



*THE NATIONAL ALLIANCE  
TO ADVANCE ADOLESCENT HEALTH*

**MEDICAID OPPORTUNITIES FOR SUPPORTING  
INNOVATIONS IN TRANSITION FROM  
PEDIATRIC TO ADULT CARE FOR DC YOUTH  
AND YOUNG ADULTS: A DISCUSSION PIECE**

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## INTRODUCTION

This Medicaid brief offers a set of six opportunities for review and consideration by the Department of Health Care Finance (DHCF) to improve receipt of pediatric-to-adult health care transition services among low-income youth and young adults, ages 12 to 26, in the District of Columbia. These policy opportunities address population health initiatives, Medicaid's current fee schedule, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), managed care contract provisions, value-based payment (VBP) pilot strategies, and My Health GPS. Importantly, DHCF has incorporated transition contract requirements in its Child and Adolescent for SSI Program (CASSIP) request for proposal and as part of provider guidance in its online HealthCheck Training and Resource Center. The intention of this brief is to stimulate discussion about additional innovative policy ideas and program strategies furthering DC's role as a national leader.

The District of Columbia provides Medicaid coverage to over 34,000 transition-aged youth and young adults.<sup>1</sup> Its Medicaid/CHIP eligibility levels for children are the second highest in the country. Not surprisingly, compared to the national average, rates of public insurance for transition-aged youth and young adults in DC are substantially higher. According to the American Community Survey, 44% of 12 through 18-year olds in DC are publicly insured – a rate that is 47% higher than the national average of 30%.<sup>1</sup> Among DC young adults, ages 19 to 26, the rate of public insurance coverage precipitously drops to 19%. These estimates underscore not only the importance of Medicaid to almost half of DC adolescents, it also reveals the erosion in public coverage that happens among DC young adults.

The goals of health care transition (HCT) for youth and young adults are twofold: 1) to improve their ability to manage their own health and effectively access and use health services and insurance, and 2) to ensure an organized process in pediatric and adult care to facilitate transition preparation,<sup>2</sup> transfer of care,<sup>3</sup> and integration into adult care.<sup>4</sup> According to the 2018 Clinical Report on Transition from the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Physicians (ACP), transition should be a standard part of care for all youth and young adults. Further, effective transition requires “shared accountability, effective communication, and care coordination between pediatric and adult clinicians and systems of care.”<sup>5</sup>

Data from the 2016-17 National Survey of Children's Health, however, reveal that only 15% of DC adolescents with special needs and 21% without special needs are receiving the services necessary for transition to adult health care.<sup>6</sup> Transition planning, when present at all, is often incomplete or late; transfer from pediatric-to-adult care is seldom a planned or coordinated handoff; and integration into adult care often fails to recognize young adults as a uniquely vulnerable patient population at high risk for dropping out of care and becoming uninsured. The literature is replete with examples of adverse impacts when a structured transition process is not in place, particularly for those with chronic conditions, including low health literacy, gaps in access and use of ambulatory care, worsening health conditions, dissatisfaction and worry, and preventable emergency room visits and hospitalizations.<sup>7</sup> The literature also shows that

expansion of insurance coverage is important but not sufficient to ensure that young adults have a usual source of care.<sup>8</sup> Clearly, this transition-aged group represents an important population requiring additional attention from Medicaid and its contracted MCOs and participating providers.

This discussion piece was prepared by staff from The National Alliance to Advance Adolescent Health, who since 2009 has been funded by DC Health to support child and adult health care delivery systems and MCOs in implementing transition quality improvements. As part of our DC Health-funded efforts, The National Alliance is available to offer assistance to DHCF with any of the suggested opportunities described in the brief. The National Alliance also operates Got Transition, the federally funded resource center on HCT. In that capacity, we are involved in numerous efforts pertaining to transition policy and program innovations. This policy brief was reviewed by Drs. Henry Ireys and Joseph Zickafoose, national experts in Medicaid and payment reform, based at Mathematica Policy Research.

