

The American Academy of Pediatrics (AAP) is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, who are deeply committed to protecting the health of the 27.8 million children and adolescents who receive health care throughout the Medicaid program.¹ Children represent over 50% of all Medicaid enrollees, but they account for less than 25% of all Medicaid expenditures – including expenditures for children with special health care needs.² Without Medicaid, these children and adolescents would not have access to the care they need to live happy, healthy, functional lives. The Academy and the pediatric societies would like to provide specific comments on a few select areas below raised by the National Governors Association (NGA). Additional AAP policy on Medicaid can be found in our Medicaid Policy Statement, which is also enclosed.

Benefit Package

Preventive care is the cornerstone of pediatrics. The value of preventive care in the Medicaid program has been sustained and promoted since its inception. Emphasizing preventive care for children and adolescents is a strong investment in our nation's future and must be maintained.

In Medicaid, preventive care is guaranteed through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Maintaining EPSDT ensures that illnesses are identified early, immunizations are not delayed, and that there is appropriate monitoring of early childhood development. We know from recent data that adherence to well-child care recommended visits is effective at lowering the risk of emergency department (ED) use and the risk of avoidable hospitalization.³ Identifying and treating conditions early prevents further complications and more serious illness in the future, which is more costly to treat.

The EPSDT protection is vitally important, however, not only in assuring that children and adolescents receive needed preventive services, but that they also receive the full range of medically necessary diagnostic and treatment services they need. Moreover, we strongly support policies that would encourage the availability of the services of primary care pediatricians, pediatric medical subspecialists, pediatric surgical specialists, developmental and behavioral service providers, care coordinators, and hospitals with appropriate pediatric expertise. Such services should be provided through the medical home, as defined by the AAP.

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, a pediatric clinician works in partnership with the family/patient to assure that all medical and non-medical needs of the patient are met. Through this partnership, the pediatric clinician can help the family/patient access and 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 child/youth and family.

Cost Sharing

Access to affordable needed comprehensive health care benefits and services is vital to providing a safety net for low-income children and children with special health care needs. Existing cost

sharing protections ensure that children and pregnant women are not prevented from accessing needed health care services because of inability to pay. The pediatric community is highly concerned that changes to cost sharing policies would drastically and negatively affect the ability of children to obtain needed care.

We know from evidence – including two new reports from the Kaiser Family Foundation and the Center on Budget and Policy Priorities⁴ – and past experience in states that have instituted cost sharing in other programs that it can prove to be a significant barrier to health care. While some nominal cost sharing requirements such as premiums or copayments may be appropriate for some populations, Medicaid must maintain the policy prohibiting cost sharing on all Medicaid benefits for children, particularly preventive services.

Adequate Medicaid Payment

The issue of low payment in Medicaid is one that has plagued the program for years. On average, Medicaid reimburses pediatricians at only 69% of the rate that would be paid under Medicare, and only 56% of commercial rates for an office visit.⁵ In some states, Medicaid payment is even lower. Such low reimbursement impedes access to quality health care. Low Medicaid payments do not cover costs and increasingly force pediatricians to make difficult business decisions of continuing to treat patients at a financial loss, or limiting participation in the Medicaid program altogether. The lack of access for patients that is created then drives utilization to expensive sites such as emergency rooms. Moreover, low Medicaid reimbursement endangers the economic viability of “safety net” providers, fragmenting the care children in Medicaid receive.

While a number of states have taken steps to increase Medicaid reimbursement rates to match those of Medicare, most have not. Any discussion of restructuring Medicaid must include steps to appropriately reimburse physicians for the care they provide children under the Medicaid program.

Enhancing Quality and Controlling Costs in the Overall Health Care System

Pediatricians applaud efforts to enhance state Medicaid quality-improvement activities for children. Such quality improvement measures should include: quality-performance measures by states to address access to care, utilization, effectiveness, and satisfaction related to preventive, primary, acute and chronic care for children; appropriate incentives; uniform and consistent EPSDT reporting with minimal paperwork burden on providers; and use of the Consumer Assessment of Health Plan Survey (CAHPS) for a representative sample of children enrolled in state Medicaid programs, especially children with special health care needs.

There should also be programs to improve the quality of pediatric care as well as tools and measures to monitor changes, especially the provision of medical homes for children with special health care needs; updated meaningful provider-assessment and –certification activities; partnership with other state agencies such as Title V offices to support practice-level improvements in pediatric care; the monitoring of enrollment patterns and reasons for enrollment

changes; implementation of general administrative review processes to ensure managed care organizations and behavioral health organizations are qualified and available; and timely, linguistically appropriate, meaningful results of quality-related activities to beneficiaries to facilitate their participation in health care decision-making.

Improving Access to Home- and Community-Based Care

We strongly recommend that Medicaid maintain eligibility, coverage, and access for children with special health care needs through home- and community-based services waivers and Katie Beckett programs.

Improving Chronic Care Management

Children with special health care needs are a unique group of children in Medicaid, and require specific treatments and systems that address their exact needs. The pediatric community strongly recommends that care for children with special health care needs to be provided in a medical home. Moreover, states should develop policies that encourage care coordination with direct involvement by the primary care pediatrician within a medical home. Such care coordination links children with special health care needs and their families to services and resources in a coordinated effort to maximize the potential of the children and to provide them with optimal health care.

