

*THE NATIONAL ALLIANCE
TO ADVANCE ADOLESCENT HEALTH*

RECOMMENDATIONS FOR VALUE-BASED TRANSITION PAYMENT FOR PEDIATRIC AND ADULT HEALTH CARE SYSTEMS: A LEADERSHIP ROUNDTABLE REPORT

Margaret McManus, MHS
Patience White, MD, MA
Annie Schmidt, MPH

September 2018

Funded by the Lucile Packard Foundation for Children's Health



TRANSITION PAYMENT ROUNDTABLE PARTICIPANTS

Ellen Albritton

Senior Policy Analyst
Families USA
Washington, DC

Charles Barone, MD

Chair, Department of Pediatrics
Henry Ford Medical Center
Detroit, MI

Joel Bradley, MD

Chief Medical Officer
United Healthcare Community Plan of
Tennessee
Member, American Academy of Pediatrics
Committee on Coding and Nomenclature
Nashville, TN

Melissa Cohen, JD, MPA

Staff Vice President, Payment Innovation
Strategy
Anthem, Inc.
Washington, DC

Barbara Cohoon, PhD, MSN, RN

Clinical Strategy Director
UnitedHealthcare Special Needs Initiative
Washington, DC

Margaret Comeau, MHA

Senior Project Director, Center for
Advancing Health Policy and Practice
Co-Principal Investigator, Catalyst Center
Boston University School of Public Health
Boston, MA

Eliot Fishman, PhD

Senior Director of Health Policy
Families USA
Washington, DC

Denise Giambalvo, MHRM

Vice President
Midwest Business Group on Health
Chicago, IL

Holly Henry, PhD, MHS

Research Program Manager
Lucile Packard Foundation for Children's
Health
Director, California Community Care
Coordination Collaborative
Palo Alto, CA

Charles Hetterich, CPA, MBA

Director, Payer Contracting and
Reimbursement
University of Rochester Medical Center
Rochester, NY

Terri Hickam, MSW, LCSW, LSCSW, CCM

Transition Program Manager
Children's Mercy Hospital
Kansas City, MO

Mark Hudak, MD

Professor and Chair, Department of
Pediatrics
University of Florida College of Medicine
Chair, AAP Committee on Child Health
Financing
Jacksonville, FL

Tisa Johnson-Hooper, MD

Senior Staff Physician
Medical Director, Center for Autism and
Developmental Disabilities
Henry Ford Medical Center
Detroit, MI

Jennifer Kyle, RN, MA
Senior Director, Product Development
UnitedHealthcare Special Needs Initiative
Minnetonka, MN

Carolyn Langer, MD, JD, MPH
Senior Vice President/Chief Medical Officer
Fallon Health
Previously Chief Medical Officer of
MassHealth
Boston, MA

Marie Mann, MD, MPH
Acting Deputy Director, Division of
Services for Children with Special
Health Needs
Maternal and Child Health Bureau
Health Resources and Services
Administration
Rockville, MD

John McCarthy, MPA
Founding Partner
Speire Healthcare Strategies
Columbus, OH

Tricia McGinnis, MPP, MPH
Senior Vice President
Center for Health Care Strategies
Hamilton, NJ

Ann Modrcin, MD, EMBA
Medical Director, Transitions to Adult Care
Program
Director, Division of Rehabilitation
Children's Mercy Hospital
Kansas City, MO

Sterling Ransone, Jr., MD, MS
Member, Board of Directors of the
American Academy of Family
Physicians
Assistant Clinical Professor, Virginia
Commonwealth University
Richmond, VA

Matt Roan
Principal
Health Management Associates
Harrisburg, PA

Brett Robbins, MD
Chief, Adolescent Medicine
Director, Med-Peds Residency Program
Professor, Departments of Medicine and
Pediatrics
University of Rochester Medical School
Rochester, NY

Gregg Talente, MD, MS
Clinical Professor, Medicine and Pediatrics
Program Director, Primary Care Internal
Medicine Residency
University of South Carolina School of
Medicine
Columbia, SC

Joseph Zickafoose, MD, MS
Senior Researcher
Mathematica Policy Research
Vanderbilt University Medical Center
Nashville, TN

We also acknowledge the expert guidance from Michael Barr, MD, MBA; Henry Ireys, PhD; David Kanter, MD, MBA; and Lou Terranova, MS. Their input prior to the meeting greatly enhanced the organization and content of the meeting and report.

TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
Background.....	1
Methods.....	1
Recommendations.....	1
Conclusion	3
INTRODUCTION	4
BACKGROUND	4
Pediatric-to-Adult Transition Clinical Foundations and Recommended Process.....	4
Evidence of Effectiveness of Structured Transition Interventions	5
Transitional Care Needs and Gaps.....	6
Key Informant Interview Findings.....	7
DISCUSSION AND PRIORITIZATION OF VALUE-BASED TRANSITION PAYMENT OPTIONS.....	8
1. Enhanced Fee-for-Service (FFS) Payment	10
2. Infrastructure Investments	11
3. Pay-for-Performance (P4P).....	12
4. Direct Payment to Consumers	13
5. Episode of Care/Bundled Payment	13
6. Per Member Per Month (PMPM)	15
DISCUSSION AND PRIORITIZATION OF TRANSITION QUALITY PERFORMANCE MEASURES	16
Population Health.....	17
Experience of Care.....	18
Utilization/Cost of Care	19
CONCLUSION AND DISSEMINATION OPPORTUNITIES.....	21
REFERENCES	23
APPENDIX A: TRANSITION PAYMENT KEY INFORMANTS	25

EXECUTIVE SUMMARY

Background

Currently, 61 million people, or 19% of the United States population, are between the ages of 12 and 26.¹ This is a critical transitional period of development for those with and without chronic conditions. During this period, to the best of their abilities, adolescents and young adults need to gain experience and skills to independently manage their own health and effectively use health services. This is best accomplished when there is an organized process in both pediatric and adult practices to ensure a gradual and continuous emphasis on health literacy and self-care skills, a planned movement from a pediatric to an adult model of care, and careful integration and retention in adult care. Yet, data from the 2016 National Survey of Children's Health reveal that 85% of youth are not receiving transition assistance from their health care providers.² The literature is replete with examples of adverse impacts when a structured transition process is not in place, particularly for those with chronic conditions that includes low health care literacy, gaps in access and use of ambulatory care, worsening health conditions, dissatisfaction and worry, and preventable emergency room visits and hospitalizations.³

Methods

In May 2018, a roundtable on value-based payment (VBP) for pediatric-to-adult transition services was held by The National Alliance to Advance Adolescent Health and funded by the Lucile Packard Foundation for Children's Health. Roundtable participants represented commercial and Medicaid payers, health plan and clinical leaders, professional organization representatives, consultants and researchers, family advocacy leaders, and foundation and federal officials. Through facilitated discussions and priority ranking, the 24 roundtable participants rated six VBP options and selected among several quality measures in the triple aim domains of population health, experience, and costs of care. Prior to the roundtable, The National Alliance project team conducted 65 key informant interviews with major stakeholder groups using a semi-structured interview format to identify: alternative payment options, possible quality measures, priority populations for initial transition pilots, and the alignment with current delivery and payment reforms. Extensive reading on Center for Medicare and Medicaid Innovation (CMMI), state, and commercial payment innovations and evaluations also informed this report. Quality measures were identified from two systematic reviews on transition measures and evaluation studies, Centers for Medicare and Medicaid Services' (CMS) Child Core Measure Set, Healthcare Effectiveness Data and Information Set (HEDIS), and the National Quality Forum. The results and recommendations from the roundtable and key informant deliberations are presented in this report.

Recommendations

1. Payment incentives are critically needed in both pediatric and adult practices/systems to accelerate improvements in transitional care.
2. Medicaid and commercial payers are encouraged to implement transition VBP pilots, which initially could start with youth and young adults with chronic conditions and focus on the transfer period. Since most pediatric and adult care delivery systems do not have

structured or coordinated transition processes in place, early VBP pilots may be different from subsequent efforts.

