

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



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June 22, 2009

The Honorable George Miller
Chairman
US House Education and Labor Committee
Washington, DC 20515

The Honorable Henry Waxman
Chairman
US House Energy and Commerce Committee
Washington, DC 20515

The Honorable Charles Rangel
Chairman
US House Ways and Means Committee
Washington, DC 20515

Dear Chairmen:

On behalf of the 60,000 primary care pediatricians, pediatric medical subspecialists, and surgical specialists of the American Academy of Pediatrics who are committed to the attainment of optimal physical, mental and social health and well-being for all infants, children, adolescents, and young adults, we write to express our sincere gratitude for your introduction of the Tri-Committee Health Care Reform Discussion Draft.

The Academy is appreciative of your attention to the fact that children need different services than do adults. The bill comes close to achieving the Academy's highest priorities for health reform. These priorities include coverage for all children in the US, age-appropriate benefits in a medical home, and appropriate payment rates to allow access to covered services. If children have access to comprehensive health services, we can prevent many of the expensive morbidities of adulthood, achieving President Obama's vision to invest in our future and bend the cost curve.

However questions remain regarding the operation of the structures set forth in the legislation and how they might impact children. We are concerned that "Exchange" plans are not required to cover medically necessary services for children, even though the bill takes a step forward in mandating that well child services be available "first dollar" in such plans. Beyond coverage, it is imperative to the Academy that children, especially children at-risk for poor outcomes, receive comprehensive coordinated care that assures their optimal growth and development. Children are not really little adults and need health services that are different from those provided to chronically ill adults.

We look forward to working through these issues as the legislative process unfolds and have listed more specific comments below. Please do not pass up this opportunity to invest in the future American workforce. We greatly appreciate your consideration of the needs of children and look forward to continuing to work with you to ensure that the life success of every child is our nation's highest priority.

Sincerely yours,

A handwritten signature in blue ink that reads "David T. Tayloe, Jr.".

David T. Tayloe, Jr., MD, FAAP
President

AAP Comments to Tri-Committee Health Care Reform Discussion Draft

The Academy's detailed comments are organized in three parts below: first, the Committee is commended for its proposals; second, areas where the Academy hopes to monitor the development of the ideas presented in the legislation as the process unfolds; and third, sections where the Academy would respectfully recommend modifications to the bill.

I. First, the Academy commends the Committee for the following aspects of the legislation:

Sec. 111. Prohibiting Pre-Existing Condition Exclusions

The Academy commends the Committees on the elimination of pre-existing conditions limitations.

Sec.1821. Payments to Primary Care Practitioners

The Academy greatly appreciates the Committees' recognition that payment rates under Medicaid are abysmal in many states. Academy chapters have repeatedly engaged in attempts to enforce the equal access clause, but this new federal commitment of funding to achieve parity with Medicare should improve access to primary care for many children on Medicaid.

Sec. 1822. Medical Home Pilot Program

The Academy applauds the establishment of a medical home pilot program in Medicaid. Since developing and evolving the concept of the medical home in the late 1960's, the Academy has been committed to seeing that all children have access to the comprehensive, coordinated primary care that the medical can provide. The level of funding available to this project is appropriate and will benefit children who receive care in the Medicaid program. We urge the Committees to include language linking this new program to the greatest extent feasible with the Maternal and Child Health Bureau (MCHB) of Health Resources and Services Administration and the services provided through the Title V Maternal and Child Health Block Grant as the experience with the medical home in that program is significant. The Academy would also

suggest that the Committee explore a prohibition on using medical home monies for practices both from the existing Medicare medical home demonstration project and this new Medicaid program.

The Academy is also appreciative of the following components of the legislation:

- Recognition that outreach to special populations, including children, is essential to improve enrollment (Sec. 205(a)(1)).
- Recognition that a child's medical home should not change due to a process of automatic enrollment (Sec. 205(b)(3)(A)).
- Recognition that some families will need culturally and linguistically appropriate assistance in signing up for Exchange plans (Sec. 205(c)(3)).
- Recognition that services such as well child services may not be listed in Medicare fee schedules (Sec. 223(a)(3)).
- Recognition that pediatricians would not be eligible for increased payment rates but for Sec. 223 (b)(1)(C).
- Inclusion of dependent coverage in the employer mandate (Sec. 312).
- Allowance for ERISA plans to elect to be subject to health coverage participation requirements (Sec. 321). Pediatricians report that they currently have difficulty obtaining immunization payments from ERISA plans, and this should alleviate that situation to some degree.
- Inclusion of family coverage in the individual mandate (Sec. 401).
- Streamlining of enrollment procedures and other steps to make it easier for children and families to obtain insurance. (Sec. 501).
- Inclusion of different age groups in research priorities as designated by the Center for Comparative Effectiveness Research (Sec. 1401(c)(4)).
- The inclusion of tobacco cessation drugs in Medicaid coverage for enrollees and particularly for pregnant women (Sec. 1812). Cessation of tobacco use by smoking family members is a pediatric issue and expanded coverage for therapies prescribed by pediatricians would greatly benefit the health of children.
- The inclusion of grants and an option for states to fund nurse home visitation services as well as family planning services (Secs. 1704, 1813 and 1814).
- Increased funding for electronic eligibility systems (Sec. 1833).
- The minimum medical loss ratio for Medicaid managed care organizations (Sec. 1855).
- Workforce solutions for primary care pediatricians (Secs. 2212-2215).
- The promise of enhancing cultural and linguistic competence through training grants (Sec. 2251).
- Funding for the prevention and wellness trust, and the inclusion of a child and adolescent health professional on the Task Force on Clinical Preventive Services (Sec. 2301).
- Expansion of the 340B program to allow discounted drugs to be purchased by children's hospitals and Title V grantees (Sec. 2501).

