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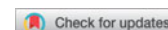
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Variability in asthma quality and costs in children with different Medicaid insurance plans in Maricopa County

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ABSTRACT

Objective: To describe the variation in asthma quality and costs among children with different Medicaid insurance plans. **Methods:** We used 2013 data from the Center for Health Information and Research, which houses a database that includes individuals who have Medicaid insurance in Arizona. We analyzed children ages 2–17 years-old who lived in Maricopa County, Arizona. Asthma medication ratio (AMR, a measure of appropriate asthma medication use), outpatient follow-up within 2 weeks after asthma-related hospitalization (a measure of continuity of care), asthma-related hospitalizations, and all emergency department (ED) visits were the primary quality metrics. Direct costs were reported in 2013 \$US dollars. We used one-way analysis of variance to compare the health plans for AMR and per member cost (total, ER, and hospital), and the chi-squared test for the outpatient follow-up measure. We used coefficient of variation to identify variation of each measure across all individuals in the study. **Results:** In 2013, 90,652 children in Maricopa County were identified as having asthma. The average patient-weighted AMR for children with persistent asthma was 0.35, well short of the goal of ≥ 0.70 , and only 36% of hospitalized asthma patients had outpatient follow-up within 2 weeks of hospitalization. AMR, total costs, and ED costs varied significantly ($p < .0001$) when comparing health plans while hospital costs and outpatient follow-up showed no significant variation. **Conclusions:** Targeting appropriate medication use for asthma may help reduce variation, improve outcomes, and increase healthcare value for children with asthma and Medicaid insurance in the US.

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Introduction

Asthma is the most common non-communicable chronic disease in children and without proper management, can lead to frequent emergency department (ED) visits, hospitalizations, missed school and work days, decreased productivity and physical activity, and premature death (1). The majority of people diagnosed with asthma can control their symptoms by receiving appropriate medical care. Although clinical guidelines to direct asthma care have been available for more than 25 years, diffusion to clinical practice remains low (2) and asthma outcomes have not significantly improved over the past 2 decades (3).

At the same time, new care concepts are emerging in the US that may promote improved chronic disease care, including asthma (4). The overall US healthcare

system is gradually moving from volume to value, but reimbursement for these new models of care is lagging. The ability to measure quality of asthma care has also advanced, as standards put forward in the Healthcare Effectiveness Data and Information Set specific to asthma allow direct comparisons of outcomes between health plans and health providers. The standards and validation of such measures have provided the framework for programs aimed at improving asthma care. In addition, the US healthcare system as a whole is gradually moving from volume to value, but reimbursement for new models of care is lagging. Not surprisingly, many successful community- or population-level interventions are still primarily grant funded and are at risk for discontinuation when grant funding ends (5). Thus, a model for a sustainable asthma improvement effort that includes payer participation is needed.

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Our hypothesis was that a fiscally sustainable asthma improvement model can be informed by variation analyses of health care quality and costs of different payers. To better understand the variation in asthma care by payer, we took advantage of a database that includes asthma quality of care measures and costs. We focused our analysis on children insured by Medicaid, as more than 1 in 3 children in the US (and nearly 1 in 2 in Arizona) use Medicaid insurance (6) and previous data suggest disproportionate management challenges in this population (7–9). The Medicaid insurance system is supported by the federal and state governments. In Arizona, money is distributed to health plans to provide support for caring for children and adults who qualify for Medicaid insurance. The algorithmic assignment of children to Medicaid plans in Arizona provides further rationale to study variation in asthma quality and cost in this specific population.

