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

American Academy of Pediatrics
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Guiding Principles for Managed Care Arrangements for the Health of Newborns, Infants, Children, Adolescents and Young Adults

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Managed care arrangements are an approach to health care delivery in which the payer or other health care entity has policies that affect where care is delivered, what services are covered, and how payment is determined. When policies are intentionally designed, transparently administered, and continuously monitored, they are more likely to improve the population's utilization of services, access to quality primary and specialty care, and access to appropriate medications. When managed care arrangements are designed well, particularly within evolving payment models, health care can be delivered in a manner that supports the goals of the Quadruple Aim: to reduce per capita costs of health care, to improve the health of populations, to improve the experience of patients receiving care, and to improve the experience of those who are providing care.

The American Academy of Pediatrics (AAP) urges payers and health care entities to use the key principles outlined in this statement when designing and implementing managed care arrangements and policies that cover newborn infants, infants, children, adolescents, and young adults to support the goal of improving the effectiveness of the health care delivery system for the pediatric population. The principles described in this statement are intended to complement those previously published in other AAP policies including "Principles of Child Health Care Financing," "Scope of Health Care Benefits for Children From Birth Through Age 26," "Patient- and Family-Centered Care and the Pediatrician's Role," and the "AAP Access Principles."

Faced with a persistent upward trajectory in health care costs, employers, state Medicaid programs, the Children's Health Insurance Program (CHIP), and other purchasers of health care continue to study and reconfigure managed care plans to find the most effective

abstract

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strategies that deliver quality health care, improve patient and family experience, and contain costs. As a means of coordinating the delivery and financing of health care services, managed care plans have advanced different approaches that include selective contracting with clinicians (narrow provider networks), medical management (medication utilization and formulary management), gatekeeper functions (prior authorizations), and new payment methodologies. The arrangements have trended in some markets toward tighter relationships; the formation of new integrated delivery systems, clinically integrated networks, or accountable care organizations; and novel payment incentives based on performance on quality metrics. As experience grows with Medicaid managed care, some programs in Oregon, Colorado, and Ohio with regional focus and better connections to community organizations that support children have demonstrated improved outcomes and/or reduced costs.[1,2] In addition, a changing regulatory landscape is altering many of the policy requirements in the Patient Protection and Affordable Care Act of 2010 (111–148), such that plans with more variability in coverage are expected to come on the market. As these trends in health care delivery continue, the American Academy of Pediatrics (AAP) recommends continued awareness of children's unique health needs in design and implementation.

In nearly all states, publicly insured children with special health care needs are enrolled in a managed care plan.[3] As the delivery and financing of health care services continue to face profound challenges, diligent and focused efforts are needed to ensure that managed care plans serve the health care needs of neonates, infants, children, adolescents, young adults (hereafter referred to collectively as children and youth), and their families.

The effect of managed care on children's access to services and actual health outcomes varies depending on how the plan is designed. Some studies report positive effects (lower emergency department use and higher outpatient use; reduced costs, especially for hospitalizations), but also report member and provider concerns regarding access to care and satisfaction.[1,2,4,5] The effectiveness of managed care in linking more children from low-income families to a medical home through gate keeping also has shown mixed results. As Medicaid enrollment shifts from state fee-for-service to managed care plans, there is a need for continued evaluations to identify trends in health care use by children as well as to monitor the provision of quality care and the experience of care. This monitoring has growing importance as the proportion of Medicaid-enrolled children in comprehensive managed care plans* increased from 67.8% in federal fiscal year 2013 to 81.1% in 2019.[6–8] When Medicaid plans are organized into regional managed care plans, they should be no less accountable to the same full regulatory requirements as traditional fee-for-service Medicaid plans.

Cost-efficient health care delivery and payment policies should be driven by performance-based incentive programs focused on improved quality of care, actual clinical outcomes, and patient experience. Special attention should be provided to patients who are high utilizers of services, particularly the many children and youth with special health care needs, in foster care, or enduring adverse childhood experiences. Risk and utilization prediction models should be validated for pediatric populations, accounting not just for chronic or pre-existing conditions, but for the increased frequency of preventive visits, the often increased need for episodic care, and the family and other social factors that affect child and youth health. Value-based payment arrangements that include coverage of children should be specifically intentional in their design of children's health coverage, recognizing the value proposition is not purely rapid return on dollars spent but rather long-term investment in the health and well-being of the population.

