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CATALYST CENTER
IMPROVING FINANCING OF CARE for Children & Youth WITH SPECIAL HEALTH CARE NEEDS

A Primer on Value-based Strategies for Improving Financing of Care for Children and Youth with Special Health Care Needs

Introduction

Value-based purchasing and value-based insurance design are gaining increasing attention as strategies for reducing health care spending and improving health outcomes – "value" being the operative concept. However, there is not enough evidence to date regarding the effectiveness of these strategies; what does exist is primarily focused on interventions impacting adults (Bachman et al, 2017). This primer will focus on opportunities to increase value in spending on health services for children and youth with special health care needs (CYSHCN) through select alternative payment mechanisms and delivery innovations, and potential roles for Title V and family leaders in these efforts.

What do we know about costs associated with the care of children and youth with special health care needs?

Children and youth with special health care needs are those who, according to the federal Maternal and Child Health Bureau (MCHB), "*have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally*" (McPherson et al, 1998). This is a broad definition that by design encompasses all aspects of health: physical, mental, behavioral, developmental, etc. As a result, there is no single data source for costs associated with the full population of CYSHCN – we can look at some high prevalence and/or high utilization conditions from claims or other data sources but not for costs associated with the MCHB-defined population as an aggregate.

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We do know some other important things about CYSHCN, however - according to the 2009/10 National Survey of CSHCN, there were approximately 11.2 million children who met this definition or 15% of the total US child population, up from 9.3 million or 12.8% in 2001 (NS-CSHCN, 2001-2009/10). Total spending on pediatric health care is a small fraction of what it is for adults (11.7% of total personal health expenditures for all children, including those with special health care needs, compared with 88.3% for all adults in 2012; NHED, 2012). However, costs associated with the care of CYSHCN, particularly those with medically complex conditions, constitute a significant portion of spending relative to children as a whole (for example, the 0.4-0.7% of children with medically complex conditions have been estimated to account for 15-33% of all health care spending on children; Berry et al, 2014).

What is meant by "value" in health care?

One way to think about achieving greater value in health care is to focus on more than just saving money; value in this context is highly dependent on whether the associated spending results in better outcomes as the result of better quality of care. The Institute for Healthcare Improvement's Triple Aim is a construct for health care delivery transformation that involves the simultaneous pursuit of reducing the per capita cost of health care, increasing the health of populations, and improving the patient experience of care (Berwick et al, 2008). Improving the patient experience of care in the Triple Aim does not simply mean patient satisfaction. The patient experience of care under the Triple Aim includes the Institute of Medicine's six dimensions of quality: care that is safe, effective, patient-centered, timely, efficient, and equitable (IOM, 2001). Title V MCH/CYSHCN professionals, family leaders and their allies have been working on foundational aspects of these dimensions for decades and as a result, have meaningful expertise to contribute in the pursuit of value-enhanced health care for CYSHCN.

Evidence-based quality measurement is critical to determining value. The depth of knowledge regarding the unique needs of CYSHCN that Title V and family leaders bring to the table can help payers and providers in identifying quality measures that truly touch on value, rather than just cost-savings (Brundage, 2016).

What is value-based purchasing and value-based insurance design?

Value-based purchasing (VBP) and value-based insurance design (VBID) are two important strategies for improving value in health care (Bachman et al, 2017). Although sometimes these terms are used interchangeably, they are actually different:

- Value-based purchasing - reimbursement strategies used by payers to incentivize providers to change their behavior or make decisions that increase value.

- Value-based insurance design – strategies by payers focused on consumers to incentivize behavior changes or decision-making that increases value.