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***Opportunity 1:***  
***Population Health Initiative: Create a multi-sector partnership to establish a structured transition process for youth with special needs***

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**Background.** A growing number of state Medicaid agencies are forming coalitions with external stakeholders to improve the health for a defined population. Examples of these consortiums include DC’s Collaborative for Medical Health in Pediatric Primary Care. This innovative public/private partnership, including the AAP Chapter, CNMC, Georgetown University Hospital, Children’s Law Center, and DC Departments of Health, Behavioral Health, and Health Care Finance, most recently has focused its attention on improving mental health for parents and young children.

**Findings.** Although DHCF and its MCOs, like many other states, are working actively to improve adolescent PCP access and well care visit rates, there is no state that has initiated a multi-sector partnership to ensure an organized process is in place in both pediatric and adult care settings for transition planning, transfer, and integration into adult care. Research consistently shows that in DC and throughout the country, youth and families are not receiving support from their health care providers or managed care systems as they move from pediatric to adult care. Further, research shows adverse population health impacts among YSHCN when a structured process is not in place.

**Recommendations.** The National Alliance recommends that DHCF consider forming a partnership with its MCOs, community health centers, academic health centers, and school-based health centers with The National Alliance to design, implement, and evaluate an innovative population health model for transition-aged youth and young adults, based on the AAP/AAFP/ACP Clinical Recommendations on Transition. Such an effort could be designed for transition-aged youth, between 16 and 25, with or without chronic conditions. It would begin with an initial assessment of DC pediatric and adult primary care systems current HCT infrastructure. This would be followed by preparation of on-line training (offered by The National Alliance). In addition, a set of common metrics could be identified.<sup>9</sup>

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***Opportunity 2:***  
***Managed Care: Expand managed care leadership pertaining to pediatric-to-adult transitional care in DC's managed care contracts***

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**Background.** Most of low-income transition-aged youth and young adults in DC are served by three general MCOs (AmeriHealth Caritas, Amerigroup, and Trusted Health Plan) and one specialty managed care plan (Health Services for Children with Special Needs/HSC). All three general MCOs serve a broad population of publicly insured transition-aged adolescents and young adults, including those with chronic conditions. The one specialty managed care plan (referred to as CASSIP), operated by HSC, serves children and young adults up to age 26 who are receiving SSI.

**Findings.** The National Alliance reviewed DC's general and specialty managed care RFPs, in effect as of October 2018, to examine the extent to which contract language on pediatric-to-adult transition is included. We examined sections on definitions/background, outreach and member education, covered services, provider networks/primary care, behavioral health, and care coordination/case management, which are summarized below.

- *With respect to the general MCO RFP*, no specific language was included for contractors to address pediatric-to-adult transitional care. However, the care coordination section called for the contractor to conduct transition planning and education on self-management of chronic conditions and to establish procedures for transfer of medical information and continuity of care for enrollees who transfer between Medicaid, Alliance, and the specialty care plan.
- *With respect to the specialty RFP (CASSIP)*, there were several contract requirements pertaining to transition to adult care: 1) In the background section, the RFP specifies that each enrollee and family receive intensive case management, care coordination, and support throughout their childhood and adolescence, including during transition from one program to another. 2) Under health education, the contractor is to encourage and support PCPs on self-management of health conditions and self-care strategies relevant to enrollees' age, health-related beliefs, cultural values, and conditions. 3) Under provider network, the RFP states that enrollees over the age of 21 shall not receive PCP services from a pediatrician, although some special-needs children may be candidates for continuing in pediatrics depending on the clinical issues and determination by the pediatrician to continue care. In addition, the contractor must assist enrollees in the transition from pediatrician to general internist or adult specialist and must ensure there is an adequate network of general internists and adult specialists available for enrollees over the age of 21. 4) Under care coordination, the RFP requires that care coordination includes transitional services and transition for enrollees aging out of the specialty plan/CASSIP. Two years before aging out of CASSIP, the contractor shall have protocols for this transition, relating to Department on Disability Services, DHCF/Long Term Care Administration, certified Medicaid providers, Community Social Service Agencies, Department of Behavioral Health, Department of Human Services, and Adult Protective Services. The contractor must assist enrollees in identifying services, sources of support, and arranging for needed services upon enrollees' disenrollment from CASSIP. Also, the contractor must have a transition plan for enrollees transferring in or out of acute care

facilities, long term care facilities, psychiatric residential treatment facilities, or other institutional care and for those entering or exiting the custody of Child and Family Services Agency or Department of Youth Rehabilitation Services. Case management staff are to facilitate the transfer of medical information from one provider to another, as well.