The AAP urges the use of the following principles when designing, implementing, and evaluating managed care plans for children:

- Primary care provider networks should provide for access to primary care pediatricians (PCPs) who demonstrate commitment to quality pediatric care, particularly those who are adopting a high-performing primary care medical home model of care, demonstrating characteristics commonly accepted as a medical home.[9]
- Specialty provider networks should provide for timely access to high-quality pediatric medical subspecialists, pediatric surgical specialists, pediatric behavioral and mental health specialists, and pediatric dental professionals (hereinafter referred to as pediatric specialists) and hospitals that have appropriate pediatric expertise.[10] "High-quality"

*Comprehensive managed care, as described by MACPAC, is an arrangement in which a managed care organization (MCO) receives a capitated payment from the state for each Medicaid enrollee and is responsible for arranging for most medical services for enrollees.[6]

pediatric specialists are those with advanced training and, when defined by a specialty's professional organization, demonstrate high-quality clinical outcomes. Expertise can be demonstrated by specialty certification or by distinct services offered and adequate pediatric patient volumes that demonstrate quality care.
- Administrative processes including eligibility determination, formulary management, and treatment authorization should consider the unique needs of the pediatric population and use pediatric-specific medical necessity criteria to inform scope of benefits decisions.
- Managed care organizations should adopt effective and transparent pediatric quality improvement programs, metrics, and utilization management that recognize the unique needs of the general pediatric and special health care needs populations in the community.

Total payments for services should be adequate to support all aspects of the Quadruple Aim,[11] thus supporting the transformation of the health care delivery system into an effective high-quality delivery system that rewards continuous quality improvement and supports a high-quality, engaged workforce. Value-based payment arrangements, when used, should take into account the specific needs of children, recognize the impact of social determinants of health (including adversity experienced in childhood), emphasize prevention and early intervention, and support the integration of behavioral health into primary care. The severe acute respiratory syndrome-coronavirus 2 pandemic has accelerated a trend toward remote (telephone, video, and digital) delivery of health care. Even as the balance changes between in person and virtual encounters, payment arrangements in all models and for all locations of service should be sufficient to support high functioning medical homes and the sustainable delivery of mental, behavioral, and addiction services as well as other specialty services.

The principles described in this statement are aligned with, and intended to specifically address, managed care arrangements based on the foundation provided by those previously published in other AAP policies including "Principles of Child Health Care Financing,"[12] "Scope of Health Care Benefits for Children From Birth Through Age 26,"[13] "Patient- and Family-Centered Care and the Pediatrician's Role,"[14] and the "AAP Access Principles."[10]

ACCESS TO A PRIMARY CARE MEDICAL HOME

Primary care is the foundation of health care delivery in a community. Pediatric patients should have access to comprehensive primary care that has expertise in the care of children. Because many families need frequent access to a primary care site, the contracted network should include locations that meet reasonable time and distance benchmarks or have other transportation supports in place.

A medical home provides care that is accessible, family centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Children who receive care in medical homes are less likely to have unmet medical and dental needs and are more likely to receive the full range of needed pediatric health care services.[15–17] Managed care arrangements can be structured to incentivize initial and ongoing investments to deliver care in a more proactive manner that supports improving the healthy growth and development of the population. These incentives can be in the form of initial grants, technical assistance, incentivized metrics, and alternate payment models.

There should exist regulatory oversight to ensure that eligible children have access to high-quality health services in a medical home and that pediatricians are adequately paid to provide these services. This oversight is even more important when there is a limited choice of available plans. Benefits and administrative policies should be publicly available and easily understandable so that families and providers can make an informed decision regarding participation and understand how to access care. To reduce barriers to seeking care, medically appropriate telemedicine visits (synchronous audio-visual encounters) should be covered and paid in parity with in-person visits. Where possible, adequate primary care and specialty networks should be available that allow families to choose between practices that have expertise in care of children and are geographically available to families for their primary care needs.

ACCESS TO PEDIATRIC-SPECIFIC SPECIALTY SERVICES

Managed care arrangements should support the development of a care delivery system that is coordinated and effectively addresses the medical needs of all children and youth,[18] including those with special health care needs as defined by the Health Resources and Services Administration Maternal and Child Health[19] and recommended by the AAP.[20]

Pediatric services, unlike those for adults, more often target prevention rather than treatment and are more likely to be habilitative rather than

rehabilitative in purpose. These services will have a significant impact that carries through into adulthood. Services particularly important for pediatric patients include screenings, assessments, and services in the realms of development, behavioral and mental health, reproductive health, as well as care management services, social work services, occupational and physical therapy, vision screening, hearing screening, and speech and language therapies. Both Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*[21] currently identify specific services recommended through the pediatric age range. Payers should construct provider networks that offer the full range of pediatric specialty services, even if it is necessary to use other networks or contract outside of traditional service areas, even crossing state lines when necessary.[22] Managed care plans should make every effort to offer a robust network of high-quality providers with pediatric expertise and facilities that are accessible and able to meet the diverse needs of the pediatric population they are serving. In particular, the youth mental health crisis has made it clear that time-efficient credentialing procedures are necessary to bring a more adequate number of professionals, such as mental health professionals, into provider networks and provider practices.

