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Children's hospitals providing a high volume of pediatric services are key to ensuring California's sick and injured children have access to high quality health care, including hospital, ambulatory, specialty, and primary care services.

California's eight private, not-for-profit, children's hospitals lose approximately $90 million each year providing outpatient services to Medi-Cal beneficiaries. Hospital outpatient rates have not been increased in more than 20 years except for court-ordered adjustments in 2001-02. Physician reimbursement also has not kept pace with increasing costs and children's hospitals report more than $65 million in hospital costs associated with physician professional fees.

Despite no corresponding increase in reimbursement, hospital costs are escalating, utilization in children's hospitals is increasing (due, in part to community hospitals closing pediatric services), and care is shifting from the inpatient setting to the outpatient.

Inadequate Medi-Cal outpatient reimbursement affects all hospitals, but there is a disproportionate impact on children's hospitals.

- Because children's hospitals provide significantly more Medi-Cal outpatient services than other hospitals (by an average ratio of 4:1), they are disproportionately affected by Medi-Cal's inadequate outpatient reimbursement.
- Similarly, due to the volume of Medi-Cal patients in children's hospitals (approximately 60 percent in aggregate), there is little opportunity for cost shifting practiced by other hospitals with a more diverse payer mix.
- Due to the above factors, children's hospitals are falling further and further behind in reimbursement of costs. The aggregate volume of Medi-Cal in children's hospitals has increased from approximately 45 percent in 1997 to almost 60 percent today. Medi-Cal outpatient losses have grown from an

average in 1997 of $2 million per children's hospital to more than $10 million today.

- For non-children's hospitals, the Medicare volume is approximately one-third. While Medicare also reimburses hospitals less than their costs, it covers a greater percentage of costs than Medi-Cal and Medicare generally includes a provider reimbursement COLA each year. Children's hospitals treat almost no Medicare patients and there is no corresponding increase in Medi-Cal provider reimbursement.

Some of the highly-specialized outpatient services provided by children's hospitals include: cardiac catheterization, echocardiology, neurology, gastroenterology, rehabilitation, treatments for spina bfida and sickle cell anemia, respiratory, pulmonology, dialysis, rheumatology, and AIDS treatments to name but a few. The children treated in children's hospitals, in need of these services, have a much higher acuity than patients treated in community hospitals.

Higher acuity patients require more resources which further exacerbates the deficient reimbursement. While Children's and UC Hospitals provide hospital care to almost 39 percent of the total pediatric patients, these hospitals treat more than 71 percent of the pediatric cancer cases, provide more than 88 percent of the state's pediatric cardiac surgeries and provide 97 percent of the pediatric organ transplants. These examples represent the significant acuity of patients treated in these hospitals which results in increased costs and utilization of resources.

One example of advances in medicine that now allows for children to be treated as outpatients is the effective, minimally invasive repair for Atrial Septal Defect - a fairly common congenital heart defect. Atrial Septal Defect is a hole in the septum or wall that typically separates the two upper chambers of the heart.

The procedure is performed by interventional catheterization in place of open heart surgery and involves placement of a tiny mesh like device (less than 1 inch in length) over the hole thereby sealing the hole. Not only is the procedure less invasive than open heart surgery, the repair is extraordinary. Instead of repairing the hole with a traditional "patch" which has the potential to develop little leaks as the child grows to adolescence and adulthood, the implant serves as a sort of frame work or foundation inside the heart wall and the heart tissue actually grows into the device and the heart heals itself.

Pediatric open heart surgery typically requires a 4-6 day hospital stay, 6-8 weeks of limited/restricted activities, a fair amount of pain, and lost school / work days for the children and their parents. The cost for open heart surgery and hospitalization is over $100,000 per case.

With the implantable device, a pediatric cardiologist with extensive additional training and certifications in interventional catheterization procedures can attach the tiny device to the end of the heart catheter tubing, artfully weave it into the atrium, insert it into the hole, expand it like a little umbrella until it seals the hole, and then remove the catheter.

For lesions that can be repaired with the implantable device, the child and family trade a 4-6 day hospital stay for one-day procedure, open chest surgery for a ¼ inch incision and a "band-aid," a lengthy recovery for a day at home and then back to school, a cost of over $100,000 per case to a cost of $47,000 per case ($11,000 to $17,000 of which is the cost of the device), and a patch for a heart that has closed the hole with it's own tissue growth. Unfortunately, Medi-Cal's outpatient fee schedule has not kept pace with either changes in treatment or with inflation/technology costs. Medi-Cal reimburses hospitals approximately $600 - $2000 for this procedure.

