POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

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Principles of Financing the Medical Home for Children

Jonathan Price, MD, FAAP,[a] Mary L. Brandt, MD, FACS, FAAP,[b] Mark L. Hudak, MD, FAAP,[c] COMMITTEE ON CHILD HEALTH FINANCING

A well-implemented and adequately funded medical home not only is the best approach to optimize the health of the individual patient but also can function as an effective instrument for improving population health. Key financing elements to providing quality, effective, comprehensive care in the pediatric medical home include the following: (1) first dollar coverage without deductibles, copays, or other cost-sharing for necessary preventive care services as recommended by *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*; (2) adoption of a uniform definition of medical necessity across payers that embraces services that promote optimal growth and development and prevent, diagnose, and treat the full range of pediatric physical, mental, behavioral, and developmental conditions, in accord with evidence-based science or evidence-informed expert opinion; (3) payment models that promote appropriate use of pediatric primary care and pediatric specialty services and discourage inappropriate, inefficient, or excessive use of medical services; and (4) payment models that strengthen the patient- and family-physician relationship and do not impose additional administrative burdens that will only erode the effectiveness of the medical home. These goals can be met by designing payment models that provide adequate funding of the cost of medical encounters, care coordination, population health services, and quality improvement activities; provide incentives for quality and effectiveness of care; and ease administrative burdens.

INTRODUCTION

The American Academy of Pediatrics (AAP) originally developed the concept of a medical home in 1967.[1] Since that time, the AAP has continuously refined its vision of the mission, structure, and function of a medical home consistent with evolving best practices. A well-implemented and adequately funded medical home not only is the best approach to optimize the health of the individual patient but can also play a key role in improving population health. As public and private

abstract

[a]*Department of Pediatrics, Nationwide Children's Hospital, The Ohio State University College of Medicine, Columbus, Ohio;* [b]*Department of Surgery, Texas Children's Hospital, Houston, Texas; and* [c]*Department of Pediatrics, College of Medicine, University of Florida–Jacksonville, Jacksonville, Florida*

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Address correspondence to Jonathan Price, MD, FAAP. E-mail: njnprice@gmail.com

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payers modify traditional ways of paying for medical care or create alternative payment models in an effort to provide greater value (an improved ratio of population health to health care expense), they should recognize the contribution to value that the medical home makes.[2,3] Pediatricians must be knowledgeable about certain basic principles in their work with payers to make the medical home fully effective in improving the health of children and to ensure the medical home's fiscal viability.

DEFINITIONS

The "pediatric medical home" delivers accessible, continuous, comprehensive, patient- and family-centered, coordinated, compassionate, and culturally effective health care. In this venue, well-trained pediatric physicians known to the child and family deliver or direct primary medical care.[4] By extension, a "pediatric medical neighborhood" includes pediatric medical subspecialists, surgical specialists, mental and behavioral health specialists, and others who work collaboratively with the pediatric medical home.

The "triple aim," as adopted by payers, is to improve the value of health care (defined as the ratio of proven benefit or quality of care to the cost of care), to improve the individual patient's experience of care, and to improve community health as a whole. The foundational document that describes the triple aim envisions that payers must undertake or delegate several crucial tasks that include partnering with individuals and families, redesigning primary care, managing population health, managing system financing, and integrating care within large systems.[5] This triple aim has expanded to a quadruple aim by recognizing that improved provider satisfaction is another key goal of the health system enterprise. Attention to how the care team experiences the quality of its work life is required to counter the erosion of provider manpower, efficiency, and empathy resulting from accelerating and often onerous administrative demands.[6]

RECOGNIZING AND DELIVERING VALUE

Approximately one-third of the US population consists of children and young adults younger than 25 years.[7] Despite recent advances, however, the vast majority of health care spending, benefit design efforts, and medical home pilot projects are focused on older adults. In a growing body of evidence, it has been demonstrated that a greater achievable health value lies in identifying, preventing, ameliorating, or treating problems that may begin early in life and have lifelong consequences.[8–12] Prevention and early interventions undertaken between birth and school entry have significant effects on adult health[13–15] and remain important when initiated in later childhood, adolescence, and early adulthood. In this respect, greater investments in medical homes that enable or enhance their unique capabilities may be expected to generate compound long-term returns.