3. At the outset, payer recognition of transition-related CPT codes⁴ is an important step since many VBP options are built on an enhanced fee-for service (FFS) foundation.
4. Proactive identification of adult primary, specialty, and behavioral care providers to care for young adults is needed, particularly for those with childhood-onset conditions, intellectual/developmental disabilities, and behavioral health conditions, with available pediatric consultation to ensure continuity of care.
5. Recognizing the variety of insurance markets and range of payment reforms underway across the country, roundtable participants stressed the need to include several VBP options from which to choose the best option for their system. Using a priority ranking method that considered importance, usability, acceptability, and feasibility, roundtable participants selected the following VBP transition payment options in rank order and offered several different examples of how each option could be structured.
 - a. *Enhanced fee-for-service (FFS) payments.* Two examples are: a) using higher fees for evaluation and management services for the purpose of incentivizing adult practices to accept a certain volume of young adults with chronic conditions, and b) paying a higher fee for care plan oversight services for pediatric practices to ensure the preparation of a current medical summary, a plan of care with health care transition (HCT) information, and communication with the receiving adult practice.
 - b. *Infrastructure payments.* Two examples are: a) making an up-front investment to upgrade electronic medical records (EMRs) to incorporate recommended transition clinical processes in pediatric and adult practices/systems, and b) supporting training and quality improvement efforts to implement recommended transition clinic processes as part of routine pediatric and adult care.
 - c. *Pay-for-performance (P4P) payments.* Two examples are: a) rewarding collaborating pediatric and adult practices for transfer of young adult patients who have reduced preventable emergency room and hospital visits during the time between the last pediatric visit and the initial adult visit, and b) structuring incentive payments for pediatric and adult practices that achieve specific transition quality performance targets, such as evidence of having a transition process in place.
 - d. *Direct payment to consumers.* (This option could be structured as a supplement to other VBP payment options.) Two examples are: a) providing an incentive (e.g., a gift card) for youth and young adults to attend their preventive or chronic care appointment(s) to plan for transfer, and b) providing an incentive for young adults to attend their initial adult visit(s), and possibly subsequent visits.
 - e. *Episode of care/bundled payments.* Two examples are: a) creating a transfer episode of care covering the year before and after transfer with assigned primary pediatric and adult accountable providers, who could be measured on the lowest average per episode cost compared to peers and rewarded with bonus payments, while those with the highest costs could have penalties imposed, and b) creating a

pediatric-to-adult ambulatory transition code (modeled after the hospital-to-home transition care management code) for use by pediatric and adult clinicians. Bundled activities could include the last pediatric/initial adult office visit, communication between pediatric/adult clinician/patient, preparation/review of transfer package, and confirmation of initial visit/welcome and orientation to adult care.

- f. *Per member per month (PMPM) payments.* Two examples are: a) creating a risk-adjusted monthly capitation for a defined period prior to transfer to cover the added costs associated with preparing youth for transfer to adult care and aligned with quality measures, such as consumer experience with the transition process, and b) creating a risk-adjusted monthly capitation for a defined period following transfer to cover the added costs associated with integrating and retaining young adults in adult care and aligned with quality measures, such as ambulatory visits.
6. Roundtable participants also prioritized, by importance and feasibility, quality measures that could be coupled with VBP strategies. The group acknowledged that given the early stage of pediatric-to-adult transition implementation, process measures may be initially selected, but outcome measures are preferred over the long term.
 - a. *Population Health Quality Measures.* The most important population health measures selected were transitional care process, social determinants of health, patient-reported health outcomes, and shared plan of care. The most feasible measures were disease-specific measures, medication reconciliation, and meaningful use requirements.
 - b. *Experience of Care Quality Measures.* The most important experience of care measure selected was consumer experience with the transition process. The most feasible measure was consumer experience with care, which can be measured using specific domains from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) (which are not specific to transition).
 - c. *Utilization/Cost Quality Measures.* The most important utilization/cost measures selected were time between last pediatric visit and initial adult visit, emergency room/urgent care visits, and preventive/primary care visits in the adult care setting. The most feasible measures were similar – emergency room/urgent care visits, preventive/primary care in the adult care setting, and hospital visits/readmissions.

Conclusion

This report is intended to guide commercial and Medicaid payers, health plans, employers, and pediatric and adult systems of care in implementing and evaluating VBP options for transition-aged youth and young adults. New VBP payment efforts have the potential to make evidence-based approaches to pediatric-to-adult transitional care more sustainable, with the promise of better outcomes; greater satisfaction for youth, young adults, and families; and lower costs for the health care system.

INTRODUCTION

On May 8, 2018, The National Alliance to Advance Adolescent Health hosted a one-day roundtable on value-based payment (VBP) for pediatric-to-adult health care transition (HCT) services. The Lucile Packard Foundation for Children's Health funded this effort. The 24 invited roundtable participants represented a diverse group of stakeholders, including payers from commercial and Medicaid agencies, health plan leaders, professional association officials and clinicians, consultants and researchers, foundation and federal officials, and family advocacy leaders.

The goals for the transition payment roundtable were twofold: 1) to prioritize payment strategies and associated quality performance measurement options, and 2) to identify opportunities for piloting and dissemination. The day-long meeting included facilitated discussions and priority ranking of specific transition payment and quality measurement options. This report summarizes the recommendations on VBP payment and quality measures for pediatric-to-adult transitional care from the roundtable participants, as well as suggestions from 65 key informant interviews conducted prior to the meeting, and a set of dissemination opportunities. This report also includes background information on the clinical foundations for transitional care, evidence of effectiveness for structured transition interventions, and transitional care needs and gaps.

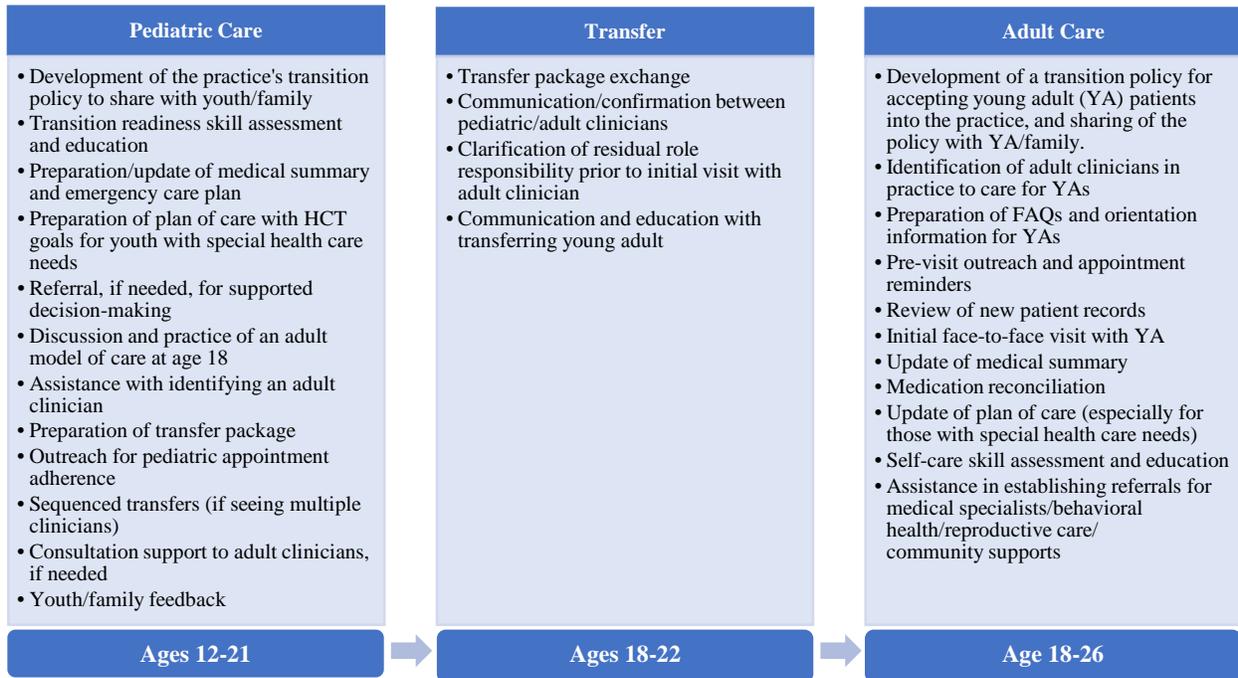
BACKGROUND

Pediatric-to-Adult Transition Clinical Foundations and Recommended Process

In 2011, the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Physicians (ACP) jointly published a clinical report on HCT.⁵ This clinical report represents professional consensus on the practice-based implementation of transition for all youth, starting in early adolescence and continuing into young adulthood. Using an age-based algorithm, the clinical report defines a set of sequential steps that include preparation of an office transition policy; a transition plan jointly developed with youth and families; a transition readiness/self-care skill assessment conducted periodically; preparation for an adult model of care with discussion of privacy and consent, a medical summary shared with youth and families and, if needed, referrals for decision-making support; assistance with identifying an adult clinician and preparation of a transfer package; confirmation of transfer and consumer feedback; and facilitated integration into adult care. An updated clinical report will be published in *Pediatrics* in October 2018.⁶

The 2011 clinical report was subsequently translated into the Six Core Elements of Health Care Transition in 2011 and updated by Got Transition in 2014,⁷ following a series of quality improvement learning collaboratives that demonstrated the effectiveness of this planned transition process in pediatric, family medicine, and internal medicine practices.⁸ The Six Core Elements, with sample customizable tools and measurement resources, are increasingly being used in primary and specialty care systems. Figure 1 displays the recommended practice-based process for transition planning, transfer, and integration into adult care.

