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The Influence of Health Care Policies on Children's Health and Development

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ABSTRACT

Rates of health insurance for children have improved significantly over the past few decades, and more children have insurance than ever before in U.S. history. Health care does improve child health and well-being, but growing understanding of social and community influences has led health care practitioners to work toward more comprehensive and community-integrated child health services to improve child and family well-being. High rates of poverty affect children's health—poor children have more acute and chronic illness and higher mortality as well. Children and youth also have more diagnosed mental health conditions than in years past. This paper reviews the current state of health insurance for children and youth and contrasts health services with the needs of children and families. It then describes new models of health care, including ones that actively connect health care with other community services, and suggests promising trends in child health care.

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From the Editor

The health of children in America has primary implications for the future of this country. In this report, the Drs. Perrin, Boat, and Kelleher review the progress made in providing health care to children, the changes that have occurred in children's health conditions, the impact of current policies, and potential innovative approaches to providing health care. Children's health could be seen as a success story of policy and practice. Greater than 90% of children in the United States have some type of health insurance coverage, which is the highest it has ever been. Major childhood diseases, epidemics, and severe malnutrition, previous primary causes of childhood mortality have largely dissipated. These have been replaced by conditions such as childhood obesity, asthma, mental health, and neurodevelopmental disorders, which are the result of interactions between genetics and social and environmental factors. The overlay of poverty, despite progress in children's health coverage, still creates health disparities between poor and non-poor children. The authors describe a range of factors that may address this disparity. These include new models of health policy, health economics, and funding (e.g., the Affordable Care Act, social impact bonds), new models of health care (e.g., chronic condition management, behavioral health integration), innovations in health care delivery (e.g., mHealth approaches), and changes in pediatric training (e.g., emphasis on integration of health and other social services).

In their commentary, two children's health leaders also focus on the continued effect of poverty on children's health. Dr. Dreyer describes the new policy on poverty and health adopted by the American Academy of Pediatrics, which emphasizes (as did Perrin et al.) integration of services and engagement with other sectors of the community. He importantly points out that health care reform for children is different than for adults, in that it focuses on long-term health outcomes for children that last into adulthood, as contrasted with the adult care emphasis on cost containment for chronic disease conditions. Dr. Chaudry, like Dr. Perrin, acknowledges the significant progress made in promoting children's health, noting that the proportion of children reported in excellent health is higher than it has ever been. Again, this positive message is tempered by disparities that poverty continues to create, but he also states that at this point in time there may be the opportunity to leverage current health care policy to address disparate outcomes. He notes the potential for innovative programs that integrate services, have a two-generation emphasis, and focus on behavior health in the context of the home.

On a final note: this is the concluding *Social Policy Report* for the current editorial team. As lead editor, I want to express my appreciation for great collaborators who have been issue editors for this report—Donna Bryant, Kelly Maxwell, and Iheoma Iruka, our outstanding copy editing and production staff, Stephanie Ridley, Leslie Fox, Gina Harrison, and the support of SRCD's central office (Amy Glaspie) and the SRCD Office of Communication and Policy (Marty Zaslow). We leave this report in the skilled hands of Dr. Ellen Wartella and her editorial team.

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The Influence of Health Care Policies on Children's Health and Development

How do current health care policies influence child health and development in America? The US has recently achieved the highest rates of child health insurance coverage in history, in part due to state Medicaid expansions and the continued growth of the state Children's Health Insurance Program (CHIP). Other health care policies—many in the public health arena—influence child health, ranging from infection control programs and policies to public nutrition programs to prevention of injurious exposures to child abuse and neglect reporting to (generally ineffective) gun violence prevention programs. For the most part, these policies provide for basic, not optimal, health protections and access to health care.

Over the past several decades, many of the scourges of child health—infectious diseases such as diphtheria or meningitis, rickets and severe malnutrition, lead poisoning, and early deaths from cancer—have diminished or even almost disappeared, in part due to effective federal policy on sanitation, food, and health care. The decline of many older diseases has been countered by new epidemics of obesity, asthma, neurodevelopmental disorders, and mental health conditions, but federal health policy has moved slowly to address these new issues. Most of the health problems that affect children and youth today reflect social and community influences rather than infections (although social factors also influence acquisition of infections and their severity). The circumstances into which a child is born have stronger relationships to her/his health and development than do genes or direct

health care services, limiting the effectiveness of health care to improve health. At the same time, greater understanding of the importance of early life experiences, early education, and family and community influences on child health and development has highlighted new and changing needs for child health care. Additionally, there is clear recognition that improving child health requires integration across multiple sectors as well as having a long-term or life course perspective. Two examples document these needs for new policy directions well—the effects of poverty on child health and the prominence of behavioral health issues for children.

Poverty affects essentially all aspects of child health and development—higher mortality from serious childhood illnesses, higher rates of accidents and injuries, higher rates of common chronic health conditions and resulting disability, less physical endurance as well as

... there is clear recognition that improving child health requires integration across multiple sectors as well as having a long-term or life course perspective.

poorer school performance and graduation rates, more risky sexual and substance abuse behaviors, and higher rates of incarceration

as adolescents. From a health perspective, decreasing poverty will improve health status and response to medical treatments as much or more than improvements in personal health care services for children. Yet, strategies to diminish poverty among U.S. families are not straightforward and require a multifaceted approach, including work to improve household income, housing, nutrition, jobs, and education among families of young children.

Rates of mental health diagnoses have grown rapidly among U.S. children and youth. Here, too, children face a highly fragmented system at every level of care for behavioral and emotional symptoms. Identification

of mental health problems can come from community services (e.g., day care or schools), health services, or family referral. Much mental health diagnosis and treatment, especially for low-income children, takes place in the public school system. Health and related service providers have little incentive currently for early identification and treatment (or referral) of children and families for behavioral health, although recent efforts to (re) integrate behavioral health with the rest of the health care sector have promise. Current federal policy in this area maintains separation of health and behavioral health services in many situations, from precluding researchers from accessing behavioral health claims for study to policies that support separation of psychiatric hospitals and institutions from other services.

How do current policies affect and improve child outcomes—and especially help to promote an effective, well-trained, healthy, and competent young adult population? This report addresses those questions and offers proposals to build stronger, cross-sector programs to enhance the health and development of children in America.

Health Insurance for Children and Families Today

Children and youth obtain health insurance through a combination of public and private sources (Bureau of Labor Statistics & the Census Bureau, 2014). The majority (although diminishing in proportion) of children still receive insurance coverage through a parent's employment benefits. Rates of employer coverage of children's insurance have slowly dropped over the past quarter century (from about 75% in 1980 to about 57% in 2014), in part due to decreasing family coverage for employees (Bureau of Labor Statistics & the Census Bureau, 2014). In years past, employee benefits usually included health insurance for the employee's household; increasingly, employers limit health benefits to the employee alone.