Methods

Data source

We used the Center for Health Information and Research (CHiR), a database that includes individuals who have Medicaid insurance in Arizona from 2013 (10). At the time of the study (2013), ~90% of Medicaid insurance recipients in the State of Arizona had plans with a managed care payment structure, with the State paying a capitated amount for each person insured by one of the available plans, and the plans, in turn, compensating providers in a fee-for-service system (11). Upon enrollment, Arizona Health Care Cost Containment System (AHCCCS), the State Medicaid program, allows members the right to choose a plan. If choice is not exercised, and close familial continuity with a plan is identified during the enrollment process, the State will enroll the member in the same plan as the close family member. After this, the State uses an assignment algorithm that is a mathematical formula that uses non-clinical factors such as market share targets and limitations for the plan, performance on various operational metrics including claims processing, and capitation rates that are favorable to the State (12). An analysis performed for purposes of business development planning showed that in 1 month (April) in 2014, of 78,362 enrollments in the AHCCCS system, 18,419 (23.5%) were a result of member choice. Other assignments were made by re-enrollments [28,658 (36.6%)], auto-enrollment [21,781 (27.8%)], and family continuity of a newborn [9,504 (12.1%)]. (Personal communication, Charlton Wilson, Internal Business Consultation Report, 2014).

Data were delivered to researchers deidentified for individuals but not for healthcare delivery systems or payers. We elected to label the payers using an assigned

code name rather than name them, as agreed upon by consensus among our research team. The study was approved by the Arizona State University IRB.

Population

The participants in this study were children 2–17 years old insured by Arizona Medicaid and living in Maricopa County with a diagnostic code for asthma in 2013 identified using the CHiR database. There were no exclusion diagnoses.

Data definitions

Children were assigned to a specific insurance payer based on payment of the majority of claims for 2013, including hospital, ED, outpatient, and pharmacy claims. Asthma-related healthcare utilization was defined as hospitalization both via the ED and directly with asthma in the first diagnostic position, ED visit with asthma in any diagnostic position, outpatient visits with asthma in any diagnostic position, and pharmacy claims data for asthma medications. We only included hospitalizations for asthma when asthma was in the first diagnostic position (but allowing any diagnostic position for other visit types) to ensure that measuring continuity of care (COC) after hospitalization was more likely to be specific for asthma-related hospitalizations. Pharmacy claims data were used to identify asthma medication possession, and medications were classified as controller, rescue, or systemic corticosteroid (see Table 1 for asthma medication classification). Costs are reported in 2013 US Dollars.

Table 1. Demographics of children in Maricopa County, AZ, with asthma and Medicaid insurance (2013).

Unique patients (n)	90,652
Gender (% male)	54.6%
Age, Mean (SD)	8.1 (4.3)
Age, 2–4 years old, %	28.3%
Age, 5–11 years old, %	50.3%
Age, 12–17 years old, %	21.4%
Race/ethnicity	
White, Hispanic, %	55.7%
White, Non-Hispanic, %	25.0%
Black/African American, %	10.0%
Asian, %	2.1%
Native American, %	3.6%
Other, %	3.6%
Persistent asthma (n and %)*	21,481 (24%)
Uncontrolled asthma (n and %)**	23,486 (26%)

Note. *Persistent asthma was defined by meeting any of the following in 2012: (1) Hospitalization with asthma in first diagnostic position (2) ED visit with asthma in first diagnostic position (3) 4 or more asthma medications dispensed in 1 year (4) 2 or more asthma medications dispensed in 1 year and 4 outpatient visits with asthma in any diagnostic position.¹³

**Poorly controlled asthma was defined as 3 or more rescue medications dispensed or >1 ED or hospitalization for asthma in 2013 with asthma in the first diagnostic position.

Persistent asthma was defined by meeting any of the following in 2012: (1) Hospitalization with asthma in first diagnostic position (2) ED visit with asthma in first diagnostic position (3) 4 or more asthma medications dispensed in 1 year (4) 2 or more asthma medications dispensed in 1 year and 4 outpatient visits with asthma in any diagnostic position (13). Poorly controlled asthma was defined as 3 or more rescue medications dispensed or > 1 ED or hospitalization for asthma in 2013 with asthma in the first diagnostic position.