Figure 1. Pediatric-to-Adult Transitional Care Process



Evidence of Effectiveness of Structured Transition Interventions

A systematic review of pediatric-to-adult transition evaluations, conducted between 1995 and 2016, found 43 studies that met rigorous inclusion criteria.³ Significant positive impacts of a structured HCT intervention were found in the triple aim domains of population health, experience of care, and health care utilization for youth and young adults with chronic conditions. With respect to population health, transition evaluation studies found greater adherence to care, improved patient-reported health and quality of life, greater self-care skills, and lower mortality. With respect to experience of care, evaluation studies found increased satisfaction with the transition and transfer process. With respect to utilization, evaluation studies found an increase in adult ambulatory visit rates, a decrease in time between the last pediatric visit and the initial adult care visit, and a reduction in emergency room visits and hospital admissions and lengths of stay.

Since publication of the systematic review, two studies, one in the United States and one in Australia, found cost reductions. Geisinger Health System reported that their transition care coordination intervention, designed for a medically complex Medicaid population, resulted in a 28% reduction in per member per month costs (\$3,931 vs \$5,450), driven by reductions in hospitalization and emergency department visits.⁹ A study in western Sydney reported an \$130,500 in hospital savings in a single year, after accounting for staff time to implement transition services for youth and young adults with Type 1 diabetes mellitus. The savings were attributed to decreased hospital admissions and lengths of stay.¹⁰

Transitional Care Needs and Gaps

The ages between 12 and 26 represent the transition age period, an essential period of development for all youth and young adults with or without chronic conditions. This is the time when youth begin to assume increasing responsibility for their own health and health care and eventually move from pediatric to adult-centered care.¹¹ Nineteen percent, or 61 million people, of the US population are between 12 and 26.¹

Among this transition-aged group, 25-30% have one or more chronic conditions.^{12, 13} Over the last several decades, due to advances in pediatric care and early identification efforts, there has been a dramatic increase in the number of youth with childhood-onset chronic conditions living into adulthood, with important implications for the adult health care system. As a result, there is a surge of young adults with chronic conditions entering adult health care offices, emergency rooms, and hospitals. There is also an overflow of young adults with chronic conditions backed up in pediatric specialty clinics and hospital complex care clinics without identified adult practices and hospitals to receive them.

According to the 2016 National Survey of Children's Health, 85% of youth with and without chronic conditions report not receiving transition planning support from their health care providers.² This lack of planned transition support often results in youth having limited knowledge of their own condition; lack of independent experiences making their own appointments, arranging for referrals, and using health insurance; difficulties identifying adult clinicians; and preventable complications and lapses in care.

The following examples of young adults with diabetes, sickle cell disease, and congenital heart disease highlight the need for a structured transition process.

- *Diabetes.* In a 2015 systematic literature review of transitional care for youth with Type 1 diabetes, studies found that the average gap in care among this population increases to 4.6 +/- 1.2 years without a structured transition program compared to 0.8 +/- 0.6 years with a structured transition. Type 1 diabetic patients disconnected from adult care experience an increased incidence of acute and chronic disease complications.¹⁴
- *Sickle cell disease.* Data from eight states showed that individuals ages 18-30 who did not receive a structured transition process had significantly higher acute care utilization rates compared to children ages 10-17 (3.61 visits vs 2.0 visits/patient/year). The 30-day readmission rate doubled from 27.4 to 48.9% respectively.¹⁵
- *Congenital heart disease.* In 12 centers across the US, 42% of young adults with congenital heart disease who did not receive a structured transition process experienced gaps in care of more than three years, including 26% of young adults with severely complex diseases. The first gap in care tended to occur during the transitional ages of young adulthood. Congenital heart disease patients with care gaps have three times greater likelihood of requiring urgent interventions.¹⁶

“Health transitions are an integral part of adolescent and young adult development and, as such, occur alongside, and in connection with, a range of other important transitions that affect many other areas of life.”
– Albert Farre, PhD, University of Birmingham, and Janet McDonagh, MD, University of Manchester¹¹

Key Informant Interview Findings

To inform the transition payment roundtable meeting, 65 key informant interviews were conducted between October 2017 and May 2018 with senior officials from the Centers for Medicare and Medicaid Services (CMS), state Medicaid agencies, commercial payers, health plans, employer coalitions, professional organizations, children's hospitals, academic and policy groups, and patient and family advocacy organizations (Appendix 1). Project staff queried key informants about alternative payment options for transition, possible quality measures, selection of priority populations for initial transition pilots, and preferred alignment with current delivery system and financing directions. The following observations and suggestions were made by key informants.

- Current delivery system and payment reforms mostly focus on high-cost adults, not children. Those that do focus on children are often directed at medically complex children. No payment reform efforts were identified pertaining to pediatric-to-adult transitional care.
- Transitional care efforts will likely have the greatest uptake if aligned with reforms related to primary care, accountable care organizations (ACOs), care coordination/chronic care management, and population health.
- To gain interest among payers, transitional care efforts should start with youth and young adults with chronic conditions identified either by condition group, by Medicaid program eligibility category (e.g., SSI, foster care, waiver), or by medical or behavioral complexity. Also, early efforts should start with youth likely to maintain eligibility with the same insurer as they transition to adulthood, such as Medicaid-insured youth on SSI living in a state with Medicaid expansion or commercially insured youth with chronic conditions likely to maintain dependent coverage until age 26. There will be more of an incentive for payers to cover HCT services for youth who are likely to remain under their plan after transfer, as opposed to youth likely to switch coverage.
- Initial transitional care pilots should focus on the transfer period. Still, a comprehensive approach for pediatric-to-adult transition is more than managing a smooth transfer. It involves the additional work related to transition preparation that occurs in pediatric practice settings and the added work related to integration into adult care that occurs in adult practice settings. (See Figure 1.)
- To control skyrocketing health care spending, public and commercial payers are rapidly implementing VBP options and moving away from traditional FFS. Six VBP payment options were suggested: 1) infrastructure investments, 2) enhanced fee-for-service (FFS), 3) pay-for-performance (P4P), 4) episodes of care/bundled payment, 5) per member per month (PMPM) payment, and 6) direct payment to consumers. The latter option could be used in combination with other strategies, but on its own was not thought likely to achieve intended transition improvements. Since payment reforms vary so much by market area, transition payment options should be broad.
- Process and outcome quality measures were discussed as part of VBP payment strategies. Key informants acknowledged their preference for selecting outcome versus process measures (though process measures will be necessary in the early stages of implementing a new payment strategy), for using existing quality measures, and for reducing administrative burden.

DISCUSSION AND PRIORITIZATION OF VALUE-BASED TRANSITION PAYMENT OPTIONS

Roundtable participants discussed six VBP options for transitional care: infrastructure investments, enhanced FFS, P4P, episodes of care/bundled payment, PMPM, and direct payment to consumers. Several key issues were raised by roundtable participants.

- Adjustment for social determinants and medical/behavioral health complexity is a critical concern and often not fully captured in current claims-based data systems.
- Early VBP strategies may be different than subsequent strategies because transition processes are not yet in place in most systems.
- Since many VBP options are built on a FFS foundation, payer recognition of transition-related CPT codes an important initial step.⁴
- Shortages of adult primary and specialty care providers represent a major barrier for youth/young adults and families as well as their pediatric providers seeking to transfer their patients.
- Lack of interoperability of various electronic medical record (EMR) systems in pediatric-sending and adult-receiving practices is problematic.
- There may be less of an incentive for payers to invest in a payment model if the transitioning youth will be switching insurance plans (e.g., aging out of Medicaid coverage or their parent's insurance plan) before the potential benefits of HCT are realized.

Following the discussion, roundtable participants were asked to review and then prioritize the six payment options. The criteria used to evaluate transitional care payment options were adapted from the National Quality Forum's Measure Evaluation Criteria.¹⁷ Each participant submitted a written ranking of the six payment options in terms of an *overall* ranking as well as an *importance* ranking (defined as having a high impact on transition performance), an *acceptability* ranking (defined as producing consistent and credible transition results), a *usability* ranking (defined in terms of potential audiences using the results for transition accountability and performance improvement), and a *feasibility* ranking (defined as implementable). Roundtable participants ranked their top two (#1 and #2) payment options and their bottom two (#5 and #6) payment options using these evaluation criteria. A score of 3.5 was given to each unranked option. Table 1 displays the average ranking from the 24 roundtable participants. Following this table is a summary of the results and a detailed review of each payment option with examples of how each could be structured. Following this section, the prioritization results for quality performance options that could be linked with VBP options are discussed.

Table 1. Prioritization of Transition Payment Options by Roundtable Participants

Payment Strategy	Overall	Importance	Acceptability	Usability	Feasibility
Enhanced FFS	1.89	2.22	1.70	2.25	1.50
Infrastructure Investment	2.62	2.33	2.39	2.89	3.15
P4P	3.09	2.83	3.37	3.07	3.35
Direct Payment to Consumers	4.11	4.67	3.74	3.80	3.76
Episode of Care/ Bundled Payment	4.43	4.17	5.20	4.57	5.02
PMPM	4.45	4.54	4.43	4.43	4.28

The prioritization results shown in Table 1 display participants’ ranking overall and according to each of the four evaluation criteria (importance, acceptability, usability, and feasibility). The lower the score, the higher the priority. The top three transition payment options were enhanced FFS, infrastructure investments, and P4P, which were ranked consistently as the top three choices for each of the evaluation criteria. The bottom three payment options, which varied somewhat by evaluation criteria, were direct payment to consumers, episode of care/bundled payment, and PMPM.