Partly as a result of the decline in employer support for dependents, public health insurance has grown substantially as the payer for children's health care. Medicaid, the major public insurance program for low-income children, differs from Medicare in several critical ways (Iglehart & Sommers, 2015). Medicare, a national health insurance program for all citizens over age 65, has national payment rates, full funding from the federal government, and common covered services for all beneficiaries, regardless of where they live. Medicaid, like Medicare, is an entitlement program, such that

any applicant meeting eligibility requirements must be enrolled. But Medicaid, unlike Medicare, has joint funding from the federal government and the states, and states maintain oversight prerogatives regarding the state's Medicaid program. Insofar as Medicaid, too, is an entitlement program, states are unable to predict their Medicaid expenditures each year. Furthermore, when the economy weakens, state revenues fall but more people meet financial eligibility requirements for Medicaid (and other public programs). Medicaid, as a joint federal-state program, has much variation across states in payment level and services covered. On average, Medicaid payments are about 2/3 the level of Medicare payments for the same service (Rosenbaum, 2014). New York and Massachusetts may cover different mental health services and pay very different rates for those services. States set eligibility requirements, payment rates, and methods of payment (e.g., managed care or direct to provider payment), covered services, and scope of benefits (e.g., hospital days or physical therapy may be covered, but the maximum yearly benefit could be just a few days or a few treatments). The variations across state Medicaid programs are dramatic, with little consistency (Kaiser Commission on Medicaid and the Uninsured, 2013).

Medicaid, initially limited to children on welfare or with severe disabilities, now includes many children with household incomes well above the limits required for public assistance through the Temporary Assistance to Needy Families (TANF) program, in most states up to 2 or 3 times the Federal Poverty Line (FPL). In the mid-1990s, Congress passed the Children's Health Insurance Program (CHIP), which provides additional insurance coverage for children in households with incomes too high for Medicaid but not eligible for employer-based programs (Artiga & Cornachione, 2016). CHIP, unlike Medicaid, is a block grant to the states rather than an entitlement program; when a state runs out of its yearly grant, it can refuse to enroll new, eligible children. Finally, implementation of the Affordable Care Act (ACA) has helped insure some additional children, both because they may be directly eligible but also because increasing coverage for adults has led parents to seek different ways to insure their children (Artiga & Cornachione, 2016). Generally, insured parents are more likely to try to find insurance for their children than are uninsured parents, and the process of enrollment for the ACA has helped parents determine whether their children are eligible for Medicaid or other programs.

While more children than ever before are covered, insurance coverage does not guarantee access. First,

large numbers of dentists and pediatricians in the US do not accept Medicaid for children in their practices because of low payment rates. Second, parents with both private and public insurance have increasing out-of-pocket costs for a variety of health care expenses from new, high cost treatments to routine visits. Finally, many children with specialty care needs lack needed services because of long wait lists for appointments at regional pediatric specialty centers where the supply of pediatric specialists remains low.

These insurance expansions—most in the public sector—have led to over 94% of children in the US now having some form of health care insurance coverage. Poor children continue to lag behind middle income children, but the gap has markedly narrowed (Bureau of Labor Statistics & the Census Bureau, 2014). This growth in public insurance for children represents substantial growth in public investment. Given the major squeeze on discretionary funding in federal and many state budgets, however, this growth has come at the expense of new funding for other public services in education or social and community services (Rosenbaum & Blum, 2015; Steuerle, 2014).

What Does Insurance Cover?

U.S. health insurance has long focused on paying for services provided—in general, the more work done (i.e., more visits, procedures, treatments), the greater the payments (i.e., fees for services provided). Providers (physicians, nurses, hospitals, health centers) must meet certain requirements for licensure and accreditation but they then receive payment for an array of services mainly focused on disorder assessment and treatment. Public and private payers will pay for a variety of services, increasingly including some preventive care and health promotion, although the original intention of insurance was catastrophic-risk protection against unexpected high (health care) expenses. Preventive services (e.g., immunizations, screening) still account for only a small percentage of total health expenditures for children.

The incentives in traditional insurance arrangements thus are to increase the number of visits or procedures for which insurance will pay. Yet, the relationship between these services and outcomes that might be valued for children and adolescents may be limited. Assessment of quality of care in traditional arrangements has often focused on assuring performance of certain services, especially monitoring activities (e.g., routine height and weight, assessment for obesity) and some preventive services (e.g., immunizations and certain screenings, such as hearing and vision or lead levels) rather than improvements in outcomes or effectiveness.

Some evidence does indicate that having health insurance improves child health, although clearly other factors—family, social, and community characteristics—have much more influence on a child’s health and well-being than does health insurance. In general, most of the evidence is that health care improves access to and use of preventive services, especially routine checkups (Edmunds & Coye, 1998). Children with health insurance appear to have better dental health as well (Leininger & Levy, 2015). But, as an example, although the US has high immunization rates, that achievement in large part

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reflects requirements for adequate vaccination at school entry rather than the success of health insurance. For very young children, more evidence supports the value of non-reimbursed services like home visiting and nutrition programs (e.g., WIC) than reimbursed routine prenatal care (Rossin-Slater, 2015). Addressing the family and community issues that have the main impact on children’s long-term well-being will require major changes in the application of incentives in health insurance—moving from a focus on medical care coverage to strategies to make health care more effective in building healthy communities (Robert Wood Johnson Foundation, 2014).

A sizable number of children experience (individually) relatively rare and complex conditions such as juvenile arthritis, hemophilia, leukemia, brain tumors, sickle cell disease, and chromosomal disorders. Although

each condition may be individually rare, adding all approximately 7,000 rare diseases (most of which manifest in childhood) together leads to a large number of children (3.5 million) with conditions that typically require much expertise and cost in their diagnosis, management, assessment for complications, and monitoring over time. This group of children may get a good deal of care from community health providers, although most of them also will need access to care and support from pediatric subspecialists—medical and surgical (Perrin, Anderson, & Van Cleave, 2014). Pediatric subspecialists, unlike many subspecialties in adult medicine, are relatively few in number and typically centralized in specialized children's hospitals and academic programs, often at some distance from where their patients with rarer chronic conditions may live.

Medicaid, as a joint federal-state program, generally serves children within a state's borders. A child who may need to travel to a neighboring or more distant state for specialized care may find that the insurance coverage does not travel with her and may face difficulty in accessing needed care. Most children's hospitals provide specialized care to children in neighboring states as well as in their home communities. While these specialized programs may contract with Medicaid agencies in neighboring states, these contracts may pay less than the in-state rate for care and can be an obstacle to needed specialized treatment. Moves to develop regionalized systems of care, with regionalized Medicaid funding, may help to improve access (Children's Hospital Association, 2015).

