

# Children’s Healthy Development: Current Options within Congressional Proposals

Revised July 28, 2009



Children’s healthy development is dependent upon a child health system that ensures:

- a regular source of health care;
- coverage for primary, preventive, and developmental care as well as disease management health services;
- quality child health services that are coordinated with other systems supporting children’s development; and
- population-level child health prevention and promotion activities that create a healthy environment for children.

This side-by-side comparison of the Senate Finance Committee’s “Expanding Coverage Options Paper,” the Senate HELP Committee’s Chairman’s Mark-Up, and the House Tri-Committee Discussion Draft describes the specific features in those documents that address:

1. A child health benefit standard and its primary, preventive, and developmental health care coverage
2. Specific Medicaid and CHIP reimbursement and coverage provisions that support such primary, preventive, and developmental services; and
3. Pilot and demonstration programs and prevention initiatives to strengthen the provision of child health care.

It then provides comments regarding the provisions and actions that might build upon and strengthen the current proposals.

Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	Comments
<b>Child Health Benefit Standard</b>			
<p>All health insurance plans in the non-group and small employer market would be required to cover preventive and primary care and mental health and substance abuse services (page 7).</p>	<p>Sec 2707 (page 12) – Group health plan or insurer offering individual or group coverage shall provide a payment structure with incentives for the implementation of case management care coordination that includes the use of a medical home model.</p> <p>Sec 2708 (page 15) – Plans shall provide coverage for and not impose cost-sharing requirements on:</p> <p>(1) items that have in effect a rating of A or B in the current recommendations of the United States Preventive Task Force</p> <p>(2) immunizations that have in effect a recommendation from Advisory Committee on Immunization Practices</p> <p>(3) with respect to children, preventive care and screenings provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).</p>	<p>Section 121 (page 22) – Minimum services to be covered under qualified health plans must include:</p> <ul style="list-style-type: none"> <li>• Rehabilitative and habilitative services</li> <li>• Mental health and substance use disorder services</li> <li>• Preventive services including A and B grade services from Preventive Services Task Force and vaccines recommended for use by Director of the Centers for Disease Control and Prevention</li> <li>• Maternity benefits</li> <li>• Well baby and well child care and oral health, vision, and hearing services, equipment, and supplies for at least children under 21 years of age.</li> </ul> <p>No cost-sharing for preventive services and well baby and well child care shall be imposed.</p> <p style="text-align: center;">• • • • •</p> <p>Section 121. Approved amendment in Education and Labor by Scott-VA changes description of covered services for children to read: “Well baby and well child care and EPSDT services at least for children under 21 years of age.”</p>	<p>It is important to establish a child health benefit standard for all coverage (public and private) based upon a child’s health needs. This starts with providing comprehensive primary health care.</p> <p>The comprehensive HRSA guidelines (e.g. Bright Futures) provide evidenced-informed practices that provide a comprehensive and developmental approach to well-child care that should be part of all children’s health coverage. This language should be included in the final version.</p> <p>The prohibition against cost sharing is important to avoiding underutilization of primary and preventive health services, and should be included in the final version.</p> <p>Mental health, substance use disorder services, oral health, vision, and hearing services should be included in coverage systems for children under the health exchange. Establishing EPSDT as part of required coverage for children under the exchange plan does this and ensures follow-up for “medically necessary services.”</p>

Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	Comments
<b>Specific Medicaid and CHIP Reimbursement and Coverage Provisions</b>			
<i>1. Required Coverage of Preventive Services</i>			
<p>(Page 46) Clarify the definition of screening and preventive services in Medicaid as including services rated A or B by the United States Preventive Services Task Force and immunizations recommended by the Advisory Committee on Immunization Practices, with incentive of additional 1% FMAP for these services if all are covered by state Medicaid plan. Requires comprehensive tobacco cessation services for pregnant women without cost sharing.</p> <p>(Page 48) Remove or limit cost-sharing for clinical preventive services rated A or B and permit states to design a proposal and apply for funds to provide refunds or other incentives to Medicaid enrollees who successfully complete certain behavior modification programs, such as smoking cessation or weight loss.</p>	Does not address Medicaid.	<p>Section 1811 (page 672) – mandates state coverage of preventive services under Medicaid described in Section 2708 (A and B clinical preventive services and immunizations).</p> <p>Section 1812 (page 675) – provides tobacco cessation counseling for pregnant women.</p>	<p>These clarifications to Medicaid coverage provide further detail to states on mandatory screening and preventive services, but do not cover the full range of evidence-informed practices nor substitute for EPSDT, which implicitly should cover these services (and already does so in a number of states). They should be viewed as part of minimum enumerated standards but not inclusive of all prevention services.</p>
<i>2. Adequacy of Medicaid Reimbursement for Primary Care and Other Medicaid Services</i>			
<p>(Page 16) Could require that all Medicaid payments to providers do not fall below a given percent (e.g. 80%) of Medicare reimbursement rates for the same or similar services.</p>	Does not address Medicaid.	<p>Section 1821 (page 689) – provides Medicaid payment for primary care services to at least at 80% of the payment rate applicable under Medicare in 2010 going to 100% in 2012, with increases coming at a 100% FMAP rate.</p>	<p>While all Medicaid services need to be adequately reimbursed, this is particularly important for primary and preventive care services. There are very substantial variations among states in Medicaid payment rates for primary care office visits and preventive visits (e.g. EPSDT). Moving to a Medicare payment standard would improve rates and would be an important step, although there is no EPSDT equivalent within Medicare. It is particularly important to provide adequate reimbursement for primary and preventive care, or these visits will not be sufficiently thorough in their screening and referral.</p> <p>In providing such reimbursement under this provision, there should be both expectations and accountability for what occurs in a primary and preventive office care visits.</p>

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<b>3. Other Reimbursement Provisions Regarding Providers</b>			
(Page 24) Optometrists, podiatrists, and free-standing birthing centers given provider status.	Does not address Medicaid reimbursement.	<p>Section 1303 (page 401) – provides increased reimbursement rate for primary care services.</p> <p>Section 1813 (page 676) – provides optional coverage for nurse home visitation and an enhanced FMAP.</p> <p>Section 1815 (page 677) – clarifies payment eligibility for a school health service.</p> <p>Section 1824 (page 694) – provides optional coverage for free-standing birth centers.</p>	These provide further clarifications on both optional and mandatory services under Medicaid, although the EPSDT provision within Medicaid, in effect, should ensure coverage of these for children in terms of their medical necessity. In some instances, The Centers for Medicaid and Medicare Services can provide guidance to states on preferred state programs that use Medicaid to cover such services.
<b>Pilot and Demonstration Programs and Prevention Initiatives</b>			
<b>1. General Prevention and Wellness</b>			
(Page 47) Establish prevention or wellness competitive grant program to improve health and wellness outcomes, including three options: (1) promotion of team-based care, (2) service integration and delivery reform plans, and (3) innovations to meet goals, with evaluation plan. The focus would be on low-income families, with DHHS identifying best practices and states required to develop plans to better integrate care.	Section 302 (page 351) – Establishes a Public Health and Prevention Trust Fund with \$10 billion in funding for each of the years 2010 through 2019, for increasing funding for programs offered under the Public Health Services Act for prevention, wellness, and public health activities, including research and health screenings.	<p>Section 3111 (page 796) – Establishes a Prevention and Wellness Trust, with \$2.4 billion in 2010 going to \$3.5 billion in 2014 for carrying out a set of activities:</p> <ul style="list-style-type: none"> <li>• Prevention task forces (\$30 million per year)</li> <li>• Prevention and wellness research (\$100 to \$250 million per year).</li> <li>• Delivery of community-based and wellness services (\$1.1 billion to \$1.6 billion per year, see section 3151)</li> <li>• Core public health infrastructure and activities for state and local health departments (\$800 million to \$1.3 billion per year)</li> <li>• Core public health infrastructure and activities for CDC (\$350 million per year).</li> </ul> <p>Section 3151 (page 812) – Establishes the community-based prevention and wellness services grant program to provide evidenced-based, community-based wellness and prevention services in priority areas or to plan for such services. At least half of all funding shall be devoted to addressing health disparities. Health empowerment zones are defined as a concept for possible funding as areas where multiple prevention activities are being developed.</p>	All these prevention and wellness initiatives are broadly written, and could include both clinical and population-based efforts specifically focused upon children's healthy development, although they would not necessarily have that focus. To ensure that there is an emphasis upon improving the quality and effectiveness of primary, preventive, and developmental child health services, there should be some directive to do so (see comments under 2. and 3., below).

Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	Comments
<i>2. Medical Homes and Community Health Teams</i>			
No specific provisions.	Section 212 (page 259) -- Establishes a multi-disciplinary community health team grant program through a state or state-designated entity to support primary care practices to incorporate prevention initiatives and patient education and care management resources into the delivery of care and integrate with community-based prevention and treatment resources. Community health teams are designed to be multi-disciplinary in nature and develop comprehensive care plans. Children are explicitly included as patients, with priority given to patients with chronic diseases and conditions. Explicit mention also is made to establishing a coordinated system of early identification and referral for children at risk of developmental and behavioral problems such and to addressing transitional health care needs in transitions from adolescence to adulthood.	Section 1822 (page 691) -- Establishes a five year medical home demonstration project for high need Medicaid beneficiaries to be appropriately coordinated with the medical home pilot in Section 302 for the Medicare population and increases the matching rate for administrative costs to 90% for the first two years and 75% for the next three years, with costs not to exceed \$1.25 billion over the five years. Section 302 (page 384) provides the language defining a medical home, largely in reference to Medicare.	Both the community health team and the medical home demonstrations include children, with a primary emphasis upon children with chronic health conditions. They are based upon providing comprehensive primary care, linked to other needed medical services. While children are included, however, the language could be strengthened in terms of its focus upon children's health needs, in particular to addressing social determinants of health and coordinating with other educational and human services that children use. There also could be some emphasis upon addressing children at risk of experiencing special health care needs as well as children with chronic conditions, although this could be covered in other demonstration programs (see comments under 3., below).

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<b>3. Other Demonstrations Programs</b>			
<p>No additional provisions.</p>	<p>Section 322 (page 366) – Amends the school-based health center definition and purpose and provides for grant awards to SBHC as determined by the Secretary.</p> <p>Section 399GG (page 376) – Establishes a five-year oral health care public education campaign, with explicit reference made to children.</p> <p>Section 314 (page 378) – Extends dental sealant school-based sealant program grant to all fifty states.</p> <p>Section 321 (page 382) – Establishes community transformation grants to states and local governments and community-based organizations to reduce chronic disease rates, health disparities, and develop a stronger evidence base of effective preventive programming. Activities specifically referenced include creating healthier school environments and developing programs targeting a variety of age levels to increase access to nutrition, physical activity and smoking cessation, enhancing safety in a community, or addressing any chronic disease priority. Includes under measures the community-specific data from the Behavioral Risk Factor Surveillance Survey [which include social determinants of child health].</p> <p>Section 324 (page 394) – creates demonstration grant program for states to improve the provision of recommended immunizations for children, adolescents, and adults through use of evidenced-based, population-based interventions for high-risk populations.</p> <p>Section 399S (page 541) – Establishes grants to promote healthy behaviors in medically underserved areas through community health workers. Explicit reference is provided to providing outreach for enrollment in Medicaid and CHIP.</p> <p>Note: The Senate HELP mark-up also includes a specific wellness program for “Healthy Aging: Living Well” (targeting the 55-64 population) and for Workplace Activities and School-Based Activities, but there is nothing specific for prevention and healthy development for young children (birth to school entry).</p>	<p>Section 1704 (page 643) – establishes voluntary nurse home visiting program for families with young children and expectant families for state grants, requiring a maintenance of effort and coordinating with any programs funded under Medicaid or CHIP. Programs shall be evidenced-based, employ well-trained and competent staff, and provide linkages to other community programs and services. The grant program is funded at \$150 million in 2010, increasing incrementally to \$550 million in 2014.</p> <p style="text-align: center;">♦ ♦ ♦ ♦ ♦</p> <p>Section 2401. Approved amendment in Energy and Commerce by McNerney-CA and DeGette-CO adds a fifth quality improvement initiative to be implemented under the Implementation of Best Practices in the Delivery of Health Care: (5) PEDIATRICS - Improving the provision of preventive and developmental health services, including interventions that can reduce health disparities and reduce the risk of developing chronic health-threatening conditions that affect an individual’s life course development.</p>	<p>While most of the pilots and demonstrations focus upon specific elements to developing quality primary, preventive, and developmental child health services, there is no overall systemic focus that provides federal leadership in supporting state innovation and diffusion of best practices in strengthening child primary, preventive, and developmental health care from a life course perspective, particularly for children before they reach school-age. A specific emphasis upon child health quality improvement in primary care should be incorporated into health reform.</p> <p style="text-align: center;">♦ ♦ ♦ ♦ ♦</p> <p>The amendment to Section 2401 in the House Tri-Committee bill provides this focus within the best practices section.</p>