American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

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STATEMENT FOR THE RECORD

PRACTICING PHYSICIANS ADVISORY COUNCIL

ON BEHALF OF

THE AMERICAN ACADEMY OF PEDIATRICS

JUNE 3, 2002

The American Academy of Pediatrics is pleased to submit this written testimony to the Practicing Physicians Advisory Council. The Academy is an organization of 55,000 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. There are 3 topics on which we would like to provide comment:

- The Medicaid Program and Beneficiary Access
- Medicare RBRVS Physician Fee Schedule
- Regulatory Issues and Their Impact on Pediatric Practice

MEDICAID PROGRAM AND BENEFICIARY ACCESS

The Academy is pleased that the Council is discussing the Medicaid program, a program serving as many people as the Medicare program. In 1998, more than 40 million Americans were enrolled in Medicaid[i] compared to 39 million Medicare participants that same year.[ii] While there are differences between the programs,

many of the issues the Council has recently discussed in the context of the Medicare program – physician participation, physician payment rates, and beneficiary access – are even more critical to the Medicaid program.

Physicians who care for children and pregnant women are disproportionately affected by Medicaid policies. More than one-quarter of all children, 22 million, are Medicaid recipients. Non-disabled children alone account for more than half of all Medicaid recipients. In 1997 Medicaid paid for 35% of all deliveries. [1]

The Academy and its members have made a strong commitment to the Medicaid program. From a 2000 survey of our membership, we know that 89.2 % of pediatricians in direct patient care participate in the Medicaid program. In fact, two-thirds of pediatricians accept all Medicaid patients that contact their practices. The same survey found that on average 30% of a pediatrician's patient caseload is Medicaid. [iii] These figures illustrate our members' pledge to ensure Medicaid children have access to a medical home.

However, inadequate reimbursement is straining this commitment. Medicaid reimbursement rates are about 64% of Medicare rates, and this ratio has declined over time. For example, in 1993 the ratio was 75% of Medicare rates. [iv] Although pediatricians remain committed to the Medicaid program, their practices are at economic risk. In the Academy survey of pediatrician participation, over half of pediatricians reported that Medicaid payments fail to cover overhead.[3] Add to that skyrocketing medical liability insurance premiums, and participation in Medicaid becomes nearly impossible.

We are seriously concerned about children and pregnant women's access to Medicaid services as Medicaid reimbursement rates continue to erode. Medicaid access problems are well documented. A recent Council report noted concern that Medicare beneficiaries do not experience the access problems found in the Medicaid system. [v] The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, the central set of Medicaid services for children, is an example of the extent of the problem. Almost half of the States report that fewer than 50% of children received any preventive care visit, and in 32 States' that participation rate is below 60%. [vi]

It is conventional wisdom that it is unrealistic to expect physicians to participate in the Medicaid program when reimbursement is low. An Academy analysis of pediatrician participation confirms that low rates of physician participation are associated with low reimbursement rates. In the one third of states with the lowest rates of pediatricians participating in Medicaid, Medicaid payment for primary care services is only 55% of Medicare. Conversely, in the one third of states with the highest levels of pediatrician participation, the Medicaid to Medicare fee ratio is 73%. Clearly, higher payment rates correlate with higher participation levels. [vii]

Yet, there is a common belief that because Medicaid is a Federal/State program, such issues as access and reimbursement should be left to State discretion. However, there is a clear federal role. Section 1902 (a) (30) (A) of the Social Security Act [viii] requires that State plans for medical assistance assure that payments are "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are

available to the general population in the geographic area." This provision, commonly known as the "equal access" provision, was added to the Social Security Act as part of the Omnibus Budget Reconciliation Action of 1989 ("OBRA '89").

Unfortunately, the Center for Medicare and Medicaid Services (CMS) (and the Health Care Financing Administration before it) has never enforced the "equal access" provision. States continue to be free to establish physician payment rates without guidance, many not reviewing their rates for several years at a time. And the unfortunate result is Medicaid payment that is woefully inadequate.

To correct this treacherous situation and to guarantee children's and pregnant women's unhindered access to the Medicaid program, we strongly urge the Council to recommend that CMS:

- enforce the equal access provision;
- require all States to raise physician Medicaid reimbursement rates to parity with Medicare;
- require all States to establish a process to review and update Medicaid provider payment rates on an annual basis;
- work with States to accurately measure the Medicaid participation rates of private, primary care pediatricians, family physicians, and obstetricians;
- work with states to examine various strategies to promote provider participation.

Finally, we also ask the Council to consider expanding its purview to include a greater consideration of Medicaid. Most importantly, we encourage the Council to urge Secretary

Thompson to create a Medicaid Federal Advisory Committee as in interim step and support legislation to create a National Medicaid Payment Advisory Commission to address the many physician payment issues related to the Medicaid program.

MEDICARE RBRVS PHYSICIAN FEE SCHEDULE

The Academy supports HR 3351/S. 1707, The Medicare Physician Payment Fairness Act of 2001. The proposed legislation will restore the across-the-board reductions in the Medicare program that will undoubtedly create new access problems for Medicare beneficiaries, particularly in rural communities.