Support For Children Living In Poverty and Those with Disabilities

A number of other programs provide some support for children and families, especially in low-income households. The full range of these programs—from nutrition to housing to juvenile justice—is beyond the scope of this report, although all can influence child health. We will focus on two programs with direct effects on poverty amelioration and links to health care eligibility: the Temporary Assistance to Needy Families (TANF) program and the Supplemental Security Income (SSI) program. Both programs provide cash assistance to low-income families but with different purposes. TANF, like Medicaid, is a joint federal-state program, with states having much flexibility in determining eligibility and payment rates. In 2012, TANF income eligibility rates varied across the nation, with a national average of about 50% of the FPL—or

less than \$13,000 for a family of four. Thus, households must generally be extremely poor to gain TANF eligibility (Falk, 2013). State payment rates vary similarly, from a high in New York of \$753 per month for a family of three to a low of \$170 in Mississippi. TANF rules, outlined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, also place limits on the number of years recipients may receive benefits. Furthermore, that welfare reform act ended any increase in funds, such that the total state and federal expenditures for TANF have remained the same for the last two decades, indicating a loss of about 32% in real dollars from inflation. About a third of households receiving TANF have children with disabilities in them, limiting parents' work opportunities and often requiring much parent caretaking over years. TANF acts as a critical safety net for the few families with young children who are eligible for benefits in lifting them out of abject poverty. Although a vital source of income for the relatively small number of households who are eligible, TANF fills a relatively small gap in services and support needed by families raising children with chronic health conditions and other threats to their health and development. Poverty is linked to numerous opportunities for stressful adverse experiences, and persistent adversity can be toxic and contribute to poor behavioral and physical health across the lifespan. Policy that addresses poverty, with understanding of the short- and long-term costs and benefits for individuals and society, should be a national priority.

The Supplemental Security Income (SSI) program provides cash assistance to low-income people with severe disabilities, including children. In general, the level of disability must be quite high—that is, most children with chronic health conditions will not meet the high standard of severity that SSI uses (Boat & Wu, 2015). Approximately 1.3 million U.S. children and youth currently receive SSI benefits, and the associated income (up to about \$8,000 per year) keeps a moderate number of households with children with disabilities above the FPL. SSI is mainly a federally-funded program, although many states supplement the monthly federal benefit. States, through their Disability Determination Services, determine financial and clinical eligibility for applicants, working under federal rules and supervision. Raising a child with a severe disability usually increases family expenses (many needed services and supplies are not covered by private or public health insurance), along with decreasing household income, as often one or both parents must limit or quit the workplace to care for a child with a

major disability. Thus, these SSI funds help to replace this income and allow families to meet some of their additional costs. Moreover, SSI eligibility almost always confers eligibility for Medicaid enrollment and services.

Both of these programs, like Medicaid, experience major variations across states. For Medicaid and TANF, states have much flexibility in determining eligibility and benefits. A recent report also documented wide variations in rates of applications, assessments, and determinations of eligibility for SSI across the states, although the reasons for these variations are not clear (and likely do not reflect major variations in rates of severe disability across the states) (Boat & Wu, 2015). Policy that promotes equity in supports and services that improve health outcomes should have a beneficial impact on the health of the U.S. population.

Recent Trends In Health Care Payment

The high rates of inflation in health care expenditures have led to much interest in finding new ways to diminish the growth of health care costs. The Affordable Care Act, especially as implemented through the Center for Medicaid and Medicare Services (CMS), has supported experimentation with new ways to incentivize preventive care for high-risk older populations—groups with high rates of hospital and emergency department care. Based mainly in Medicare and not Medicaid, these strategies have begun to apply new notions of prevention and keeping populations healthy (or healthier). Payment approaches have included sharing financial risk with providers—if providers can cut costs for populations, for example, by decreasing hospital use, the provider may share in the savings accrued. Providers have responded by implementing health care teams, dedicated case management, new health status monitoring technologies (including extensive use of mHealth), home care, and others. Payers, with Medicare leading the way, have experimented with new ways to pay for health care, including incentives to meet newer quality standards, sharing savings through implementing new programs, and fully capitated arrangements, where providers get a fixed dollar amount for providing a full range of services to a defined population over some time period (Burwell, 2015). These strategies have worked relatively well for specific populations that have traditionally used large amounts of health care services, achieving lower expenses in a relatively short period of time (18-36 months) (Powers & Chaguturu, 2016). Applying a similar short-term savings approach works less well for children who generate only a small fraction of total U.S. health care costs, and where the opportunities

for major health care cost savings in a short period of time are much more limited. Improvement of child health, however, represents an appealing long-term strategy for reducing adult health care costs.

What Are the Needs of Children and Families That Health Care Policies Can Address?

Several characteristics distinguish children from older populations. They have substantially more racial and ethnic diversity than any other group, and their development influences what diseases they experience, how those conditions manifest at different ages, and how children respond to treatment (Forrest, Simpson, & Clancy, 1997; Perrin & Dewitt, 2011). Children depend very much on adults—initially, parents and family and later, teachers and others—for their health care and developmental needs. Although in general, children are healthier than other populations, they too experience much chronic illness, at increasing rates over the past decades. And finally, they have much higher rates of poverty than any other age group, and poverty has pervasive influences on health and wellness and on growth, development, and educational achievement.

The past few decades have seen much change in the health conditions that children face. Many serious infectious diseases have disappeared with effective immunization programs (e.g., measles, diphtheria, tetanus, meningitis). Tuberculosis affects far fewer children than in decades past; many conditions that would have led to early death now have treatments that have greatly improved life expectancy for those who experience them (e.g., leukemia, complex congenital heart disease, cystic fibrosis). Main causes of death today among children and adolescents are accidents and suicides rather than malnutrition and epidemics (Rosenbaum & Blum, 2015).

These strong improvements in child health have been accompanied by major growth in four groups of common health conditions among children: obesity, asthma, mental health conditions (e.g., depression, anxiety, attention deficit hyperactivity disorder), and neurodevelopmental conditions (e.g., autism spectrum disorders, adverse consequences of prematurity). Diagnoses of these conditions, not typically fatal, have experienced huge growth over the past half century. Parents in 1960 reported less than 2% of children as having a chronic health condition severe enough to interfere with their lives on a daily basis. That percent has grown by over 400% to a rate today of over 8% (Field & Jette, 2007).

And rates of less severe chronic conditions (usually in the same four categories) have also grown such that some studies indicate that 25-35% of people under age 20 years will have experienced some chronic health condition in their first two decades (Van Cleave, Gortmaker, & Perrin, 2010). Some of this growth does represent improved survival owing to advances in medical and surgical care that have improved the outcomes of young people with conditions such as spina bifida and cystic fibrosis, but the large majority reflects the growth of these four common condition groups. Recent data also note well the growth of disability among young Americans of working age, with increasing numbers having severe obesity, mental health impairments, or developmental disorders that limit their ability to pursue educational opportunities or employment (Field & Jette, 2007).

