

Advancing Health Outcomes for Children in Medicaid and CHIP

Georgetown University Center for Children and Families Conference

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Improving Outcomes for Children through Medicaid and CHIP

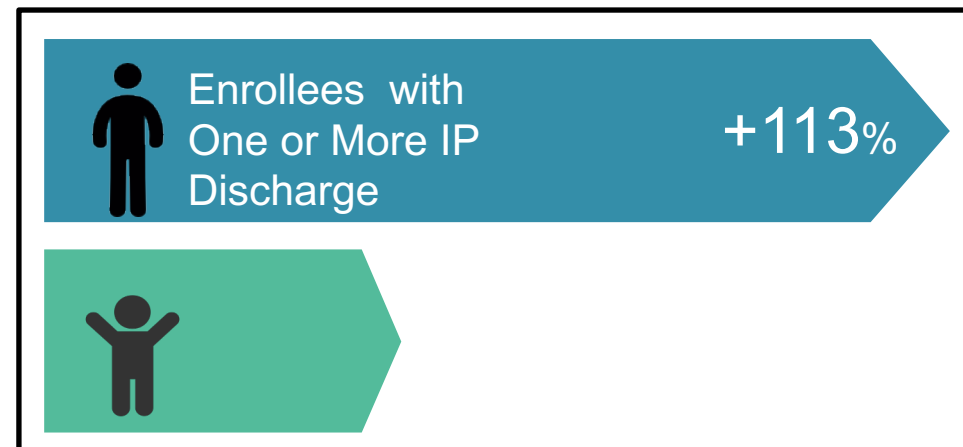
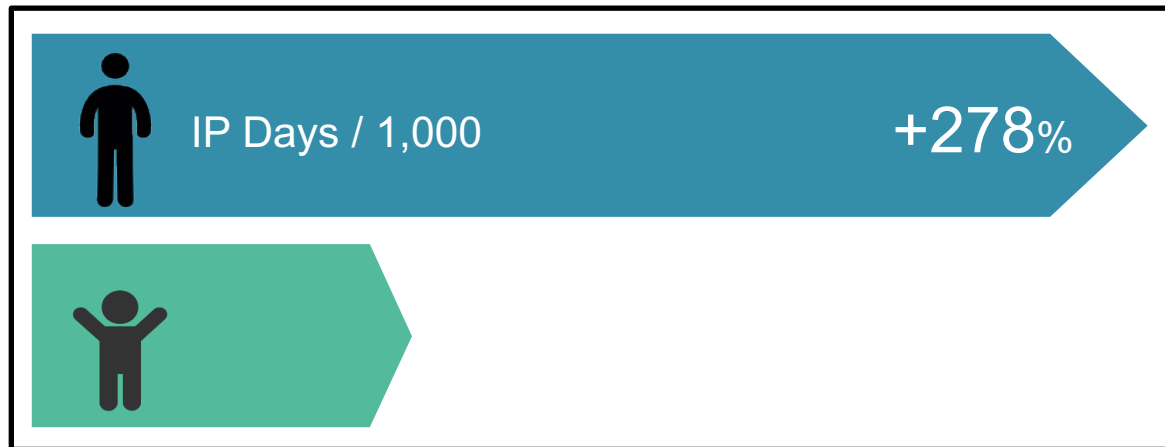
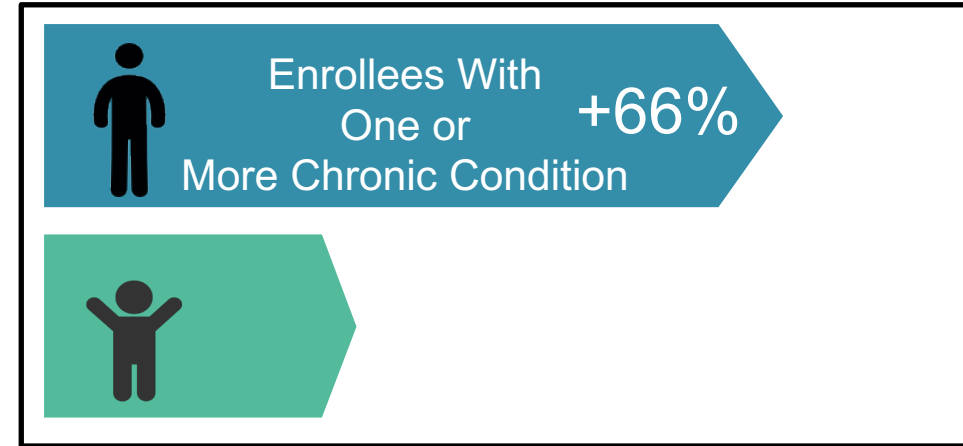
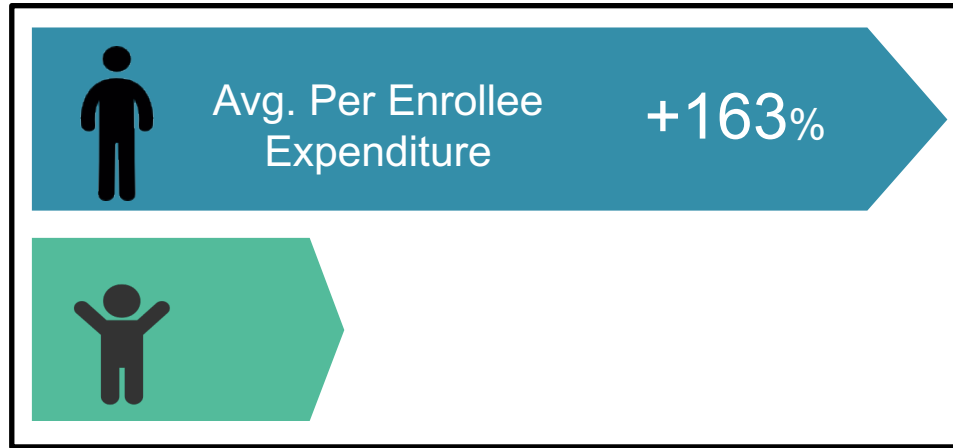
Two primary (but ideally related) approaches:

