September 30, 2013

The Honorable Max Baucus
Chairman
U.S. Senate Committee on Finance
Washington, D.C. 20510

The Honorable Orrin G. Hatch
Ranking Member
U.S. Senate Committee on Finance
Washington, D.C. 20510

Dear Chairman Baucus and Ranking Member Hatch:

On behalf of the American Academy of Pediatrics (AAP), a non-profit organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, we welcome this opportunity to respond to your request regarding our nation’s mental health system. In particular, we commend you for your interest in successful models of integration. As pediatricians who care for children with mental health and substance use disorders, it is critical for the health of all children that mental health care is integrated within a child’s medical home.

We also appreciate your recognition of the impact of mental health conditions on children and adolescents. In fact, nearly 1 in 5 children in the U.S. suffers from a diagnosable mental disorder, but only 20 to 25 percent of affected children receive treatment. There are countless more children who face mental and behavioral impairments that do not meet the criteria for a diagnosis whose needs are not being met by the current system. Many Federal agencies, the AAP, and other professional organizations have made a large and coordinated effort to include substance use screening and brief intervention as part of general medical care for teens. Recent data released by the Substance Abuse and Mental Health Services Administration (SAMHSA) show that rates of alcohol use, binge drinking, and prescription medication use by teens all decreased. Despite this encouraging decrease, only 10 percent of teens with substance use disorders enter treatment.

Families and children need access to mental health screening and assessment and a full array of evidence-based therapeutic services to appropriately address mental health and substance use disorders. The identification, initial assessment, and care of mental health problems should take place in a child’s medical home. The medical home is an approach to providing comprehensive primary care in which a care team works in partnership with a child and child’s family to assure that all the medical and non-medical needs of the patient are met and that care is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children and adolescents, including children and adolescents with special health care needs. Shortages of mental health professionals with pediatric expertise throughout the country, and, specifically, of child and adolescent psychiatrists nationwide, necessitate greater primary care clinician involvement in mental health care.
With the appropriate training and collaborative relationships, primary care clinicians can and should deliver mental health services to children and adolescents in the primary care setting. This setting is ideal for initiating services to children with emerging developmental and behavioral and common mental health disorders such as attention-deficit/hyperactivity disorder (ADHD), depression, disruptive behavior disorders, anxiety disorders, and substance abuse. The primary care setting provides opportunities for early identification and intervention, counseling, guidance, care coordination, and chronic illness management. Colocation of a child and adolescent psychiatrist, psychologist, or social worker in the primary care setting can expand the range of provided services. Even after specialty referral or consultation, the primary care clinician plays a critical role in ongoing communication and co-management to monitor the child’s progress, support the child and family, and ensure coordination of care.

The AAP is pleased to offer the following recommendations that address key impediments that primary care and specialty clinicians encounter when providing mental health services to children and adolescents in the primary care setting. Many of these recommendations are contained in a joint statement authored by the AAP and the American Academy of Child and Adolescent Psychiatry entitled, “Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration,” as well as the extensive work documented in the report of the AAP’s Task Force on Mental Health, which lays the groundwork for a community-based program of preventive and treatment services in mental health.

Additionally, the AAP’s “Medicaid Policy Statement” and “Scope of Health Care Benefits for Children From Birth Through Age 26” offer recommendations for the mental health services children should receive in the Medicaid program and health insurance generally. The Academy’s Model Contractual Language for Medical Necessity for Children also contains important information regarding the needs of children in all health care. Copies of these statements are attached to this letter. The AAP recommends that all Medicaid programs adhere to the recommendations outlined in Bright Futures.

**Barriers, Recommendations, and Reform Ideas**

Current and recent Medicaid payments strategies have made it difficult for primary care clinicians to integrate mental health into their practices. The use of mental health carve outs by public and private insurers, including Medicaid managed care organizations, can be a major barrier to access to mental health care for many children, especially for children with emerging mental or behavioral health conditions. Mental health carve outs stigmatize mental health by treating conditions affecting the brain as separate and different from conditions affecting the body. Mental health intake procedures that bypass the primary care clinician, without requirements for communication between mental health professionals and primary care clinicians, without care coordination mechanisms, and, too often, without pediatric expertise among mental health providers, impede primary care clinicians’ delivery of mental health services in the medical home.
When Medicaid programs carve out mental health from primary care, the fragmentation that results can harm access to quality mental health care for children. For instance, pediatricians report that fragmented Medicaid mental health systems too often have cumbersome and repetitive intake procedures, poor communication between mental health providers and primary care clinicians, inadequate surveillance of physical health for children served in the mental health system, and lack of awareness of the mental health needs and treatment plan in the primary care system.\(^1\) Mental health carve outs make the early identification and treatment of mental health problems in children and adolescents more difficult, meaning problems may become more severe and costly before treatment can ensue.

The AAP recommends Medicaid payment policy changes in the following three areas to improve children’s mental health care: 1) enhancing the ability of primary care clinicians to provide mental health services in their practices, 2) supporting the co-location of mental health professionals in pediatric practices, and 3) supporting other enhancements to community-based prevention, identification, and treatment of mental health conditions in children.

1) *Enhancing the ability of primary care clinicians to provide mental health services in their practices*

*Primary care clinicians should be allowed to provide and authorize services for common mental health conditions of childhood and adolescence. Medicaid, including Medicaid managed care organizations, should include primary care clinicians in mental health networks and ensure the coordination of mental health specialty care with the primary care clinician through ongoing communication, exchange of information, and co-management.* Careful consideration should be given to the impact on child health of the practice of limiting access to a child’s mental health record by a mental health professional and how that affects the ability of a primary care clinician to provide comprehensive care for the child.

*Payment under Medicaid must be sufficient for the range of mental health services provided by primary care clinicians to address the range of mental health problems encountered, including the identification and management of emerging problems or symptoms not rising to the level of a diagnosis. Medicaid payment should not be denied simply because physical and mental health services occur on the same day. Medicaid payment should cover visits primary care clinicians and mental health professionals have with parents only (i.e. when the patient is not physically present) and other non-face-to-face components of care and consultation (e.g. contact between primary care clinicians and psychiatrists, counselors, therapists, schools, and other involved agencies).* One such example is treatment-planning and treatment-team meetings, in which the most appropriate service delivery does not include the patient. Requiring that insurers like Medicaid allow primary care clinicians to be paid for services on reported mental health diagnostic codes, incentivizes appropriate and accurate diagnostic coding.
Current Procedural Terminology (CPT) codes 96110 and 99420 should be included in the list of services that qualify for the Medicaid payment increase under the Patient Protection and Affordable Care Act (ACA). CPT code 96110 is a developmental screening code that primary care clinicians use in the early identification of mental and behavioral health impairments. Similarly, CPT code 99420 (Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)) should be included in the list of codes that qualify for the Medicaid payment increase. AAP recommends including child and adolescent psychiatrists and pediatric neurologists in the definition of those providers eligible for the Medicaid payment increase. We also recommend that Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and Medicaid allow payment for parental postpartum depression screening by pediatricians since unidentified and untreated parental depression is a major cause of behavioral health problems in young children.

2) Supporting the co-location of mental health professionals in pediatric practices

The AAP recommends that Medicaid be incentivized to establish multidisciplinary mental health treatment teams based in pediatric and psychiatric group practices, such as through the application of “incident to” payment methodology to mental health professionals who are co-located in such practices. Co-location of mental health professionals allows both better direct on-site mental health services and consultation and training of primary care clinicians to make them better able to identify and manage mental health issues in their practices. Physicians have a long-established pattern of extending access to their medical services through the employment of nurse practitioners and physician assistants in their offices to treat patients under a physician’s supervision. Medicare pays for these services as if they are provided directly by the physician as long as they are provided according to Medicare “incident to” regulations. Private insurance companies and Medicaid agencies typically follow the same billing conventions for medical services but do not provide similar economic incentives for mental health and substance abuse services provided by psychiatric advanced-practice nurses, psychologists, and social workers employed in medical and psychiatric group-practice settings, even though they meet the same “incident to” standards. Without this incentive, traditional payment models have not adequately recognized that a psychologist or social worker employed by a primary care clinician or child and adolescent psychiatrist and working in the same office suite can effectively deliver team-based care that improves access to care and increases the complexity of service provided by the practice. It is also important that payment cover both the direct services and the consultation with primary care clinicians.

Pediatricians have worked to create integrated systems at the state level. After successful advocacy by pediatricians and many other mental health advocates in North Carolina,
several changes to the state’s Medicaid program were made to help address mental health systems issues including payment. Key among those changes were payment for up to 6 visits to a mental health/substance abuse provider without assigning a diagnosis and up to 26 unmanaged visits in a calendar year for Medicaid recipients up to age 21, primary care referral for up to 26 mental health visits annually for children under the age of 21, expansion of “incident to” rules, and direct Medicaid enrollment of independently practicing licensed clinical social workers, licensed psychologists, and advance practice nurses allowing them to bill for services delivered in their offices. Although not all of these Medicaid changes are still in place in North Carolina, pediatricians report that they had an important impact on improving mental health care for children in the state.

The AAP maintains information on co-location projects happening throughout the U.S. between pediatricians and mental health professionals towards the goal of continually improving the delivery of health care to children and their families. More information on these projects can be found on our website at aap.org/mentalhealth.

3) Enhancements to integrate mental health into community primary care

The Massachusetts Child Psychiatry Access Project (MCPAP) offers a system of regional children's mental health consultation teams designed to help primary care providers meet the needs of children with psychiatric problems. In Massachusetts, the program has enrolled 95% of all primary care practices. In this program, child psychiatry teams are available to consult with primary care providers on a near real-time basis. The MCPAP team often helps with medication consultation, diagnosis and assessment, and referral to treatment programs as appropriate. Primary care providers report higher ratings of their ability to serve children with mental health problems as a result of the program. Additionally, more than 25 states are participating in the National Network of Child Psychiatry Access Programs in the development of similar programs tailored to the needs of their specific state. AAP would encourage support at the federal level for statewide models similar to MCPAP and we would be happy to assist the Committee in the development of such a proposal.