Health insurance, therefore, should cover the full range of essential services for children. These services include the traditionally recognized areas of newborn care; acute, urgent, and emergent outpatient care; inpatient and chronic care services; and prescription drugs. Essential services also include screening and early detection of developmental and behavioral problems and the full range of preventive and wellness services, including anticipatory guidance, habilitative and rehabilitative therapies and devices, oral health and vision care services, behavioral and mental health services, reproductive and pregnancy-related care, substance use disorder treatment, and transition to adult care services as well as home health, palliative, and hospice care services.[16] To achieve the full downstream effects of early-in-life prevention and intervention, payers should also cover other services, many of which can be integrated with the medical home. These include home visitations during pregnancy, infancy, and early childhood, the importance of which to child cognition and health have become well recognized.[17–20] Other evidence-based programs that have been shown to improve important short- and long-term child outcomes include Reach Out and Read, Healthy Steps, the Video Interaction Project, Incredible Years, medical-legal partnerships, and the Triple P Positive Parenting Program.[21–26]

PROVIDING EFFECTIVE COMPREHENSIVE CARE IN THE MEDICAL HOME

Accomplishing the goal of providing effective, comprehensive care in the medical home requires the following.

1. Insurers provide first dollar coverage for the preventive care services recommended in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*[13] and for vaccines recommended by the AAP and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. All should be exempt from cost-sharing.
2. Health insurers adopt a uniform definition of medical necessity to include those services that promote optimal growth and development as well as prevent, diagnose, and treat the full range of pediatric physical, mental, behavioral, and developmental

conditions, in accord with evidence-based science or evidence-informed expert opinion.[16,27] Expert pediatric providers must be included in adjudication of disputes over medically necessary services for children.

3. Cost-sharing policies relating to deductibles, copays, and coinsurance focus only on discouraging inappropriate, inefficient, or excessive use of medical services. They should not deter appropriate use of primary care or specialist services. Out-of-pocket limits should be set as a function of family income rather than in absolute terms. Out-of-pocket limits should be minimized for these services. A generous number of primary care visits or, alternately, outpatient visits in general should be available without a deductible and with minimal cost-sharing limitations. A similar approach should apply to medically necessary services and procedures that are typically provided by medical subspecialists, surgical specialists, and mental and behavioral health specialists. High-deductible health plans are not appropriate for the pediatric population because they are not congruent with these principles.[28] A developing body of evidence suggests that high-deductible health plans indiscriminately discourage families from seeking high-value and/or medically necessary medical services. Hence, high-deductible health plans not only decrease inappropriate or excessive use but also restrict access to appropriate care.[29,30]
4. The provider and patient become able to determine from the payer the patient's cost responsibility at the time of service to achieve timely and efficient collections necessary to sustain the medical home.

IMPROVING THE PATIENT AND PROVIDER EXPERIENCE OF CARE

For children to receive accessible, continuous, comprehensive, and coordinated care from the medical home, payment for services must be timely and adequate. For the medical home to plan effective delivery of care, the payment methodology for encounters, coordination of care, quality improvement, and data generation must be understandable, transparent, and verifiable and must incentivize improving the patient experience of care. This can effectively be accomplished by implementation of the following principles, which will also improve provider satisfaction, the fourth item of the quadruple aim.

A. Adequate and Fair Payment for Medical Encounters

1. Base payments for encounters should reflect the complexity of service.[31]
2. Payers should value the additional global services that a practice incurs to effect transition of care, especially from pediatric to adult providers[32] as well as from hospital to home care and from home or hospital to residential or other treatment venues, by paying fairly for existing transition *Current Procedural Terminology* (CPT) codes.
3. Payments for vaccines, medications, and medical supplies should be based on the total costs of acquisition, patient counseling, storage, inventory tracking and reporting, quality control, administration, and documentation. Payments should be updated promptly for changes in purchase cost.
4. Appropriate non–face-to-face encounters via telephone and video and those on digital platforms, such as the Internet, e-mail, electronic health record portals, and other secure encrypted communication, that provide meaningful care should be paid for adequately to facilitate optimal function of the medical home and to improve patient and family satisfaction. These interactions may occur between the patient and family and the medical home or between the medical home and specialty care providers. These visits have their greatest value when they are performed within the medical neighborhood because they facilitate more timely access to care, promote continuity and thereby enhance quality, and prevent use of more-expensive medical venues. Payers should recognize this greater value by incentivizing patients and families to coordinate care through the medical home.

B. Adequate and Fair Payment for Coordination of Care

1. Payment for coordination of care allows services outside of face-to-face encounters that optimize care. This is especially important for children with special health care needs. Examples of these services include providing reminders and other outreach to patients and coordination and communication with medical subspecialists, surgical specialists, therapists, educators, and community resources.
2. Payment should be proportional to the specific services provided in this regard by the medical home and should consider the complexity of the patient panel. It is essential to understand that complexity relates not only to patient-specific medical and psychological factors but also, and especially in pediatrics, factors specific to parents and caregivers as well as overarching household and social factors, such as food and housing insecurity, neighborhood and household

violence, poverty, immigration status, and need for legal services.[33]

3. Coordination payments could be made as enhanced fee-for-service payment or as supplemental per-member per-month payment. Supplemental per-member per-month methodology can also enable providers to establish and maintain health information technology and collect data for quality improvement and population health initiatives. Payers should pay fairly for existing CPT codes that apply to care management of children with chronic and/or complex medical and behavioral conditions.

