



**Children's Health Fund**

# **2020 COVID-19 Policy Report**



## Introduction

Children's Health Fund (CHF) values health equity. Understanding that racism and systems of oppression have a significant impact on health, we foster programming that mitigates the disparate impact that lack of access to essential services has on communities of color. The COVID-19 pandemic has accelerated this work. When the pandemic began, we knew the communities of color served by our National Network partners would be disproportionately impacted not only in the short term, but also during the recovery, and we adapted our efforts to address the specific needs of these communities. From increasing access to screening and testing for COVID-19, to directing support for families to mitigate impacts from lost wages, remote learning, trauma, and access to food, our partner programs support the diverse needs of their patients and families. In short, their work provides better access to healthcare, while at the same time focusing on the social determinants of health, the primary driver of health outcomes. By supporting our partner programs' efforts in this way, CHF aims to narrow the equity gaps for Black and brown communities exacerbated by COVID-19.

Children already traumatized by racism, xenophobia, housing instability, economic uncertainty, and community violence are less able to cope with the additional trauma caused by COVID-19. That additional trauma varies across the country. For some families, it is the death of a significant person due to COVID-19.; for others, it is unemployment. Most experience the isolation and limitations of stay-at-home orders, and many children will have even greater academic difficulties. For these reasons, CHF focuses its advocacy on five key areas: 1) increased access to telehealth; 2) improved broadband access; 3) mitigating the effects of service gaps for children of immigrants; 4) support for community health centers; and 5) federal spending on children's budget priorities.

## Advocacy and Policy Priorities

### **1. Telehealth - Increasing Access to Care**

While the pandemic forced many physicians to temporarily close or severely limit the services they offered, many healthcare providers initiated or greatly expanded telehealth services to maintain primary care. Patients continued their acute and chronic care virtually and even had remote check-ups. Mental health clinicians counseled virtually either via telephone or video conferencing. Case management teams assessed families for food and housing security, and for signs of stress, anxiety or depression. Even dentists offered care virtually.

#### **Telehealth improves healthcare access**

Not only did telehealth meet many of the immediate needs of patients during an emergency, but in some cases it also proved to be a superior service delivery model. Ongoing telehealth benefits include removing transportation barriers; increasing access to subspecialty physicians often found only in urban areas; creating a safe place for adolescent patients to discuss sensitive issues; assessing student and resident work unobtrusively by attending physicians; bringing

multidisciplinary teams together in one visit; and of course, it decreased the risk of COVID-19 infection. Providers can observe their patients' homes giving them valuable insight into the environment where the family lives. Patients were more likely to keep telehealth appointments compared to in-person appointments, especially for mental health care. Because there is a shortage of mental health providers in many communities, telemental health care is particularly valuable to address the surge in depression, anxiety, and trauma caused by the pandemic.

A Zeldis Research survey found that the use of teledentistry for children increased from 11% pre-pandemic to 16% use by May 2020. Teledentistry could bring important help to families living in rural areas with annual incomes of less than \$50,000, where only 52% felt they had access to dental care.

### **Medicaid**

During the pandemic response, regulations changed quickly, and providers were able to use whatever platform and equipment they had available. They were also able to bill for telehealth services that were not billable in the past. Medicaid broadened its coverage of telemedicine to increase access during the crisis. Before access to telehealth expanded, it was limited to patients in rural areas who needed to travel to designated medical facilities to access it.<sup>1</sup> Telehealth (and telephonic health) provides the tools and methodology to serve children and families in marginalized communities, whether rural or urban. There is an opportunity to sustain these services long term to maintain the high level of access they provide.

### **Importance to CHF**

In 2019, Children's Health Fund partners had 2,481 telehealth visits. In the first half of 2020, that number soared to 45,610 virtual visits. Last year, eight partner programs had telehealth projects that ranged in size from a handful to over 1,300 visits, and in scope from subspecialty care, to acute school-based services, to mental health counseling. In the first half of 2020, the number of programs offering virtual visits more than doubled to twenty-three, and two programs had more than 16,000 virtual visits each. Services in 2020 include acute, chronic, and preventive medical services; dentistry; behavioral health; and case management.

### **Policy**

Telehealth should not serve as a replacement for in-person visits, but is an important tool to increase healthcare access, which will ultimately lead to better health outcomes and lower overall costs. We endorse the American Academy of Pediatrics telehealth recommendations in response to COVID-19 and recommend continuation of:

- Coverage for all types of telehealth care. This includes live video, store-and-forward, remote patient monitoring, telephone care, electronic consults, virtual check-ins, and e-visits.
- Allow for the home as an originating (patient) and distant (provider) site.
- Waive any geographic restrictions.
- Provide telehealth care for new and established patients.

