

# **Pediatricians' Perspectives on Value Based Insurance Design and Payment**

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## **ABSTRACT**

Objective: To obtain a snapshot of the perspectives of pediatric practices dealing with VBID and the impact on their practice on (a) characteristics of pediatric practices that have contracted with health plans that have implemented value-based insurance design (VBID) products (including value based payments or VBP) and currently serve CYSHCN under these contracts; and (b) the effect the products have had on the delivery of pediatric care in the medical home practice setting, focusing on children and youth with special health care needs (CYSHCN) who have a range of health care needs.

Methodology: American Academy of Pediatrics (AAP) members involved in AAP groups on medical home, child health financing, community pediatrics and practice administration and management were invited to complete an on-line (Survey Monkey) survey. Follow-up in-depth interviews were conducted with a small set of selected practices by targeting practices having at least one-third of their revenue or patient mix under value based payment or value based insurance design products.

Results: Based on the surveys and follow-up interviews of pediatricians based on their experiences with VBID, VBP and the effect on the delivery of care, identified key themes include:

- Most interviewees believed that access and provision of care improved as a result of participating in value based programs; however, not sure whether actual outcomes have improved. There were also mixed responses regarding whether the practice experienced an increase in revenue (pay increase).
- Pediatricians reported that as a result of their participation in payer value based models, access was expanded through new office hours, open access scheduling, and patient recall and reminders
- Pleased to see the movement towards value and greater focus on pediatric quality metrics
- Pediatricians felt changes in practice operations related to:
  - Increased monitoring and reminders for screenings/testing
  - Increased data analytics by the practice
  - Increased staffing for administration and clinical care
  - Increased administrative work by the practice

## **Introduction: The Acceleration of Value Based Programs**

The movement to value based health care is accelerating. In 2015, the Health and Human Services (HHS) and the private sector Health Care Transformation (HCT) Task Force announced plans to support rapid expansion of value based payment contracts. HHS calls for 50% of all Medicare provider payments to be made through alternative, value based

payments by 2018.<sup>1</sup> The HCT Task Force announced its commitment to have 75% of its members business into value based payment by 2020.<sup>2</sup> The group includes some of the nation's largest health plan carriers and non-profit health systems including Ascension Health, as well as Trinity Health, Partners HealthCare, Advocate Health Care, Aetna, the Health Care Services Corp. (which runs five state Blue Cross plans), employers Caesars Entertainment and the Pacific Business Group on Health, and others. The two largest commercial carriers, UnitedHealthcare and Anthem have already begun transitioning to VBP.

These programs seek to incentivize providers and health plan enrollees to adopt behaviors to increase quality and/or decrease costs through various strategies including:

- Value based payment: Defined by Centers for Medicare and Medicaid Services (CMS) as a system in which some or all services will be variably adjusted upward or downward from a standard payment, based on performance using predetermined metrics intended to define quality of care and/or healthcare outcomes.<sup>3</sup>
- Value based insurance design: Bases a consumer's out-of-pocket costs according to the value of a medical service or product for a specific patient population.<sup>4</sup>
- Value based benefit design: Addresses the way health benefits are structured and utilized by employees. Its focus is broader than just the insurance design and includes other types of incentives.<sup>5</sup>

### **What is the effect on pediatric practices?**

Providers are being asked to accept increased risk sharing through value based payments as incentives to improve quality of care. The impact of these changes on the design and delivery of pediatric health care, especially on children and youth with special health care needs (CYSHCN), is unclear. The AAP, working with the Catalyst Center has convened a Learning Community comprised of scholars, practitioners, family members and policymakers to explore these issues from their respective viewpoints. One aspect of this effort is to develop a white paper on pediatrician's perspectives on VBP and VBID and their effect on the delivery of pediatric care in the medical home practice setting with particular emphasis on the range of health care services necessary for CYSHCN.