Another example of intensive pediatric hospital outpatient treatment is administering chemotherapy. One children's hospital incurs $300,000 in costs associated with outpatient chemotherapy every month that is un-reimbursed by Medi-Cal.

Hospital care for seriously and chronically ill children in California is concentrated at regional specialized centers. This provides better care for the children by ensuring an appropriate concentration of pediatric subspecialists. And the state's children's hospitals work cooperatively to ensure children receive the care they need.

The increased demand for care provided in the regional children's hospitals is further exacerbated by the decreasing number of pediatric services in community hospitals. As the *LA Times* reported earlier this year, in the last decade, even as the number of children has grown in the state, more than 65 hospitals have either eliminated their children's units or shut down altogether. Inpatient children's beds and corresponding pediatric outpatient services have decreased by 19 percent over the last decade.

Children's hospitals struggle to meet patient demand for services due to both physician shortages and reimbursement shortfalls. The examples provided are for routine or non-urgent care. All children's hospitals are committed to seeing patients with urgent needs as soon as possible and they all work collaboratively with each other and with the University of California in an effort to meet the health care needs of patients to the maximum extent possible.

One California children's hospital spent more than a year recruiting for two pediatric neurologists. During these vacancies, only 21 percent of patients were able to schedule appointments within the first 30 days of the referral being made.

One children's hospital's wait times for specialty clinic appointments averages 38 days. Another children's hospital has at least a four-week wait to get an outpatient appointment with the Rheumatology Department.

One hospital gastroenterology clinic has been recruiting for two additional physicians, for two years. During this time, the clinic has struggled to keep pace with demand, currently seeing only 25 percent of all new referrals within the first 30 days of being referred. The hospital's goal is see at least 70 percent of the referrals within 30 days. This means that three out of every four new referrals for children requiring

gastroenterology services must either wait more than a month to be seen at the closest regional facility, or must leave their area to been seen by a pediatric specialty provider in another area of the state.

All children's hospitals struggle to meet demands related to endocrinology. One hospital reports new patients have to wait four to six months for an initial appointment with an endocrinology specialist. Another endocrinology clinic is able to see only 49 percent of all new referrals within 30 days of receiving the referral. These situations have become particularly challenging for diabetics such that the clinics have to significantly limit the acceptance of new referrals of children presenting with Type I or Type II diabetes.

One hospital has difficulty meeting demand for outpatient genetic services, seeing only 46 percent of referrals within the first 30 days of the initial referral. Also due to reimbursement issues, the same hospital closed its dermatology clinic.

Each children's hospital on average loses more than $3 million annually on care provided to Medi-Cal beneficiaries in the emergency department alone and loses more than $1,500 on each outpatient surgery for which Medi-Cal is the payer.

Children require more frequent testing and monitoring since their condition can change from relative wellness to a critical imbalance in a very short span of time. Infants and young children have limited language skills, hindering the diagnostic and treatment processes. Similarly children have limited tolerance of painful and invasive procedures, thus procedures take longer and can involve sedation or anesthesia. Notwithstanding these facts, Medi-Cal reimburses pennies on the dollar of cost for outpatient surgery – regardless of the complexity of the case, the surgical team or the length of surgery.

Physicians and other health care professionals at children's hospitals routinely coordinate the care for pediatric patients because a seriously ill child may need to see several subspecialists to address his/her complex health needs. But there is no reimbursement provided for this coordination which only further compounds the impact of the inadequate Medi-Cal reimbursement. Within the context of a pediatric treatment plan, there must be access to all appropriate pediatric care including pediatric sub-specialists, regional pediatric programs and institutions, special care centers with multi-disciplinary teams, pediatric durable medical equipment, and other necessary care.

Children's hospitals face other cost pressures as well. These eight hospitals train future pediatricians and specialty care providers, providing graduate medical training for more than 650 full-time residents.

Children's hospitals are conducting research specific for pediatrics rather than attempting to adapt research done for adults to fit children's unique needs. The pediatric research done at children's hospitals attracts world-class pediatric physicians and scientists. Research done at children's hospitals is done with the primary goal of improving outcomes in pediatric patients. For example, Children's Hospital and Research Institute

at Oakland is in the top 10 pediatric research institutes and children's hospitals in the country for NIH funding.

A health care system that ensures access to care for California's children requires appropriate financing to support and sustain providers that promote quality care with optimal outcomes, efficiency and patient/family satisfaction.