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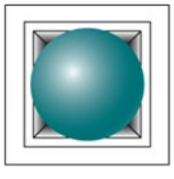
A Guide for Designing a Value-Based Payment Initiative for Pediatric-to-Adult Transitional Care

Margaret McManus, MHS
Patience White, MD, MA
Annie Schmidt, MPH
The National Alliance to Advance Adolescent Health



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For more information, please contact Peggy McManus at MMcManus@TheNationalAlliance.org.

INTRODUCTION

Transition-aged adolescents and young adults (AYA), between 12 and 26, comprise almost 20% of the US population.[1] Among the 65 million in this age span, an estimated 25-35% have a chronic condition.[2,3] Preparing all AYA, and especially those with chronic conditions, to manage their own health care and effectively move from a child/family-centered to an adult/patient-centered approach to care is critical for their health and well-being. Yet, national survey data reveal that a small minority – about 20% – have received transition preparation assistance from their health care providers.[2] Without access to a planned transition approach, AYA face adverse outcomes, including gaps in care, dissatisfaction and worry, problems with treatment adherence, and avoidable morbidity and hospitalization.[4,5,6]

The American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Physicians (ACP) call for pediatric and adult care systems to update their health care transition (HCT) processes using Got Transition's Six Core Elements of Health Care Transition™.[7,8] This structured approach includes a set of customizable tools for all three phases of transition – preparation, transfer, and integration into adult care. In addition, the federal Maternal and Child Health Bureau recognizes pediatric-to-adult HCT as an essential part of a comprehensive system of services and as a national performance measure, calling on payers, public health programs, and health care systems to improve access to needed transition supports for all AYA.[9]

Pursuing value-based payment (VBP) options, which offer financial incentives for meeting certain performance measures, represents an important opportunity to encourage transitional care improvements in pediatric and adult primary, specialty, and behavioral health care settings (see Step 4). Although VBP arrangements are expanding rapidly among Medicaid, Medicare, and commercial payers,[10] these payment innovations have yet to consider pediatric-to-adult transitional care. In 2020, CMS released guidance for states to advance VBP in Medicaid, encouraging the use of multiple strategies.[11] In fact, in states like Oregon and Texas and many others, Medicaid managed care contracting targets have stipulated that a specific high percentage of provider payments be based on VBP methods.

As payers and their contracted plans and provider networks implement new VBP programs, this is an opportune time to make the case for including pediatric-to-adult transitional care. Several tools are available to make the case to Medicaid and commercial insurers, including sample business case statements[12] and Got Transition's tip sheet that is customizable for individual states.[13] See here for an example of how Oregon public health officials customized this tip sheet to engage their state Medicaid officials in the importance of focusing on pediatric-to-adult transitional care as part of their health care transformation efforts.[14]

This guide contains a step-by-step approach for state Medicaid and managed care organizations (MCOs) as well as commercial payers interested in starting a VBP initiative around pediatric-to-adult transitional care. Each of the steps, listed below, includes several issues and strategies to consider, tips, and examples from MCOs.

Information for this report is drawn from technical assistance (TA) provided by The National Alliance over the past two years to senior officials in state Medicaid agencies, commercial carriers, MCOs, integrated care systems, and public health programs. It also comes from recent previous work developing VBP recommendations with extensive expert guidance from key stakeholders and from ongoing work operating the federally funded national resource center on HCT, Got Transition. With funding from the Lucile Packard Foundation for Children's Health, we conducted outreach to a broad set of payers to inquire about their interest in pediatric-to-adult transitional care VBP pilots. Several payers and MCOs were also identified as potential early adopters based on evidence of managed care contract requirements on transitional care and participation in our past work on VBP and transitional care. In the end, we focused most of our TA on Medicaid payers in Texas, New York, Oregon, and Colorado as well as Medicaid plans (Florida Department of Health (DOH) Children's Medical Services (CMS) Health Plan, operated by Sunshine Health; Texas' AmeriGroup; DC's Health Services for Children with Special Needs), a large integrated health plan (Intermountain Healthcare), and public health/Title V programs in Florida, Oregon, and Rhode Island. Table 1 provides a summary table of the four plans that have gone the farthest in designing and, in the case of DC, implementing a VBP transitional care pilot.[i]