II. The Academy intends to pay close attention to the ideas contained in the following sections to attain greater clarity regarding their impact:

Sec. 122. Essential Benefits Package Defined.

The Academy commends the Committees on the inclusion of habilitative services and well baby and well child care. The wording of these two standards, in conjunction with the payment provision in (a)(1) appears to imply that *Bright Futures*¹ (“[payment will be provided] in accordance with generally accepted standards of medical or other appropriate clinical or professional practice”) would be the standard for well baby and well child care services. However, many insurance companies currently limit *Bright Futures* visits, resulting in children not being followed as closely or regularly as the Academy considers optimal. Investing in children could best occur if *Bright Futures* is specifically referenced to confirm that well child and well baby visits meet the appropriate standard.

Secs. 205(d and e) Special Duties Related to Medicaid and CHIP and Choice of Medicaid Coverage for Medicaid Eligible Individuals

The Academy appreciates the attention paid to populations, such as those currently covered by CHIP, who will be transitioning to Exchange plans. The Academy is eager to confirm that no child would lose benefits or access to services as a result of the changes to the programs as set forth in these sections. In particular, populations such as foster children, older adolescents and others in non-traditional settings may be impacted by these transitions in unexpected ways. Additionally, it should be confirmed that children with access to EPSDT in Medicaid-expansion states funded with CHIP dollars will not lose access to those services as a result of moving to Exchange plans. We would urge caution and analysis of the special needs of these different populations as we transition to a reformed health care system.

¹ *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents—3rd edition.*
www.BrightFutures.AAP.org

We would urge the Committees to leave children in Medicaid/CHIP up to 275% of poverty so that states can provide seamless care coordination for special needs children through Title V. Community-based care coordination should be available to these children as opposed to disease management programs of commercial insurance companies. It is the Academy's firm belief that special needs children will lose when they are assigned to a multitude of health plans that do not understand the value of community-based care coordination. Community-based care coordination may be the single most important feature of health insurance plans for special needs children.

Sec. 224 Modernized Payment Initiatives and Delivery System Reform.

The Academy commends the Committees for their willingness to explore new payment options under the public plan. This willingness holds the promise to reward pediatricians, families, and children for their work on the medical home, which was first established by the Academy, and which could lead to vast system reform. As this idea progresses, please keep in mind that children often need different services than do adults in their medical homes and thus, structures specific to their needs should be included.

Sec. 245(c)(3). Transition for CHIP

This section is unclear. The Academy is hopeful that final legislative language allows the greatest flexibility so that families whose incomes change will choose plans with the best benefits available for their children. The Academy would urge the Committees to recognize the essential services that children receive through Medicaid, and encourage the Committees to prioritize their continued coverage in a reformed system.

Sec. 1223 IOM Report on Impact of Language Access Services.

The Academy applauds the Committees' desire to analyze how translation services can be improved. The Academy would suggest that children and their families be a particular focus of the report.

Sec. 1302(b)(1). Patient-Centered Medical Home Services

The Academy applauds the Committees' recognition of the patient-centered medical home concept in Medicare. As the demonstration project laid out in Sec. 1302 can become the model for the medical home project in Medicaid, we would urge the recognition by the Committees that in the child health context "evidence-informed" guidelines is a more appropriate standard than "evidence-based." The Academy is acutely interested in confirming that pediatric practices could receive per member per month financing from the Medicare program as a result of this section under either the Independent or Community-based patient centered medical home models, especially for children with special health care needs, who may qualify under the "high need beneficiary" definition. The Academy is also interested to confirm that the community-based model will include pediatrics, as the terminology "per beneficiary per month" seems to imply that non-Medicare beneficiaries would not be eligible to trigger such payments.

Sec. 1303. Rate Increase for Selected Primary Care Services.

The Academy applauds the Committees' recognition that Medicare payment rates are emulated by other payors. The 5% bonus (10% bonus in a health professional shortage area) may also have the effect of significantly aiding many children through this emulation. Structured to flow down to private payers, such a structure could allow many pediatric practices to see more Medicaid children if it is clear that this bonus would be included in private sector payment.