For children and adolescents with serious mental illness, the Medicaid Health Home Option enacted as section 2706 of the ACA allows states to receive a 90 percent federal match for health home services for populations that have chronic conditions or have one serious and persistent mental health condition. The Medicaid Health Home program could enable states to better meet the needs of children enrolled in the Medicaid program with modifications and wider adoption by states. It is our understanding that the uptake of this program by states to address children’s mental health needs has been low. Thought should be given to policies that would enable more states to use this option for children and adolescents. For example, allowing states to submit a plan for children and adolescents only or expanding the definition of eligible individuals with a serious
and emotional condition to include children and adolescents with a mental health condition with an expected duration of 12 months or longer even if that condition does not rise to the level of a Diagnostic and Statistical Manual of Mental Disorders-V could spur more integrated care for these populations in particular.

The enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) was an historic step toward ending the discriminatory practice of imposing higher cost structures and treatment limitations on mental health as compared with physical health. The AAP looks forward to the issuance of final rules implementing MHPAEA and will be following closely how mental health parity will be assessed and enforced, including in qualified health plans sold in exchanges starting in 2014.

The AAP appreciates this opportunity to provide comments on improving the mental health and substance abuse system for children and adolescents. If we may be of further assistance, please contact Tamar Magarik Haro at the American Academy of Pediatrics’ Washington, D.C. office at (202) 347-8600.

Sincerely,

Thomas K. McInerny, MD, FAAP
President

TKM/tmh

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ii Case Study: The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care. The Commonwealth Fund pub. 1378 Vol. 41 March 2010
Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY
Committee on Health Care Access and Economics TASK FORCE ON MENTAL HEALTH

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The online version of this article, along with updated information and services, is located on the World Wide Web at:

http://pediatrics.aappublications.org/content/123/4/1248.full.html
SPECIAL ARTICLE

Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY
Committee on Health Care Access and Economics

TASK FORCE ON MENTAL HEALTH

INTRODUCTION

“Mental Health: A Report of the Surgeon General”1 documents the high prevalence of mental health needs of America’s youth. Although almost 1 in 5 children in the United States suffers from a diagnosable mental disorder, only 20% to 25% of affected children receive treatment. This is a troubling statistic, especially when considering that treatment of many mental disorders has been deemed highly effective. The Surgeon General’s report highlights the challenges of gaining access to mental health services in a complex and often fragmented system of health care. Without intervention, child and adolescent psychiatric disorders frequently continue into adulthood. For example, research shows that when children with coexisting depression and conduct disorders become adults, they tend to use more health care services and have higher health care costs than other adults. If the system does not appropriately screen and treat them early, these childhood disorders may persist and lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood. No other illnesses damage so many children so seriously.2 On the other hand, early identification and treatment of children with mental health problems has the potential to reduce the burden of mental illness and its many consequences. Furthermore, data from a number of sources have demonstrated that enhanced access to outpatient mental health services is cost-effective.3

The American Academy of Pediatrics (AAP) and the American Academy of Child and Adolescent Psychiatry (AACAP) have created this joint position paper to ensure the mental health and wellness of our children and adolescents. With the implementation of the federal mental health parity law, many more children may be seeking mental health treatment.4 Shortages of children’s mental health professionals will make the coordination of care between pediatricians and child and adolescent psychiatrists even more necessary. By addressing the administrative and financial barriers that primary care clinicians and children’s mental health professionals face in providing behavioral and mental health services to children and adolescents, we hope to improve access, collaboration, and coordination for pediatric mental health care. The National Business Group on Health has endorsed this document.

IMPORTANCE OF THE PRIMARY CARE SETTING

With the appropriate training and collaborative relationships, primary care clinicians can and should deliver mental health services to children and adolescents in the primary care setting. This setting is ideal for initiating services to children with emerging developmental and behavioral problems and common mental health disorders such as attention-deficit/hyperactivity disorder (ADHD), depression, anxiety disorders, and substance use. The primary care setting provides opportunities for early identification and intervention, counseling, guidance, care coordination, and chronic illness management. Primary pediatric mental health care is friendly to families and fully coordinated with the child’s other health care. Colocation of a child and adolescent psychiatrist and/or other mental health professionals in the primary care setting can further expand the range of provided services. Furthermore, enhancing access to outpatient mental health services reduces psychiatric hospitalizations and does not significantly increase the overall cost of mental health care.3,4

Children whose problems do not improve with initial intervention1 and/or children with more severe degrees of impairment or complex coexisting conditions require mental health specialty consultation and, often, specialty treatment. The AACAP publication “When to Seek Referral or Consultation With a Child and Adolescent Psychi-

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*The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 applies to group health plans providing mental health or substance abuse benefits and insuring 50 or more employees, whether the plans are self-funded (regulated under ERISA) or fully-insured (regulated under state law). However, the new law does not apply to individual health plans offered by businesses with 50 or fewer employees.

†The term “mental” throughout this position paper is intended to encompass behavioral, neurodevelopmental, psychiatric, psychological, emotional, and substance use issues. It also encompasses somatic manifestations of mental health issues, such as eating disorders and functional gastrointestinal symptoms. This is not to suggest that the full range or severity of all mental health problems falls within the scope of pediatric primary care practice but, rather, that children and adolescents may suffer from the full range and severity of mental health conditions.
a critical role in ongoing communication and comanagement to monitor the child’s progress, support the child and family, and ensure coordination of care. The medical home can provide family-centered, coordinated, collaborative care that is multidirectional and addresses the child holistically, which is particularly critical for children with a complex constellation of needs.

In some circumstances, such as a disaster or terrorist event, or residence in communities with high rates of posttraumatic stress disorder or high-risk inner city or rural areas, the need for mental health services may be far greater and the resources even less adequate than in other areas. For many, if not most, children affected by a critical event or those who reside in these communities, primary care clinicians will be the first and often only responders to children’s mental health needs.

UNDERLYING PRINCIPLES
The AAP and the AACAP endorse the following principles:

- Families and children need access to mental health screening and assessment and a full array of evidence-based therapeutic services to appropriately address mental health conditions.

- The identification, initial assessment, and care of mental health problems ideally take place in the child’s “medical home,” where he or she will benefit from the strengths and skills of the primary care clinician in establishing rapport with the child and family, using the primary care clinician’s unique opportunities to engage children and families in mental health care without stigma.

- Primary care clinicians can be trained and equipped to recognize mental health problems, to manage common mental health problems, and/or to determine when mental health specialty care or referral is indicated.

- To support primary care clinician involvement in mental health care, payment for assessment and treatment of mental health problems must be adequate and comparable with payment for services addressing other medical illnesses. Furthermore, payment must be proportionate to the complexity of the situation and the additional time and work required in managing mental health conditions.

- Primary care clinicians and families must have continuous access to consultation and collaboration with child and adolescent psychiatrists and with other members of the mental health services system who are equipped to provide support to family members of all ages.

- The consultation and collaboration process must be supported adequately through economically viable models recognizing the shortage of mental health professionals with pediatric expertise in many regions of the country and, specifically, of child and adolescent psychiatrists nationwide.

- Primary care clinicians must be recognized as a portal of entry to the specialty mental health system and an ongoing source of care and coordination for children and adolescents in the mental health specialty system.

ISSUES AND SOLUTIONS
A number of barriers impede primary care clinicians’ delivery of mental health services. These barriers include:

- insufficient payment for the range of mental health services provided by primary care clinicians to address the range of mental health problems encountered, including the identification and management of emerging problems or symptoms not rising to the level of a diagnosis;

- lack of payment to primary care clinicians and mental health professionals for visits with parents only (ie, when the patient is not physically present);

- lack of payment to primary care clinicians and mental health professionals for other non-face-to-face components of care and consultation (eg, contact between primary care clinician and psychiatrist, counselors, therapists, schools, and other involved agencies);

- lack of incentives for the establishment of multidisciplinary mental health treatment teams based in pediatric and psychiatric group practices, such as the application of “incident to” payment methodology to colocation of mental health professionals;

- inadequate communication and comanagement mechanisms among primary care clinicians, mental health professionals, school personnel, and others providing mental health services, family support, and/or case management;

- insurance plan policies that preclude payment to primary care clinicians when mental health diagnostic codes are reported or that limit access to mental health care in other ways (eg, lack of coverage for recommended assessment and treatment services, limited or no coverage for out-of-network providers [even when in-network providers are not able to see new clients], and high out-of-pocket expenses for certain medications);

- mental health intake procedures that bypass the primary care clinician, without requirements for communication between mental health professionals and primary care clinicians, without care coordination mechanisms, and, too often, without pediatric expertise among mental health providers:

- administrative and financial barriers that limit access to effective psychosocial interventions; and

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6“Incident to” services are described as those services furnished by an allied health professional, employed under the same tax identification number as the supervising physician, to an established patient incident to the physician’s professional services in the physician’s office (whether located in a separate office suite or within an institution) or in a patient’s home (see www.cms.hhs.gov).

7These issues may create barriers in both mental health “carve-outs” (separate panels of mental health care providers, access through a toll free number or other separate process outside the primary care system) and “carve-ins” (medical and mental health benefits combined in a single plan with a single entry point).

8These issues may create barriers to both mental health “carve-outs” (separate panels of mental health care providers, access through a toll free number or other separate process outside the primary care system) and “carve-ins” (medical and mental health benefits combined in a single plan with a single entry point).
● lack of procedural and diagnostic parity in mental health and physical health benefits.

In addition, there are barriers to colocating child and adolescent psychiatrists and other mental health professionals in primary care settings. Physicians have a long-established pattern of extending access to their medical services through the employment of nurse practitioners and physician assistants in their offices to treat patients under a physician’s supervision. Medicare pays for these services as if they are provided directly by the physician as long as they are provided according to Medicare “incident to” regulations. Private insurance companies and Medicaid agencies typically follow the same billing conventions for medical services but do not provide similar economic incentives for psychiatric services provided by psychiatric advanced-practice nurses, psychologists, and social workers employed in medical and psychiatric group-practice settings, even though they meet the same “incident to” standards. Without this incentive, there is no recognition that a psychologist or social worker employed by a child and adolescent psychiatrist or primary care clinician and working in the same office suite delivers team-based care that improves access to care and increases the complexity of service.