1. Value-based payment (VBP): moving from paying for volume to paying for “value”
2. Focus on social determinants of health / reducing adverse childhood experiences

National and State VBP Focus is on Adults

- Discussions about VBP in Washington, and across the country, have largely focused on adults
- This is because adults, and particularly sick adults, represent most health care spending
- Many adult-focused VBP models encourage providers to seek quick savings through the reduction of spending on high-cost services:
 - Hospitalizations
 - Emergency department visits
 - High-end imaging

Children are Much Lower Cost and Healthier than Adults



Source: L. Kennedy-Shaffer and C. Shearer. July 2016. *Understanding Medicaid Utilization for Children in New York State: A Chartbook*. New York: United Hospital Fund.

Common VBP Models Don't Work for Most Children

- Total cost of care models don't work well for most children
 - Most children generate little medical expense (>10% of total health care expenditures)
 - Very few children with high medical needs
 - Except for regional tertiary referral centers that see a large volume of kids with complex care needs.
- Children's health status is largely defined by factors not under the control of clinicians
 - Patterns of medical expenditure tend to be more sensitive to random events
 - Strong associations between the social determinants of health and adverse childhood events with future health status

Need to Address Social Determinants of Health (SDOH)

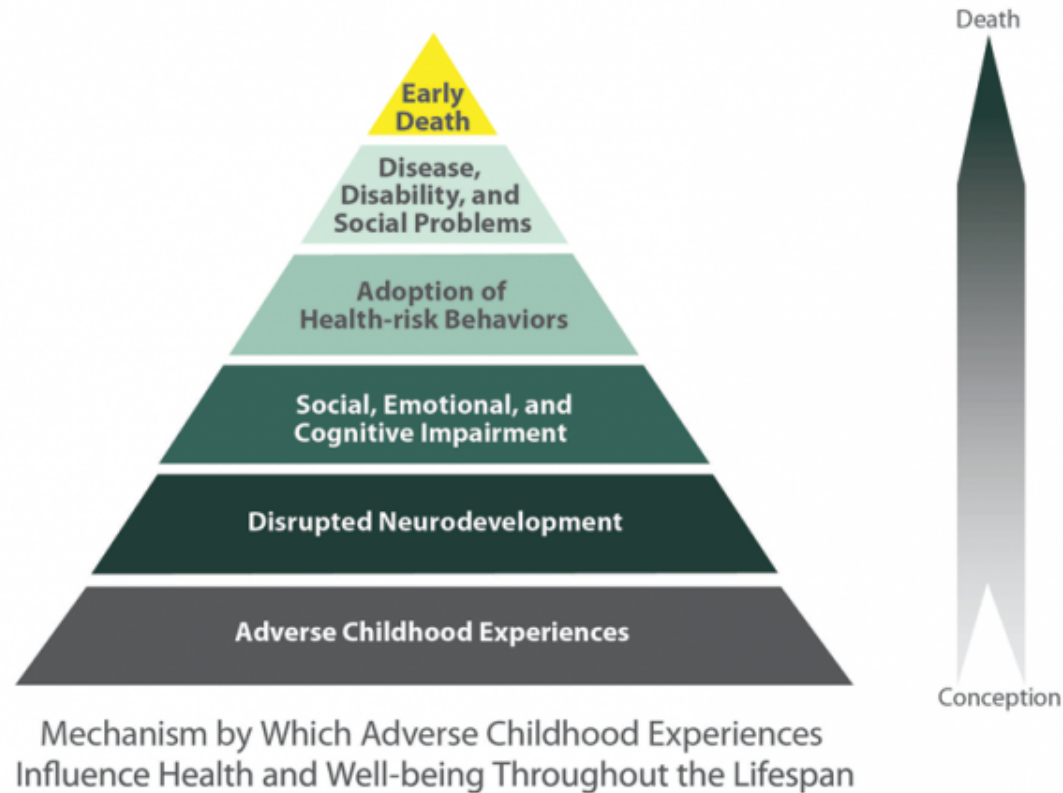
Approximately 80% of modifiable contributors to healthy outcomes fall within the broad category of SDOH. States are catching on to this!