Table 1. HCT VBP Initiatives in Selected Medicaid Health Plans

Health Plan	Pilot Population	HCT Activities* Addressed	Pilot Duration & Start Date	Payment Methods	Quality Measures
DC Health Services for Children with Special Needs (HSCSN)	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 Healthcare/Select Health (SH)	SH ACO Medicaid-Insured and SH Commercial Insured Enrollees with Congenital Heart Disease	Transition preparation and transfer	12-24 months Winter 2021	• Recognizing selected HCT CPT codes	• Enrollee HCT Feedback Survey • Enrollees that complete 1 or 2 visits in adult clinic

*HCT activities encompass transition preparation, transfer, and integration into adult care

[i] DC's Health Services for Children with Special Needs (HSCSN) VBP pilot was funded by the WITH Foundation, but it is included in this report as it represents an important example to share. A more detailed report on this initiative will be published in 2022.

STEP 1. DEFINING THE HCT INTERVENTION VBP PILOT

Issues and Strategies to Consider

1. *What components of the HCT process do you want to focus on, and over what period of time?*

   One should start by deciding if the intervention will involve all three components of HCT (preparation, transfer, and integration) or just one or two components. A deciding factor is how long do you want to spend conducting the pilot or how soon do you need data to decide if the process is working or needs further changes. If you are considering including all three HCT components in your pilot, it will take several years as transition preparation starts around ages 14-16 and continues through integration into the adult practice around the ages of 18 through age 21. If you are interested in a shorter time frame, focusing on transfer is the component best suited to start with. Step 6 in this guide includes an example of quality improvement (QI) workplans for pediatric and adult practices focusing on the transfer period. In a transfer pilot, it can easily extend to a 24-month period or longer depending on the HCT process that is established and on how much time the recruitment of youth takes. Typically, a transfer pilot involves several activities – a final pediatric visit, preparation and sharing of a medical summary with the patient and the new adult practice, communication between sites and the patient in advance of initial adult visit, preparation and sharing of welcome and orientation information about the new practice, the initial adult care visit, and updating of the medical summary. The transfer component is also the hardest of the three components as it involves coordination between the pediatric and adult practices, including how they will communicate, efficiently schedule timely visits and transfer the medical summary and any additional medical information, and ensure the young adult (YA) completes the first adult visit in the new practice.

Tips

When starting a HCT pilot, be sure to allow time in the beginning of the pilot to help the practices develop the needed infrastructure, such as choosing and embedding the customized HCT tools (e.g., a transition readiness assessment and medical summary template) into their electronic health record (EHR). In addition, they will need time to incorporate the chosen HCT process into their practice flow. MCOs can play a complementary role, given their care management infrastructure for special-needs populations. For example, they may want to play an important role in ensuring patients are reminded of their final pediatric and initial adult visit, given the high loss-to-follow-up during transfer. They may also want to extend additional care management support to adult primary care practices to help connect transferring young adults to other specialty, behavioral, and/or reproductive providers available to accept new patients.

Example

Intermountain Healthcare designed a pilot for youth with congenital heart disease. The goal of the program is to provide patient and family education to allow for successful transition from pediatric to adult health care. Their HCT intervention includes transition education and transfer of care, as shown in Table 3.

Table 3. Intermountain Healthcare Congenital Heart Disease HCT Preparation, Education, and Transfer Pilot Program

Preparation: Age 12 through transfer of care > 18 years of age
Goals: 1. Identify transition-aged youth 2. Assess HCT readiness 3. Offer education in skill-building needed 4. Document progress in chart
Steps: 1. Pediatric cardiology nurses identify appropriate patients during standard pre-clinic screening and add patient to a REDCap database registry 2. Family and YA receives education packet, cardiology passport, and readiness assessment (RA) to be discussed by pediatric cardiologist 3. EHR capacity to track RAs and template available for heart condition education topics discussed
Transfer of Care: ≥ 18 years of age
Goals: 1. Complete needed transition education from the RA 2. Complete cardiology healthcare passport in EHR 3. Identify appropriate adult cardiology provider 4. Facilitate transfer of care to appropriate adult cardiology provider
Steps: 1. Pediatric cardiologist places "PCH Cardiology Transition Clinic" order when the YA is ready to transfer care and recommends adult cardiology provider and follow up plan 2. Youth scheduled for 1 hour virtual transition visit with physician assistant who goes over education received, repeats heart condition knowledge assessment, discusses any knowledge gaps, completes final RA and passport (medical summary), and places in the chart 3. Adult provider chosen and appointment scheduled. REDCap registry is completed and YA is removed from pediatric cardiology transition education list 4. Records are available in EHR for when the YA goes to first adult cardiology visit