RECOMMENDATIONS
The following are recommendations to insurance purchasers, payers, and managed behavioral health organizations. They address a set of key impediments that primary care and specialty clinicians encounter when providing mental health services to children and adolescents in the primary care setting. We believe these recommendations support the underlying principles listed above and call for specific corrective actions.

1. Allow primary care clinicians to provide and authorize services for common mental health conditions of childhood and adolescence.
2. Compensate primary care clinicians for the mental health services they provide, including steps in the assessment and engagement process preceding a definitive diagnosis.
3. Promptly implement procedures to fully support parity in benefits packages, eliminating separate deductibles, high copays, and annual spending limits lower than those established for medical services.
4. Support the principle of diagnostic parity. Mental health disorders result in distress and functional impairment just as medical illnesses do.
5. Support the principle of procedural parity, paying similar rates for similar services. For example, children’s mental health professionals as well as primary care clinicians should be paid appropriately when reporting evaluation and management Current Procedural Terminology7 (CPT) codes.
6. Remove disincentives for appropriate and accurate diagnostic coding by allowing primary care clinicians to be paid for services on reported mental health diagnostic codes.
7. Support the emerging use of standardized tools by paying for mental health screening at routine medical visits and paying for the administration, scoring, and interpretation of standardized mental health assessment instruments.
8. Recognize circumstances such as treatment-planning and treatment-team meetings, in which the most appropriate service delivery does not include the patient or, at times, even family members. In these situations, there should be payment for primary care clinicians, child and adolescent psychiatrists, and other mental health professionals for time spent in consultation. These would be recorded with medical team conference codes (99366–99368).
9. Support payment for primary care clinicians, child and adolescent psychiatrists, and mental health professionals for sessions with parents without the patient present. This is best accomplished by paying for evaluation and management CPT codes, including those for non–face-to-face services.
10. Restructure mental health plans to include primary care clinicians in mental health networks and ensure coordination of mental health specialty care with the primary care clinician through ongoing communication, exchange of information, and coordination.
11. Support colocation models of mental health professionals working within medical settings by applying Medicare “incident to” payment regulations to mental health services rendered in pediatric primary care and child and adolescent psychiatry practices.
12. Support payment for evidence-based psychosocial interventions as well as psychopharmacologic therapy.
13. Support payment for non–face-to-face aspects of care, such as communication with community providers including early education and child care professionals, teachers, social workers, therapists, and case managers, and other nonclinical aspects of caring for children with mental health problems (eg, care-plan oversight, health-risk assessment). There should also be financial support for coordination (CPT codes 99339–99340).
14. Enhance coordination between the primary care clinician and other treating providers by encouraging the development and use of systems such as interprofessional electronic communications, including telemedicine, that are an integral part of emerging care processes.
15. Develop a risk-adjustment system that takes into account the complexity of the child’s needs.

CONCLUSIONS
Primary care clinicians have unique strengths, skills, and opportunities to identify and address the unmet mental health needs of children and adolescents; however, many administrative and financial barriers currently prevent them from fulfilling their potential. By collabo-
rating with primary care clinicians, child and adolescent psychiatrists, and other mental health professionals, as well as professionals associated with schools, public agencies, and community organizations, to implement the recommendations put forward in this paper, insurance purchasers, payers, and managed behavioral health organizations can increase access to behavioral and mental health services for children and adolescents in a cost-effective and clinically significant manner.

AAP TASK FORCE ON MENTAL HEALTH
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REFERENCES
ERRATA


An error occurred in this article published in the March 2009 issue of Pediatrics (doi:10.1542/peds.2008-1203). On page 1028, in Table 4, under the heading Ethnicity reads “Hispanic 32 (50); White, non-Hispanic 15 (23).” This should have read: “Hispanic 15 (23); White, non-Hispanic 32 (50).”

doi:10.1542/peds.2009-0986


Several errors occurred in this article published in the February 2009 issue of Pediatrics (doi:10.1542/peds.2008-0763). On page 449, in the Discussion section, line 60 reads, “In a domestic survey in Sweden.” This should have read “In a domestic survey in Finland.”

Page 446, in the Results section, in Table 1, under the heading “Died Before 28 d of Postnatal Life” reads “23 (53.3), 40 (42.1), 56 (22.2), 59 (16.8), 34 (9.4), 24 (6.3), 19 (3.9), 254 (13.0).” This should have read “33 (53.3), 67 (42.1), 86 (22.2), 90 (16.8), 54 (9.4), 41 (6.3), 27 (3.9), 398 (13.0).”

Table 2, under the heading “Died Before 28 d of Postnatal Life” reads “254 (13.0).” This should have read “398 (13).”

doi:10.1542/peds.2009-1032


An error occurred in this special article published in the April 2009 issue of Pediatrics (doi:10.1542/peds.2009-0048). The name of Harsh K. Trivedi, MD, was inadvertently omitted from the core group of individuals involved in the development of the paper. We regret the error.

doi:10.1542/peds.2009-1059


An error occurred in this special article published in the April 2009 issue of Pediatrics (doi:10.1542/peds.2008-2381). Page 1226, under the heading “Selective Serotonin Reuptake Inhibitors,” reads: “The absolute risk difference in the response between treatment and intervention groups was ~20% for both age groups, . . . ” This should have read: “The absolute risk difference in the response between treatment and control groups was ~20% for both age groups . . . ”

doi:10.1542/peds.2009-0876
Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY
Committee on Health Care Access and Economics TASK FORCE ON MENTAL HEALTH

Pediatrics 2009;123;1248
DOI: 10.1542/peds.2009-0048

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Medicaid Policy Statement
COMMITTEE ON CHILD HEALTH FINANCING
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DOI: 10.1542/peds.2013-0419

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://pediatrics.aappublications.org/content/131/5/e1697.full.html
### Medicaid Policy Statement

**COMMITTEE ON CHILD HEALTH FINANCING**

*Pediatrics* 2013;131:e1697; originally published online April 1, 2013;

DOI: 10.1542/peds.2013-0419

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POLICY STATEMENT

Medicaid Policy Statement

COMMITTEE ON CHILD HEALTH FINANCING

KEY WORDS
Medicaid, Child Health Insurance Program, benefits, coverage, financing, payment, eligibility, outreach, enrollment, managed care, quality improvement

ABBREVIATIONS
AAP—American Academy of Pediatrics
AARA—American Recovery and Reinvestment Act
ACA—Patient Protection and Affordable Care Act
CHP—Children’s Health Insurance Program
CMS—Centers for Medicare and Medicaid Services
CPT—Current Procedural Terminology
DHHS—Department of Health and Human Services
EHB—essential health benefits
EPSDT—Early and Periodic Screening, Diagnosis and Treatment
FMAP—federal medical assistance percentage
FPL—federal poverty level
HMO—health maintenance organization
MCO—managed care organization
MOE—maintenance of effort
PCMH—patient-centered medical home

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abstract

Medicaid insures 39% of the children in the United States. This revision of the 2005 Medicaid Policy Statement of the American Academy of Pediatrics reflects opportunities for changes in state Medicaid programs resulting from the 2010 Patient Protection and Affordable Care Act as upheld in 2012 by the Supreme Court. Policy recommendations focus on the areas of benefit coverage, financing and payment, eligibility, outreach and enrollment, managed care, and quality improvement. Pediatrics 2013;131:e1697–e1706

HISTORY OF MEDICAID PROGRAM

The Medicaid program was enacted in 1965 as Title XIX of the Social Security Act with funding streams derived from both federal and state governments. All states have participated in this voluntary program since Arizona joined in 1982. Federal law designates which groups of people must be eligible for Medicaid enrollment and what core medical benefits must be provided. Each state may then expand eligibility criteria, enhance benefits, contract with managed care organizations (MCOs) to administer the Medicaid program, and apply for waivers to develop specialized programs for particular populations. For instance, states have had the option to enroll children whose families have an income at or below 200% of the federal poverty level (FPL) in Medicaid, although only 6 states had chosen to do so by 1997 when the State Children’s Health Insurance Program (CHIP) was enacted by Congress as Title XXI of the Social Security Act.

By 2009, total Medicaid enrollment had grown to include 34.2 million infants, children, and adolescents younger than 21 years. Medicaid provided benefits to 39% of the US pediatric population and covered 48% of all births. In 2009, Medicaid payments to providers for all age groups had expanded to $326.0 billion.* Although children younger than 21 years represented 53% of all Medicaid enrollees, they

*These figures differ from the Medicaid data provided by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary1 for several reasons. The higher CMS estimate of total Medicaid costs for fiscal year 2009 of $380.6 billion includes nonprovider expenses such as disproportionate share hospital payments, administration costs, the Vaccines for Children Program, and other adjustments. Calculated costs per participant also differ for 3 reasons: (1) CMS uses estimated “person-year equivalents” (50.1 million) for fiscal year 2009 rather than “ever participants” (62.9 million unique participants covered by Medicaid for at least 1 month) as the basis for the calculation; (2) the AAP considers 19- and 20-year-old participants to be children, whereas CMS considers them to be adults; and (3) CMS segregates both children and adults who are blind and/or disabled into a separate “disabled” category.
accounted for only 29% of all Medicaid provider payments. In 2009, Medicaid expenditures averaged $2630 per child younger than 21 years compared with $6459 per adult between the ages of 21 and 64 years and $11,812 per senior citizen 65 years or older.²