| Economic Stability | Neighborhood and Physical Environment | Education | Food | Community and Social Context | Health Care System |
|--------------------|---------------------------------------|---------------------------|---------------------------|------------------------------|---|
| Employment | Housing | Literacy | Hunger | Social integration | Health coverage |
| Income | Transportation | Language | Access to healthy options | Support systems | Provider availability |
| Expenses | Safety | Early childhood education | | Community engagement | Provider linguistic and cultural competency |
| Debt | Parks | Vocational training | | Discrimination | Quality of care |
| Medical bills | Playgrounds | Higher education | | | |
| Support | Walkability | | | | |

Health Outcomes
 Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Trauma-informed Care Can Mitigate Adverse Childhood Experiences (ACEs)

Nearly half of all children in the U.S. are exposed to ACEs. States are not as attuned to this.



- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Intimate partner violence
- Mother treated violently
- Substance misuse within household
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

The Meaning of Value is Different for Children

“**Value**” in a child-focused VBP model means:

- Addressing issues that affect children **into and throughout** their adult lives
 - primary care and prevention
 - trauma-informed care to mitigate ACEs and address other social determinants of health
- **Not** about reducing hospital usage or managing expensive chronic conditions
- However, *there is* room for a more traditionally-focused VBP model for medically complex children

A Child-Focused Value-Based Payment Model

1. Primary care-focused VBP model for healthy children

- Capitation payment for primary care
- Care coordination payment
- Performance bonus opportunity

2. Total cost of care model for medically complex children

- Where there is a *sufficiently large population* (primarily tertiary referral centers)
- Evolve from shared savings to shared risk, but should not become full-risk due to the impact high-cost outliers
- Earned savings should be based on quality performance
- Quality measures need to be relevant to the health status of the population

Validated Measures for Child-focused VBP

| Measure Domain | Measure Name | Measure Steward |
|--------------------------------------|--|-------------------------|
| Preventive Care | Childhood Immunization Status | NQF 0038 |
| | Immunizations for Adolescents | NQF 1407 |
| | Developmental Screening in the First Three Years of Life | NQF 1448 |
| | Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life | NQF 1516 |
| | Dental Sealants on Permanent Molars for Children | Oregon Health Authority |
| | Dental Sealants for 6–9-Year-Old Children at Elevated Caries Risk | NQF 2508 |
| Behavioral Health Care | Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication | NQF 0108 |
| Chronic Illness Care | Medication Management for People with Asthma | NCQA HEDIS |
| Patient and Family Experience | Clinician & Group CAHPs | CG-CAHPS |

Key Take-Aways

- Value must be defined differently in a child-focused VBP model.
- Child-focused VBP has the potential to improve health outcomes for children in Medicaid, CHIP and beyond, but few states are engaging because of the overriding focus on cost management.
- There are currently available validated measures for children's health care. Most focus on preventive care. SDOH-related measures are just now being developed.
- There is an opportunity to expand state focus on SDOH to look “upstream” and to address ACEs.

Thank You

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