However, it is unclear from the Committees' language in this section whether this increase will be included in an adjuster to the physician fee schedule or through some other formula change.

Sec. 1310. Expanding Access To Vaccines

The Academy is strongly supportive of improving vaccine access and financing for appropriate populations in the United States and elsewhere. There is concern that the current Vaccines for Children Program (VFC) leads to deficiencies in state Medicaid payments to physicians for

vaccine administration. The Academy will further analyze this section to confirm that it will in no way impact the level and amount of funding available for childhood immunization.

Sec. 1802. Requirements and Special Rules for Certain Medicaid Enrollees and for Medicaid-Eligible Individuals Enrolled in a Non-Medicaid Exchange-Participating Health Benefits Plan.

The Academy appreciates the attention paid to the interaction of the Exchange and Medicaid programs. However, as many pediatricians report significant problems with accessing wrap-around services in current structures, the Academy is concerned that the default of purchasing Exchange plans and wrapping around Medicaid services may make accessing those services difficult for families. Children should not be denied services due to bureaucratic hurdles in a reformed system, and no child should be denied entitled benefits or worse off as a result of health reform. The Academy opposes moving children out of Medicaid/CHIP who are at or below 275% of poverty. This is because special needs children desperately need insurance plans that understand the importance of community-based care coordination and have a critical mass of patients to make community-based care coordination a reality for the families of these children.

Sec. 1811. Required Coverage of Preventive Services

The Academy applauds the Committees' emphasis on preventive services and respectfully suggests that the new eligibility categories for adolescents should also reference well child care as do Exchange plans. This section should also apply cost sharing limits on such services for adolescents. No child or adolescent on Medicaid should receive fewer services than in Exchange plans and "first dollar" coverage should be the standard for all preventive services recommended by the Health Resources and Services Administration in its Bright Futures publication.

Sec. 1851. Health-Care Acquired Conditions

The Academy applauds the Committees' desire to increase quality, and its recognition that populations in Medicaid are different from populations in Medicare. It should be made clear that the list of Health-care Acquired Conditions (HACs) in Medicare is not applicable to children in

Medicaid for a host of clinical reasons. The Committees should consider instead the modified list recommended by the Academy in correspondence with the Secretary in 2008 based on the clinical differences of children versus adults. For instance, at least one type of bacterial infection (Group B Strep) commonly occurs immediately after birth in babies, but the presence of this infection triggers non-payment due to Medicare's HAC list.

Approximately 30% of pregnant women have Group B Strep in their vaginal flora so pediatricians have little control over the occurrence of Group B Strep infections in newborns. The Committee should encourage the Secretary to base the HAC policy on the best available clinical evidence for all populations.

III. The Academy would respectfully recommend the following modifications to the legislation:

Sec. 122. Essential Health Care Benefits.

While the Academy is deeply appreciative of the first dollar coverage of immunizations recommended by the Centers for Disease Control and Prevention and well child services, the Academy has significant concern with the ability of the Health Benefits Advisory Committee (HBAC) to limit coverage for medically necessary pediatric benefits. While pediatric benefits are listed as one of the groups of benefits that must be examined, the chair is the Surgeon General, and the HBAC must include a pediatric representative, it is unclear what the HBAC would recommend for children. The fact that the HBAC is required to have only a single pediatric representative could result in a significant lack of expertise in this body regarding the diverse and complex needs of infants, children, adolescents and young adults, who comprise almost one-third of the US population. The Academy urges the Committee in the strongest terms to exempt medically necessary pediatric benefits from the purview of the HBAC. Too many times pediatricians and other child advocates have found that they are consulted too late or serve

as “one member of eighteen” on committees or structures focused on adults. These odds almost always put children at extreme disadvantage and diminish their needs.

We are hopeful that the HBAC process will achieve a result similar to that produced by the National Business Group on Health in its creation of the Model Maternal and Child Minimum Benefit Package, but there appear to be few assurances that children would not be treated as little adults by a body like the HBAC which could be unfamiliar with children’s needs.

Sec. 204(b)(5). Wrap-Around Coverage for Medicaid Eligible Individuals

The Academy appreciates the Committees’ clear desire to provide coverage to Medicaid eligible children whose parents choose to enroll them into exchange plans, but there is concern that such wrap-around structures have historically proved problematic. We would urge the Committees to reconsider the appropriateness of enrolling children into Exchange plans, versus traditional Medicaid, which pediatricians believe produces a much less convoluted way to access services for children.

Sec. 242. Affordable Credit Eligible Individual.

Sec. 246. No Federal Payment for Undocumented Aliens

The Academy applauds the inclusion of families in the list of those eligible for credits, and also commends the Committees for their thoughtful handling of the reality of families with varied backgrounds, but is concerned that families with no documented members may be ineligible for credits. Children do not choose whether to follow their parents to this country and have health needs that may not only impact on themselves, but also their communities, unless addressed through the health system. There are serious public health ramifications to situations where children are not vaccinated for communicable diseases, or have other unaddressed health care needs in the home, school or community.