Overall prioritization results differed little by professional affiliation, as shown in Table 2. Payers, professional association officials/clinicians, and foundation/federal/advocacy leaders agreed on their top three choices: enhanced FFS, infrastructure investments, and P4P. Consultants and researchers selected as their top two choices P4P and enhanced FFS, and episode of care/bundled payment and direct payment received a tie vote for third.

Table 2. Prioritization of Transition Payment Options by Professional Affiliation

Professional Affiliation	Ranking of Transition Payment Options	
Payers	1. Enhanced FFS 2. P4P 3. Infrastructure investment	4. Direct payment 5. PMPM 6. Episode of care/ bundled payment
Professional Association Officials/Clinicians	1. Enhanced FFS 2. Infrastructure investment 3. P4P	4. Direct payment 5. Episode of care/ bundled payment 6. PMPM
Consultants/Researchers	1. P4P 2. Enhanced FFS 3. Episode of care/ bundled payment [†]	3. Direct payment [†] 5. Infrastructure investment 6. PMPM
Foundation/Federal/ Advocacy Leaders	1. Infrastructure investment 2. Enhanced FFS 3. P4P	4. PMPM 5. Episode of care/ bundled payment 6. Direct Payment

[†] = tie

The following six payment options are presented by overall prioritization order, with descriptions of how each option could be structured and specific implementation issues raised by roundtable participants and key informants.

1. Enhanced Fee-for-Service (FFS) Payment

Enhanced FFS payment arrangements are built on a traditional FFS/RVU (relative value units) architecture, with payment amounts positively adjusted for selected codes. Roundtable participants ranked enhanced FFS payment as their first choice overall and also as their first priority in terms of importance, acceptability, usability, and feasibility.

Enhanced FFS payments for transitional care could be structured in a variety of ways, listed below.

- Use a higher fee/RVU for evaluation and management services for the purpose of incentivizing adult practices to accept a certain volume of young adults with chronic conditions.
- Pay a higher fee for care plan oversight services for pediatric practices to ensure the preparation of current medical summary, plan of care with transition information, and communication with adult clinicians.
- Recognize transition-related CPT codes⁴ for clinicians who have established a formal collaboration between pediatric and adult practices/systems.
- Allow both pediatric and adult primary care and specialty clinicians to bill for the same patient for a limited period of time before and after transfer to ensure continuity of care and avoid emergency room and hospital use.
- Pay an enhanced fee if both pediatric and adult practices/systems have established a structured transition process with evidence of communication/consultation, exchange of a medical summary, and a care plan for transferred patients.
- Create a set of CPT Category II transition codes (i.e., supplemental tracking codes) paid at a higher level that align with transition quality performance.

“In a fee-for-service world, it is very challenging to get physicians to adopt new behaviors unless they’re going to get reimbursed. On the other hand, sometimes you do see some very interesting halo effects. We started reimbursing for developmental screening on the Medicaid side. It wasn’t a lot but then again it wasn’t a huge burden on the practices. What we did see, which was very encouraging, is that once they started doing this for the Medicaid population, they automatically administered these screenings for the commercial population without necessarily any reimbursement from the payers.” – Carolyn Langer, MD, JD, MPH, Fallon Health

Implementation Issues: It is important to have FFS options that both pediatric and adult clinicians can operationalize. An enhanced FFS stimulates greater uptake of services that payers want to have utilized, such as preventive care services. Providing transitional care for patients with chronic conditions requires extra time and greater practice costs.

Clinicians contribute a higher level of cognitive management, including non-face-to-face coordination services, as well. The extra time and cost can be disincentives that may influence clinicians' behavior and discourage them from providing HCT services on the pediatric side and accepting new young adult patients on the adult care side. An enhanced FFS that paid for the extra costs of transition would act to counter these barriers. One could consider piloting an enhanced fee option with a children's hospital that partners with an adult system of care or federally qualified health center to facilitate transition of patients into adult practices with available pediatric consultation support, as needed. For both individual clinicians and systems, it is important to avoid administrative burden while ensuring program integrity protections. Also, since many transition-related codes have not been recognized, it is unclear what the expected costs to payers might be.

2. *Infrastructure Investments*

Infrastructure payments are investments that seek to generate fundamental change at the practice and systems levels. Infrastructure investments aim to support a practice/system as it undergoes an operational change, such as upgrading a health care system's EMR.

Roundtable participants, including professional and clinical leaders, prioritized infrastructure payments as their second choice overall and also in terms of importance, acceptability, usability, and feasibility.

Infrastructure payments could be structured in a variety of ways, listed below.

- Upgrade EMRs to incorporate recommended transition clinical processes in pediatric and adult practices/systems.
- Provide continuous outreach and identification of the adult primary and specialty care workforce to care for young adults with chronic conditions, especially those with intellectual/developmental conditions, behavioral health conditions, and childhood-onset conditions.
- Support the development of collaborative pediatric and adult clinical networks.
- Participate in training and quality improvement efforts to implement recommended transition clinic processes in pediatric and adult practices/systems.
- Develop pediatric specialty consultation arrangements with adult clinicians/systems.
- Build care coordination supports for adult practices accepting young adults with chronic conditions.
- Provide quality oversight and monitoring of the HCT process in both pediatric and adult settings.

“If you want to connect the pediatric universe to the adult care universe, you need to have some way to talk to each other because if you don't, we are not going to be able to transition these kids.” – Sterling Ransone, Jr., MD, MS, Virginia Commonwealth University

Implementation Issues: Since most ACOs, primary care practices, specialty clinics, and hospitals have no structured transition process, upfront infrastructure investments are important at the outset to stimulate a planned and sustainable transition process. Conducting pilots would enable systems to learn the cost of infrastructure investments. There are limited private/commercial funding options available for HCT infrastructure improvements, and the future of Center for Medicare and Medicaid Innovation (CMMI) infrastructure investments is unclear. Still, several federal authorities (e.g., waivers and state plan amendments) may be useful in restructuring Medicaid health care delivery or payment.¹⁸ For example, states can specify pediatric-to-adult HCT as a covered comprehensive transitional care service within the Health Home benefit.

3. *Pay-for-Performance (P4P)*

A P4P strategy rewards providers based on their performance on selected quality measures. Roundtable participants prioritized P4P as their third choice, and scored it consistently as third highest in importance, acceptability, usability, and feasibility.

P4P could be structured in a variety of ways, listed below.

- Reward pediatric clinicians/practices who transfer their patients with a current medical summary/plan of care and evidence of communication with new adult clinicians/practices. Similarly, reward adult clinicians/practices with evidence of communication with previous pediatric clinician, a timely appointment for their new young adult patients, and pre-visit calls/text appointment reminders.
- Reward pediatric and adult clinicians/practices/systems who achieve specific transition quality performance targets.
- Reward pediatric and adult practices who show evidence of improvement in their transition process using Got Transition's [Current Assessment of Health Care Transition Activities](#), available on Got Transition's website (gottransition.org).
- Reward pediatric practices who reconnect their 16-18 year-old patients who have not made a primary or preventive visit in 2 years or longer and initiate a planned transfer process, with evidence of preventive and primary care visits in the current year, an updated medical summary, and assistance in identifying an adult clinician.
- Reward adult practices who are able to reconnect new young adult patients who have made their initial appointment but failed to make any follow-up visits, with evidence of preventive and primary care visit in subsequent year, and referral follow-up (if needed) for other medical/behavioral/reproductive/community services.
- Reward collaborating pediatric and adult practices for transfer of patients who have reduced preventable emergency room and hospitalization visits during the time between the last pediatric visit and the initial adult visit.

Implementation Issues: It is important for P4P options to be time-limited and clearly linked to outcomes that are measurable in claims data or EMR systems. Also, P4P is often adjusted according to risk, which can be trickier for a young adult population. On the one hand, payers may not want to disadvantage a practice with young adult patients with whom they have had greater follow-up challenges. On the other hand, adjusting

away these challenges may decrease incentives for practices to address them. The small population of transferring youth within a practice may be a barrier if the payment for a limited number of patients is an insufficient incentive for clinicians; a possible approach is to utilize a measure that is generalizable across a larger population, such as experience of care (e.g., the Consumer Assessment of Healthcare Providers and Systems (CAHPS) or measures applicable to the geriatric population transitioning between health care settings. P4P options that support shared accountability between pediatric and adult practice are noteworthy, but implementation challenges can be anticipated because the two systems have not historically worked together.

4. Direct Payment to Consumers

Health plans may offer direct payments or financial incentives to consumers in order to encourage youth and young adults to attend their health care visits or adhere to recommended treatment. Roundtable participants prioritized the direct payment option as their fourth choice but did not score it consistently across the other four criteria. Participants noted that this payment option could be structured as a supplement to other payment options.

