

The Role of COVID-19 in Transitioning to a Better Pediatric Payment Model

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The coronavirus disease 2019 (COVID-19) pandemic has quickly impacted health care systems and especially primary care pediatricians. Although fortunately cases of severe COVID-19 and the associated multisystem inflammatory syndrome in children have been rare, the disruptions caused by the COVID-19 pandemic have exposed the financial vulnerability of independent pediatric practices that rely primarily on fee-for-service revenue. Social distancing and stay-at-home advisories have led to the cancellation of routine well-child and follow-up visits for many children and young adults nationwide, as evidenced by the steep drop in childhood vaccines since March.¹ Furthermore, social distancing has led to a significant reduction in the incidence of common infections and playground and sports injuries, further diminishing the need for office visits.² And, even when children do become ill or injured, parents fear exposing their children to infection by bringing them for care during the pandemic. Yet although children have been relatively spared from the brunt of direct health effects of COVID-19, social isolation and lack of school attendance have placed them at increased risk for mental health disorders, missed screenings for lead poisoning, poor nutrition and/or exercise habits, and undetected child abuse, which are situations that call for a strengthening of the primary care infrastructure to assure children's health needs are met.

In our own affiliated primary care network, in-person visits initially fell by ~75% after statewide COVID-19 restrictions, causing severe disruptions in cash flow given the predominately fee-for-service environment and leading to drastic drops in practice income and furloughs and/or layoffs of a significant number of practice staff. Federal support from the Paycheck Protection Program enabled practices to remain open, and, although total visit volume (combining in-person and telehealth visits) has recently returned to normal seasonal levels, a resurgence of COVID-19 could imperil practices' financial health if revenues drop again. The income reduction was particularly challenging for small and midsize pediatric practices and threatened to drive many independent practices out of business. Compensation reductions were reported nationally and affected providers in all payer arrangements. This pandemic-induced drop came on

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DOI: <https://doi.org/10.1542/peds.2020-008672>

Accepted for publication Oct 14, 2020

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

To cite: Lee MA, Sprecher E, Vernacchio L. The Role of COVID-19 in Transitioning to a Better Pediatric Payment Model. *Pediatrics*. 2021;147(1):e2020008672

top of the decade-long decline in office visits pediatricians were already experiencing amid increasing competition from urgent care centers and retail clinics, which may undermine the primary care–family relationship.^{3,4} To stabilize their revenue and provide service to patients, many pediatricians have rapidly accelerated the use of telehealth visits and have clamored for increased reimbursement equal to in-person care. However, similar to the situation with urgent care and retail clinics, patients can access telemedicine services outside of the medical home from a wide variety of market competitors, and continued payment parity from insurance companies for telehealth services is not assured. Taken together, these challenges suggest the need to ensure the long-term survival of pediatric practices by advocating for necessary changes to the current primarily fee-for-service payment model for pediatric primary care.

One alternative to the fee-for-service reimbursement model is a risk-based global capitation model. The case for such arrangements rests on the concept that primary care providers can control the cost of care, which will lead to shared savings while retaining quality. However, pediatric

primary care is relatively inexpensive to begin with and pediatricians have little control of the cost of care for their highest-cost patients, who are often complex and managed by subspecialty providers or experience unpredictable acute illnesses or events. In some settings, pediatricians take part in full capitation and, in addition to financial performance risk, they receive enhanced payment for measurable outcomes (pay for performance). However, full-risk capitation is not likely to be the best long-term model for independent pediatric practices because this model requires large networks, often with a hospital anchor, to guarantee a broad risk pool. Some integrated pediatric networks do incorporate quality- and value-based payments to providers, but the predominant compensation to providers, even within capitation arrangements, is still on a productivity model. Furthermore, to maximize risk-adjusted capitation rates, these schema encourage heavy documentation burdens to improve coding for risk adjustment and enhance payments with little to no benefit for patients.^{5,6} Now is an opportune time to pursue alternative payment models for smaller independent pediatric practices that

avoid the pitfalls of fee-for service and full-risk capitation models (Table 1).

