Talking Points on AAP Endorsed Principles on Benefit Plan Coverage and Payment

In conjunction with the AAP Endorsed Principles on Benefit Plan Coverage and Payment, the following talking points and policy references are provided to support the key messages on payment issues as a guide in contacts with payers.

HEALTH CARE BENEFITS FOR CHILDREN AND ADOLESCENTS MUST BE COMPREHENSIVE, ALIGNED WITH THE RECOMMENDATIONS OF THE AMERICAN ACADEMY OF PEDIATRICS AND APPROPRIATELY PAID.

• Health care benefits for children and adolescents should begin with the full array of services recommended by the American Academy of Pediatrics (AAP). [1]
• Payment methods should be developed that cover all the health care needs of children as defined by the AAP policy statement "Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents, and Young Adults Through Age 21 Years" and the periodicity of visits and procedures described in the AAP statement "Recommendations for Preventive Pediatric Health Care." [2]
• The methods used for pediatric health care payment should consider age, chronicity, and severity of underlying health problems (case mix, risk, or severity adjustment) and geographic considerations. [2]

ALL PAYERS MUST RECOGNIZE THE FULL SPECTRUM OF HIPAA CODES SETS (ie, CPT, HCPCS, AND ICD-9-CM) AND THEIR GUIDELINES AND PROVIDE APPROPRIATE PAYMENT

• All payers must recognize the importance of incorporating and paying for all services with values on the Medicare RBRVS physician fee schedule while refining their payment schedules to incorporate annual updates and revisions.
• If appropriate access to health care is to be ensured for all children, Medicaid programs and other payers must recognize the inequities in payment for some pediatric services and correct these deficiencies. [3]

HEALTH PLANS AND PAYMENT SYSTEMS MUST SUPPORT THE FAMILY-CENTERED MEDICAL HOME MODEL THROUGH ADEQUATE BENEFITS COVERAGE AND APPROPRIATE PAYMENT.

• The American Academy of Pediatrics (AAP) believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. [4]
• It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care.
• The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with them.
• Retail Based Clinics (RBCs) are not medical homes and the AAP is opposed to waiving or lowering co-pays or offering financial incentives for visits to RBCs in lieu of visits to pediatricians' or other primary care physicians' offices. Payer incentives should not
promote fragmentation of care but instead should recognize and reward systems of care that promote continuous, coordinated, and comprehensive care. [5]

PREVENTIVE CARE MUST BE COVERED AS A FIRST DOLLAR BENEFIT AND APPROPRIATELY PAID.
- Coverage should be provided for preventive services including, but not limited to, well-child care, immunizations, and appropriate screenings. [6]
- Preventive services should be "first-dollar" coverage (ie, covered before the deductible is met). [6]
- Screenings and tests, such as vision, hearing, and developmental are identified with a specific CPT code and should be separately paid and not considered as incidental to the preventive care visit.

PEDIATRICIANS MUST RECEIVE ADEQUATE AND SEPARATE PAYMENT FOR VACCINES AND THEIR ADMINISTRATION(S).
- Pediatricians cannot be expected to subsidize immunizations and inadequate payment for vaccines and immunization administration negatively impacts access.
- Payment systems need to pay separately and not bundle the vaccine, immunization administration and office visit into a single payment. Each of these are separately reported services each entailing its own relative values and resource-based expenses.
- Payment for immunization administration should be consistent with the current Medicare Resource-Based Relative Value Scale (RBRVS) values and be at least 100% of the current Medicare RBRVS physician fee schedule.
- Optimal payment for vaccines should be based on a percentage of the actual cost incurred by the practice, incorporating applicable taxes and shipping/handling charges plus an appropriate margin to cover vaccine storage and acquisition costs.
- The CDC private payer vaccine price list should be used as the basis for determining vaccine acquisition costs. Unlike sources of average wholesale price (AWP), the CDC private payer vaccine price list is not proprietary and is a more readily transparent source of actual vaccine acquisition costs. It is based on the manufacturer’s price for vaccines and is updated as soon as prices changes are reported as opposed to ASP and AWP which are updated quarterly. The price list is transparent as it is posted on the public CDC website at: http://www.cdc.gov/vaccines/programs/vfc/cdc-vac-price-list.htm
- Payment for the vaccine product should be at least 125% of the current CDC vaccine price list for the private sector
- Fee schedules and health plan coverage benefits should be updated in a timely manner

BENEFIT PLAN DESIGN MUST INCLUDE COVERAGE AND PAYMENT FOR PEDIATRIC OBESITY ASSESSMENT, EVALUATION AND TREATMENT.
- Coverage needs to be provided for pediatric obesity services including, but not limited to, clinical assessment, prevention, evaluation and treatment of obesity by the primary care physician to avoid more expensive future costs for treatment of adult obesity and related co-morbidities.
- Payers must recognize pediatricians as critical providers of health services on obesity and obesity prevention to all children (age 0-21 years).
- Lack of payment is a disincentive for physicians to develop prevention and treatment programs and presents a significant barrier to families seeking professional care.
BENEFIT PLAN DESIGN MUST INCLUDE COVERAGE AND PAYMENT FOR MENTAL HEALTH SERVICES, INCLUDING THOSE PROVIDED BY GENERAL PEDIATRICIANS.

