Center for Health Care Strategies

Medicaid Primary Care Payment Reform: Considerations for Creating Alternative Payment Models for Child Health Care

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TAKEAWAYS

- Current Medicaid financing and the fee-for-service (FFS) payment system do not adequately support pediatric primary care.
- Alternative payment models (APMs), which shift from FFS payment to instead support and incentivize high-quality care, offer the potential to support more comprehensive care for children.
- This brief outlines considerations to guide state Medicaid agencies in developing primary care APMs that include children, reviewing the benefits and challenges of adopting a single primary care APM for both children and adults versus a separate, child-focused APM.

Pediatric primary care is critical in supporting healthy development and disease prevention that is foundational for lifelong health and long-term social outcomes.[1,2] However, current levels of financing and the fee-for-service (FFS) payment system do not adequately support pediatric primary care.[3,4] One potential strategy to support more comprehensive care for children is adopting alternative payment models (APMs). These models move away from the current FFS payment approach to instead support and incentivize high-quality care.[5] Recently, many primary care APMs have also focused on increasing overall levels of payment for primary care.[6,7,8] As policymakers, providers, and child health advocates explore APMs to enhance child health, it is important to consider opportunities to align with the broader momentum for payment reform, while also addressing children's unique health needs.[9,10] Particularly for Medicaid, which serves two in five children in the country, there are ample opportunities to use payment levers to improve care delivery and enhance health outcomes.[11]

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This brief explores:

1. Opportunities for primary care APMs to support pediatric primary care transformation;
2. Whether broad-based primary care payment models (serving both adults and children) can effectively address children's needs or if separate, child-focused models are more appropriate; and
3. Considerations for state Medicaid agencies in designing primary care APMs that include children.

The brief is informed by a literature review, interviews with subject matter experts, and lessons from the *Accelerating Child Health Transformation* initiative, made possible by the Robert Wood Johnson Foundation. The initiative explored strategies to transform pediatric care by promoting upstream prevention, enhancing connections to community supports, and ensuring that care is comprehensive and family centered. Widespread adoption of these strategies requires changes within practice settings as well as payment and accountability levers to support these enhanced approaches to care.

The Case for Including Children in Primary Care APMs

Among Medicaid stakeholders, there is ongoing debate about whether APMs are appropriate for child health services. Medicaid modeled many existing APMs after Medicare initiatives, such as the Medicare Shared Savings Program. These initiatives were designed to achieve short-term cost savings by focusing on adults with complex health and social needs, as these populations seemed to offer greater potential for a quick return on investment through reductions in avoidable and expensive hospital services.[12] However, most pediatric care emphasizes long-term prevention and the financial benefits of high-quality pediatric care are typically realized over decades and across various sectors. Thus, this incentive system is often a poor fit for child health providers.[13,14] Moreover, due to limited numbers of child-focused APM models and the predominant focus of APM evaluations on Medicare models, there is limited evidence on the impact of Medicaid APMs on children's health. Although the available evidence is mixed, some positive outcomes, particularly related to preventive care, suggest potential benefits of APMs for children.[15]

Despite this history, it is important to consider how to adapt APMs to support children's health as: (1) FFS may be a poor fit for primary care for both children and adults; and (2) recently, the focus of Medicaid primary care APMs have evolved to focus less on primary care as a route to savings and more as a mechanism for enhanced investments in

primary care. The current FFS system tends to under-value preventive services and primary care, which are particularly central to pediatrics.[16] FFS payment also fails to adequately incentivize team-based, coordinated care and lacks flexibility to easily incorporate innovative models of care.[17,18] Additionally, primary care payment reform is a priority for many state policymakers and may present an opportunity to better support children's health, including by enhancing total payment to primary care providers in a way that is tied to quality incentives. For example, some Medicaid programs are exploring or implementing population-based payment models that include both adults and children.[19] Population-based payment models are advanced APMs that shift at least a portion of FFS payment to an upfront, prospective payment tied to quality outcomes. These models aim to provide more flexibility for providers to best meet their populations' needs, ensure more financial stability for practices to sustain access to care, and often seek to increase investment in primary care to enhance quality of care.[20,21]

Are broad-based primary care APMs effective for children, or are child-focused primary care APMs needed?

