EVERYONE BENEFITS, SO ALL SHOULD PAY

Pediatric Primary Care Payment Reform

TRANSFORMING PEDIATRICS TO SUPPORT POPULATION HEALTH

POLICY BRIEF | APRIL 2020

Robert W. Seifert, MPA
Hilary Deignan, JD, MEd

University of Massachusetts Medical School

Lisa Honigfeld, PhD
Eminet Gurganus, MPH

Child Health and Development Institute

Child Health and Development Institute of Connecticut, Inc.

Connecticut Health FOUNDATION
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This policy brief is the first of two in CHDI's *Transforming Pediatrics to Support Population Health* policy brief series, developed with funding from the Connecticut Health Foundation.

Healthy and resilient children grow up to be healthy and productive adults. Investing in children's health and well-being from birth is tied to a healthier population long-term. Services that promote child well-being can be seen as both a public good and important for improving equity. When all children and families receive the services they need to develop into healthy adults, society as a whole benefits.

To realize the vision of long-term population health and health equity, the transformation of pediatric primary care delivery is essential. Virtually all children receive primary care services making it a near universal point of access. For widespread results, it is important for all payers of pediatric primary care services to simultaneously support and participate in practice and payment transformation.

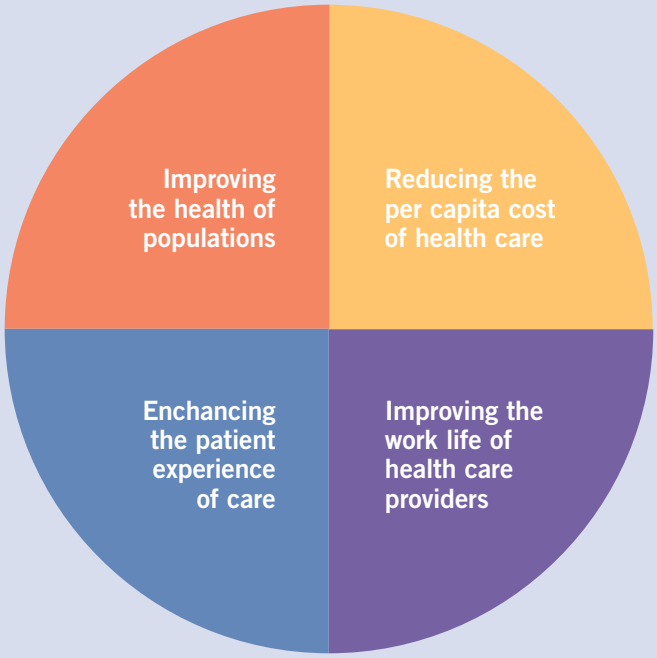
This brief presents the rationale for engaging all payers in practice transformation and summarizes challenges and lessons learned from existing practice transformation efforts. It grows out of recommendations made by a study group on pediatric primary care payment reform convened by the Child Health and Development Institute of Connecticut and the Connecticut Health Foundation in 2018.[1]

The Need for Pediatric Primary Care Payment Reform

Connecticut is in the midst of ambitious efforts to transform how health care is paid and delivered. These changes—which are also happening in many other states—reflect thinking by policy makers, providers of health care and related services, insurers, employers, and others with an interest in improving the health care system.[2] The goal of these efforts is commonly described as a Quadruple Aim: improving the health of populations, enhancing the patient experience of care, reducing the per capita cost of health care, and improving the work life of health care providers.[3]

Innovative pediatric practice models can contribute to achieving these goals, potentially lowering costs and improving lifelong individual and population health. The models provide evidence-informed care to children and families and focus on family strengths, early intervention, disease prevention, and health promotion over the life course. A long-range focus for children is critical. Early investments in child and family health and well-being have the potential to prevent adult chronic health conditions and their associated impacts such as unemployment or underemployment, frequently missed work days, justice involvement, and housing instability.[4] As participants in New York State's practice transformation efforts put it, "Promoting optimal child health across the life course… will lead to lower longer-term health care costs and utilization (principally by preventing chronic conditions in adulthood) and better outcomes for non-health sectors by improving child development."[5]

