Schuyler Center for Analysis and Advocacy

What Does Value Mean From a Child Perspective?

Value:

- *the amount of money that something is worth: the price or cost of something*
- *something that can be bought for a low or fair price*
- *usefulness or importance*

(Merriam Webster, http://www.merriam-webster.com/dictionary/)

New York State is well down the path to instituting significant changes in how the State pays for health care for low-income and disabled individuals, many of them children. Like many other states, New York is testing new payment methodologies in an effort to achieve savings and positive changes in health care delivery and health outcomes. An important component of the newer methodologies is developing a shared and measurable understanding of *value.*

Until now, most of the attention on new payment and care delivery models has been focused on populations of adults with chronic conditions and significant behavioral health needs. This is because a substantial proportion of expenditures are associated with medical care for a relatively small number of people with significant health care needs, primarily due to more than one chronic condition and/or behavioral health conditions. Many of the recent initiatives are seeking to generate better health and medical savings in the short-term by improving care management for this population. While a small proportion of children have significant and disparate health care needs, most children are relatively physically healthy and thus have not been the focus of initiatives focused on relatively short-term savings and health improvements.

The lack of focused attention on understanding *value* from a child perspective is concerning. To the extent that system transformation initiatives currently underway aim to fundamentally change New York's entire health care delivery system, the current focus on adults poses the risk of New York creating a system that, by design, ignores the unique qualities and needs of children. That is, we are designing and building a system that doesn't focus on achieving better outcomes for children and the adults they will become.

Despite a lack of discussion of the unique needs of children in the State's deliberations about value-based payment (VBP), the approaches being suggested (shared savings, shared risk, bundles, capitation, and continued fee-for-service approaches for preventive services) are applicable to payment for services for children in New York Medicaid.

With the support of the United Hospital Fund, we commissioned a report, written by Bailit Health, proposing a child-centered approach to value-based payment in Medicaid.[1] Grounded in data on children's utilization of health care services, literature on children's health and medical care, and expert interviews, the report concludes that there are substantial differences in children's health care utilization compared to adults and differences in the "value" of children's health care. It argues for a distinct approach to value-based payment, not modeled

on approaches that were designed for adult populations. The report notes the detrimental effect that childhood adversity has on early childhood development and long term health outcomes.

Starting this month, the New York State Department of Health (DOH) will convene a subcommittee and clinical advisory group charged with developing recommendations about value-based payment for children that our President and CEO, Kate Breslin, will co-chair together with Dr. Jeanne Alicandro from IPRO. The subcommittee will forward its recommendations to the State's Value-Based Payment Workgroup, composed of large institutional providers; payers; community-based providers of physical and behavioral health; consumer advocates; State agency staff from an array of agencies; and other experts.

The Schuyler Center recommends that the Value-Based Payment for Children subcommittee and clinical advisory group consider the following:

Social determinants of health, including poverty. The World Health Organization describes the social determinants of health as *the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems*. People from lower-income families are more than twice as likely to face serious illness or premature death and the vast majority of premature mortality and morbidity is attributable to social, behavioral, and environmental factors, yet we continue to spend most health-related money on medical care, not the social determinants.[2] In March 2016, the American Academy of Pediatrics (AAP) issued a policy statement regarding the important role that poverty and "related social determinants" play in adverse outcomes across the life course.[3] Supporting decades of evidence about social determinants, a recent randomized clinical trial demonstrates the short-term positive outcomes for children, associated with screening for and addressing families' social needs.[4] One important question will be how to improve payers and providers interest in and capacity to help address child and family social needs.

Family and caregiver health. A child's physical, mental and social well-being is intimately connected to the health and well-being of her/his parents and caregivers, so in seeking better health and well-being for children, parental health is essential. Parental depression and stress, for example, is associated with children's poorer physical health and well-being.[5] Ensuring improved health outcomes for children and their future selves requires addressing parental and caregiver health.

Early identification and connections. The AAP recommends linking families to appropriate services, in part by using screening tools with high sensitivity and specificity. The AAP's Bright Futures Guidelines also recommend that all children be screened for developmental delays and disabilities at well-child visits.[6] Yet, evidence shows a significant gap between these recommendations and what happens in practice. Rather than simply require or incentivize screenings, a value-based payment arrangement could incentivize the outcomes expected when children are appropriately screened and connected to the right set of resources.

Risk adjustment for psychosocial and economic risk factors. Payers already use severity of illness in determining payment levels. A psychosocial risk score, based at least in part on a screening tool, should be considered in value-based arrangements.[7] The Bailit Health team recommends capitation and a care coordination payment that are risk-adjusted for "medical and social risk factors".[8]

Financing that rewards preventing disease in the long-term, as compared to current financing that focuses primarily on treating preventable diseases.

We further urge investigation into **maternal, infant and early childhood home visiting and other evidence-based practices** that improve child and family health and **measures outside of the health and medical realm**.

Children whose social, emotional and physical needs are identified and met have a much greater likelihood of being healthy for a lifetime, while children whose needs are not met are more likely to be unhealthy. New York has great opportunity right now to improve children's health, generating improved adult health and system savings.

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[1] *Bailit Health*. (2016, July 13). Value-Based Payment Models for Child Health Services. www.scaany.org.

[2] Jonas, J., Eder. J., Noonan, K., Rubin, D., Fieldston. E. (2015). Shifting the Care and Payment Paradigm for Vulnerable Children. *Policy Lab at the Children's Hospital of Philadelphia*. http://policylab.chop.edu/sites/default/files/pdf/publications/PolicyLab_EtoA_ShiftingCarePaymentParadigm_2015.pdf

[3] *American Academy of Pediatrics*. (2016, March). Poverty and Child Health in the United States. http://pediatrics.aappublications.org/content/early/2016/03/07/peds.2016-0339

[4] Gottlieb, L.M., Hessler, D., Long, D., Laves, E., Burns, A.R., Amaya, A., Sweeney, P., Schudel, C., Adler, N.E. (2016, September 6). Effects of Social Needs Screening and In-Person Service Navigation on Child Health. *JAMA Pediatrics*. http://archpedi.jamanetwork.com/article.aspx?articleid=2548441

[5] *National Research Council and Institute of Medicine.* (2009) Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention. http://www.ncbi.nlm.nih.gov/books/NBK215117/doi: 10.17226/12565

[6] *American Academy of Pediatrics*. Bright Futures Guidelines. https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx

[7] Jonas, J., Eder. J., Noonan, K., Rubin, D., Fieldston. E. (2015). Shifting the Care and Payment Paradigm for Vulnerable Children. *Policy Lab at the Children's Hospital of Philadelphia*. http://policylab.chop.edu/sites/default/files/pdf/publications/PolicyLab_EtoA_ShiftingCarePaymentParadigm_2015.pdf

[8] *Bailit Health*. (2016, July 13). Value-Based Payment Models for Child Health Services. www.scaany.org.