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Cornell Health Policy Center

State Policy Levers to Improve Medicaid Pediatric Provider Payment

September 2025

KEY FINDINGS

- Over the past five years, states have implemented numerous strategies to improve Medicaid pediatric provider payment, but most have been small in scale and incremental. Most changes have applied to services delivered to both children and adults rather than pediatric care specifically.
- States have used a variety of policy levers make changes, including state plan amendments, state directed payments, state legislation (e.g., house and senate bills, budget appropriations) and Section 1115 waivers, with state plan amendments and state directed payments being the most common.
- Innovative approaches included large-scale value-based investments in primary care with a pediatric focus (Massachusetts), coordinated managed care incentives to improve child health outcomes (Ohio), and multi-mechanism Medicaid rate increases for pediatric services (Virginia).

MOTIVATION FOR STUDY

The United States is experiencing a shortage of pediatricians, a challenge partly attributable to lower compensation relative to other physician specialties.[1–3] On average, pediatricians' lifetime earning potential is 25% less than physicians caring for adults.[4] This disparity is further compounded by the fact that over half of U.S. children are covered by Medicaid,[5] which reimburses pediatric services at lower rates than both Medicare and private insurance.[6]

State Medicaid programs have multiple policy levers available to increase reimbursement for pediatric services. Raising Medicaid payment rates has the potential to expand provider participation in the program and, in turn, improve access to care for children.[6] Despite this, there remains limited evidence on the specific policy approaches states have implemented to increase Medicaid rates for pediatric providers, the design of these rate changes, and their potential impact on the pediatric workforce and access to care.

METHODOLOGY

The research team conducted a two-part study consisting of a policy landscape analysis and qualitative interviews with key experts. The policy landscape analysis examined state policy actions to increase Medicaid reimbursement rates for pediatric providers and services implemented between January 2019 and March 2025. An initial set of 5 states with known pediatric payment policy reforms during the study period was identified by the study team. An additional 15 states were identified by the experts interviewed. The final sample included the following 20 states: CA, CO, CT, DE, GA, MA, MD, NC, NE, NJ, NM, NY, OH, OR, PA, RI, SC, VA, VT, WA. The methodology consisted of a detailed review of legal databases, state plan amendments, state directed payment documentation, waivers, state websites, and online searches for other policy documents to provide a comprehensive understanding of each state's policy landscape. Simultaneously, researchers conducted a series of in-depth interviews with 24 Medicaid and pediatric experts, including state Medicaid directors, academics, pediatricians, and leaders of professional associations involved in pediatric care and systems. Interviews identified innovative approaches used by states to improve pediatric provider payment.

FINDINGS

1) Since January 2019, states have implemented numerous strategies to improve Medicaid pediatric provider payment, but most have been small in scale and incremental. Most changes have applied to services delivered to both children and adults rather than pediatric care specifically.

The observed strategies to improve pediatric provider payment among the 20 states can be grouped into one of seven categories described in Exhibit 1: service specific increases, service code specific increases, alternative payment models, Medicare or commercial parity, uniform percentage increases, hospital specific payments, supplemental payments, or uniform dollar increases.

Exhibit 1. Provider Payment Alteration Strategies Observed in Policy Mapping

Service Specific Increase	Rate increases applied to specific services for pediatric Medicaid beneficiaries
Service Code Specific	Rate increases applied directly to pediatric fee-for-service billing codes
Alternative Payment Models	Changes to provider payment structure, often through the implementation of unique and innovative payment approaches (e.g., value-based payment, Accountable Care Organization (ACO) infrastructure, per-member-per-month capitation)
Medicare or Commercial Parity	Changes to Medicaid provider rates that are benchmarked to Medicare or commercial rates
Uniform Percentage Increase	Percentage rate increases applied to all Medicaid reimbursed services
Hospital Specific Payments	Rate increases offered directly to individual hospitals, can be service specific or uniformly applied
Supplemental Payments	Payments, often distributed through lump sums, provided to hospitals, practices, or individual providers to supplement standard Medicaid reimbursements
Uniform Dollar Increase	Dollar level increases applied to all Medicaid reimbursed services