STEP 2. IDENTIFYING TRANSITION-AGED POPULATIONS FOR A VBP INITIATIVE

Issues and Strategies to Consider

1. *What population to start with?*

   Payers and plans often prefer to start a VBP pilot with a group of AYA who have chronic conditions, often a specific condition (e.g., those with intellectual and developmental disabilities, congenital heart disease) or those in certain program eligibility groups (e.g., those receiving SSI or those in state Title V special-needs programs). Another option is to consider all transition-aged AYA, between 14 and 25, to create a population-based, longitudinal approach to transition. Alternatively, one can select youth in a certain age group – e.g., 17 to 19 – to allow time to begin the process of preparing for transfer on the pediatric side, completing the actual transfer, and having time to integrate into the new adult practice to ensure care continuity. Or, one could select two populations – those that are ages 21 and older who need more expedited attention – and a younger age group – ages 17-20, who have more advance time to plan for this transition.

2. *What data should be collected about the population?*

   Once your population and age range have been selected, look at the population numbers enrolled by individual years to determine the size of the potentially eligible group. Then, determine what proportion of

this group were last seen by a pediatric clinician (i.e., a general or subspecialty pediatrician or pediatric nurse practitioner), and what proportion were last seen by a family or internal medicine physician or family nurse practitioner. Likely, you will want to focus on those who are still being seen by pediatric clinicians. With this group, there are several utilization indicators to review, including the geographic location/zip codes for this potential pilot group, the percentages with an assigned primary care provider (PCP), and the percentages with a preventive care visit in the past year, any primary or specialty ambulatory visit (not including urgent care), an emergency department (ED) visit, and/or an inpatient hospital admission. Based on this background profile, it will be possible to not only begin to identify potential sites that have the largest number of potential participants, but also to consider some utilization targets that you may want to include as quality performance measures – such as increasing by 10% the use of preventive/ambulatory care or decreasing by 10% the rates of ED visits.

Tips

Start with a pilot population who regularly uses care. If they haven't been to their PCP or specialist in the past year or two, it may be difficult to engage them in a new VBP initiative. Also, it is wise not to start with the most complex patients. However, having a way to take into account the medical and social complexity of the pilot group is very helpful, especially when thinking about payment adjustments for complexity. The ages chosen will impact the length of the pilot and vice versa; the younger the age of pilot participants, the longer the pilot, if transfer is part of the intervention.

Example

Let's say you choose AYA with intellectual and developmental disabilities (ID/DD) as your pilot population. Table 4 below provides ideas of what data to collect and what measures to consider. See Step 5 in this guide for additional information on HCT quality measurement options and issues to consider.

Table 4. Data and Measurement Ideas for AYA with Intellectual and Developmental Disabilities

Sample pilot population
• AYA with ID/DD
What data should be collected about this population?

• Total number of AYA with ID/DD, by individual years – ages 16, 17, 18, 19, 20, 21, 22, 23, 24, 25
• Of these individuals:
  ○ % 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)

Here are some measurement ideas that could be considered once a baseline is established:
• Increase by x% the number of YA, ages 22-26, being seen by adult PCPs • Increase by x% the number of 16-21 year olds with a pediatric PCP with access to their current medical summary; with documentation in their medical record about anticipatory guidance on transition preparation • Increase by x% the number of transition-aged AYA who transfer and have their initial adult PCP visit within 6 months of last pediatric visit • Reduce by x% the number of 16-25 year olds who experience gaps care (>12 months) in pediatric and adult care settings • Reduce by x% the number of 16-25 year olds with 1 or more ED visits; with 1 or more inpatient hospital admissions

STEP 3. SELECTING ACCOUNTABLE PEDIATRIC AND ADULT SITES

Issues and Strategies to Consider

1. *Should the VBP pilot focus on primary, specialty, or behavioral health care?*

   Oftentimes payers and MCOs prefer to start a pilot focusing on primary care. Still, there is no right answer. However, if the pilot is with either specialty or behavioral health care, it will be important to also consider how to emphasize the inclusion of primary care on the adult side. Eventually each of these care sites should have a systematic process for supporting the transition from pediatric to adult health care.