AAP members were asked to complete a survey on VBID and VBP and select pediatricians were then interviewed as to obtain information from pediatric practices that have worked with health plans that have implemented value-based insurance design (VBID) products to learn of the effect the products have had on the delivery of pediatric care in the medical home practice setting.

### **How the study was conducted and limitations**

#### **General Survey**

AAP staff solicited key groups within the Academy to complete an on-line survey on VBID. These groups included pediatricians in office or system practices focused on medical home, child health financing, community pediatrics and practice administration and management. The call to complete the survey was directed to those pediatric practices that have worked with health plans that have are about to implement VBID products and/or VBP.

The survey was open from May-Sept 2015. Ninety responses were received to the on-line survey and one was eliminated as a duplicate submission.

From the survey responses, some general observations were made and it was determined to conduct in-depth interviews those practices reporting that at least one-third of their revenue or patient mix was under VBP or VBID products. By targeting practices with this level of experience would be expected to represent a critical mass having a substantial impact on practice operations.

#### Pediatrician Interviews

Questions developed by AAP and Catalyst Center project staff were sent to selected pediatricians prior to the interviews. Pediatricians were asked to be prepared to discuss the open-ended questions provided and to have appropriate staff experts participate in scheduled interviews.

The purpose of the interviews was to gather qualitative data on the experience and perceptions of pediatricians and key staff on with more experience with VBIP payment and the steps they took to prepare and adapt. Follow up interviews were conducted in 2016 by the author. Because of the small number of pediatricians interviewed, quantitative analysis was not performed. Participants' responses are reported in aggregate and represent the views of their respective practices.

#### Characteristics of Respondent Practices

There were 89 total survey responses to the on-line survey. Of these, 90% were from primary care pediatricians and 10% were specialists. About 67% or 2/3 were in private practice and 33% were in an employed practice setting.

Approximately 22% of the respondents reported having at least 33% of their practice revenue derived from non-traditional (i.e., non-Fee-for-Service) payments with an equal amount reporting practice revenue between 33%-50% and over 50% of practice revenue due to value based payment. This may include Capitation (per member per month); pay for performance, bundled payments; shared savings arrangements and/or enhanced fee-for service payments for meeting certain criteria (such as medical home certification).

*Question: What percentage of your practice revenue is derived from non-traditional (i.e., non-fee-for-service) payments? Total responses =83*

Answer Choices	Responses
<b>Less than 33%</b>	<b>78.31%</b>
<b>33% – 50%</b>	<b>10.84%</b>
<b>More than 50%</b>	<b>10.84%</b>
Total	

About 28% of respondents reported having a patient case mix covered by a VBID product. An almost equal amount had 33%-50% and over 50%.

*Question: What percentage of your patient case mix is covered by a Value Based Insurance Design (VBID) product? Total responses =83*

Answer Choices	Responses
<b>Less than 33%</b>	<b>72.29%</b>
<b>33% - 50%</b>	<b>13.25%</b>
<b>More than 50%</b>	<b>14.46%</b>
Total	

As shown in the table below, the majority of respondents had relatively few CYSHCN patients covered under a VBID product.