For adolescents and young adults with special health care needs, an appropriate network must include adult providers able to care for complex conditions that arise in childhood or support co-management and transitions between pediatric and adult care team members.

As health outcomes for children are often influenced by social determinants, many vital services, particularly for children with special health care needs, will occur outside of the traditional medical setting (eg, school-linked clinics, home visiting programs, and early education programs). Care management activities should be informed by pediatric expertise and awareness of health determinants that may differ from the adult population. This combination of factors necessitates a broad array of provider network and health plan benefits. Regional managed care plans should recognize that pediatric specialty services often are more geographically distant than adult focused services, increasing the need for targeted contractual arrangements as well as for long-distance coordination between primary and specialty care providers, telemedicine encounters, and transportation supports for families.

ELIGIBILITY AND TREATMENT AUTHORIZATION

Policies that define medical necessity should include health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals or organizations, such as the AAP, EPSDT services, and *Bright Futures*,[21] to promote optimal growth and development in children and youth and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities. Furthermore, new evidence, new community influences, and emerging societal changes dictate the form and content of necessary health care for children.[21]

Managed care organizations should recognize the unique needs of children compared with adults when designating the scope of health benefits and medical necessity guidelines. Financial savings realized from changes in utilization should be reinvested to preserve and extend access to comprehensive and coordinated preventive, acute, and chronic care for all children with a focus on reducing disparities of outcomes. As the regulatory environment changes to allow more flexibility in plan design, attention should remain on the unique needs of children covered in health plans, along with continued transparency to consumers regarding benefits and administrative policies.

Children and youth with special care needs represent a group of children with diverse chronic and complex conditions who use a disproportionate volume and intensity of health care services. The managed care arrangements should support the primary care medical home's access to the necessary components of a treatment team of diverse expertise to support increased coordination, service integration, and services for children, youth, and their families that often existed outside of traditional medical systems.[23–25] Examples include behavioral health integration into medical settings, dedicated care manager services for high-complexity patients, and partnerships with home health services. Payment arrangements should recognize the increased costs to provide effective care coordination for children with special health care needs, as well as children in foster care or enduring other adverse conditions. These populations are best served when eligibility and treatment policies are flexible and designed and implemented with expert pediatric input and when clear processes are in place for prior authorizations and appeals.

QUALITY IMPROVEMENT

Quality improvement initiatives should be relevant to the unique

needs of children and use validated metrics that can monitor significant processes of care or important pediatric health outcomes, the pediatric experience of care, and key aspects of health care service utilization. The metrics chosen and the characteristics of the improvement initiatives should be transparent to providers and patients and families and have had the benefit of the expertise of pediatric providers in their design and implementation. Effective metrics have a focus on prevention, behavioral health, and habilitative outcomes because these are broadly relevant to improving the long term health of the pediatric population alongside measures that focus primarily on less common chronic conditions. Where possible, performance and outcome measures should align across all payers and use standard definitions from national resources that are therefore more likely to be easily extracted from electronic health records.

Annual public reporting or monitoring should inform consumers of the quality of the health network, with respect to performance compared with pertinent state or national benchmarks, required medical loss ratios, patient experience of care, and enrollment retention.

FINANCING AND PAYMENT

Payment methods should encourage flexibility and innovation in health care delivery to best meet the needs of the population, whether care occurs within the walls of the office or in the patient's home. Payers will continue to introduce and evaluate value-based benefits, comparative effectiveness processes, and patient-centered outcomes research to support or refine their medical management and benefits coverage. Payment models and quality incentives should meet pediatric-specific needs by supporting traditional encounter-based care, including prolonged face-to-face services, while also supporting care occurring outside the examination room, including telephone, video, and digital encounters that provide meaningful care, remote physiologic monitoring, interprofessional consultations, care coordination, long-term care, transitional care, and case management supports. Parity in coverage and payment should exist between in-person visits and medically appropriate telemedicine visits. Necessary care coordination includes that with community health organizations and community mental health organizations in addition to medical specialty services. Initial investments are often necessary to support practice transformation, because transformation often requires technology investments and staff training for new roles to support population management. An adequately financed medical home allows the primary care medical home to expand its treatment team with more diverse expertise including but not limited to behavioral health consultants, nurse care managers, lactation consultants, nutritionists, nurse educators, and peer navigators. These team members may be located within the walls of a primary care clinic or within various community health and social support organizations that significantly benefit child health, thereby becoming key parts of a "medical neighborhood."[26] Savings that a payer may realize from more efficient and quality care should be shared with the provider network, patients, and families and community resources that support the health of the population served. Value-based payment strategies, when included in a managed care arrangement, should promote the integration of behavioral health and social services into both primary care and specialty care settings. Payment strategies, in all their aspects, should adapt to significant disruptions of health care utilization, such as public health emergencies and disasters, so that health care providers can themselves adapt and deliver needed care for their patients. Risk stratification should account for social determinants and family factors in addition to medical complexity.