Quadruple Aim of Payment Reform



It is critical, however, for innovative practice models to be paired with innovative payment approaches. Current payment methods erect barriers to the widespread adoption of innovative practice models. Pediatric practices typically receive payment only for specific medical services and screening provided to a child and are not adequately compensated for family-strengthening supports, coordination with behavioral health and non-medical social services, and other services that promote health and well-being—all of which are important to a child's lifelong health trajectory. Overcoming these barriers is a driving force in pursuing payment transformation, which would reward effective health promotion and reimburse providers for positive outcomes instead of volume of care.

WHY ALL PAYERS?

The potential cost savings that innovative pediatric interventions provide across the lifespan are significant and affect many sectors beyond health care. Healthy children are more likely to consistently attend and do well in school, participate in the workforce as adults, and maintain health over their lifespan. To fully realize these benefits, it is necessary that all payers invest in robust pediatric primary care.

Pediatric Practices Depend on Payments from Public and Private Insurers

The participation of all payers is essential for transforming pediatric primary care to promote lifelong health and well-being. Reforms to care delivery are fundamental, and to effect population level change, all children and families need access to them, so all payers should cover them.

Practically, **pediatric practices and accountable care organizations cannot reasonably be expected to transform care delivery for some children and families but not for all.** Not only would this be operationally inefficient and financially burdensome, but delivering different care to different patients based on who is paying for it raises ethical concerns.[6] To ensure access and widespread participation, practice changes that are widely accepted as improving children's health over the lifespan should be available to all children and families, and all payers should participate.

Medicaid is often the largest insurer of children in a state, which can allow initial model testing among large practices, such as federally qualified health centers and hospital-based primary care centers, which serve predominantly children insured by public payers. Securing participation among Medicaid providers is a significant step toward comprehensive adoption. Several states, including **New York** and **Oregon**, have started down the path of pediatric payment reform with Medicaid as the vanguard payer.[7] Children covered by Medicaid tend to be of lower socioeconomic status and potentially stand to benefit the most from improved pediatric primary care. Still, there is value in committing to universal payment systems to ensure that all children receive the same set of comprehensive, evidence-informed services.

