THE NATIONAL ALLIANCE
TO ADVANCE ADOLESCENT HEALTH

Margaret A. McManus, *President*

PEDIATRIC TO ADULT TRANSITIONAL CARE AND VALUE-BASED PAYMENT TECHNICAL ASSISTANCE

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THE NATIONAL ALLIANCE
TO ADVANCE ADOLESCENT HEALTH

Margaret A. McManus, *President*

TO: Texas VBP Transition Team

FR: Got Transition/National Alliance Team

RE: Health Care Transition and VBP TA

DATE: July 23, 2021

Hi Alicia and Texas Team,

There are two attachments: 1) the compilation of our VBP TA, with the addition of structural and outcome measures for family practices (included in the 7/22/21 memo), and 2) Got Transition resources that you requested on measurement and readiness assessments from our last call.

You asked for us to look into measuring gaps in care. Attached please find a really nice article on care gaps in adolescents with complex chronic conditions transitioning to adulthood. Here are some highlights:

1. Gaps in pediatric to adult transitional care occur in a sizeable proportion of this population (between 7-76%, depending on condition)
2. Care gaps are associated with increased morbidity, long term complications, number of hospitalizations, need for urgent intervention, and higher rates of health risk behaviors. "Therefore, developing measures to prevent such care gaps are of utmost importance."
3. Significant risk factors for care gaps were (I bolded ones that I thought were especially relevant to our HCT VBP work.)
    a. Living independently from parents
    b. Male
    c. Travel distance to closest adult specialized center
    d. Lower family income
    e. Milder disease activity
    f. Fewer outpatient visits in pediatric care over the 3 year period before transfer
    g. Last visit taking place outside university hospital
    h. History of at least one missed appointment

4. Significant protective factors
    a. Higher income
    b. Having at least 1 comorbid condition
    c. Having a written referral to a specific professional who would provide adult follow-up care
    d. Attending first or second outpatient visit
    e. Greater independence in attending appointments
    f. Belief that follow-up should be continued in specialized care
    g. Higher levels of self-efficacy
    h. Abstaining from substance use

There is no care gap measure that we found. However, we think it could be interesting to have your MCOs 1) identify adolescents and young adults, ages 14-21 and 22-26 who have not had an outpatient visit in the past 2 years to set a baseline and then work on reducing this care gap, and 2) identify adolescents & young adults who have documented a last pediatric visit/transfer date in the medical record and have made the initial adult appointment within 6 months of last pediatric visit/transfer date…again, starting first with a baseline and then improving on it going forward.

Got Transition Resources Requested

- HCT Process Measurement Tools:
  - Pediatric: https://www.gottransition.org/6ce/?leaving-process-measurement
  - Adult: https://www.gottransition.org/6ce/?integrating-process-measurement

- Transition Readiness Assessments Customized for Specific Populations
  - ACP resources for individuals with IDD and their caregivers: https://www.acponline.org/system/files/documents/clinical_information/high_value_care/clinician_resources/pediatric_adult_care_transitions/gim_dd/idd_transitions_tools.pdf
  - IEP resources:
    - Transition readiness assessment: https://www.gottransition.org/resource/?tra-iep-english
    - Sample goals: https://www.gottransition.org/resource/?sample-goals-for-tra-iep
  - Mental health:
    - Transition readiness assessment: https://www.gottransition.org/resource/?sample-tra-mentalhealth-maryscenter
    - Wellness plan: https://www.gottransition.org/resource/?sample-wellness-plan-mentalhealth-maryscenter

THE NATIONAL ALLIANCE
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Margaret A. McManus, *President*

TO: Texas VBP Transition Team

FR: Got Transition/National Alliance Team

RE: Suggestions for Health Care Transition Pay-for-Quality Bonus Pool: Structural and Outcome Measure Options for Pediatric and Adult Practices

DATE: July 22, 2021

This updated memo provides a set of structural and outcome measure bonus options for MCOs to consider including in Pay-for-Quality Bonus Pools for pediatric, adult, and family medicine practices. What is new from the last version is the addition of the family medicine section.

For Pediatric Practices:

Pediatric Practice Health Care Transition (HCT) Structural Measure Bonus Options

Each of these 5 structural measures could have 1 or more points assigned to them, and an annual bonus could be established based on the practice's score. For each measure, a linked sample tool is provided from Got Transition's Six Core Elements of HCT.