PRINCIPLES OF MANAGED CARE FOR CHILDREN AND YOUTH

Access to Appropriate PCPs

1. Payer physician networks should offer to their pediatric members an adequate panel of PCPs, preferably those who offer a robust medical home. As the medical specialty concerned with the physical, mental, and social health of children from birth through young adulthood, pediatricians understand a child's growth and developmental progression and have expertise in the common chronic medical and mental health conditions of children and youth. Pediatric expertise is particularly important in the care of children and adolescents with special health care needs.
2. Payers should enable primary care practices with pediatric expertise to serve as the child's medical home and enable these practices to deliver care that is comprehensive, preventive, and capable of delivering acute and chronic care services. These services may exist within a clinic or accessed through partnerships with community agencies and medical specialists. The patient is best served when there is a high degree of integration among services and collaboration with the managed care agency, particularly in areas of care coordination and health

information exchange. In areas in which pediatricians are not available, payers should enable and finance pediatric consultation that is available 24 hours a day, 7 days a week, such as through communication channels connecting pediatric medical and surgical specialty services or through relationships with out-of-network pediatric providers. The primary hub for the coordination of care for the patient is usually the primary care medical home, although it may reside with a pediatric medical subspecialist for certain children with highly complex physical and/or mental health problems (eg, cystic fibrosis, juvenile idiopathic arthritis, renal disease, or cancer).

3. For many physical, developmental, mental health, and social problems, the PCP may need to broaden the treatment team so that appropriate community public programs (eg, Title V Program for Children with Special Health Care Needs) and other community organizations that support child health can assist with care and/or care coordination. Often, community organizations provide added abilities to improve population health, particularly when social determinants of health are primary drivers. Managed care plans should assist the PCP by identifying and fostering linkages to available resources and by ensuring that its network of pediatric specialties is comprehensive.
4. Children from more vulnerable populations often need sources of care available with increased capacity and specialization to ensure that services meet their more diverse needs. Payers may need to contract beyond the usual geographic boundaries of their service area. To reduce geographic disparities and to support care delivered by the primary care clinic, telehealth (phone, video, digital communications, etc) is an effective strategy to achieve effective health care delivery by and through the medical home.

Access to Pediatric Specialty Services

1. When children need the services of pediatric specialists or other health care professionals in addition to the PCP, managed care plans should use clinicians with appropriate pediatric training and expertise. Pediatric specialists should have completed an appropriate fellowship in their area of expertise and be certified by specialty medical and surgical boards if such certification is available. When such specialists are not available, plans may include other specialists to provide certain pediatric services if they demonstrate relevant continuing pediatric education and pediatric case volumes. Plans should seek guidance when available from specialist professional societies regarding quality of care expectations (eg, American College of Surgeons Optimal Resources for Children's Surgical Care, available at https://www.facs.org/~/media/files/quality%20programs/csv/acs%20csv_standardsmanual.ashx).[27] Network adequacy assessment[28] should include considerations to geography, number of specialists with pediatric expertise, access to primary care providers that provide preventive care following Bright Futures recommendations and have the support services of a medical home, as well as needed specialty mental health services. One form of measurement should include monitoring the frequency of out of network referrals needed to meet the needs of the pediatric population with a goal of less than 20% of referrals in a specialty.
2. To assist the formation of care teams of providers with varied expertise, the credentialing process for adding providers to a managed care organization's panel should be streamlined.
3. Managed care organizations should recognize that pediatric patients have needs that require contracting arrangements with different services than may be a priority for adult populations. These include services supporting preventive care, habilitative services, and behavioral health.
4. The referral process for pediatric specialists should be transparently developed by health plans in collaboration with pediatricians, pediatric specialists, patients, and families and updated if barriers to care are identified.
5. Access to specialty services within the managed care organization can be expedited by creating a "presumptive authorization" category where the need for care or consultation by a pediatric specialist or supporting provider is so unambiguous and/or urgent to obviate individual preauthorization (eg, hernia, appendicitis, and new onset diabetes).
6. To improve efficiency of care delivery, managed care plans should foster and financially support care coordination, such as interdisciplinary communication with the pediatric patient's medical home to include the PCP, pediatric specialists, home health services, telehealth, and any other professional service providing care for the patient.[23]
7. For the sake of timely and efficient delivery of care, payment barriers to more than 1 provider rendering services in the same day should be eliminated.