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<sup>1</sup> <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>

- Ensure coverage of both COVID-19 related services and other services.
- Ensure access to all licensed clinicians available to treat via telehealth as long as services provided are clinically appropriate.
- Not default to existing telehealth care vendor contracts but ensure coverage to the pediatric medical home as well as pediatric medical subspecialists and surgical specialists.
- Follow the March 17 HHS OCR guidance and subsequent FAQ and allow for good faith use of non-HIPAA compliant end-to-end communication apps/platforms.
- Eliminate any frequency limitations and communicate clearly with providers as to policy change time frames.
- Pay for telehealth care visits at parity with in-person visits.
- Provide retroactive payment at parity to the start of the COVID-19 crisis.
- Pay a transmission/facility fee or otherwise help compensate practices for associated telehealth care costs.
- Waive cost sharing for telehealth visits and ensure payment to providers is inclusive of what would otherwise be a cost sharing amount.

## 2. Broadband Access - Increasing Coverage for Communities of Color

According to the Federal Communications Commission's (FCC) Eighth Broadband Progress Report, 19 million Americans still lack access to fixed broadband service at threshold speeds. In rural areas, nearly one-fourth of the population—14.5 million people—lack access to this service. In tribal areas, nearly one-third of the population lacks access. Even in areas where broadband is available, approximately 100 million Americans still do not subscribe. The report concludes that until the Commission's Connect America reforms are fully implemented, these gaps are unlikely to close. Because millions still lack access to or have not adopted broadband, the Report concludes broadband is not yet being deployed in a reasonable and timely fashion.<sup>2</sup>

The House Committee on Energy and Commerce authorized \$4 billion toward expanding the FCC's E-Rate program to provide more internet access across the country. Only \$1.5 billion has been appropriated, which will not get enough families with school aged children connected to the internet during this school year. Families without broadband access (37% of rural students and 21% of urban students) will be forced to congregate in fast food and civic parking lots; send their children to school, if available, despite familial risk; or allow students to fall further behind in their education. The digital divide disproportionately affects communities of color: 35% of Native American students, 30% of Black students, and 26% of Hispanics students have inadequate internet access at home compared to only 18% of white students.

### Importance to CHF

Broadband service is crucial for the communities served by Children's Health Fund and our partners. It allows for access to telehealth, including subspecialty care and mental health counseling. Broadband is needed not only for online education for our students during the pandemic, but also for homework at any time and primary care visits when needed. Access to

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<sup>2</sup> <https://www.fcc.gov/reports-research/reports/broadband-progress-reports/eighth-broadband-progress-report>

the internet is such an important communication tool that the United Nations declared it a human right. Lack of broadband access marginalizes communities, further diminishing the likelihood that children in those communities will reach their full potential for health and well-being.

### **Policy**

Children's Health Fund recommends appropriating at least \$4 million, of the \$5 million authorized, to expand the FCC's E-Rate program and completing implementation of the Connect America reforms.

## **3. Immigration - Mitigating the Effects of Service Gaps**

The Centers for Disease Control (CDC) reported that more than a third of coronavirus related deaths among Hispanics (34.9%) compared to only 13.2% of whites were in people younger than 65. Reasons cited for the increased risk of COVID-19 infection and death include toxic stress from racism; limited access to healthcare; employment as an essential worker or a job that cannot be performed from home; and crowded or unstable housing conditions. Immigrants face all of those risk factors and many are excluded from relief programs offered by the federal government. The Migration Policy Institute estimates that 6 million immigrants work in frontline occupations such as healthcare, food production, and transportation. An equal number work in economically hard-hit industries such as food service and domestic household services.

Noncitizens have greater difficulty accessing and paying for medical care. A Migration Policy Institute analysis showed that over a quarter of the uninsured population in 2018 were noncitizens. Immigrants often do not receive health insurance from their jobs and generally do not qualify for public coverage. Not only were unauthorized immigrants excluded from the \$2 trillion Coronavirus Aid, Relief, and Economic Security (CARES) Act, but their U.S. citizen and legal permanent resident relatives were also excluded. An estimated 3.7 million children who were either U.S. citizens or green-card holders did not receive cash benefits.

Additionally, immigrants who have been in the United States less than 10 years have higher rates of dental diseases and receive dental care less often than nonimmigrants. The care received by immigrants tends to be more costly treatment for disease rather than disease prevention. Inequities in oral health care among recent immigrant children is a serious public health issue that has an impact on the economy, school attendance, work attendance, and long-term health.

