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COVID pandemic as an incubator for a renewed vision of pediatric value-based healthcare

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COVID-19 has stressed primary care pediatric practices. In addition, other market pressures that began before the pandemic make this an optimal time to re-examine pediatric payment models. CMS is encouraging changes in the Medicare market toward alternative payment models. However, success is limited for older adults, and while components of these models can work for pediatricians, the needs of children, young adults and their families are different from older adults. The rapid evolution of telemedicine, and the incursion of retail clinics and urgent care centers are eroding same day office visits and at the same time practices are merging or being acquired by larger organizations including hospitals and insurance companies. All of these changes will require a change in culture and approach in pediatric practice, and modified payment models must incentivize the best care for patients and families and create the opportunity for pediatricians to succeed.

It would be hard to overstate the challenges the COVID-19 pandemic presents to primary care pediatricians; first and foremost, how to provide necessary care to children while keeping themselves, their families, and their staff safe. One jarring reality of the pandemic was the precipitous drop in office visits experienced by pediatricians in early 2020 as COVID-19 infection rates soared across the U. S., yet there were already indications that practices needed to change prior to the pandemic. As providers and practices re-emerge, they recognize that the pandemic intensified market conditions that were slowly infringing on general pediatric offices. The pressures for change come from large market influences such as Medicaid expansion, the consolidation of health systems and the expansion of digital health, as well as local market adaptations that include the presence of retail clinics, urgent care clinics and telehealth, sure signs of increasing parent demand for just-in-time care.

There is no question that in order for pediatric practices to thrive, and for pediatricians to be able to deliver the best care possible to patients and families, the structure of payment to primary care pediatricians (PCP) needs to change.

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Medicaid Services (CMS) National Health Expenditures fact sheet reported the following:

- NHE grew 4.6% to $3.8 trillion in 2019, or $11,582 per person, and accounted for 17.7% of Gross Domestic Product (GDP).
- Medicare spending grew 6.7% (21% of total NHE); Medicaid spending grew 2.9% (16% of total NHE)
- Private health insurance spending grew 3.7% (31% of total NHE); Out of pocket spending grew 4.6% (11% of total NHE)
- Per person personal health care spending for the 65 and older population was $19,098 in 2014, over 5 times higher than spending per child ($3749) and almost 3 times the spending per working-age person ($7153).
- In 2014, children accounted for approximately 24% of the population and about 11% of all PHC (personal health care) spending.

Primary contributors to the rise in costs are hospital expenditures, physician services and prescription drugs, due to a combination of price increases and utilization. Importantly, and more relevant to pediatrics, approximately 40–50% of children and young adults are covered by Medicaid and the Children’s Health Insurance Program (CHIP) and this has grown substantially during the COVID pandemic. Medicaid spending growth, even coupled with expansion of Medicaid coverage in a portion of states, is still slower than Medicare spending growth. This highlights two trends that are critical for children: 1. the elderly population growth is faster than the child population growth; and, 2. the over-65 population makes up only 15% of the total population yet consumes substantially more healthcare dollars in total and per person than children. Therefore, to truly rein in healthcare spending overall there needs to be a focus on improving population health, beginning in childhood, in order to eventually decrease the medical utilization of the older adult population.

These efforts must recognize that payment solutions designed to reduce the current cost of care for older adults also tend to be foisted on children and young adults, even though the patterns of care and needs of the younger population are vastly different.

CMS has emphasized two main areas to gain efficiency in the market with the goal of reducing cost while improving quality. The first was the HiTech Act which led to widespread use of electronic health records and the second has been the effort to build Accountable Care Organizations (ACO) in order to move away from Fee-For-Service (FFS) payments and allow for more innovation in care models. The principle goal is to achieve the Triple Aim as defined by the Institute for Healthcare Improvement; improving the patient experience of care (including quality and satisfaction), improving the health of populations and reducing the per capita cost of healthcare. Both of these major policy initiatives have encouraged the market to consolidate since the needed infrastructure is costly to implement and maintain. Health systems continue to get larger and hospitals and payers are purchasing practices to gain network size with the hope of building efficiencies at scale. However, despite the goal of reducing cost, experience has shown that larger networks can lead to price increases in their communities. Pediatric practices and networks of primary care pediatricians have also gotten swept up in the consolidation of primarily adult networks rooted in Medicare participation, while focus on the needs of pediatric providers and their patients are not the core goal of these new enterprises. In addition, because Medicaid is such a dominant payor for pediatrics and Medicaid reimbursement is far lower than Medicare, there are fewer resources available to invest in building and maintaining the needed infrastructure for care coordination and quality improvement. Even so, there are pediatric-focused clinically integrated networks developing around the country, usually anchored by a children’s hospital, which have the potential to foster change focused more specifically on pediatric needs.