As shown in Exhibits 2 and 3, most states used several strategies to increase pediatric provider payment, and the most common strategies utilized were service specific and service code specific reimbursement adjustments. These were often utilized to make small adjustments (usually only a few percentage points). Alternative payment models were commonly used, however, the form of these changes varied by state and the effect on provider payment was often minimal, as many of these changes were designed to lower costs and increase quality of service at comparable payment rates. Uniform percentage increases and parity initiatives benchmarking Medicaid pediatric payment rates to Medicare or commercial rates were utilized at similar frequencies. Most strategies utilized by states to increase pediatric provider payment were not exclusive to pediatric care but rather applied to services delivered to both children and adults.

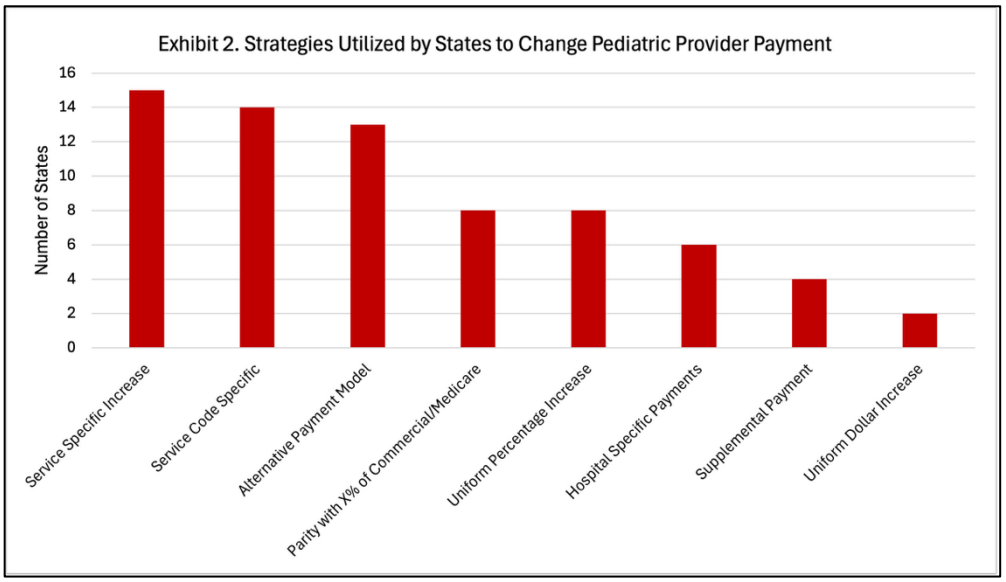


Exhibit 3. Strategies Utilized by States to Change Pediatric Provider Payment

	CA	CO	CT	DE	GA	MD	MA	NE	NJ	NM	NY	NC	OH	OR	PA	RI	SC	VT	VA	WA
Service Specific	X	X	X			X	X		X	X	X			X	X	X	X	X	X	X
Service Code Specific	X	X	X		X		X			X	X	X		X	X	X	X		X	X
Alternative payment models	X	X		X		X	X			X	X	X	X	X		X		X		X
Medicare or Commercial Parity	X		X							X	X			X		X			X	X
Uniform Percentage Increase	X				X	X				X				X				X	X	X
Hospital Specific Payments	X		X		X		X								X				X	
Supplemental Payment							X					X			X				X	
Uniform Dollar Increase									X					X						

*Cells marked with "X" indicate that the state has taken that action type within project timeframe