Except for a few special programs (eg, family planning services, American Indian/Alaskan Native populations, administrative costs), the federal government funds a different proportion of each state’s Medicaid budget.³ This federal medical assistance percentage (FMAP) for each state is based on a formula that relates the 3-year rolling average per capita income in the state to that for the entire United States. By law, the minimum and maximum FMAPs are 50% and 83%, respectively.³ Before the passage of the 2009 American Recovery and Reinvestment Act (ARRA: Pub L No. 111-5), the FMAP varied across states from 50% to 76%. Under ARRA and other FMAP “extension legislation” (Education, Jobs, and Medicaid Assistance Act of 2010 [Pub L No. 111-226]), FMAPs temporarily increased through June 2011 (eg, to a range of 62%–85% in the second quarter of fiscal year 2010). These enhanced FMAPs transiently decreased state Medicaid expenditures for fiscal year 2009 through fiscal year 2011. However, with the sunset of ARRA FMAP legislation and more Medicaid beneficiaries due to continued poor economic conditions and other factors, state Medicaid costs increased sharply in fiscal year 2012 and are expected to continue to climb through fiscal year 2019.⁴

**IMPACT OF THE ACA AND THE 2012 SUPREME COURT DECISION ON THE MEDICAID PROGRAM**

Passage of the Patient Protection and Affordable Care Act (ACA)⁵ in 2010⁵ profoundly changed the Medicaid program through its expansion of Medicaid eligibility to all legal residents younger than 65 years with individual or family incomes at or below 138% of the FPL.⁵ Hence, the ACA not only added a large population of adults (ages 19 through 64) who became newly eligible for Medicaid, but in many states, the expansion also increased the number of eligible children (through age 18) by mandating a higher minimum income eligibility.⁶ The ACA directed the federal government to fund Medicaid expansion in full through 2016 and then at lower but still significant levels thereafter (tapering to 90% funding by 2020). The landmark Supreme Court decision upheld the constitutionality of the ACA with respect to the contested “individual mandate” for every American to obtain health insurance by a 5 to 4 margin.⁶ However, the Court also struck down as unconstitutional an enforcement provision of the ACA that would have allowed the Department of Health and Human Services (DHHS) to withhold all federal Medicaid funding from states that declined to participate in Medicaid expansion. By a 7 to 2 majority, the Court ruled that this provision constituted undue coercion on states by the federal government; in a remedy, however, the Court upheld the constitutionality of the Medicaid expansion as an individual state option.

Legal scholars generally agree that the narrowly written Court decision did not invalidate other changes made by the ACA to the Medicaid program that pertained to existing populations.⁶ The constitutionality of 3 provisions in particular has special importance for the pediatric population. First, Section 2001(b) of the ACA imposes a “maintenance of effort” (MOE) requirement that disallows states from restricting eligibility or reducing benefits for current child Medicaid beneficiaries until 2019. Second, Section 2001(a) (5) (b) expanded Medicaid eligibility for children under 19 by raising the minimum qualifying family income level to 138% of the FPL. Third, the ACA required states to improve outreach and simplify enrollment of any person currently eligible for Medicaid.⁶

Many children now covered by Medicaid lose health insurance as they become young adults, so that how states choose to respond to the opportunity afforded by the ACA to participate in the adult Medicaid expansion can have a great impact on many pediatric patients. It is likely that additional negotiations will ensue in the future between the secretary of the federal DHHS and state Medicaid agencies that have initially

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²Beginning in 2020, the federal government will still fund 90% of the additional costs associated with newly eligible participants under the ACA. If the ACA Medicaid expansion were to be adopted by all states, the Congressional Budget Office had estimated that the total increased cost of the Medicaid program attributable to Medicaid expansion from 2014 to 2019 would be $564 billion dollars, of which $500 billion, or 89%, would have been funded by the federal government.⁵

³Encompassing the Patient Protection and Affordable Care Act and the amendment law associated with that act, the Health Care and Education Reconciliation Act (Pub L No. 111-152).

⁴The ACA established a new national floor of Medicaid coverage at 133% of the FPL with a standard 5% of income disregard that constituted part of a simplified modified adjusted gross income calculation designed to harmonize means-tested eligibility (Medicaid disregards the first 5% of one’s income before calculating the proportion to the FPL). The ACA had mandated a minimum income level for Medicaid eligibility at 138% of the FPL beginning in 2014.

⁵The number of children newly eligible for Medicaid in a given state as a result of the change in qualifying FPL will depend on that state’s current choice of percentage of FPL as the eligibility criterion for Medicaid for older children as well as that state’s implementation of and enrollment within CHIP. There are currently 2.6 million children below 138% of the FPL who are not currently insured by Medicaid or by CHIP. In addition, an unknown number of children with family incomes between 100% and 138% of the FPL who are currently insured by CHIP would rollover to Medicaid coverage and about 4.5 million children with family incomes between 100% and 138% of the FPL who are now covered by private insurance would potentially be eligible for Medicaid.
signaled reluctance to pursue full-scale Medicaid expansion.\textsuperscript{6}

This revision of the American Academy of Pediatrics (AAP) Medicaid Policy Statement advocates for the provision and funding of children’s services in the Medicaid program and highlights changes in or new opportunities for state advocacy efforts as a result of the passage of the ACA and the 2012 Supreme Court decision.

The AAP continues to voice strong support for the Medicaid program and over the years has offered a continuing series of recommendations aimed at enhancing care and improving outcomes for children.\textsuperscript{7} In particular, the AAP has long advocated innovative approaches to care (such as pediatric medical homes) that aim to achieve better health outcomes while reducing costs of care. The AAP stands ready to support newer population health-based programs (eg, Medicaid accountable care organizations) that seek to attain those same objectives. AAP members have been integral providers in both regular Medicaid and in state-specific Medicaid waiver programs and consequently have working experience with reform efforts of varying success.

**BENEFITS AND MEDICAL HOME**

Beyond a core set of mandated benefits, federal guidelines provide states with wide discretion in benefit design. The AAP recommends that all state Medicaid agencies:

1. Provide all children at a minimum the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit and all other mandatory and optional benefits as outlined in the AAP statement “Scope of Health Care Benefits for Children From Birth Through Age 26.”\textsuperscript{8} Ensure that the medical necessity definitions used by each state for purposes of justifying medical services covered by Medicaid payment are consistent with the EPSDT policy. Furthermore, each state’s process for determining medical necessity should rely on the expertise of pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. Ensure that in the process of making decisions on the basis of medical necessity, the medical, behavioral health, and developmental care needs of the child are fully considered and that appropriate comprehensive benefits are available to address the full range of these needs.\textsuperscript{9}

2. Develop appropriate benefits that address the needs of pregnant women. Pregnant women should be afforded the full range of maternity care (preconception, prenatal, labor, delivery, and postpartum) recommended in the Guidelines for Perinatal Care issued jointly by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. Detail the full scope of pediatric Medicaid benefits in consumer brochures, on Web sites, and, most importantly, in state plan documents and managed care contracts. State agencies should provide a clear comparison of pediatric Medicaid benefits and networks among managed care plans so that families can choose a plan that is most appropriate for the needs of their child(ren).

3. Ensure that all children have timely access to appropriate services from those qualified pediatric medical subspecialists and pediatric surgical specialists who are needed to optimize their health and well-being.

4. Ensure that Medicaid provider networks are sufficient to guarantee that children who transition from pediatric to adult care providers do not experience disruption in services.

5. Adopt periodicity schedules as defined in the AAP guidelines.\textsuperscript{10} Immunization schedules should also be consistent with national guidelines as periodically revised by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the American Academy of Pediatrics, and the American Academy of Family Physicians.\textsuperscript{11}

New or continuing efforts in which the AAP and its members can participate that can result in enhanced benefits for children enrolled in Medicaid programs include the following:

1. Develop and then facilitate the implementation of a working pediatric medical home model that...
incorporates Bright Futures guidelines\textsuperscript{12} and treatment services as codified in EPSDT.

2. Work with Medicaid and private insurance companies to standardize parameters for the medical home concept.\textsuperscript{13,14} The wide variation in both panel size and family demographics encountered across pediatric practices suggests that a variety of models may be needed.

3. Develop and direct a program that educates parents, patients, and physicians about the advantages of a pediatric medical home.\textsuperscript{15}

4. Partner with AAP state chapters, other pediatric health care providers, and families with children who are Medicaid beneficiaries to monitor and recommend improvements to state Medicaid programs and to the Centers for Medicare and Medicaid Services (CMS).

5. Assist parents, patients, and physicians to understand the full scope of Medicaid benefits.

**FINANCING AND PAYMENT**

Medicaid fee schedules and capitated payments to primary care and subspecialty providers are significantly lower than payments for comparable services from Medicare and private insurance companies. Low Medicaid payment is the primary reason that physicians limit participation in the program with resulting barriers to patient access for primary care and subspecialty health care services.\textsuperscript{16–22} Even at academic medical centers that serve as “safety nets” for uninsured or underinsured patients, reduced access may be reflected by significantly longer wait times for subspecialty care.\textsuperscript{23} Hence, the initial intent of Title XIX to provide truly equal access to quality primary and subspecialty care has not been fulfilled. Other documented reasons why providers decline or limit participation in Medicaid include delayed or unpredictable payments, confusing or burdensome payment policies and paperwork, and nonadherence to scheduled visits.\textsuperscript{17,18,22}

Although the MOE provision in the ACA proscribes states from restricting their current Medicaid eligibility rules until 2019 for children, states may choose instead to reduce their expenses by limiting nonmandatory services for adults, trimming payments for services, revoking any higher payments to specific groups of physicians, and cutting hospital payments. States have voiced alarm that high unemployment rates and increasing numbers of families enrolled in Medicaid will critically affect their budgets. In addition, as the US population ages, the growing number of seniors who become eligible for Medicare will also swell the ranks of seniors dually eligible for Medicaid coverage. The CMS Office of the Actuary has estimated that if each state fully implemented the ACA Medicaid expansion, state Medicaid expenditures would more than double over the decade from 2009 to 2019, from $132.3 billion to $313.3 billion.\textsuperscript{24}

To the extent that any state chooses to participate in the ACA Medicaid expansion, it will be vital that federal and state governments not compromise necessary coverage for children nor fail to provide adequate payment for pediatric care. In addition, states must be cognizant that ACA continued federal disproportionate share hospital payments to all states, anticipating that Medicaid expansion to the adult population would provide replacement revenue for safety net hospitals. Hence, states that choose not to participate in Medicaid expansion may risk the viability of some safety net hospitals.