1. Written process that describes practice's approach to transition, privacy and consent, and age of transfer
    - For sample policy, click here
2. Documented process in EMR for identifying transition-aged youth's receipt of transition services, transfer date, and date of first visit to the new adult practice(s)
    - For sample registry, click here
3. Documented process for conducting periodic self-care skills assessments as part of routine primary and preventive care, starting at age 14 and continuing through the age of transfer.
    - Click here for a sample transition readiness assessment for youth
4. ***NEW**: Documented process for including transition self-care skill-building as part of a youth's plan of care
    - For sample plan of care, click here
5. Documented process for transfer of care, including preparation and exchange of medical summary and emergency care plan with youth and adult practice, communication between pediatric and adult practices, including joint telehealth visit with pediatric and adult providers and transferring young adult patient, and confirmation of completion of initial adult visit.
    - For sample medical summary and emergency care plan, click here
    - For sample transfer checklist, click here
    - For toolkit with suggested content for a joint telehealth visit, click here

Pediatric Practice HCT Outcome Measure Bonus Options

In the initial year, you could consider establishing a baseline. From there, you could set goals – 20%, 40%, 80% for meeting some or all of these.

1. % of individuals, ages 18 and older, who transferred and made their initial adult primary care visit within 6 months of the final pediatric visit
2. % of pediatric practices transferring their patient with summary of care record using certified EHR technology and completing electronic exchange of summary of care record to new adult practice
3. % of individuals, ages 18 and older, who transferred to adult care with access to their current medical summary and emergency care plan
4. % of individuals, ages 18 and older, whose new adult practice received their current medical summary and emergency care plan at time of transfer
5. % of individuals, ages 18 and older, who felt prepared for the transfer to adult care (click here for Got Transition's sample feedback survey for pediatric practices).
    a. *(Note: See also our transition suggestions for the STAR Kids CAHPS Survey on page 5. Alternatively, for sample Transition Feedback Survey for Youth/Young Adults, click here)*

***NEW: For Family Medicine Practices**

Family Medicine Practice HCT Structural Measure Bonus Options

Each of these 5 structural measures could have 1 or more points assigned to them, and an annual bonus could be established based on the practice's score. For each measure, a linked sample tool is provided from Got Transition's Six Core Elements of HCT.

1. Written process that describes practice's approach to transition and an adult approach to care, including privacy and consent.
    - For sample policy, click here
2. Documented process in EMR for identifying transition-aged youth's receipt of transition services,
    - For sample registry, click here
3. Documented process for conducting periodic transition readiness assessments as part of routine primary and preventive care, starting at age 14 and continuing into young adulthood.
    - Click here for a sample transition readiness assessment for youth
4. Documented process for including transition self-care skill-building as part of a youth's plan of care
    - For sample plan of care, click here

Family Medicine Practice HCT Outcome Measure Bonus Options

In the initial year, you could consider establishing a baseline. From there, you could set goals – 20%, 40%, 80% for meeting some or all of these.

1. % of individuals, ages 18 and older, who felt prepared for the transfer to an adult approach to health care (click here for Got Transition's sample feedback survey for family medicine practices).
    a. *(Note: See also our transition suggestions for the STAR Kids CAHPS Survey on page 5. Alternatively, for sample Transition Feedback Survey for Youth/Young Adults, click here)*

For Adult Practices

Adult Practice HCT Structural Measure Bonus Options:

Each of these 5 structural measures could have 1 or more points assigned to them, and an annual bonus could be established based on the practice's score. For each measure, a linked sample tool is provided from Got Transition's Six Core Elements of HCT.

1. Written process that describes practice's approach to transition, privacy and consent, and approach to accepting and partnering with new young adult patients
    - For sample policy, click here
2. Documented process in EMR for identifying new young adult patient's initial appointment and receipt of transition services
    - For sample registry, click here
3. Documented process for integrating new young adults into the adult practice, including providing a set of Frequently Asked Questions, ensuring receipt of transfer package, participating in a joint telehealth visit between pediatric and adult provider and transferring young adult, making pre-visit appointment reminder calls, and confirming with pediatric practice that initial appointment was made
    - For sample transfer checklist, click here
    - For sample Welcome & Orientation tip sheet with Frequently Asked Questions, click here
    - For toolkit with suggested content for a joint telehealth visit, click here
4. Documented process for conducting periodic self-care skills assessments as part of routine primary and preventive care, starting at the initial appointment and continuing through age 25.
    - For sample self-care skills assessment for young adults, click here
5. ***NEW:** Documented process for including self-care skill-building as part of a youth's plan of care
    - For sample plan of care, click here

Adult Practice HCT Outcome Measure Bonus Options

In the initial year, you could consider establishing a baseline. From there, you could set goals – 20%, 40%, 80% for meet some or all of these.

