

Value-Based Payment for Children's Health Care 2018



Value-Based Payment for Children's Health Care

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 have a much lower hospitalization rate due to the success of vaccine preventable diseases, such as common respiratory and gastrointestinal disease. Unique, child-focused VBP models are needed because of the differences between adults and children in terms of current investment of prevention and early intervention of health care needs that will result in decreasing the disease burden and cost.

The Value in the VBP model for children is in the prevention and improved management of chronic conditions, plus addressing issues affecting children 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 a pediatric-focused VBP model based on the Patient Centered Medical Home system of care. The recommendations were informed by a 2016 United Hospital Fund report on pediatric VBP authored by Bailit Health, and aligns with the Value Based Payment presentation, "What You Should Know about What Is Coming" by presenter Rick MacCornack, PhD to the Washington Chapter of the American Academy of Pediatrics on November 4, 2017.

The science is clear that an individual's health trajectory is affected during early childhood, and providers need to screen for social determinants of health and ACEs, provide interventions such as parental education, support, and 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 and screening for social determinants of health, development, parental depression, and behavior, plus community and clinical care coordination.

Recommendation: Pediatric Value Based Payment Model (P-VBP)

Fee for Service and Supplemental Value Based Payment for PCMH System of Care includes:

1. Fee for Service Payment for E&M Codes, presently compensated

Preventive care

Acute Care

Chronic care

Health Homes

Access to Baby and Child Dentistry (ABCD) Program

Integrated Behavioral Health

Pediatric Access Line (PALs)

Recommend enhanced compensation/Medicare rates

2. Fee for Service Payment for E&M Codes presently uncompensated

After Hours care

Behavioral screening

Developmental screening including ACEs and Maternal Depression

Recommend FFS payment at enhanced compensation/Medicare rates

3. Supplemental Value Based PMPM Payment for presently uncompensated services

Care Coordination

Access to Care

24/7 non face-to-face care

Recommend PMPM Payment that covers the cost of care to provide the service, or at Health Homes rates

This pediatric value based supplemental payment will achieve the Medicaid Transformation goal of providing targeted services that address the needs of our 0-19 year population and address key determinants of health. The proposed pediatric value based payment is an enhanced FFS for E&M codes, a PMPM for care coordination, and contracted reimbursement for value based care programs in a population based model. The pediatric value based payment model contains the key infrastructure components of provider engagement and leadership for access and capacity, care coordination management based on EMR capabilities, and links to social determinants of health, the key elements of value based care capabilities.

Care Coordination PMPM Payment

The primary care Fee for Service (FFS) and program contract payments should be complemented with a care coordination PMPM payment, paid on a per-patient-per-month basis. The care coordination PMPM payment should fund care coordination for children with medical and social risk factors, but also should cover tracking and recall for preventive health services for all children, making early intervention possible. The payment should 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 children and families, the care coordinators could be RN, CMA, social workers or community health workers.

Care Coordination & Management



Underlying most successful VBP contracts is a formalized care coordination process, often tiered or tailored based on risk and linked with strong, evidence-based case management.

Key Elements

- Single or coordinated “point of entry” for assessment (minimizing duplication with respect to patient assessment of patient medical, behavioral and other needs)
- Coordination across specialties and sites of care
 - Health risk management
 - Health promotion/wellness
 - Links to behavioral health, as needed, e.g., co-location of services
 - Post-discharge follow-up
 - Adherence to treatment plans
 - Facilitation with referrals
 - Identifying and addressing gaps in care
- Patient-centered comprehensive care planning
 - “Map” journey through system
 - Identifying “hand-offs” and individual roles
- Integrated into care management platforms/ population health management systems
- Widely available to entire care team
- Monitoring by care managers and providers
- Part of care coordination protocols
- Patient engagement
 - Patient activation
 - Health management programs
 - Virtual services
- Evidence-based case management
 - Development and use of common clinical protocols
 - Delivering patient-centered care
 - Disease management (acute and chronic)
 - Medication management
 - Pharmacy links
 - Links to long-term care and supportive services, other services

Implementing VBP for Children's Health Care

There is an immense opportunity, while considering and designing a pediatric VBP model focused on health care for children, to build a common approach across many payers. A Pediatric VBP model 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. A Pediatric VBP model with common parameters helps 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 Pediatric VBP model 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 implement the Pediatric VBP model in a collaborative fashion. Common parameters will include the structure of the payment model and quality performance measures. Washington's managed care plans also have a critical role for ensuring the success of the Pediatric VBP model at this juncture. Managed care plans should strive for collaboration and synergy, recognizing the opportunity to achieve a higher impact on improved health and long-term cost savings through an aligned pediatric value-based payment model for children's health care.