Another significant market trend affecting pediatricians is the presence of retail clinics (many based in pharmacies), urgent care centers and telemedicine providers, but there is little data on the quality of care for children in these venues. All three were growing prior to the pandemic but 2020 permanently embedded them nationally within healthcare. In addition, in the first half of the pandemic, pediatricians saw a
substantial reduction of sick visits and well visits, yet those practices able to stand up tele-medicine were able to recover lost volume in about 6 months. Pediatricians can compete with these disparate entities disconnected from the medical home model, but only by offering convenient scheduling, considering more “walk-in” capacity when COVID allows and offering telemedicine themselves. Otherwise it is clear that larger market players will continue to siphon off high-volume, low complexity visits that currently generate important revenue for practices. Unfortunately, continuing to cede business to outside companies devalues the pediatric expertise and connectedness to families that pediatric practices offer.

Concerns about cost have led CMS and commercial payers to change reimbursement to Alternative Payment Models (APM) for providers in order to incentivize behaviors that impact patient care utilization and cost such as excessive ED use, hospital re-admissions and pharmacy expense. APM have subtle but impactful differences and often require significant corporate structures along with IT and EHR infrastructure, so how pediatricians can succeed in these arrangements is critical to understand. In order to contemplate a better payment model for pediatric primary care, one first needs to review the marketplace and recognize that there are really only a few payment options from which to choose. Most pediatricians in independent practice are paid fee-for-service (FFS). Insurers pay each office visit and ancillary service at a contracted amount with the remainder as a patient responsibility. Independent Practice Associations (IPA) group a number of small practices together to add negotiating strength often leading to higher payment rates. Many IPAs are owned by or connected to hospitals with a similar objective for increased payment while hospitals also hope to secure referral volume. Pay-for-Performance (P4P) agreements add incentives for quality performance. For pediatricians, quality measures are generally important preventive health measures (i.e. vaccination rates, well-visits and patient satisfaction), which highlights the challenge to measure other core pediatric activities in a meaningful way to support reimbursement. Value-Based Care and Contracting (VBC) focuses on outcomes as the primary incentive for surplus payments, but outcomes in pediatrics may be years or generations down the road-i.e. successful schooling, prevention and recovery from adverse childhood events (ACE), safe parenting, healthy domestic relationships and careers are all goals of excellent pediatric care.

Tying interventions in childhood to these long-term outcomes in a measurable way is not achievable currently.

Finally, capitated arrangements with health systems as ACO usually require a large network-almost always anchored by a hospital. Payment rates in capitation are set using historic benchmarks for the cost of all services for an attributed population of patients. The total expenses in a given year are measured with some degree of surplus sharing if the organization can save money by adding or modifying services that improve quality while reducing cost. If they are unable to reduce costs they may need to contribute financially to the deficit created by over-spending the budget. Most payments to the organization are on a per-member per-month (PMPM) basis. The budgeted amount of money is usually impacted by risk-adjustment, a complex calculation examining diagnosis coding to compare the “riskiness” or likelihood of medical complications, and therefore spend, of one organization relative to another in order to achieve payment fairness. Risk models derived from adult experience may not adequately account for pediatric medical and social circumstances. In all of the models, it is most common for providers to still be paid by the larger organization mostly on a productivity basis (fee schedule or relative-value-unit (RVU)-based payment), although some organizations have moved to salaries with performance incentives. So while APM are touted as the payment wave of the future they still have substantial FFS components in terms of how incentives function for providers. Despite continued emphasis on these arrangements, savings in the CMS program have been limited to a small number of organizations, usually physician led as opposed to hospital -led, and the total savings thus far in
Medicare measure in the billions of dollars in a multi-trillion dollar industry. Like adult providers, pediatricians require larger networks for negotiating strength, but also for critical infrastructure such as IT systems including cybersecurity, electronic health records and interoperability with hospitals, social service organizations and schools. For example, a large system approach may allow for the building and oversight of care coordination and integrated behavioral health services. Pediatricians also have a long history of providing comprehensive “medical home” functions for patients and families and VBC places a larger emphasis on primary care engagement leading to the reduction of emergency department utilization and hospitalizations.