The patient-weighted asthma medication ratio (AMR) was calculated as follows:

$$\frac{\sum_{i=1}^n \left(\frac{\# \text{ of controller medications for patient } i}{\# \text{ of controller and rescue medications for patient } i} \right)}{n \text{ (number of patients)}}$$

The AMR is a quality measure endorsed by the National Committee for Quality Assurance as a measure of medication prescribing quality for asthma for patients with persistent asthma (14). An AMR ≥ 0.7 is associated with improved asthma outcomes in children with Medicaid insurance (15). The AMR was calculated for children with persistent asthma for this study.

The COC measure selected for this study is an outpatient visit within 2 weeks of discharge from an asthma hospitalization. The selection of the COC measure is based on a hospital-based quality care outcome, which is the Home Management Plan of Care (HMPC) of the Children's Asthma Care (CAC)-3 (15). To be compliant with the COC subcomponent of the HMPC, an appointment for outpatient follow-up care must be made or information that facilitates the scheduling of outpatient-follow-up must be provided. We selected a 2-week time period after hospitalization for this study, as there is not a specific time period stipulated in the HMPC of CAC-3.

To better capture and visualize the variation across quality and cost dimension by payer, we carried out a relative value analysis. We define value for this study to be the quality of care divided by costs. We use the term "relative value" because a) the analysis provides a view of a given organization in the context of a peer group and b) even the best performing organizations within the group can and should identify opportunities for improving the value of care they provide on a continuous basis. To that end, quality and cost metrics were first converted into indices (by calculating the average for each metric, then determining the relative position of each organization with the respect to that average). An overall quality index was determined by averaging the indices across the four quality metrics (hospitalizations, ED visits, AMR, and COC). Next, we identified cost per member for each health plan in our dataset. The value index was quality on the y-axis and

costs on the x-axis. The relative value index is not a validated measure and was constructed for the purpose of visualizing the relationship between asthma quality measures and costs.

Finally, to better understand variations in health care across Maricopa County, we performed a geographic analysis. We arbitrarily defined geographic hot spots of poor asthma outcomes by identifying census tracts with >450 ED visits in 2013. We performed comparison analyses of children being in geographic hot spots with the overall study population.

Statistics

The population size was determined by the available number of children in the CHiR database meeting the inclusion criteria in 2013. Demographics are described using total number and percentage. Health care quality and costs are described in the entire sample and for each payer in total counts and per insured child by payer. Mean and range were described per member for quality measures and costs. We used one-way analysis of variance (ANOVA) to compare the health plans for AMR and per member cost (total, ER, and hospital), and the chi-squared test for the outpatient follow-up measure. A coefficient of variation was calculated for direct cost categories (standard deviation divided by mean), with higher values indicating more variation across payers and more suitable for interventions to address variation.

Results

In Maricopa County, 90,652 children had an asthma diagnosis and were insured by Medicaid in 2013. Slightly more of the children were male (55%), the majority were Hispanic (56%), 24% had persistent asthma, and 26% had uncontrolled asthma. Estimated asthma prevalence for our sample population (2–17 years of age and insured by Medicaid) in Maricopa County was 10%. Population demographics of our data sample are summarized in Table 1.

Hospitalizations due to asthma (direct or via ED) occurred on average in 1 in 160 children, while overall ED visits occurred on average in 1 in 4 children. Children with asthma made outpatient visits on an average of 1.3 times during 2013. Average patient-weighted AMR was 0.35, well short of the ≥ 0.70 target (14). Thirty-six percent of children had an outpatient visit within 2 weeks of a hospitalization for asthma. Average annual cost per patient was \$449 USD. Table 2 summarizes the population-wide quality and cost metrics by setting.

Next we examined quality and cost metrics across the various payers that insure our sample population. First we present demographics of children enrolled in

Table 2. Summary health care cost measures in children with asthma and Medicaid insurance in Maricopa County, AZ (2013).