As part of a collaborative effort to ensure a Pediatric VBP model that supports pediatric care, it is important to recognize that current Medicaid payments do not cover the cost of delivering health care, and the development of the new Pediatric VBP model 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 Patient Centered Medical Home as a usual source of care for children costs less in the near-term. The care coordination PMPM dollars included in the Pediatric VBP model can help support the activities that regularly occur in Patient Centered 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, thereby lowering the lifelong costs of health care, welfare, education and the justice system.

Steps to Get Ready for Value Based Payment

P-TCPI 2016-2017

CMS awarded a four year Pediatric Transforming Clinical Practice Initiative (P-TCPI) grant to lead organizations WCAAP, Washington DOH, and Molina Healthcare. The first two years of P-TCPI has focused on transforming clinical practice to achieve Value Based Care based on population health management and the Patient Centered Medical Home system of care.

Patient Centered Medical Home

The American Academy of Pediatrics first introduced the medical home concept in 1967. Leading primary care oriented professional societies released the Joint Principles of the Patient Centered Medical Home in 2007, and soon after the National Committee for Quality Assurance developed the Patient Centered Medical Home (PCMH) recognition program. As of January 2017, 11,974 practices have been recognized.

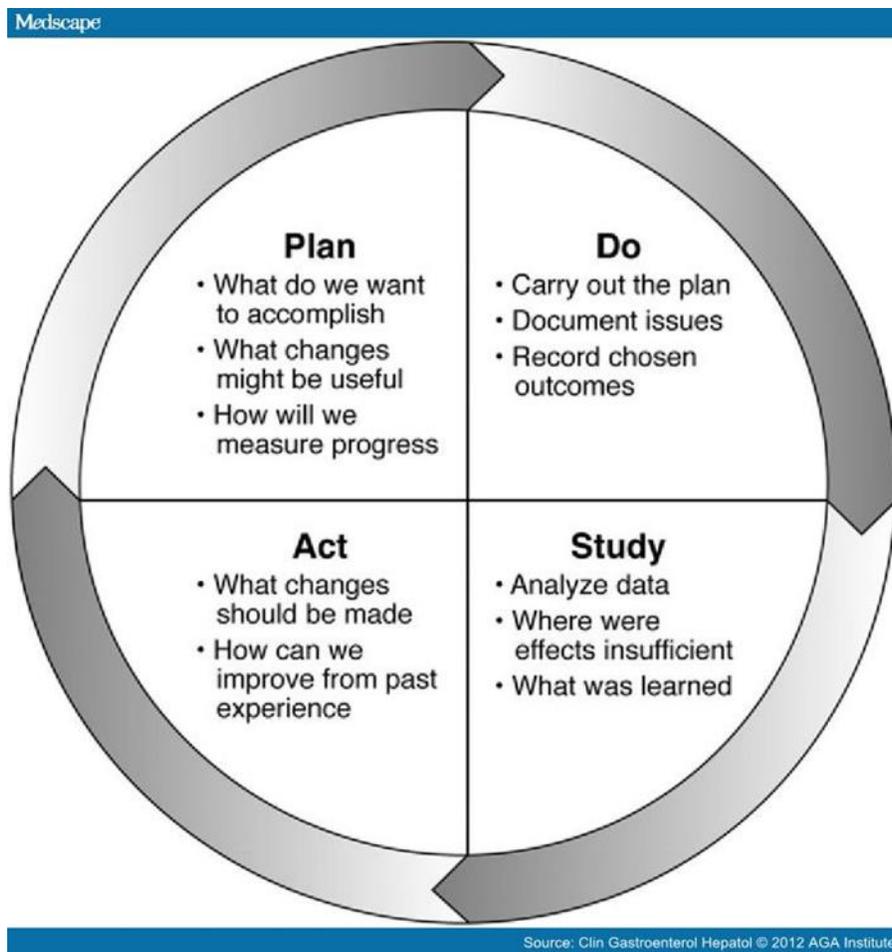
The Medical Home model of care has been developed from evidence-based guidelines and best practices. Six overarching concepts guide the Pediatric Primary Care Clinician (PPCC) to become high performing and produce Value Based Care. Threaded throughout these concepts is the importance of care coordination and patient engagement:

1. **Team-Based Care and Practice Organization:** Helps structure a practice's leadership, care team responsibilities and how the practice partners with patients, families and caregivers.
2. **Knowing and Managing Your Patients:** Sets standards for data collection, medication reconciliation, evidence-based clinical decision support and other activities.
3. **Patient-Centered Access and Continuity:** Guides practices to provide patients with convenient access to clinical advice and helps ensure continuity of care.
4. **Care Management and Support:** Helps clinicians set up care management protocols to identify patients who need more closely-managed care.
5. **Care Coordination and Care Transitions:** Ensures that primary and specialty care clinicians are effectively sharing information and managing patient referrals to minimize cost, confusion and inappropriate care.
6. **Performance Measurement and Quality Improvement –** Improvement helps practices develop ways to measure performance, set goals and develop activities that will improve performances.