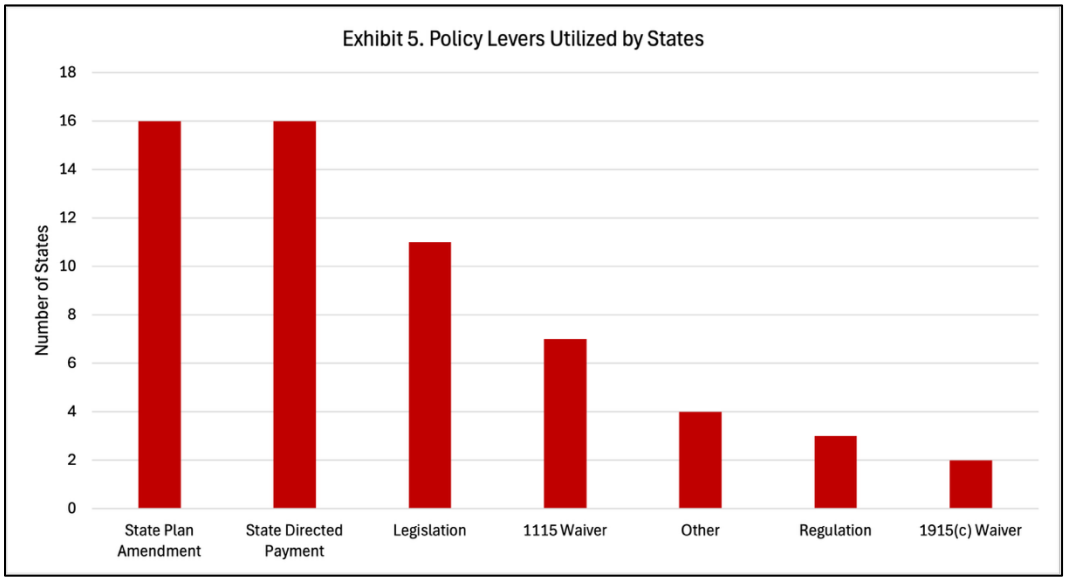
2) States have used a variety of policy levers to make changes, including state plan amendments (SPAs), state directed payments (SDPs), state legislation (e.g., house and senate bills, budget appropriations) and Section 1115 waivers, with SPAs and SDPs being the most common.

In the sampled states, a total of seven levers used to increase pediatric provider payment were identified: SPAs, SDPs, state legislation, Section 1115 waivers, regulations, Section 1915(c) waivers, and ballot measures. Exhibits 4-6 explain and track utilization of these levers.

Exhibit 4. Policy Levers to Alter Provider Payment and State Examples	
State Plan Amendments	Definition: Medicaid SPAs are proposed changes to the administration of individual state Medicaid programs which must be approved by the Centers for Medicare and Medicaid Services prior to implementation. Example: Washington SPA: To increase availability of pediatric and adult behavioral health services and incentivize adoption of the primary care behavioral health model, Washington utilized an SPA to implement a 10% rate increase for certain Resource-Based Relative Value Scale codes identified in the fee schedule, effective January 11, 2020.[7]
State Directed Payments	Definition: Medicaid SDPs allow states to direct their Medicaid Managed Care Organizations to pay providers at a certain rate or require them to use a certain payment model (e.g., value-based care). Example: Rhode Island SDP: Rhode Island implemented an SDP which offers an additional $3 per-member-per-month payment to qualified Patient Centered Medical Homes (PCMH) providing services to children, incentivizing the uptake of the integrated PCMH model by primary care practices and coordinating primary care reform with Medicare and commercial payers offering similar incentive payments.[8]
State Legislation	Definition: State legislatures can pass bills that appropriate funds for enhancing provider payment, directly alter payment rates paid by Medicaid, or make changes to provider payment models, among other possible policy changes. Example: Virginia FY2025 Budget Amendment: In its fiscal year 2025 budget, Virginia reserved approximately $147.1 million from the general fund and $267.5 million from non-general funds to provide increased Medicaid reimbursement rates for physicians who provide primary care and psychiatric services. These increases ensured Medicaid reimbursement for these services to at least 100 percent of the equivalent Medicare rate.[9]
Section 1115 Waiver	Definition: Section 1115 waiver demonstrations offer states the ability to apply for a waiver from the Centers for Medicare and Medicaid Services to implement and test innovative approaches to care delivery and provider payment under the Medicaid and CHIP programs. Example: Massachusetts Primary Care Sub-Capitation Program 1115 Waiver: Massachusetts's waiver enables the state Medicaid Authority to pay primary care providers, including pediatric providers, at rates that vary from the approved rates under the state Medicaid state plan. These enhanced payments are granted through ACOs under a shared savings and shared losses incentive scheme and based on factors such as provider class or clinical practice tier, or on the health status or rating category of the beneficiary served.[10-11]
Regulations	Definition: Regulation can be used to implement new rules that directly adjust Medicaid provider payment rates or payment models. Example: Ohio Regulation: The Ohio Department of Medicaid operates the Comprehensive Primary Care (CPC) program, along with a pediatric-focused extension called CPC for Kids. Both programs use a PCMH model that promotes team-based, primary care delivery led by a primary care practitioner. CPC for Kids offers additional, optional requirements and incentives tailored to pediatric practices. Participating practices qualify for annual bonus payments based on performance in pediatric-specific activities, such as providing support for children in foster care and strengthening behavioral health care connections.[12]