Because Medicare RBRVS is widely adopted by private payers and state Medicaid programs, it often affects those outside of Medicare, particularly children. Recent CMS action on the vaccine administration codes (90471 and 90472) is a prime example. In the November 1, 2001 final rule on the revisions to the Medicare RBRVS physician fee schedule published in the *Federal Register*, CMS published only the practice expense and the professional liability insurance relative values for two vaccine administration codes (90471 and 90472), stating that the service does not have physician work.

The rationale guiding CMS' decision does not reflect what actually happens in a physician's office. The recommended childhood immunization schedule is complex. The National Childhood Vaccine Injury Act requires that physicians provide mandated vaccine information statements (VIS) for each vaccine as it is given, explain the benefits to the patient and community as well as the possibilities of adverse reactions to vaccines, and document risk communication, manufacturer and lot numbers.

Using only the published components, carriers following the Medicare physician fee schedule are able to set an approximate reimbursement of $3.98 per vaccine. This rate is far below cost studies which were undertaken in the early years of the Vaccines for Children (VFC) program for the Centers for Disease Control and Prevention, as well as the total value approved by the AMA/Specialty Society Relative Value Scale Update Committee (RUC), $10.14. Immunizations are a critical part of a pediatric practice. The 60% reduction in administration fees ($10.14 to $3.98) is much less than overhead costs.

Our current success in preventing childhood illnesses through immunization has been made possible by federal/state programs, which allow children to be immunized in their physician's office. A "grab and stab" system of immunization, without time for parental understanding, is neither good for children or our national immunization system. If physicians can no longer afford to provide immunizations as part of comprehensive well-child visits, parents will be referred to public clinics. An unintended consequence of the CMS action is the inconvenience it poses to parents who will now need to go to one place for their child's preventive health visit and another for immunizations. This fragmentation of the child's medical home threatens our success in providing timely immunizations. Immunizations delayed are immunizations denied. This is a particularly harmful example of the Medicare RBRVS system setting policy for internal reasons, without addressing the impact these decisions will have on the rest of the health care system.

The Academy requests that the Council recommend that CMS:

- publish the RUC recommended physician work values along with the practice expense and professional liability insurance RVUs for the immunization administration codes, 90471 and 90472;
- add a Medicaid representative and a pediatric provider as permanent members of the RUC, to avoid further unintended effects on the pediatric health care system.

REGULATORY ISSUES AND THEIR IMPACT ON PEDIATRIC PRACTICE

The Academy would also like to highlight a specific regulatory issue related to the Needlestick Prevention Act and Childhood Immunizations. We are concerned that the mandated use of safe sharps for administering vaccines poses an added burden for the nation's childhood immunization program with no documentation of added safety and with a clear increase in the costs of immunization.

According to a past OSHA advisory position, the use of disposable gloves for injections for routine childhood immunizations is not mandated, as the process was considered low risk for blood borne pathogen (BBP) exposure. In May 2001 OSHA reversed its interpretation of the standards as to whether routine immunizations are high-risk procedures for employee exposure to BBP. This requirement significantly increases the cost of administering vaccines. As we have already discussed, payment for vaccine administration is already threatened.

We ask the Council to recommend that the Department of Health and Human Services:

- exempt injections for vaccine delivery from mandated safe sharps to allow studies of percutaneous sharps injuries in ambulatory health care facilities where childhood immunizations are provided;

- share in financing this unanticipated additional cost.

The American Academy of Pediatrics appreciates the opportunity to provide this written testimony. Should you have any questions about it, please contact Jean Davis, Director, Division of Health Care Finance and Practice at 800/433-9016 ext 4325.

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[i] American Academy of Pediatrics, Division of Health Policy Research. *FY 98 Medicaid State Reports*. Elk Grove Village, IL: American Academy of Pediatrics; 2001.

[ii] Health Care Financing Administration. Medicare Enrollment Trends 1966 – 1999. 2000. November 16, 2000. http://www.hcfa.gov/stats/enrltrnd.htm accessed May 13, 2002.

[iii] American Academy of Pediatrics, Division of Health Policy Research. Pediatrician Participation in Medicaid/SCHIP: Survey of Fellows of the American Academy of Pediatrics, 2000. Elk Grove Village, IL: American Academy of Pediatrics; 2001.

[iv] Norton S, Zuckerman S. Trends in Medicaid Physician Fees, 1993-1999. *Health Affairs* 19; 4: 2000.

[v] Practicing Physicians Advisory Council. Report Number Thirty-Eight to the Secretary U.S. Department of Health and Human Services. December 10-11, 2001

[vi] HCFA Form 416 reports for Fiscal Year 1997.

[vii] American Academy of Pediatrics Division of Health Policy Research. State Medicaid Payment and Participation by Primary Care Pediatricians in Private Office-based Settings.

[viii] Social Security Act (S) 1902(a)(30)(A); 42 U. S. C. A. (S) 1396a(a)(30)(A).