2. *How best to find interested pediatric and adult sites?*

   Consider natural partnerships like a pediatric program and an adult program in the same institution. Ideally, a pilot with pediatric and adult programs that already have close ties and relatively large flow of patients from one to another makes sense. Finding pediatric sites with a sizeable number of the pilot population you want to focus on is important. Even more important is choosing pediatric sites that are committed to this work and have solid senior leadership support. Once the pediatric site has been selected, there are several ways to think about identifying adult sites to partner with – learning about existing referral sites that the pediatric practice already uses, geo-mapping where the transitioning pediatric pilot population resides, and looking at the adult sites used by the parents/caregivers. Finding available adult providers to care for YA with ID/DD, behavioral health conditions, and complex medical conditions can be challenging and time-consuming. Payers and MCOs may need to consider how to best to incorporate VBP options to build and grow their adult workforce capacity.

Tips

Starting a transition pilot in primary care can be very useful, even for those with chronic conditions. Although in pediatric subspecialty care many physicians serve also as PCPs, that is not the case in adult care. Thus, finding a PCP is essential in adult care. This adult PCP can also be helpful in finding adult subspecialists and other clinicians needed by the transitioning YA, including sexual/reproductive care, mental/behavioral health care, as well as referrals to other community services. If multiple transfers will be needed out of pediatric care, staggering the timing of them can be helpful. Though some systems have developed a robust care coordination infrastructure to manage multiple transitions at one time, this is more the exception than the rule. To find adult PCPs, it can be helpful to look at adult clinicians who have completed their training in the past 10 years; their practices are less likely to be full. Although it might be easier if pediatric and adult sites have the same EHR, the medical summary will still need to be created.

Example

In Florida, the DOH Children's Medical Services (CMS) Health Plan, operated by Sunshine Health, a subsidiary of Centene Corporation, provides managed care to its children and youth with special health care needs on Medicaid. CMS Health Plan, operated by Sunshine Health officials identified two large pediatric groups to partner in supporting a pilot group of CMS Health Plan enrollees. These sites were chosen for three main reasons: 1) *Engagement* – both groups have enthusiastic leadership teams eager to participate in the pilot; 2) *Reputation* - both groups are focused on the pediatric population and are well-known and respected in the community; and 3) *Mature Infrastructure* – both groups have advanced technologies and EHRs, mature policies and procedures, and established referral pathways. With these two pediatric sites, two adult primary care sites

– both federally qualified health centers – were identified and invited to participate. Subsequent joint meetings were held with senior leaders from the CMS Health Plan, operated by Sunshine Health, and both the pediatric and adult sites to review and customize the pilot plan. It should also be noted that the CMS Health Plan, operated by Sunshine Health, assembled a team in 2019 to develop a transition-aged youth (TAY) program, building on Got Transition's Six Core Elements of HCT. This work involved establishing a TAY policy, tracking and monitoring receipt of core elements, conducting annual transition readiness assessments, creating goals and action steps based on assessment results that are part of enrollees' plan of care, assistance with transfer, and feedback from members and families through the CMS Health Plan Consumer Advisory Board. In addition, Florida HATS modules are used for care manager training.

STEP 4. CHOOSING VBP AND FFS OPTIONS

Issues and Strategies to Consider

1. *What are the VBP options that can be considered?*

   There are several VBP options payers and MCOs can consider. In 2018, The National Alliance convened a roundtable of payers, clinicians, researchers, and advocates to develop and prioritize VBP methods for HCT.[15] Table 5 provides a few examples of options to consider for six types of VBP: enhanced fee-for-service (FFS), infrastructure investments (i.e., a one-time only payment to support a practice/system change), pay-for-performance (P4P), direct payment to consumers, per-member per-month (PMPM), and episodes of care/bundled payment. More detail and additional options to consider are included in The National Alliance's Report, *Recommendations for Value-Based Transition Payment for Pediatric and Adult Health Care Systems: A Leadership Roundtable Report.*[15]