In 2011, Medicaid payments for evaluation and management services across all states averaged ∼64% of the Medicare rates and lagged even further behind payments by private insurers.\textsuperscript{25} The ACA provides federal funding to Medicaid programs and state-financed Medicaid managed care plans to pay eligible physicians at Medicare rates for certain evaluation and management services, preventive care, and immunization administration during 2013 and 2014 (but not subsequently), including well-child (“checkup”) codes (Current Procedural Terminology [CPT] codes 99381–99385, 99391–99395). Payment at this level should be sustained beyond 2014 and expanded to include all Medicaid services. This will require intense federal and state-specific advocacy.

The AAP proposes the following recommendations for federal and/or state action:

1. Ensure that Medicaid payments to providers for the goods and services involved in caring for children not only pay for the related work and practice expenses but also provide a sufficient return to make continued operation of a practice or facility economically feasible. In a broader context, payments should be sufficient to enroll enough providers and facilities so that, as required by federal law, Medicaid patients have “equal access” to care and services as do nongovernmentally insured patients in that geographic region. Failure to provide this fair level of payment will lead to continued early attrition of current pediatric providers as well as failure to attract physicians to pursue careers in primary or subspecialty pediatric care. To achieve this aim, the AAP recommends the following:

   a. Increase base Medicaid payment rates for all CPT codes, including pediatric specific CPT codes (eg, well-child checkup,
counseling, and developmental assessment), to all providers to the 2012 or 2009 regional Medicare fee schedule rate, whichever is higher, or, in the case of preventive services without a Medicare payment, to a rate calculated by applying Medicare fee schedule methodology to the published values of work, practice expense, and professional liability insurance relative value units adjusted for the geographic region. These payment rate principles should be made permanent (ie, extended beyond the 2014 termination date) with the minimum level of payment per CPT code established as the greater of the 2012 Medicare actual or calculated rate or the current year’s rate.

b. Establish a methodology to provide additional fair payment to a practice that recognizes the extra resources that might be invested on behalf of its Medicaid patients to promote wellness (eg, to pay for more vigorous outreach to increase participation rates with well-child checkups) and to provide care coordination of infants and children with complicated physical and/or mental health illnesses (eg, to pay for care coordinators, social workers, extended office hours, home visitations, dental care, durable medical equipment, etc). At present, fee-for-service payments (even if increased to Medicare rates) and current Federally Qualified Health Center payments do not fully pay for these extra resources.

c. Reward practices that meet or exceed AAP-approved predefined quality and performance metrics with incentive payments.26

d. Require Medicaid managed care plans to determine payment based on the principles outlined in (a) and (b) so that pediatric providers and patient-centered medical home (PCMH) programs are appropriately compensated. Similarly, require managed care plans to make providers eligible for additional incentive payments, as in (c), if, for instance, providers demonstrate improved outcomes, reduction of total Medicaid costs, and robust efforts to transition children with special health care needs to adult care. Provide input to Medicaid managed care plans about possible designs and implementations of structured incentive programs based on quality and performance parameters advocated by the AAP.

e. Explore the feasibility of adjusting fee-for-service or capitated payments to a provider on the basis of a risk-adjustment mechanism that accounts for the extra costs associated with caring for children with chronic conditions and other key pediatric diagnoses among the children in the provider panel.

f. Establish a mechanism within state Medicaid agencies and Medicaid MCOs for rapid adjustment of fee-for-service or capitated payments to providers for recommended new vaccines and other new technologies that rapidly achieve translation from clinical trials to standard clinical practice.

g. Require that paperwork in support of claims is not unduly burdensome and that clean claims are paid within 30 to 45 days of submission, so that practices can meet their cash flow obligations.

2. Oppose the conversion of Medicaid financing to an annual allotment or block grant programs with a fixed budget. Block grant proposals typically result in cost shifting from federal to state budgets and do not reduce overall health costs or improve quality of care. In fact, institution of block grants in combination with re-ocation of the MOE provision in ACA would likely restrict eligibility and reduce benefits for children to result in the loss of the individual child’s guarantee to access Medicaid services. Recently, the concept of using “per capita caps” to control Medicaid expenditures has resurfaced, but ultimately, this mechanism of funding poses the same risks for children as do block grants.

3. Work with the AAP to study the feasibility of implementing pediatric-specific accountable care organizations through carefully structured demonstration projects.27,28

4. Pay primary care physicians for behavioral health services that physicians are qualified and competent to provide. Eliminate carve-outs for behavioral health coverage.

5. Mandate that states perform an in-depth assessment of the fiscal viability of any health plan before contracting with that plan to administer a Medicaid program and conduct annual audits to verify continued fiscal stability of the health plan. Require states that contract with MCOs to publish their physician payment methodologies and rates for each child eligibility group on an annual basis.

6. Advocate for federal and state agencies to partner with organizations, such as the AAP, to educate
physicians about programmatic changes in Medicaid fee-for-service or managed care environments (eg, pay-for-performance and PCMH programs). Physicians should understand the quality and cost control objectives of new initiatives and the linkage between fully documenting achievement of these goals and payments to physician practices.

7. Pay for the administration of immunizations (including multiantigen vaccines) and for counseling using the current CPT code set. Payments for vaccines should be at least 125% of the current Centers for Disease Control and Prevention private sector price list and payment for immunization administration should be, at minimum, 100% of the Medicare rate for each vaccine administration CPT code.

8. Ensure, wherever possible, the availability of at least 2 financially viable Medicaid MCOs in every region to allow for patient choice. Requests for proposals for organizations to serve as Medicaid third-party administrators and the ensuing selection process should be fully transparent.

9. Explore innovative methods to establish trust funds to support graduate medical education specific to the provision of primary and subspecialty care for Medicaid participants that will help maintain a qualified pediatric provider workforce.

10. Require Medicaid to provide full payment for trained interpreter services for patients with limited English proficiency. This will assist in thorough and accurate communication between provider and participant, increased accuracy of diagnosis and more appropriate treatment plan, and increased participant understanding and adherence to treatment, thus avoiding adverse clinical consequences.

11. Pay for observational care, urgent care, day medicine services, and necessary interhospital transport services, including transport of neonates from tertiary or quaternary neonatal or pediatric intensive care units to step-down convalescent units.

12. Implement policies and procedures to ensure equitable and prompt payment to providers and facilities for pediatric services rendered to Medicaid patients out of state. States should work together and with the federal government to achieve uniform and seamless processes to pay for these services.

13. Require all payers to report financial data on an annual basis so that the medical loss ratios (the percentage of total funding that is spent on patient care functions) are clearly delineated and transparent to the public.

14. Require states to develop clear and transparent rules and regulations related to ACA provisions for recovery audit contracting processes. Each state must ensure that physicians who are licensed and have practiced in the state supervise the work of certified professional coders with expertise in pediatric primary and subspecialty care. Key stakeholders, including physicians and the public, must have direct input in the process to avoid flawed statistical analysis. Payment errors due to both undercoding and overcoding should be included in a final reconciliation report. A clear and fair appeals procedure that is accomplished in a timely manner must be part of the formal recovery audit contracting process.

ELIGIBILITY

The AAP endorses the ACA-mandated expansion of Medicaid eligibility to include all children who live in families with an income below 138% of FPL. The AAP recommends that states implement the following additional measures to facilitate enrollment of children eligible for Medicaid or CHIP benefits:

1. Remove the 5-year waiting period for eligible children and/or pregnant women who are lawfully residing in the United States consistent with the provisions of the CHIP Reauthorization Act (Pub L No. 111-3).

2. Identify uninsured children who are not financially eligible for Medicaid and if possible facilitate enrolling them in CHIP.

3. Ensure that children who are moved by the state into a foster care program are tracked and immediately enrolled in and covered by Medicaid until age 21 using the Chafee option.

4. Ensure that newborn infants eligible for Medicaid are assigned to a specific plan immediately after birth so that timely provision of services in the first few months of life is not impeded by anticipated difficulties in payments of claims.

OUTREACH, ENROLLMENT, AND RETENTION

The AAP recommends that states strengthen their outreach, enrollment, and retention efforts to enroll all eligible uninsured children in Medicaid, CHIP, or exchange coverage.

For fiscal year 2012, the FPL thresholds are $15,415 for a single adult and $31,809 for a family of 4, with the exception of Alaska and Hawaii, where thresholds are 25% and 15% higher, respectively.

A Medicaid option, known as the Chafee option, allows states to extend Medicaid to former foster children but only up to age 21. Currently, there are 21 states that use the Chafee option to provide health care coverage to former foster youth (Chafee Foster Care Independence Act of 1999).
1. Use multiple sites and replicate other effective strategies as have been implemented in CHIP to maximize and maintain enrollment of individuals eligible for Medicaid.

2. Optimize coordination of Medicaid, CHIP, and exchange program outreach through the use of streamlined eligibility determination, redetermination and enrollment processes including the use of short and easily understood common application forms, and expanded use of online enrollment. Once a child is enrolled, coverage should continue for 12 months.

3. Consider using the medical home to enroll patients and provide a fair payment for the administrative expense of this procedure.

4. Adopt practices that result in a “no wrong doors” approach to enrollment. All venues for Medicaid, CHIP, and exchange program enrollment should be able to evaluate an applicant’s eligibility for any of these programs and to process the appropriate application.

5. Advocate support for federal policies to provide incentives to states to increase enrollment and retention in Medicaid and to continue those incentives for CHIP programs.

**MANAGED CARE**

In recent years, fiscal and policy considerations have encouraged states to contract with MCOs to administer the Medicaid program. As of fiscal year 2009, an estimated 61% of Medicaid beneficiaries 0 through 20 years of age were enrolled in a Medicaid health maintenance organization (HMO). The AAP recommends that all MCOs should adopt a pediatric medical home model for all children that adequately addresses their needs, including those with special health care needs. Network adequacy should be determined by periodic evaluation of the number of Medicaid providers whose panels are open to all new Medicaid patients. The AAP recommends that states adopt the following minimum set of practices and standards in their approach to Medicaid MCOs:

1. Ensure that MCOs (these may be either HMOs or provider-sponsored networks) provide educational materials to families that are culturally effective and written at literacy levels and in languages used by Medicaid recipients. The use of audiovisual aids should be encouraged.