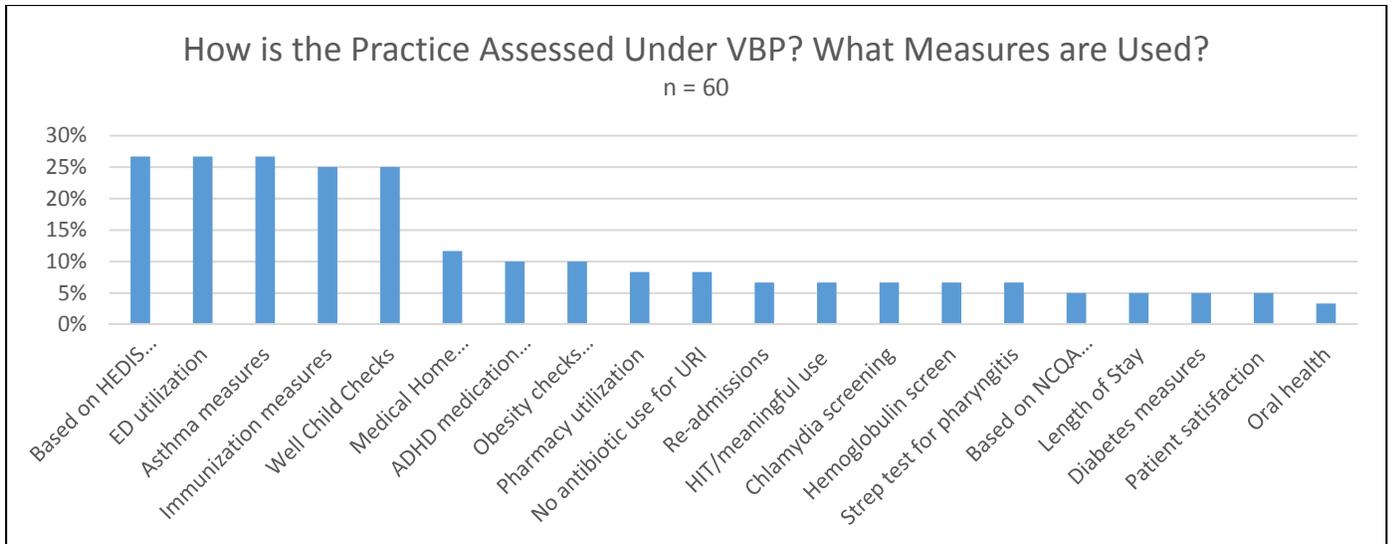
*Question: What percentage of patients covered under a VBID product include children and youth with special health care needs (CYSHCN)? Total responses =83*

Answer Choices	Responses
<b>Less than 5%</b>	<b>46.99%</b>
<b>5%-10%</b>	<b>22.89%</b>
<b>11%-20%</b>	<b>16.87%</b>
<b>21%-35%</b>	<b>4.82%</b>
<b>36%-50%</b>	<b>3.61%</b>
<b>More than 50%</b>	<b>4.82%</b>
<b>Total</b>	

**Survey findings**

Survey respondents identified Healthcare Effectiveness Data and Information Set (HEDIS) measures as the most common type of methodology used to assess the practice under VBP. HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA) and the majority of health plans use HEDIS to measure performance on important dimensions of care and service. This was true among the respondents in this survey. The most commonly reported HEDIS performance measures were asthma management, Emergency Department (ED) utilization, well-child checks and immunizations.

Below is a summary of the survey findings.



Practices reported that new quality measurement strategies and enhanced care management processes were the most frequently cited change in practice operations as a result of VBID and VBP.