Table 5. Value-Based Payment Options to Consider

Enhanced Fee-for-Service (FFS)
Use a higher fee/relative value unit for evaluation and management (E/M) services for the purpose of incentivizing adult practices to accept a certain volume of YA with chronic conditions.
Pay enhanced fees for E/M services for a defined period of time if both pediatric and adult practices have established a structured HCT process with evidence of communication/consultation, exchange of a medical summary, and a care plan for transferred patients.
Infrastructure Investments
Upgrade EHRs to incorporate recommended HCT clinical processes in pediatric and adult practices.
Build care coordination supports for adult practices accepting YA with chronic conditions. *(Note: NASHP's Care Coordination Standards for CYSHCN describe key elements of care coordination, including transition.)*
Pay-for-Performance (P4P)
Reward pediatric clinicians who transfer their patients with a current medical summary and evidence of communication with new adult clinician. Similarly, reward adult clinicians with evidence of communication with previous pediatric clinician, a timely appointment for their new YA patients, and pre-visit calls/text appointment reminders.
Reward pediatric and adult practices who achieve specific transition quality performance targets (e.g., reduced preventable ED visits and hospitalizations during the time between the last pediatric visit and the initial adult visit; improvements in their transition process using Got Transition's Current Assessment of HCT Activities for pediatric practices and adult practices).
Direct Payment to Consumers
Provide a gift card for AYA to attend their last pediatric visit and initial adult visit.
Provide a gift card for AYA to complete a survey (e.g., Got Transition's Youth/Young Adult Feedback Survey) about their transition process or experience with care.

Per Member Per Month (PMPM)
Create a risk-adjusted monthly PMPM for the year prior to and after transfer to cover the added costs associated with preparing youth for transfer to adult care and integrating YA into adult care. This payment could be aligned with quality performance measures, such as experience with the transition process and/or primary care utilization. *(Note: see Table 7 for an example PMPM payment method.)*
Enhance PMPM care coordination payments for 18-30 year-olds still in pediatric care who need to transfer, linking payment to specific quality performance options, such as evidence of completion of initial adult visit.
Episode of Care/Bundled Payment
Create a transfer episode of care covering the year before and after transfer, with corresponding and coordinated pediatric and adult clinician responsibilities. A risk-stratified payment amount could be established with defined responsibilities for sending and receiving practices. Quality performance options could include not only costs but also adherence to care, medication adherence, and consumer experience.
Create a pediatric-to-adult joint transition visit code for use by pediatric and adult clinicians. Bundled activities could include the last face-to-face visit, communication with adult clinician and patient, preparation of transfer package, and confirmation of initial adult visit. Quality performance options could include evidence of shared transfer package received prior to initial adult visit, a transition experience survey, and avoidable ED visits and hospitalizations prior to the initial adult visit.

2. *What FFS options can be considered?*

Each year, Got Transition and the AAP release a Transition Coding and Payment Tip Sheet, which includes a list of transition-related CPT codes, their descriptions, Medicare payment rates, and a set of clinical vignettes to illustrate how certain codes can be used.[16] Table 6 lays out a HCT crosswalk to selected CPT codes where they exist.

Table 6. Crosswalk to CPT Codes

HCT Service	CPT Coding Options
Annual transition readiness assessment	Health risk assessment (96160)
Self-care skill-building as part of routine preventive and chronic care	E/M codes (99202-99205, 99211-99215) can be used for patients with chronic conditions. For those without chronic condition, no options exist.
Preparation/update of transition plan of care	Care plan oversight (99339, 99340), non-face-to-face prolonged services (99358, 99359), or care management services (99490, 99439, 99491, 99487, 99489, G2064, G2065)
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, G2065)
Outreach to transition-aged AYA not lost to follow-up	Care management services (99490, 99439, 99491, 99487, 99489)
Identification of adult clinicians	No options
Preparation of transfer package	Care plan oversight (99339, 99340), non-face-to-face prolonged services (99358, 99359), or care management services (99490, 99439, 99491, 99487, 99489, G2064, G2065)
Communication/consultation between pediatric and adult clinicians	Interprofessional telephone/internet/EHR consultation (99446-99449, 99451, 99452)

Tips

It is important to recognize that FFS is still a predominant method of payment and that many VBP options are built on an FFS foundation. Recognizing transition-related CPT codes is an important initial step, and oftentimes, a combination of VBP and FFS makes the most sense. To start, it can be useful to review your state's current Medicaid fee schedule to learn whether there are codes not currently recognized as well as

the fee level in comparison to Medicare fees. Next, it will be important to look at your own practice's coding and payment policies to evaluate gaps for HCT services in order to effectively advocate within your system and with payers. See here for a letter template to payers regarding recognition of HCT services. Early VBP strategies may also be different than subsequent strategies because transition processes are not yet in place in most systems. When you decide on your VBP methods, also decide how you will track the implementation both of the pilot intervention and the VBP (e.g., through claims data or an EHR registry).