**Recommendations.** The National Alliance recommends that DHCF consider applying some or all of the same transition recommendations used in the CASSIP RFP to the general managed care RFP, recognizing that all three general MCOs have a sizeable population of youth and young adults with chronic conditions. Moreover, professional recommendations on transition are for all youth and young adults. Alternatively, DHCF may want to consider updating both the CASSIP and general MCO RFP to establish a set of contract provisions that are consistent with the AAP/AAFP/ACP Clinical Report that will further DC's role as a leader in the country. The National Alliance would welcome the opportunity to assist DHCF in offering suggested language. For example, the contracts could include specific steps for working with adolescents and their families related to transition planning (e.g., periodically conducting a transition readiness/self-care skill assessment and offering needed self-care education, preparing/updating a medical summary, assisting with identifying adult PCPs), transfer (e.g., preparing a transfer package, communicating between pediatric and adult PCPs), and integration into adult care (e.g., welcome and orientation of new young adults, pre-visit outreach and appointment reminders, update of readiness/self-care skill assessment, update of medical summary, linkages to other adult providers and community supports). Also included in these specific steps would be education and referrals to ensure health insurance continuity and public program eligibility as an adult. DHCF could consider evaluating the degree to which these requirements are met as well as family and beneficiary experiences with the services.

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### *Opportunity 3:*

#### *Medicaid Fee Schedule: Recognize Transition-Related CPT Codes*

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**Background.** There are several transition-related CPT codes that align with the delivery of recommended transition services in pediatric and adult primary and specialty care settings. Each year, Got Transition and the American Academy of Pediatrics (AAP) publish a coding and reimbursement tip sheet that lists these codes and their corresponding Medicare fees and relative value units.<sup>10</sup> Studies show that both pediatric and adult providers report lack of payment as a significant barrier.

**Findings.** According to DC's 2018 fee schedule, the only transition-related codes that are covered are for hospital-to-home transitional care management services (CPT 99495, 99496). Currently, DC Medicaid does not recognize CPT codes that support pediatric-to-adult transition services, including assessment of transition readiness, transition planning and care management services, consultation between pediatric and adult providers, and prolonged services related to transition.

**Recommendations.** The National Alliance recommends recognition of the following 10 CPT codes in DC Medicaid’s fee schedule.

**CPT codes for transition-related services**

Code	Service Description	100% Medicare Payment, 2019		
		Office	Facility	RVUs (Non-Facility/Facility)
96160	Administration of patient-focused health risk assessment instrument	\$3.24	NA	0.09/NA
99358	Prolonged services before and/or after direct patient contact, first hour	\$113.52	\$113.52	3.15/3.15
99359	Prolonged services before and/or after direct patient contact, each additional 30 minutes	\$54.78	\$54.78	1.52/1.52
99487	Complex chronic care management services, 60 minutes	\$92.98	\$52.98	2.58/1.47
99489	Complex chronic care management services, each additional 30 minutes	\$46.49	\$26.67	1.29/0.74
99490	Chronic care management services, at least 20 minutes per calendar month	\$42.17	\$32.44	1.17/0.90
99446	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report; 5-10 minutes of medical consultative discussion and review	NA	\$18.38	NA/0.51
99447	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report; 11-20 minutes of medical consultative discussion and review	NA	\$36.40	NA/1.01
99448	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report; 21-30 minutes of medical consultative discussion and review	NA	\$54.78	NA/1.52
99449	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report; 31 minutes or more of medical consultative discussion and review	NA	\$73.16	NA/2.03