Mental and behavioral health play an increasing and critical role in any consideration of child health and its impact on long-term health outcomes. For example, most mental health disorders of adults have their roots in childhood or adolescence. For several decades, child mental health was treat-

ed—and paid for—as a set of conditions separate from and distinct from the other conditions that children experience. Prevention in mental health gained little attention. Community physicians and pediatric subspecialists had little incentive or support to identify mental health conditions early or to prevent them through effective parent counseling or referral to community agencies. As a result, children with moderate to severe mental health conditions were not identified until they had quite severe symptoms, where earlier identification and intervention could have had major benefit. In more recent years, payers and program leaders, including a number of state Medicaid programs, have begun to address this separation and are working to reintegrate behavioral health into general pediatric care.

The effects of persistent mental health problems on children's functioning are clear, along with greater recognition that mental health conditions also generate or complicate many other health conditions. For

adults, the co-occurrence of mental health conditions with chronic diseases such as heart disease or diabetes is associated with much higher costs (Melek et al., 2013). Children with chronic health conditions have higher rates of mental or behavioral health concerns as well. The opportunities within the health sector include addressing mental health concerns on all visits, systematic early identification through screening, building on longer-term trusting relationships to institute treatment, and providing services directly in the health sector (see below for co-location of mental health practitioners in pediatric settings as well as parent training activities carried out in pediatric practices) (American Academy of Pediatrics Task Force on Mental Health, 2010; Institute of Medi-

cine & National Research Council, 2014). Given the substantial role of public schools in mental health care provision, it is also critical to have effective, ongoing collaboration between schools and (other) health providers. Unfortunately, budget constraints in school districts have diminished availability of health care personnel in schools. Similar attention to early childhood health has been even more spotty

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in preschool and child care settings.

Families seek responses to their needs in a delivery system that is a good deal broader than medical care, incorporating a wide array of community, public health, education, and other services (Perrin et al., 2007). These service systems are highly fragmented, and families' access to and use of services depends on many factors, including financing, physical access, knowledge, and beliefs. In mental and behavioral health, fragmentation is particularly obvious, with some care from mental health clinicians and primary care providers, especially in screening and identification of younger children, but a good deal more in public schools and for many in the juvenile justice system. Current incentives for collaboration across sectors are limited, but the opportunities that could accrue from coordination and collaboration are substantial (Cuellar, 2015).

Asthma, obesity, mental disorders, and neurodevelopmental conditions all reflect an interaction of genetic

susceptibility with the influences of social and other environmental phenomena. Their prevention and management require a multidisciplinary and multi-institutional response, not something that the health care sector alone can manage. It will, nonetheless, be critical to find ways to prevent the onset and severity of these conditions, or the nation will face larger numbers of citizens who depend on public institutions and services for their livelihood, and fewer young people resilient and capable to participate effectively in the nation's economy (Field & Jette, 2007).

Over the past decade, increasing evidence has documented the importance of early life experiences for the well-being of young children—influencing their readiness for school and literacy at age 8 and their ability to succeed in adolescence and young adulthood. Particularly difficult circumstances lead to “toxic stress,” where very young children face persistent adversity with consequent impact on their neuroanatomy and the functioning of their brain and other body systems. Toxic stress, much more prevalent among poorer children (although not limited to children growing up in poverty), can have permanent effects on the developing child (American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health, 2012). Family functioning is a strong predictor of child developmental outcomes and health. Child health and development are inextricably intertwined—healthy children grow better, develop more skills, and have better school readiness. Similarly, children whose development has had support from parents and community services are healthier, pursue less risky behaviors, and have lower rates of the common chronic mental health and other health conditions in childhood and adulthood (Campbell et al., 2014). As addressed above, policies that promote better family functioning and support of children can broadly improve children's health and development.

New Models of Health Care

Recognition of the unaddressed and changing needs of children and families in the presence of changing financial incentives has fostered the development of new models of care. Most of these include the concept of medical homes and some elements of interdisciplinary care teams—associating medical professionals with other professionals who can expand the work and attention of the health care program (Patient-Centered Primary Care Collaborative, n.d.). Team functions (not specific team members) tend to fall into four main areas:

chronic condition management, behavioral health integration, improving early childhood experiences, and linking households with critical community services. The growth of common chronic conditions has led to greater use of nurses or nurse practitioners to monitor care and progress over time and to help children and families with adherence to medical treatments. Greater recognition of mental health needs among children and the interconnection of behavioral issues with health and illness has led to programs of co-locating or integrating mental health professionals in pediatric practice (Kolko & Perrin, 2014; Williams, Shore, & Foy, 2006). Other programs to support better attention to behavioral health in pediatric care have included primary care physician backup systems in over 30 states, where physicians can easily and expeditiously consult a mental health practitioner by phone to help care for behavioral issues in the practice (Sarvet et al., 2010). Increasing understanding of the critical importance of early childhood has led practices to include home visiting and other parent support programs among their services or to collaborate with home visiting programs in the community. A focus on two generation health (child and parents) as essential for child well-being has begun to achieve traction in some pediatric health care settings. Finally, many practices have incorporated staff members who are or become knowledgeable about community culture and resources, learn to refer households to appropriate community services, and follow up to assure that families receive the services they need (Berkowitz et al., 2015). In all of these cases, family members (and children in developmentally appropriate ways) are central members of the team—teams reflect co-production with patients and families.

Financial support for these practice innovations has been limited; private payers rarely reward these innovations in traditional payment schemes because they often focus on non-professionals, diverse settings, and linkage of social and educational services with medical care, areas without a history of health care payment. Equally challenging, Medicaid (the largest payer for child medical care) has been much less active in child health care reform than with adults. To date, the development of federal policy around value-based purchasing has largely been driven by Medicare policy including the encouragement of both accountable care organizations and bundled payment initiatives. Primary care clinicians participating in the transformation to team-based care and related initiatives complain that they do so at their own financial risk (Chesluk & Holmboe, 2010).

Nevertheless, many clinicians and a few health systems have learned the value of these changes and have worked to obtain external funding or to reorganize the financing of the practice to support the changes. In a number of states, Medicaid programs have supported innovations, developing some incentives for practices similar to those in Medicare (i.e., care coordination, behavioral health integration, and chronic care management) (Centers for Medicare & Medicaid Services, n.d.; Hervey, Summers, & Inama, 2015). The largest of these are the statewide accountable care organizations (ACOs) undertaken by a handful of states to enroll all Medicaid managed care children and adults into provider networks that take both clinical and financial risk for the patients. Anecdotal experience to date suggests that cost growth in these ACOs has been lower than overall Medicaid cost growth in the respective states (Lloyd, Houston, & McGinnis, 2015). CMS has fostered both the start and expansion of some of these and related experiments in care transformation.