2. Provide appropriate written, oral, and Web-based information and counseling to Medicaid eligible patients that allow informed patient choice of MCO-based network options for primary care physicians, pediatric medical subspecialists and pediatric surgical specialists, and pediatric hospital and ancillary services.

3. Assign Medicaid participants to an MCO that allows retention of the patient’s medical home.

4. Recognize that pediatricians are primary care physicians who are eligible for pediatric patient assignment in all default enrollment systems.

5. Ensure that the provider network of all Medicaid MCOs contains the following components:
   a. Sufficient numbers of providers trained in primary care and subspecialty pediatrics, as well as pediatric surgical specialists.
   b. Sufficient numbers of physicians and other licensed providers of oral health, mental health, developmental, behavioral, and substance-abuse services so that medically necessary services are accessible within a reasonable length of time.

6. License an MCO as a pediatric Medicaid provider only if its comprehensive pediatric network can provide children with quality care across the full continuum of care and hold that MCO accountable.

7. For Medicaid programs to be responsive to the needs of both patients and providers, it is essential that the programs be subject to either competition among at least 2 and when possible 3 MCOs in a region or to regulation that is regularly updated to reflect continuing input from patients and providers. Provider service networks (not-for-profit organizations created and governed by providers) should be evaluated and approved on a level playing field with HMOs.

8. Require that Medicaid administrative processes such as site visits and audits are simplified to minimize the burden for providers and office staff. Results of these processes should be available as a report card and transparent to prospective Medicaid enrollees.

9. Implement dedicated planning and oversight when MCOs contract for care delivery to children with special health care needs (including children with complex and/or rare diseases, children with behavioral/mental health conditions, and foster care children).

10. Establish an All Payer Claims Database and require MCOs to participate fully in reporting encounter
data. This would allow health policy analysts and researchers in government, academia, and the private sector to examine regional patterns of utilization, access to care, and quality of care and inform efforts to construct “best practice” models of care.

QUALITY IMPROVEMENT AND PROGRAM INTEGRITY

The AAP recommends that, as appropriate, CMS and the AAP, or state Medicaid agencies and state AAP chapters, should work collaboratively to develop and/or enhance quality-improvement activities that can benefit all children.

1. CMS should encourage collaboration among the Agency for Healthcare Research and Quality, the National Committee for Quality Assurance, the National Quality Forum, the AAP, and the CHIP Reauthorization Act Pediatric Healthcare Quality Measures Centers of Excellence. These organizations can evaluate current quality and performance measures with a goal of recommending modifications or achieving consensus around new measures that pertain to pediatric patients, including children with special health care needs. These measures should align with the recommendations outlined in the AAP policy statement “Principles for the Development and Use of Quality Measures.”

2. States should require health plans to use the core set of pediatric quality improvement measures that were created as part of the CHIP Reauthorization Act. These measures quantify access to care, utilization of services, effectiveness of care, patient outcomes, and satisfaction of both patients and providers related to preventive, primary, acute, and chronic care for children. States should develop mechanisms for public reporting of these measures that allow Medicaid beneficiaries to compare outcomes among MCOs. Consistent with federal statute, states should require that all Medicaid programs provide access to quality primary and subspecialty pediatric care that is equal to that achieved through private payers (“equal access” mandate).

3. At a minimum, states should establish Medicaid Advisory Committees whose membership includes pediatric primary care and subspecialty providers. These committees can advise state Medicaid agencies on issues related to the identification, implementation, and evaluation of quality measures and improvement programs as well as issues related to eligibility, enrollment, formulary, network adequacy, access, and medical necessity. To achieve maximal benefit, each state Medicaid agency should employ a physician with pediatric expertise who can continuously assist the agency with these issues as they relate to pediatrics.

4. Federal and state agencies should work with the AAP to develop tools and measures to monitor potential changes in the quality of pediatric care and the outcomes of the pediatric population. These tools and measures will be helpful in evaluating the effect of PCMHs and the impact of reform on children with special health care needs.

5. States should assume central responsibility for key administrative procedures that pertain to all Medicaid providers. These procedures could include meaningful provider assessment, education (eg, fraud and abuse training), and credentialing activities that would apply for all payers within the Medicaid or CHIP programs.

6. States should report results of peer review and reviews of medical records in a timely manner to providers, plans, and beneficiaries consistent with applicable federal and state laws related to confidentiality, peer review privilege, and care review privilege.

7. States should monitor enrollment patterns and develop prospective means to assess reasons for changes in enrollment to ensure that MCOs do not encourage children with a high level of need to switch to other plans.

8. States should provide timely, meaningful, linguistically and culturally appropriate summaries of quality and performance measure and programs to beneficiaries to guide their choice of Medicaid plan.

CONCLUSIONS

By 2019, if the ACA Medicaid expansion were to be implemented by all states, 16 million additional individuals would gain insurance coverage through Medicaid and CHIP. Regardless of state variations in participation in the ACA Medicaid expansion, Medicaid will remain as the largest single insurer of children. Additional legal proceedings and federal/state negotiations may clarify how DHHS will implement Medicaid expansion in the new adult population. In the meantime, the AAP supports state chapter advocacy efforts to expand Medicaid to the newly eligible population. Although AAP chapters might not take the lead in advocacy, they can provide pediatric expertise to coalition efforts and highlight the positive effects expansion will have on young adults.

To date, governmental health policy on both state and federal levels has not adequately met the medical, behavioral, and developmental needs of children. The ACA has provided a framework to redress some of these deficiencies. The AAP, through its network of chapters, sections, committees, councils, and staff and in partnership with other
allied organizations, can collaborate with both federal and state agencies to monitor implementation of those aspects of the ACA that promise to enhance the care and outcomes of children and young adults and perhaps suggest refinements for future regulations. Success in these endeavors will not only enhance the health and well-being of the children for whom pediatricians care but also will enrich our ability to provide the quality of care to which we aspire.

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Scope of Health Care Benefits for Children From Birth Through Age 26
COMMITTEE ON CHILD HEALTH FINANCING
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Scope of Health Care Benefits for Children From Birth Through Age 26

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POLICY STATEMENT

Scope of Health Care Benefits for Children From Birth Through Age 26

abstract

The optimal health of all children is best achieved with access to appropriate and comprehensive health care benefits. This policy statement outlines and defines the recommended set of health insurance benefits for children through age 26. The American Academy of Pediatrics developed a set of recommendations concerning preventive care services for children, adolescents, and young adults. These recommendations are compiled in the publication Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, third edition. The Bright Futures recommendations were referenced as a standard for access and design of age-appropriate health insurance benefits for infants, children, adolescents, and young adults in the Patient Protection and Affordable Care Act of 2010 (Pub L No. 114–148). Pediatrics 2012;129:185–189

This policy statement sets forth recommendations for the design of a comprehensive benefit package that covers infants, children, adolescents, and young adults through age 26 and is consistent with the Maternal and Child Health Plan Benefit Model: Evidence-Informed Coverage.1 These benefit recommendations apply to all public and private health plans. The services outlined in this statement encompass medical care, preventive care, critical care, pediatric surgical care, behavioral health services, and oral health for all children, including those with special health care needs.

That payment schedules must cover the fixed and variable costs of providing the services is implied in the identification of services and products necessary to ensure the health of children. In addition, payments should be adequate so that physicians, pediatric service providers, and manufacturers will have continued incentive to remain in (or enter into) the business of caring for the health and developmental needs of children. Because of the variety and complexity of systems for delivering care and for providing payments, a complete discussion is beyond the scope of this statement; however, without adequate payment there is significant risk that children and families will be unable to access services and products needed to maintain and promote health in children. This risk is compounded by the recognition that health in adulthood is predicted by health in childhood. It is critical to stress that adequate payment for the provision of child health care services is a vital investment in life span health.

This statement replaces the 2006 statement “Scope of Health Care Benefits for Children from Birth Through Age 21.”2

COMMITTEE ON CHILD HEALTH FINANCING

KEY WORDS
ancillary services, diagnosis, durable medical equipment, emergency care, health care insurance benefits, hospitalization, preventive services, physician services, prescriptions, therapeutic services

ABBREVIATIONS
AAP—American Academy of Pediatrics

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All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

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ESSENTIAL BACKGROUND

All infants, children, adolescents, and young adults through 26 years of age must have access to comprehensive health care benefits to ensure their optimal health and well-being. These benefits must be available through Medicaid, the Children’s Health Insurance Program (CHIP), and private health insurance plans, whether the plan sponsor is a commercial insurance company, a self-funded employer, or other arrangement. The Patient Protection and Affordable Care Act of 2010 (Pub L No. 111-148) also mandated the establishment of health insurance exchanges, wherein health plans must provide a minimum set of health benefits. The minimum health benefits for pediatrics include essential services, such as preventive care, hospitalization, ambulatory patient services, emergency medical services, maternity and newborn care, and mental health and substance abuse disorder services. Also included in the set of benefits are behavioral health, rehabilitative, and habilitative services and devices; laboratory services; chronic disease management; and oral, hearing, and vision care. Some of these benefits may be available or provided through the educational and public health systems for children with special needs and children who are uninsured or have inadequate coverage.

Health care benefits should begin with the full array of services recommended by the American Academy of Pediatrics (AAP). Coverage determinations of existing interventions should be based on evidence of usefulness and understanding of risks. Health care benefit coverage should reflect changes in treatment modalities and should adapt to new evidence and changes in standards of care, as well as innovations in care. Recognizing the importance of scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. If sufficient scientific evidence for an intervention is not available, professional standards of care must be considered. If professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions must be based on consensus pediatric expert opinion (according to the AAP working definition in “Model Contractual Language for Medical Necessity for Children”). The benefits should be delivered in an efficient manner by appropriately trained professionals, including primary care pediatricians and other generalists, pediatric medical subspecialists, pediatric surgical specialists, and pediatric dental professionals. These services should be delivered and coordinated in a comprehensive, patient- and family-centered, physician-led medical home—the setting for primary care delivered or directed by well-trained physicians who are known to the child and family, who have developed a partnership of mutual responsibility and trust with them, and who provide accessible, continuous, coordinated, and comprehensive care.