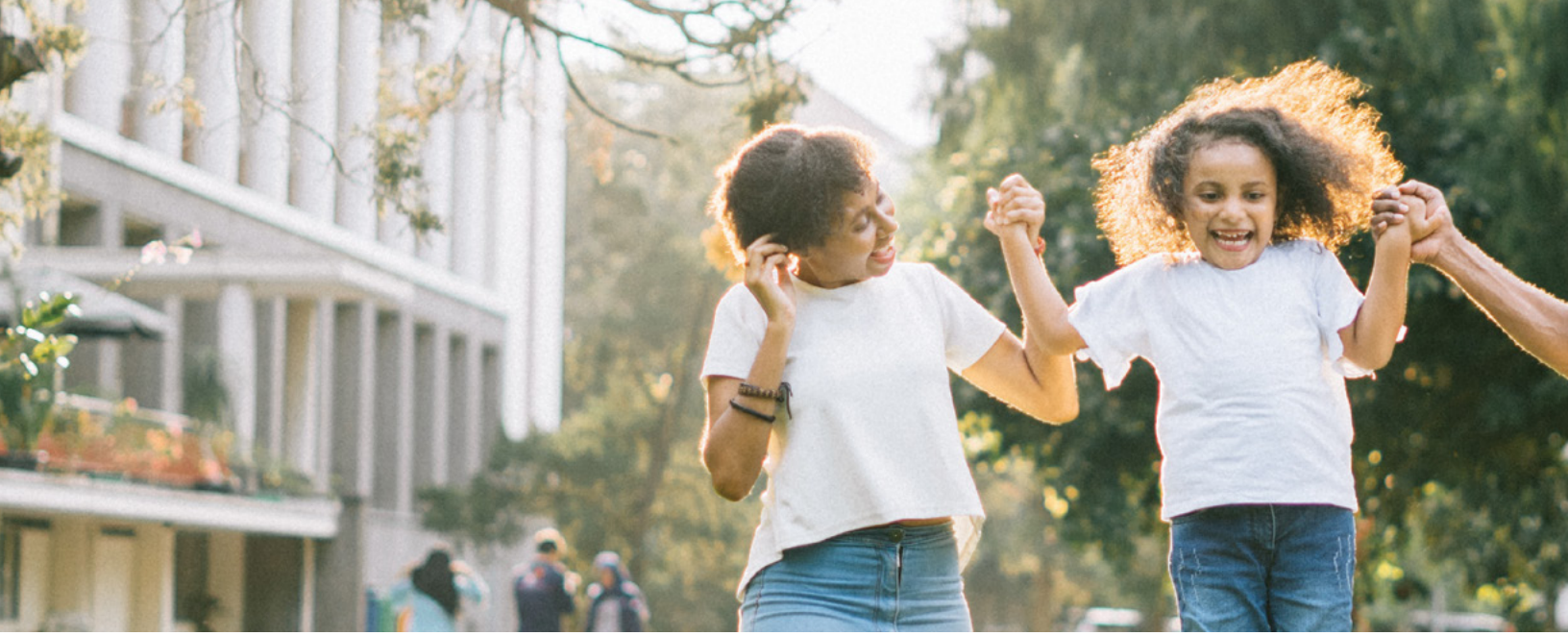
Though Medicaid often leads, an alternative approach is playing out in **Colorado**. The Pediatric Care Network is a clinically integrated network of 1,400 pediatric providers, including more than 160 primary care physicians and more than 40 primary care clinic locations in the Denver area.[8] The network launched in 2017 and built the data sharing, quality metrics, care coordination, and other capabilities needed to function as a pediatric accountable care organization and accept value-based payments. It started with one value-based contract with a private payer as the network formed and was in the early stages of implementation. Recognizing that these payment arrangements are the direction the health care system is heading, the network hopes eventually to engage public payers. Close to half the children in Colorado are covered by Medicaid,[9] and just three commercial insurers dominate private coverage.[10]

The **Connecticut** Children's Care Network offers an example of a pediatric clinically integrated network that is successfully engaging public and private payers.[11] A collaboration between Connecticut Children's Medical Center and a network of independent primary care practices, the Care Network will leverage care coordination, improved communication, and connections to community programs to improve the overall well-being of children insured by Medicaid and private payers.

Ensuring Equity

Health equity means that "everyone has a fair and just opportunity to be as healthy as possible."[12] For children, that opportunity means access to not only medical care, but also to the family supports, behavioral health care, and early interventions that promote children's healthy development. Universal participation among payers in payment reform for pediatric primary care can reduce health inequities across the lifespan by making such comprehensive care available to all children, with a particular focus on those who are at risk for compromised outcomes due to social risk factors (e.g., race, ethnicity, socioeconomic status, etc.).[13] If payers measure and reward outcomes, such as the lessening of health disparities, rather than simply paying for each service provided, they motivate pediatric practices to pursue approaches that promote health equity. This shift is especially important for payers such as Medicaid that finance care for populations who are more likely to experience inequities in health care, but focusing only on the Medicaid population does not reach all families that can benefit. The participation of all payers can also increase family participation in programs by minimizing any perceived stigma associated with public programs.[14]

Value-based payment programs around the country have used various strategies to prioritize equity in their implementation. For example, **Louisiana** targets health disparities when measuring quality performance in value-based payment models by requiring managed care organizations to report performance measures stratified by factors such as race and ethnicity.[15] **Michigan** provides bonus payments as incentives for managed care organizations to report the impact of their programs on addressing social determinants.[16] **Oregon**'s coordinated care organizations track data on a designated "disparity measure."[17] To date, equity-focused value-based payment programs have been led by Medicaid, as is the case in the above examples. Nonetheless, the strategies utilized by Medicaid offer important lessons for payment models that can engage multiple payers.