Section 1915(c) Waiver	Definition: Section 1915(c) waiver demonstrations offer states the ability to design and implement home and community-based services waivers to provide long-term care and support services to individuals in their home or community, as opposed to institutional settings. Example: Colorado's Primary Care Case Management Capitation 1915(c) Waiver: Colorado established a primary care case management reimbursement scheme wherein providers serving as case managers for qualifying pediatric Medicaid enrollees receive enhanced rates under a per-member-per-month capitation system to comprehensively coordinate patient care.[13-15]
Ballot Measure	Definition: A ballot measure, where voters directly vote upon a proposed policy (as opposed to a legislative process), can be used to implement changes to the Medicaid provider rates via tax funding. Example: California Proposition 35: This ballot measure provides funding to support 87.5% Medicare fee schedule parity for the California Medicaid program, including care for pediatrics, via a direct tax on managed care insurance plans.[16]

As indicated by Exhibits 5 and 6 below, the most common policy levers observed were SPAs and SDPs. SPAs were often used to change pediatric provider payment through alterations to the state Medicaid fee-for-service fee schedules. SDPs were most utilized to provide changes to pediatric provider payment under Medicaid Managed Care, in which states direct their Medicaid Managed Care Organizations (MCOs) to pay providers at a certain rate. For both SPAs and SDPs, individual policies to adjust payment rates were often implemented narrowly for individual services or service codes. Legislation and Section 1115 Waivers were also used in states to institute changes to pediatric provider payment. These were typically used to institute broader changes applying to all or many services or redesigning the way in which payments were made.



*Other includes Ballot Measures in California, Notices in Massachusetts and New York, and MCO Contracting in Ohio

Exhibit 6. Policy Levers Utilized by States to Change Pediatric Provider Payment																				
	CA	CO	CT	DE	GA	MD	MA	NE	NJ	NM	NY	NC	OH	OR	PA	RI	SC	VT	VA	WA
State Plan Amendment	X	X	X		X	X	X		X	X	X	X		X	X	X	X		X	X
State Directed Payment	X	X		X	X	X	X		X	X	X	X		X	X	X		X	X	X
Legislation	X	X				X	X		X	X					X	X		X	X	X
1115 Waiver	X	X					X				X			X		X		X		
Other	X						X				X		X							
Regulation							X						X							X
1915(c) Waiver		X															X			

*Cells marked with "X" indicate that the state pursued the policy lever within project timeframe
**Other refers to the use of Ballot Measures in California, Notices in Massachusetts and New York, and MCO Contracting in Ohio

3) Innovative State Approaches to Advance Payment Rates and Care: Massachusetts, Ohio, and Virginia

- **Massachusetts – Large-Scale, Value-Based Investment in Primary and Pediatric Care**
  Massachusetts' *MassHealth Primary Care Sub-Capitation Program,*[10-11] launched in April 2023 under the state's 1115 waiver, was a $115 million annual investment in primary care. Building on its earlier ACO Pilot (2016) and statewide Medicaid ACO program (2018), the state now requires ACOs to pay primary care practices—serving both adult and pediatric members—a per-member per-month population-based payment. The model offers enhanced flexibility in care delivery while requiring providers to meet clear standards for healthcare access and team-based, integrated care.