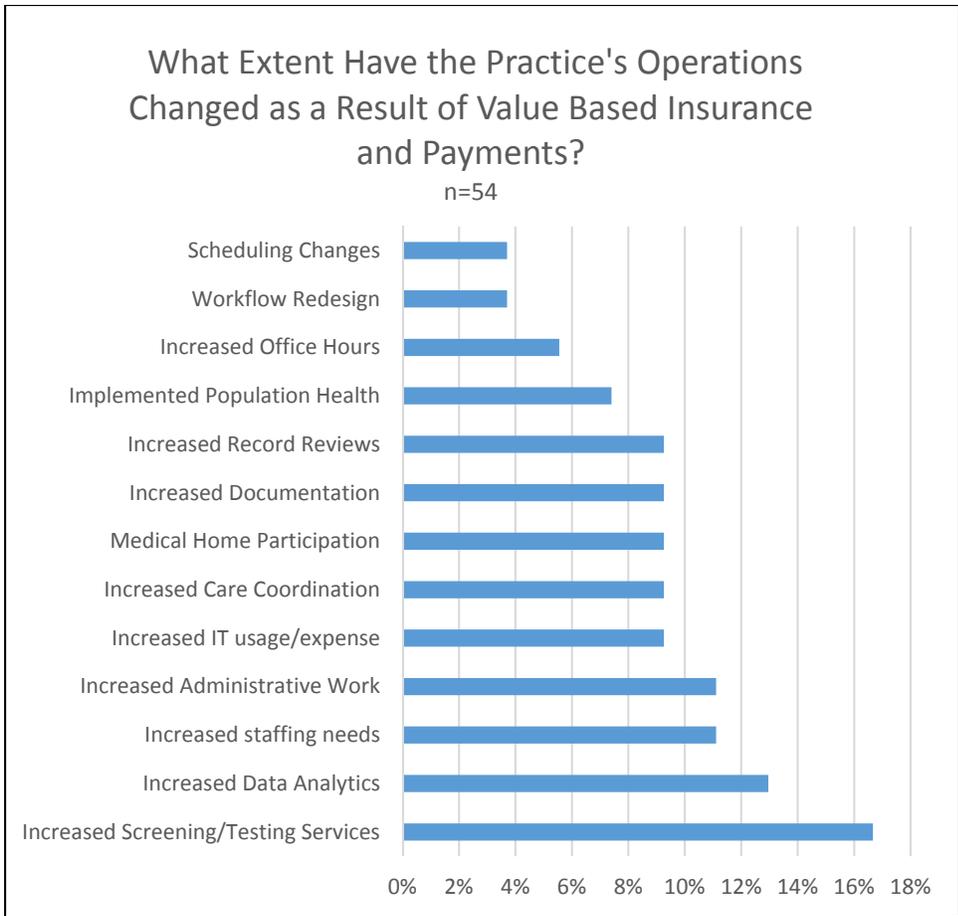
*Question: Has the emergence of VBID and VBP resulted in the need to change any of the following practice operations? Respondents were allowed to check more than one item*

Answer Choices	Responses
<b>Upgrade electronic records system</b>	<b>40.00%</b>
<b>Upgrade practice management system</b>	<b>31.67%</b>
<b>Enhance care management process within the practice</b>	<b>85.00%</b>
<b>Implemented new quality measurement strategies</b>	<b>88.33%</b>

