



TESTIMONY TO THE HEALTH COMMITTEES OF THE NEW YORK STATE
ASSEMBLY AND SENATE

By Larry Levine

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Chairman Gottfried, Chairman Rivera, and members of the combined New York State Assembly and Senate Health Committees. Thank you for the opportunity to speak to you this morning about the proposed single payer healthcare legislation.

My name is Larry Levine. I'm the President and CEO of Blythedale Children's Hospital in Valhalla, New York. Blythedale is New York state's only specialty children's hospital. We combine expert medical and rehabilitative care to treat medically complex infants, children, and adolescents. 100% of our admissions come from acute children's hospitals and large academic pediatric programs. We are essentially an extension of the critical care units of these acute facilities as 65% of our referrals come from PICUs and NICUs. Despite the medical fragility and social complexity of our patients, we are proud to report that 91% are discharged home. Our average length of stay is between 6 to 8 weeks.

Key treatment areas include: ventilator weaning; acquired and traumatic brain injuries; post-acute neonatal care; complex feeding problems; pre/post medical management and rehab of organ transplant patients; pulmonary hypertension; rehab related to cardiac disease and cancer; and a variety of rare genetic syndromes and neurological conditions.

My testimony is not about ideology. It's not about my personal political opinions. It's the product of my 43 years of professional experience in healthcare, primarily with children's hospitals. I speak as an employer, providing health insurance to our staff; a negotiator, dealing extensively with commercial and Medicaid managed care plans; and as the head of a children's hospital who has spent years listening to the concerns of parents of sick children.

We all recognize that the current health care system, even in our great state of New York, is dysfunctional. We all know that our country spends the most money on healthcare as a percentage of the national GDP, yet our outcomes are not commensurate with the enormity of the expenditures.

Whether you're a patient, a doctor, a hospital, or an employer—everyone has complaints:

- Huge deductibles and enormous out-of-pocket expenses
- High premiums
- Inability to see a specialist who is out of network
- Medical care and tests that are denied or delayed
- Endless paperwork and complicated and confusing rules about accessing care, submitting claims and obtaining prior authorization

While we each may rank the problems differently, I think we can all agree that something must be done to fix this broken system. Some say that it is simply necessary to tweak our health care system, that it is solidly built upon the foundation of free market forces.

I reject that notion—because it is precisely the conflicts that arise out of free market forces that have spawned the many significant problems we have experienced for years.

Support of the existing system is based on two myths.

The first is that because 95% of New Yorkers have some form of healthcare coverage, there's no real crisis.

But there is a crisis, because that coverage too often results in denials, so that so many New Yorkers are effectively underinsured. There are crises every day. Coinsurance and deductibles force individuals and families to make gut wrenching decisions about when or even if to get care. And the delaying or forfeiting of care can lead to disastrous and tragic consequences.

Myth #2: a single-payer government sponsored health care program will lead to socialized medicine.

In 1965, there were dire predictions that Medicare would destroy our healthcare system. Even the American Medical Association, among many interest groups, strenuously lobbied against Medicare.

But they lost. And for the past 54 years, Medicare has provided millions of Americans nearly unlimited access to doctors and hospitals, with over 90% of them participating in Medicare. For people 65 and older, the threat of bankruptcy because of medical and hospital bills, which destroyed so many lives, ended.

What's the difference between Medicare and a single payer system for all? Simply that all New Yorkers would have freedom to use the doctors and hospitals of their choice. And, notably, contrary to its opponents' fears, Medicare has been an economic boom to doctors and hospitals, proving a steady and reliable source of income not realized prior to its passage. The reality is that an American ideal—freedom of choice—is actually denied by our current health insurance system, which precludes some patients from seeing doctors of their choice because they're out of network.

To narrow my focus, I want to address three problems my hospital encounters daily:

1- Reimbursement is cut off in the midst of inpatient treatment at our hospital on a determination that it is no longer medically necessary.

These determinations are based on payers' proprietary clinical guidelines for length of stay and level of care. The problem? The guidelines are completely standardized, so that while they may be appropriate for appendicitis or hip replacements, they don't consider the complex needs, complications and multiple conditions of medically fragile children. Our kids are shoehorned into guidelines that don't fit, and payment is denied for continued stays and essential services.

Why is this happening?

- a- Because the guidelines are so standardized, they ignore the fact that medically fragile kids require longer lengths of stay due to their slower pace of recovery.
- b- Those making the decisions to deny payment are usually not pediatric specialists.

For example, infants in our ventilator weaning program who work hard to breathe, are at risk of losing weight due to the effort they must expend. As

neonatal and pediatric intensive care specialists know, we must therefore be cautious in weaning. Though an infant may not be in respiratory distress, we sometimes have to slow or even pause the weaning for a period if an infant is either losing or not gaining necessary weight—which can itself lead to long term growth and developmental problems. Sometimes we must even temporarily raise the ventilator settings. Payers will then cut reimbursement—claiming the child has plateaued-- when he is actually simply in the midst of the delicate process of weaning.