Example

Table 7 shares an example of the payment method Texas' AmeriGroup is planning for their pilot with a Medicaid waiver population.

Table 7. Texas' AmeriGroup Payment Method

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 adult PCP and transferring patient (CPT 99214 with modifiers 95 and 77) @ $100 • 1 final office visits with established patients (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 new adult PCP following initial visit, if needed (CPT 99449) @ $50 • Comprehensive care management (G2065) @ $20/month X 12 months = $240

STEP 5. CHOOSING QUALITY METRICS

Issues and Strategies to Consider

1. *What relevant HCT measures are currently in use?*

With few exceptions, it is likely that no measures will be found. Still, it is important to pull together an inventory of measures in use to discover what opportunities might exist for improving HCT. It is also useful to refer back to the initial transition-aged population analysis (see Step 2 in this guide). This analysis will likely suggest opportunities for performance improvement (e.g., reductions of YA over age 22 seen by pediatric practices). You may also find that there are state-specific measures that have been developed to strengthen medical home capacity or care coordination or consumer experience. For example, payers or MCOs – in an effort to improve medical home capacity – may be offering bonuses if certain requirements are met. To such a list, it may be possible to add measures, such as follow-up for missed appointments, gaps in care, or referral tracking related to pediatric-to-adult transitional care. Payers and MCOs may also be incentivizing person-centered care planning, with measures pertaining to self-care supports and

individualized care planning. Again, incorporating transition readiness/self-care skills assessments and transition care plans would align well.

2. *What HCT measures options could be considered?*

Measuring whether pediatric and adult sites have an organized HCT process in place is important since research finds that with a structured process, positive outcomes result in terms of patient health and wellbeing, experience, and utilization.[4,5,6] Many quality improvement efforts undertaken by Got Transition and others have used either the Current Assessment of HCT Activities or the HCT Process Measurement Tool to set a baseline and measure improvements over time. Both tools are available for pediatric and adult providers on Got Transition's website here. It is also possible to use an EHR registry to examine the availability of a structured transition process as well as the receipt of recommended transition services in pediatric practices and adult practices, as well as in family medicine practices.

Different utilization measures important to HCT could also be considered. For example:

- % 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
- % of individuals, ages 18 and older, who transferred to adult care with access to their current medical summary and emergency care plan
- % of individuals, ages 18 and older, who kept their second appointment with their adult PCP

Measuring consumer experience with the HCT process can also reveal critical opportunities for improvement. It is possible, for example, to draw on questions asked in the National Survey of Children's Health and adding them to the CAHPS survey for parents of transition-aged youth. These questions are as follows:

1. Have your child's doctors or other health care providers (HCPs) talked with you about having this child eventually see doctors or other HCPs who treat adults?
2. Has this child's doctor or other HCP actively worked with this child to understand the changes in health care that happen at age 18?
3. Has this child's doctor or other HCP actively worked with this child to gain skills to manage his or her health care?
4. As his or her last doctor visit, did the child have a chance to speak with a doctor or other HCP privately, without you or another adult in the room?

Also, Got Transition has several tools that can be used or customized for use with AYA and/or parents and caregivers, as Florida's CMS Health Plan, operated by Sunshine Health, is doing (see example below).

Tips

Consider ways to involve information technology (IT) stakeholders early in the selection of VBP quality measures, especially given the limited functionality of most EHRs with respect to HCT. Also consider measures that are important to payers, clinicians, and transition-aged AYA/families alike and that represent an opportunity for improvement over time. Aligning these measures with incentive programs is very

important. Imagine, for example, creating a one-time only infrastructure payment for systems that incorporate specific HCT functionality – not unlike what was done in many states in their efforts to support medical home improvements. Or imagine creating a bonus pool with points for evidence of having a structured HCT process in place.

Example

Florida's CMS Health Plan, operated by Sunshine Health, is planning on using Got Transition's Current Assessment of HCT Activities with its pediatric and adult pilot practices. It also plans to request that patients in the pilot complete the Youth/Young Adult HCT Feedback Survey following the initial adult visit.