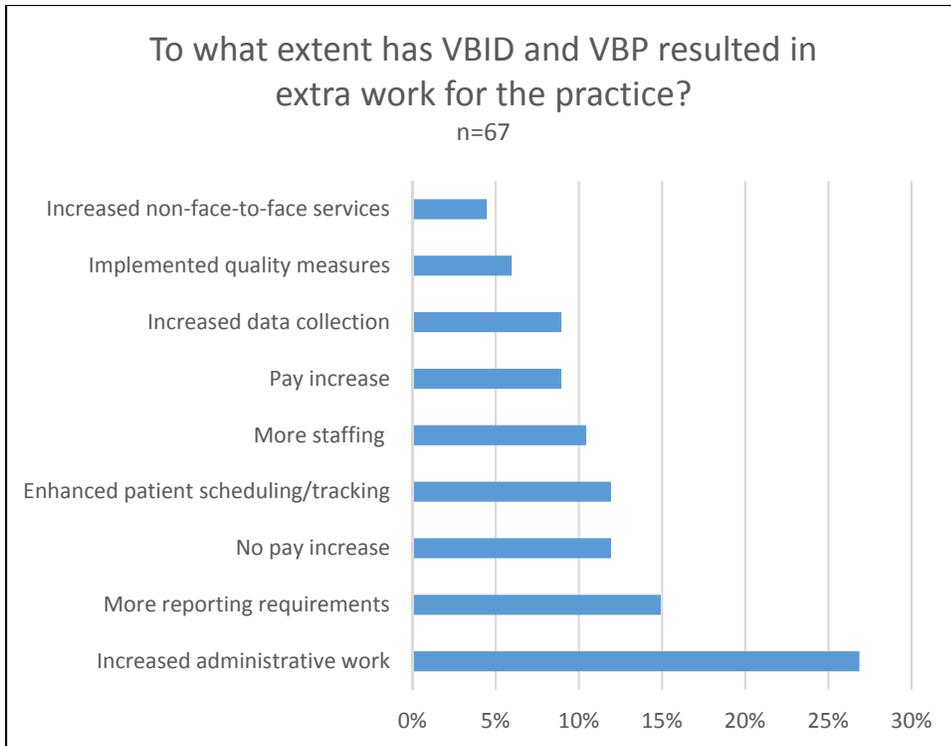
Total Respondents: 60

Specific changes in practice operations most frequently reported include

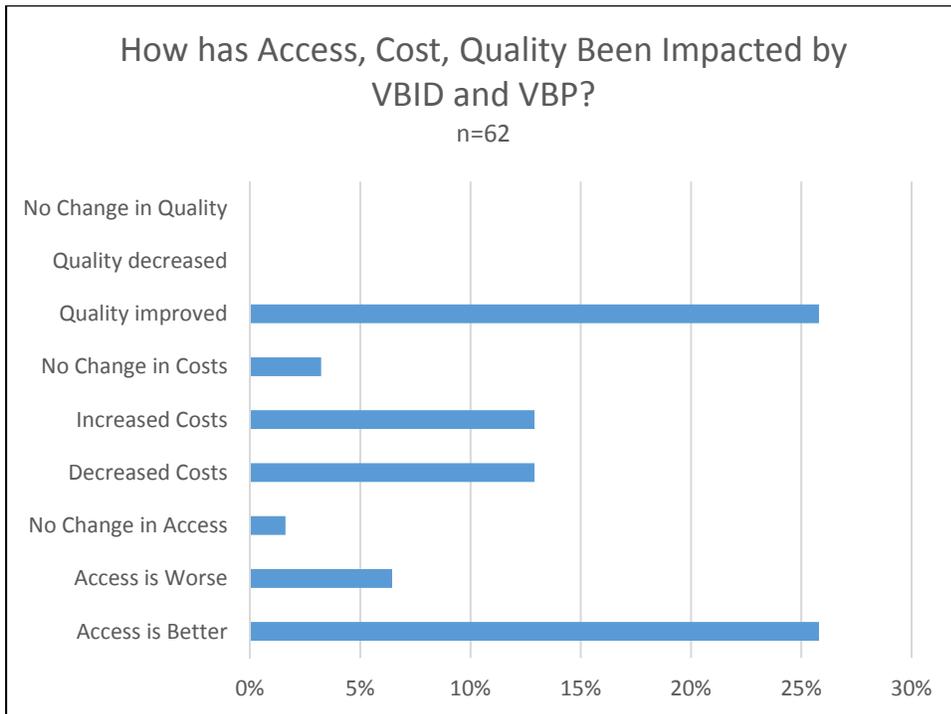
- Increased monitoring and reminders for screenings/testing
- Increased data analytics by the practice
- Increased staffing for administration and clinical care
- Increased administrative work by the practice



Respondents were asked to report to what extent VBID and VPB resulted in extra work for their practice and if there were any impacts to access to care, quality of care, and cost of care. Increased administrative work required to implement and maintain operations under value based contracting and additional reporting requirements were the most frequently cited impacts.



While survey respondents stated that access and quality were improved under value based products there was a mixed perception of whether costs decreased or increased. Mixed responses on whether the practice experienced an increase in revenue (pay increase) were reported, as well.



## Key themes voiced by the pediatricians:

### ➤ Trade offs in practice expense vs payment

- “It has increased work and overhead but improved quality of care”  
-Primary care pediatrician, New York
- “Too early to tell...but it resulted in much better care coordination. Much attention to calling patients proactively, much more attention to evidenced-based care and elimination of costly unnecessary visits.”  
-Primary care pediatrician, North Carolina
- “Costs of management (paperwork) have increased more than the incentive payment.”  
-Primary care pediatrician, New York