Value-based purchasing – some examples

Examples of VBP strategies, organized on a continuum of increasing financial risk for both payers and providers, include:

- **PM/PM** – Per Member/Per Month is a payment strategy that does exactly what it sounds like it does. Providers receive a flat amount from a payer for each of their enrolled patients, on a monthly schedule, to support activities they aren't paid for under fee-for-service, like care coordination.
- **Pay for Performance or P4P** is a payment strategy that offers financial rewards to providers who meet or improve their performance on specific quality, cost, or other benchmarks – this strategy lends itself particularly well to chronic diseases which have readily accessible, evidence-based clinical interventions and existing quality measure benchmarks to put into practice. Under pay-for-performance, a pediatrician might receive a small extra payment for effectively managing the blood sugar levels of a child with Type 1 diabetes over a pre-determined period of time, for example.
- **Bundled payments**, also known as **episode of care payments** involve reimbursement based on the expected costs associated with a limited, defined "episode of care." An example of a defined episode of care familiar to Title V staff and family leaders might be an uncomplicated, hospital-based labor and delivery. Instead of all the various providers billing separately under a fee-for-service model, the hospital gets a lump sum for the "bundled" set of services associated with the birth. Instead of being incentivized for doing MORE medically, the hospital is incentivized to do WELL overall, because they get to keep whatever funds are left over after their costs are met. For CYSHCN, a familiar example of a defined episode of care might be treatment of an acute asthma flare. Of course, quality measurement and monitoring are key to ensuring that necessary care isn't being limited as a way to control costs. For example, if a quality metric is the percent of post-partum women leaving the hospital exclusively breast-feeding, inclusion of a hospital-based lactation consultant in the bundled payment rate might be considered. If an associated quality metric is reducing hospitalizations or emergency department visits for asthma treatment, family education and home assessments for triggers could be beneficial non-medical services included in a bundled payment.
- **Shared savings programs** align financial incentives across a broader array of providers than bundled payments do: primary, specialty, inpatient, outpatient, etc. Under a shared savings program, providers get to keep what they save. But they're also

at greater risk for what they spend, because under this model they're responsible for more than just a defined episode of care. If they don't save money, they don't get any additional money. This model offers greater incentives for coordination and collaboration because everyone involved is sharing some of the benefit as well as some of the risk. Children who are typically healthy are sometimes not included in shared savings programs, because the opportunity to save money on their care is minimal (Bailit, 2011). For children with special health care needs, particularly those enrolled in Medicaid, some examples of activities under a shared savings program might include behavioral health integration, multidisciplinary complex care teams, and telehealth as a vehicle to help decrease avoidable emergency department visits (Perrin et al, 2017).

- **Capitation/global payments**, which ACOs typically use, move completely beyond fee-for-service to full risk for a specific population's total cost of care. Risk adjustment, a discussion of which follows, is critical in this model to ensure that providers are not at undo risk when caring for patients with costly health problems.

Examples of value-based insurance design

Value-based insurance design is focused on patients/consumers and generally operates using a carrot or stick approach. Examples of carrots may include lower premiums or lower cost-sharing for participating in wellness programs, or removing co-pays for receiving preventative care. Examples of sticks may include higher cost-sharing for accessing "low value" services, which are often defined as those without evidence, or those which achieve the same quality outcomes of lower cost services.

Different stakeholders perceive value in different ways. What may appear to a payer to be a "low value" service may be highly valued by patients and families, for a variety of reasons. For a child with a chronic physical disability, this might involve covering habilitative therapy services, which do not improve functional ability but instead maintain it. Applying VBID is optimal when it includes clinical nuance, which acknowledges that:

1. Health services vary in the health benefit they produce.
2. The benefit obtained from a health service depends on who is receiving it, why they are receiving it, who is delivering the service, and the setting in which it is being delivered.

An MCH-specific example of this might be a health plan that offers lower co-pays for low-risk pregnant women delivering in well-staffed, reputable birthing centers, and requiring higher co-pays for low-risk deliveries in more expensive academic medical centers.

Accountable Care Organizations – a conduit for delivering value

An Accountable Care Organization (ACO) is an integrated delivery system (provider groups and/or larger institutions like hospitals) which contract with payers to improve the cost, quality of care, and health outcomes for a defined population of patients. It's not a VBP strategy in and of itself; it's an increasingly prevalent delivery system reform by which reducing costs, increasing health outcomes and improving the patient experience of care (the Triple Aim) can be achieved through care integration.