1. % of individuals, ages 18 and older, who transferred and made their initial adult visit within 6 months of the final pediatric visit
2. % of adult practices receiving summary of care record referral and who conduct clinical information reconciliation for medication, medication allergy, and current problem list.
3. % of individuals, ages 18 and older, with access to their current medical summary and emergency care plan
4. % of individuals, ages 18 and older, who kept their second appointment with their adult primary care provider.
5. % of individuals, ages 18 and older, who felt prepared for the transfer to adult care (and click here for Got Transition's sample feedback survey for adult practices). *(Note: Is it possible to add or modify any question(s) to the TX CAHPS Survey for adults, ages 18 and older, to complete?)*
6. % of individuals, ages 18 or older, who have had a self-care skills assessment and documented self-care education in the EMR?

THE NATIONAL ALLIANCE
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Margaret A. McManus, *President*

TO: Texas VBP Transition Team

FR: Got Transition/National Alliance Team

RE: Suggestions for Health Care Transition Pay-for-Quality Bonus Pool: Structural and Outcome Measure Options for Pediatric and Adult Practices

DATE: June 7, 2021

This memo provides a set of structural and outcome measure bonus options for MCOs to consider including in Pay-for-Quality Bonus Pools for both pediatric and adult practices.

For Pediatric Practices:

Pediatric Practice Health Care Transition (HCT) Structural Measure Bonus Options

Each of these 5 structural measures could have 1 or more points assigned to them, and an annual bonus could be established based on the practice's score. For each measure, a linked sample tool is provided from Got Transition's Six Core Elements of HCT.

1. Written process that describes practice's approach to transition, privacy and consent, and age of transfer
    - For sample policy, click here
2. Documented process in EMR for identifying transition-aged youth's receipt of transition services, transfer date, and date of first visit to the new adult practice(s)
    - For sample registry, click here
3. Documented process for conducting periodic self-care skills assessments as part of routine primary and preventive care, starting at age 14 and continuing through the age of transfer.
    - Click here for a sample transition readiness assessment for youth
4. ***NEW**: Documented process for including transition self-care skill-building as part of a youth's plan of care
    - For sample plan of care, click here
5. Documented process for transfer of care, including preparation and exchange of medical summary and emergency care plan with youth and adult practice, communication between pediatric and adult practices, including joint telehealth visit with pediatric and adult providers and transferring young adult patient, and confirmation of completion of initial adult visit.
    - For sample medical summary and emergency care plan, click here
    - For sample transfer checklist, click here
    - For toolkit with suggested content for a joint telehealth visit, click here

Pediatric Practice HCT Outcome Measure Bonus Options

In the initial year, you could consider establishing a baseline. From there, you could set goals – 20%, 40%, 80% for meeting some or all of these.

1. % of individuals, ages 18 and older, who transferred and made their initial adult primary care visit within 6 months of the final pediatric visit
2. % of pediatric practices transferring their patient with summary of care record using certified EHR technology and completing electronic exchange of summary of care record to new adult practice
3. % of individuals, ages 18 and older, who transferred to adult care with access to their current medical summary and emergency care plan
4. % of individuals, ages 18 and older, whose new adult practice received their current medical summary and emergency care plan at time of transfer
5. % of individuals, ages 18 and older, who felt prepared for the transfer to adult care (click here for Got Transition's sample feedback survey for pediatric practices).
    a. *(Note: See also our transition suggestions for the STAR Kids CAHPS Survey on page 5. Alternatively, for sample Transition Feedback Survey for Youth/Young Adults, click here)*

For Adult Practices

Adult Practice HCT Structural Measure Bonus Options:

Each of these 5 structural measures could have 1 or more points assigned to them, and an annual bonus could be established based on the practice's score. For each measure, a linked sample tool is provided from Got Transition's Six Core Elements of HCT.