Setting	Count	Total cost (Average cost per member)	Coefficient of variance (CV)*
Direct hospitalizations	37	\$84,000 (\$2,266)	0.8
Hospitalizations via ED	537	\$1,500,000 (\$2,770)	1.0
ED visits	22,025	\$9,900,000 (\$449)	1.3
Outpatient visits	122,201	\$26,900,000 (\$220)	2.1
Medications dispensed	193,035	\$60,100,000 (\$316)	2.7

Note. *CV = standard deviation divided by mean.

Table 3. Demographics of population for each payer (2013).

Demographic variable	P1	P2	P3	P4	P5	P6	P7	P8
Gender (% male)	53.9	54.5	54.3	54.4	54.1	55.4	67.7	53.3
Age								
Age, 2–4 years old, %	28.6	26.8	27.7	25.9	32.6	30.8	22.4	36.7
Age, 5–11 years old, %	50.6	49.4	50.6	52.4	50.4	49.8	56.9	36.5
Age, 12–17 years old, %	20.6	23.7	21.6	21.6	16.8	19.3	20.6	26.7
Race/ethnicity								
White, Hispanic, %	54.7	55.3	61.7	61.0	60.1	67.5	33.8	36.2
White, Non-Hispanic, %	26.2	26.9	22.7	22.3	21.7	15.6	33.4	39.2
Black/African American, %	10.3	10.8	9.0	8.8	11.1	10.5	5.2	16.5
Asian, %	3.0	1.5	1.4	1.4	1.9	1.5	1.4	0.8
Native American, %	2.6	2.0	2.1	3.5	1.9	2.2	1.9	4.1
Other, %	3.0	3.2	2.7	2.6	3.0	2.3	2.4	2.8
Uncontrolled asthma (%)	24%	25%	23%	22%	20%	23%	39%	19%

each Medicaid plan (Table 3). Plans 1–6 represent “acute” managed Medicaid plans, which provide coverage to the general population and account for 93% of our patient population, while Plans 7 and 8 serve special populations that have quantitatively and qualitatively different case management systems and payment strategies as components of their care. One of these plans serves children with significant developmental disabilities (P7), while the other serves children in the foster care system (P8), which includes case management, social services, financial support, and additional requirements. Two acute managed plans were excluded from payer-level analysis due to the small size of their insured population. We also excluded the Indian Health Service from payer-level comparisons as it lacked complete data on medication dispensing. Payer-level quality and cost metrics are summarized in

Table 5. Average annual cost per member, by payer (2013).

Health plan	Direct admission	Admission via ED	ED visit	Outpatient visit	Medication
P1	\$1,710	\$2,699	\$363	\$206	\$291
P2	\$1,859	\$2,848	\$426	\$205	\$308
P3	\$1,797	\$2,309	\$531	\$174	\$307
P4	\$4,582	\$3,116	\$457	\$200	\$281
P5	\$2,473	\$2,469	\$491	\$166	\$237
P6	\$1,937	\$2,400	\$430	\$169	\$194
P7	\$1,396	\$2,327	\$476	\$340	\$839
P8	—	\$2,347	\$343	\$195	\$249
Overall population	\$2,266	\$2,770	\$449	\$220	\$316

Table 4. Significant variation between payers for AMR ($p < .0001$) but not 2 week outpatient follow-up ($p = 0.38$) were found.

Table 5 summarizes average cost and overall spending by category and payer. ED costs ($p < .0001$) and total costs ($p < .0001$) had significant variation across payers, while there was no significant variation between Hospital costs ($p = 0.53$).

We constructed a basic value relationship by creating a quality and cost indices for each plan. The relative value of asthma care for each plan is shown in Figure 1. Six of the eight plans were in the “high-value” quadrant.