8. Specialty services often include the need for access to specialty medications. Formulary pharmacy design should include classes of medications and preferred medications that align with evidence-based care. Often, pediatric needs will differ from adults so that pediatric-specific preferred drugs should be available within each drug class. Either a separate pediatric formulary or separate pediatric coverage policies may be necessary. Because changes to a formulary are changes to treatment plans, formulary changes should only occur after advance notice has been provided to prescribers and should only change in favor of medications that are therapeutically equivalent for a patient and result in treatment plans with equal or better ease of compliance. During formulary changes there should also be a mechanism to continue coverage for medications that are currently being titrated or were already shown effective within an individual's existing treatment plan.

Eligibility and Treatment Authorization

1. Managed care policies should be transparent and provide appropriate written, oral, and web-based information and counseling to current and potential beneficiaries that allow informed patient choice of a managed care organization, network options for primary care physicians, pediatric specialists, and pediatric hospital and ancillary services. The development of such policies should allow for meaningful input from providers, patients, and their families.
2. Families and pediatricians should be fully informed of the plan's participating clinicians within the chosen network. This should include an up-to-date listing of the plan's participating health care professionals whose practices are currently accepting new patients (including conditions under which a practice is accepting new patients) served by the managed care plan. The roster of the provider network should be continuously updated by the managed care plan to reflect newly participating physicians as well as prompt deletion of nonparticipating providers. In addition, published information should also include resources on care coordination, community resources, and other services.
3. Families should receive education at the time of enrollment to help them understand fully their health plan benefits (including limitations on the amount, duration, and scope of services; cost-sharing requirements; and participating health care professionals). Carriers that offer multiple managed care plans should provide a clear comparison of pediatric benefits and networks across managed care plans so that families can choose a plan most appropriate for their needs. Plans should develop materials with the advice and review of families so that they are clear, using language that is easy for patients and families to understand. Materials should be available in the family's primary language.
4. After enrollment, health insurance payment policies for providers should be clearly defined. Managed care plans should provide details on the scope of pediatric benefits in consumer brochures, websites, benefit coverage documents, and managed care contracts. Insurance benefit definitions should include Current Procedural Terminology (CPT) and diagnosis codes that clearly define covered services. Fee schedules should be available with clear payment policies regarding diagnosis and procedural policies. Formularies should be easily accessed and understood by providers. Accurate and up-to-date fee schedules should be available to providers.
5. Managed care plans should provide accurate and reliable online patient eligibility data, timely authorization review, transparent and efficient claims adjudication to allow for point-of-service payment information available to clinicians, patients, and their families while preserving appropriate confidentiality when needed for care of adolescents and young adults. Enrollment of newborn infants immediately following delivery allows for prompt access to care. Processes should be in place to ensure that newborn infants are recognized in the system so as not to delay early preventive care. Managed care plans need to make every effort to provide timely and accurate verification of eligibility to the physician and should not retroactively rescind payments because of an internal plan error. Plans should be bound by their confirmation of eligibility so that physicians can expect payment once a clinic verifies eligibility.
6. The treatment authorization process for elective services initiated by the PCP should efficiently facilitate timely appropriate referral for specialty consultations, hospital inpatient and outpatient care, and other treatments. Emergency-based services and life-saving medications should not require

prior authorizations that could delay care, particularly medications needed for daily control of chronic condition (ie, insulin or cardiac and seizure medications). When benefits are federally mandated (ie, by EPSDT, *Bright Futures*), payers should not place authorization barriers to accessing such services.