### **Importance to CHF**

Nineteen Children's Health Fund partner programs serve children who recently immigrated to the U.S. Fourteen of those sites have a programmatic focus on immigrant care. One site has a medical legal partnership devoted to immigration needs, with hopes to assist other programs to develop similar projects. Another CHF site trains medical students and pediatric residents in best practices in the care of children who have recently immigrated. Immigration issues have been an important focus in CHF's national conferences since 2017.

## Policy

Children's Health Fund endorses the American Academy of Pediatrics recommendations for immigrant children:

- Health coverage should be provided for all children regardless of immigration status. Neither immigrant children with legal status nor their parents should be subject to a 5-year waiting period for health coverage or other federal benefits.
- Private and public insurance payers should pay for qualified medical interpretation and translation services. Given the increased cost-effectiveness and quality of care provided with medical interpretation, payers should recognize and reimburse for the increased time needed during a medical encounter when using an interpreter.
- Both the separation of children from their parents and the detention of children with parents as a tool of law enforcement are inhumane, counterproductive, and threatening to short- and long-term health. Immigration authorities should not separate children from their parents nor place children in detention.
- Immigration enforcement activities should not occur at or near sensitive locations such as hospitals, health care facilities, schools (including childcare and Head Start), places of worship, and other sensitive locations. Pediatricians have the right to report and protest any such enforcement. Medical records should be protected from immigration enforcement actions. Health systems should develop protocols to minimize fear and enhance trust for those seeking health care.
- Children in immigration proceedings should have access to legal representation at no cost to the child. Medical-legal partnerships that include immigration representation (eg, Terra Firma) and efforts to increase legal representation (eg, KIND, the Young Center for Immigrant Children's Rights, RAICES) should be supported practically and financially at local, state, and federal levels.

## 4. Community Health Centers - Continued Support

Community Health Centers, also known as Federally Qualified Health Centers (FQHC), by serving over 30 million patients a year are a key component of the public health infrastructure. The fact that 9 million of those patients are children attests to the fact that FQHCs are a crucial part of the Child Health Safety Net. Not only do community health centers save the overall healthcare system nearly \$24 billion annually, they perform just as well or better than other healthcare providers on 94% of quality measures. FQHCs are governed by at least a 51% patient-majority board of directors making them accountable to the communities they serve. Community Health Centers see all patients without regard to insurance status or the ability to pay. And they are located in medically underserved communities in all fifty states and five U.S. territories.

The populations served by Community Health Centers demonstrate how crucial they are for the Safety Net. In 2019, Health Centers cared for over 1 million individuals and families who work in the agricultural industry as seasonal or migrant workers; over 1.4 million people who were unstably housed; and over 5 million children and adults who live in public housing. More than 60% of Health Center patients are people of color, and 14.5 million patients had incomes below the federal poverty line. On a national scale, approximately one in five Medicaid patients seek care at Community Health Centers. In nine states and Washington, D.C., that statistic is one in four.

Not only do FQHCs offer medical and behavioral healthcare, they provided over 17 million dental visits to over 6.7 million patients in 2019. Nationally far too many children have untreated cavities with striking inequities by race. Children ages 4 to 6 years old with untreated dental cavities in permanent teeth ranged from 47% in Native Americans, to 28% in Hispanics, to 19% in Blacks, to 14% in whites.

The COVID-19 pandemic greatly harmed Community Health Centers. Services and some entire clinics were closed for weeks during the stay at home orders early in the pandemic. Virtual visits were reimbursed at lower rates. And personal protective equipment was scarce and available only at inflated rates. These factors contributed to vastly reduced revenue and increased costs, which forced many FQHCs to furlough or layoff staff.

### Importance to CHF

Nine Children's Health Fund partners are Federally Qualified Health Centers. The original CHF program and the two newest partners in our National Network are FQHCs. The CHF Community Health Center partners work in rural, suburban, and urban communities; in fixed-site and mobile clinics; and serve the entire range of FQHC focus populations: individuals experiencing homelessness, agricultural workers, public housing residents, school students, and people living below the federal poverty line.

### Policy

Children's Health Fund agrees and supports the National Association of Community Health Centers policy recommendations:

- COVID-19 emergency funding of \$7.6 billion. Monies to fund detection, prevention and diagnosis of COVID-19, as well as address health center revenue losses, enable them to stay open, and alleviate some of the pressure on emergency departments.
- Stabilize current services and expand care to 10 million patients; \$41.9 billion over 5 years. Recovery from the COVID-19 pandemic will likely result in increased demand for essential primary care services. Health centers need long-term financial stability to maintain current services, meet staffing needs, and deliver reliable, quality services. Managed growth of health center capacity will allow expansion of services to additional medically underserved patients in high need areas, in response to the COVID-19 aftermath and provide services to all regardless of ability to pay.
- Critical expansion of workforce programs to address shortfall: \$7.8 billion over 5 years. This includes funding for the National Health Service Corps Loan Repayment Program, \$6 billion over 5 years; Teaching Health Centers Graduate Medical Education (GME) Program, \$931 million over 5 years; and the Nurse Corps Loan Repayment Program, \$87 million over 5 years. Federal government data projects a national shortfall of up to 160,000 physicians and one million nurses by 2025.
- Crucial infrastructure investment: \$20 billion. There has not been significant investment in health center capital funding since the American Recovery and Reinvestment Act (ARRA) of 2009. This funding will address the critical facility needs, as well as, acquisition and upgrades of needed equipment and technology to develop integrated systems of care, including data tracking and sharing, and virtual visits.



- 340B. Protect Health Centers' ability to retain 340B savings on drugs dispensed to Medicaid Managed Care patients consistent with current statute.

## 5. Federal Spending - Keeping Children's Programs a Priority

The effects of widespread layoffs and furloughs due to the COVID-19 pandemic are already apparent. Even as industries begin slowly reopening, some positions will not immediately return because of the financial toll on businesses. The World Bank projects that this year, the global economy will shrink by 5.2% representing the biggest recession since World War II. The duration and progression of this recession is unclear. This will depend on, "the intensity and duration of restrictions to stem the pandemic, global spillovers from developments in major economies, the ability of policymakers to prevent financial market stress and protect firms and households hurt by the recession, the behavior of the virus, and the success of medical and other scientific advances to contain it."<sup>3</sup> Child poverty is expected to increase dramatically; research indicates that we could see an increase of over 50% as a result of extensive layoffs and furloughs during the pandemic.<sup>4</sup>

Far more children than adults live below the Federal Poverty Line, yet children's share of the federal budget was only 9% in 2019 or about \$6,700 per child. As a share in the economy, investment in children only accounted for 1.9% of the gross domestic product (GDP). The Child Tax Credit is the largest source of federal support, even greater than the Medicaid program; together the two programs constitute over 60% of the federal support for children. Prior to COVID-19, children's share of the federal budget was projected to drop about 2% over the next decade, as built-in spending on Social Security, Medicare, Medicaid, and interest payments on the debt consume a growing share of the budget.

Under the Trump Administration's proposed FY 2021 budget, spending on children's discretionary programs would be reduced by 22%. The proposal includes cuts to special education; elimination of the preschool development block grant; reduced Head Start funding; and reduction in housing programs. Medicaid would require able-bodied parents to work in order for children to continue to be covered by Medicaid. Spending on immunizations for special populations, uninsured, and underinsured children would further worsen the reduced rates of immunizations caused by the pandemic, especially in marginalized communities that already had low immunization rates. Lower immunization rates allow community outbreaks of infections such as measles.

The Trump Administration budget also targets nutrition programs that are particularly important to low-resource communities. A 4% reduction in the Supplemental Nutrition Assistance Program (SNAP) and a 6% cut to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) would be detrimental to families living below the federal poverty line.

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<sup>3</sup> <https://www.worldbank.org/en/news/press-release/2020/06/08/covid-19-to-plunge-global-economy-into-worst-recession-since-world-war-ii>

<sup>4</sup>

<https://static1.squarespace.com/static/5743308460b5e922a25a6dc7/t/5e9786f17c4b4e20ca02d16b/1586988788821/Forecasting-Poverty-Estimates-COVID19-CPSP-2020.pdf>



### Importance to CHF

Children's Health Fund partners are dedicated to promoting the health and well-being of children living in some of this country's most under-resourced communities. But our efforts cannot have the desired impact without child safety net programs for food, housing, education, and immunizations. Elimination of child poverty and addressing basic needs must come from federal action.

### Policy

Children's Health Fund opposes reductions to the programs that are crucial for the health and wellbeing of children living below the federal poverty line:

- Supplemental Nutrition Assistance Program (SNAP)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Head Start
- Special Education
- Preschool Development block grant
- Immunization programs
- Medicaid work requirements
- Housing Assistance programs

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### About Children's Health Fund

Children's Health Fund is committed to ensuring high-quality healthcare for children living in this country's most marginalized communities. We understand the role that racism and systems of oppression play in shaping health and are committed to addressing these root causes that perpetuate inequities. The programs we support bring comprehensive primary care directly to children and families where they live, learn, and play; we partner with communities to create a supportive environment to decrease the impact of trauma on children; and we work to improve the quality of life for families through policy and advocacy efforts that drive systems change. Collectively, these efforts help to advance health equity. We support 26 programs that comprise a national network of local partners located in 15 states, Puerto Rico, and Washington, D.C.