Direct payments to consumers could be structured in a variety of ways, listed below.

- Provide an incentive (e.g., a gift card) for youth and young adults to attend their preventive/primary/chronic care appointments to plan for transfer.
- Provide an incentive for young adults to attend their initial and, possibly also, subsequent adult visit.
- Provide an incentive for youth and young adults to adhere to care and medication recommendations.
- Provide an incentive for youth and young adults to complete a survey about their transition process or experience with care.

Implementation Issues: Several state Medicaid agencies have had positive effects with using financial incentives for youth to make an annual preventive care visit.^{19, 20} This could be structured in a variety of ways (e.g., gift cards), based on what youth and young adults suggest would be preferential. To select effective incentives, it is important to obtain input from youth and young adults. Incentives do not necessarily need to be financial. Other options, such as gamification strategies (e.g., through apps or other devices) can be used to engage youth and young adults and encourage a planned transition, transfer, and integration into adult care. Financial or other incentives for the parents/caregivers can be considered, as well.

5. Episode of Care/Bundled Payment

Within an episode of care or bundle of services, payment is linked to the provision of a defined set of services to address a specific health issue over a given period of time. In the case of transitional care, the transfer to adult care could be the triggering event, and the last two pediatric visits and the initial two adult care visits could be included as part of the transfer episode of care. Overall, episode of care/bundled payment and PMPM were scored very closely, as shown in Table 1, though episode of care/bundled payment received a slightly higher ranking.

Specific ideas for structuring an episode of care/bundled payment are listed below.

- Modeled after the CPT code for hospital-to-home transitional care management services (99495, 99496) code, create a similar pediatric-to-adult ambulatory transition care management code (or episode of care) for use by the adult receiving clinician for the care of a group of new young adult patients with moderate-to-high complexity. These bundled activities could include a face-to-face visit, communication between pediatric clinician and patient, education to support self-care, assessment of treatment and medication management, identification of community resources, referrals, and scheduling follow-up. This payment approach could be linked to a timely initial primary care appointment (in less than 6 months), medication reconciliation, preparation of an updated medical summary/plan of care, and consumer experience survey. State Medicaid agencies could consider this code and the one below.
- Create a pediatric-to-adult ambulatory transition care management code for use by pediatric and 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, a transition experience survey, and avoidable emergency room and hospitalizations prior to the initial adult visit.
- 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 transfer episode of care covering the year before and after transfer and name the primary pediatric and adult accountable providers. These providers could be measured on average per episode costs; those with the lowest costs, compared to peers, could be rewarded with bonus payments, while those with the highest costs could have penalties imposed.

“Bundles are challenging because they need to be very detailed and defined: the starting point, the stopping point, what is in, what is not. At the end of the day, maybe both providers get a piece of the bundle. Usually it is one person getting the bundle. Sometimes that works well if you think you can confine all of the services within your system.” – Charles Hetterich, CPA, MBA, University of Rochester Medical Center

Implementation Issues: There is no CPT code for pediatric-to-adult ambulatory care transition at this time, and therefore the value of such a service has not been calculated. Most existing episode of care payment examples pertain to high-cost predictable adult specialty care or procedural events, including prenatal care. As with the prenatal care

example, it is important to specify the triggering event and define a “closed loop” episode of transition that can be monetized, with an agreed upon bundle of services that is not too prescriptive. This approach would require collaboration between pediatric and adult practices/systems. Because it is challenging to determine how to allocate payment to each side, bundles could alternatively be constructed on both the pediatric and the adult side. As with other payment models, a complication to consider is the potential for the young adult’s health insurance plan to change during the transition period.

6. *Per Member Per Month (PMPM)*

A PMPM payment method is a set monthly amount paid to a provider/system for each patient under their care; it is often risk-adjusted based on patient complexity. Overall, the PMPM and episode of care/bundled payment options were ranked very closely, as shown in Table 1. PMPM was ranked as slightly less favorable overall.

Specific ideas for structuring a PMPM payment are described below.

- Create a risk-adjusted monthly capitation fee for the year prior to transfer to cover the added costs associated with preparing youth for transfer to adult care. This payment could be aligned with quality performance measures, such as experience with the transition process or experience of care.
- Create a risk-adjusted monthly PMPM for the year following transfer to cover the added costs associated with integrating young adults into adult care. This payment could be aligned with measures, such as transition process of care, primary care utilization, and experience of care.
- 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 defined in the next section of the report.

Implementation Issues: Payers are experienced with the PMPM payment approach. Health care providers are also accustomed to PMPM; however, it would be difficult to divide the payment between pediatric and adult care practices/systems. The challenge in incorporating transition into existing care coordination efforts is allocating payment to support specific transition services. Clear parameters that define a transfer scenario are essential as well as adequate payment to ensure that the work occurs in both pediatric and adult practices. As with other payment models, the PMPM option may work best for clinicians with a large volume of transferring patients. A challenge is to define the population eligible for payment. Many youth and young adults at greatest risk for an unsuccessful transfer have not made a preventive care visit in the past two or more years.

DISCUSSION AND PRIORITIZATION OF TRANSITION QUALITY PERFORMANCE MEASURES

Value-based payment strategies incorporate incentives for quality of care, which are often organized according to the triple aim domains of population health, experience of care, and utilization/cost of care. To identify a set of quality measures for use in transitional care, the project team relied on two systematic reviews: one related to HCT measures¹⁴ and the other to transition evaluation evidence.³ In addition, measures from CMS' Child Core Measure Set,²¹ Healthcare Effectiveness Data and Information Set (HEDIS),²² and National Quality Forum²³ were also considered. Table 3 displays the ranking of population health quality measures. Table 5 displays the ranking of experience quality measures. Table 7 displays the ranking of utilization/cost quality measures.

“As a payer, we are becoming more sophisticated in the value-based payment arrangements that we’re offering. We’re really looking to reduce burden on the provider by reducing the number of metrics and really pushing for outcomes instead of process metrics. That’s the promise that we’re making to providers as we’re trying to convince them to move to some sort of downside risk.” – Melissa Cohen, JD, MPA, Anthem

Roundtable participants offered the following comments about choosing quality measures as part of VBP strategies for transitional care.

- When possible, use existing measures that are relevant to a broader population.
- Because practices typically work with many different payers, coordinate and align measures among these payers.
- When selecting measures, take into account the feasibility and administrative burden; providers already report on a sizeable list of measures.
- Make sure to avoid confounders, taking into account what the patient and provider can control.
- Work to incorporate risk stratification, including but not limited to social determinants of health. (*Note:* Given limited time, the group did not select options for risk stratification.)
- Plan to supplant process measures that may be used at the start of VBP transition pilots with subsequent outcome measures as a preferred strategy when transitional care processes are in place.
- Consider implementing quality measures at the plan rather than the practice level. There may be a relatively small number of transferring youth and young adults in a given practice, which can affect the validity of the measure.
- Work with practices/plans in the selection and refinement of transition quality measures.

Roundtable participants were asked to prioritize quality measures within each of the three triple aim domains (population health, experience of care, and utilization/cost) based on *importance* and *feasibility*. Participants ranked their top two choices (#1 and #2) and bottom two choices (#5 and #6) for the population health and utilization/cost domains using these evaluation

criteria. For the experience of care domain, since there were fewer options, participants ranked only their top choice (#1) and bottom choice (#6). A score of 3.5 was given to unranked options. Tables 3, 5, and 7 display the final average ranking from the 24 roundtable participants for each domain, and Tables 4, 6, and 8 display the ranking by professional affiliation. The lower the score, the higher the priority.

Population Health

A total of nine population health measures were reviewed and prioritized based on importance and feasibility: patient-reported outcomes, adherence to care, medication reconciliation, self-care knowledge/skills, disease-specific measures, transitional care process, meaningful use requirements, social determinants of health, and shared plan of care. In contrast to consistent prioritization results for transition payment options, roundtable participants varied in their ranking of quality measures, as shown in Table 3. With respect to importance, the top-ranked measures were transitional care process, social determinants, patient-reported outcomes, and shared plan of care. In terms of feasibility, the top population measures were disease-specific measures, medication reconciliation, and meaningful use requirements.

Prioritization of importance and, to a lesser extent, feasibility of population health measures varied by professional affiliation, as shown in Table 4. There was consensus, however, among payers, clinicians, and researchers/consultants that the transitional care measure was important. The other population health measures were not consistently ranked in terms of importance by professional affiliation. With respect to feasibility, there was agreement among all professional groups that disease-specific outcomes and medication reconciliation were among the most feasible.

Table 3. Prioritization of Population Health Quality Performance Measures

Population Health Quality Performance Measure	Importance	Feasibility
Transitional care process ^a	2.88	3.07
Social determinants of health	3.13	3.54
Patient-reported outcomes	3.15	4.20
Shared plan of care ^b	3.15	3.59
Self-care knowledge/skills	3.23	4.24
Adherence to care/guidelines	3.42	4.17
Meaningful use requirements ^c	4.06	2.89
Disease-specific measures	4.08	2.22
Medication reconciliation	4.15	2.67

^a Suggested transitional care process measures are Got Transition’s Current Assessment of Health Care Transition and Got Transition’s Health Care Transition Process Measurement Tool. Both are available on Got Transition’s website at gottransition.org.

