Value-Based Opportunities for Improving Child Health and Well-Being in Connecticut

FOR DISCUSSION

Background

To date, value-based payment (VBP) programs have largely focused on adult populations. This is typically because potential savings for children over the short term are small compared to those for adults. Interventions to improve outcomes for adults can yield a short-term return on investment, even in the same performance year as the interventions. The result is that pediatric care has historically been a low priority for VBP strategies that require savings within short timeframes. Yet, the health and cost benefits of high-quality pediatric care coupled with interventions to reduce social drivers of health that have a negative impact on children over the long term are significant.

Costs savings associated with improved health and well-being for children over their lifetimes also accrue beyond the healthcare sector, such as in the education, child welfare, juvenile and criminal justice, and workforce sectors. Accounting for benefits across sectors allows for a better use of existing resources and greater social and fiscal impacts for communities and the state.

There are some pediatric-specific metrics built into alternative payment methodologies (APMs), but they tend to be HEDIS process metrics focused at closing gaps in clinical care and not longer-term metrics that capture health and cost outcomes over a longer horizon and across sectors.

Connecticut has an opportunity to be one of the first states in the nation to take a life-course, multi-sector perspective when choosing health and cost metrics for VBPs and making investments in children's health and well-being, particularly investments that reduce disparities. This approach will pay off over the long-term and help address the lifetime disparities in health and well-being that persist among low-income, communities of color in Connecticut.[1]

Pursuing Value-Based Pediatric Care Opportunities

A significant portion of current health care and social service spending is the result of not preventing costs through interventions that start in childhood. If Connecticut were to implement strategies to measure and reward health, well-being, and costs outcomes over a longer horizon and across sectors, it could help the state achieve tremendous savings. For example, in December 2019, OHS released a preliminary analysis of the Health Enhancement Community Initiative's[2] potential impact on

[1] In 2019, Connecticut ranked 41st in disparities in health status where the higher the ranking the larger the disparities. America's Health Rankings analysis of CDC, Behavioral Risk Factor Surveillance System, United Health Foundation, AmericasHealthRankings.org, Accessed 2020.

[2] This initiative initially part of the State Innovation Model and has been maintained under the Office of Health Strategy.

Connecticut's Medicaid spending. The analysis showed that reducing the prevalence of adverse childhood experiences (ACEs) and obesity for individuals younger than 21 could yield a potential savings of between $112 million to $320 million from 2021-2030.[3] If non-healthcare sector savings from improved health promotion and prevention were included, these savings would be even higher.

Recent developments in Connecticut create opportunities to pursue these longer-term value-based pediatrics strategies. The developments and opportunities include the following.

Executive Orders

In January 2020, Governor Ned Lamont issued two executive orders, Executive Order Numbers 5 and 6, that could create paths for longer-term value-based strategies that begin during childhood.

Executive Order Number 5

Executive Order Number 5 aims to reduce the rate of health care costs, which "outpaces the growth of the Connecticut and regional economies" and impacts the state's budget. Under the order, the Office of Health Strategy (OHS) is responsible for developing health care quality and spending targets for the next five years, including increasing primary care's portion of spending to 10% by 2025 and monitoring the adoption of APMs.

Opportunities: OHS and its Quality Council should include benchmarks that measure:

- Child health and well-being, quality of care, and costs for children over a long timeframe. Much of what contributes to future poor outcomes and costs begins in childhood, and the impact of early childhood interventions that prevent poor outcomes and promote resilience and protective factors must be measured over a long time horizon.

- Increases in pediatric primary care spending within the total healthcare expenditures growth benchmarks. With appropriate investment and more flexible payment, pediatric primary care—a service used by more than 99% of children—can help children achieve better health over their lifetimes, including addressing the social drivers of health that contribute or cause poor outcomes and higher preventable costs.

- Impact across multiple sectors. While this executive order targets healthcare spending, we know that we children fail in school, job prospects, and overall success in life largely as a result of their physical and mental health, which are two things that can be addressed as part of pediatric primary care. A more holistic, cross-sector approach to implementation of primary care, would allow Connecticut to help children and families achieve overall health and well-bring and maximize the State's cost savings across sectors.

Executive Order Number 6

Signed on the same day, Executive Order Number 6 also aims to reign in growing health care costs, improve health outcomes, and reduce health disparities. It calls for the creation of an Advisory Board for Transparency on Medicaid Cost of Quality that will provide advice on the content, metrics, and goals for

[3] Preliminary projections based on CMS Office of the Actuary national trend projections through 2030, adjusted for Connecticut.

public reporting of Medicaid cost and quality. The public reporting will form the basis for future initiatives to develop and implement payment and delivery strategies.

Opportunities: The Department of Social Services (DSS) and the new Board should:

- Broaden the horizon of measurement to include a life-course perspective in which investments in children's health pay off over a long period of time and reduce existing disparities.
- Include metrics that reflect management of trauma exposure/ACEs, including increasing resiliency in childhood to mitigate future behavioral/emotional issues.
- Include metrics that incent improvements in social drivers of health, such as life functioning and reduction in risky behaviors such as substance use, school absenteism, justice system involvement, child welfare system involvement, and housing instability.
- Avoid the pitfall of only adopting APMs with the usual process-focused metrics such as well child visits and immunizations or relying strictly on efficiency metrics such as low acuity emergency department visit rates.

Braided and Blended Funding

Connecticut already has multiple systems and services that work to improve children's health and well-being. Many communities have brought together partners across sectors to address the multiple, interrelated factors that impact health and well-being of residents in their communities and some are further enhancing those partnerships under the Health Enhancement Community Initiative. However, partners' efforts are often hampered by siloed state, federal, and philanthropic funding for discreet programs and services—even if those programs and services are targeting the same people and families. This leaves community partners having to patch together funding and constantly trying to fill gaps.