With innovation grants and systems improvement awards from CMS, states have experimented with a variety of programs, some focused on specific chronic conditions (obesity, asthma), others on behavioral health integration in primary care, and still others with bundled payments for episodes of care, an intermediate payment state between fee for service and capitation.

The statewide ACO initiatives have not had specific measurement or quality incentives for care focused on children, but fourteen pediatric health systems around the country have engaged in exclusive pediatric risk contracts while many more have plans to do so (Makni, Rothenburger, & Kelleher, 2015). These efforts have had dedicated pediatric networks and child specific goals for care improvement. Two have published evaluations suggesting modest quality improvements and significant cost savings (Christensen & Payne, 2016; Kelleher et al., 2015).

The use of ACO contracting to transform care is shifting incentives markedly in some places, but a larger effect in practice transformation will likely come from the bundled payment initiatives undertaken by Arkansas (Chernew et al., 2015), Ohio, and other states. The provision of incentives for providers that meet minimum quality standards and save money, with corresponding penalties for high cost providers for specific diagnoses and procedures, results in tight referral networks of low cost providers and careful followup of high cost patients. Notably, these efforts include partnerships among Medicaid and the largest private insurers so that all providers are affected.

Together, these efforts have started a movement to better use newer measures of quality (Anglin & Hosain, 2015; Blumenthal & McGinnis, 2015). What should indicate value in child health care? What outcomes should health care payers (public and private) use to assess care?

Where do patient and parent experience of care and partnership appear in measures? Would school readiness at age 5, literacy at age 8, and high school graduation serve as good measures? Quality of life, functioning at a high level, and freedom from health symptoms and conditions are potentially important con-

siderations. In behavioral health, increasing evidence indicates the greater importance of improving functioning and academic performance than controlling symptoms (Cuellar, 2015).

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Training the Pediatric Workforce

While pediatric training has evolved in response to emerging needs of children over the last several decades, several gaps remain for residency and fellowship training that deserve attention. These include health promotion and prevention in general, parent and family health and

functioning assessment and support as it influences child health, and behavioral health, along with skills in epidemiology, behavior change, and clinical management. Although training content is not legislated, several important programs and organizations have responsibility to consider and set expectations for pediatric training that can respond more to the overall health needs of children. These include individual training programs, the Pediatric Residency Review Committee (RRC), and the American Board of Pediatrics (ABP). The latter two influence training outcomes by defining criteria for accreditation of training curriculum and experiences (RRC) and expected competencies for post-training certification (ABP). These regulatory bodies de facto set expectations for pediatric training and its outcomes and thereby set national training policy. The organizations must embrace greater attention to health promotion and prevention, family function, and behavioral health of children, and how to embed these elements of care widely into pediatric practice. Physicians should also have facility and familiarity with digital monitoring and communications devices, basic epidemiology and population health skills to lead community health efforts, and basic business skills to operate in large corporate enterprises across multiple settings.

A further need for pediatric training is experience in creating and working effectively within interdisciplinary teams. Currently, medical trainees rarely work with trainees and practitioners in other relevant health professions such as nurses and nurse practitioners, psychologists and social workers, and community health workers. The needs of children and families call for planning, integration, and delivery of care that is transdisciplinary, a term that has come to define partners who go beyond working in the same place to those who adopt integrated planning and delivery of comprehensive care. An example arises from the creation of integrated behavioral and traditional medical care, where pediatricians should develop competencies in sharing responsibility for behavioral health outcomes of children.

Integration Across Sectors— Beyond Health Care to the Health of Communities Where Children Live

What are potential solutions to the long-standing disconnect between traditional child health services, the growing population of children with chronic conditions including behavioral health, and the social and community determinants of children's health and development?

One innovative solution to expanding funding for health promotion and disease prevention for children and families is the expansion of social financing broadly and social equity or impact bonds (SIBs) in particular. This class of investments uses innovative finance tools to engage private capital and oversight in addressing social needs and to create “shared value” (Porter, 2010). SIBs also are known as pay-for-success bonds and are not classical bonds in that they have elements of both bonds and stocks. Private investors enter into fixed period investments with return contingent on savings generated by the public agency for successful improvements. In the original Rockefeller Foundation bond at Petersborough prison in London, investors were returned funds based on the effectiveness of the recidivism prevention programs supervised by social agencies and investors. SIBs have been established to prevent teen pregnancy in Washington, DC, special education among young children in Utah, and asthma exacerbations among children in Fresno, CA, and South Carolina. For specific social problems, they show promise, but across broader social issues, inability to project a clear return on SIB investments will be a barrier to their attractiveness.

Two more general approaches for intervention have been suggested to address the multifactorial nature of health and mental health risk and resilience for children, especially the large number of children living in poverty. First, early childhood support programs that connect center-based child activities with family support can have lasting effects. Two carefully-designed and implemented long-term studies have shown that providing comprehensive child and family support during early childhood can have long-lasting payoffs for children and the community. Both the Abecedarian Project (in rural North Carolina) and the Perry Preschool Project (in more urban Michigan) randomized low-income households, predominantly African-American, to intervention and control groups and have now followed the children for over four decades (Campbell et al., 2014). Among the results have been higher high school and college graduation rates for the intervention groups; as well as later first pregnancies, lower rates of obesity, diabetes and hypertension, higher incomes and job retention, and substantially lower rates of incarceration among males (Campbell et al., 2014). Although both of these programs had health components, they mainly represent coordination of family support and early education with other community services.

The second approach is a more recent and rapidly growing attention to ‘place-based’ or geographically

circumscribed, community development interventions that share common principles for neighborhood and child development. These include locally developed coalitions with community residents as leaders and members, asset-based development with local strengths' assessments, support from anchor institutions such as medical centers or universities, and a comprehensive service package to include at a minimum housing, jobs and education reform linked to health care services. Such initiatives presume that long-term sustainability requires neighborhood commitment and involvement, and the health of children and families will always be vulnerable unless underlying risks like homelessness and unemployment are addressed (Fryer & Katz, 2013; U.S. Department of Health and Human Services, n.d.). National foundations have been leaders in this effort including the Casey Foundation Two Generation Approach, the Robert Wood Johnson Foundation Culture of Health initiatives, and the Kellogg Healthy Communities. The federal Promise Neighborhoods are similar. Independent of these efforts, several neighborhood initiatives are being spearheaded by pediatricians and children's hospitals oftentimes connected with Medicaid financial risk contracts. For example, the Lower Price Hill initiative in Cincinnati, the Southern Orchards initiative in Columbus, and the East Milwaukee initiative in Wisconsin all are linked to organizations with Medicaid capitation contracts. Here, the organizations have recognized that investment in non-traditional programs such as housing may lead to decreased health care costs. While many of these initiatives across the country begin with extended provision of health care services in community settings, Medicaid and other payers are often recognizing the importance of the other components, often with the maxim, "Housing First." In fact, Medicaid waivers like the one in New York now allow Medicaid dollars to be used in focused populations for rent support in recognition of the critical role of housing in maintaining health.

