



THE Children's
Health FUND

Testimony before the New York State Departments of Health and Insurance

Partnership for Coverage Public Hearing
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Good Morning my name is Deirdre Byrne, Director of Policy for The Children's Health Fund (CHF). The Children's Health Fund is committed to providing health care to the nation's most medically underserved children and their families through the development and support of innovative primary care medical programs, response to public health crises, and the promotion of guaranteed access to appropriate health care for all children.

Our comprehensive programs serve homeless families in the New York City shelter system; low-income, housed families at our community health center in the South Bronx; and school children through our Harlem Children's Health Project located within the charter school of the Harlem Children's Zone. Since its inception in 1987 by singer/song writer Paul Simon and pediatrician and child advocate Dr. Irwin Redlener, CHF has grown to support twenty-one programs nationwide. Each program faces and overcomes unique challenges with their patient populations due to access to care issues, not the least of which is health insurance coverage, which varies greatly from state to state.

I appreciate the opportunity to present testimony at this hearing today and thank you for soliciting input from stakeholders throughout New York as you seek to expand coverage and improve health outcomes for all New Yorkers.

Health Insurance - Key to a Medical Home

Health insurance is a vital first step for families and children accessing the health care system and public programs including Child Health Plus and Medicaid have helped

insure millions of children and therefore access care.¹ Children with health insurance are

¹ Duderstadt, Karen G., et al, *The Impact of Public Insurance Expansions on Children's Access and Use of Care*, Pediatrics, Vol 118 No.4 October 4, 2006, pp. 1676-1682.

more likely to have regular doctor visits, current immunizations and, in general, are in better health than uninsured children.² Children who are healthy are more likely to be successful in school and successful in life. There is a family connection in insurance status as children whose parents are insured are more likely to have health insurance themselves.³

We are pleased that Governor Spitzer has prioritized children in his first year in office and plans to expand insurance to all children in the state. We stand in disbelief with him that the Department of Health and Human Services struck down New York's waiver application to cover children in families who make up to 400 percent of the federal poverty level, among other improvements.

CHF supports Governor Spitzer's efforts to simplify enrollment procedures for Family Health Plus and expand income eligibility for Child Health Plus as a way to reach more uninsured children in our state. Currently, there are 400,000 children uninsured in New York State. With a Child Health Plus participation rate of eighty-eight percent of children in families who make under 200 percent of the federal poverty level, it is clear that New York has made great efforts to reach the uninsured. Clearly, there is a disconnect between New York's plans to insure more children and the federal administration that is attempting to scale back coverage in the name of program integrity.

² Seid, Michael, *Missing Link: Connection Found Between Government Health Insurance and Better Child Health*, Rand Review, Spring 2007.

³ Sylvia Guendelman, et al, *The Effects of Child-Only Insurance Coverage and Family Coverage on Health Care Access and Use: Recent Findings among Low-Income Children in California*, Health Services Research 41 (1), 125-147, 2006.

According to a report from the Lewin Group, 287,000 children in New York State are eligible but not enrolled in Medicaid or Child Health Plus. Thanks to programs like Medicaid and Child Health Plus (CHP) almost 2 million medically underserved children in New York State have insurance coverage. New York's programs have historically served as a model for other programs across the nation including the federal State Children's Health Insurance Program in 1997. They should continue to serve as building blocks to insure more children and families throughout the state.

Concurrently, efforts should be made by state officials to meet with federal officials to clarify the intricacies and daily challenges of running such a complex insurance program for so many children and families. New York's Medicaid reputation must be salvaged before making headway into expansion.

In order to maximize enrollment in these vital programs, we suggest the Department of Insurance and Department of Health explore:

- Continuous health insurance coverage under Medicaid and Child Health Plus with efforts made to ease the renewal process;
- Streamlined enrollment, including options to enroll children if their parent has applied for other public programs such as WIC or Food Stamps;
- Further investment in facilitated enrollment professionals; and
- Parent-children linkages, as studies have shown that when a parent is insured, their child is more likely to be insured and have improved access to regular care.

The Medical Home

CHF's New York programs see children from all walks of life, from families who have spent up to a year in a New York City shelter, to street kids (adolescents living a transient lifestyle on the city streets), to children who are housed but whose access to care is tenuous. These children have great needs, but our unique primary care programs manage to bridge the gap between them and the health care system by providing care in the medical home model, as recommended by the American Academy of Pediatrics: care that is accessible, continuous, coordinated, culturally sensitive, and timely. Coordinated care is especially important for children with chronic diseases, including asthma and diabetes. CHF's Referral Management Initiative addresses the logistics of access to specialty care for patients, including transportation and appointment management.

