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Payment reform for kids

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Comprehensive care for children – including greater attention to behavioral health, socio-emotional development, and strong family relationships – may hold the key to lifelong health and well-being. With this premise, a group in Connecticut has just published recommendations for improving pediatric primary care through payment reform.

An important focus in health policy today is on changing the way we pay for care. There is broad consensus that the predominant fee-for-service payment method does not necessarily motivate care that will result in the best health outcomes. The evolving view is that payment constructed to reward the *value* of care delivered, rather than the volume of services, is a preferable method for improving the population's health, and that value-based payment, properly applied, will bring positive changes to how care is organized and delivered. So many health reform initiatives – by

state governments, private payers and providers, and others – have as a centerpiece a shift to value-based payments, particularly for people with complex, high-cost health care needs.

Those initiatives have not, by and large, had pediatric care as a primary target of reform. Most children are relatively healthy and inexpensive to treat. With important exceptions, most of children's use of the health care system is for routine well visits, not for complex, high-cost care, and the conventional view therefore is that there is little to gain, in either improved delivery or costs, from using value-based payments to shift incentives.

Yet there could be a large long-term benefit to population health, and to social equity, by making payment innovations in pediatric primary care. A large and growing body of evidence connects children's development and well-being with the presence or absence of costly, chronic health conditions in adulthood. Factors both medical and non-medical, even when they do not appear to have immediate health effects on children, can disrupt brain development, immune systems, and other biological systems, which can affect health (and other social and economic) outcomes decades and even generations later. Stressful family situations or events, unstable housing, poverty and discrimination and other experiences create disparities in child health and development, which help to perpetuate health and economic disparities across the lifespan. Because most children engage with it at frequent, regular intervals, pediatric primary care is well positioned to effect long-term improvements in population health by addressing both the medical and non-medical determinants of lifelong health.

The Child Health and Development Institute (CHDI) and Connecticut Health Foundation (CHF) recognize the potential for enhancements to pediatric primary care to improve long-term population health. Health care stakeholders in Connecticut are in the midst of multi-faceted work on payment and delivery reform. CHDI and CHF sought a voice for the importance of pediatrics in reform and convened a Pediatric Primary Care Payment Reform Study Group, comprising 20 members representing a range of stakeholders – pediatricians, commercial insurers, Connecticut's Medicaid program, hospital administrators, public health officials, parent advocates, researchers, and others involved in child health and development. Commonwealth Medicine Health Law and Policy staff provided research support and facilitated the study group's activities.

The Study Group considered current pediatric practice in the context of its potential to improve long-term population health, identified key gaps between current practice and an ideal where pediatric primary care made a strong contribution to population health, and considered what features in payment methods would be essential to motivate the required changes. The group considered past research, promising practices and examples of potential models from around the country, in addition to consulting its own collective expertise in its deliberations.

The Study Group's report offers its recommendations, essentially a set of principles for payment reform in pediatrics, including:

1. Payment reforms in pediatrics should reward effective health promotion and prevention among all children, receiving care in all practice settings, and covered by all payers.

2. Payment methods for pediatric primary care should motivate the restructuring of practices that can improve population health, health equity, health care quality, and address costs.
3. Stakeholders in Connecticut should support efforts to improve measurement and should supply data to strengthen evidence that connects effective pediatric primary care to education outcomes, workforce participation, and adult health and well-being.
4. The participation of all payers in payment reform solutions in pediatric primary care is essential to success.
5. Payment methods need to recognize the variety of service sectors' (medical, education, social services, etc.) overlapping encounters with and responsibilities for children and consider the possibilities of cross-sector collaborations and blended or braided funding.
6. The benefits of improved pediatric primary care are a public good; they accrue across the lifespan, to many spheres of social policy, and to the state's economy in general. As with public education, a public sector role in some form is warranted.

Connecticut's vision of health reform includes recognizing the important influence of non-medical factors on population health and shifting the focus of the health care system to prevention and community-wide solutions. Changes to pediatric care delivery and payment, as embodied in the Study Group's recommendations and further developed as part of Connecticut's reform activities, can make great contributions to realizing this vision.

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