American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

141 Northwest Point Blvd
Elk Grove Village, IL 60007-1098
Phone: 847/434-4000
Fax: 847/434-8000
E-mail: kidsdocs@aap.org
http://www.aap.org

September 12, 2002

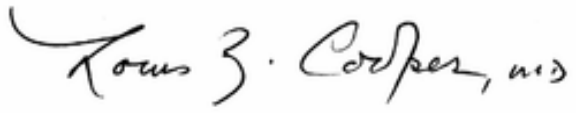
Diana Motsiopoulos
Administrative Coordinator
Practicing Physicians Advisory Council
7500 Security Blvd
Mail Stop C5-17-14
Baltimore, MD 21244-1850

Dear Ms. Motsiopoulos:

The American Academy of Pediatrics would like to submit the attached testimony for the September 23 and 24, 2002 meeting of the Practicing Physicians Advisory Council and is pleased to have the opportunity to present it personally before the Commission. The testimony addresses the issue of Medicaid Beneficiary Access that the Commission has identified as an agenda item for the meeting.

The Academy is an organization of 57,000 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. The Academy looks forward to presenting its testimony before the full Commission. Dr. Julia Pillsbury, a Board-certified pediatrician in private practice from Dover, Delaware will testify on behalf of the Academy. If you have any questions, please contact Edward Zimmerman, Co-Director, Department of Practice and Research, at 800/433-9016 ext 7917.

Sincerely,



Louis Z, Cooper, MD, FAAP
President

LZC/epz

TESTIMONY OF THE AMERICAN ACADEMY OF PEDIATRICS

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

STATEMENT FOR THE RECORD

PRACTICING PHYSICIANS ADVISORY COUNCIL

ON BEHALF OF

THE AMERICAN ACADEMY OF PEDIATRICS

September 23, 2002

The American Academy of Pediatrics is pleased to be able to present its testimony on a key issue before the Practicing Physicians Advisory Council. I am Dr. Julia Pillsbury, a Board-certified Pediatrician in private practice from Dover, Delaware.

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. The topic I have been asked to focus is on the Medicaid program, specifically beneficiary access, preventive care, and immunizations.

MEDICAID PROGRAM, BENEFICIARY ACCESS, AND PREVENTIVE CARE

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, 20. 4 million of who are children and adolescents, were enrolled in Medicaid [1] compared to 39 million Medicare participants that same year.[2] However, this is an incomplete picture. Recent Academy research revealed that while 11 million children and young adults were uninsured for all of 1998, an additional 12 million had gaps in their insurance coverage that typically exceed 3 months. These children and young adults are the shadow uninsured that "churn" on and off public

programs, they also impose administrative costs on the system in terms of enrollment and eligibility verification.

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. [3] 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. [4] 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 a continued dramatic increase in premiums for professional liability insurance (PLI) and the projected constriction in the number of PLI carriers, the perfect storm is brewing and access to the Medicaid program may become 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. [5] However, recent reports from both the American Medical Association (AMA) and the American Academy of Family Physicians (AAFP) report that more and more physicians are also closing their doors to Medicare beneficiaries due to ongoing decreases in Medicare reimbursement. It now appears that both children and the elderly are seeing their access to care being jeopardized by declining reimbursement rates.

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%. [6]

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. [7]

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 [8] 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 is woefully inadequate. In a March 9, 2001 letter to Penny Thompson, then Acting Director of the Center for Medicaid and State Operations, the Academy provided detailed suggestions for enforcement of this provision through measurement of provider participation, children's enrollment and continuity of care, and children's receipt of services. We would welcome the opportunity to share this correspondence with you.

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 publish their payment schedules to managed care organizations (MCOs) and 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.

Most importantly, the Academy encourages the Council to urge Secretary Thompson to create a National Medicaid Payment Advisory Commission to address the many physician payment issues related to the Medicaid program. When the Physician Payment Advisory Commission (PPAC) was replaced with the Medicare Payment Advisory Commission (MedPac), a crucial site for the formal discussion of Medicaid payment and other programmatic issues disappeared. Given the impact that Medicare payment policies mandated by CMS (including the Medicare physician fee schedule) have on Medicaid and private payors, it is critical to establish this Commission. A new forum has to be developed to discuss and vent key Medicaid payment and operational issues and to advise CMS and Congress on physician coding and payment policies related to State Medicaid Programs.

Additionally, the Academy continues to maintain that there is a pressing need for the establishment of a national pediatric Medicaid database, similar to the Medicare BMAD database. While pediatrics continues to work within the realm of Medicare through its involvement in the CPT and RUC processes, there is a limit to how much can be accomplished without the resource of a national pediatric database. An example of the limitations posed on pediatrics due to the lack of a national pediatric Medicaid database was evident during the Evaluation and Management Documentation Guidelines (EMDG) project. While pediatrics was one of the 20 specialties for which clinical examples were to be developed, Academy representatives were told that due to an extremely low frequency of pediatric charts discovered during the Medicare pre-payment audits, pediatrics would have to be excluded from the initial round of clinical example development. The existence of a pediatric Medicaid database would have allowed the Academy the opportunity to enjoy the benefits of participation on the project similarly enjoyed by societies representing adult medicine.

IMMUNIZATIONS

A cornerstone of both public health and the future of children's health is immunizations. In its recent comments on the 2003 Medicare Physician Fee Schedule, the Academy commended CMS for acknowledging that the model of immunization administration may be different in the pediatric population than it is in the Medicare population. In the proposed rule, CMS notes that it will "consider whether the amount of counseling of the patient and/or family may be different for childhood immunizations than for the typical Medicare service, and will consider whether coding changes to reflect these differences would be appropriate." The Academy agreed that pediatric specific immunization administration codes may be the best way to accurately reflect the physician work in administering vaccines in the pediatric population within the constraints

imposed by Medicare budget neutrality. Toward that end, the Academy proposed a set of Healthcare Common Procedure Coding System (HCPCS) Level II codes and descriptors for 2003. The set of four "G" codes were designed for children up to 18 years of age and included percutaneous, intradermal, subcutaneous, intramuscular and jet injections for one vaccine, single or combination vaccine/toxoid provided at a visit and additional vaccines given during a single encounter and for intranasal or oral routes as well. The Academy urges the Council to support the development of these codes and the assignment of the RUC-recommended work relative value units (RVUs) and direct practice expense inputs. The Academy would be pleased to share with the Council the specific descriptors for these codes and the appropriate RUC-recommended values.

Thank you and I would be pleased to answer any questions now or at a time you have designated.

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

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

[3] 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.

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

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

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

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

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