1. Written process that describes practice's approach to transition, privacy and consent, and approach to accepting and partnering with new young adult patients
    - For sample policy, click here
2. Documented process in EMR for identifying new young adult patient's initial appointment and receipt of transition services
    - For sample registry, click here
3. Documented process for integrating new young adults into the adult practice, including providing a set of Frequently Asked Questions, ensuring receipt of transfer package, participating in a joint telehealth visit between pediatric and adult provider and transferring young adult, making pre-visit appointment reminder calls, and confirming with pediatric practice that initial appointment was made
    - For sample transfer checklist, click here
    - For sample Welcome & Orientation tip sheet with Frequently Asked Questions, click here
    - For toolkit with suggested content for a joint telehealth visit, click here
4. Documented process for conducting periodic self-care skills assessments as part of routine primary and preventive care, starting at the initial appointment and continuing through age 25.
    - For sample self-care skills assessment for young adults, click here
5. ***NEW:** Documented process for including self-care skill-building as part of a youth's plan of care
    - For sample plan of care, click here

Adult Practice HCT Outcome Measure Bonus Options

In the initial year, you could consider establishing a baseline. From there, you could set goals – 20%, 40%, 80% for meet some or all of these.

1. % of individuals, ages 18 and older, who transferred and made their initial adult visit within 6 months of the final pediatric visit
2. % of adult practices receiving summary of care record referral and who conduct clinical information reconciliation for medication, medication allergy, and current problem list.
3. % of individuals, ages 18 and older, with access to their current medical summary and emergency care plan
4. % of individuals, ages 18 and older, who kept their second appointment with their adult primary care provider.
5. % of individuals, ages 18 and older, who felt prepared for the transfer to adult care (and click here for Got Transition's sample feedback survey for adult practices). *(Note: Is it possible to add or modify any question(s) to the TX CAHPS Survey for adults, ages 18 and older, to complete?)*
6. % of individuals, ages 18 or older, who have had a self-care skills assessment and documented self-care education in the EMR?

THE NATIONAL ALLIANCE
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Margaret A. McManus, *President*

TO: Texas VBP Transition Team

FR: Got Transition/National Alliance Team

RE: Suggestions for Texas STAR Kids CAHPS Survey

DATE: June 7, 2021

Dear Texas Team,

Below please find our suggestions for the Texas STAR Kids CAHPS Survey, building on the current section on Transition Issues. It would also be terrific to obtain consumer feedback directly from the consumer after they have been integrated into adult care. We have a link to our youth/young adult, and parent/clinician transition feedback surveys below.

Currently, your STAR Kids CAHPS survey has one question drawn from the National Survey of Children's Health, which is asked of parents with children ages 12-21, who respond yes to this question: Do any of your child's doctors or other health care providers treat only children?

1. Have they talked with you about when your child will need to see doctors or other health care providers who treat adults? Response options: Yes, No, Don't Know, Refused.

We would recommend considering the following additional questions, which are also from the National Survey of Children's Health. These align with the measure options we previously shared – at least on the pediatric side.

1. Has this child's doctor or other health care provider actively worked with this child to:
   a. Gain skills to manage their health and health care (*For example, by understanding current health needs, knowing what to do in a medical emergency, or taking medications they may need?)* Response options: Yes, No, Don't Know
   b. Understand the changes in health care that happen at age 18? *(For example, by understanding changes in privacy, consent, access to information, or decision-making?)* Response options: Yes, No, Don't Know
2. Did you and this child receive a summary of your children's medical history? (*For example, medical conditions, allergies, medications, immunizations*)? Response options: Yes, No
3. Have this child's doctor or other health care providers worked with you and this child to create a plan of care to meet their health goals and needs? Response options: Yes, No (if No, skip to a later question)
   a. If yes, do you and this child have access to this plan of care? Response options: Yes, No
4. Does this plan of care address transition to doctors and other health care providers who treat adults? Response options: Yes; No; No, child already sees providers who treat adults.

You could consider asking the following question of parents of youth, ages 18-21.

1. Overall, how ready did your child feel to move to an adult doctor or health care provider about making the move to adult health care? Response options: Very, Somewhat, Not at all

Got Transition has a HCT Feedback Survey for Parents/Caregivers as well as one for youth and young adults.

We look forward to getting your feedback on these suggestions on our next call.