A number of promising programs have focused on the integration of public and private efforts to link multiple services at the community level. Much of this work has focused on early childhood, recognizing that interventions must address both child issues and the needs of parents. These programs recognize that parent health and well-being—and meeting the needs of parents—is critical to improving the health of children. Care must address two generations and not focus only on children. Examples include the major commitment of the business community to improving early childhood education (see

<http://www.americaspromise.org>; <http://toosmall.org>), public efforts to integrate services so that households find a seamless set of programs to help them meet their needs (Fryer & Katz, 2013; U.S. Department of Health and Human Services, n.d.), and the inclusion of early childhood and community investment in a number of state budgets. Governors recognize that one of the major expenses in state budgets involves maintaining or financing prisons for (mainly) young males—an investment with very little return for the state or community. They also have recognized that prevention of the need for incarceration can be a wiser investment. A recent report from the Robert Wood Johnson Foundation calls for greater investment in children and communities and for making the communities where we work and live and raise children "healthy communities" (Robert Wood Johnson Foundation, 2014). Experiences reflecting this approach also have integrated a variety of services at the community level—including health care—to support health and child growth. The Federal Reserve Banks, which invest large amounts of resources each year in communities, have recognized the importance of community development and coalitions to achieve the kinds of communities that will strengthen the local economy and the lives and preparation of workers. Below, we will consider ways that the health care sector can support and engage with these community efforts and how health care policies could aid that integration.

Federal policy is also influential in the link between the education sector and health care. Health insurance and access to a usual source of care can improve academic outcomes (Institute of Medicine, 2009). Specifically, Medicaid access for children results in better grades, fewer missed days, greater graduation rates, and higher long term earnings (Cohodes, Grossman, Kleiner, & Lovenheim, 2014). When schools aid in insurance enrollment during school registration or other events, they are promoting better performance in school. The Patient Protection and Affordable Care Act (ACA) also recognized the link between health and schools. More than \$200M was authorized for expansion of school health clinics, purchase of new equipment for school clinics, and modernization of the same. CMS also modified its 'free care policy' allowing Medicaid reimbursement as first payer for school-based services (U.S. Department of Health and Human Services, 2014). Finally, schools, in partnership with health care agencies, can provide wrap around case management to high risk children who are chronically absent, homeless, or at risk of falling behind (Suter & Bruns, 2009).

New Strategies in Health Care— What’s Most Promising

New ventures in health care financing and organization could assist the broader attention to prevention, health promotion, and community integration. Health care payment approaches that pay for value rather than services provided, with value defined as outcomes indicative of child and adolescent wellness and development, should be considered (e.g., readiness for next developmental steps, such as school entry). Such incentives move well beyond fee for service to payment for achieving specified goals or potentially global budgeting (payment for all health services over a specified period of time). These payment arrangements provide incentives for health care providers to account for social and community influences on the health status of their patients and to engage community partners to improve those outcomes. Doing this will require incentives for coordination and new measures to assess outcomes related to functioning and performance. CMS recently announced a new program to support healthy neighborhoods—experimenting with payment to enhance health care connections with the community and recognize the multiple community players that influence health (Centers for Medicare & Medicaid Services, n.d.). The neighborhood for a child includes the multiple service programs, including of course schools, that impact a child (Perrin et al., 2007), and for children with more complex chronic conditions, the subspecialists (often not in the same geographic neighborhood) that the child needs.

New information technologies can enhance these systems of community care. Mobile health (mHealth) developments include the ability to monitor a child with a chronic condition (e.g., asthma) at a distance but in real time; to assess the middle ear status of a child with fever and earache while she stays in school; to communicate with children and families about the value of certain health behaviors (including immunizations, safe

sex, adequate sleep, physical activity); and to examine growing premature infants for retinopathy at a distance. While these and additional forms of mHealth development hold great promise, their yield and implementation will be determined more by federal policy than by technical limitations because investment and growth are affected by a myriad of federal issues at the moment.

Oversight of mHealth technologies at the federal level is distributed among several agencies. The Food and Drug Administration issued guidance in 2012 that it would regulate some devices and forms of mHealth as ‘medical devices’ and modified that guidance in 2013 to include mobile medical apps (U.S. Food and Drug Administration, 2013). For items classified as medical devices, registration, pre-release testing and post-release safety monitoring are all required, considerably raising the costs and stakes for development and sales of mHealth devices. The Federal Trade Commission also plays an important role in assessing whether mHealth advertising claims are met or fair and has the lead federal role in data breaches due to device malfunction or negligence. When data breaches do occur, the Office of Civil Rights within the U.S. Department of Health and Human Services supervises penalties which may amount to \$50,000 per individual patient’s data loss. Finally, the Federal Communications Commission regulates all mHealth tools that use part of the electromagnetic spectrum or transmit personal data as communications devices (Center for

Connected Health Policy, n.d.). They specifically set aside part of the electromagnetic spectrum for transmission of personal medical information in 2012 and monitor the use of public airwaves (Office of the National Coordinator for Health Information Technology, n.d.).

Perhaps most importantly, licensing restrictions and outdated federal telemedicine restrictions discourage innovation and spread of telehealth generally. Telehealth offers many opportunities in health care, including decentralizing subspecialty care to communities through distance evaluation and treatment, providing mental

CMS recently announced a new program to support healthy neighborhoods—experimenting with payment to enhance health care connections with the community and recognize the multiple community players that influence health ...

health services in homes and community settings, and providing new skills to community practitioners (Burke & Hall, 2015). Licensing of physical therapists, nurses, and physicians, among others, precludes cross-state interactions requiring clinicians from the originating site to seek multiple state licenses. While interstate compacts are being pursued in some places, short-term solutions are not in sight. Similarly, older legislation prevents Medicare and Veterans Administration patients from receiving telemedicine services in urban areas, at home, in community health centers, and in some other locations. The wide-reaching nature of these exclusions strongly discourages investment in mHealth and telemedicine (American Telemedicine Association, n.d.). A variety of bills have been introduced in Congress aimed at individual pieces of the logjam, but progress has been slow.

Finally, the growing collection of biologic data—phenotypic and genomic—will help guide more targeted therapies and support better health surveillance and prediction of health outcomes. Greater understanding of environmental influences—toxic exposures, social and community interactions—will also improve prediction of critical health outcomes, as well as help target useful interventions to improve health.

As the focus sharpens on understanding child and family health risks and orienting medical care to reduce these risks, identifying individual risks will be increasingly possible and important. Risks are not only socially but biologically determined. Children are born with genetic health risks and resilience, and are both born with and acquire epigenetic health risk and resilience traits. National research funding priorities should acknowledge and promote studies aimed at identifying these risk and resilience factors and using that information along with socioeconomic risk and resilience factors to individualize or be selective in efforts to mitigate health risks in early life. A partnership of biological and socioeconomic research has potential to advance the promotion of child health to levels not achievable by either alone.