STEP 6. GETTING STARTED

Issues and Strategies to Consider

1. *What are the initial steps to launch a pilot?*

The initial step to starting a HCT intervention is to have leadership buy-in so all the members of the team are on the same page with regards to what success looks like and feel their leadership is supporting the HCT work. Bringing your HCT team together is the next important step. The membership of the team should be the major stakeholders of this process – that includes the pediatric and adult health care teams, parent and youth representatives, nursing and care management staff, along with IT experts. This team will choose the intervention tools and processes and create a change package for the practices involved. The change package is a guide that includes the timeline for the pilot, population of patients in the pilot, and the tools the team has decided to use along with the reporting and payment strategies agreed upon. An example of a pediatric change package from the HSCSN transfer pilot included the following: a transition policy letter, registry to keep track of the activities each patient will complete, a readiness assessment tool, the template for HCT plan of care for transition preparation, medical summary template, a transition check list and a summary of the new payment processes and expectations from each practice. A similar one was developed for the adult practices, including a welcome and care policy, a registry, tip sheet with Frequently Asked Questions (FAQs) to share with YA, HCT plan of care template, medical summary template, readiness assessment, tip sheet for the providers with sample content to cover in the initial visit, and feedback surveys for YA and clinicians.

Next the team should elicit feedback internally from the payer/plan, the pediatric and adult teams, and from transition-aged AYA and parent/caregivers. Once the process is outlined, consider how to engage pediatric and adult practices to join the first pilot and how best to interest the transition-aged AYA and parents/caregivers to be a part of this pilot, such as creating a flyer or sending a letter about the pilot for patients so they can see the extra attention they will receive during this transition time. The pediatric and adult practices will want to know in advance of the pilot the size and health needs of the patient population as well as the timetable for accomplishing the activities in the change package. To review steps on how to implement the Six Core Elements, see here.

Tips

To support pediatric and adult practices incorporating the new HCT processes into their practice, take advantage of any QI teams already available in their system or through the payer/MCO to help support this QI work. In addition, Got Transition has an Implementation Guide for each of the Six Core Elements. The

guides include sections on what to consider in developing the core element content and process as well as QI tools customized for each core element. In addition, the guides include sample tools from other health systems. The guides are all available on Got Transition's website here.

As you start the process, be sure regular meetings are scheduled with the initial oversight team and the practice teams participating in the pilot to ensure feedback on the progress of incorporating the HCT process into their practices and to discuss common problems, allowing for joint problem-solving of issues. A high-risk time for YA in the HCT process is the transfer, as many YA do not follow up with their new adult provider and become lost to follow-up. The team and the pilot sites should develop protocols/strategies on how to keep the YA engaged in their health care by outlining steps to be taken by both the pediatric and adult practice when YA do not attend. In addition, during the transfer time period, the YA has to come to several appointments, including the final pediatric visit and the first adult visit and, for YA with medical or social complexity, a joint visit either face-to-face or by telehealth with all three parties – the pediatric and adult practice, the YA, and their family if needed. Careful attention should be paid to how timely schedules can be arranged as efficiently as possible.

Example

Table 8 shares a sample workplan for an 18-month HCT pilot.

Table 8. HCT Quality Improvement Workplan and Tools for Pediatric and Adult Practices

Pediatric HCT QI Activities	Timetable	Tools
Form HCT Team 1. Identify QI team (e.g., pediatric clinician, practice manager, nurse care manager, practice manager, IT staff, YA/F representatives) 2. Establish connection with adult practice accepting transferring YA	Month 1	Implementation Guide
Project Start-Up 1. Participate in kick-off meeting of participating pediatric and adult practices to review project workplan, tracking and measurement, and regular QI meetings 2. Complete Got Transition's Current Assessment of HCT Activities to establish baseline on HCT implementation	Month 2	Current Assessment of HCT
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) 1. Transition planning (Core Element 4) 2. Transfer of care (Core Element 5) 3. Transfer completion (Core Element 6)	Months 2-3	Transition Planning Transfer of Care Transfer Completion
Identify & Invite Interested YA Patients 1. Create a simple tracking sheet to monitor receipt of HCT core elements 2. Invite pilot group, explaining timetable, added transition assistance, and participating adult practices	Months 4-5	Sample Registry
Start HCT Transfer Pilot 1. Complete final pediatric visit 2. Prepare and share medical summary 3. Joint Communication/Telehealth Visit, if requested/needed	Months 6-15	Sample Medical Summary Joint Telehealth Visit Toolkit
Project Ending 1. Complete Got Transition's Current Assessment of HCT activities to see improvements made and opportunities for continued improvements and sustainability 2. Review results from registry to look at receipt of core elements by pilot group 3. Review results from Y/YA HCT Feedback Surveys received from adult practices 4. Share your findings with other practices to encourage sustainability and spread	Month 18	Current Assessment of HCT Y/YA HCT Feedback Survey