  The state has also strengthened expectations for ACOs to invest in pediatric preventive care and coordinate care for children with complex needs, supported by *MassHealth CARES for Kids*—a targeted case management benefit for children with medical complexity. Additional commitments include $43 million over five years for loan repayment and residency training to strengthen and diversify the primary care and behavioral health workforces, as well as expanded behavioral health and substance use disorder services. Together, these measures comprehensively align system- and provider-level incentives to strengthen quality pediatric care.

- **Ohio – Coordinated Managed Care Efforts to Improve Pediatric Outcomes**
  Ohio's *Medicaid Managed Care Quality Withhold Program* (Jan 2024–Dec 2025),[18] withholds 3% of all MCO capitation payments and ties payout for providers to collective success on seven projects—three of which are pediatric-focused. These pediatric projects specifically aim to improve preventive care, disease management, and behavioral health outcomes. This model links reimbursement to collective MCO performance on pediatric-focused metrics.

  Notably, Ohio's government has a strong focus on children's health.[19] Ohio's *Outcomes Acceleration for Kids (OAK) Program* [20] (2024) is a partnership between the Ohio Medicaid Department, state children's hospitals, and Medicaid Managed Care Entities in six regions to focus on four areas: asthma, mental health, sickle cell disease, and well-child visits. Each region has dedicated teams to address care gaps using coordinated improvement strategies. Complementing this, the *OhioRISE Program* [21] (2022) serves children with complex behavioral health needs through a managed care prepaid inpatient health plan.

- **Virginia – Multi-Mechanism Rate Increases to Strengthen Pediatric Care**
  Virginia has leveraged multiple policy levers to increase Medicaid reimbursement for pediatric care. Key actions include SPA-based supplemental payments set at 191% of Medicare rates for physicians at freestanding children's hospitals, a SDP requiring a 63% increase in MCO payments to physicians affiliated with the Children's Specialty Group (a team of pediatric specialty providers providing specialized medical care for children and adolescents at Children's Hospital of The King's Daughters), and service-specific payment boosts (e.g., 12.5% increase for early intervention services, 5% increase for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), 28.6% increase for primary care, and 30% increase for children's vision) accomplished through appropriation acts and regulations.

  More generally, the state's 2025 budget amendment seeks to raise rates for primary care physicians, pediatricians, and psychiatrists to 100% of Medicare rates in 2025. On the behavioral health side, Virginia implemented a 10% rate increase for select services and began reimbursing for collaborative care management in 2024. This multi-pronged approach demonstrates how layered policy levers can be combined to enhance pediatric provider payment and access to care.

IMPLICATIONS

States have used a variety of strategies, including but not limited to alternative payment models and parity initiatives benchmarking Medicaid pediatric payment rates to Medicare or commercial rates, to increase pediatric provider payment. A range of policy levers, particularly state plan amendments and state directed payments, have been used to enact these strategies. Our findings demonstrate a variety of innovative models aiming to improve children's healthcare and outcomes. Additional rigorous research is needed to understand which of these approaches are most effective at achieving these aims in which (e.g., urban versus rural) contexts.

The 2025 One Big Beautiful Bill Act (OBBBA) makes significant changes to the Medicaid program. While these changes directly target adults, they will have significant spillover effects on children's insurance coverage and health care.[22] Several OBBBA provisions are expected to directly impact efforts to increase pediatric provider payment. Specifically, OBBBA caps state directed payments under Medicaid MCO contracts, which will limit states' ability to use this mechanism to increase pediatric payment rates moving forward. In addition, the OBBBA prohibits states from establishing new provider taxes or increasing the rates of their existing taxes. States use these taxes to fund the state-share of Medicaid spending, and this restriction will reduce state Medicaid budgets. To operate within smaller budgets, states will have to make difficult choices to constrain provider payment, eligibility, or benefits. In the context of the OBBBA, states will need to emphasize cost-effective approaches that support delivery of high-value pediatric care.

FOR MORE INFORMATION

If you have questions or want further detail about specific states' Medicaid policies, please contact CHPC at chpc@cornell.edu or directly email the authors of this study, listed on the following page.

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