Reduce Disincentives to Invest

Because the full value of early health promotion, prevention, and intervention is not apparent for years or even decades, the return on investment to payers—that is, reduced health care costs over a lifetime—is difficult to calculate.[18] The current health care payment system, and efforts to reform it, do not include incentives to recognize such long-term payoffs. This is true for self-insured employers focused on their business and finances, for investor-owned health plans trying to provide quality care for their current members and a return for their stockholders, and for state Medicaid programs that are answerable to elected officials and the public. With this uncertainty about future returns, an individual payer might not be motivated to take on the additional cost required to support more robust pediatric services that can benefit everyone in the long run. In fact, the incentive may be to hold back and reap the benefits of another payer's investment.

Effective pediatric primary care is a public good, akin to public education. In a private market, buyers tend to underinvest in such goods because they cannot prevent others who do not pay from sharing in the benefits. This "free rider" problem is related to the disincentive where the benefits of paying to enhance the pediatric primary care system are dispersed across sectors, payers, and time. A typical solution to the undersupply of public goods is that government pays for them using tax revenue, but solutions that ensure universal participation of private payers are also possible.[19]

A mechanism to include all payers in pediatric payment and practice innovations would reduce the disincentive of others reaping the benefits, while simultaneously improving population health through reductions in childhood onset of chronic health conditions and reducing costs for all payers in the long term. Because the benefits from pediatric interventions are not all immediate, both the initial cost of pediatric interventions and the resulting gain from better care for a given child will be distributed broadly, as other health plans, employers, and public programs assume responsibility for health care costs over a person's lifespan. In this way, **"unique approaches for children provide an opportunity to truly bend the cost curve by preventing children from becoming the high-cost, high-need Medicaid utilizers of the future."**[20] This is true for other insurers as well; all payers will benefit from this trend.

Vermont's Blueprint for Health is a statewide, multi-payer medical home initiative with a distinct pediatric component. Payers that provide coverage for the services offered under the Blueprint include the state's Medicaid program, health plans that cover state employees, and commercial insurers whose share of the private market is at least five percent (but not self-funded employer plans). Vermont secured the participation of these insurers by requiring it in legislation.[21]

A Common Sense of Value

As payment methods shift from being volume-based to value-based, a definition of value becomes essential. **In addition to reducing costs, value-based payments seek to effect specific outcomes: most expansively, population health improvements such as reduced incidence of chronic illness or increased life expectancy.** For example, Partners for Kids, the largest pediatric accountable care organization in **Ohio**, defines value as preventing adult chronic disease and realizing the benefits of adult wellness (e.g., increased educational attainment, work productivity, reduced crime, and increased quality of life).

Assessing progress toward these outcomes requires the adoption of measures of the effectiveness of care that affects these outcomes at each stage of life. For example, the population health outcome of the rate of premature death due to suicide is linked to the prevalence of mental health issues in the community. Adult mental illness is less likely when young children and adolescents develop resiliency to buffer the effects of stress, and resiliency depends in large part on the strength of family relationships, which can be supported in the pediatric primary care setting through expanded care teams working with families to ensure their access to a variety of community services and supports. Applying clear, validated measures to these factors in each link of the chain shows how pediatric care can affect population health.[22]

Common parameters across payers—the outcomes and measures, in service to population health goals, which define what value is—help to focus delivery systems on what the community deems important. In contrast, multiple sets of parameters lead to different foci in health care, often dictated only by who is paying for the care. This dilutes the potential overall impact of payment reform and can frustrate providers. The state of **Washington** recognizes the importance of a common approach across payers to achieving long-term systemic goals: "Value-based payment models with common parameters could assist providers who care for children in focusing on the most important clinical and quality outcomes that will eventually affect the long-term costs of the health system. Value-based payment models with common parameters help reduce the 'ping-pong' effect that multiple payment models can have on providers, where multiple foci eventually dilute the effect of any given model."[23]

Addressing Barriers

Requiring payers to cover specific services is not a new idea: insurers are already required to cover essential health benefits, as outlined in the Affordable Care Act and further defined by each state. Every state also has its own set of mandated health insurance benefits.[24] In addition, there are numerous examples of voluntary participation in system transformation initiatives.[25] Notwithstanding such positive trends, securing multi-payer participation requires overcoming significant challenges. This section identifies key barriers, and importantly, highlights innovations that are being implemented across the country to overcome these barriers.

