



American Academy of Pediatrics



**TESTIMONY OF
MARSHA RAULERSON, MD, FAAP
ON BEHALF OF THE
AMERICAN ACADEMY OF PEDIATRICS**

before the

**COMMITTEE ON HEALTH, EDUCATION,
LABOR AND PENSIONS**

UNITED STATES SENATE

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Department of Federal Affairs
601 Thirteenth Street, N.W.
Suite 400 North
Washington, D.C. 20005
202-347-8600 / 800-336-5475 / Fax 202-393-6137

Good morning. I appreciate this opportunity to testify today before the Committee on Health, Education, Labor and Pensions on Primary and Specialty Care. My name is Marsha Raulerson, MD, FAAP, and I am proud to represent the American Academy of Pediatrics (AAP), a non-profit professional organization of 60,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults.

I am a pediatrician in private practice in Brewton, Alabama; I serve as a member of the AAP's Committee on Federal Government Affairs. I have been taking care of children and adolescents in Brewton since 1981. In the 2000 census, Brewton had a population of 5,498. The largest close city is Pensacola, FL and the closest Alabama hospital specializing in children is 90 miles away in Mobile. Brewton is located in the piney woods of Alabama and its major industry is pulp wood. My practice, Lower Alabama Pediatrics, is 70% Medicaid and we do our best to provide a medical home to all of the children we can reach.

In 2006, I did not break even in my practice because Medicaid patients require so many services and payments are so low. I had to dip into my own savings to keep my practice afloat. Nevertheless, I believe that I have a calling to provide these services to this population, many of whom are children who have severe and long lasting health needs. I have since converted my practice to a rural health clinic.

What is a Medical Home?

AAP believes that every child, regardless of health status, should have a medical home. A medical home is a place, a process and people who partner to improve health outcomes and the quality of life for children and families. In a medical home, care is delivered or directed by competent, well-trained physicians who provide primary care, managing and facilitating all aspects of pediatric care: preventive, acute and chronic. The Academy has led the development of a body of literature surrounding the medical home, including dozens of studies that examine the impact of care coordination on patient outcomes.¹

Children and adolescents deserve a high performance health care system that includes medical homes to promote system-wide quality with optimal health outcomes, family satisfaction, and value. A medical home offers families full service high quality health

¹ The U.S. Department of Health and Human Services' Healthy People 2010 goals and objectives state that "all children with special health care needs will receive regular ongoing comprehensive care within a medical home," and multiple federal programs require that all children have access to an ongoing source of health care.

care and provides comprehensive, coordinated, compassionate, culturally competent care for children.

History of Medical Home

The Academy first pioneered the concept of the medical home in the 1960's as a way to describe the "gold standard" of primary care for children—particularly children with special health care needs.

In March 2007, the AAP joined with the American Academy of Family Physicians, American College of Physicians and the American Osteopathic Association to publish a set of joint principles for the patient-centered medical home. This consensus statement describes the principles of a patient-centered medical home: personal physician, physician-directed medical practice, whole person orientation, coordinated care, quality and safety, enhanced access, and appropriate payment. In addition to these important concepts, the specific needs of pediatric populations also include:

- **Family- centered partnership:** A medical home provides family-centered care through a trusting, collaborative, working partnership with families, respecting their diversity and recognizing that they are the constant in a child's life.
- **Community-based system:** The medical home is an integral part of the community-based system. As such, the medical home works with a coordinated team, provides ongoing primary care, and facilitates access to and coordinates with, a broad range of specialty and related community services.
- **Transitions:** The goal of transitions is to optimize life-long health and well-being and potential through the provision of high-quality, developmentally appropriate, health care services that continue uninterrupted as the individual moves along and within systems of services from adolescence to adulthood.
- **Value and Payment:** To assure optimal quality of care for all children, the health system must provide appropriate payment for medical home services. A high-performance health care system requires appropriate financing to support and sustain medical homes that promote system-wide quality care with optimal health outcomes, family satisfaction, and cost efficiency.

Making a Medical Home Available to All Children: Financing the Medical Home

Medical homes do not just happen. Transforming a medical practice into a medical home has been described as trying to rebuild a bicycle while riding it. But change cannot just be limited to the willingness of the doctor—everyone in the health care system has a role to play. Thus, AAP calls for partnerships among private and public payers, employers, clinicians, and families and patients to ensure that medical home payment reforms are implemented in ways that assure quality, financial sustainability, and equity among payers and providers that assure children and youth receive all recommended and needed services.

