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August 31, 2006

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Chair

Citizens' Health Care Working Group

7201 Wisconsin Avenue

Suite 575

Bethesda, Maryland 20814

Dear Dr. Maryland:

On behalf of the 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists of the American Academy of Pediatrics, I write today to comment on the Citizens' Health Care Working Group (the CHWG) Interim Recommendations (the Report). The Academy has long supported universal coverage for children and is pleased that the Report comes to a similar conclusion: that the United States public believes that all Americans should have quality health care coverage.

The Academy's comments to the Report focus on Principles for Children's Access to Care, the Medical Home, Payment Rates, and Pediatric Quality.

Health Care for Children is Different

Children account for only about 25 percent of the total population and account for less than 11 percent of all personal health care spending. The vast majority of children cost the health care system very little - 95 percent of all children account for only about six percent of all U.S. personal health care spending. There simply is not much money in pediatrics in comparison to the rest of the health care marketplace. Thus, government programs play a large role in pediatric health care.

The Academy believes that children have been well-served by the government through the Medicaid and SCHIP programs, which have achieved a level of coverage, that while not universal, provides significant benefit for millions of children throughout the United States. SCHIP in particular is a success story, even as it faces reauthorization in 2007. Beyond simple coverage, services in Medicaid like Early and Periodic Screening Diagnostic and Treatment (EPSDT) also pay for robust care so that children in the United States on Medicaid stay healthy.

While proud of the steady march in the rates of children's coverage through the decades, The Academy believes that there is vast room for improvement in both programs and in health care access and coverage for US children.

Principles for Children's Access to Care

Our experience with the state and federal interaction of Medicaid and SCHIP influences our unique perspective as physicians to infants, children, adolescents, and young adults. The Academy has long supported enhanced access to quality health care for children because every child in America deserves it. To achieve optimal outcomes for these children, the Academy believes that the health care system should be reformed to maximize access to quality, comprehensive pediatric and prenatal health care. The Academy has endorsed specific principles on access to care that any health reform proposal that includes children should encompass:

1. Every child must have health insurance.
2. Health insurance should be a right, regardless of income, for all children, pregnant women, their families, and ultimately all individuals.
3. All health insurance plans should have a comprehensive age appropriate benefits package such as that of the American Academy of Pediatrics (AAP).
4. All children should have access to primary care pediatricians, pediatric medical subspecialists, pediatric surgical specialists, pediatric mental and dental professionals, and hospitals with appropriate pediatric expertise.
5. All health plans should have levels of reimbursement that promote unrestricted access to health services for children.
6. Health insurance should be fully portable and provide continuous coverage.
7. Administrative aspects should be streamlined and simplified.
8. Families should have a choice of clinician(s).
9. Health plans should complement and coordinate with existing maternal and child health programs to ensure maximum health benefits to families.

The Academy believes that reform proposals that comply with these principles will ensure children's access to quality care. In the current health care structure, a host of reasons can limit children's access to care which then cascade into expensive adverse outcomes. Families who make too much to qualify for Medicaid or SCHIP may forego periodic visits for their children. These families are much less likely to receive critical preventive and routine services needed for their children to stay healthy. As a result, children become sicker and the society as a whole pays more because treatment becomes more complicated and often is delivered in an expensive emergency room setting.

The general tenor of the Report recognizes this reality. Nevertheless, the Academy believes that in the second recommendation contained in the Report, the notion of vulnerable populations should be expanded to include all children. The second recommendation currently notes that low income and uninsured people, and people living in rural and underserved areas, should be targeted by the expanded community health center concept. Children should also be included in this list so that providers based in the community are paid to provide the routine care appropriate for children. Additionally, the recommendation should also spur the adoption of the Academy's medical home model and also recognize the

importance of the contributions made by private sector providers in caring for vulnerable children.

The Academy applauds the CHWG for understanding that children's coverage and health care needs differ markedly from adults'. This understanding is reflected in the CHWG proposed group that would establish definitions of a core benefits package. This proposed group, defined in the Report as "an independent non-partisan private-public group to identify and update recommendations for what would be covered under high-cost protection and core benefits," could be a boon to children's coverage if it defines a core benefits package for children appropriately. The Academy agrees that medical professionals should be relied upon in such a proposed group and notes the Academy's recommended benefits package as an age appropriate structure for all children in the United States. The recommended benefit package is available at <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;100/6/1040>. An analysis of its cost is available at <http://www.aap.org/research/pedmedcostmodel.cfm>.

Medical Home

The Report addresses care coordination in Recommendation 4. The Academy believes that care coordination is best achieved in the pediatric context through the medical home model.

The notion of a medical home has been promoted by a number of medical disciplines including pediatrics, family practice, and internal medicine. The concept has been in the forefront of pediatrics and the Academy has a policy strongly endorsing a medical home. A medical home is not a building, but is defined as primary health care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. In a medical home, the clinician works in partnership with the patient/family to assure that all medical and non-medical needs of the patient are met. A medical home is critical to efficient and effective care. The medical home serves to coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the individual. Accessibility to a medical home is critical for children.

The Academy believes that the concept of a medical home should be included in any reform proposal that would impact children. Thus, Recommendation 4 in the Report, which addresses care coordination, should be changed to recommend that care coordination for children is best achieved through the structure outlined in the Academy's medical home policy statement.