The table on page 9 lists some of the key barriers and potential solutions to pediatric primary care transformation that includes all payers. Barriers include the difficulty of estimating a return on investment that would persuade payers to participate; confronting the free rider problem that arises from some insurers' disincentive to participate, absent a convincing return on investment; and the challenge of building stakeholder support for change. Possible solutions include balancing short- and long-term outcome measures in payment models, mandating or incentivizing payers' participation, and prioritizing stakeholder engagement and participatory decision making.

Barrier	Potential Solution	Examples
Establishing return on investment	Ensure the inclusion of long-term measures in payment models	University Hospitals Rainbow Care Connection's accountable care organization (Cleveland, **Ohio**) includes long-term metrics such as literacy, positive parenting, and safe sleep.[26] The **Washington** Chapter of the American Academy of Pediatrics recommends that the implementation of value-based payments for children's health care recognize "the financial impact that high quality children's health care can have on the entire health care system, in the near and long term."[27] Nemours Children's Health System has developed a tool, based on evidence from research literature and **Maryland** Medicaid data, for states to estimate the long-range cost savings from interventions to reduce pediatric obesity.[28]
	Identify short-term measures that indicate progress towards long-term outcome measures	Health Share of **Oregon**, a Coordinated Care Organization, has as one of its goals kindergarten readiness, which is associated with lifelong health and well-being, and a bundle of early childhood metrics that track progress toward this goal.[29]
	Create a short-term financing solution, to be replaced by a more sustainable long-term solution when return on investment becomes apparent	**Connecticut's** Health Enhancement Community model calls for near-term financing from grants, tax credits, and public sources to support start-up and demonstrate savings, as a bridge to long-term, sustainable funding from public and private insurers when savings have become evident.[30]
Free rider problem	State government mandate of insurer participation	**Vermont** Blueprint for Health requires all commercial insurers with more than 5 percent of the market to participate.[31]
	Encourage/incentivize voluntary participation	For the Comprehensive Primary Care initiative, CMS (Medicare) used its leadership position to convene private payers in seven markets to align payment methods, and incentivized clinicians and provider organizations to bring payers to the table.[32]
Build political will by gaining stakeholder support	Promote robust stakeholder engagement during the planning and implementation of proposed changes	**New York** State developed a number of models for implementing Medicaid Value-Based Payments to allow providers flexibility.[33]
	Recognize and respond to regional differences in health needs	Healthier **Washington** (Medicaid) has the goal of building healthy communities using a regional approach.[34] Each **Oregon** Coordinated Care Organization is given "broad latitude on how to serve its population" through a local focus on performance metrics.[35]

CONCLUSION

This policy brief outlines how redesigning pediatric primary care is beneficial to the health and prosperity of children, families, and communities and explains why it is important for all insurers to participate in paying for comprehensive services that promote socioemotional development and long-term well-being. A redesigned pediatric model that improves lifelong outcomes for children is a public good that benefits all, which justifies a broad base of funding. While public policies such as mandates would ensure broad participation, creating such mandates requires political will and the support of stakeholders. That will is not apparent today—all of the patient-centered medical home initiatives created since 2011 have relied on payers' voluntary participation, for example.[36] Most pediatric accountable care organizations that provide an enhanced range of services are driven by state Medicaid programs, with the goal of engaging commercial insurers in the future. It seems clear that to attract private payers' voluntary participation, payment models need to show evidence of a return on investment, and there must be a mechanism to distribute an appropriate level of returns to payers.