For more information on this model of care: <https://www.ncqa.org>.

Process Improvement to Transform Pediatric Clinical Practice

The PDSA tool is used to achieve and improve the benchmarks for HEDIS outcome measures, utilization measures, and the TCPI AIM statement. The Institute of Health uses the PDSA tool to promote quality improvement and quality metrics. The PDSA cycle starts with determining the nature and scope of the problem, deciding what changes can and should be made, developing a plan for a specific change, identifying team members who should be involved, isolating data that should be measured to understand the impact of change, and deciding where the strategy will be targeted. Change is then implemented, and data and information are collected. This is how the Medical Home team will transform the system of healthcare in the delivery of their programs and services.



P-TCPI 2018-2019

In Years 3 and 4 of the P-TCPI, our main priorities remain transforming to value based care and achieving value based payment to cover the cost of care. In preparing for VBP, pediatricians have pursued the following steps to transform their clinical practice:

1. Understand the Different types of Payment Models: As practices contemplate value based payment, it is important they understand the different types of value based payment models, and how to succeed under those models.

2. Prepare to Capture and Report Quality Data: Unlike alternative payment arrangements of the 1990s, the new generation of value based payment has a strong focus on measuring population health and rewarding clinical process improvement. Therefore, it is of utmost importance that practices develop the ability to accurately capture data and generate performance measures for internal improvement and external reporting.

3. Identify Personnel to Support Quality Improvement: Many practices require infrastructure to succeed under VBP. This means adding staff to the Medical Home clinical care team, such as an RN to manage care coordination and Health Homes, an EMR Manager to produce data that drives quality care and improved HEDIS measures, additional CMAs with transformed care policies to improve care procedures, and Community Health Workers to assist in community care coordination and patient engagement and support, plus a behavioral health therapist on site to integrate pediatric behavioral health. Some small independent practices may consider addressing these needs by entering some form of a partnership with other like practices to employ staff, share resources, and achieve economies of scale.

4. Manage Social Determinants of Health: To address social determinants of health, some payers will support a care coordination function within the practice. In this example, practices may consider hiring one or more care coordinators, and must set up systems to effectively screen for these risk factors; effectively link children and their families to any available community resources; and provide practice-based interventions, such as education and behavioral health services, as appropriate and feasible. Care coordinators connect with families to bring them into care, support families with complex needs, and/or assist families in accessing available social and economic support systems to address the social determinants of health such as housing and food insecurity.

5. Proactive Population Health under Value Based Payment Models: Prior to the shift toward value based payment, physicians typically focused attention on the patients who came to the office for a well or sick visit. Under VBP models, however, physicians are held responsible for a defined group of patients regardless of whether the patients have come to the office for appointments. This shift in focus requires a different approach to managing a pediatric practice.

6. Identifying and Acting Upon Gaps in Care: After practices identify their patients, it is important for practices to then identify and act upon gaps in care if they are to be successful under VBP. Practices must analyze their EHR data to identify ways to improve on quality measures for which they are accountable. For example, if a physician is accountable for ensuring that children receive their well child visits on time, the practice must identify which patients have yet to be seen during the year, or who may have missed a visit. The practice then needs to identify a process for reaching out to these patients to encourage them to make an appointment, or identify and help remove barriers the patients may have to making and/or attending an appointment, pointing to the aforementioned need for investments in clinic personnel to identify patients as well as staff to support families' social determinants of health.

7. Seek Reimbursement that Covers the Cost of Care: Investing in children's health and wellness erases health disparities and ensures that all of Washington's children, regardless of insurance type – Medicaid or commercial – are healthy and ready to learn. Value Based Payment to Pediatric Primary Care Clinicians that covers the cost of providing PCMH system of care will require increased dollars upstream, but will provide evidence-based, 24/7/365 comprehensive care that will meet and exceed HEDIS quality and utilization outcome measure benchmarks.

8. Address Patient Access and Provider Workforce Capacity Issue: Enhanced reimbursement covering the cost of PCMH care will encourage Pediatric Primary Care Clinicians to remove the cap on the number of Medicaid patients in their payer mix, and accept new Medicaid patients into their practice. Adequate reimbursement will allow pediatric clinics to offer a competitive salary to recruit and retain additional pediatricians, increasing the capacity to care for more Medicaid patients, thus allowing the opportunity for more than half of the children in our state to have a Medical Home.

Conclusions

The goals of Healthier Washington provide an opportunity to develop a Pediatric VBP model 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 Primary Care Clinicians should collaborate to design and implement a VBP model based on these recommendations.