C. Implementing Well-Designed Incentives and Eliminating Disincentives

1. To achieve the full benefits of the medical home, its financiers should not simultaneously incentivize efforts that undermine it.
2. Vaccines, including the influenza vaccine, provided by the Vaccines for Children program and the Centers for Disease Control and Prevention are properly viewed as an important type of "in-kind" financing. As such, they should be supplied in a way that is as timely and adequate as monetary financing. In particular, release of annual influenza vaccine to accessible medical homes should be prioritized. Delayed delivery relative to other venues, such as pharmacies and retail-based clinics, results in lost opportunities for families to engage the medical home and potentially benefit from other interventions or health education at the same time.
3. Payers should not design cost-sharing to encourage the family to use venues, including retail-based clinics and telehealth ventures, that do not meaningfully communicate with the medical home or that deviate from professional standards of care (eg, fail to adhere to antibiotic stewardship principles or fail to conduct patient evaluations adequate for the complaint). Likewise, payers should not support provision of care to children younger than 2 years by acute care venues that lack pediatric expertise.[34]

D. Easing the Administrative Burden

1. Payers using fee-for-service payments should consistently adhere to CPT definitions of services. Providers waste administrative resources encoding the same service differently for different payers. Resultant errors in billing can reduce revenue. In addition, variant coding enfeebles a practice's ability to conduct internal analyses of its services.
2. Pediatricians choose from among specific quality improvement programs designed by the American Board of Pediatrics or one of its chartered entities for maintenance of certification (MOC). They also separately participate in specific programs designed by health care payers to qualify for incentive payments. Synergy between these programs would ease administrative burden within the medical home and better promote community health. Payers and MOC program administrators, via sponsorship or other means of collaboration, can develop and share large amounts of data, which can increase the impact of these programs on health outcomes. The efficiency of the medical home would benefit from reducing the multiplicity of efforts necessary to satisfy separate MOC and payer incentive rules.

IMPROVING THE HEALTH OF THE POPULATION

Pediatricians and payers can improve community health outside the traditional office encounter in a variety of ways. A venue committed to being a medical home for children and young adults should seek broadly innovative ways of improving health outcomes for children in its practice and can also consider extending its efforts to the greater pediatric community.[35,36] Payers should value and encourage research and initiatives that are likely to elevate health outcome trajectories over the long-term.[37] Continuous real-time sharing of data about patient populations between payers and practices can be a powerful way to help both groups respond to health needs in a timely way. All public and private payers should invest in providers, families, and communities to achieve better short-term health outcomes and to stimulate changes that will result in sustained improvement in the long-term life course.

Payers Have a Unique Opportunity and Ability to Enhance the Effectiveness of the Medical Home and Incentivize Families

A payer that covers both a parent and a child has important timely data about the family unit that may allow the medical home to optimize a child's comprehensive care. Payers and providers should consider sharing such data. Social determinants of health (including parental and socioeconomic factors) largely shape many adverse conditions and experiences affecting vulnerable children. Some childhood adverse conditions begin during fetal development; some are associated with preterm birth. Other conditions involve situations, actions, and deficiencies that cause children to become medically, behaviorally, or emotionally complex. Many social determinants of health culminate with children reaching maturity in socioeconomic conditions and habitual

behavior patterns associated with lifelong chronic and expensive adult conditions.[38] Relevant parental factors include the parents' or caregivers' employment status; past and present physical, mental, or behavioral health; use of tobacco and other substances; previous experience with and attitudes toward medical care; and competencies as parents or caregivers. Knowledge of these parental factors may allow the medical home to tailor medical care and parental education to prevent or mitigate those adverse childhood experiences that are predictable yet potentially modifiable. These same factors also influence whether a parent creates and maintains a relationship with a pediatric medical home for their child. Some payers already incentivize pregnant mothers to remain engaged with their prenatal care, such as by providing portable safe sleepers and play yards or coupons for infant products for those who attend nearly all of their prenatal visits; those with the data and resources should also incentivize parents to engage appropriate services on their own behalf and engage with a comprehensive, coordinated medical home for their children. Resources should also be deployed when necessary to provide or subsidize essential transportation for necessary encounters.