The greatest barrier to payer participation is the lack of evidence of return on investment, though some recent developments may contribute to the case to convince payers to participate in innovative payment arrangements. For example, the return on investment tool developed by Nemours Children's Health System for states to estimate the long-range cost savings from interventions to reduce pediatric obesity[26] can inform additional return on investment analyses to bolster support for pediatric health promotion and prevention services.

RECOMMENDATIONS

While the evidence base for pediatric practice transformation grows, a hybrid payment model might engender broader payer participation. Payments in the near term using time-limited public funds, private foundation grants, financing through Medicaid demonstration waivers, and other sources could provide a bridge to a time when stronger evidence bolsters the public good argument and supports a return on investment estimate, motivating stakeholders to agree to a value-based payment model that captures long-term gains and distributes them equitably. To move in that direction, policy makers with influence over health care delivery and payment might consider the following actions:

1. **Convene stakeholders, including public and private payers, with a mandate to develop consensus around a definition of value for pediatrics and appropriate long- and short-term outcome measures.**
2. **Use a stakeholder group to debate and develop incentives to encourage payer participation.**
3. **Support research, data analysis, and the development of tools and new measures to produce robust estimates of return on investment.**
4. **Consider creative, short-term public funding of regional pilots, to allow providers to expand their delivery of enhanced, evidence-informed services to children while limiting risk to payers in the early stages of transformation.**

REFERENCES

1. Seifert RW, Deignan H. Transforming pediatrics to support population health: Recommendations for practice changes and how to pay for them. Child Health and Development Institute of Connecticut and Connecticut Health Foundation. February 2019.
2. One such initiative is the Connecticut State Innovation Model (https://portal.ct.gov/OHS/Content/State-Innovation-Model-SIM) Accessed December 4, 2019.
3. Bodenheimer T, Sinsky C. From triple to quadruple aim: Care of the patient requires care of the provider. *Ann Fam Med*. 2014;12(6):573–576. doi:10.1370/afm.1713.
4. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics. Policy statement: Early childhood adversity, toxic stress, and the role of the pediatrician: Translating developmental science into lifelong health. *Pediatrics*. 2012;129(1).
5. Brundage S, Shearer C. Reforming payment for children's long-term health: Lessons from New York's children's value-based payment effort. United Hospital Fund. August 2019.
6. This was one of the stakeholder concerns raised by large pediatric practices, children's hospitals, and MCOs during the work to develop the New York Pediatric Medicaid Value-Based Payment strategy. (Suzanne Brundage, United Hospital Fund, personal communication.)
7. McConnell KJ. Children's health subcommittee and clinical advisory group. Value-based payment for children: Report to the NYS Medicaid VBP workgroup. New York State Department of Health, September 2017; Oregon's Medicaid Coordinated Care Organizations. *JAMA*. 2016;315(9):869–870. doi:10.1001/jama.2016.0206.
8. https://www.pediatriccarenetwork.org/our-network/. Accessed October 1, 2019.
9. LaPointe J. CO's pediatric care network brings value-based care to children. *RevCycle Intelligence*. Oct. 3, 2017. https://revcycleintelligence.com/news/cos-pediatric-care-network-brings-value-based-care-to-children. Accessed September 30, 2019.
10. Kaiser State Health Facts. Market Share and Enrollment of Largest Three Insurers–Large and Small Group Markets. https://www.kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-large-group-market and https://www.kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-small-group-market/. Accessed December 4, 2019.
11. Connecticut Children's Medical Center. https://www.connecticutchildrens.org/carenetwork/about-connecticut-childrens-care-network/. Accessed February 19, 2020.
12. Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What is health equity? Robert Wood Johnson Foundation. May 2017.
13. Peacock-Chambers E, Ivy K, Bair-Merritt M. Primary care interventions for early childhood development: A systemic review. *Pediatrics*. 2017;140(6).
14. Dodge KA, Goodman WB, Murphy RA, O'Donnell K, Sato J, Guptill S. Implementation and randomized controlled trial evaluation of universal postnatal nurse home visiting. American Journal of Public Health. 2014;104(S136–S143).
15. Louisiana Department of Health. http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf. Accessed February 26, 2020.
16. Center for Healthcare Strategies, Inc. https://www.chcs.org/advancing-health-equity-in-medicaid-emerging-value-based-payment-innovations/. Accessed February 26, 2020.
17. Ibid.
18. Additional benefits to other sectors, such as education, criminal justice, and social services, are equally difficult to quantify.
19. Nichols LM, Taylor LA. Social determinants as public goods: A new approach to financing key investments in healthy communities. *Health Affairs*. 2018;37(8):1223–1230.
20. Brundage SC, Shearer C. Achieving payment reform for children through Medicaid and stakeholder collaboration. United Hospital Fund. March 11, 2019. https://uhfnyc.org/publications/publication/achieving-payment-reform-children/ Accessed December 4, 2019.
21. State of Vermont. https://blueprintforhealth.vermont.gov/
22. Seifert and Deignan.
23. TCPi Pediatrics, The Washington Chapter of the American Academy of Pediatrics. Value-based payment for children's health care. 2017. http://19zoo424iy3o1k9aew2gw2ir-wpengine.netdna-ssl.com/wp-content/uploads/2017/09/2017-VBP-policy.pdf. Accessed October 1, 2019.
24. National Conference of State Legislatures. State insurance mandates and the ACA essential benefits provisions. http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx. Accessed October 2, 2019.