Opportunities: An important solution is to pursue braided and blended funding opportunities. Braiding and blending funding brings together support from multiple sources to fund benefits across sectors. These types of strategies would give communities more flexibility in improving health outcomes and trajectories and reducing costs for children over their lifetimes. Connecticut has successfully done this before[4] and can look for other opportunities (e.g., health care, early and elementary education, child welfare, family supports, housing services) that would enable a more seamless system of care and services to ensure children's health and well-being and funding mechanisms that support such collaboration. Additionally, a public-private Wellness Trust could serve as the mechanism for aggregating funds toward a common purpose and ensuring accountability for the use of funds.

Hospital Settlement

In 2019, the state reached a settlement agreement with Connecticut's hospitals related to provider taxes. The settlement included language describing the potential implementation of Medicaid VBPs that would start in SFY 2023. Given that hospitals are long-standing providers in communities, they are able to have an enormous impact on the health outcomes and costs for their patients over their lifetimes.

---

[4] Examples: United Way 211 Child Development Infoline, the formation of the Office of Early Childhood, and the new federally funded Integrated Care for Kids (InCK) Model.

New VBPs could reward them for intervening during childhood to prevent future poor outcomes and higher costs.

Opportunities: DSS, the Connecticut Hospital Association, and hospitals should adopt VBP arrangements that include metrics for improving child health outcomes and health trajectories.

Anchor Institutions

The governor asked the Office of Health Strategy to work with hospitals and the Connecticut Hospital Association on an anchor institution strategy. Anchor institutions are organizations that are rooted in their surrounding communities and who work outside their own walls to contribute to the health and well-being of their communities through various strategies, such as offering employment opportunities, purchasing goods and services locally, and supporting access to goods and services that are vital to health and well-being. They can be a catalyst to improve the economic vitality of their communities and reduce poverty, which are critical for improving children's health and well-being.

Opportunities: The Office of Health Strategy, hospitals, and the Connecticut Hospital Association should include among their priorities strategies specifically aimed at improving children's health and well-being over their lifetimes and measure children's health and well-being over a longer time horizon within the state and hospital service areas.

Children At Risk For Not Achieving Optimal Health and Development

Children who are at risk for not achieving optimal health and development, estimated at 30% of the pediatric population,[5] are a prime target for VBP strategies because they are at risk for using disproportionate amount of pediatric health care resources if there risks are not addressed early. This population includes children who have chronic medical conditions like asthma, genetic and congenital anomalies, mental/behavioral health issues, developmental disabilities such as autism, and mild and moderate developmental delays. Social drivers of health also can greatly impact the future health care needs and utilization of these children and place stress on family members.

Opportunities: VBP strategies should include metrics that reflect the effectiveness of early screening for medical, developmental, and behavioral health needs as well as linkage to community-based services and supports for families and reward services that contribute to desired outcomes.

Potential Measures

As part of the development of the Health Enhancement Community Initiative, the Office of Health Strategy worked with stakeholders and consultants to identify potential metrics for child well-being. The measures fall into three categories based on ease of measurement:

- Category 1: Publicly available measures that can be analyzed with minimal administrative burden.
- Category 2: Data currently collected in some form but that which will require additional data agreements and/or new levels of analysis prior to being utilized for measurement.

[5] Child Trends Data Bank. 2013. Screening and Risk for Developmental Delay. Indicators of Child and Youth Well-Being. https://www.childtrends.org/wp-content/ uploads/2015/10/111_Developmental-Risk-and- Screening.pdf

- Category 3: Data requiring the highest level of administrative burden to be developed and/or analyzed for the purposes of measurement.

Opportunities: At minimum, the category 1 pediatric metrics indicated below should be adopted with additional consideration for metrics within the other 2 categories. *Category 1 measures require limited administrative burden to measure.* Additionally, it is critical to capture data by race and ethnicity to monitor reductions in disparities.

Category 1:

- Child obesity prevalence
- Substantiated child abuse/neglect cases per 1,000 population ages 0 to 8 years
- Rate of chronic absenteeism
- Performance level on all six domains of the Kindergarten Entrance Inventory (language skills, literacy skills, numeracy skills, physical/motor skills, creative/aesthetic skills, and personal/social skills)

Category 2:

- Disruptive behavior disorder prevalence among population under 18 years
- Children referred to Juvenile Court per 1,000 population under 18 years
- Incarcerated caregiver per 1,000 population under 18 years
- Children in placement with the Department of Children and Families per 1,000 population under 18 years
- Rate of school suspensions

Category 3:

- Percent of students starting Kindergarten and first grade who need special education but had not received an early intervention before Kindergarten
- Percent of children in grades 9 through 12 experiencing at least one traumatic event in the past 12 months; specifically exposed to violence
- Food insecurity rate: % of children in families that state within the past 12 months who were worried that food would run out before having money to buy more

Note that, in some cases, adoption of such expanded definitions of pediatric health outcomes for APMs will require development of new standardized tools and methodologies to collect the data at the provider level.

Potential Next Step

In 2018, the Child Health and Development Institute (CHDI) in collaboration with the Connecticut Health Foundation convened a pediatric primary care payment reform study group. The recommendations included above are derived from the work of that group, which can be found in its final report, Transforming Pediatrics to Support Population Health. CHDI is prepared to reconvene the contributors to this report and additional partners to ensure that the Office of Health Strategy receives input specific to pediatric care in implementing Executive Orders No. 5 and No. 6.