These services should include but are not limited to the following broad categories: preventive services; physician/health care provider services; emergency care; hospitalization and other facility-based care; therapeutic services/durable medical equipment/ancillary services; and laboratory, diagnostic, assessment, and testing services.

PREVENTIVE SERVICES

Preventive services primarily assess risk factors for, or prevent the development of, medical conditions or developmental disorders that affect health or development. Preventive services include the following:

A. Health supervision with comprehensive preventive care, according to the AAP “Recommendations for Preventive Pediatric Health Care,” and Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.

B. Immunizations according to recommendations included in the most current version of the “Recommended Childhood and Adolescent Immunization Schedules.”

C. Educational, counseling, and support services for all children, including but not limited to the following:
   1. Anticipatory guidance relating to normal growth and development;
   2. Tobacco-cessation counseling and treatment services for children and/or household contacts; and
   3. Services related to the maintenance of a healthy weight—prevention, management, and treatment of pediatric obesity, malnutrition, eating disorders, or nutritional deficiency, including nutrition counseling and follow-up with physician or credentialed nutritionist and all necessary laboratory services, including evaluation of risk factors.

D. Preventive pediatric oral health services, including the following:
   1. Oral health risk assessment, fluoride varnish, sealants, and similar preventive oral care;
   2. Provision of anticipatory guidance examinations and/or diagnostic investigations; and
   3. Oral surgery, including moderate sedation and general anesthesia services, as indicated, to treat oral health problems.

E. Early intervention services for mental health/substance abuse.

F. Preventive vision services, including screenings and examinations by individuals trained in the care of children for the purpose of
early identification of vision problems.

G. Preventive audiology services, including screening and evaluations by professionals trained in the care of children to provide early detection and diagnosis of hearing problems. These services include newborn and other age-appropriate hearing screenings.

H. Preventive reproductive health services, including coverage for counseling and education to promote healthy choices regarding sexuality, as well as appropriate and effective means of minimizing risks of sexually transmitted diseases and preventing unintended pregnancy. Coverage should also be provided for transition of care to other specialists for treatment of pregnancy in young women or appropriate specialists for children with sexually transmitted diseases for whom treatment is beyond the scope of usual pediatric care.

I. Preventive prenatal care, including prenatal consultation with a pediatrician, as well as counseling and services for all pregnancy and fetal management options, including evaluation of psychological risk factors that may affect the health and safety of the infant or family.

J. Preventive postpartum care, including the following:

1. Newborn screening for metabolic and genetic disorders, as well as hearing screening and other appropriate tests;
2. Prompt follow-up visit in the physician’s office (as in between 48 and 72 hours following discharge) when indicated by the infant’s condition and/or on the recommendation of the infant’s physician;
3. Lactation counseling to increase successful breastfeeding initiation and duration; and
4. A reasonable length of stay for the newborn infant to permit identification and treatment of early problems and to ensure that the family is able and prepared to care for the infant at home.

PHYSICIAN/HEALTH CARE PROVIDER SERVICES

Physician/health care provider services are delivered (1) in the primary care/medical home setting, (2) by a medical subspecialist or surgical specialist in coordination with the child’s primary care physician, or (3) under the direction of the primary care physician in the patient’s home or other setting. These services are directed toward diagnosis, appropriate treatment, rehabilitation, or palliative care of diseases and congenital or acquired health conditions. Physician/health care provider services include the following:

A. Diagnosis and treatment of medical conditions.
B. Educational counseling and support services for all children (see also the previous section on preventive services).
C. Transition to adult medical care services for youth.
D. Palliative and hospice care for children with serious or life-threatening conditions.
E. Pediatric medical subspecialty services, including team subspecialty care, family planning, and reproductive services.
F. Pediatric surgical care, including the following:
   1. Pediatric surgical care and surgical specialty services, including comprehensive repair of congenital anatomic malformations; and
   2. Anesthesia and acute and chronic pain management services provided by clinicians with training and expertise in special considerations of pediatric anesthesia care.

G. Behavioral health services, including the following:

1. Mental health services, including (a) diagnostic evaluation and care planning/coordination services; (b) age-appropriate counseling interventions, including individual, group, or family therapy; family-child interaction training; and behavioral therapy training; (c) psycho-educational testing; (d) crisis management; (e) inpatient and day treatment; and (f) residential care. These services should be covered for behavioral and mental health problems that occur in childhood, impair child or family function, threaten the future health of the child, or impair social relationships and/or academic success.
2. Services for disorders relating to substance use, abuse, and dependence, including (a) screening, early intervention, and crisis management; (b) appropriate treatment interventions; (c) inpatient and outpatient treatment; and (d) residential care.
3. Comprehensive medical and psychological evaluation, treatment, and care coordination for suspected or substantiated child physical, emotional, or sexual abuse and/or neglect in both inpatient and outpatient settings.
4. Individual and family grief and bereavement counseling.

H. Prenatal and neonatal services, including the following:

1. Genetic counseling and related services, as indicated;
2. Prenatal case management, including consultation with a pediatrician;
3. Care in response to complications resulting from problems during pregnancy, labor, or delivery;
4. Care of all newborn infants, including the following:
   a. attendance of a pediatrician or neonatology-trained provider for management of high-risk deliveries or where mandated by hospital regulations;
   b. health supervision;
   c. treatment of congenital anomalies and other medical and surgical conditions; and
   d. newborn intensive care services.
   i. Physician-directed, accurate pediatric medical information shared by telephone, telemedicine, e-mail, and/or other Internet services for established and new patients related to pediatric care. This information may include responses to patient or family questions, or may consist of outreach to specific patients relating information deemed important to their health, which may not merit the need for an office visit intervention. These communications should be compliant with regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA [Pub L No. 104-191]).
   j. Home health care services, where appropriate.
   k. Coverage of medical home— or physician-based care coordination and/or case management services (case management may be provided by a case manager or other qualified health care provider working collaboratively with the patient's family and health care team to develop, monitor, and revise a plan to meet the patient's immediate and ongoing health care needs; all children with special health care needs and women with high-risk pregnancies should have access to and coverage for case-management services), including arrangement, coordination, sharing of information among care providers, and monitoring of health care and developmental services to meet the needs of a patient and his or her family."

**EMERGENCY CARE, HOSPITALIZATIONS, AND OTHER FACILITY-BASED CARE**

These services address acute health care needs, ongoing illness, health or developmental conditions, or injury.

   a. Emergency medical and trauma services specifically for children. These services should be covered without regard to preferred provider networks or preferred facility designations, if facility selection is involuntary.
   b. Inpatient hospital and critical care services, including labor and delivery/birth center services, acute care, psychiatric care, inpatient rehabilitation, and substance abuse services.
   c. Intermediate or skilled nursing facility care in residential and rehabilitative/habilitation settings.
   d. Telemedicine services for emergency departments or inpatient facilities that do not have pediatric coverage for critically ill children.
   e. Emergent and nonemergent transfer/transport to a hospital or health facility, between health facilities, and between home and health facilities when indicated.

**THERAPEUTIC SERVICES/DURABLE EQUIPMENT/ANCILLARY SERVICES**

These include specialty services performed in the health care provider's office or delivered in the patient's home or a health care facility, as well as products needed for maintenance of health or treatment of disease.

   a. Coverage for medications, biologics, or other compounds included in the US Pharmacopeia with evidence of safety and effectiveness for the treatment of specific conditions.
   b. Pediatric oral health services, including the following:
      1. Restorative pediatric dental care, including oral surgery with appropriate sedation or anesthesia as needed to correct dental or oral health problems; and
      2. Orthodontic services and appliances to correct problems with tooth and jaw alignment that contribute to other medical conditions.
   c. Vision services, including corrective lenses, surgery, or other treatments by professionals trained in the care of children, and access to pediatric ophthalmologists for treatment of medical conditions of the eye.
   d. Corrective audiology and speech therapy services, delivered by those trained in the care of children. These services include assistive technology (hearing aids, cochlear implants, and so forth) and speech therapy services for children with speech delay.
   e. Nutritional evaluation and counseling services by pediatricians, dietitians, nutritionists, and other therapists for eating disorders (including primary obesity, anorexia, and bulimia) and specific nutritional deficiencies.
   f. Special diets, infant formulas, nutritional supplements, and delivery (feeding) devices for nutritional

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support and disease-specific metabolic needs.

G. Physical, occupational, speech (including speech-generating devices), and respiratory therapy for rehabilitation and habilitation provided in medical centers, private/public-sector offices, schools, residential settings, and the home.

H. Home health care services, including but not limited to physician supervision of care, therapies, private-duty nursing, and home health aides.

I. Rehabilitative and habilitative services and devices.

J. Rental, purchase, maintenance, and service of durable medical equipment, including but not limited to the following:

1. Equipment necessary to administer aerosolized medications and monitor their effects (nebulizer, spacers for inhalers, peak flow meters);

2. Glucometers, insulin pumps, and enteral nutrition pumps;

3. Breast pumps and accessories;

4. Prostheses/braces, wheelchairs, lifts, and other mobility aids;

5. Ventilators, positive airway pressure devices, and other pulmonary treatment and monitoring equipment;

6. Cardiorespiratory monitors, such as pulse oximeters or apnea monitors;

7. Home dialysis equipment;

8. Automated home blood pressure monitors; and


K. Disposable medical supplies, including but not limited to the following:

1. Diapers for developmentally compromised patients;

2. Urine catheters and ostomy supplies;

3. Tracheostomy care needs, suction catheters for managing pulmonary secretions, and other tubing and/or mask needs;

4. Tubing for delivering intravenous or enteral fluids; and

5. Test strips, lancets, syringes, needles, insulin pump supplies, and other diabetic supplies.

L. Respite services for caregivers of children with special health care needs.

LABORATORY, DIAGNOSTIC, ASSESSMENT, AND TESTING SERVICES

These include services that determine the risk, presence, severity, prognosis, or cause of an illness or testing for diagnosing a specific illness, injury, or disability.