7. Plans should provide timely responses to treatment authorization requests (including 24-hour access and approvals in the case of emergencies) based on the nature and urgency of the patient's needs. Managed care plans should allow member access to emergency care consistent with the "prudent layperson"[29] standard that considers pediatric clinical recommendations for common conditions (ie, fever in infant or respiratory distress in children) that may differ from adult diagnosis-based assessments for ambulatory sensitive conditions. Plans should adopt transparent processes for authorizations and evaluate and share studies on the effects of previous authorizations on patient access, costs, and quality of care.
8. Before making a determination that any item or service (including emergency care) furnished to a person younger than 27 years is not medically necessary, the managed care plan should consider whether an item or service (1) is appropriate for the particular age and health status of the person, and (2) is supported by evidence-based or evidence-informed clinical practice guidelines developed for children's health care services that are endorsed or approved by appropriate medical professional societies or governmental public health agencies. Managed care plans should describe the process by which physicians are to provide justification for medical necessity. A panel of reviewers with pediatric expertise should provide support in creating and reviewing policies regarding medical necessity.[30]
9. Formulary design should take into account the specific needs of children and embrace evidence-based guidelines. Pharmacy benefits must recognize that off-label use of medications and compounded medications are often essential to meet the unique needs of children.[31] Because titrating medications in a treatment plan can be a long and difficult process, changes to existing formularies must be to bioequivalent medications. Pediatric considerations for formulary and prior authorization policies also include but are not limited to availability of liquid medications, pediatric-specific antibiotic guidelines, and appropriate nutritional products.
10. Health plans should recognize and reward the unique skills that pediatricians possess to address pediatric mental health and substance use disorders and remove barriers to patients' access to mental health care, as outlined by the AAP and American Academy of Child and Adolescent Psychiatry.[32–34] Managed care plans should implement parity in mental health benefits, including diagnostic and treatment parity for pediatricians and child and adolescent psychiatrists without "carving out" benefits to contract with other professionals who are more difficult to access or have less pediatric expertise. By addressing the administrative and financial barriers that primary care clinicians, mental health providers, and substance abuse professionals currently encounter in providing behavioral and mental health services to children and youth, managed care plans can improve access, collaboration, and coordination for pediatric mental health care and support growth of integrated care models, which are models that result in sharing records between primary care and mental health providers and developing care plans by collaboration between medical and behavioral health providers, patients, and families.
11. To maintain access to and provision of high quality care and quickly ease administrative burdens in the event of a public health emergency or disaster, payers should develop contingency plans to rapidly adapt their network credentialing, prior authorization, and formulary processes.

Quality Improvement and Management

1. Pediatricians, pediatric specialists, and patients and families should have an active role in developing quality improvement processes and research in outcomes that matter to patients, families, and providers.[35] Any cost-containment process, pay-for-performance program, tiered benefits, differential physician payments, or value-based benefit design should be reviewed in light of potential effects on pediatric access and quality of care. Such programs should use standardized quality or outcome metrics developed or

endorsed by organizations with expertise in child health quality (eg, the National Quality Forum and AAP) so that providers can monitor numerators and denominators in their own practice and seek to improve performance.

2. Managed care plans have developed a broad and diverse institutional knowledge related to utilization of services and outcomes-based research. As a result, managed care plans should participate in patient registry development and thoughtful quality outcomes research based on the principles articulated in the AAP policy statement "A New Era in Quality Measurement: The Development and Application of Quality Measures."[35] Health care payers are in a unique position to collaborate with the pediatric community to develop and implement changes that systematically advance children's health care. Managed care plans should actively engage pediatricians in both community and hospital settings in outcomes research and quality improvement efforts, such as developing patient registries or working toward a single national pediatric database similar to the Medicare Part B database. Collaborative research on the relative efficacy of virtual versus in person approaches to various aspects of the care of children, adolescents, and young adults such as motivational interviewing; screening, brief intervention, and referral for treatment; therapeutic alliance-building between pediatricians, patients, and families; and appropriate provision of confidentiality will be vital. Additionally, such activities can be coordinated with other quality improvement procedures in which providers participate, including but not limited to, maintenance of certification and other licensing activities.
3. Plans should promote recommended preventive services as well as early identification and treatment of health problems, including developmental and behavioral problems in children and youth by providing benefits coverage and appropriate payment to physicians for all screenings, assessments, and treatment as recommended in the EPSDT standards and *Bright Futures*. A selection of these measures should be included in physician incentive or pay-for-performance programs.
4. Plans should report a uniform standard set of encounter data in compliance with the Health Insurance Portability and Accountability Act (Pub L No. 104–191 [1996]).
5. States should publish uniform data for health plans that offer consumers and purchasers the opportunity to evaluate and compare performance, including relevant financial information, among competing plans. The measures reported by states on a managed care plan's performance should emphasize quality standards, such as timely access to care, patient satisfaction, and health outcomes. Where possible, results of external review of managed care plans, including out-of-state review of Medicaid managed care plans, should be available to the public.
6. Managed care contracts should exclude provisions that restrict information and advice that physicians can provide to a patient concerning medical options, including but not limited to advice on noncovered treatment options and information about the patient's plan and competing health plans.
7. Managed care programs should collaborate with their clinicians and community resources to identify appropriate family practice and internal medicine medical homes that provide optimal care for children with special health care needs so that they can transition to skilled adult care providers at the appropriate time.