Medicaid stakeholders may consider how to build on existing primary care APM efforts to advance children's health and ensure that children's needs are not overlooked. One key question to inform states' payment reform strategy is whether including children in broad-based primary care models (that also serve adults) is appropriate, or if children would benefit more from separate, child-focused models.

Currently, many state-designed primary care APMs include both adults and children.[22] These models generally operate the same for both adult and child participants, except for the inclusion of a limited number of child-specific quality measures. However, because children have unique health needs, some states may prefer to design more child-specific models, including for primary care.[23,24,25,26,27] There are currently limited examples of child-focused primary care APMs. Ohio has designed and Colorado is developing a customized track within their primary care APMs to better align payment incentives with children's needs.[28,29] The CMS Innovation Center's Integrated Care for Kids (InCK) Model, while not primary care-specific, provides an example of an APM model developed solely for children.[30]

As Medicaid agencies, providers, and child health advocates consider opportunities to address children's needs through primary care APMs, an important starting point is considering the state's goals for improving child health outcomes and what level of

model customization is needed to address these goals. To support state child health stakeholders in these activities, the following sections outline the potential benefits and challenges of developing a single primary care APM to serve both children and adults (a "one model approach") versus developing a separate, child-focused primary care APM.

	One Model Approach	Child-Focused Model
Potential Benefits	• Aligned goals • Opportunity to invest adult cost savings into child health	• More robust engagement of child health stakeholders • Flexibility to address children's health needs
Potential Challenges	• Inadequate balancing of stakeholder needs • Misaligned incentives	• Administrative burden • Difficulty making the case

Potential benefits of the one model approach:

States may choose to implement one APM that includes both their adult and child populations if the intended outcomes are similar and the state is interested in distributing savings across populations.

Aligned goals: While adults and children may have different health needs, models that support and incentivize enhanced primary care may be well-positioned to support both populations. Payment and care delivery reform efforts often focus on broad quality improvement strategies that benefit both pediatric and adult populations. Models focusing on patient-centered medical home objectives — such as improving quality outcomes, offering more comprehensive care, improving access to care, enhancing patient and family experience, and expanding team-based care — can benefit both groups. These models may also allow providers sufficient flexibility to customize care for their specific populations.[31] For example, Washington State's Primary Care Transformation Initiative aims to hold all participating providers accountable for broadly beneficial capabilities, such as same-day appointments, empaneling patients, measuring quality improvement, and providing culturally attuned care.[32] Maine's Primary Care Plus program takes a similar approach and requires practices in its program's more advanced tiers to screen and track social needs, and support patient connections to community health workers — both important strategies for pediatric care.[33,34,35] If the model's goals are applicable to both child and adult populations, it may make sense to incorporate both rather than duplicate efforts.

Additionally, some advanced primary care models are prioritizing increasing the level of payment to primary care practices to support access and quality improvement. For example, Massachusetts' Primary Care Sub-Capitation Program, a population-based payment model, aims to increase primary care investment for both adult and pediatric practices, largely through enhanced per member per month payments tied to practices meeting state-defined care delivery capabilities.[36,37] This type of enhanced, upfront payment can potentially give pediatric practices more flexibility to pursue innovative care models and financially support the provision of high quality, comprehensive care.