^b Suggested template for a shared plan of care is available in the report, *Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs*, available at https://www.lpfch.org/sites/default/files/field/publications/achieving_a_shared_plan_of_care_full.pdf

^c Suggested meaningful use measures are from CMS and include use of health information exchange for care transitions or referrals (including a summary of care record), medication reconciliation, patient-specific education, patient electronic access, and secure messaging.

Table 4. Prioritization of Population Health Measures by Professional Affiliation

Professional Affiliation	Importance	Feasibility
Payers	<ol style="list-style-type: none"> 1. Social determinants of health[†] 1. Transitional care process[†] 2. Shared plan of care 	<ol style="list-style-type: none"> 1. Disease-specific measures 2. Medication reconciliation[†] 2. Social determinants of health[†]
Professional Association Officials/Clinicians	<ol style="list-style-type: none"> 1. Transitional care process 2. Shared plan of care 3. Patient-reported outcomes 	<ol style="list-style-type: none"> 1. Medication reconciliation 2. Disease-specific measures[†] 2. Transitional care process[†]
Consultants/Researchers	<ol style="list-style-type: none"> 1. Adherence to care/guidelines 2. Transitional care process 3. Self-care knowledge/skills 	<ol style="list-style-type: none"> 1. Disease-specific measures 2. Meaningful use requirements 3. Adherence to care/guidelines[†] 3. Medication reconciliation[†]
Foundation/Federal/Advocacy Leaders	<ol style="list-style-type: none"> 1. Patient-reported outcomes[†] 1. Self-care knowledge/skills[†] 2. Social determinants of health 	<ol style="list-style-type: none"> 1. Disease-specific measures 2. Medication reconciliation 3. Patient-reported outcomes

[†] = tie

Experience of Care

Three experience of care measures were considered and ranked: youth/young adult/caregiver experience with the transition process, youth/young adult experience with care, and clinician experience with the transition process. The top choice in terms of importance was youth/young adult/caregiver experience with the transition process, followed closely by experience with care; the top choice in terms of feasibility was youth/young adult experience with care, followed closely by youth/young adult/caregiver experience with the transition process, as shown in Table 5. Among the professional affiliations, clinician experience with the transition process was consistently selected as the least important measure. Rankings by professional affiliation are displayed in Table 6.

Table 5. Prioritization of Experience of Care Quality Performance Measures

Experience of Care Quality Performance Measure	Importance	Feasibility
Youth/young adult/caregiver experience with transition process ^a	2.79	3.36
Youth/young adult experience with care ^b	2.83	3.29
Clinician experience with transition process	4.23	3.74

^a Suggested surveys to measure experience with transition process are Got Transition’s Health Care Transition Feedback Survey for Youth, Health Care Transition Feedback Survey for Parents/Caregivers, and Health Care Transition Feedback Survey for Young Adults; all are available on Got Transition’s website at gottransition.org.

^b Suggested surveys to measure experience with care measures come from CAHPS and include items related to getting needed care, how well doctors communicate, health plan customer service, and enrollees’ ratings of health care personal doctor, specialist, and health plan.

Table 6. Prioritization of Experience of Care Measures by Professional Affiliation

Professional Affiliation	Importance	Feasibility
Payers	<ol style="list-style-type: none"> 1. Youth/YA/Caregiver experience with transition process 2. Youth/YA experience with care 3. Clinician experience with transition process 	<ol style="list-style-type: none"> 1. Youth/YA/Caregiver experience with transition process[†] 1. Youth/YA experience with care[†] 1. Clinician experience with transition process[†]
Professional Association Officials/Clinicians	<ol style="list-style-type: none"> 1. Youth/YA/Caregiver experience with transition process 2. Youth/YA experience with care 3. Clinician experience with transition process 	<ol style="list-style-type: none"> 1. Youth/YA experience with care 2. Youth/YA/Caregiver experience with transition process 3. Clinician experience with transition process
Consultants/Researchers	<ol style="list-style-type: none"> 1. Youth/YA/Caregiver experience with transition process[†] 1. Youth/YA experience with care[†] 3. Clinician experience with transition process 	<ol style="list-style-type: none"> 1. Youth/YA/Caregiver experience with transition process 2. Youth/YA experience with care[†] 2. Clinician experience with transition process[†]
Foundation/Federal/Advocacy Leaders	<ol style="list-style-type: none"> 1. Youth/YA experience with care 2. Youth/YA/Caregiver experience with transition process 3. Clinician experience with transition process 	<ol style="list-style-type: none"> 1. Youth/YA experience with care 2. Clinician experience with transition process 3. Youth/YA/Caregiver experience with transition process

[†] = tie; YA = Young Adult

Utilization/Cost of Care

A total of ten utilization/cost of care measures were discussed and prioritized by roundtable participants, including preventive/primary care visits in the adult care setting, emergency room/urgent care visits, hospital visits/readmissions, provision of online scheduling/appointment reminders, time between last pediatric and first adult visit, initial appointment wait time, referral tracking/loss to follow-up, missed appointments, duplicative tests/procedures, and cost of care, as shown in Table 7. The top three choices in terms of important utilization/cost measures were time between last pediatric visit and initial adult visit, emergency room/urgent care visits, and preventive and primary care visits in the adult care setting. Roundtable participants ranked emergency room/urgent care visits, preventive/primary care visits in the adult care setting, and hospital visits/readmissions as the most feasible.

Members of the four professional affiliations varied in terms of their ranking of importance and feasibility of utilization/cost measures, as shown in Table 8. Most agreed, however, that emergency care/urgent care visits, hospitalization, and preventive/primary care are important and feasible to measure. Overall, cost of care was not among the most important and feasible measures, with only consultants/researchers including cost among their top three choices.

Table 7. Prioritization of Utilization/Cost Quality Performance Measures

Utilization/Cost Quality Performance Measure	Importance	Feasibility
Time between last pediatric and first adult visit	2.40	3.17
ER/urgent care visits	2.83	2.61
Preventive/primary care visits in adult care setting	2.85	2.96
Referral tracking/loss to follow-up	3.38	3.76
Hospital visits/readmissions	3.48	2.89
Provision of online scheduling/appointment reminders	3.50	3.39
Cost of care	3.56	3.39
Missed appointments	4.02	3.96
Duplicative tests/procedures	4.15	4.00
Initial appointment wait time	4.44	4.63

ER = emergency room

Table 8. Prioritization of Utilization/Cost Measures by Professional Affiliation

Professional Affiliation	Importance	Feasibility
Payers	<ol style="list-style-type: none"> 1. Time between last pediatric and first adult visit 2. ER/urgent care visits 3. Hospital visits/readmissions[†] 3. Referral tracking/loss to follow-up[†] 	<ol style="list-style-type: none"> 1. ER/urgent care visits 2. Hospital visits/readmissions 3. Cost of care
Professional Association Officials/Clinicians	<ol style="list-style-type: none"> 1. Preventive/primary care visits in adult care setting 2. Time between last pediatric and first adult visit 3. ER/urgent care visits 	<ol style="list-style-type: none"> 1. Preventive/primary care visits in adult care setting 2. Time between last pediatric and first adult visit 3. ER/urgent care visits[†] 3. Hospital visits/readmissions[†]
Consultants/ Researchers	<ol style="list-style-type: none"> 1. ER/urgent care visits 2. Cost of care 3. Preventive/primary care visits in adult care setting[†] 3. Hospital visits/readmissions[†] 	<ol style="list-style-type: none"> 1. ER/urgent care visits 2. Hospital visits/readmissions 3. Cost of care
Foundation/ Federal/Advocacy Leaders	<ol style="list-style-type: none"> 1. Time between last pediatric and first adult visit 2. ER/urgent care visits 3. Preventive/primary care visits in adult care setting 	<ol style="list-style-type: none"> 1. Provision of online scheduling/ appointment reminders 2. Preventive/primary care visits in adult care setting[†] 2. Hospital visits/readmissions[†]

[†] = tie; ER = emergency room

CONCLUSION AND DISSEMINATION OPPORTUNITIES

Pediatric-to-adult transitional care is the subject of increased national attention and concern as evidence mounts that structured processes to facilitate a planned and coordinated transition from pediatric to adult care are seldom in place in primary, specialty, behavioral, and hospital care or in the health plans that support pediatric and adult care delivery systems. The vast majority of youth and their parents/caregivers as well as young adults report that they are not receiving needed anticipatory guidance and support to ensure a transition that includes structured planning, coordinated transfer, and a welcoming integration into adult care.

“Transitioning patients in crisis is always bad.” – Ann Modrcin, MD, EMBA, Children’s Mercy Hospital in Kansas City, MO

This report is intended to guide commercial and Medicaid payers, health plans, employers, and pediatric and adult systems of care in implementing and evaluating VBP options for transition-aged youth and young adults between ages 12 and 26, especially those with chronic conditions.