System of care elements needed by CYSHCN served by ACOs

Title V and family leadership organizations have expertise in the specific system of care elements needed by CYSHCN to be successfully served in ACOs:

- Access to a medical/health home model of primary care,
- A robust specialty care provider network,
- Protections and incentives for providers/organizations that have high/intense patient acuity, and
- Quality measures that are family-centered and pediatric-specific when applicable.

The importance of risk adjustment in achieving value

To date, there has not been a substantial amount of work done on risk adjustment for MCH populations, especially for CYSHCN, but financial protections for payers are an important consideration in VBP and VBID strategies (Tobias et al, 2012).

What is risk adjustment? When health plans receive a set amount for each member they cover, the plan takes on the risk that they will not spend more on the member's health care than they have collected in premiums. Members with disabilities and special health care needs, including children, are riskier for plans because they can be predicted to have higher costs than the average member. Something called "adverse selection" happens when a plan attracts a larger number of sicker people than healthy ones. If adverse selection occurs in too great a proportion over too long a period of time, it can undermine the financial stability of the plan as a whole.

Risk adjustment provides a way for plans who enroll higher cost members to "level the playing field" in terms of their financial stability. They get some extra money to serve as a cushion; for example, from a pot that all plans have contributed to.

Risk adjustment is also important to purchasers, providers, and families. Because payers are being protected, risk adjustment can help increase access to robust provider networks and limit discriminatory practices.

Conclusion

Maternal and child health professionals, family leaders and their allies have been working for decades to improve systems of care for women, children, including those with special health care needs, and families. As a result, the elements that are key to increasing value in health care services are familiar to them and they have meaningful expertise and experience to contribute.

Title V staff and family leaders have access to sources of MCH-specific data that decision-makers require to ensure VBP/VBID strategies meet the unique needs of mothers and children, including those with special health care needs. Examples include the National Survey of Children's Health, the National Survey of Children with Special Health Care Needs, the needs assessment conducted by state Title V programs every five years and consumer surveys, among others. Some Title V programs are service delivery providers, and as such have access to clinical and claims data.

Given their expertise and experience, Title V staff and family leaders can take the following actions to improve value-based payment and delivery reform efforts (CDC, 2014; Anderson et al, 2017):

- Develop formal and informal relationships with payers, providers, and others involved in VBP/VBID strategy development; serve on advisory committees, respond to surveys and network. Ensure decision-makers know about the data and other resources you have to offer.
- Lead collaborative partnerships such as Collaborative Improvement and Innovation Networks (CoIINs) focused on achieving the Triple Aim for MCH populations and invite payers, providers and others to participate.
- Work to ensure that payers, providers and other policymakers include families, particularly those from racially, culturally, and economically diverse backgrounds, in the design, implementation, and evaluation of their payment and delivery reform projects.
- Take advantage of educational opportunities to increase the health and health care financing literacy of yourself, your colleagues, and the families you serve. Attend webinars, read tutorials such as Public Insurance Programs and Children with Special Health Care Needs: A Tutorial on the Basics of Medicaid and the Children's Health Insurance Program (CHIP) and Health Care Coverage and Financing for Children with Special Health Care Needs: A Tutorial to Address Inequities, ask questions!

- Stay informed of current trends in health care financing, including new changes, strategies, and approaches. The May 2017 supplemental issue of *Pediatrics* entitled, "Innovative Health Care Financing Strategies for Children and Youth with Special Health Care Needs" is available to all readers free of charge and includes papers on a wide variety of VBP/VBID topics.

The Catalyst Center is available to help

Since 2005, the Catalyst Center has been researching and disseminating state-level financing strategies aimed at increasing health insurance coverage for CYSHCN and reducing financial hardship and medical debt for their families. Our staff can assist state Title V programs and their partners, policy makers, family leaders, researchers, and other stakeholders by answering questions, facilitating connections, and providing educational resources such as tutorials and policy briefs on innovative strategies such as value-based purchasing and value-based insurance design.

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