The mantra now is to pay for value not volume but how will that really work for pediatricians where successful primary care interventions can take years to “pay-off” in a return of healthier adults and potentially lower medical costs while insurers want to see returns in 1-5 years? Additionally, addressing the social environment surrounding children and families, including income, racial and ethnic disparities in access to services, food, housing, education and healthcare, is critical to develop a system that leads to safe and healthy development for children and young adults. The role pediatricians play and how to pay for the services delivered in pediatric offices are a key element of success. It is critical that pediatricians examine what works, what can be managed and use evidence to advocate for the best reimbursement.

So what does this mean for primary care pediatricians? With almost guaranteed volume between newborn care, well-child care, and sick visits, FFS has functioned reasonably well for providers for decades but there is no real accountability for outcomes. FFS is probably the best incentive for direct and quick access to a provider, since even with a copayment as patient responsibility, relatively immediate service is delivered. But the work of primary care pediatricians often extends well beyond the confines of a specific office visit. For example, triaging and replying to the many phone calls (and now EHR messages) from parents typically received each day; reviewing information from outside sources such as specialists and schools and other involved community agencies; and advising families on related issues such as counseling for HPV vaccines and now COVID vaccines and testing, behavioral health, nutrition, exercise, obesity, education, and social issues that arise in children’s lives, where early identification and support can mitigate lifelong disease and expense. In the past, these non-reimbursable services were essentially covered by FFS revenue generated from the many quick sick visits for minor illnesses. But these less acute sick visits have been declining for many years now due to a combination of higher co-pays disincentivizing such visits, the proliferation of urgent care centers, and parents’ ability to access information from the internet and elsewhere to manage minor health issues without an office visit. To create a more rational model for pediatric primary care, elements of care that add value to children’s long-term health need to be reimbursed explicitly and incentivized, with measurable cost and quality. In addition, parents need to understand how and where the most appropriate location would be to obtain the services they need. Some suggest that moving away from FFS is the primary key to driving the elements of the care system to work together but all incentive and payment systems have upsides and downsides, so a rush to capitation in pediatrics may not be optimal. The financing and payment for pediatric care primarily needs to support a comprehensive system to care for children. Pediatricians need to consider and manage the cost of care for patients; however, focusing on short-term expense reduction as the key component of value-based care for the lowest cost segment of the healthcare system will neither save substantial amounts of money nor likely benefit the children and families in the long run. In order to think about payment in pediatric primary care one needs to understand where the expenses are highest for children and whether primary care pediatricians can affect them, especially when payer agreements include financial risk for the clinicians.
In pediatric networks, success in a capitated model will require significant alignment with a tertiary pediatric hospital because the children with the highest medical cost need specialized pediatric services and often for long periods of their lives.