To better understand the potential impact of geography, each child was assigned a zip code based on their home address. Geographic hotspots, where >450 ED visits occurred in 2013 ($n = 12$ zip codes) were identified. Demographically, these geographic areas (which account for 1/3 of our overall patient population), show a similar age and gender distribution, as well as percentage of children with persistent asthma as non-hot-spot areas. Seventy percent of children that originate from these zip codes identified as Hispanic (vs. 56% in our overall sample). Average annual cost per patient, the costs of ED visits, and elective admissions were slightly but not significantly higher than those observed in the overall patient sample. See Tables 2 and 3 for demographic and cost comparisons between the “hotspots” and overall

Table 4. Quality measures and asthma-related costs in children with Medicaid insurance in Maricopa County, AZ, by payer (2013).

Health plan	Members (n)	Annual asthma hospitalizations (Direct or via ED), per member	Annual ED visits, per member	AMR [#]	2-week follow up ^{##}	Per member cost (\$USD)
P1	34,863	0.005	0.29	0.35	0.35	\$422
P2	18,446	0.007	0.22	0.38	0.47	\$446
P3	12,623	0.005	0.18	0.34	0.37	\$409
P4	7,743	0.008	0.18	0.34	0.37	\$415
P5	5,969	0.006	0.18	0.31	0.30	\$353
P6	4,844	0.009	0.21	0.26	0.34	\$347
P7	2,762	0.003	0.23	0.52	0.22	\$913
P8	2,237	0.004	0.15	0.4	0.25	\$356
Overall population	90,652	0.006	0.24	0.35	0.36	\$449

Note.

[#] Asthma medication ratio = controller + reliever medications/controller medications, as measured in individuals with persistent asthma, ANOVA for AMR between plans, $p < .0001$.

^{##} 2-week follow-up is an outpatient visit within 2 weeks of a hospitalization for asthma, chi-squared test for 2-week follow-up between plans, $p = 0.38$).

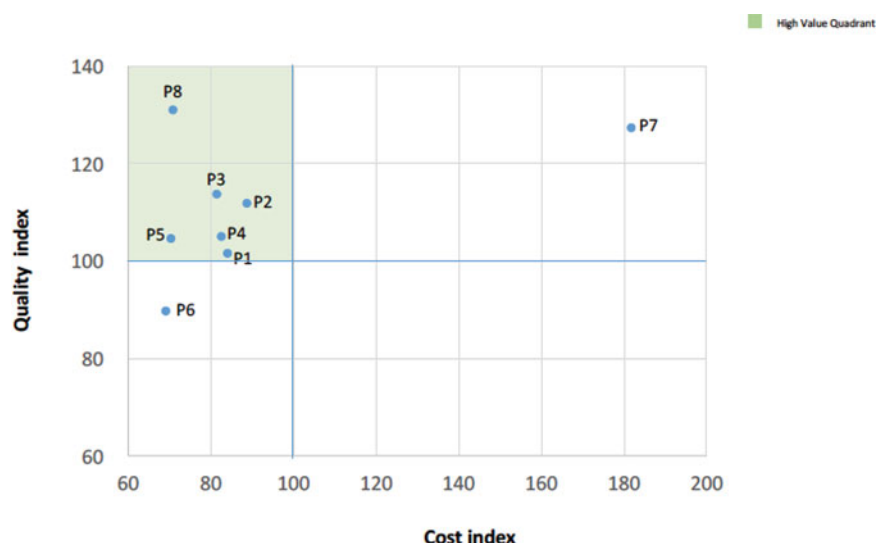


Figure 1. Relative value of care provided to children with asthma by payer (2013). Quality and cost metrics were first converted into indices. An overall quality index was determined by averaging the indices across the four quality metrics: hospitalizations, ED visits, asthma medication ratio (AMR), and continuity of care (COC).

patient sample. In terms of healthcare quality, children in “hotspots” had similar average per patient hospitalizations (0.007 vs. 0.006), ED visits (0.25 vs. 0.24), and AMR (0.33 vs. 0.35). COC mirrored that of the overall patient sample (36%). The higher rate of healthcare utilization is likely explained by the higher than average asthma prevalence in these geographic areas (range 15–22% vs. 10% county-wide), as highlighted in Table 4.