Roundtable participants and key informants suggested several potential opportunities for disseminating the recommendations contained in this report.

- Share the recommendations from this report widely with CMS, state Medicaid agencies, commercial payers, business groups, health plans, foundations, and family and disability groups to encourage transition payment pilots.
- Identify states and health plans to implement transition payment pilots and work in close collaboration with pediatric and adult care delivery systems that have experience with or are interested in implementing structured transition processes consistent with the AAP/AAFP/ACP Clinical Report, such as Got Transition’s Six Core Elements of Health Care Transition. Invest in measuring the impact of these pilots, using the quality measures described in this report, and share the results widely.
- Encourage employers, commercial payers, and state Medicaid agencies to specify contract requirements that call for a structured transition process consistent with the AAP/AAFP/ACP Clinical Report.
- Involve youth, young adults and parents/caregivers in the dissemination of this report to increase recognition of the need for structured transitions to adult care, including their experiences when structured transition planning did not occur.
- Identify key committees and staff in state legislatures and Congress (e.g., Senate Finance Committee; Senate Health, Education, Labor and Pension Committee; House Energy and Commerce and Ways and Means Committees; Senate and House Armed Services Committees) to gain support for including pediatric-to-adult transitional care in legislative proposals.

“Data helps me understand; stories make me care.” – Margaret Comeau, MHA, Catalyst Center/Boston University School of Public Health

- Encourage health professional educational leaders to incorporate transition into their curriculum.
- Disseminate recommendations from this report at conferences attended by Medicaid and commercial payers, employers, health plans/ACOs, pediatric and adult clinical leaders and educators, and youth/family and disability groups.

Patterns of care established in adolescence and young adulthood have long-term impacts on future adult health. Payers, employers, and health plans have a critical role to play in establishing the needed infrastructure within and between pediatric and adult care delivery systems to ensure a structured approach to transitional care consistent with professional recommendations. Given the low US performance on transitional care for youth with and without chronic conditions, now is a critical time to invest in HCT for and young adults.

“A modest investment that succeeds in establishing a solid and successful transition will have a multiplicative return of investment in the longer term.”
 – Mark Hudak, MD, AAP
 Committee on Child Health
 Financing

THE NATIONAL ALLIANCE TO ADVANCE ADOLESCENT HEALTH is a nonprofit organization whose mission is to achieve long-term, systemic improvements in comprehensive health care and insurance coverage for adolescents, with focused attention on those from low income families and with special health care needs. Through policy analysis, technical assistance, quality improvement, and advocacy, The National Alliance works to promote effective transitions from pediatric to adult health care as part of its Got Transition program. In collaboration with others, The National Alliance also works to expand the availability of adolescent-centered care, access to mental health services, and improvements in health insurance coverage for adolescents and young adults.

For more information about HCT and this report, please visit thenationalalliance.org or contact Annie Schmidt at Aschmidt@TheNationalAlliance.org.

LUCILE PACKARD FOUNDATION FOR CHILDREN’S HEALTH was founded in 1997 as an independent public charity, established to ensure a continued source of funding and support for the health and well-being of children. Its mission is to elevate the priority of children’s health and increase the quality and accessibility of children’s health care through leadership and direct investment. The Foundation engages in grantmaking, research, policy advocacy, and community engagement to support efforts that promote development of a system that delivers family-centered, high-quality health care and related services.

For more information about the Foundation, visit lpfch.org

REFERENCES

1. U.S. Census Bureau. Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2016. <http://www.factfinder.census.gov>. Published 2016. Last accessed July 25, 2017.
2. Lebrun-Harris L, McManus M, Ilango S, Cyr M, McLellan S, Mann M, et al. Transition preparation among youth with and without special health care needs in the United States. *Pediatrics*. 2018;142(4):e20180194.
3. Gabriel P, McManus M, Rogers K, White P. Outcome evidence for structured pediatric to adult health care transition interventions: A systematic review. *Journal of Pediatrics*. 2017;188:263-269.
4. McManus M, White P, Schmidt A, Kanter D, Molteni R, Salus T. 2018 Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care. Washington, DC: Got Transition; April 2018.
5. Cooley WC, Sagerman PJ, Transitions Clinical Authoring Group, American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics*. 2011;128(1):182-200.
6. White PH, Cooley WC, Transitions Clinical Authoring Group, American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics*. Forthcoming.
7. Got Transition. Six Core Elements of Health Care Transition. Available at <https://www.gottransition.org>. Accessed March 9, 2018.
8. McManus M, White P, Barbour A, Downing B, Hawkins K, Quion N, et al. Pediatric to adult transition: a quality improvement model for primary care. *Journal of Adolescent Health*. 2015;56(1):73-78.
9. Maeng DD, Snyder SR, Davis TW, Tomcavage JF. Impact of a complex care management model on cost and utilization among adolescents and young adults with special care and health needs. *Population Health Management*. 2017;20(6):435-441.
10. Burns K, Farrell K, Myszka R, Park K, Holmes-Walker DJ. Access to a youth-specific service for young adults with type 1 diabetes mellitus is associated with decreased hospital length of stay for diabetic ketoacidosis. *Internal Medicine Journal*. 2018;48(4):396-402.
11. Farre A, McDonagh JE. Helping health services to meet the needs of young people with chronic conditions: Towards a developmental model for transition. *Healthcare (Basel)*. 2017;5(4).

12. Estimates from the 2016 National Survey of Children's Health. <http://childhealthdata.org>. Accessed June 12, 2018.
13. Institute of Medicine and National Research Council of the National Academies. *Investing in the Health and Well-Being of Young Adults*. Washington, DC: The National Academies Press; 2014.
14. Findley MK, Cha E, Wong E, Faulkner MS. A systematic review of transitional care for emerging adults with diabetes. *Journal of Pediatric Nursing*. 2015;30(5):e47-e62.
15. Brousseau DC, Owens PL, Mosso AL, Panepinto JA, Steiner CA. Acute care utilization and rehospitalizations for sickle cell disease. *JAMA*. 2010;303(13):1288-1294.
16. Gurvitz M, Valente AM, Broberg C, Cook S, Stout K, Kay J, et al. Prevalence and predictors of gaps in care among adult congenital heart disease patients: HEART-ACHD (The Health, Education, and Access Research Trial). *Journal of the American College of Cardiology*. 2013;61(21):2180-2184.
17. Measure Evaluation Criteria and Guidance for Evaluating Measures for Endorsement. Washington, DC: National Quality Forum; 2017.
18. Centers for Medicare & Medicaid Services (CMS). "At-a-Glance" Guide to Federal Medicaid Authorities Useful in Restructuring Medicaid Health Care Delivery or Payment. Baltimore, MD: CMS; 2012.
19. Centers for Medicare & Medicaid Services (CMS). Paving the Road to Good Health: Strategies for increasing Medicaid adolescent well-care visits. Baltimore, MD: CMS; 2014.
20. National Academy for State Health Policy (NASHP). Promoting preventive services and healthy behaviors through Medicaid and CHIP: Idaho's preventive health assistance program. Washington, DC: NASHP; 2018.
21. Centers for Medicare & Medicaid Services. 2018 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child core set). <https://www.medicare.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-core-set.pdf>. Accessed August 3, 2018.
22. National Committee for Quality Assurance (NCQA). Healthcare Effectiveness Data and Information Set (HEDIS). <http://www.ncqa.org/hedis-quality-measurement/hedis-measures>. Accessed August 3, 2018.
23. National Quality Forum. Quality Positioning System (QPS). <http://www.qualityforum.org/QPS/QPSTool.aspx#>. Accessed August 3, 2018.

