Value-based Purchasing

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Policy Terms for Pediatrics Given the dynamic landscape of health and health care policy, child advocates may feel challenged in understanding and responding to the major issues that impact children. We created Policy Terms for Pediatrics (PTP) to empower individuals invested in improving child health through policy and advocacy.

Value-based Purchasing

WHAT DOES IT MEAN

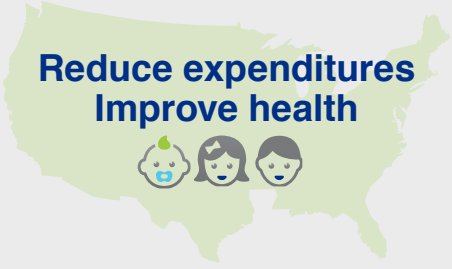
Value-based purchasing (VBP): payment structured linked to performance improvements by health care providers. VBP is designed to reduce inappropriate care by holding providers accountable for the cost and quality of care provided, also known as value-based care.

Fee for service (FFS): payment structure based on the amount of services (i.e., visits, test) provided by provider. It is also referred to as volume-based reimbursements.

	VALUE-BASED PURCHASING (VBP)	FEE FOR SERVICE
How are services billed?	Fixed values based on pre-determined populations, quality metrics, and/or reduction in healthcare expenditures	Traditional billing structure based on individual services provided (e.g. office visit, vaccination, genetic testing)
Outcomes included in payment model?	Yes	No
How are providers reimbursed?	Incentive payment structures based on quality, health outcomes, and cost containment	Payment structure based on volume of services provided

WHY DO WE CARE

The United States spends nearly $3 trillion annually on health care. However, children account for about $230 billion (about 7.6%) of health care spending. Due to the relatively small impact children have on health costs relative to adults, VBP models may overlook pediatric-specific needs. However, it is important to acknowledge that children have different needs than adults, particular children with special health care needs (CSHCN), and deserve payment models that are tailored to them.



CSHCN are defined by the Maternal and Child Health Bureau as children "who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." Because of their medical complexity, the health care expenditures for CSHCN are nearly twelve times that of a child without special health care needs. Unlike VBR, VBP incentives can encourage collaboration across

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provider type thereby improving care coordination, reducing redundancies in service, and potentially reducing avoidable hospitalization. This shift could lead to reduction in health care expenditures.

Additionally, VBP can lead to improved population health. Incentives for outcomes and cost containment encourages providers and health care institution to observe population-level trends in order to better understand the needs of the population, and subpopulations, under their care. These observations can lead to innovative approaches that can improve the quality of care delivered and the overall population health.

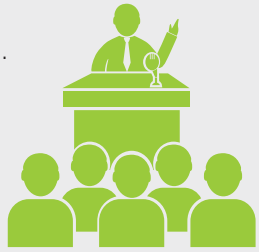
It is important to note that VBP models can also have unintended negative consequences. Failure to take into account the unique needs of children could burden providers and health care institutions that disproportionately provide care to children. Payment structures set to adult standards may not account for differences in evidence-based pediatric guidelines and care delivery in pediatric settings. This may lead to significant underpayment for services, or uncompensated care, which could impact the viability of many smaller hospitals, community based practices, and office-based physicians. Loss of service providers could reduce access to care for children needing those service options, particularly those in rural and suburban areas.

As third-party payers look for innovative ways to improve health care quality and lower cost, it is important that the health care needs of children are represented. For state-managed health plans such as CHIP and Medicaid, it is important that payments models are reflective of the complex needs of CSHCN. Incentives meant to drive quality improvement and cost containment are negated if they result in uncompensated care. Significant financial loss may result in providers reducing or changing population served. These changes can reduce access and increase burden on families and remaining service providers consequently having an inverse effect on quality and outcomes.

WHAT DO WE DO

As VBP becomes the standard model for reimbursement, child advocates must:

1. Think critically about the services they provide and their utility to the patients.
2. Prepare for a more coordinated, integrative, and value-based health care system.
3. Collaborate with lawmakers to design care reimbursement models that understand what quality pediatric care entails.



START BY READING MORE...

https://catalyst.nejm.org/what-is-value-based-healthcare/_

https://ccf.georgetown.edu/2016/06/22/embracing-opportunity-measure-value-childrens-health-care/_

https://www.childrenshospitals.org/newsroom/childrens-hospitals-today/articles/2017/04/population-health-resources-to-help-childrens-hospitals-move-from-volume-to-value_

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