Financing and Payment

1. Payment methods should be developed that cover all the health care needs of children, as defined by the AAP policy statement "Scope of Health Care Benefits for Children From Birth Through Age 26,"[13] with the periodicity of visits, screenings, and procedures described in the AAP statement "Recommendations for Preventive Pediatric Health Care"[36] and the current edition of the *Bright Futures*,[21] as well as "Principles of Child Health Care Financing."[12] Payment models should not discourage providers from caring for patients who are most in need of expert care.
2. The methods used for pediatric health care payment should consider age, chronicity, and severity of underlying health problems (case mix, risk, or severity adjustment), service area market, and geographic considerations. If payments are made to the patient-centered medical home on a fee-for-service model for chronic condition management, the payments should support the additional visits and time spent on care plan development and complex disease management, as reflected in CPT codes for care plan oversight, non–face-to-face care, complex and transitional care, meaningful care provided by telephone and electronic consultations, and recommended care coordination services provided by nonphysician professionals. The payment structure should encompass recognition of all CPT and Healthcare Common Procedure Coding System codes

based on their relative value units (RVUs). If payers adopt a payment model that supports activities without RVU assignment, total payments should reflect the complexity of the physician's patient panel mix, expanded care-management responsibilities, after-hours accessibility, and new quality-improvement activities. Any risk or utilization prediction models should be validated for the pediatric population. All payment models should include necessary up-front investments and infrastructure.

3. Managed care plans should make transparent all policies and procedures regarding coverage and payment determinations, including fee schedules and claims edits. Any changes affecting payment to the pediatrician must be provided in writing and in advance to provide timely notification and allow the physician practice adequate time for review, appeal, and negotiation. There must be a specified period for repayment requests applied equally to payers and clinicians. Payers should not reduce payments on future claims to adjust contested claims already paid by managed care plans. Payers should ensure that physician practices have accurate and timely electronic access to all plan policies.
4. Appropriate payment for immunizations should be based on all costs incurred by the practice to deliver vaccines and should include a reasonable margin to encourage provision of these services within the medical home. Actual cost calculation should include the purchase price, applicable taxes, shipping and handling charges, and total additional costs associated with vaccine inventory management, including but not limited to finance costs, immunization registry reporting, vaccine administration, personnel costs, and factors for inventory control, loss prevention, inventory shrinkage, and vaccine storage (including specialized refrigerators and freezers, temperature controls, and alarms).[37] Vaccine counseling should be paid for adequately per antigen whenever it is performed, and whether delivered in person or not. Fee schedules and health plan coverage benefits for immunizations must be updated in a timely manner and made effective retroactive to the date new recommendations for new vaccines are published by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
5. Payment for physician services for newborn care should be separately identified as unique and distinct from maternal services and should ensure adequate and clearly identified payment to attending physicians who provide care for newborn infants to ensure consistent and continuous coverage for the neonatal period and for subsequent pediatric care. Enrollment should be timely and use identifiers to support prompt enrollment and clear identification of multiple births, such that coverage does not affect the ability to seek care for the visits in the first 60 days of life. Services in the newborn period are defined in *Bright Futures* and include screening for parental conditions that could affect newborn health.
6. All capitated rates should be adjusted for case-mix differences based on patient age, geographic location, modifiers for children with special health care needs, known patient outliers, and a pediatric diagnostic classification system. As payers develop risk-adjustment techniques, they should incorporate a pediatric focus, including a recognition that both social factors and caregiver factors[9,38] (eg, caregivers' physical health, mental health, or use of medical care) are major determinants of children's health. For most children and youth, utilization is more often influenced by episodic conditions and by patient and family social factors than by chronic conditions in the personal past medical history as in the adult population. Furthermore, the data necessary to design a risk adjustment methodology that would reasonably predict the cost of delivering effective preventive and habilitative care resulting in meaningful outcomes for children and youth is inherently different than that assembled for older adults.[39] At this time, risk adjustment methodologies for pediatric populations are less capable to predict utilization than are adult models[40]; therefore, these methodologies should be interpreted cautiously and not be the predominant determinant of payment rates.[41] Information about carved-out services, outlier payments, stop-loss provisions, reinsurance or shared-risk arrangements for individual children, and aggregate plan loss or profits should be clearly specified in the contract. Any additional services (meaningful use

reporting, attestations to facilitate data correction, and so forth) to be covered under the capitation rate must be subject to mutual agreement between the health plan and the contracting physician.

