

# Value-Based Payment for Pediatric Providers

# Value-Based Payment for Pediatric Providers

## VBP in Washington

Under an agreement with the federal government, the Health Care Authority is testing new and innovative approaches to providing health coverage and care. This initiative is called *Healthier Washington* (<https://www.hca.wa.gov/about-hca/healthier-washington>). One of Healthier Washington's goals is to move **90 percent of state-financed health care to VBP by 2021**. While much of the focus to date has been on adult care, to reach state goals of 90 percent of payments in value-based care, VBP must also focus on child health care.

Traditionally, most health care in the US has been reimbursed on a fee-for-service (FFS) basis, whereby providers are financially incentivized to maximize office visit volume without reward for quality care or patient outcome. Medicaid and commercial insurers are moving away from this payment model because it has contributed to increases in health care costs, particularly in specialist, testing and hospital services. For pediatric primary care providers, FFS payment has not only forced an orientation to visit volume; it has impeded opportunities to spend more time with the neediest children and their families and on non-reimbursed but high-value activities. Value-based payment, in contrast, aims to disrupt the volume incentive and a) support non-visit treatment modalities, b) support time on traditionally non-reimbursed activities such as care coordination, and c) reward high quality and efficient care.

# Value-Based Payment for Pediatric Providers

## 4 Steps to Get Ready for VBP

**1. Understand the Different Types of Payment Models:** As your practice contemplates value-based payment, it is important to understand the different types of value-based payment models, and how to succeed under those models. Here is an overview of common VBP models:

### Supplemental Payment

In addition to FFS payment, the insurer provides funds to practices for completing certain activities, or hitting performance targets. For example, the Rhode Island Patient Centered Medical Home Kids Initiative pays pediatric practices \$2.50 per member per month for care coordination and \$1.00 per member per month for practice transformation expenses (e.g., developing reporting capabilities). In return, these practices commit to transforming their care and meeting some contractual guidelines. Over time, the payers will transform portions of the supplemental payment into incentives to reduce ED visits and attain certain levels of quality.

### Episode-Based Payment

The insurer defines fixed budgets or payments for a defined procedure (e.g., tonsillectomy), acute illness (e.g., upper respiratory infection), or care of a chronic condition (e.g., asthma). Episodes have clearly defined terms of what services are excluded and included in the payment, and for their time-period. For example, the Arkansas Medicaid program has implemented episode-based payment for pediatric services for attention deficit/hyperactivity disorder, oppositional defiant disorder, tonsillectomy, and acute exacerbation of asthma. (See inset below.)

### Example of Episode-Based Payment for Acute Exacerbation of Asthma

In Arkansas, Medicaid providers are paid on an episode-based payment basis for the management of acute exacerbations of asthma. The episode includes:

- any costs related to an emergency department or inpatient stay for an acute exacerbation of asthma (which triggers the start of an episode);
- all inpatient and outpatient facility and professional services, medications and treatment for post-discharge complications, readmissions or repeated ED visits within 30 days of the initial ED visit or inpatient stay.

Performance on quality measures determines whether a physician can receive savings payments.

# Value-Based Payment for Pediatric Providers

---

## 1. Understand the Different Types of Payment Models: *continued*

### Shared Savings / Shared Risk

Practices may share in savings (or losses) on the total cost of care for their patient population with a given payer if their costs come in below (or above) a pre-determined target, or relative to a control group. Quality performance usually adjusts the practice's share of savings or losses. This program is feasible only for large patient populations and usually includes only shared savings.

### Capitation

Practices receive a monthly prospective payment for common, high-volume services delivered by the practice, regardless of whether the patient seeks care or how much care they receive. A quality incentive supplemental payment opportunity often complements the capitation payment.

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

**3. Identify Personnel to Support Quality Improvement:** Many practices require infrastructure to succeed under VBP. This often entails personnel to run EHR reports and interpret payer reports, as well as to establish processes to address opportunities for quality improvement. Some small independent practices consider addressing these needs by entering some form of a partnership with other like practices to share resources and achieve economies of scale.

# Value-Based Payment for Pediatric Providers

**4. Manage Social Determinants of Health:** New pediatric value-based payment models are starting to recognize the profound affect social determinants of health have on childhood development and children’s future adult health status. To address these social determinants of health, some payers will support a care coordination function within the practice. In this example, practices may consider hiring one or more care coordinators, and must set up systems to effectively screen for these risk factors; effectively link children and their families to any available community resources; and provide practice-based interventions, such as education and behavioral health services, as appropriate and feasible. Care coordinators may be professional or lay personnel (e.g., community health workers) who can connect with families to bring them in for care, support families with complex needs, and/or assist families in accessing available social and economic support systems to address the social determinants of health such as housing and food insecurity.

## Population Health Under Value-Based Payment Models

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

### Who are my patients?

#### ENROLLMENT

In use by Medicaid managed care plans and commercial HMO products, enrollment entails a family selecting a primary care provider upon enrollment in a health insurance product. These members have chosen your practice to receive their primary care - but may conceivably end up receiving their primary care elsewhere, by choice.

#### ASSIGNMENT

In use where there are Medicaid managed care plans, assignment is when a Medicaid beneficiary does not choose a primary care provider upon enrollment in Medicaid, so one is chosen for the plan member. These members will receive communication about who is his/her assigned primary care physician. The plan member may or may not have ever seen the practice for care prior to assignment, and could seek out care elsewhere.

#### ATTRIBUTION

More commonly used in the commercial PPO market, attribution refers to health plan algorithms that define which physicians are responsible for which patients based on where the patient has received the preponderance of care in the past. Since attribution is based on claims, a member who is attributed to a practice may have moved or switched practices without their attributed physician’s knowledge.

*continued*

# Value-Based Payment for Pediatric Providers

---

Health plans can assist practices in identifying a physician's patient panel by routinely sending updated roster lists of patients (e.g., monthly). It is then the practice's responsibility to maintain an internal up-to-date list of those patients for whom the health plan will hold the practice responsible for performance under a VBP contract.

## Identifying and Acting Upon Gaps in Care

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