We urge you to consider the medical home model when you form primary care standards and quality care initiatives. Comprehensive pediatric primary care drives down visits to emergency rooms by providing patients with action plans for managing their children's chronic care, such as correctly identifying asthma triggers and managing care before it warrants emergency room care attention.

Cost Savings

We know that the Department of Insurance and the Department of Health are working to understand why New York ranks so high in spending, yet low on quality of care standards. However, when considering the Medicaid program and children, it is important to realize that New York State ranks first in Medicaid spending for the elderly

and disabled of all fifty states.⁴ Spending for children is in the middle of the pack: including both state and federal payments, it costs \$1,869 to insure a child in New York through Medicaid. When looking for cost savings, it is important to realize that insuring children is the most economically advantageous option for the state.

Chronic conditions are known drivers of cost in health care. Asthma and obesity are two chronic conditions that are increasing exponentially in younger populations. CHF has developed unique programs to address the high incidence of asthma and obesity in our patient populations.

Asthma

In order to address the high rates of asthma in our patient population CHF established the Childhood Asthma Initiative (CAI) in 1997 as an effective and replicable model of asthma care that serves homeless and poor, medically underserved children in New York City. The program was replicated in Washington DC in 2004. By incorporating best practices, National Institutes of Health - National Heart Lung and Blood Institute's (NHLBI) Guidelines for the Diagnosis and Management of Asthma into primary care visits, CAI's model has reduced asthma severity and hospitalization rates. CAI's team-centered approach includes clinical care, community education and mental health services. The goals of the initiative are to reduce asthma severity, prevent emergency room and in-patient hospital use to the extent possible, and improve the lives of homeless and poor children with asthma.

⁴ The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2007.

The outcomes of the childhood asthma initiative are positive, with a reduction in emergency room use by a subset of patients from 53% to 20%, hospitalizations reduced from 18% to 3%, persistent asthma reduced from 75% to 59%, and moderate-severe asthma reduced from 49% to 39%. Based on these clinical outcomes, CHF estimates that delivery of guidelines-based asthma assessment and treatment in pediatric primary care may save up to \$2500 per child with asthma per year. These savings are primarily achieved in reduced emergency room utilization.⁵

We recommend that the state of New York look to evidence based models, such as the CHF Childhood Asthma Initiative, to address chronic diseases, as there is an opportunity realize savings in the health care system and improve the medical care and quality of life for patients.

Obesity

Another chronic condition, obesity and overweight, is becoming a swelling tide of co-morbidities, including heart disease and diabetes, that are directly related to obesity and overweight. For the first time in decades, the life expectancy of today's children will be lower than that of their parents, if current trends persist.⁶

⁵ The Children's Health Fund. Benefits of Best Practice: Asthma Care for High-Risk Children. 2006. Internet: <http://www.childrenshealthfund.org/publications/pubs/AsthmaWP1206.pdf>

⁶ Olshansky SJ, Passaro DJ, Hershow RC, Layden J, Carnes BA, Brody J, Hayflick L, Butler RN, Allison DB, and Ludwig DS, "A Potential Decline in Life Expectancy in the United States in the 21st Century," *New England Journal of Medicine*, 352:11, 1138-1145.

To help combat this issue, CHF and the Community Pediatrics Program of the Children's Hospital at Montefiore created the Starting Right Initiative in 2001. This program is designed to create a new model of care for medically underserved pediatric populations, and increase awareness of pediatric overweight and its potential health consequences, including Type 2 diabetes. The Starting Right program's family-focused primary care and nutrition services provide much needed quality care for this high risk population. If we invest the time and energy in tackling pediatric obesity, there is hope that the rates of co-morbidities will decline. One way to ensure this is to provide nutritional counseling and authorize Medicaid reimbursement for those services. This is achieved by making overweight or obesity a billing diagnosis. Currently, interventions for overweight and obesity cannot be reimbursed until they are considered secondary to preventable chronic conditions like diabetes or hypertension. While that it not too late for intervention, it is all the more difficult to reverse.