Care coordination is often complex and many barriers exist, but states, with federal support, should offer incentives to identify children with special health care needs and offer plan providers enhanced payments for providing a medical home, including family education, practice-based care coordination, and transition to adult care. States should also implement special planning and oversight of the use of managed care for children with special health care needs, including children in foster care and children with mental health conditions. This should cover benefit specifications for specialty or chronic care services, composition of pediatric provider networks, policies for flexible service authorization, care coordination, quality-performance measures for preventive care delivery for children with various types of chronic conditions, family participation, pediatric risk-adjustment mechanisms, and other financial incentives for high-quality care.

Comprehensive Waiver Reforms

The Academy understands the desire by states to streamline the process for obtaining waivers to federal Medicaid law, or for allowing changes to programs without the use of waivers. However, we are concerned with any proposal to allow for waivers or other changes to Medicaid without the appropriate input of all stakeholders in Medicaid, as well as safeguards to ensure that states do not unnecessarily deny care to children. In recent years with some state waiver proposals, we have seen a reluctance to provide full details of proposals initially. Moreover, in some instances, states have been hesitant to allow for the necessary feedback from all Medicaid stakeholders. It is therefore very important that any effort to allow for the streamlining of waivers or changes is

balanced with the need to provide minimum standards, adequate protections for health care for children, and appropriate input from all Medicaid constituents.

Judicial Reforms

Since the Medicaid program is a federal-state partnership, and states are the administrators of Medicaid, it is understandable that states require full operational authority over their Medicaid programs. However, it is critical that such programs meet the basic standards outlined by federal Medicaid law and that adequate protections for children are in place. Without the ability to seek enforcement of federal standards, federal Medicaid law in essence becomes a series of “suggestions.” The legal system provides the only real recourse to seek enforcement when states drastically fall short of federal standards. This last safety net ensures that enrollees receive the care to which they are entitled under the program, and must not be compromised. While acknowledging the right of states to make operational changes, we do not feel that such changes should be allowed to break federal Medicaid law or fall short of federal standards set by Congress. The Academy therefore recommends that any proposal to restructure Medicaid does not impede in any way the ability of those involved in the program to seek assurances that children receive the care to which they are entitled, even through the courts when necessary.

Prescription Drug Improvements

While we understand the need to control the cost of prescription drugs in the Medicaid program, it is vital that efforts to control prescription drug spending are not simply placed on the backs of children. In federal fiscal year 2000, children represented 54.6% of all Medicaid enrollees, but accounted for only 22.9% of prescription drug expenditures in the program.⁶ Children are not the drivers of prescription drug expenses in Medicaid. No prescription drug control should in any way limit the ability of a child to obtain the medication he or she needs, either through pharmacy benefit limitations, cost sharing, or any other means.

In closing, the American Academy of Pediatrics and the pediatric societies seek to ensure that any restructuring of Medicaid is done with the 27.8 million children the program serves foremost in mind. Together with the State Children’s Health Insurance Program (SCHIP), Medicaid is this country’s only and vital safety net for children. Medicaid provides health insurance to nearly one-third of children in the United States, and it is essential that any restructuring of Medicaid not undermine protections for them in the program. Children have no means of obtaining health insurance on their own – in those instances where children are eligible for Medicaid, it is their sole source of assuring their health. We must not compromise children’s health in the name of reform.

This statement was endorsed by the Ambulatory Pediatric Association (APA), American Pediatric Society (APS), Association of Medical School Pediatric Department Chairs (AMSPDC), and Society for Pediatric Research (SPR), the Society for Adolescent Medicine (SAM). The pediatric societies represent pediatric researchers, full time academic and clinical faculty responsible for the training of pediatricians, and the leadership of medical school pediatric departments. The Society for Adolescent Medicine (SAM) includes over 1400

physicians, nurses, psychologists, social workers, nutritionists and others involved in service delivery, teaching or research on the health and welfare of adolescents.

Please consider us as resources throughout your discussions on Medicaid reform.

¹ Medicaid Statistical Reports (MSIS/2028 Reports) for Federal Fiscal Year 2002. *Centers for Medicare and Medicaid Services*.

² AAP 2002 Medicaid State Reports, based on CMS/MSIS2082 data. *American Academy of Pediatrics*.

³ Hakim R, Bye B. Effectiveness of Compliance with Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries. *Pediatrics*. 2001; 108:90-97.; Hakim R, Ronsaville D. Effect of Compliance with Health Supervision Guidelines Among US Infants on Emergency Department Visits. *Archives of Pediatrics and Adolescent Medicine*. 2002; 156: 1015-1020.

⁴ Ku L. The Effect of Increased Cost-Sharing in Medicaid: A Summary of the Findings. May 31, 2005. *Center on Budget and Policy Priorities*.; Artiga S, O'Mally M. Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences. May 2005. *Kaiser Commission on Medicaid and the Uninsured*.

⁵ Zuckerman et al. Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation. *Health Affairs Web Exclusive*. June 23, 2004.; 2002 Pediatric Medical Cost Model. *American Academy of Pediatrics*.