National Association of
Children's Hospitals

Champions for Children's Health

N · A · C · H

September 7, 2011

Honorable Patty Murray
Co-Chair
Joint Select Committee on
Deficit Reduction
448 Russell Senate Office Building
Washington, DC 20510

Honorable Jeb Hensarling
Co-Chair
Joint Select Committee on
Deficit Reduction
129 Cannon House Office Building
Washington, DC 20515

Dear Chairmen Murray and Hensarling:

As the Joint Select Committee on Deficit Reduction pursues proposals to reduce our nation's debt, the National Association of Children's Hospitals (N.A.C.H.) respectfully urges your consideration of a broad and balanced range of measures that would support economic growth and reduce the overall federal deficit. We also ask for your specific consideration of the impact of any measures that you may propose upon our country's children. The members of our Association are specifically concerned about Medicaid and the Children's Hospitals Graduate Medical Education Program (CHGME). Both are essential and vital investments in the future of health care for all children and children's hospitals.

Medicaid

Medicaid is the largest health insurer for American children, covering more than one in three kids, and its role in children's coverage is growing. For example, according the Healthcare Cost and Utilization Project (HCUP), private insurance's coverage of hospital stays among children declined from 55 percent in 2000 to 45 percent in 2009, while Medicaid's coverage for the same stays increased from 37 percent to 47 percent. This trend has been driven in part by the economic downturn, which has led to a loss of private insurance, and illustrates Medicaid's singular role in providing a health care safety net for children and the countercyclical budget pressure it faces during difficult economic times.

Nearly every state has cut Medicaid program budgets over the past three years of economic recession and continuing high unemployment, according to the National Conference on State Legislatures, with more cuts anticipated. For example, according to the National Association of State Budget Officers, states' FY 2012 Medicaid budgets are expected to decline by 2.9 percent.

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These reductions have focused on reducing provider payments, imposing pharmacy controls, and eliminating optional benefits. At least two-thirds of the states cut provider payments in FY 2010 alone. While such cuts may reduce state and federal Medicaid spending in the short term, they will not change the trajectory of the rate of growth of health care spending.

They also exacerbate Medicaid's already low provider payments, raise barriers to access to care, and increase uncompensated care, which can raise costs in the long term. On average, Medicaid reimburses children's hospitals only 77 percent of the cost of care provided, including disproportionate share hospital (DSH) adjustments. A recent study that appeared in the New England Journal of Medicine found that children with Medicaid coverage are significantly more likely to be denied an appointment than privately insured children. Further cuts would only exacerbate access issues that already exist.

Much of the growth in Medicaid spending has been due to enrollment growth. Children's health care costs have not been the major cost drivers in Medicaid, despite this growth. Although children, including children with disabilities, represent 50 percent of Medicaid enrollees, they only account for 25 percent of Medicaid spending. Per capita Medicaid spending for adults and the elderly is more than twice and nearly five times higher, respectively, than for children.

Given these trends and program dynamics, N.A.C.H. urges the Committee to pursue policies with respect to Medicaid that would help to control the growth of clinical costs through improvements in the quality and integration of health care, rather than policies and spending cuts that simply shift costs to states, patients, providers and other payors. It is essential that children's health services do not disproportionally bear the burden of Medicaid spending reductions.

Children's hospitals, which account for less than 5 percent of the nation's hospitals, provide 47 percent of all inpatient hospital care for children covered by Medicaid and almost all hospital care for children with complex conditions. Children's hospitals are already pursuing innovative care models and other improvements in the quality and efficiency of the care they provide. We support policies that encourage wider adoption of models of integrated care and look forward to the opportunity to work with you to advance these efforts in Medicaid and to find solutions that can protect children and reduce the growth rate of health costs. For example:

- Medical Home Programs for Medically Complex Children: Several children's hospitals already have medical home programs that coordinate and manage primary and specialty health care for children with long-term, severe chronic conditions. The programs have documented higher quality of care, reduced costs, and improved outcomes and quality of life for enrolled children and their families. A recent analysis of one such program at Arkansas Children's Hospital found state Medicaid savings of $1179 per child per month. Currently, these programs are not reimbursed for many services that are

essential in achieving these savings. Payment reform that would more adequately reflect these services would allow more programs to be established and existing programs to grow, benefiting children and providing state and federal Medicaid savings.

- Pediatric Accountable Care Organization (ACO) Demonstrations: The ACA included authorization of a pediatric accountable care organization demonstration. Although funds were not specifically provided for the demonstration, children's providers, including children's hospitals, have been pursuing pediatric ACOs and similar demonstrations, such as medical homes for children with complex chronic conditions noted above, through CMS and the Center for Medicare and Medicaid Innovations. Children's hospitals generally employ or have close affiliations with specialty and primary care pediatric physicians and are uniquely positioned to demonstrate that payment mechanisms and financial incentives that support coordination and integration of care can both reduce costs and improve quality outcomes.

- Quality Transformation: The National Association of Children's Hospitals and Related Institutions operates the largest quality improvement network in pediatrics – the Quality Transformation Network (QTN). The QTN is a large and growing group of children's hospitals combining forces to improve care and outcomes for high-impact clinical issues. For example, the QTN's efforts to reduce central line associated blood stream infections has saved 338 lives and over $100 million dollars over a five years. Expanding this effort across hospitals to reach more children would increase already significant savings. There are many other opportunities to expand QTN savings and to achieve additions savings through of other shared efforts and provider collaboratives.

