribution of any earned savings should be predicated on accessible performance relative to a pre-negotiated measure set that addresses measures relevant to the health status of the target population, with increased distribution linked to higher performance.

Framework.” *The Commonwealth Fund*, publication number 12, 77, May 2009.

4 Rosenthal M.B., Frank R.G., Li Z., Epstein A.M. “Early Experience with Pay-for-Performance: From Concept to Practice.” *Journal of the American Medical Association* 2005; vol. 294: 14.

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The total cost of care model should be complemented by a **care coordination payment**. Care coordination resources should include individuals with higher clinical credentials than would be needed for children without medical complexity, and should reflect the intensive care coordination activities associated with caring for these children.

Implementing VBP for Children’s Health Care

There is an immense opportunity, while considering and designing VBP models focused on health care for children, to build a common approach across many payers. VBP models with common parameters could assist providers who care for children in focusing on the most important clinical and quality outcomes that will eventually affect the long-term costs of the health system. VBP models with common parameters help reduce the ‘ping-pong’ effect that multiple payment models can have on providers, where multiple foci eventually dilute the effect of any given model.

The Health Care Authority stands uniquely positioned to provide leadership by identifying a VBP model with common parameters for the provision of health care for Medicaid children, as the state has the most to gain by improving the care of children in the long run. Since one out of every two children relies on Apple Health for health coverage, the Health Care Authority should convene managed care plans and providers to further develop these the VBP models

in a collaborative fashion. Such common parameters might include the structure of the payment model and the quality performance measures.

Washington’s managed care plans also have a critical role for ensuring the success of VBP models at this juncture. Managed care plans should strive for collaboration and synergy, recognizing the opportunity to achieve higher impact on improved health and long-term cost savings through aligned value-based payment models for children’s health care.

As part of a collaborative effort to build VBP models that support pediatric care, it is important to recognize that current Medicaid payments do not cover the cost of delivering health care, and the development of any new models needs to recognize the financial impact that high quality children’s health care can have on the entire health care system, in the near- and long-term. For example, access to a medical home as a usual source of care for children costs less in the near-term. The care coordination fees recommended in both payment models can help support the activities that should regularly occur in medical homes. Similarly, providing integrated behavioral health services in the pediatric primary care setting “offers a unique opportunity for early intervention on a population level to prevent behavioral health problems from interfering significantly with functioning in both childhood and adulthood,”⁵ thereby lowering the lifelong costs of health care, welfare, education and the justice system.

5 Tobin Tyler E., Hulkower R., Kaminski J. “Behavioral Health Integration in Pediatric Primary Care: Considerations and Opportunities for Policymakers, Planners, and Providers.” *Milbank Memorial Fund* March 2017.

See www.milbank.org/wp-content/uploads/2017/03/MMF_BHI_Executive-Summary-FINAL.pdf. (Last accessed September 13, 2017.)

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Conclusions

The goals of *Healthier Washington* provide an opportunity to develop pediatric VBP models that will improve the quality of care provided to children, improve the health and productivity of future generations, and lower the cost of health care in the long run. The Health Care Authority, managed care plans and pediatric health care providers should collaborate to design and implement VBP models based on these recommendations.