The acute costs of care in pediatrics are distributed very differently than in adults, especially in terms of what is modifiable by primary care clinicians. In fact, the largest dollar amount in pediatric hospital payments is for newborn services (healthy and NICU), which cannot realistically be impacted by primary care for children. Many other high-cost cases include severe acute injuries, specialty pharmaceutical cost (treatments with biologics and genetic therapies), care for genetic or congenital disorders especially those that require ICU care or extensive surgery and cancer/transplant treatments, again not areas where primary care pediatricians play a big role in determining the final cost. Pediatric practices also experience tremendous variability with regard to patients with these conditions because of the relatively rare occurrence of most severe disorders, which affects the likelihood that risk adjustment will accurately capture the work in individual primary care practices. Therefore, an ACO agreement must either exclude these services or offer significant re-insurance. However, once these services are removed from the risk pool, the total medical expenses at risk are reduced even further making the burden of trying to manage to a budget higher than the potential cost savings for the overall population. That does not mean pediatricians and patients cannot benefit from capitated payments or that efforts should not be made to manage expenses and improve quality. However, the incentives and penalties need to be commensurate with the effort and the potential to succeed under the agreement, which should carry a narrow band of risk. Pediatric primary care requires adequate funding, and relying on fee-for-service billing while market competitors are pulling small fragments of revenue away is short-sighted. Given the amount of effort pediatricians put into meeting family needs and providing preventive care, per-member/per month (PMPM) payments to pediatricians should form a component of their compensation. It should account for all preventive services, a portion of urgent or problem-based care and account for the value of support needed to create a comprehensive medical home in the practice, including enhancements for connectivity to interpreter services, social service organizations, and more. Enhanced PMPM rates should incentivize additional needed services such as integrated behavioral health or more depth in care coordination. In addition, payment should continue in FFS for ancillary services, and with supplemental FFS payments to continue same-day and problem-based services and access. For example, Pediatricians, in particular, experience significant volume surges during influenza season and patients and providers will benefit from incentives to encourage expanded access to services at these times. Ideally, these fees should cover video/telephone and in-person visits at the same rates so that the family receives the service they desire. In a fully capitated world, the incentive for treatment slants toward what is most efficient for the provider, not necessarily what is most desired by the patient or family. Therefore, including a FFS incentive neutralizes the choice of venue and balances out the options.

On the other end of the spectrum, children’s hospitals and pediatric sub-specialists will likely continue primarily as FFS and not accept full capitation as a primary method of re-imbursement. Nationally, there is significant deeper regionalization of services because of the expertise around specific conditions and procedures that is needed for children. Hospitals and specialists can participate in capitation arrangements with clinically integrated networks but it will remain hard to deliver overall culture change around cost and performance when a substantial portion of hospital and specialty revenue comes from outside of these arrangements. In order to align incentives, one needs to look at what the patients and families want or need from a specialty center, and how that connects to the primary care medical home. For highly specialized, comprehensive care for orphan diseases, complex surgical repairs, and devastating genetic disorders-families need access to these centers given the broad variation in disease course and treatments. However, with FFS, there is no direct financial incentive, other than the value of customer satisfaction, to...
manage the patients effectively when they are not in the office, or to collaborate meaningfully with their primary care clinician. Therefore, a secondary reimbursement stream for managing the population of patients when they are not at the hospital ought to be in play. Think of it as “care-coordination” dollars with a set of expectations that include measuring the frequency and quality of communication with families and PCP, patient and parent satisfaction, identification of risks and barriers to effective care and the identification of paths to break those down, sometimes in conjunction with external agencies, schools or the PCP. Previously the expectation has been that enhanced commercial FFS reimbursement would fund these activities, but the downward pressure on rates from commercial payers and the increase in Medicaid volume, from within and out of state, make this untenable.

To summarize, primary care pediatricians need PMPM revenue across a wide base of payers, that should increase in value with the addition of substantial services such as integrated behavioral health and advanced care coordination, in combination with additional FFS incentives for adequate access to visits and ancillary services. Ideally, they will have enough contribution to overhead to support the needed growing labor costs and appropriate IT, EHR and real estate. In order to maintain negotiating power and to align the best care pathways for the children they care for, most pediatricians will benefit from deeper integration with a tertiary hospital. For their part, the hospitals need to work more closely with families and the community of pediatricians to make sure patient’s needs are met across the spectrum of their care. Payment reform will encourage clinicians to move in this direction, but it will still require significant changes in operations and a cultural shift that likely needs to start in medical school and residency, in order to move away from seeking visit volume to managing populations of patients inside and outside of the office setting. In all, the comprehensive support network for children includes families, community, schools, social service agencies, behavioral health resources and more, and it is imperative that pediatricians work toward the best possible integration of these services and are paid adequately to incentivize the required effort.

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