Opportunity to invest adult cost savings into child health: Pediatric providers and child health policy experts often question the benefits of APMs given the emphasis around short-term cost savings. Benefits of pediatric primary care are often realized over the long term, leaving little room for significant short-term savings. However, there may be ways to adjust shared savings methodologies to better support investments in child health. Incorporating children into a primary care APM that also includes adults could allow short-term savings from the adult population to support investment in, and ultimately help realize, long-term quality improvement and cost-savings in the pediatric population. While states have not explicitly designed primary care APMs this way, this is an area for potential innovation. For example, experts have considered how states could explore new ways of benchmarking costs, such as evaluating cost at the family rather than the individual level, to sustain interventions that have been historically challenging to finance.[38] Success with this type of arrangement would likely require development of explicit policies to prioritize investment in child health care delivery within a larger model. While including children and adults in the same APM is not the only possible way to invest saving from adult populations in child health, doing so is one potential way to support multigenerational care and/or navigate the political challenges of developing a child-specific model (see "Difficulty Making the Case").

Potential challenges of the one model approach:

States choosing to implement the one model approach may find it difficult to adequately address concerns from stakeholders representing both populations and develop incentives appropriate for both populations.

Inadequate balancing of stakeholder needs: While including an array of stakeholders in developing a model can support greater buy-in, states need to be intentional in how they engage stakeholders to ensure that all perspectives are adequately considered. When pursuing a broad-based primary care APM with both children and adults, it is important to ensure the unique needs of children are not overlooked. Given the history of value-based payment models focusing on adult needs

and cost savings, states may need to dedicate additional time engaging child health providers to: communicate how primary care APMs can address their concerns, discuss the financial implications of new APMs, and ensure transparency regarding the assumptions built into pediatric rate and risk adjustment methods.

Misaligned incentives: Primary care models sometimes emphasize managing chronic conditions that are common and costly among adult populations but are less relevant in pediatric care. Adults have a higher prevalence of chronic conditions than children, and the types of conditions affecting children differ significantly from those affecting adults.[39] States with APMs emphasizing chronic condition care may need to consider how to modify incentives to be relevant and appropriate for pediatric populations. For example, Colorado's primary care population-based payment model, APM 2, includes a chronic condition shared savings incentive.[40] In response to feedback from child health stakeholders that the chronic condition incentive is often not relevant for children, the state is developing a pediatric-specific APM track that excludes this incentive. [41]

Additionally, approaches to treatment and care management of chronic conditions appropriate for adults may differ from what works best for children and their families. For example, pediatric chronic care often requires a collaborative, supportive approach given the important decision-making role of parents and caregivers and the added complexities of addressing family needs, unlike treating an adult patient who typically has autonomy.[42] Moreover, pediatric care places a greater emphasis on prevention, such as screenings, vaccinations, and supporting healthy development, which should be reflected in model design.[43] Models that support both populations should include incentives that prioritize services that positively impact health outcomes for each group. If different types of incentives cannot be built into the same model, the model may fail to achieve the intended impact on the various populations, potentially necessitating separate models.

Potential benefits of a separate, child-focused model:

States may choose to implement a separate model for children if the state has capacity for robust engagement with child-focus stakeholders across systems and the state is interested in increasing uptake of specific innovative care delivery models for children.

More robust engagement of child health stakeholder: When developing a pediatric focused primary care APM, states may have more capacity and leeway to delve into child health-specific topics during stakeholder engagement efforts. For example, the health needs of children change over their lifespan — infants require different services than

school-aged children or older adolescents.[44] By narrowing the focus of the model to only address children's needs, states may have the opportunity to engage in more nuanced discussions of how primary care APMs can support children's evolving needs as they grow.

Additionally, children and families often interact with a variety of health and social systems that are often siloed.[45] Developing a child-focused APM may offer opportunities for states to engage stakeholders in other child-serving sectors, including early childhood and education. This cross-sector engagement can inform a more holistic model that provides funding and accountability mechanisms that go beyond medical care. For example, in the CMS Innovation Center's InCK Model lead organizations convene Partnership Councils that include cross-sector child health stakeholders to support service coordination and model design.[46*]

In addition to supporting a model more attuned to children's unique needs, robust stakeholder engagement can foster a stronger, more collaborative relationship between a state's Medicaid agency, pediatric providers, families, and other cross-sector partners given the focus on improving child-focused programs. This collaboration is especially important to guide the development, implementation, and evaluation phases of the model.