Payers Have a Unique Opportunity and Ability to Shape the Community

For children and youth, and especially for those with special health care needs, high-quality care must support family members, who provide the bulk of day-to-day care and advocacy for the child. Some metrics of quality outcomes pertinent to pediatrics reflect enhancements to the family's ability to support the child. Parents, for example, indicate that a meaningful outcome of a health intervention is reducing the number of school days and workdays that an illness, injury, or condition cause to be missed within the family.[39]

A key factor that impedes delivery of quality care is a lack of appropriate, affordable, community-based family services and supports.[40] In addition, a lack of appropriate pediatric-oriented medical, surgical, mental health, substance use, and other therapeutic services within a geographic area or a payer's network of providers can impose a significant barrier. Payers, public and private, should invest in the necessary infrastructure to support the pediatric medical home and medical neighborhood.

Where they exist, payers should support community-based efforts that identify children and adults in high-risk families, provide care coordination, and measure results in housing, education, employment, and engagement with the health system.[41,42]

Payments for Quality Improvement Activities Should Be Adequate and Fair

Ideally, "pay-for-performance" or similarly named programs can be used to promote high levels of quality, value, and outcomes. These programs reward providers either monetarily or by reducing administrative burdens. Examples of the aims of such programs include reducing inappropriate antibiotic use, promoting cost-effective medications, and rewarding follow-up in the medical home after hospitalizations and emergency department visits. Many of the elements that constitute proper design of such programs are delineated in a forthcoming AAP policy statement, "Beyond Fee-for-Service: New and Evolving Payment Models and Pediatrics" (S. Berman, MD, M.L. Hudak, MD, unpublished observations). Some programs are demonstrating positive results.[43] On the other hand, pay-for-performance programs are still evolving. Many adult programs have features that are not pertinent to improving care provided to children or that cannot easily be translated into pediatric equivalents.

1. Pediatricians should be involved in the creation and revision of performance goals, the metrics used to quantify them, and the process of validating them. Uniquely pediatric performance goals include use of evidence-based or evidence-informed screenings, interventions, and coordination that promote the optimal growth and development of children and youth.
2. The criteria for achieving rewards should be transparent. Incentives are ineffective if a provider does not know how a payment was earned or not earned.
3. A detailed "explanation of payment" document should explain how an incentive payment (or lack thereof) was determined and delineate which encounters or actions led either toward or away from a goal.
4. Providers should be able to use such transparency in an active and timely process to appeal payer errors.
5. Payment models that aim to calibrate fee-for-service payments, distribute incentive payments, or impose financial penalties on the basis of process or medical outcome metrics must incorporate a rational, robust, and validated risk adjustment methodology that accounts for the strong influence of social determinants of health on many metrics. Payment models should not discourage providers from caring for patients who are most in need of expert care. Moreover, payers should choose process or quality metrics in consultation with pediatric providers to ensure that the metrics are relevant to improving the care or outcomes of care in children, meaningful to the pediatrician, and feasible to accomplish within the medical home.

6. A robust electronic health record facilitates effective quality improvement activities within the practice population through its ability to create registries and track process and quality outcomes. Payment models should consider ways to encourage investment in this important yet costly infrastructural need.

CONCLUSIONS

For a medical home for children to be both effective and fiscally viable, payers must adequately finance the full range of services required to optimize the physical, developmental, emotional, and behavioral well-being of children, which critically influence health throughout the life course. Some support is required to engage families initially with the medical home. Once engaged, appropriate support is needed for encounters, care coordination, continuous quality improvement, implementation of an effective electronic health record system, and innovative efforts to improve community health. This support should not impose additional administrative burdens that will erode the effectiveness of the medical home. Payers should consider how best to achieve better health care value without encouraging fragmented care outside the medical home.

LEAD AUTHORS

Jonathan Price, MD, FAAP
Mark L. Hudak, MD, FAAP
Mary L. Brandt, MD, FACS, FAAP

COMMITTEE ON CHILD HEALTH FINANCING, 2018–2018

Jonathan Price, MD, FAAP, Chairperson
Mark L. Hudak, MD, FAAP, Past Chairperson
Suzanne K. Berman, MD, FAAP
Mary L. Brandt, MD, FACS, FAAP
Kenneth M. Carlson, MD, FAAP
Angelo P. Giardino, MD, FAAP
Lawrence Hammer, MD, FAAP
Kimberly Heggen, MD, FAAP
Stephen A. Pearlman, MD, MS, FAAP
Beena Gaind Sood, MD, MS, FAAP

LIAISIONS

Peter G. Szilagyi, MD, MPH, FAAP – *Medicaid and CHIP Payment and Access Commission*

STAFF

Lou Terranova, MHA

ABBREVIATIONS

AAP: American Academy of Pediatrics
CPT: *Current Procedural Terminology*
MOC: maintenance of certification

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