Children's Hospitals Graduate Medical Education

As the Committee makes difficult decisions about discretionary programs, we urge your careful consideration of programs that are essential to the health care infrastructure and workforce of our country. The CHGME program is a vital investment in the future health care workforce for our children and in ensuring children's access to health care. We respectfully urge the Committee to protect the stable funding that the CHGME program has had over the past decade.

Congress enacted CHGME in late 1999 with broad bipartisan support to provide freestanding children's hospitals with the same federal GME funding that Medicare GME provides to other teaching hospitals. The 56 freestanding children's hospitals receiving CHGME train 40 percent of all pediatricians and 43 percent of all pediatric specialists. According to the Health Resources and Services Administration (HRSA), the hospitals trained more than 5,600 full-time equivalent residents in 2009.

CHGME has been a great success. In the 1990s, prior to the enactment of CHGME, the number of pediatric subspecialty residents in children's hospital residency programs had declined slightly. The Future of Pediatric Education Task Force reported that the lack of federal GME

funding for freestanding children's hospitals was a major threat to the future adequacy of the pediatric workforce. CHGME has enabled children's hospitals to reverse this decline and increase their training capacity by 35 percent, in response to local, state and national needs. However, even with the growth in these programs, our nation continues to face a shortage of pediatric specialty providers, as can be seen in the long wait times many parents face in trying to access needed care for their children. In children's hospitals, the prevailing benchmark for scheduling an appointment with a specialist is that it be scheduled within two weeks. But children's hospitals, which tend to have the greatest concentration of pediatric specialists, report that for certain specialties, wait times can exceed 2-3 months.

The program has delivered great value, ensuring access to care for children throughout the country, especially in underserved areas. CHGME has enabled the hospitals to expand and strengthen their teaching programs, meeting the needs of the children in underserved communities. The programs are providing residents with enhanced experiences in community-based primary care in underserved areas and increasing children's access to care. According to HRSA[1], the program improves access to health care by not only ensuring an adequate supply of pediatric providers, but also by expanding the capacity of the health care safety net as freestanding children's hospitals care for underserved children in both inpatient and outpatient settings.

The program met a critical need when it was enacted and, in the absence of broader GME reform, continues to be as needed today. CHGME addressed an unintended but serious inequity in federal GME funding. The freestanding children's hospitals were essentially left out of a GME financing system that had come to depend on Medicare, as other payers were increasingly unwilling to pay for the costs of teaching, and were facing increasing financial pressures in their ability to sustain their teaching programs without sacrificing clinical care. Prior to enactment of CHGME, children's teaching hospitals, on average, received less than 0.5 percent of the federal support for training that adult teaching hospitals received through Medicare. Even with CHGME, there is still a significant equity gap between adult teaching hospitals and children's teaching hospitals. In FY 2011, on a per-resident basis, children's hospitals will receive only 62.1 percent of the support that Medicare GME provides adult teaching hospitals.

As you know, the Obama administration proposed the elimination of the CHGME program in its FY2012 budget. The children's hospitals cannot absorb the loss of CHGME funding without reducing training and services. Other sources of support, such as Medicaid GME or competitive grant programs, cannot fill the void. Most state Medicaid programs pay GME under fee-for-service, not managed care; and these funds are not targeted towards children's hospitals. Some states do not provide GME funding at all.

Competitive grants, including the primary care residency expansion (PCRE) grants funded in the ACA, can provide valuable funds to expand the primary care workforce. However, these

[1] HRSA Online Performance Index accompanying FY 2012 budget submission: http://www.hrsa.gov/about/budget/performanceappendix2012.pdf

funds are generally of limited duration and available to only a limited number of teaching institutions. For example, five children's hospitals were among the 82 PCRE grantees, but these grants provided expanded funding to their existing CHGME funding which would be useless if that underlying funding were eliminated.

The CHGME program is vital to increasing access for all children to needed medical services. The program has a long history of bipartisan support and children's hospitals are currently working with Congress to reauthorize and fund this essential program. Earlier this year the House Energy and Commerce Committee unanimously favorably reported legislation to reauthorize the program, and we expect the Senate H.E.L.P. Committee to mark up a similar bipartisan bill in September.

In conclusion, we urge the Joint Committee to weigh carefully the potential impact proposed recommendations would have on children's health care, especially including proposed changes to the Medicaid and CHGME programs. As longstanding leaders in health care delivery and innovation, children's hospitals have much to contribute as the Joint Committee considers streamlining federal health programs and generating savings through improved care. We recognize the difficult task the Joint Committee faces and would welcome further discussion on the ideas we have presented above. We appreciate the continued opportunity to work with Congress and the administration as we each strive to lower costs and improve health care quality and delivery for America's children.

Sincerely,

Lawrence A. McAndrews

Lawrence A. McAndrews
President and Chief Executive Officer
National Association of Children's Hospitals

CC: Honorable Max Baucus
Honorable Xavier Becerra
Honorable Dave Camp
Honorable James Clyburn
Honorable John Kerry
Honorable Jon Kyl
Honorable Robert Portman
Honorable Pat Toomey
Honorable Fred Upton
Honorable Chris Van Hollen