Discussion

Children with asthma in Maricopa County experience variation in quality and costs across different Arizona Medicaid insurance plans. Moreover, children with Medicaid insurance score poorly for appropriate medication use and COC across all payers, suggesting significant opportunities for improvement. Costs of care not only varied by payer in this sample, but also varied across all individuals in the study. The highest variation—both individual level and in comparison across health plans—was for medications, further suggesting that medication management may be a high-yield target for quality improvement efforts (16). To our knowledge, no previous study has compared costs and quality among different Medicaid insurance payers within the same state or county.

Some interesting observations emerge when the results of our study are compared with previous studies of children with asthma who have Medicaid insurance. For example, rates of ED visits for asthma in our sample were higher than previous estimates. In a study using the National Ambulatory Medical Care Survey Emergency Department, it was estimated that in 2010 there were

13,652 ED visits in children with Medicaid in AZ at a total cost of \$5.9M USD (17). Our study found that in Maricopa County alone, there were 22,025 ED visits at a cost of \$9.9 M USD. These differences likely reflect our choice to include ED visits where asthma was listed in any diagnostic position, which likely overestimates the ED visits specific for asthma. In another study with similar age, gender distribution, and Medicaid insurance to the current study, ED visits occurred in 11% of the sample and hospitalizations in 1.1% of the sample (14).

The CAC-3 measure to establish outpatient follow-up after hospitalization was previously reported to be 55.5% (95% CI 48.9–62.1) in the US (15). Actual hospital follow-up visits, as measured using the CHiR database, were lower (36%) likely because many appointments that are established at hospital follow-up are not completed and because we defined the follow-up period as 2 weeks. Even the best health plan on this measure had less than 50% follow-up with an outpatient provider after a major event like hospitalization, suggesting a major gap in COC for children at highest risk. However, it is also noticeable that Plans 7 and 8, which generally scored well on most quality measures, had lower outpatient follow-up rates following hospitalization, perhaps because non-outpatient visit care methods were used to manage patients.

In a study using a national Medicaid database, AMR > 0.70 was associated with a 31% reduction in ED or hospitalization over a 6-month period (14). Thus, our finding that the AMR for children with persistent asthma ranges from 0.26 to 0.52, well below the AMR of 0.70 that is associated with improved asthma outcomes for Medicaid payers (14), suggesting a major gap in the appropriate use of asthma controller medications. Maricopa County is

not an outlier for asthma medication adherence. Adherence to controller medications in children with Medicaid insurance is low nationally; more than 60% of children are no longer obtaining their controller medications 90 days after receiving an initial prescription (18). Yet, in a study of 14 State Medicaid plans, the estimated potential savings of increasing adherence to controllers to 40% would generate a savings of \$95 per patient per year, and increased to even more savings at each higher adherence level (19).

Previous studies addressing low medication adherence and COC in children with asthma and Medicaid insurance suggest a number of possible interventions for Maricopa County and other places with similar Medicaid insurance populations. Garbutt et al. have demonstrated that practice variation in providing preventative asthma services impacts patient outcomes, with improved outcomes observed for children receiving more tertiary preventive care (20). It is notable that the payers with the overall highest quality measures (Plans 7 and 8) had plans with additional care management strategies built into them, and that the plan with the overall highest value, as measured for the purposes of this study, had additional social and financial supports in place for children. It is also instructive to note P7 and P8 as plans which, respectively, have the highest and lowest percentage of children with persistent asthma; the higher costs for P7 likely reflect a higher risk population at baseline where 39% of children were defined as having persistent asthma in the previous year.