***Opportunity 4:***

***EPSDT/HealthCheck: Expand guidance to health care providers to incorporate health care transition as a routine part of EPSDT***

**Background.** Clinicians have been slow to adopt HCT as a basic standard of high-quality patient-centered medical homes for adolescents and young adults. To support clinicians as they incorporate transition into routine preventive care, The National Alliance published a toolkit in 2018 with sample transition questions and anticipatory guidance for adolescents and young adults, ages 11-26.<sup>11</sup> This toolkit is modeled after the AAP’s Bright Futures<sup>12</sup> and aligned with recommendations from the 2018 clinical report on transition published jointly by the AAP, American Academy of Family Physicians (AAFP), and American College of Physicians (ACP).<sup>5</sup>

**Findings.** DC is the only Medicaid program in the country that includes up-to-date information about pediatric-to-adult transition on its EPSDT website. Specifically, HealthCheck’s online HealthCheck Training and Resource Center includes a special section on current transition recommendations, with links to Got Transition’s Six Core Elements of Health Care Transition, the 2018 AAP/AAFP/ACP Clinical Report on Transition, and the clinician toolkit on incorporating transition into preventive care. DC’s HealthCheck periodicity schedule follows Bright Futures, which does not specify transition under developmental/behavioral assessment or under anticipatory guidance.

**Recommendations.** The National Alliance recommends that DHCF consider a Medicaid transmittal letter to all of its HealthCheck providers, encouraging them to:

- Conduct transition readiness skill assessments starting at age 14 and repeat periodically throughout adolescence. (Note: Got Transition’s [transition readiness assessment tool](#) can be used for this purpose.) See coding option in Policy Opportunity 2 for this assessment: CPT 96160.
- Use the sample questions and anticipatory guidance provided in the HCT [clinician toolkit](#) in preventive care visits during early, middle, and late adolescence as well as young adulthood.
- Assist their adolescent patients, ages 18-21, who will be aging out of Medicaid as a child to apply for Medicaid eligibility as an adult or to seek marketplace coverage through DC Health Link.

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### *Opportunity 5:*

#### *Value-Based Payment (VBP): Initiate a transition VBP pilot for youth and young adults with chronic conditions transferring from pediatric-to-adult care*

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**Background.** The National Alliance to Advance Adolescent Health, with funding support from the Lucile Packard Foundation for Children’s Health, convened a roundtable in May 2018 of payers, health plans, clinical leaders, federal and foundation leaders, and advocacy groups to prioritize VBP strategies for pediatric-to-adult HCT services. A resulting report, *Recommendations for Value-Based Transition Payment for Pediatric and Adult Health Care Systems*,<sup>9</sup> calls for public and private insurers to implement VBP pilots, with an initial focus on the transfer period for youth and young adults with chronic conditions.

**Findings.** DC Medicaid, like other Medicaid programs in the US, has not implemented a VBP option that specifically incentivizes pediatric-to-adult transition. However, with recently awarded funding support from the WITH Foundation, The National Alliance will collaborate with the HSC Health Care System to pilot a VBP approach for DC publicly insured young adults, ages 18-26, with developmental disabilities. Since this will be the first VBP initiative in the country, we are very interested in involving DHCF and the Department on Disability Services as active participants in the planning of this work. Importantly, DHCF has incorporated VBP options into its health home program – using a one-time incentive payment to support care plan development and a risk-adjusted per member per month payment to provide health home services; a pay-for-performance component will be implemented beginning in 2019. DC Medicaid and its MCOs have also implemented financial incentives to consumers to encourage preventive care visits.