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Commentary

Poverty and Child Health in the United States: Addressing the Social Determinants of Health in the Medical Home

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Perrin, Boat, and Kelleher (2016) in this issue give us an erudite discussion of health care policies and their impact on children's health and development. Their discussion ranges from health insurance, the new or "millennial" morbidities facing children, newer models of health care payment and delivery, integration across sectors beyond health care, and promising new developments. I will comment on and expand on some of the important points made in their report.

Poverty is the elephant in the room. The authors rightly point out that poverty affects essentially all aspects of child health and development and that family, social, and community influences are more strongly related to child health and developmental outcomes than either genes or direct health care services. The truth, as the authors recognize, is that direct health care has a real but limited ability to improve child health and well-being. Perrin and his co-authors also stress the importance of early childhood experiences and the long-term impact, for better or worse, which these experiences have

on children. They describe new models of health care which include support for parenting, two-generation approaches, and inclusion of staff who are knowledgeable about community resources and can refer families to obtain community resources as well as make sure the families get the services they need.

The American Academy of Pediatrics (AAP) has recently released a new policy, *Poverty and Child Health in the United States*, which focuses on what the health care delivery system can do to impact the health problems of poor children (AAP Council on Community Pediatrics, 2016). The recommendations in this policy statement regarding improvements in health care practice address many of the issues brought up in the report by Perrin and his co-authors.

The AAP recommends that pediatricians and other health care providers caring for children in poor or low-income families screen for risk factors within the social determinants of health in order to assist families in meeting their basic needs (e.g., food, housing, heating, child care). The point of screening of course is to connect families with

community resources that help them meet these basic needs.

The AAP also recommends that practices and health care systems serving poor or low-income children consider integrating programs in the medical home that address parenting as well as behavioral health. There are a number of evidence-based programs that could be adopted. Early literacy promotion can be addressed with Reach Out and Read, a widely adopted intervention that reaches 4 million children each year and has been shown to improve language development in preschool children, as well as encourage parents to read to their children and engage in interactive play (Diener, Hobson-Rohrer, & Byington, 2012; Mendelsohn et al., 2001). VIP, or the Video Interaction Project, which combines early literacy with guided parent-child interactions, enhances responsive parenting, and has also been shown to improve cognitive, language, and social-emotional development of children (Mendelsohn, Dreyer, Brockmeyer, Berkule-Silberman, & Morrow, 2011). Healthy Steps for Young Children, a manual-based primary care strategy, and programs such as Incredible Years and Triple P, which

integrate behavioral health into primary care, have been shown to promote parenting and address common behavioral problems in early childhood (Bauer & Webster-Stratton, 2006; Minkovitz et al., 2007; Perrin, Sheldrick, McMenamy, Henson, & Carter, 2014). These interventions in primary care have an important positive impact on early brain and child development and ameliorate the toxic stress of poverty on families and children.

Pediatricians are also encouraged by the AAP to engage with other sectors in the community, especially education, child care, home visiting, local and state health departments, and community development programs. This recommendation is consistent with Perrin and his co-authors call for “integration across sectors—beyond health care to the health of communities where the children live” (Perrin et al., 2016). Furthermore, echoing the concerns of the authors of this report about the impact of mental and behavioral health on the long term health outcomes of children, the AAP asks pediatricians to develop strategies to address family and child mental health issues, including screening and referral for maternal depression.

Health care reform in the U.S. is very different for children than for adults. For adults, the primary aim is cost-saving, and therefore quality measures and financial incentives have focused on high cost chronic conditions of adults. For children, short-term cost-saving is not usually applicable. Improving long-term child outcomes, although potentially saving billions of dollars, is far in the future. Even those future savings, while to some degree in the health care system, are often in other sec-

tors, including education and criminal justice. The difficulty, as the authors describe, is encouraging public health insurance and private insurers to incentivize the changes in health care delivery that they and the AAP are recommending for children in view of the pressures to focus on decreasing health care expenditures for expensive adult health care. Alternatively, other sectors that will benefit from the health and well-being of children, adolescents, and young adults might be involved in financing these improvements. The authors rightly stress the need to develop newer measures of quality to indicate value in child health care. Perhaps, as they ask, measures of school readiness and academic success are the correct ones to indicate child health outcomes in today’s and tomorrow’s world.

Advocacy will be required by all of us who care for and care about children in order to affect a change in this value proposition. As the AAP recommends in its new policy on poverty and child health (AAP Council on Community Pediatrics, 2016), our society needs to invest in young children, to create incentives to improve population health with the goal of reducing health disparities, to enhance health care financing to support comprehensive care for at-risk families, and to support integrated models of care in the medical home that promote effective parenting and school readiness, such as Healthy Steps, Reach Out and Read, Video Interaction Project, Incredible Years, and Triple P Positive Parenting Program.

As Perrin and co-authors stress, health care payment must be targeted to address value based on child and adolescent wellness and development, with measures that track

the child’s readiness to be successful in the next developmental step. In order to do this, we will need to collaborate across sectors and reach out to our community partners, and government will need to support families meeting their basic needs, support and expand strategies that promote employment and that increase parental income, and improve the communities in which children are living so that they may thrive and not just survive.

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Commentary

The Opportunity for Health Care Policies to Advance Child Health and Development

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“**T**he Influences of Health Care Policies on Children's Health and Development,” by Drs. Perrin, Boat, and Kelleher provides a cogent and timely summary of recent progress, current challenges, and pending opportunities for policy to effect child health and development. In this brief commentary, I echo and emphasize a few key points in the report and argue that the current moment presents some unique, but complex opportunities to better integrate health and human services for low-income families with children and to not treat children's health in isolation of their parents' health and community contexts.

The links between childhood poverty and children's health and well-being

A key theme the authors effectively support and develop is that “poverty affects essentially all aspects of child health and development.” The strength and consistency of the relationship between poverty and the health conditions and outcomes in the United States can be found in findings from a whole host of nationally representative surveys and observational studies. Table 1 summarizes several health and development indicators from the National Health Interview Survey for 1997 and 2014.

At least three things stand out in this data. First, there has been very significant progress for all children, both poor and non-poor children on some important measures. Great progress has been made in children

having health insurance coverage, which declined more than 70 percent for children in poor families from 21 percent to 6 percent and for children in non-poor families from 6 percent to 3.5 percent. We also see significant increases in children reported to be in excellent health from 40 percent to 49 percent among children in poor families and from 63 percent to 69 percent in non-poor families.