EMR And Information Technology Workgroup to Better Support Pediatric-to-Adult Transitional Care

Draft, June 7, 2021

Texas Medicaid is seeking EMR/IT experts from its MCOs to join a work group to assist in developing strategies to address gaps in current EMR functionality and needed enhancements to support pediatric-to adult health care transition (HCT). The 2018 AAP/AAFP/ACP Clinical Report calls for a structured process to be in place in all primary, specialty care, and behavioral health settings serving youth and young adults, ages 12-25, with and without special health care needs. The structured transition process recommended is called the Six Core Elements of Health Care Transition, developed by Got Transition. Evidence shows that with a structured approach to transition planning in pediatric care, a coordinated transfer, and a facilitated integration into adult care, statistically significant outcomes occur for youth with special needs pertaining to population health, experience, and utilization (e.g., reduced hospitalization).

Texas Medicaid is committed to supporting system-wide improvements in the provision of pediatric-to-adult HCT, especially for its STAR Kids and STAR+PLUS enrollees. For the past 6 months, with Got Transition, we have developed a preliminary set of options for managed care contract provisions, structural and outcome measures, fee-for-service and value-based payment, and content for training webinars for transition specialists and service coordinators – all consistent with professional transitional care recommendations. Indeed, Texas Medicaid is on the forefront in leading this new work, which is still very much in the design phase.

We are seeking to identify EMR/IT experts from each interested MCOs to meet monthly with us for the next 6-12 months to accomplish the following:

1. Make documenting, tracking, and accessing information about HCT accessible
    a. See pediatric and adult registry examples
2. Establish a transfer episode of care to ensure preparation of enrollees and caregivers, identification of accountable pediatric and adult providers, number(s) of transitions required (e.g., primary and specialty care transitions), evidence of exchange of medical and emergency care information and communication between pediatric sending and adult receiving clinicians, and completion of initial 2 adult visits.
3. Allow population management strategies for transition-aged youth and young adults, including proactive follow-up of missed appointments, appointment reminders, embedding a transition readiness or self-care skills assessment tool to develop and document education about self-care skills, changes in health care that occur at age 18, differences between pediatric and adult care, and, if needed, plans for decision-making supports.
    a. Note: Got Transition has ready-made tools related to these topics that can be linked.
4. Document HCT structure and outcomes measures that are part of the VBP options under development.

If interested, please submit a brief bio and your position title. We anticipate starting these monthly virtual calls in September 2021.

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Margaret A. McManus, *President*

TO: Texas VBP Transition Team

FR: Got Transition/National Alliance Team

RE: Suggestions for Health Care Transition Contract Language and Quality Measures

DATE: May 13, 2021

This memo contains suggestions for MCOs to ensure that their contracted pediatric and adult practices have a structured process for transition planning, transfer of care, and integration into adult care, consistent with AAP/AAFP/ACP Clinical Recommendation on HCT. Adding a HCT definition to MCO contracts would help to clarify what is meant by transition. We have attempted to draft some text that encourages MCOs to introduce VBP around transitional care, giving them several options, which align with the last section in the memo on Pay-for-Quality Bonus Pool Structural and Outcome Measures.

HCT Contract Language for STARKids and Star+Plus

Definitions:

Health care transition (HCT) is the process of moving from a child to an adult model of care with or without transfer to a new practice, starting at ages 12-14 and continuing into young adulthood. Got Transition's HCT Timelines lay out suggested steps for youth/young adults and parents/caregivers to prepare for this transition process. Transition goals include:

a. Improving the ability of youth and young adults to manage their own health and effectively use health services to the best of their abilities, and
b. Having an organized clinical process in pediatric and adult practices to facilitate transition preparation, transfer of care, and integration into adult care

Provider Networks: MCOs are encouraged to establish alternative payment methods to incentivize pediatric and adult primary and specialty practices in the provision of recommended HCT services. Options include but are not limited to:

a. Participation in a *new* Transition Pay-for-Quality Bonus Pool (See below)
b. Enhanced FFS to incentivize adult practices to accept a certain volume of young adults transitioning out of STARKids
c. Use of infrastructure payments to improve EMR functionality for transition
d. Pay for performance to reward pediatric and adult practices who establish a coordinated transfer episode, with preparation/exchange/reconciliation of a current medical summary, participation in a joint telehealth call, and evidence of completion of initial adult visit.
e. Per member per month payment, adjusted for complexity, for year prior to transfer and year after transfer to recognize the added work involved in planning a coordinated transfer and ensuring a facilitated integration and retention in adult care.
f. Recognition of selected FFS codes relevant to transition. *(Note: we can add a list of these)*

HCT Transition Pay-for-Quality Bonus Pool Measures

1. HCT Structural Measure Bonus Options

   The sample tools listed below are for pediatric and adult practices. Each of these 5 structural measures could have 1 or more points assigned to them, and an annual bonus could be established based on the practice's score.