Then there was the time when an insurance medical director insisted we switch an infant from one type of ventilator to another to wean him quicker. This infant weighed less than 5 kg—and the ventilator was not FDA approved for use with his weight. Of course we refused to change ventilators, and reimbursement was denied.

2- Insurance companies often ignore the need for medical resources to be in place before a medically fragile child can be safely discharged. The child, for example, on a ventilator, with a severe brain injury, or with spinal muscular atrophy is going to require specialty trained pediatric professional care—whether at home or in a pediatric skilled nursing facility. When there are insufficient pediatric home care nurses or a bed in a pediatric skilled nursing facility is unavailable, we cannot discharge the patient until an appropriate discharge plan can be put into place.

Yet the payer's reaction is frequently that it's our problem, not theirs, and we are denied reimbursement while we search for appropriate resources for the child.

Sometimes, available home care agencies may be out of network, or won't take a child's case because they consider the reimbursement too low. Other times, there are not enough pediatric trained home care nurses, so that only partial coverage is available.

To meet this problem, we created a program that trains parents to become competent and confident caregivers, so that they can fill in the gaps when home care nurses are not available. In this way, the child can avoid a nursing home, and instead, come home. Yet we encounter reimbursement denials while we are training the parents so that we can certify their readiness to care for their child-- who may be medically cleared but will continue to be cared for in the hospital if her parents need a little more time to learn. That extra time can be life-changing for

a child and her family, who want nothing more in the world than to be home together. But sometimes this is unreimbursed.

The bottom line: Blythedale never varies from what we know to be the most appropriate treatment, or prematurely discharges a patient because of an insurance denial. We always do the right thing. But what that means is that we must continually invest time and money fighting decisions through a third party payer's long, twisted and arduous internal appeals process.

Many times we are denied reimbursement for necessary patient care by reviewers who are usually not pediatric care specialists and therefore don't understand medical necessity related to our children's complex conditions. We then have to proceed to external appeals, where medical reviews are conducted by pediatric critical care and neonatal physicians who understand the child's disease(s) and Blythedale's role and course of treatment. We win the vast majority of these external appeals: in over 80% of the cases, the denials are overturned. But at what cost!

3) Insurance companies have complex and onerous rules, which divert enormous hospital resources.

Each of the payers has its own processes and rules related to processing authorizations, issuing denials, peer to peer discussions, appeal letters for internal appeals and ultimately external appeals. The time from an insurance denial to an external appeal decision is from 4 – 6 months, during which, of course, there is no reimbursement. While there are some general rules that guide categories of payers such as NY Medicaid managed care versus commercial managed care, within the categories there is a tremendous variation. It is a complex process to determine and follow each payer's rules for reimbursement. Too often, we then find the rules have changed.

To complicate matters, we also care for children whose families have health insurance through "self-insured" plans. Often these plans are domiciled in other states, even though the family lives and works in the state of New York. Each self-insured plan has its own rules that we as hospital providers must understand. Most important, as I understand it, these plans are not regulated by DFS or DOH. We are dealing with one self-insured plan, for example, that owes us over \$600,000. We have been working on this case since August, spending hundreds of hours, with no reimbursement yet in sight.

This byzantine process has forced me to hire a whole department to chase after reimbursement. My Chief Medical Officer spends about 25% of his time writing appeals letters. Our pediatric specialists must divert time out of their days to spend on calls with insurance companies, justifying our care.

What a colossal waste of time and money this is! Can you imagine if that time and money could instead be used for patient care?

And what about the millions of people whose care is rationed or denied, and who can't hire departments to fight for them?

It will, of course, be important to make sure that the new system actually results in access to the care that medically fragile children require. To that end:

- Rates of payment to health care providers must be adequate to ensure that New Yorkers receive the high quality, specialized care that they need, whether that is care for medically fragile children or highly specialized cancer care or effective behavioral health interventions;
- Coverage for children should track Medicaid's current mandates and include all services necessary for a child's health or development;
- Any care management or utilization review of specialized services provided to medically fragile children must be undertaken by qualified professionals - specifically pediatric sub specialists - and must be based on the best interests of the child and not solely driven by cost considerations; and
- Patients, including medically fragile children, must have seamless access to post-acute services, either at home or in specialized facilities, that meet their longer-term needs.

With confidence that these and other important elements of the new healthcare system will be appropriately addressed and on behalf of the children of Blythedale, and on behalf of all those needing care, I ask you to pass the New York Health Act.

Thank you for your time and for your dedicated efforts to improve the New York healthcare system.