Making the Case for Value-Based Payment Reform in Children’s Health Care

Child and adolescent health in the United States continues to lag behind that of other industrialized nations, with the US health care system falling short in tackling current threats (eg, childhood obesity and substance use epidemics) as well as future threats (eg, rising adult health disparities that may reflect adverse childhood influences). The emphasis on short-term financial returns partly explains this failure insofar as well-being outcomes for children are best measured over the long term. Attracting the attentions of payers and policy makers to increased and innovative funding for children’s health care has been difficult, as more costly adult needs often overshadow child-specific needs. The move toward value-based payment reform presents a critical opportunity for children’s health providers to make the case for the value of high-quality children’s health care, which warrants increased resources, and payment models that are specifically designed to improve children’s short- and long-term health and well-being outcomes.

Value-based payment reform refers to changing payments to support care that achieves improved health and experience outcomes at lowered costs. Such payment reforms have broad political support, with growing adoption of these changes in adult health care. However, these reforms are diffusing unevenly into children’s health care and are heavily influenced by Medicaid policy. We make a case for engaging children’s health care professionals in value-based payment reform efforts and provide a payment reform framework with examples from children’s health care.

What Makes Paying for Children’s Health Care Different?

Children and adolescents have unique health care needs, often called the 4 D’s, that should inform the design of payment reform. Developmentally, payment models should accommodate children’s evolving needs from infancy to adolescence and prioritize the value of supporting successful development. Because children depend on caregivers for much of their well-being, payment reforms should encourage steps to address the effect of the family unit. Children are also epidemiologically distinct from adults; reform vehicles should account for the greater emphasis on disease prevention but also for the high numbers of rare chronic conditions treated in children’s health care. Finally demographically, more than half of all children in the United States are insured by Medicaid and CHIP (Children’s Health Insurance Program), creating opportunities for reforms to significantly affect the highest-risk youth and social determinants of children’s health.3

The 4 D’s contribute to the challenge that children’s health care benefits may take years to decades to realize a financial and health effect. Payment reform in children’s health care can lay the foundation for an approach that emphasizes linking resources to accountability (ie, clinician financial risk and/or reward) for proximal measures that are associated with long-term outcomes.4 Children’s health care professionals can help identify demonstrable short- and medium-term effects that are associated with improved health over the long term. Examples include early identification and effective management of developmental and behavioral issues, resulting in better educational outcomes and lower education costs (eg, increased school readiness and reduced special education and in-school therapy) and prevention of unintended adolescent pregnancies. Further work is also needed on developing, selecting, and tracking the right quality metrics to best demonstrate the value of children’s health care in the short term and long term. Better monitoring and evaluation of largely state-based payment reform efforts that target children’s health are also needed, which can foster collaborative efforts and support shifting more resources to effective reforms of children’s health care.

A Framework for Payment Reform in Children’s Healthcare

The Health Care Payment Learning and Action Network developed an Alternative Payment Model (APM) Framework to organize, track, and evaluate progress toward payment reform.1 We present examples of payment models for children’s health care within each category.

Category 1: Fee for Service

Fee for service (FFS), the predominant payment method in children’s health care, does not effectively support many valuable child health care services (eg, family-centered care coordination and screening for and addressing high-risk social situations and school problems). In addition, FFS payments, particularly in public programs, are at risk of declining further in efforts to control short-term costs.

Category 2: FFS Linked to Quality and Value

Category 2 reforms retain a FFS structure. Examples linking FFS to quality and value include payments for infrastructure development (eg, coordination capacity for pediatric medical home care) or rewards for performing well on quality measures (eg, pay for performance). For example, clinicians who demonstrate improved functional status for abused children or children with autism in the Texas Delivery System Reform Incentive Payment Projects5 receive a bonus on FFS rates. Currently, many category 2 programs rely on process-of-

© 2018 American Medical Association. All rights reserved.
care measures or investments in capacity, incentivizing better quality but often still paying for traditional medical services. These programs can be stepping stones toward more transformative models for better long-term outcomes.

**Categories 3 and 4: APMs**

Alternative payment models introduce a payment component based on accountability for patients and populations, which allows more flexibility to shift to care models that are difficult or impossible to sustain under models that are primarily FFS. Alternative payment models exist on a spectrum based on how much accountability and flexibility clinicians have, from building on a FFS architecture (category 3) to population-based payments linked to full accountability for quality and spending (category 4). Episode-based APMs are increasingly used in Medicaid. Arkansas Medicaid, for example, implemented an asthma exacerbation bundle (ie, all care 30 days after an exacerbation of asthma with shared savings for costs under the 75th percentile). Accountable care organizations are another APM adopted by some children's health systems, which bear financial risk for the health care of a defined pediatric population, oversee care across a continuum of health care services, and provide cost and population health metrics.4

Partners for Kids at Nationwide Children's Hospital is a full-risk, population-based model that receives a Medicaid per-member, per-month, age- and sex-adjusted payment. It has demonstrated lower costs than FFS or managed care organizations, with mixed results on quality measures.6 Oregon has created coordinated care organizations that are locally governed to address community needs on a single global budget; their children's health focus areas include substance use and developmental screenings, adolescent well-child checks, and pediatric dental sealants.5

Some APMs facilitate delivery partnerships between health care organizations or payers (eg, Medicaid and/or CHIP) and health-related social services (eg, Early Head Start, child welfare, and juvenile justice programs) through enabling more payments for coordinating such services in conjunction with accountability for showing improvements in outcomes. These partnerships are of particular interest in addressing social adversity in childhood that affects lifelong health. Population-based partnerships, especially in high-risk communities, can enable broader screening across multiple social service sites, reduced loss to follow-up, infrastructure development for shared accountability and cost savings, and more optimal combinations of services.3,7

Opportunities also exist to develop condition-specific models, such as for pediatric asthma, which would hold clinicians accountable for the total cost and quality of care, beyond a single exacerbation. Unique APMs for children with medical complexity could include reimbursement for the total cost of care, which can support care coordination and more effective interventions to influence outcomes.8 Finally, payment models could link accountability between parent and child clinicians for jointly relevant health measures (eg, parental tobacco use and maternal depression), although shared payment and health data would be required.

**An Opportunity for Children's Health Care Providers in Payment Reform**

Children's health care providers can drive accelerations in innovative value-based payment models for children's health. More attention to developing, monitoring, and evaluating which children-specific payment models work, particularly among the most vulnerable youth, is needed. These data will facilitate payment approaches and care models that increase the quality, cost-effectiveness, and child centeredness of care, with clear goals and demonstrated effects that hold potential for much-needed increased overall financial support for child health.

---

**REFERENCES**


© 2018 American Medical Association. All rights reserved.