Adult HCT QI Activities	Timetable	Tools
Form HCT Team 1. Identify QI team (eg, adult clinicians, practice manager, nurse care manager, practice manager, IT staff, YA/F representatives) 2. Establish connection with pediatric practice sending transferring YA	Month 1	Implementation Guide
Project Start-Up 1. Participate with pediatric and adult practices in kick-off meeting to review project workplan, tracking and measurement, and regular QI meetings 2. Complete Got Transition's Current Assessment of HCT Activities	Month 2	Current Assessment of HCT
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) 1. Orientation to adult practice (Core Element 3) 2. Integration into adult practice (Core Element 4) 3. Initial visits (Core Element 5)	Months 2-3	Orientation to Adult Practice Integration into Adult Practice Initial Visits
Learn about Number of YA Interested in Transferring to identify adult clinicians interested in seeing YAs	Months 4-5	
Start HCT Transfer Pilot 1. Joint communication/telehealth visit, if requested/needed 2. Review of medical summary 3. Complete initial adult visit 4. Have Y/YA anonymously complete HCT Feedback Survey (after initial adult visit)	Months 9-18	Joint Telehealth Visit Toolkit Y/YA Feedback Survey YA Feedback Survey
Project Ending 1. Complete Got Transition's Current Assessment of HCT Activities to see improvements made and assess opportunities for continued improvements and sustainability 2. Review results from registry to look at receipt of core elements by pilot group 3. Review results from Y/YA HCT Feedback Surveys 4. Share your lessons learned and findings to encourage sustainability and spread	Month 18	Current Assessment of HCT Y/YA Feedback Survey YA Feedback Survey

CONCLUSION AND LESSONS LEARNED

Payers have the opportunity to increase the percentage of youth with and without special health care needs receiving necessary HCT services by creating incentives for pediatric and adult practices to provide these services. This guide lays out steps to consider throughout the process of designing a VBP pilot for HCT.

The design of a VBP initiative takes a significant amount of time and upfront planning. The impact of a new pilot on a practice's current workflow and payment methods must be considered, keeping in mind the complexity of the intervention, the interconnecting roles of team members with and between pediatric and adult settings, the tracking and measurement requirements, and changes to coding and payment. Guidance from the practice's leadership on how best to align an HCT process within their system is crucial. Medicaid/MCO leaders are also critical members of the team who can help to identify avenues within the payer's current approach to VBP and their plans for the future.

From discussions with payers, it was clear that family engagement is essential in the process of designing an HCT intervention. Engage early on with AYA and family advocates who are members or part of advisory groups in the process of developing a VBP pilot.[17] It can also be very useful to partner with your state's Title V Program, many

of which selected HCT as a priority need in 2020.[18] A report published by Got Transition, *Health Care Transition in State Title V Programs: A Review of 2021 Block Grant Applications/2019 Annual Reports and Recommendations*, is a useful resource to learn if your state prioritizes HCT and if so, what strategies are in their action plan to increase receipt of HCT services.

Several factors associated with the COVID-19 pandemic have served as major barriers to the development of VBP pilots for HCT, including the disruption in in-person care, competing priorities, and financial insecurity. Still, payers were interested in learning about payment options for HCT, and those that we partnered with were receptive to modifying the HCT intervention activities to include virtual services – such as joint telehealth visits with the pediatric and adult providers and the AYA. Got Transition's joint telehealth toolkit includes information about suggested content that can be covered in a joint telehealth visit.[19]

Another limitation is the absence of examples of VBP HCT pilots. An important motivator for payers to implement VBP is data that show a positive return on investment. While studies have shown that HCT is associated with improvements in population health, patient experience, and health care utilization, studies have not focused on cost of care as an outcome.[4,5,6]

This guide provides a foundation for payers and MCOs to use when designing a transitional care VBP pilot. The field is still young, but the payers and MCOs we have been partnering with are paving the way for others by designing innovative methods to finance and measure quality of HCT interventions.

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