We propose a blended model of per-member-per-month (PMPM) payments plus smaller fee-for-service payments for independent practices, which could both ensure financial stability and incentivize access. Under such a model, PMPM payments would cover a substantial portion of revenue and depend in part on incorporating high-value primary care capabilities such as integrated behavioral health, population health activities, validated screening for behavioral and/or developmental and social needs, and care coordination. One concern with capitation arrangements is disincentivizing pediatricians from taking on medically and psychosocially complex patients. The vast majority of pediatric practices care for some children with medical complexity, and adding care coordination payments for such children can be included in the PMPM rate without exposing the practices to financial risk for medical expenses that are rarely under the control of primary care pediatricians. Payers ensuring adequate payment for care coordination services, as well as integrated behavioral health and support for addressing social

TABLE 1 Summary of Various Payment Schema for Primary Care

| Type of Payment | Current Use | Advantage | Disadvantage |
|-----------------------------|--|---|--|
| FFS | Broad use, most common independent practices | Incentivizes productivity, administrative burden is for billing and collections only. | No payment for electronic or phone communication and care coordination, cumbersome billing requirements. |
| Full capitation | Large networks, usually anchored by a hospital, often connected to adult networks; payment is budgeted PMPM at enterprise level, risk adjusted with reconciliation against total medical expense and quality performance | Enables internal decisions on reimbursement to providers and spending on programs to support patient care and improve quality. Most payment to providers is RVU or productivity based with performance bonus. Some networks are salary and bonus. | Adult networks focus less on pediatricians. Scale is needed to tolerate market risks. Substantial administrative burden and data analytics. Primary care pediatrics' ability to reduce cost of care is less evident. |
| PMPM plus simpler FFS model | Newer method, direct payment to provider | PMPM payment goes directly to the provider, adjusted by the depth of services (ie, integrated BH, medical home functions); a simpler FFS component. Quality performance measurement and bonus potential. Less focus on total cost of care. PMPM supports total care effort. | Will work best with broader implementation and multiple plans as opposed to just one. Medicaid is a large payer in most markets, but there are blends of commercial payers with managed care and FFS, so it will take time to gain ground. |

BH, behavioral health; FFS, fee for service; RVU, relative value units.

determinants of health, will prevent such cherry picking. Additional modest fee-for-service payments for each in-person or telemedicine encounter and ancillary services would allow clinicians and patients to choose the mode of interaction best suited to their needs. If such encounters were reimbursed at a fixed rate irrespective of modality or complexity, clinicians would face reduced burdens of complex documentation and coding requirements. Office procedures (eg, immunization administration, minor surgical procedures, long-acting reversible contraception) and evidence-based testing could still be tied to appropriate small fee-for-service payments to allow practices to provide services that are beneficial to patients. Importantly, a blended reimbursement model would allow for longer-term and more predictable planning for practices and could accelerate the introduction and use of technologies. It would also protect pediatric practices from a continued reluctance of patients and families to travel to pediatric offices (and wait in waiting rooms) even after the worst of the current pandemic has passed. It could spur the adoption of more team-based care and use of care extenders when practices are less tied to revenue-generating visits with a clinician, as Perrin and Oreskovic suggest.⁷

As we continue to navigate these challenging times in which pediatric primary care practices face questions of their survival, we can take advantage of the COVID-19 pandemic to envision a different and more stable future for pediatric primary care. The pandemic has illustrated the tenuousness of the current reimbursement model, and in response, we should think beyond the simple dichotomy of fee-for-service versus capitation. A carefully constructed blended model with the proper incentives to incorporate high-value services and helpful technologies could enable pediatricians to deliver excellent care with lower operational costs and in a form that meets patients and families where they are. Getting there will require clinicians and payers (including state Medicaid programs in exceedingly difficult budgetary times) working together for the future of independent pediatric practice. But if such a strong and more rational reimbursement model could be brought to life, primary care pediatricians will be in a better position to serve their patients and face the next great challenge, whatever that may be.

ABBREVIATIONS

COVID-19: coronavirus disease
2019

PMPM: per member per month

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Pediatrics 2021;147;

DOI: 10.1542/peds.2020-008672 originally published online October 23, 2020;

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