### ➤ Differing & Conflicting Quality Measures

- “Really need more pediatric oriented, evidence based measures. The few measures that exist for pediatrics (antibiotics for URI, QS for Strep, ADHD visits) are not good reflection of what we really do to help to improve the health of populations. Vaccines and well-check frequency are good...but that’s not enough”  
-Primary care pediatrician, Virginia
- “Burdensome to have different metrics...different reporting methods for different payers. Inefficient when care gap information is not available to providers at the point of care.”  
-Primary care pediatrician, Pennsylvania

### ➤ Impact on Small Practices

- “Data analysis is crucial and if you don’t have an EMR, it’s tough to do. You also need to have administrative staff to extract the data. Everything from medical home to payer for performance comes out of your EMR.”  
-Primary care pediatrician, Hawaii
- “Spent 2 million to start this up. Can’t do it as a small practice, but did it through the IPA and the health system. Needed a lot of education for staff.”  
-Primary care pediatrician, Virginia
- “Lack of intra-operability between practice EHR and Payer databases is a big hindrance and cause of much additional work. Great that practices are rewarded for quality but lag time in getting claims data to the payer and back to provider means useful data not in the hands of provider at point of care, at least not easily.”  
-Primary care pediatrician, Colorado

## **Overall Perceptions Reported by Pediatricians**

The surveyed and interviewed pediatricians found value based transition to be mostly positive in the following areas:

- Increased movement towards value and a perceived need for greater focus on pediatric quality
- Improved care coordination through staffing changes
- Opportunity to explore new models
- QI process improvement

However, there were mixed opinions as to whether value based payment models resulted in a net increase in total payment to the practice after factoring in additional practice overhead costs to implement the necessary changes in practice operations. The increased administrative burden to the practice arising from coordinated care management, data collection and reporting requirements were among the concerns expressed by practices. An oft reported “hassle” by the pediatricians was the many and, at times, conflicting quality measures required by payers to receive enhanced payments. The survey indicated that pediatricians would prefer to identify a core set of quality metrics applicable to all payers to implement at the practice setting.

## **Pediatrician Interviews**

As noted, interviews were conducted with pediatricians reporting a relatively higher degree of experience with value based payment models by either having at

least one-third of their revenue or patient mix under VBP or VBID products. Those interviewed voiced a strong consensus that market forces by payers implementing value based payment and VBIP as the impetus for their involvement in these programs. All of the practices interviewed were recognized medical homes and had incorporated an EMR system with a single exception. One interviewee had recently left private practice for a position as a Medical Director for a hospital population health program.

### **Impact on the Practice**

- Underscored the importance of being a medical home provider and having an EMR as key elements for practices in the current value based environment. Most noted that their payers had included enhanced payments for practices being a recognized medical home.
- Demonstrated that having an EMR assisted in the data collection and reporting. Data gathering was reported by pediatricians as a major responsibility of the practice operating under a value based system and having a well-designed EMR significantly facilitated the data analytics by the practice.
- Revealed that capitation or payment by per member per month (PMPM) was the most common payment model used.
- Raised practice awareness of what the practice needed to do to meet payer benchmarks:
  - Track well-checks within recommended timeframes pro-actively
  - Hire additional staff for care coordination and greater use of a care team approach
  - Change staffing and scheduling processes to enhance ability to track and direct patient flow and recalls
  - Review prescribing habits. Some interviewees reported that there have been conflicts with payers over use of generic prescriptions and going outside of the formulary
  - Educate practice staff on new processes and procedures
- All reported on the need to add either clinical or administrative staff to handle increased workload for documentation, reporting and care coordination. The type of additional staff added depended on the practice's prioritization of specific value based requirements. For instance, adding clinical staff was needed for team based care, care coordination, case management. Increasing administrative staff was needed to enable data collection and reporting.
- Major challenges reported include accessing timely and meaningful data from payers. Real time access to payer data would have allowed practices to analyze results and implement improvements more rapidly instead of waiting months for data. Some reported a related concern that reconciling the payer data with practice data was time and staff intensive.