**Recommendations.** Building on DC’s current VBP experience and The National Alliance’s recent report findings, we recommend consideration of the following options (in addition to the newly funded VBP project with HSC for young adults with intellectual and developmental disabilities). First, an interested MCO and one or more of their pediatric and adult primary care practices will need to be identified. The National Alliance is well positioned to offer some suggestions for consideration based on our ongoing transition work with various DC health systems. Second, once the partners are selected, a 3-6-month planning period will be needed to identify the patient population eligible for transfer, determine the transition clinic process infrastructure and staffing needs in both sites, review the pros and cons of alternative VBP options, and finalize a set of quality metrics. Again, The National Alliance is available to aid in this planning process. There are several VBP options that could be considered, which are described in further detail in our report on value-based transition payment.<sup>9</sup>

1. For the year before and after transfer, pay both pediatric and adult practices a higher fee/RVU for selected evaluation and management services for the added work involved in preparing youth to transfer and integrating young adults into adult care, if they have a structured transition process in place.
2. Provide a one-time only infrastructure payment for participating practices to upgrade their electronic medical record to incorporate transition clinic processes and support training efforts to build a collaborative pediatric and adult clinical network.
3. Reward participating pediatric and adult practices who achieve specific transition quality performance targets (e.g., reduced preventable emergency room visits and hospitalizations during time between the last pediatric and initial adult visit).
4. Create a transfer episode of care covering the year before and after transfer with named accountable pediatric and adult PCPs. These providers could be measured on average per episode costs; those with the lowest costs compared to peers could be rewarded with bonus payments.
5. Create a risk-adjusted monthly capitation fee for the year before and after transfer to cover the added costs associated with preparing youth for transfer and integrating them into adult care.

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*Opportunity 6:*

*My Health GPS Program: Incorporate pediatric-to-adult transitional care into training and guidance for participating primary care entities*

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**Background.** The District of Columbia is one of 23 states with an approved health home program, serving Medicaid-insured children and adults with multiple chronic conditions. My Health GPS, which started in July 2017, includes the following set of federally defined core services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social supports. My Health GPS services are currently delivered by interdisciplinary teams in 12 primary care settings throughout DC.



**Findings.** DHCF guidance to DC’s health home entities does not include any explicit mention of pediatric-to-adult transition under its transitional care service description. The My Health GPS’ Provider Manual defines comprehensive transitional care as the planned coordination of transitions between health care providers and settings. The comprehensive care management service definition specifies that information to complete the biopsychosocial needs assessment should be obtained from all providers, including those specific to pediatric beneficiaries. Although the remaining health home service descriptions include general mention of health literacy, self-management, and navigating health and behavioral health systems, there is no specific reference to pediatric-to-adult transition-aged populations. In September 2018, The National Alliance staff had a conference call with DC’s health home officials to discuss possible strategies for incorporating pediatric-to-adult HCT into My Health GPS health home services. DHCF officials planned to consider opportunities for incorporating pediatric-to-adult transition into their training manual and learning opportunities.

**Recommendations.** The National Alliance recommends that DHCF consider adding more specific language on pediatric-to-adult HCT in its My Health GPS Provider Manual, if feasible. For example:

- **Comprehensive Care Management.** As part of the plan of care for beneficiaries starting at age 14, DHCF could encourage the preparation and sharing of a current medical summary and emergency care plan with beneficiaries/families. In addition, the plan of care could include specific plans for transfer from pediatric-to-adult care, including assessing beneficiaries’ needs for decision-making support. As part of the in-person needs assessment, DHCF could make available Got Transition’s standardized [transition readiness](#) and [self-care skill assessment](#) for use with transition-aged populations.
- **Care Coordination.**\* As part of the list of included linkages, referrals, and coordination, DHCF could consider adding services for transition-aged populations, including assisting the beneficiary in identifying adult medical and behavioral health providers who accept patients with multiple chronic conditions and have Medicaid coverage, assisting with obtaining Medicaid eligibility as an adult, and assisting with the SSI redetermination application at age 18. (Note: over one third of adolescents lose SSI eligibility as part of this process.)
- **Comprehensive Transitional Care.** This service definition could be expanded, as suggested in italics below, to read: Comprehensive transitional care shall consist of the planned coordination of transitions between healthcare providers and settings, *including pediatric-to-adult care, to ensure continuity of care* and reduce emergency department and inpatient admissions, readmissions and lengths of stay. *Pediatric-to-adult health care transition services shall include, but are not limited to, the following:*
  - *Ensuring that a current medical summary and plan of care has been prepared;*
  - *Ensuring that an adult primary care provider has been identified;*
  - *Ensuring that initial and follow-up appointments with the adult provider are scheduled and kept;*
  - *Facilitating linkages to other adult care providers – e.g., reproductive, behavioral, medical specialty providers.*