Flexibility to address children's needs: Building a separate, child-focused model may provide states with more flexibility to create incentives and quality measures that support the adoption of more comprehensive, coordinated care to meet children's unique needs. In 2024, the National Academies of Sciences, Engineering, and Medicine (NASEM) released a report on improving child health, highlighting many evidence-based pediatric care models that support healthy development, enhanced care coordination, relational health, and/or addressing health-related social needs for children. However, these models have not been adopted broadly.[47] One example is HealthySteps, which leverages team-based care to support practices in implementing preventive services, such as screening, parental guidance, behavioral health consultations, and care coordination.[48,49] Some states, including Maryland and Arkansas, provide enhance payment for practices offering HealthySteps. Maryland provides enhanced FFS payments, while Arkansas provides an enhanced per-beneficiary per-month payment.[50] States designing primary care APMs, such as population-based payment models, may similarly consider how to develop rates or quality measures to support enhanced models of care. Supporting these types of innovative care delivery models will likely require states to increase total levels of payment for pediatric primary care to further support team-based care and enhanced services for children with high levels of need.

[*] As of March 12, 2025, the CMS Innovation Center announced it was considering making changes to this model: https://www.cms.gov/newsroom/fact-sheets/cms-innovation-center-announces-model-portfolio-changes-better-protect-taxpayers-and-help-americans

Another opportunity to leverage primary care APMs is to support enhanced coordination across child-serving health and social sectors. For example, one aim of CMS Innovation Center's InCK model is to support enhanced coordination of services across medical, public health, and social services (e.g., schools, child welfare agencies).[†] Similarly, Ohio's Comprehensive Primary Care (CPC) value-based payment model has a child-specific track, CPC for Kids, which incentivizes cross-sector coordination. Highest performing practices can earn bonus payments for activities, such as coordinating with school-based health care and providing enhanced support for children in foster care.[51] Designing a child-specific model may give states greater flexibility to design tailored incentives and provide enhanced resources to support these collaborations.

Potential challenges of a separate, child-focused model:

States choosing to implement a separate model for children may find it difficult to convince stakeholders that a separate model is needed and may find it adds administrative burden for health plans and providers.

Administrative burden: Creating separate models may discourage providers of adults and children, such as family practices and Federal Qualified Health Centers, from participating due to increased administrative demands. For instance, managing billing and reporting requirements for multiple models may require additional staff time and resources. States designing child-focused models may want to consider how they align with other APM initiatives. For example, simplifying the enrollment policies for multiple models could increase participation from providers who care for both adult and pediatric populations.

Difficulty making the case: Making the case to stakeholders, such as state, insurer, or hospital leadership, to prioritize pediatric primary care APMs presents several challenges. Achieving cost-savings is often a state goal for APMs and since the pediatric population is generally healthier than adults, it is difficult to demonstrate short-term cost savings in APMs for children. Additionally, states face numerous competing priorities and limited resources. Policymakers and other child health stakeholders may hesitate to invest in pediatric-focused models when there are few examples of success compared to adult models. For these reasons, it may be more politically feasible for states to build support for a broad-based model serving both adults and children.

[†] As of March 12, 2025, the CMS Innovation Center announced it was considering making changes to this model: https://www.cms.gov/newsroom/fact-sheets/cms-innovation-center-announces-model-portfolio-changes-better-protect-taxpayers-and-help-americans

Design Considerations for States

There is no clear consensus on the best way to design an APM to support pediatric primary care. State Medicaid agencies seeking to build on the momentum of primary care payment reform should consider their state-specific goals and policy environment to determine whether creating a single primary care APM can effectively serve both adults and children or whether a child-focused primary care APM is preferable. When making this decision, states may consider the following factors:

- ✓ ***How strongly does the state aim to incentivize specific care delivery models?*** States considering broad goals that are applicable to both children and adults — such as improving access to care or supporting team-based care — may benefit from creating one model (likely with customized quality metrics for providers serving children). In these cases, design features, such as payment and high-level care delivery requirements, may be applicable to both populations. However, if a state is focused on bringing a specific child-focused delivery model to scale, a child-specific primary care APM can help ensure appropriate funding and incentives. For example, incentivizing specific pediatric primary care delivery models, like those described in the 2024 NASEM child health report, may require customized rate development, quality measures and incentives, and training supports for providers.[52] These adjustments will help tailor the model to effectively meet the unique needs of pediatric care.