Payment Rates

One area that the Report does not address is payment rates to pediatric providers who serve the same populations as those receiving care in Federally Qualified Health Centers (FQHCs). While an innovative idea appears in the Interim Report focused on community-based providers, new funds would be limited to those that "serve the same populations and provide

comparable services” as FQHCs. This is short-sighted, and will not adequately address access barriers to children’s care. The immediate solution to the payment rate issue is a better analysis of Medicaid payment rates through a Medicaid MedPAC structure.

Beyond community-based health centers, payment levels to other providers like pediatricians have a direct impact on the availability of quality care, because low Medicaid payments for services provided to children threaten access to medical homes. Low reimbursement rates create a host of problems that upset the delicate balance of the health care system. When reimbursement rates do not cover the cost of providing services, the result is cost shifting to private insurers. This increases insurance rates, driving employers and employees out of the private market, and swelling the ranks of the uninsured. In the case of children, any increase in the number of uninsured creates more demand for public programs. Public programs should then pay providers adequately to address this increased demand, but often fail to, further threatening access to care.

Reimbursement rates also impact the pediatric work force. While medical homes are needed for every child, their continued existence depends on physicians becoming primary care providers. Disturbing trends in the medical profession now act as barriers to medical students selecting primary care fields of practice. The average graduating medical student has outstanding debts of over \$100,000 making the selection of low reimbursement primary care careers less tenable. Since over 30% of the children in this country are now covered by Medicaid, unless reimbursement rates for care are comparable to the private market, individual providers in primary care practices will be simply unable to absorb the significant loss of income for 1/3 of their patients given educational debt and office overhead costs. This reality is particularly problematic in poor communities and rural areas where a greater proportion of children are enrolled in government health insurance programs like Medicaid and SCHIP.

There are few examples of the Medicaid program reimbursing providers at rates that are on par with Medicare and private sector rates. This disparity in payment compounds the problem of differential reimbursement between public and private health plans further. A federal response to this problem is needed, as Medicaid payments vary significantly state-to-state. The Academy believes that a structure similar to the Medicare Payment Advisory Commission (MedPAC) could increase our understanding of payment under Medicaid throughout the United States. Analyses provided by such a “Medicaid MedPAC” could help address access problems through discovery and wider exposure of various payment inadequacies and their impact on access to care for children. Without this sort of national response, the disparity of reimbursement will continue to negatively impact access for vulnerable children. The CHWG recommendation in this area will not adequately impact access, and should be changed to implement a Medicaid MedPAC to help address the overarching issue of payment.

Pediatric Quality

The Academy commends the CHWG for its focus on quality of care issues. Like the public participants in the process, the Academy believes in the importance of focusing on evidence-

based medicine. The Academy also agrees with public participants that greater investment in health information technology and moving to an integrated system of electronic health records could improve administration and treatment and reduce medical errors. In a perfect world, these initiatives could become an engine for advancing quality improvement and evaluating health care outcomes throughout the health care system. The Academy also agrees with respondents to the Internet poll that more investment by providers in health information technologies could provide a means to improve quality and increase administrative efficiency.

Nevertheless, improving quality depends on measuring performance, and purchasing health IT systems depends on adequate resources to do so. As to measures, neither government, the private health care marketplace nor private philanthropy focuses in a significant way on the quality of health care provided to children. The Academy has stated in other contexts that the Centers for Medicare and Medicaid Services (CMS) must provide leadership in funding the development of consistent, reliable quality and performance measures for children. This issue should be further explored by the CHWG as funding is yet again the basic problem in developing pediatric quality measures and implementing their use.

Currently, most state Medicaid programs lack either the financial resources or sufficient pediatric population, or both, to fund the development of appropriate pediatric measures. Despite the fact that more than half of all Medicaid recipients are children, CMS lacks the federal responsibility, authority, and resources to play more than a role of facilitator of state initiatives. CMS uses its authority and resources as administrator of Medicare to play a powerful role in influencing quality and performance measurement of adult health care. But the federal agency plays no comparable role in Medicaid and SCHIP for children. The absence of CMS leadership is a setback not only for children who are assisted by Medicaid and SCHIP but for all children, since these programs have such a disproportionately large impact on the financing of health care for children and, therefore, the financing of the nation's pediatric health care infrastructure.

As the health care system begins to rely on quality and performance measurement, not just price, to determine the allocation of health care goods and services, it is essential we ensure the development of appropriate pediatric measures, because pediatric health care is so different from adult care. The lack of such development could result in either the application of inappropriate adult measures to pediatric health care or the exclusion of pediatric health care from measurement, neither of which is in the best long-term interests of children's health and the health care system.

The Academy believes that there is an inseparable link between quality outcomes and health care cost reductions. In order to reduce healthcare expenditures, for patients, insurers, and government, quality of care must be improved. Quality can best improve with better seamless integration of care and alignment between providers that truly puts patients' interests first. Failure to address these points means that any reform will instead be a shell game with no improvement in the core processes of healthcare.

Conclusion

The Academy appreciates the opportunity to comment on the important work of the CHWG and looks forward to the debate it will help to spur in Congress and throughout the nation.

Sincerely,

Eileen M. Ouellette, M.D., J.D. FAAP

Eileen M. Ouellette, MD, JD, FAAP
President

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