7. When primary care is capitated, contracts should include fee-for-service carve-outs for high-value, unexpected or high-cost services including but not limited to preventive services, mental health services, immunizations, hospitalization, emergency services, transplant services, and, in the case of adolescents and young adults, pregnancy and other reproductive health services.
8. All recommended preventive services (as defined by *Bright Futures*), including pediatric immunizations, should be covered as first-dollar coverage and not be subject to deductibles and/or copayments or any other cost-sharing mechanism under the health plan. Payment for *Bright Futures*-recommended preventive care services needs to be in full and not be bundled or considered incidental to the office visit.
9. Payers should optimally determine out of pocket limits as a function of family income rather than as a universal absolute. Important beneficial services and procedures usually provided by pediatric specialists should likewise be considered for exemption from deductibles in high-deductible health plans. Consideration should be given such that high-deductible health plans be offered only to adults and not children.[42]
10. Health plans that pay pediatricians for pediatric care on a fee-for-service schedule should use the most current Resource-Based Relative Value Scale as the basis for their fee schedule. The American Medical Association and Specialty Society Relative Value Scale Update Committee RVU values are appropriate for PCPs and pediatric specialists. A single multispecialty, regionally adjusted conversion factor applied to the current-year RVUs should be incorporated. Other proprietary conversion factors skew payment rates and should not be allowed. Health plans should use the most current version of CPT codes and adhere to CPT guidelines regarding the use of codes. When the health plan payment schedule is predominantly fee-for-service, payment contingencies should be in place for any period of significant interruption of medical visit utilization, such as in a public health emergency or disaster.
11. In all payment systems and methodologies, pediatric services within the context of the medical home should be appropriately assessed to ensure that pediatric primary and specialty services are appropriately valued in terms of practice expense, professional liability, and physician work. Payers should encourage patients and families to access the medical home. They should also support care that must occur elsewhere because of acuity, capacity, off-hours, or the need for injury care or special procedures, provided that care is of equivalent or superior quality and provides bidirectional communication with the medical home. They should not equivalently support care that falls short of those expectations.[43]
12. Evolving payment methodologies must not disrupt high-quality services for children and should protect primary care physicians against undue financial risk as well as arbitrary assignment to tiered or differential payment levels. Risk levels for office-based PCPs should be based on a population, not individual, basis and payments should be adjusted based on case-mix analysis. Any payment incentives, including shifting of risk to the clinician by the managed care plan, need to be fully transparent and supported by data and resources for the clinician to manage the risk and make informed clinical and financial decisions. Value-based payment arrangements that include children should recognize the value proposition of long-term investment in improved health rather than rapid reduction in costs. Cost savings and improved population health should be recognized by payments for nontraditional services and supports that reduce barriers to care, such as transportation, housing, caregiver mental health, caregiver supports, and legal services. In addition, value-based payment strategies should support the integration of behavioral health and social services, the use of telehealth within the medical neighborhood, and recognize the value of preventive and habilitative services, particularly for children with developmental disorders.
13. Mandatory clinician participation in every contracted service offered by a given managed care plan carrier should be prohibited, such that physicians are allowed to determine their level of participation and acceptable risk, individually or as a physician group, within the health plans.
14. Federal requirements for capitation should apply to all managed care plans. Federal and state governments should preapprove all contracts with managed care plans in which enrollees are primarily beneficiaries of Medicaid or CHIP

and require the federal and state governments to guarantee clinician payments if plans become insolvent.

15. Many of the responsibilities for managing the care of pediatric inpatients are being coordinated between hospitals and physicians as part of integrated delivery systems or accountable care organizations that use a variety of payment methodologies: prospective payment, case rate methodologies, or bundled or global fee arrangements. Pediatricians and pediatric specialists should collaborate with hospitalists, hospital quality assurance managers, case managers, medical directors, and administrators to define workflows and policies to optimize efficiency and clinical outcomes for patients requiring hospital care.
16. Financial incentives are needed to support the medical home infrastructure, expansion of the treatment team, and ongoing practice transformation to expand the function of the primary care medical home. Incentives could include initial grant funding that supports technology and personnel investments as well as incentivizing metrics that demonstrate improvements in care coordination and the patient experience.

CONCLUSIONS

Managed care arrangements, when developed in an intentional manner, that work to better support the needs of patients, families, clinicians, payers, and society have the potential to increase the effectiveness of health care delivery. During this evolution, specific and consistent attention must be given to fundamentals of quality as defined by the National Academy of Medicine (formerly the Institute of Medicine). Adult and pediatric primary care physicians provide the backbone for any integrated health care delivery system. The current health care reform environment and managed care payers have focused on controlling health care costs. However, meeting ambitious goals pertaining to elevating the quality of care will require investment in services that improve population health, particularly services for which evidence suggests a substantial potential to recoup long-term savings. The greatest efficiencies are possible when health care delivery is shaped by the needs of the population and aligns with the goals of payers, providers, and patients. To achieve the greatest pediatric health care value, payers, employers, and clinicians must consistently focus on enhancing access to health care and improving health outcomes while supporting the patient experience and safety. Long-term savings will be more surely realized when the focus on prevention occurs early so as to reduce the burden of chronic disease among future adults. Pediatricians need the tools and support of the health care delivery system to ensure the health and readiness of tomorrow's adult population.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
CHIP: Children's Health Insurance Program
CPT: current procedural terminology
RVU: relative value unit

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