   6. Written process that describes practice's approach to transition, privacy and consent, age of transfer, and approach to accepting and partnering with new young adult patients.
      - For sample policies, click here for pediatric policy and here for adult policy
   7. Documented process in EMR for identifying transition-aged youth's receipt of transition services, transfer date, and new adult practice(s)
      - For sample registry, click here
   8. Documented process for conducting periodic transition readiness/self-care assessments as part of routine primary and preventive care, starting at age 14 and continuing through age 25.
      - Click here for a sample transition readiness assessment for youth
      - Click here for a sample self-care assessment for young adults
   9. Documented process for transfer of care, including preparation and exchange of medical summary and emergency care plan with youth and adult practice, communication between pediatric and adult practices, including joint telehealth visit, and evidence of completion of initial adult visit.
      - Click here for a sample medical summary and emergency care plan
      - Click here for a sample transfer checklist
      - Click here for a sample Welcome & Orientation tip sheet with Frequently Asked Questions
   10. Practices maintain an up-to-date listing of adult primary and specialty practices.
      - Click here for Got Transition's Finding an Adult Doctor tip sheet, which can be customized to include a list of practices.

2. HCT Outcome Measure Bonus Options

   In the initial year, you could consider establishing a baseline. From there, you could set goals – 20%, 40%, 80% meet 3 or more of these.

   a. % of individuals, ages 18 and older, who transferred and made their initial adult visit within 6 months of the final pediatric visit
   b. % of pediatric practices transferring their patient with summary of care record using certified EHR technology and completes electronic exchange of summary of care record to new adult practice
   c. % of individuals, ages 18 and older, who transferred to adult care with access to their current medical summary and emergency care plan
   d. % of adult practices receiving summary of care record referral and conducts clinical information reconciliation for medication, medication allergy, and current problem list.
   e. % of individuals, ages 18 and older, whose new adult practice received their current medical summary and emergency care plan at time of transfer
   f. % of individuals, ages 18 and older, who felt prepared for the transfer to adult care (click here for Got Transition's sample feedback survey for pediatric practices, and click here for Got Transition's sample feedback survey for adult practices). *(Note: Is it possible to add or modify any question(s) to the TX CAHPS Survey?)*

Pediatric to Adult Transitional Care Structural Measures/Scorecard
April 2021

Points could be assigned for each measure (*note: the sample tools listed below are for pediatric and adult clinicians; we also have sample tools for family medicine clinicians on our website)*:

1. Documented process that describes STARKids and STAR+Plus approach for advance planning for coordinating the aging out process from STARKids and facilitating the integration into STAR+Plus.
    - For sample policies, click here and here
2. Documented mechanism for identifying and tracking youth and young adults anticipating and completing 1) transfer from pediatric to adult care and 2) moving from STARKids to STAR+Plus.
    - Click here for a sample registry to document adult visit completion
3. Documented process that describes transition specialist's role in both STARKids and STAR+Plus for coordinating transfer of care, including preparation and exchange of medical summary and emergency care plan with youth and adult provider, communication between pediatric and adult providers, including joint telehealth visit, and evidence of completion of initial adult visit.
    - Click here for a sample medical summary and emergency care plan
    - Click here for a sample transfer checklist
    - Click here for a sample Welcome & Orientation tip sheet with Frequently Asked Questions
4. Evidence of MCOs having up-to-date listing of adult primary and needed specialty providers.
    - Click here for Got Transition's Finding an Adult Doctor tip sheet, which can be customized to include a list of providers.
5. Documented process for ensuring that transition specialists receive ongoing education and training on HCT Clinical Recommendations (from AAP/AAFP/ACP), Got Transition's Six Core Elements of HCT, and MCO contract requirements on HCT.