In turn, improving COC requires more than simply increasing the number of outpatient visits for children with asthma and Medicaid insurance (21,22) or paying providers to report outcomes and perform chart audits (23). Instead, successful interventions are characterized by active outreach to children and their families (for example, with community health care workers), and reproducible reduction in ED and hospitalizations for asthma, with an estimated return-on-investment of 1.9 (24–26). Other models of reaching out to children include programs designed to enhance medication adherence at the time of hospital discharge (27), ED-related interventions intended to influence long-term outcomes (28), and mobile asthma health care units (29). Moreover, programs directed at children who live in geographic asthma hotspots (and in our study are at least in part the result of a 1.5–2x higher prevalence of asthma compared to other zip codes in the county) may have the highest impact on county-level asthma health. Interestingly, the State of Arizona's Medicaid Program had performed a state-wide, contractor-wide performance evaluation and improvement project focused on improving asthma care for children between the years 2008 and 2012. In that project, the Medicaid agency, in collaboration with its

contracted health plans, undertook a number of interventions including review of pharmacy reports to guide outreach and education to providers and enrollees, as well as provision of general education for providers, parents, foster caregivers and Child Protective Services, and specialists on asthma control using national asthma treatment guidelines. While the methods used in the state-wide project for measuring the quality of asthma care differ slightly from the current study, there are some similarities in findings across the two studies and our latest results demonstrate that continued efforts will be needed to achieve optimal outcomes in this vulnerable population (30).

There are limitations when applying our findings to developing an interventional program that includes payers. First, the variation by health insurance payer may be occurring for many different reasons. Enrollment into insurance plans is not randomized; therefore, unmeasured confounding is a risk when comparing across plans. For example, specific groups (e.g., children with developmental disabilities or foster children) are over-represented in P7 and P8, and therefore may introduce confounding when comparing across plans. P7's asthma programs were actually managed under contract by the same plans known as P1, P2, and P5. However, P7 did have a non-clinical case management program provided by the State. While these case managers were not known to have focused on asthma, they did provide general support for patients and their families and the P7 includes a benefit that included long-term supports and services that was not available to the patients enrolled in the other plans in this study (Personal communication with quality managers, Charlton Wilson). P8 participated in the same programs as other plans. Their medical director at the time shared that P8 used an asthma care coordinator who had quarterly reports on members with chronic asthma to determine the asthma medication gaps in care. They contacted the custodial guardians and primary care provider to close gaps in care using template faxes and other standardized communications. They also used newsletter articles (member/caregiver and provider) as methods to educate their patients (Charlton Wilson, Personal communication with Dr Sue Stephens, retired medical director). This strategy was quantitatively and qualitatively the same as the other plans. However, the outreach to a custodial parent was different as this was a plan for children in a foster home (Personal opinion, Charlton Wilson).

Second, the impact of geographical location of children's homes could be related to environmental exposures, socioeconomic status, or other unmeasured risk factors. Our data suggest that the increased health care utilization in geographic hotspots is driven primarily by increased overall asthma prevalence rather than increased

per child utilization. Third, the influence on care from the healthcare delivery system is difficult to measure in our dataset (and in most cases in Maricopa County, independent of payer), other than for hospitalization and ED care which have a clearly associated “health system” assigned in CHiR. Without being able to control for healthcare delivery system (broadly or specifically), we have less certainty about the overall relative contribution of payer to the variability in outcomes. For example, if a high proportion of a payer’s population sought care at a lower quality healthcare system, then the system may be the dominant explanation for the outcome variability. It should be noted, however, that payers may be able to influence the systems they contract for patient care and select higher quality providers, assuming a reliable system to identify such high quality providers. Payers may also influence healthcare delivery by deploying new models of payments that encourage tertiary prevention by providers and incentivize new models of care that reduce hospitalizations, ED visits, and even un-necessary physician visits.

Conclusions

Quality and costs vary among children with different Medicaid insurance plans in Maricopa County, with overall quality for all payers falling short of goals. We identified the highest individual-level variation for asthma medication costs and also found significant variation by health plan for a measure of appropriate asthma medication use (the AMR). These findings suggest that a focus on appropriate medication use for asthma may help reduce variation, improve outcomes, and increase healthcare value for children in the US with Medicaid insurance.

Declaration of interest

The authors do not have any conflicts of interest to report related to the content of this article.

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