- ✓ ***To what extent does the model focus on short-term cost savings?*** Short-term cost savings incentives are one of the major obstacles in securing buy-in from pediatric providers given the limited opportunities to reduce costs in the short term in the pediatric population.[53] Primary care providers, especially in small or rural practices, may opt out of primary care APMs that emphasize short-term cost savings due to the limited financial upside for pediatric providers. These models may be viewed as inappropriately incentivizing reduced primary care services for children. Creating a separate, customized primary care APM model may be more appropriate for cases when states plan to incentivize short-term cost savings for the adult population.

- ✓ ***What is the state's current stakeholder environment?*** As described above, child health stakeholder buy-in to primary care APM models is important for successful model design and implementation. States should consider whether their stakeholder environment would be more conducive to one model approach or a child-focused primary care APM. For example, the successful development of a child-focused primary care APM will require active participation from pediatric providers in model design and pediatric providers with a high degree of readiness to implement an innovative APM. In addition, states with a governor and state legislature whose policy priorities include a strong focus on improving the health and well-being of children may have more financial supports and policy levers to promote widespread adoption

of a child-focused primary care APM. In states lacking strong provider and political interest in child health APMs, a broad-based primary care model may be a more feasible route for supporting pediatric primary care and potentially building stakeholder buy-in for future APM innovations to support child health.

Additionally, for both a one model approach and child-specific primary care APMs, there are a few cross-cutting considerations to design primary care APMs to appropriately support children's health. Regardless of which primary care APM approach states opt to pursue to support child health, it is important to consider:

- ✓ ***Does the model provide adequate primary care investment and other supports to improve pediatric care?*** States should consider how the model will incentivize and financially sustain new care delivery approaches, such as expanded care teams or integrated behavioral health services into primary care. States may assess the capacity of providers and health systems to implement proposed care enhancements. This could inform the type of support, such as technical assistance, enhanced rates, provider training, and/or infrastructure investments needed to enable higher quality pediatric preventive services.

- ✓ ***How will the model prioritize data collection and evaluation?*** Currently, there are limited data on the impact of APMs on improving child health outcomes or addressing pediatric health disparities. When developing an APM, it is important to consider how to integrate metrics and prioritize evaluations to identify resulting shifts in care and corresponding improvements in access and outcomes for children.

- ✓ ***Does the APM align with other Medicaid levers to improve child health?*** Primary care APMs are just one of multiple strategies Medicaid agencies use to support the health and well-being of children. In addition to provider payment reform efforts, many states are implementing 1115 waivers to address the health-related social needs of their Medicaid populations. States are also considering ways to offer continuous enrollment for children aged 0-6 to guarantee access to care during a critical window for development.[54] By aligning their payment reform efforts with other policy innovations and clearly communicating to stakeholders the value of APMs, states can create a cohesive strategy for enhancing child health.

Conclusion

Historically, APM development has focused on improvements in adult primary care, but the increased focus on high quality primary care can also benefit the pediatric population. State Medicaid agencies prioritizing primary care payment reform may consider the benefits and drawbacks of including children in broad-based APMs versus developing child-specific models. Currently, there is no clear consensus on which approach best supports care delivery transformation for children. However, states can advance the field by clearly articulating their child health goals and their rationale for how payment reform can support those goals, as well as by contributing to the development of the evidence base, irrespective of the chosen approach.

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ENDNOTES

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