25. Takach M, Townley C, Yalowich R, Kinsler S. Making multipayer reform work: What can be learned from medical home initiatives. *Health Affairs*. 2015;34(4):662–672.
26. Perrin JM, Zimmerman E, Hertz A, Johnson T, Merrill T, Smith D. Pediatric accountable care organizations: Insight from early adopters. *Pediatrics*. 2017;139(2). e20161840.
27. TCPi Pediatrics.
28. Connecticut State Innovation Model (SIM) Health Enhancement Community Initiative Proposed Framework, Final Version. Approved June 2019. https://portal.ct.gov/-/media/OHS/SIM/Population-Health-Council/Resources/CT-SIM-HEC-Framework---final.pdf?la=en. Accessed October 3, 2019.
29. Health Share of Oregon. Ready & resilient. 2017–2020. https://www.healthshareoregon.org/storage/app/media/documents/RR_Narrative_Final.pdf. Accessed October 1, 2019.
30. Connecticut State Innovation Model (SIM) Health Enhancement Community Initiative Proposed Framework, Final Version. Approved June 2019. https://portal.ct.gov/-/media/OHS/SIM/Population-Health-Council/Resources/CT-SIM-HEC-Framework---final.pdf?la=en. Accessed October 3, 2019.
31. 8 V.S.A. § 4088f. The Blueprint for Health is a multi-payer medical home initiative.
32. Rajkumar R, Conway PH, Tavenner M. CMS—Engaging multiple payers in payment reform. *JAMA*. 2014;311(19):1967–1968. doi:10.1001/jama.2014.3703.
33. Brundage S, Shearer C. Reforming payment for children's long-term health: Lessons from New York's children's value-based payment effort. United Hospital Fund. August 2019. https://uhfnyc.org/media/filer_public/da/51/da519808-cb2c-43e1-afcb-8d626b07d795/uhf-cmwf-childrens-vbp-20190822c.pdf "Because the development of VBP models for children's health services is still in a relatively early stage, payment model design should include input from children's health stakeholders. New payment models should also be tested in combination with innovative primary care models to ensure the incentive structures are appropriate." (page 2)
34. https://www.hca.wa.gov/about-hca/healthier-washington/initiative-1-transformation-through-achs. Accessed October 3, 2019.
35. Shenoy S, Rork MM. Oregon Medicaid transformation: Is coordinated care the answer? *The Actuary*. February 2018. https://theactuarymagazine.org/oregon-medicaid-transformation/. Accessed September 13, 2019.
36. Takach, et al.

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The Child Health and Development Institute gratefully acknowledges the support of the Connecticut Health Foundation, which provided funding for this policy brief and whose staff have been partners in our health reform work.