These reforms should be based on the medical home joint principles and the payment structure should encompass recognition of relevant payment codes, expanded care coordination responsibility, new quality improvement activities, and up-front investments and support for infrastructure. AAP recommends the following.

- All private and public payers should adopt a comprehensive set of medical home payment reforms that include three components:
 - A contact or visit-based fee component that recognizes and values evaluative/cognitive services and also preventive counseling based upon Bright Futures.
 - A care coordination fee to cover physician and non-physician clinical and administrative staff work (telephone care, on-line communication, conferences with the “care team”) linked to the delivery of medical home services.
 - A performance or pay-for-performance fee for evidence-based process, structure, or outcome measures and paid as a bonus. This bonus should take into consideration the complexity of the patients who are in the panel of the practice. In return for this bonus, physicians should assist payers in addressing such cost centers as emergency department utilization and unnecessary hospitalization.

- Vaccines and their administration costs must be adequately paid for to exceed total direct and indirect expenses and updated when new vaccines are adopted into recommended schedules or when vaccine prices increase.

- Payments should be closely tied to evidence-informed medicine, and methods used for payment should consider the child’s age, chronicity, and severity of underlying problems, and geographic adjustment.

- Payment policies should recognize and reward systems of care that promote continuous and coordinated care “24/7”, including care coordinated between generalists and specialists, population-based prevention, and should discourage the use of clinics that provide episodic care only for minor conditions.
- Competition should be structured so that practices are rewarded for providing access, service, and quality; cheaper care is probably not better care.
- The Centers for Medicare and Medicaid Services should update the Resource-Based Relative Value Scale to take into account the value of the complex and comprehensive nature of cognitive care and practice expenses associated with the medical home model of care, provide health information technology support, and create incentives for continuous quality improvement.
- Congress should sponsor ongoing, large-scale Medicaid medical home pilot projects for children and youth. It should also support an all-payer pilot project of the medical home model for children and youth. Congress should evaluate current state Medicaid and CHIP programs and share information among the states about state programs that are providing good medical homes for children.

Making a Medical Home Available to All Children: Ensuring Sufficient Workforce to Meet Children’s Needs

Meeting the health needs of America’s eighty million infants, children, adolescents, and young adults and providing them with a medical home will require a strong and stable pediatrician workforce comprised of appropriate numbers of well-trained pediatricians, pediatric medical subspecialists, pediatric surgical specialists, and other child health professionals and specialist physicians. Moreover these professionals will be needed where children are--in all rural, suburban and urban communities.

Workforce shortages exist in pediatric medical subspecialties and pediatric surgical specialties. I previously stated that the nearest locus of comprehensive specialty care is 90 miles away. This specialty shortage has real impacts in my community and in urban areas as well. Initiatives are needed to recruit medical students and residents into specific pediatric disciplines and to underserved geographic regions. These initiatives must address the comprehensive needs of children and adolescents.

Federal policies should address and improve the uneven geographic distribution of the physician workforce, including pediatrics, enhance the delivery of culturally effective

health care and include mechanisms to educate and train an appropriate supply of pediatric medical subspecialists and pediatric surgical specialists.

Congress should consider the extension of student-loan deferment until the completion of residency education, and make educational loans tax deductible. In addition, federally-sponsored student loan deferment and forgiveness programs and other incentives for residents and pediatricians should be expanded to ensure a health care workforce that is adequate to meet patients' needs. These incentives also should support pediatricians pursuing academic research careers or practicing in designated underserved communities.

Conclusion

In conclusion, on behalf of the American Academy of Pediatrics and the children and adolescents I take care of in Alabama, I would like to urge the committee to keep children foremost in mind while you consider reforms to our health care system. This is a unique moment on our country's history and an opportunity for us to finally place children first.

Providing all children with health care designed for them – a medical home – that emphasizes their healthy development and prevents illness when possible is an investment in our country's future. This investment coupled with needed improvements in health care financing and a strong primary and specialty workforce will provide all children and adolescents the greatest chance to lead long and healthy lives.

Thank you again for the opportunity to testify. I look forward to your questions.

Marsha Raulerson, MD, FAAP