A. Laboratory and pathology services.

B. Diagnostic, assessment, and therapeutic services, such as radiology services, and including age-appropriate sedation as needed.

C. Standardized assessment and monitoring tools for identification, diagnosis, and monitoring of educational, developmental, behavioral, and mental health conditions.

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Essential Contractual Language for Medical Necessity in Children
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Essential Contractual Language for Medical Necessity in Children
COMMITTEE ON CHILD HEALTH FINANCING

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POLICY STATEMENT

Essential Contractual Language for Medical Necessity in Children

abstract

The previous policy statement from the American Academy of Pediatrics, "Model Language for Medical Necessity in Children," was published in July 2005. Since that time, there have been new and emerging delivery and payment models. The relationship established between health care providers and health plans should promote arrangements that are beneficial to all who are affected by these contractual arrangements. Pediatricians play an important role in ensuring that the needs of children are addressed in these emerging systems. It is important to recognize that health care plans designed for adults may not meet the needs of children. Language in health care contracts should reflect the health care needs of children and families. Informed pediatricians can make a difference in the care of children and influence the role of primary care physicians in the new paradigms. This policy highlights many of the important elements pediatricians should assess as providers develop a role in emerging care models. Pediatrics 2013;132:398–401

The American Academy of Pediatrics (AAP) published the policy statement “Model Contractual Language for Medical Necessity in Children” in July 2005. The chief principles articulated in that statement are still relevant, but given the structural shifts in the health care delivery system, they no longer adequately address the unique needs of children. This revised policy statement is an update of the 2005 statement.

In light of the passage and ongoing implementation of the Patient Protection and Affordable Care Act (ACA [Pub L No. 111-148]) in 2010, contractual obligations, as expressed in health plan-provider and health plan-beneficiary agreements, have a new significance with respect to the array of health care benefits made available to children and families. In particular, a much used term—“medical necessity”—is, in fact, generally ill defined. As stated in the previous policy statement, “The term ‘medical necessity’ is used by Medicaid and Medicare and in insurance contracts to refer to medical services that are generally recognized as appropriate for the diagnosis, prevention, or treatment of disease and injury.” The term is found in insurance contractual language, and, as stated in the 2005 policy statement, “…an intervention will be covered if it is an otherwise covered category of service, not specifically excluded, and medically necessary.”
would appear that this statement provides a straightforward presentation of medical necessity. However, health insurance coverage is moderated by a host of federal regulations and statutes, state mandates, and other rules. Provider agreements are usually written to incorporate these rules and regulations. As the US Department of Health and Human Services moves to implement the provisions of the ACA, essential health care benefits are not guaranteed to be the same in every state. Consequently, benefits for children may vary from state to state or plan to plan and may contain specific exclusions. The AAP advocates for quality health care for children that promotes optimal growth and development with measures intended to prevent, diagnose, detect, ameliorate, or palliate the effects of physical, genetic, congenital, mental, or behavioral conditions, injuries, or disabilities.

Individuals with health insurance coverage, whether it be Medicaid, Medicare, or commercial insurance coverage, may be unaware of payment or benefit restrictions for the medical services they seek. In addition, services ordered by a physician might only be covered if conditions of medical necessity are met. Medical necessity means that a decision is needed about appropriateness for a specific treatment of a specific individual. The 2005 AAP statement drew on model language developed by Stanford University; however, more specific considerations are needed for children because of their unique needs. Now, as the US Department of Health and Human Services is charged with implementation of the ACA, it is time to address medical necessity and the needs of children. Although Medicare has become the de facto standard of health care benefits and directly influences commercial health care benefit plans, it is important to realize that health care standards designed for adult care often will not meet the needs of children. By and large, the Medicaid program provides coverage for a significant number of children, and it, too, can be influenced by health care standards designed for adults.

A definition of medical necessity for children must recognize that the needs of children differ from those of adults. The foundation for medical necessity for children should be based on the comprehensive, fully inclusive set of services provided by the Early and Periodic Screening, Diagnosis, and Treatment regimen embodied in Medicaid as well as the preventive care recommendations in Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, as stipulated in Section 2713 of the ACA. The language in the Stanford statement considered the scope of health problems, evidence of effectiveness, and value of the intervention. Medical necessity should be guided by these criteria, but health plan and even Medicare language generalizes across populations, as opposed to focusing on specific individuals or groups, including children, often in a manner that is blind to their particular needs. A definition of medical necessity is needed that is more functional or operational and specific to meet the needs of children. Informed pediatricians can help advance such a definition.

Variability in “Essential Health Benefits,” as intended by the ACA, is also cause for concern. There are 10 categories of Essential Health Benefits, including item 10—pediatric services including vision and oral care. The states are allowed individually to define the benefits for each of these 10 categories. Therefore, there is a great likelihood of significant variation in pediatric benefits throughout the nation. States are likely to use different methods of determining medical necessity.

Some examples may help to illustrate the unique needs of children. One such example is the nuance between rehabilitative and habilitative services. Rehabilitative and habilitative services and devices are specifically addressed as 1 of 10 necessary categories of Essential Health Benefits in the ACA. Currently, in many instances, health care coverage is limited to rehabilitative services, referring to the need to restore a lost function. Habilitation suggests a function or skill not yet acquired or attained. More specifically, the National Association of Insurance Commissioners defines habilitation as “health care services that help a person keep, learn, or improve skills and functioning for daily living.” With today’s medical knowledge, conditions poorly understood in the past may now be subject to significant improvement, even functions that have not yet been acquired. Habilitation and rehabilitation services are usually provided by the same professionals, the only difference being the indication for therapeutic intervention. The case is also illustrated when one considers speech therapy for a child with autism or physical therapy for a child with hypotonia—motor skills and developmental milestones not yet achieved. Every newborn infant is a well of unknown potential. The terms habilitative and rehabilitative should be interchangeable where children are concerned. Developmental milestones represent standards achieved by most children in a given time frame, but not all children follow the same trajectory. A primary focus needs to be on the potential for functional gain—hence, habilitative services.
Evidence of effectiveness is a cornerstone of medical necessity, yet such data for children may not be readily available. It would be beneficial if medical necessity was governed by traditional evidence grading, and if not available, a hierarchy or algorithm of standards should be applied. The AAP has published 2 policy statements to aid decision makers in classifying clinical recommendations and ensuring transparency in issuing clinical guidelines.\(^4\),\(^5\) If patient-centered or scientific evidence for children is insufficient, then professional standards of care for children must be considered. The AAP, other pediatric medical specialty societies, and consensus expert pediatric opinion could serve as references for defining essential pediatric care in the context of medically necessary services. Hence, the pediatric definition of medical necessity should be as follows: health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals, such as the AAP, to promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities.

Value is another parameter in the consideration of medical necessity. Value is not simply a cost-benefit assumption. Value, in fact, may be a subjective consideration. The recipient may have an entirely different perception of value than the provider or payer. Value implies quality (ie, access to age-appropriate care, in an appropriate setting, by appropriate personnel) plus desired outcome at a reasonable cost. Pediatricians recognize the so-called marginal effect of some services—extensive interventions for limited or no essential benefit. However, children deserve the intent embedded in the Medicaid provision of the Early and Periodic Screening, Diagnosis, and Treatment regimen, specifically treatment. Given a pediatric definition of medical necessity as mentioned previously, the value of services might also be considered. Examples in which this is particularly true include children with autism spectrum disorders, neurodevelopmental disorders, or expressive speech delay, conditions for which needs are unique and improvement may be slow. Similarly, services that have been provided for an appropriate period of time by an appropriate provider could be discontinued if there is no measureable benefit. In short, services should be provided to children, but continuity is only ensured if there is evidence of a significant measureable benefit. It may be that the only therapeutic benefit is maintenance at a given level of function. If this facilitates more manageable daily living, then the service has value. This might best be exemplified by the continuation of occupational or physical therapy for a child with neurologic damage if only to facilitate safe transfers or to minimize the usual contractures. The goal is to achieve value for both the recipient and the provider. Resources are limited, but every child, with or without disability, deserves the opportunity to declare his or her potential for improvement in his or her daily life. Difficult decisions are part of medical necessity. Cost should not be the basis for denial of services, but the delivery of care in a setting that demonstrates lower cost could be acceptable if quality is not compromised.

Transparency in today’s health care delivery system is essential to credibility. Health plans need to be clear with respect to the evaluation and determinations of medical necessity. The decision pathway, authority credentials of decision makers, and timeliness in the process should feature identifiable criteria or benchmarks in rendering decisions relevant to medical necessity. The expectations of all health plans, including Medicaid and Medicare, should be clear in anticipation of medical necessity requirements, and similarly, the decision-making process should be equally transparent. Consideration might be given to the role of a family advocate or ombudsmen in protecting children and families and intervening to aid in solving their problems related to medical necessity decisions.

As health care reform advances, contracts between providers of care and health care organizations, whether they are medical group practices, accountable care organizations, or health plans, will define expectations and obligations. Essential language should exist to address the unique needs of children in the context of medical necessity. The right of a child to optimal growth and development should be a universal expectation limited only by the restraints of physical or genetic conditions. New and emerging health care delivery models, including accountable care organizations, bundled payments covering hospital and physician services, disease-management models, and others, will influence how health care services are managed for beneficiaries. There will also be contractual arrangements with providers of primary and specialty care, and federal and/or state regulations will influence these contractual relationships. This time of transition affords pediatricians
an opportunity to affect not only overall health care benefits but also the medical necessity decisions that affect pediatric care. All of these agreements should feature essential language that recognizes the unique needs of children and ensures more equitable care for all children. The AAP and its member pediatricians are the informed advocates who can advance a better understanding of medical necessity decisions on behalf of children.

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