Texas Transitional Care Quality Measure Options
April 2021

HCT Process Measure Options

- Pediatric to Adult Transitional Care Structural Scorecard (attached to this email).

HCT Outcome Measure Options

- Evidence of initial adult PCP visit within 6 months following last pediatric visit
- Electronic exchange of medical summary and emergency care plan
    - Pediatric provider transferring their patient creates a summary of care record using certified electronic health record technology and completes electronic exchange of the summary of care record*
    - Adult provider receiving transfer referral conducts clinical information reconciliation for medication, medication allergy, and current problem list*
    - Adult provider receiving transfer referral exchanges receives report confirming initial adult visit completed*
- Medical summary and emergency care plan received by transferring youth/young adults at time of transfer*
- Reductions in loss to follow-up among transition-aged youth and young adults in pediatric and adult care
- New questions could be added on Texas STAR Kids CAHPS Survey

*****These examples have been adapted from existing measures

Training Webinars on Pediatric-To-Adult Transitional Care
April 2021

Webinar #1: Transition from Pediatric to Adult Health Care: Evidence and Clinical Care Recommendations

Audience: Transition Specialists and Service Coordinators

Learning Objectives:

1. Review current health care transition (HCT) outcome evidence and the AAP/AAFP/ACP Clinical Report recommendations for a structured HCT intervention.
2. Describe key lessons learned from implementing HCT performance improvement programs using examples in primary and subspecialty settings.
3. Review new HCT tools and resources available through www.gottransition.org

Content:

I. Background
   a. Current state of HCT from National Survey of Children's Health
   b. Evidence for structured HCT approach

II. Six Core Elements Structured HCT Process
   a. AAP, AAFP, ACP Clinical Report recommendations
   b. Review of Six Core Elements and tools from Pediatric and Adult Packages
   c. Measurement Options
   d. Implementation Guide, with example of one core element's implementation
   e. QI Primer

III. Examples from two systems on lessons learned on Implementing the Six Care Elements
   a. Seven system Got Transition Learning Community of both primary care and subspecialty practices
   b. SE US Region Consortium of 14 PCORI Sickle Cell Disease pediatric and adult sites.

IV. New Tools at www.gottransition.org
   a. Family Toolkit
   b. Youth/Young Adult Page
   c. Joint Telehealth Transition Toolkit
   d. 2021 Coding and Payment Tip Sheet

Presenters: Patience White, MD, MA and Peggy McManus, MHS, Got Transition
TX Medicaid Official

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Margaret A. McManus, *President*

TO: Texas VBP Transition Team

FR: Got Transition/National Alliance Team

RE: Crosswalk of STAR Kids Managed Care Advisory Panel Recommendations on HCT and Options to Review for MCO Contracting, Payment, and Quality Measurement

DATE: March 10, 2021

This memo provides a cross-walk of possible HCT options with those recommended by the STAR Kids Managed Care Advisory Group. We have noted this alignment with *. At our next meeting, we would like to get your input on the options you are most interested in under each of the 5 topics, including any that we might have missed. Based on this guidance, we will be in an excellent position to provide more specificity going forward.

1. STAR Kids Topic/Issue: *Medicaid fee schedule gaps impede provision of HCT services and collaboration between pediatric and adult providers.*

   Options:
   A. Create a new HCPCS code for joint telehealth visit between pediatric and adult providers and young adult/caregiver.*
   B. Allow 2 assigned pediatric and adult providers to bill for same patient.*
   C. Recognize selected HCT-related codes on Medicaid fee schedule (additional codes could be considered):
      i. CPT 96160. Health and behavior risk assessment (for conducting transition readiness/self-care skill assessment)*
      ii. CPT 99358, 99359. Prolonged services, non-face-to-face (for preparing/updating medical summary and emergency care plan)*
      iii. CPT 99446-99449, 99451, 99452. Interprofessional phone/internet/EHR consultations (for consultations between pediatric providers and new adult providers)*

2. STAR Kids Topic/Issue: *Limited time to coordinate services with STAR+Plus plans when non-MDCP, PPN, or PPECC member ages out of STAR Kids at age 21.*

   Option:
   A. Establish coordinated contract provisions for the aging out process requirements in STAR Kids plans and for new members integrating into STAR+Plus plans. Also, extend the time period for the age-out process in STAR Kids and the new members integration in STAR+Plus plans from 6-9 months to 12 months.