The National Alliance also recommends additional training/quality improvement assistance to its My Health GPS entities on best practices related to effective pediatric-to-adult transition. The National Alliance is available to provide this assistance, as needed. Finally, we recommend that My Health GPS primary care entities consider identifying their transition-aged population (ages 12 to 26) to determine which youth/young adults need assistance in transitioning from pediatric-to-adult medical/behavioral health care.

\*In April 2019, DHCF released an updated My Health GPS provider manual and explicitly included the provision of support to children transitioning from a pediatric practice to an adult practice as an activity under the Care Coordination service.

## **CONCLUSION**

Medicaid has a critical role to play in establishing the needed infrastructure within pediatric and adult health care systems to ensure a structured approach to transition from pediatric-to-adult care and coverage. The District of Columbia has already demonstrated its leadership in transition quality improvements, HealthCheck guidance, and CASSIP contract provisions. Now is the time for DC to expand its leadership role by establishing additional new Medicaid policy and program innovations. We welcome the opportunity to review and discuss these policy opportunities with you.

## REFERENCES AND ENDNOTES

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- <sup>1</sup> State Health Access Data Assistance Center (SHADAC) analysis of pooled 2015, 2016, 2017 American Community Survey (ACS) Public Use Microdata Sample files, prepared for The National Alliance to Advance Adolescent Health, November 2018.
- <sup>2</sup> Transition preparation services include development of the practice's transition policy to share with youth/family; transition readiness skill assessment and education; preparation/update of medical summary and emergency care plan; preparation of plan of care with HCT goals for youth with special health care needs; referral, if needed, for supported decision-making; discussion and practice of an adult model of care at age 18; assistance with identifying an adult clinician; preparation of transfer package; outreach for pediatric appointment adherence; sequenced transfers (if seeing multiple clinicians); consultation support to adult clinicians, if needed; and youth/family feedback.
- <sup>3</sup> Transfer of care services include transfer package exchange; communication/confirmation between pediatric and adult clinicians; clarification of residual role responsibility prior to initial visit with adult clinician; and communication and education with transferring young adult (YA).
- <sup>4</sup> Integration into adult care services include development of the transition policy for accepting YA patients into the adult practice and sharing of the policy with YA/family; identification of adult clinicians in practice to care for YAs; preparation of FAQs and orientation information for YAs; pre-visit outreach and appointment reminders; review of new patient records; initial face-to-face visit with YA; update of medical summary; medication reconciliation; update of plan of care (for those with special health care needs; self-care skill assessment and education; and assistance in establishing referrals for medical specialists/behavioral health/reproductive care/community supports.
- <sup>5</sup> White P, Cooley C, Transitions Clinical Report Authoring Group, American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics*. 2018;142(5):e20182587.
- <sup>6</sup> United States Census Bureau. National Survey of Children's Health (NSCH). Available at: <https://www.census.gov/programs-surveys/nsch/data.html>. Accessed January 3, 2019. The estimates for youth with special needs should be interpreted with caution due to large confidence intervals.
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- <sup>9</sup> McManus M, White P, Schmidt A. 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.
- <sup>10</sup> McManus M, White P, Schmidt A, Kanter D, Molteni R, Salus T. 2018 Coding and Reimbursement Tip Sheet for Transition from Pediatric-to-adult Health Care. Washington, DC: Got Transition, April 2018.
- <sup>11</sup> White PW, Schmidt A, McManus M, Irwin, Jr. C. Incorporating Health Care Transition into Preventive Care for Adolescents and Young Adults: A Toolkit for Clinicians. Washington, DC: Got Transition, 2018.
- <sup>12</sup> Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 4<sup>th</sup> edition. Elk Grove, IL: American Academy of Pediatrics, 2017.