CHF is currently analyzing outcome data from our family-centered clinical nutrition program. Preliminary data show clinical changes that may be directly attributed to ongoing nutrition counseling sessions for obese children and their families. These changes include the cessation of a long-standing pattern of weight gain, weight loss, measurable reduction in the degree of obesity, and lifestyle changes consistent with improved long-term health outcomes including better diet and increased physical activity. CHF strongly urges the State Department of Health to accept "pediatric obesity" (Body Mass Index at or above the 95th percentile) as a diagnosis for which clinical nutrition services may be reimbursed by Medicaid and SCHIP. There is reason to believe that this low-cost service may prevent later and far more costly health problems.

SSI Beneficiaries

As the state moves forward in seeking health care cost savings as could be achieved through managed care plans, I would like to talk about a certain population that could mistakenly be targeted for savings, SSI beneficiaries. The current federal definition of childhood “disability” to establish eligibility for Social Security benefits (SSI-D) is extremely stringent. The child must have “a medically determinable physical or mental impairment which results in marked and severe functional limitations; and can be expected to result in death; or has lasted or can be expected to last for a continuous period of not less than 12 months.”⁷ SSI benefits are further limited by the requirement for income means testing. The program as restructured by the federal government only serves children in poor or low income families who have special health care needs, defined as a severe disability associated with a diagnosed medical condition.

This is a group of children who are known to be high users of health care. Even with health insurance, the families of children with special health care needs experience significant health-related financial burden, which is most significant for the poorest families.⁸ For this reason, they have been, appropriately, carved out of Medicaid managed care. The “caps” that managed care organizations typically apply limiting the number of reimbursable therapy services are unrealistic and clinically contraindicated for children who meet the disability threshold for SSI eligibility. There is little question that families would end up absorbing still more out of pocket expenses if the managed care carve-out

⁷ US Social Security Administration. “What Does “Disabled Mean for a Child?” Internet: <http://www.socialsecurity.gov/ssi/text-eligibility-ussi.htm#disabled-child>

⁸ Paul W. Newacheck and Sue E. Kim. A national profile of health care utilization and expenditures for children with special health care needs. 2005. *Archives of Pediatrics and Adolescent Medicine*, 159, 10-17.

were to be discontinued. Their cost of care could also be problematic to the managed care organization, and this could potentially be passed along to members as increased cost of insurance. These are unacceptable outcomes and further indicators that the managed care carve-out for SSI recipient children should remain in place.

I would like to make an addition point about potential changes in health care financing for children with disabilities. CHF is strenuously opposed to the change in federal rules for Medicaid reimbursement to states of therapy services delivered in non-medical settings proposed by the federal Centers for Medicaid and Medicare Services (CMS). Delivery of physical, occupational, and speech-language therapy in home, community and school settings is consistent with state level compliance with the Individuals with Disabilities Education Act. New York, like all other states, relies on Medicaid reimbursement to partially offset the costs of Early Intervention, preschool special education, and special education services. It is completely inappropriate for the federal government to penalize states for compliance with federal law.

Further, the distinction CMS proposes to make between “habilitation” and “rehabilitation” services is discriminatory against infants with disabilities including genetic syndromes, birth defects, and complications of extreme prematurity. This distinction may violate the Americans with Disabilities Act. CHF would be delighted to work with New York State in opposing this unacceptable suggested change in federal rule making.

State Models - Caution

We know that states like Massachusetts are moving forward with universal coverage and New York should be mindful of the progress of that state and others who have made strides in health insurance coverage. There are cautionary lessons to be learned from other states as well. West Virginia has experimented with personal responsibility to the detriment of the practice of medicine in the state by requiring Medicaid beneficiaries to swear that they, and their children, will follow a prescribed regime of care in order to receive an enhanced benefit package.⁹ If the beneficiary, child or adult, does not adhere to that regime, ie, misses an appointment, they risk losing their enhanced coverage and receiving a scaled back benchmark plan. The crux of this situation for physicians, is that the state expects them to document families and children who do not adhere to the requirements, risking their insurance coverage in the process. We do not support this form of personal responsibility nor bare-bones coverage policies.

⁹ The state plan amendment can be viewed here:
http://www.wvdhhr.org/bms/oAdministration/bms_admin_WV_SPA06-02_20060503.pdf

Conclusion

Thank you for holding these hearings throughout the state. New York has made great strides to address the challenge of health insurance and undoubtedly will move forward to address the remaining two million uninsured children and adults throughout the state.

We at the Children's Health Fund look forward to the outcome of these hearings and wish to be a resource to both the Department of Health and Department of Insurance in the future.