Second, children in poverty continue to have worse health conditions and have greater health needs. They continue to be four times as likely to be reported to be in fair or poor health, nearly twice as likely to be uninsured, 30 percent more likely to have ever been diagnosed with asthma or determined to be obese, almost twice as likely to have needed to visit an emergency room in the last year, and twice as likely to have been found to have a learning disability.

Table 1—Selected Population-Based Indicators of Well-Being for Poor and Non-poor Children in the United States, 1997 & 2014

Indicator	1997 (unless noted)		2014 (unless noted)	
	% of Poor Children	% of Non-poor Children	% of Poor Children	% of Non-poor Children
Health Conditions/Outcomes (for children between 0 and 17 years, unless noted)				
Reported to be in excellent health	39.5% ^a	63.2% ^a	48.9% ^b	66.9% ^b
Reported to be in fair to poor health	4.4% ^a	1.0% ^a	3.2% ^b	0.8% ^b
Uninsured for health care	21.3% ^a	5.9% ^a	6.2% ^b	3.5% ^b
Ever told has asthma	12.9% ^a	11.7% ^a	11.0% ^b	8.2% ^b
Obesity (age 2-19) (2009-2012)	11.9% ^c (1988-1994)	7.8% ^c (1988-1994)	21.2% ^d (2009-2012)	15.7% ^d (2009-2012)
Made one or more emergency room visits in past 12 months	25.1% ^a	18.0% ^a	24.4% ^b	12.7% ^b
Missed 11 or more school days in past 12 months because of illness or injury (ages 5-17)	9.5% ^a	4.9% ^a	4.8% ^b	2.9% ^b
Developmental Conditions/Outcomes				
Learning Disability (ages 3-17)	10.2% ^a	6.6% ^a	10.1% ^b	5.3% ^b

^a Summary health statistics for U.S. children: National Health Interview Survey, 1997.

^b Summary health statistics for U.S. children: National Health Interview Survey, 2014.

^c Ogden, C. L., Lamb, M. M., Carroll, M. D., & Flegal, K. M. (2010). *Obesity and socioeconomic status in children and adolescents: United States, 2005-2008* (NCHS Data Brief No. 51). Atlanta, GA: CDC/National Center for Health Statistics.

^d Bloom, B., Jones, L. I., & Freeman, G. (2013). *Summary health statistics for U.S. children: National Health Interview Survey, 2012*. National Center for Health Statistics. Vital and Health Statistics Series 10(258).

Third, as the authors note, there are child health conditions that have remained persistent or growing challenges, particularly childhood obesity and asthma, and these afflict the children of the poor disproportionately. More than one in five children in poor families was found to be obese and one in nine had been diagnosed with asthma. These conditions remain particularly troubling because of their lifelong consequences for individuals and long-term costs for health care in the United States.

Leveraging Medicaid's expansions

Improvements in children's health insurance coverage have been due to the significant expansions over the last 20 years in Medicaid and creation of the Child Health Insurance Program (CHIP). In fact, as the authors note, during this same time employer-sponsored health insurance for children through parents' employers declined from 66 percent to 55 percent between 1997 and 2014, public health insurance coverage doubled from 21 percent to

42 percent of all children, and this accounted for the entire increase in children's health insurance coverage (Martinez, Cohen, & Zammitti, 2016). With more than 90 percent of children now having insurance coverage across all income groups for the first time ever and the majority of poor and near-poor children covered by public insurance, the opportunity to leverage health care to address the determinants of children's health, development, and well-being are unprecedented (Iglehart & Sommers, 2015). The Medicaid expansion

sions in the Affordable Care Act (ACA) for adults, including children's parents, represent their own important opportunity to support children's health and development.

The expansions in coverage represent a necessary condition for greater integration to support children's development, particularly for children from economically disadvantaged families, but will not by itself directly translate into improvements in care or be sufficient to significantly reduce the health disparities for poor children. This will require concerted efforts at innovation and adaptation, particularly in how Medicaid policies get implemented in states. As the authors note Medicaid coverage has some disadvantages in that it often provides lower reimbursement rates, is not accepted as a form of payment from a significant number of health care providers, and can vary greatly across the states (Rosenbaum, 2014). These challenges need to be considered when state administrators also seek to strategically build on some inherent strengths that Medicaid offers for improving children's health. Under the basic law, Medicaid provides a most comprehensive and strong benefit package with an affirmative obligation to screen and treat children for a wide range of health needs including asthma, mental health, and others (Paradise, 2015). In addition, Medicaid offers flexibility in its provisions and for states to seek waivers for designing and demonstrating innovations. For example, Medicaid managed care programs have been able to provide air conditioners for asthmatic children as a very cost-effective component of a service plan, and states have used broad waiver authority to innovate by supporting housing co-

ordination services for patients that have shown to reduce health costs (Barta, 2006). States will have to think creatively to experiment and develop policies to leverage the possibilities that Medicaid expansions offer to advance children's health and development.

Besides the expansion of Medicaid and opportunities it offers for improving children's and parents' health, the Affordable Care Act provides many opportunities to potentially improve child health and development in addition to expanding insurance coverage. Among these, mental health parity and the opportunities to integrate medical and behavioral health services, the incentives and support in Medicaid for states to establish health homes, and the creation of the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program are all important avenues, but all of them require significant work at the state, community, and programmatic levels to lead to widespread improvements in children's well-being (Glied & Oellerich, 2014).

Child health and development are two-generational

The health problems of parents and children are highly correlated, and a mother's own health is a strong predictor of a child's health status (Glied & Oellerich, 2014). For children, parents' health conditions can significantly effect their own development and well-being. A prevalent example is the effects that untreated maternal depression can have on young children's development (Schmit, Golden, & Beardslee, 2014). Despite the high incidence of depression and the effectiveness of treatments and interventions, there

remains limited diagnosis and treatment with the Institute of Medicine task force finding only 35 percent of those with depression receiving treatment (Institute of Medicine, 2009). In the health care system, children and adult parents see different doctors in very different provider systems (Glied & Oellerich, 2014). Mothers often regularly attend their children's pediatric care visits because of the frequency and families' compliance with well-child visits, even when they are not going to see their own primary care provider (Howell, Golden, & Beardslee, 2013). Given this, an important direction for policy would be to have pediatricians systematically screen mothers with depression and offer referrals for care and treatment, and to seek serving families in two-generational programs such as home visitation programs (Ammerman et al., 2013). Moving beyond the profound challenges for children of one particularly prevalent health condition like maternal depression that affects health development, we need to begin developing approaches to deal with the health of family members as one. In addition, health care systems must evolve to more comprehensively address children's health and related needs and coordinate more closely with the human services systems for children and families (Weil, Regmi, & Hanlon, 2014).

Ultimately, the opportunity for health care policies to have a greater and lasting influence on children's health and development will depend on evaluating, learning from and adapting concerted activities that emanate across states to better integrate service systems and program areas to improve child outcomes.

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