- Establish parity between medical services and mental health services so that coverage of the management treatment of substance abuse and mental health disorders is the same as coverage of other chronic conditions. [7]
- Provide appropriate payment for counseling, coordination of care, and consultations to enable pediatricians and other primary care providers to provide primary mental health services. [8]
- Contracts should include payment for interpretive and indirect services, such as staff conferences, consultation between clinicians, and contacts with professionals in other sectors, such as schools and law enforcement. [7]
- Primary care clinicians are trained and capable to diagnose and treat developmental and behavioral health and should not be excluded from provider networks for diagnosis and treatment.
- When appropriately documented, payers should pay for developmental screening and not consider the service as incidental to the preventive care visit.
- Provider panels need to include in the network licensed professionals who are Medical Doctors (MD), Doctors of Osteopathy (DO) and allied health professionals who are available and able to treat children and adolescents.

BENEFIT PLANS MUST PROVIDE COVERAGE AND PAYMENT FOR ORAL HEALTH PREVENTIVE SERVICES PROVIDED BY PEDIATRICIANS.

- As part of the Recommendations for Preventive Pediatric Health Care, oral health screening is provided as early as six months and at the 9, 12, 18, 24, 30 and 36 month preventive care visits. Risk assessment, counseling of caregivers on oral health practices, fluoride varnish application, and referral to a dentist would also be provided as needed.
- The primary thrust of early risk assessment is to screen for parent-infant groups who are at risk of early childhood dental caries and would benefit from early aggressive intervention. The ultimate goal of early assessment is the timely delivery of educational information to populations at high risk of caries to avoid the need for later surgical intervention. [9]
- Payment for preventive services provided by physicians related to children’s oral health including assessment, anticipatory guidance and the application of fluoride varnish should be a covered benefit and paid as separate services (ie, not bundled with the preventive care visit).

PHYSICIANS MUST BE PAID FOR NON-FACE TO FACE SERVICES, INCLUDING TELEPHONE CARE AND ELECTRONIC CONSULTATIONS, PROVIDED TO ESTABLISHED PATIENTS.

- The AAP supports payment for telephone care services provided by physicians to established patients, including the following categories of medical services:
  - calls for physician management of a new problem, including counseling, medical management, and coordination of care not resulting in an office visit within 24 hours;
  - calls for physician management about an existing problem for which the patient was not seen in a face-to-face encounter in the previous 7 days; and
  - calls related to care plan oversight for patients with special needs in residential settings and/or those with a chronic disease who require physician supervision over a period of time during a calendar month. [10]
- Relative value units (RVUs) are published on the Medicare Resource-Based Relative Value Scale (RBRVS). Total 2008 RVUs are as follows:

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PHYSICIAN TIERING AND PAY FOR PERFORMANCE PROGRAMS MUST EMPHASIZE QUALITY, BE BASED ON VALID QUALITY AND EFFICIENCY MEASURES, AND PROVIDE POSITIVE INCENTIVES FOR PERFORMANCE IMPROVEMENT.

- Pediatricians must be involved in measure selection as well as processes for data collection and reporting.
- The primary purpose of performance measurement should be to identify opportunities to improve patient care, and patient health status, outcomes, and satisfaction and not be a means to reduce physician payments.
- Quality measures should:
  - Be significant and reflect impact on children’s health
  - Be appropriate for children’s health
  - Be scientifically credible
  - Be feasible
  - Address what can be improved
- Payment programs should provide adequate incentives to motivate change and be based on positive rewards and not penalties.
- The AAP supports the pay for performance principles outlined by the American Academy of Family Physicians:
  1. Focus on improved quality of care
  2. Support the physician-patient relationship
  3. Use evidence-based clinical guidelines
  4. Involve practicing physicians in program design
  5. Use reliable, accurate, and scientifically valid data
  6. Provide positive physician incentives, and

References
1. Scope of Health Care Benefits Health for Children From Birth to 21
   http://aappolicy.aappublications.org/cgi/content/full/pediatrics;117/3/979
2. Guiding Principles for Managed Care Arrangements for the Health Care of Newborns, Infants, Children, Adolescents and Young Adults
   http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/2/828
3. Application of the Resource-Based Relative Value Scale to Pediatrics
   http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;122/6/1395
4. The Medical Home
   http://aappolicy.aappublications.org/cgi/content/full/pediatrics;110/1/184
5. AAP Principles Concerning Retail Based Clinics
   http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/6/2561
6. High Deductible Health Plans and the New Risks of Consumer-Driven Health Plans
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7. Improving Substance Abuse Prevention, Assessment, and Treatment Financing for Children and Adolescents
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8. Insurance Coverage of Mental Health and Substance Abuse Services for Children and Adolescents: A Consensus Statement
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