CHILDREN'S HEALTH *alliance*

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TO: The Honorable Rob Nosse, Chair
House Committee on House Behavioral Health and Health Care

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SUBJECT: Statement in Support of HB 2742 related to the Health Care Cost Growth Target Program

Chair Nosse and members of the committee, the 170+ pediatrician members of the Children's Health Alliance supports HB 2742 which excludes certain costs from consideration as total health expenditures for the purpose of the Health Care Cost Growth Target program and would like the committee to consider the exclusions listed in HB 2742 to include services provided for child health care. Children's Health Alliance pediatricians care for approximately 190,000 children and their families in the Portland metro area and Salem and are committed to improving the health of all Oregon's children.

The Children's Health Alliance is a strong supporter of the evolution of value-based payments in primary care, and has actively participated in the state's efforts to engage the provider community. We have been a long-standing committee member on the Primary Care Payment Reform Collaborative and Value-Based Payment Workgroup and participate in several Clinically Integrated Networks designed to reduce cost and improve quality. Through this work, we have been actively engaged in identifying opportunities for reduced costs in children's health care. Despite our efforts, this experience has demonstrated that there are few opportunities for reduced expenditures. We believe in the importance of *investing* in children's health and would like to change the conversation of children's health care from *cost* to *investment.*

The Oregon Health Authority has demonstrated its investment in children and the important role of addressing the needs of children and families as critical to health equity through Oregon's most recent 1115(a) Medicaid waiver. Oregon has specifically focused on children and youth, recognizing that because children and families of color experience inequitable environments which are linked to poor outcomes, they must focus on children, youth and families to meet the state's health equity goal and bend

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the health care cost curve.[1] The waiver, and its investment in children's health coverage has the opportunity to play a pivotal role in addressing children at the most critical time of development and in stabilizing the environment in which they grow by supporting families and caregivers.[1] As Oregon seeks to slow the growth rate of health care, it encourages smart, flexible spending through mechanisms such as a global budget that allow flexibility in the spending of funds. Often, the goal of the global budgets is to encourage focusing on upstream interventions that help to *prevent* illness, rather than paying to *treat* illness.

Because of the need and desire to increase the investment in children's health to help realize the long-term benefits, the Children's Health Alliance recommends that HB 2742 exclude the services provided to children under 18 from total health expenditures, or alternatively, excluding pediatric-only providers from the providers included in the accountability measures in the Health Care Cost Growth Target program. While many of the services provided to children would fall under costs of essential services, as outlined in HB 2742, we believe that an explicit acknowledgement of the desire to invest in children's health would better reflect the intention of the program in aligning with state priorities.

The value proposition for children's health services stems from promoting optimal child health across the life course, which will lead to lower long-term health care costs and utilization (principally by preventing chronic conditions in adulthood) and producing savings and better outcomes from non-health sectors by improving child development. This stands in contrast to adult health care, where the value proposition typically comes from reducing costs over a one-to-two-year timeframe while maintaining or improving quality through more efficient care and better disease management.[3]

Literature focused on effective payment models for children consistently recognizes that there are limited opportunities for short-term, direct health care cost savings among pediatric populations compared to adult populations. The pediatric population is generally healthy and, on average, health care spending is lower for pediatric populations than adult ones. Pediatric care is largely focused on development and preventive care, and children have fewer chronic conditions than adults….To the extent that opportunity for savings in pediatric care does exist, such savings would likely be smaller than the cost savings for the adult population, and the savings may accrue to systems beyond health care such as social supports or education….In some areas of care, such as primary care and behavioral health, increased investment may actually be needed to expand access to preventive care or treatment that may have long-term ROI but limited near-term cost savings. There is no consensus on the extent to which there may be shared savings opportunities for children with complex needs, and in some cases, high utilization and costs may be unavoidable.[2]

We believe that containment of health care cost growth is critical to our ongoing efforts in healthcare. However, we are wary about the unintended consequence of the focus of cost reductions strategies in children's health. If the focus of the efforts are to contain costs, the preventive care that can help achieve a longer ROI might be discouraged as a means of achieving cost-savings.[3] The Commonwealth Fund reviewed the costs of pediatric care, and found that 90 percent of child enrollees in Medicaid accounted for only half of all child health expenditures, with low expenditures and low inpatient health care utilization while high usage of primary care services, such as well child visits and immunizations.[3] The remaining half of expenditures were accounted by 10 percent of children who represented children with physical or behavioral health "complexity", whose health conditions were very heterogenous. These children typically were medically fragile or had complex chronic conditions affecting multiple organ systems or severe disabilities. These conditions often create high-cost outliers. The unpredictability of these conditions and their rarity in any single provider system makes risk-bearing for this vulnerable group of children especially hard.[3] The Commonwealth Fund concludes that the current investment in children's health may not be enough to fully meet the unique needs of children.[3]

We applaud Oregon's efforts to contain health care costs through the Health Care Cost Growth Target program, and participated in the analysis and discussions related to costs found in the initial year of the Program. As we looked at the cost trend data in the pediatric-only programs, we identified several trends:

1) The cost of care for children (under the age of 18) was fraction of the cost for adults, typically about 12% of overall healthcare expenditures in the commercial population, and was approximately 40% of the adult total cost of care (on a per-member-per-month basis).
2) Because of the lower overall costs, an increased percentage over the previous year reflects a much lower overall cost of care than when compared to adults, making the cost trends subject to swings and variability due to outliers.
3) The costs associated with the first year of life are often associated with NICU costs, the high volume of preventive care, or the costs of immunizations, all services for which pediatric providers have limited ability to influence or reduce.
4) An increase in cost was generally reflective of a small number of individual patients who required intense services for the year. These "outliers" might be children receiving NICU services, a child with a rare or complex medical condition that was a result of birth or early development, or expensive medication, rather than poor management of a chronic condition.
5) Pediatric providers rarely have the opportunity to influence the high cost and complex patients; they are either managed in the hospital in the early months of life or they are managed by specialists, who make the decisions of care.

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Holding primary care providers accountable for the health care costs for children, when so little of the cost is under their control, does not make sense, especially when society should consider *investment* in children's health, rather than *cost containment* of children's health. We recommend the Committee consider excluding services provided for children's health in the list of excluded services for HB 2742.

The Children's Health Alliance appreciates the opportunity to provide testimony on HB 2742 and urges your support and recognition of the importance of the investment in children's health.

[1] Oregon Health Authority. Issue Brief: Children's Health and Oregon's 1115 Waiver

[2] K. Brykman, R. Houston, M. Bailey. *Value-Based Payment to Support Children's Health and Wellness: Shifting the Focus from Short-Term to Life Course Impact*. Center for Health Care Strategies. September 2021.

[3] S.C. Brundage, C. Shearer. *Reforming Payment for Children's Long-Term Health: Lessons from New York's Children's Value-Based Payment Effort.* The Commonwealth Fund, United Hospital Fund. August 2019.

[4] C. Bruner, Ph.D., N. Z. Counts, J.D., P.H. Dworkin, M.D., *Identifying Next Steps for Pediatric Value-Based Care*. Advancing Kids. November 2017.

[5] Oregon Health Authority. Sutainable Health Care Cost Growth Target Recommendations Report.

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