### **Impact on Patients and Families**

- Pediatricians reported that participation in payer value based models resulted in access expansion through extended office hours, open access scheduling, and patient recall and reminders.
- Most interviewees believed that access and provision of care improved as a result of participating in value based programs, however they were not sure whether actual patient health outcomes have improved. Most cited the need for additional data from payers to assess health outcomes.
  - A general consensus by the interviewees was that the case management and care coordination was beneficial for CYSHCN.
  - Respondents indicated a potential concern regarding the need to identify patient mix severity and acuity level and account for risk management for CYSHCN under capitated arrangements. Otherwise, practices may be hesitant to take on high risk patients under a capitated arrangement if the VBP does not recognize the additional services necessary for high risk patients.

### **Impact on Payer Relationships**

- Need for close working relationship with payers by providers and for both payers and providers to regard each as partners.
- Increased reliance on payers for timely and meaningful data. Many interviewees reported on the need to work closely with payers to have input on the types of data that is most meaningful to the practice. One interviewee reported having monthly meetings with their payer to review data and quality metrics.
- Payers can also be a resource for infrastructure support, including IT and data analytics, and care coordination. Some payers provided support for care coordinators either through payments or by providing care coordinator staff (who were employed by the carrier).
- Pediatrician input to payer quality metrics was viewed as necessary and essential. To address concerns that practices need to meet different quality metrics from multiple payers, one interviewee advised that practices need to prioritize and select those metrics on which the practice chooses to concentrate.
- In response to the concern noted about how pediatric quality metrics are developed, project staff contacted a few pediatricians who are or were employed as medical directors for health plans. Each were interviewed to ascertain the process used to develop quality metrics that form the basis of payment and the degree of pediatrician input. Two pediatricians represented Medicaid managed care plans and one pediatrician represented a national, commercial carrier. All reported basing quality measures on existing resources, such as HEDIS measures, and those developed by medical specialty societies. Pediatric measures are based on existing HEDIS measures. Due to the need to meet state requirements, the Medicaid plans also incorporated input from medical groups in developing measures. As for pediatrician input, all reported having mechanisms to solicit input from various medical specialties, including pediatrics. However, it was

acknowledged that the focus is primarily on adult high cost drivers, and while there are pediatric markers, they are not exclusive to CYSHCN.

## **Conclusion and Opportunities**

Overall, those completing the survey and those interviewed believed that VBID is too early to assess the impact on patient health outcomes. From the practice level, the consensus appears to be that VBID and VBP make the practice more aware of need to track patients and to dialogue with the payer on best treatment options, including advocating for non-covered services. A few pediatricians commented that this has fostered a more team approach in care coordination. It is important for the practice to refine their tracking of patient mix severity and acuity level. All pediatricians who were interviewed agreed for the need for payers to share meaningful data with the practice ideally in real time.

Based on the pediatrician survey responses and interviews, the transition from volume to value will vary by market, the key players and conditions in each community. It is believed that multiple value based models will be pursued simultaneously rather than a one size fits all approach.

There are opportunities for pediatricians to work with payers and families in the transition to value based payment:

- Define value that incorporates a consensus from the patient/family, provider and payer points of view. Whereas each may have different perspectives on quality and value, consensus among families, their providers and payers is needed to obtain value.
- Payers as partners in providing data necessary for the practice to implement change to enhance quality and access and reduce cost of care. Pediatricians and payers need to collaborate as partners in identifying and sharing appropriate data in a timely manner to help practices implement and maintain changes.
- Identify areas payers can assist practices with practice transformation. Pediatric practices may not have access to resources for infrastructure change and would need to work with payers to identify supports for change in a value based environment.

This paper provides insights into pediatric perspectives on VBP at this early stage of their implementation. It also identifies opportunities for further study and improvement on the application of VBP and VBIP to pediatric patients including CYSHCN. More robust and in-depth assessments are needed on the relationship between value based insurance products and value based payment on quality of care, particularly outcomes in the delivery of pediatric services in the practice setting.

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