3. STAR Kids Topic/Issue: *Limited coordination of services between STAR Kids and STAR+Plus plans ensure member receipt of recommended HCT services.*

   Options:
   A. Create a new pay-for-quality bonus pool measure on pediatric-to-adult transitional care for STAR Kids and STAR+Plus plans (modeled after Colorado's structural measures).

B. Establish a transfer episode of care between STAR Kids and STAR+Plus plans covering the year before and after transfer and create a risk-adjusted monthly capitation fee for accountable plans or pediatric and adult providers overseeing transfer.
C. See also FFS options listed under 1A and 1B.
D. Establish coordinated contract provisions and/or system readiness criteria for STAR Kids and STAR+Plus plans, building on current STAR Kids Adult Transition Planning requirements, including hiring and training of Transition Specialists in STAR+Plus plans. Such provisions/criteria could also provide more explicit guidance on what HCT services should be coordinated – for example, assistance with and selection of adult primary and specialty providers; preparation/exchange of medical summary and emergency care plans; communication between sending and receiving health care providers.*
E. Establish coordinated provisions in other sections of STAR Kids and STAR+Plus contracts consistent with AAP/AAP/ACP Clinical Recommendations on HCT (e.g., provider networks, EPSDT, care coordination).*

4. STAR Kids Topic/Issue: *Improve HCT through adoption of HCT standards and best practices.*

   Option:
   A. Create new online training resources on recommended HCT processes (Got Transition's Six Core Elements of HCT) that would be required for transition specialists in STAR Kids and STAR+Plus plans.*

5. STAR Kids Topic/Issue: *Lack of Medicaid adult primary and specialty care providers available to care for complex patients aging of out pediatric care.*

   Options:
   A. Create VBP options to incentivize the expansion of new adult networks to care for medically complex patients in coordination with pediatric complex care clinics (e.g., infrastructure payment for care coordination support, bonuses for accepting certain volume of new patients).*
   B. Implement new VBP pilot with STAR Kids plan(s) and identified pediatric practice(s) to establish a planned transition into adult care process for those 18 and over, who need to transfer out of their pediatric primary or specialty care and require assistance in finding adult doctors and ensuring a smooth integration into adult care, for those who remain in STAR Kids until their 21st birthday.*
   C. Establish contract provisions and/or system readiness criteria for both STAR Kids and STAR+Plus plans regarding their adult provider network capacity to serve young adults with medical complexity, intellectual and developmental disabilities, and chronic mental/behavioral conditions, including regular surveys of adult provider networks.*

Transition Payment Options

3/2/21

Enhanced Fee-for-Service
1. 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.
2. 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.
3. Recognize transition-related CPT codes for clinicians who have established a formal collaboration between pediatric and adult practices/systems.
4. 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.
5. 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.
6. 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.
Infrastructure Investments
1. Upgrade EMRs to incorporate recommended transition clinical processes in pediatric and adult practices/systems.
2. 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.
3. Support the development of collaborative pediatric and adult clinical networks.
4. Participate in training and quality improvement efforts to implement recommended transition clinic processes in pediatric and adult practices/systems.
5. Develop pediatric specialty consultation arrangements with adult clinicians/systems.
6. Build care coordination supports for adult practices accepting young adults with chronic conditions.
7. Provide quality oversight and monitoring of the HCT process in both pediatric and adult settings.
Pay-for-Performance
1. 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.
2. Reward pediatric and adult clinicians/practices/systems who achieve specific transition quality performance targets.
3. 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).
4. 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.
5. 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.

6. 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.
Direct Payment to Consumers
1. 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.
2. Provide an incentive for young adults to attend their initial and, possibly also, subsequent adult visit.
3. Provide an incentive for youth and young adults to adhere to care and medication recommendations.
4. Provide an incentive for youth and young adults to complete a survey about their transition process or experience with care.
Episode of Care/Bundled Payment
1. 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.
2. 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.
3. 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.
4. 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.
Per Member Per Month
1. 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.
2. 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.
3. 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.

Source: McManus M, et al. *Recommendations for Value-Based Transition Payment for Pediatric and Adult Health Care Systems: A Leadership Roundtable Report.* Washington, DC: The National Alliance to Advance Adolescent Health, 2018. Available here.