APPENDIX A: TRANSITION PAYMENT KEY INFORMANTS

CMS and Other HHS Officials

Alexander Billioux, MD, DPhil

Director, Division of Population Health
Incentives and Infrastructure
Senior Advisor, Center for Medicare and
Medicaid Innovation (CMMI)
Centers for Medicare and Medicaid Services

Mary Pat Farkas, MSA

Technical Director for Health Homes, Programs
of All-Inclusive Care for the Elderly, and
Coordination of Benefits/Third Party
Liability
Disabled and Elderly Health Program Group
Centers for Medicare and Medicaid Services

Renee Fox, MD

Medical/Health Policy Advisor, Children and
Adults Health Programs Group
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services

Ashley Gavin, DPA

Public Health Analyst, Division of Population
and Health Incentives and Infrastructure
Centers for Medicare and Medicaid Services

Richard Jensen, MPP

Senior Policy Advisor, CMMI
Centers for Medicare and Medicaid Services

Gavin Kennedy, MURP

Acting Director, Division of Behavioral Health
and Intellectual Disability
Office of Disability, Aging, and Long-Term
Care Policy
Office of the Assistant Secretary for Planning
and Evaluation

Michael Nardone, MPA

Director, Disabled and Elderly Health Program
Group
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services

D.E.B. Potter, MS

Program Analyst, Division of Behavioral Health and
Intellectual Disability
Office of Disability, Aging, and Long-Term Care
Policy
Office of the Assistant Secretary for Planning
and Evaluation

Paul Rosen, MD, MPH, MMM

Medical Officer, Transforming Clinical Practice
Initiative
Centers for Medicare and Medicaid Services

Susan Ruiz

EPSDT Lead, CMS San Francisco Regional Office
Division of Medicaid and Children's Health
Operations
Centers for Medicare and Medicaid Services

Deirdra Stockmann, PhD, MUP

Health Insurance Specialist, Division of Quality and
Health Outcomes
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services

Joshua Traylor, MPH

Health Insurance Specialist and Project Officer
State Innovation Models Initiative
Centers for Medicare and Medicaid Services

Kristina West, MS

Policy Analyst, Division of Behavioral Health and
Intellectual Disability
Office of Disability, Aging, and Long-Term Care
Policy
Office of the Assistant Secretary for Planning and
Evaluation

Ellen-Marie Whelan, MS, PhD

Chief Population Health Officer, Center for
Medicaid and CHIP Services
Centers for Medicare and Medicaid Services

State Medicaid Officials

Jennifer Blanchard, MSW, MPP

Director, Community and Care Integration Reform
Minnesota Department of Human Services

Curt Curnow, MHA

Director, Quality and Health Improvement
Colorado Department of Health Care Policy and
Financing

David Kelley, MD, MPA

Chief Medical Officer, Office of Medical
Assistance Programs
Pennsylvania Department of Public Welfare

Carolyn Langer, MD, JD, MPH

Senior Vice President/Chief Medical Officer
Fallon Health
Previously Chief Medical Officer, MassHealth

Gina Robinson

Program Administrator, Client and Clinical Care
Program Office
Colorado Department of Health Care Policy and
Financing

Alice Weiss, JD

Director, Health Care Policy and Research
Administration
DC Department of Health Care Finance

Commercial Insurers/Health Plans

Joel Bradley, MD

Chief Medical Officer
United Healthcare Community Plan of Tennessee
Member, American Academy of Pediatrics
Committee on Coding and Nomenclature

Lili Brillstein, MPH

Director, Episodes of Care
Horizon Blue Cross Blue Shield of New Jersey

Tom Davis, MD

Director, Comprehensive Care Clinic
Geisinger Health Solutions

Simon Hambidge, MD, PhD

Chief Executive Officer
Denver Community Health Services
Professor of Pediatrics and Epidemiology,
University of Colorado

Tracy Johnson, PhD

Director, Health Care Reform Initiatives
Denver Health and Hospital Authority
Assistant Professor, Colorado School of Public
Health

John Keats, MD

Market Medical Executive
Cigna HealthCare

Jennifer Kyle, RN, MA

Senior Director, Product Development
UnitedHealthcare Special Needs Initiative

Hongmai Pham, MD, MPH

Vice President
Provider Alignment Solutions
Anthem

Sunny Ramchandani, MD, MPH

Deputy Chief Medical Officer
Aetna

Julie Schilz, BSN, MBA

Staff Vice President
Care Delivery Transformation
Anthem

Professional Organizations

Jeannine Engel, MD

Physician Advisor, Billing Compliance
University of Utah Health
Member, American College of Physician's Coding
and Payment Policy Subcommittee

Robert Hall, JD, MPAff

Director, Government Relations
American Academy of Family Physicians

Mark Hudak, MD

Professor and Chair, Department of Pediatrics
University of Florida College of Medicine
Chair, AAP Committee on Child Health Financing

David Kanter, MD, MBA, CPC

Vice President of Medical Coding
Pediatrix Medical Group
Member, AAP Committee on Coding and
Nomenclature

Marielle Kress, MPP

Assistant Director, Department of Federal Affairs
American Academy of Pediatrics

National Organizations

Chris Adamec, MPH

Policy Director
Patient-Centered Primary Care Collaborative

Kamala Allen, MHS

Vice President, Program Operations
Director, Child Health Quality
Center for Health Care Strategies

Richard Bankowitz, MD, MS, MBA

Chief Medical Officer
Executive Vice President, Clinical Affairs
America's Health Insurance Plans

Michael Barr, MD, MBA

Executive Vice President, Quality Measurement
and Research Group
National Committee for Quality Assurance

Kent Moore

Senior Strategist for Physician Payment
American Academy of Family Physicians

Charles Norlin, MD

Director, Medical Home Portal Project
Director, Utah Pediatric Partnership to Improve
Healthcare Quality
University of Utah School of Medicine

Jill Rinehart, MD

President, AAP Vermont Chapter
Clinical Associate Professor of Pediatrics, Robert
Larner College of Medicine, University of
Vermont

Brooke Rockwern, MPH

Senior Analyst, Health Policy and Regulatory
Affairs
American College of Physicians

Lou Terranova, MS

Senior Health Policy Analyst, Division of Health
Care Finance
American Academy of Pediatrics

Susan Dull, RN, MSN, MBA

Director, Collaborative Learning and
Improvement
Care Transformation Lead, CARE Award
Project Team
National Association of Children's Hospitals
and Related Institutions

Clif Gaus, ScD, MHA

Chief Executive Officer
National Association of ACOs

Kathleen Giblin, RN

Senior Vice President, Quality Innovation
National Quality Forum

Ann Greiner, MUP

President and Chief Executive Officer
Patient-Centered Primary Care Collaborative

Rhys Jones, MPH

Vice President, Medicaid Advocacy
America's Health Insurance Plans

Jacqueline Kueser, MS

Leader, Care Transformation Informatics
Payment Model Lead, CARE Award Project Team
Children's Hospital Association

Tricia McGinnis, MPP, MPH

Senior Vice President
Center for Health Care Strategies

Elisa Munthali, MPH

Senior Vice President, Quality Measurement
National Quality Forum

Academic and Policy Consultants

Sara Bachman, PhD

Director, Center for Advancing Health Policy and
Practice
Research Professor, Health Law, Policy and
Management
Boston University School of Public Health

Jan Berger, MD, MJ

President and Chief Executive Officer
Health Intelligence Partners

Margaret Comeau, MHA

Senior Project Director, Center for Advancing
Health Policy and Practice
Co-Principal Investigator, Catalyst Center
Boston University School of Public Health

Paul Grundy, MD, MPH

Chief Medical Officer
Global Director, Healthcare Transformation
IBM Healthcare and Life Sciences

Henry Ireys, PhD

Director, Program Improvement Division
Mathematica Policy Research

Marsha Lillie-Blanton, DrPH

Associate Research Professor, Department of Health
Policy and Management
Milken Institute School of Public Health
George Washington University

Joe Parks, MD

Medical Director
National Council for Behavioral Health

Kathryn Santoro, MPP

Director, Policy and Development
National Institute for Health Care Management
Foundation

Karen VanLandeghem, MPH

Senior Program Director
National Academy for State Health Policy

Patricia MacTaggart, MBA, MMA

Lead Research Scientist, Health Policy and
Management
Milken Institute School of Public Health
George Washington University

Jeanne McAllister, MS, MHS

Adjunct Associate Research Professor of Pediatrics
Indiana University School of Medicine

John McCarthy, MPA

Founding Partner
Speire Healthcare Strategies

Bert Miuccio

Chief Executive Officer
HealthTeamWorks

Matt Roan

Principal
Health Management Associates

Tim Westmoreland, JD

Research Professor, Public Policy
Professor from Practice
Georgetown University Law Center

Joseph Zickafoose, MD, MS

Senior Researcher
Mathematica Policy Research
Vanderbilt University Medical Center

Children's Hospitals

Richard Antonelli, MD, MS

Medical Director, Integrated Care
Medical Director, Physician Relations and
Outreach
Boston Children's Hospital/Harvard Medical
School

Paula Holmes, BSN, MPH

Senior Director, Accountable Care
Seattle Children's Hospital

Thomas Klitzner, MD, PhD

Director, California Children's Services Programs
Mattel Children's Hospital at UCLA
Director, Pediatric Medical Home Program at
UCLA
Vice-Chair for Academic Affairs, Department of
Pediatrics

Peter Margolis, MD, PhD

Co-Director, James M. Anderson Center for Health
Systems Excellence
Cincinnati Children's Research Foundation Professor
of Pediatrics
Cincinnati Children's Hospital Medical Center

Frances O'Hare, MD

Director, Transition Medicine for Primary Care
Assistant Professor, Medicine and Pediatrics
Boston Children's Hospital/Harvard Medical School

Karen Spencer, MD, MS, MPH

Assistant, Department of Neurology
Instructor of Neurology
Boston Children's Hospital/Harvard Medical School

Ashlea Tade, LPN

Program Manager
Seattle Children's Hospital

Business Groups and Patient Organizations

Eliot Fishman, PhD

Senior Director of Health Policy
Families USA

Denise Giambalvo, MHRM

Vice President
Midwest Business Group on Health

Beverley Johnson

President and Chief Executive Officer
Institute for Patient and Family-Centered Care