January 4, 2016

Jeremy Silanskis
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20501

Re: CMS-2328-FC; Medicaid Program; Methods for Assuring Access to Covered Medicaid Services (42 CFR 447)

Dear Mr. Silanskis:

The American Academy of Pediatrics (AAP), a non-profit professional organization of 64,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical subspecialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, appreciates the opportunity to respond to the Final Rule with Comment Period Methods for Assuring Access to Covered Medicaid Services.

The Academy believes that CMS must carefully consider the special needs of children and youth (see the attached AAP Scope of Health Care Benefits for Children from Birth through Age 26 policy statement) when constructing measurements of access to care. The health care needs of infants, children, and adolescents are significantly different from those of adults so that measurements accurately documenting access to necessary services will require additional thoughtful deliberation.

The Academy has long advocated the key role of adequate provider payment rates in ensuring equal access to necessary medical services. The Academy supports many aspects of the Rule, but would respectfully urge at a minimum the adoption of the following three critical recommendations: (1) that the payment rates in effect during 2014 constitute the baseline states must use to analyze access to care; (2) that the national immunization infrastructure be strengthened through appropriate VFC reforms including appropriate administration payments which should be included as components of every state’s access to care analysis; and (3) that a federal ombudsman be empowered to field ongoing access challenges experienced by the pediatric and broader Medicaid community.
Thank you for the opportunity to comment on the Final Rule. If the AAP may be of any assistance, please do not hesitate to contact Robert Hall in our Washington, D.C. office at 202-724-3309 or RHall@aap.org.

Sincerely,

[Signature]

Benard P. Dreyer, MD, FAAP
President

BPD:rh
The American Academy of Pediatrics (AAP or the Academy) is grateful for the opportunity to comment on the Methods for Assuring Access to Covered Medicaid Services Final Rule with Comment Period (42 CFR 447) (the Rule) and we do so with respect to the specific needs of children and youth (ages birth through 21 years).

Earlier this year, the Supreme Court ruled in Armstrong v. Exceptional Child Center, Inc., 135 S. Ct. 1378 (2015) that the Medicaid statute does not provide a private right of action to providers to enforce state compliance with §1902(a)(30)(A) of the Social Security Act (the “equal access provision”) in federal court.

The equal access provision requires that State Medicaid plans must “provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and services are available to the general population in the geographic area.”

Children comprise more than half of all Medicaid enrollees, and access to care and services is vital to their healthy growth and development. Ensuring that children enrolled in Medicaid have access to medically-necessary care and services depends on adequate payment rates to Medicaid physicians and other providers. Appropriate payment is associated with a greater likelihood of attachment to a medical home. In turn, having a usual source of care is associated with lower health care costs. Low payment, capitation, and paperwork concerns all relate to low Medicaid participation by pediatric health care providers. Addressing these factors will ensure sufficient capacity to appropriately serve children enrolled in Medicaid.

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I. AAP’s Three Primary Policy Recommendations

The Academy offers three key recommendations as well as some less critical suggestions enumerated below in section II. First, the baseline for primary care access analyses for children and youth should be based on payment rates to primary care physicians and subspecialty physicians sub-boarded under a primary care specialty that were in effect during 2014. Second, immunization administration payment rates should be improved and analyzed in any access analysis to support the national immunization infrastructure. Third, a federal call center/ombudsman should be established to receive, track, analyze, and act on complaints.

A. Use 2014 Payments as a Baseline to Assess Access

A specific baseline for comparison of changes in access is not established in the Rule.\(^4\) The Academy would urge CMS to require that the baseline be set at 2014 payment rates for Evaluation and Management (E/M) codes, a list recognized elsewhere as constituting primary care services.\(^5\) Use of 2014 E/M code payment rates would accomplish a number of objectives. First, the Academy fervently hopes that widespread public disclosure of the extent to which current rates are lower than 2014 rates would spur states to pay more adequately. Payment rates before the provision were appalling in many states and made it highly challenging for pediatricians to care for the number of Medicaid children in their communities who needed care. In addition, use of 2014 as a baseline for analysis will reward states that extended the Medicaid Payment Equity provision after 2014. These states should not be penalized for extending this provision with state dollars, while states that reverted to 2012 rates (or even set rates below those paid in 2012) should be appropriately spotlighted. Third, use of this information would be highly efficient and create at most a minimal administrative burden for states. Payment rates from 2014 for both fee-for-service and managed care plans should be immediately available for every state as each state was required to pay at least these rates for two years. Additionally, new 2015 payment rates should be immediately available for States that did not extend the provision and updated providers and CMS through State Plan Amendments (SPAs) and other communications regarding the 2015 rates.

To facilitate the use of 2014 rates as a baseline, the Academy would respectfully urge that CMS establish a template or model plan, contrary to its stated decision not to. While CMS is correct that, “Each state Medicaid program is unique,” most states have not appropriately used their flexibility to date to establish rates in compliance with the equal access provision. And while access measures may be specific to the characteristics of each state, a template or specific format for states to conduct their access monitoring review plans would be helpful for CMS to insure compliance and a “safe harbor” for states. We respectfully urge CMS to identify model plans and a uniform template for states to consider as they develop their own plans. Allowing the chaotic and widespread use of other standards based solely on state borders will lead to confusion, lack of comparability state-to-state and unnecessary complexity for CMS, States, providers, and ultimately, patients trying to access care financed by the Medicaid system.

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\(^4\) See 42 CFR 447.203(b)(1)(v).

\(^5\) See SSA §1902(jj).
Medicaid payment matters for access to care and for the success of pediatricians in smaller practices and in certain – mainly rural – parts of the country where the great majority of children and youth are Medicaid beneficiaries. The AAP urges CMS to use Medicare rates – as were mandated during 2014 under the Affordable Care Act – as the baseline for payment. Some pediatric preventive E/M codes will require imputation of a Medicare rate using published relative values units and the Medicare conversion factor. The Academy finds no rationale why Medicaid payments should systematically undervalue health care services for children and youth. A service provided to a child is not necessarily less complicated or time-consuming than a similar service rendered to an adult because the child is younger or smaller; in fact, pediatric services not infrequently require greater effort due to a higher degree of medical complexity or procedural difficulty.

The Academy urges CMS to monitor, eliminate, and/or redress unfair administrative payment impediments adopted by payers. For example, Tennessee Medicaid has instituted a “PCP lock-in” program. This requires an electronic check of a Medicaid member’s enrollment in a provider’s panel, which essentially constitutes a preauthorization for every primary care visit. If a PCP sees a patient who the Medicaid plan does not recognize as assigned to him on the day of service, that provider is denied payment. This strategy acts against the goal of increasing primary care access for individuals in a highly mobile population who may require primary care services before a change in PCP can be registered in the plan’s database.

Furthermore, CMS should prevent delay or denial of payment for legitimately rendered services. For example, one of Tennessee’s managed Medicaid programs did not pay for flu vaccine administration to children for eight months. It did not reprocess developmental screening claims that had been inappropriately denied for six months. Another managed Medicaid program in Tennessee routinely denies newborn claims due to “computer glitches.” Timeliness of payments is also important for determining whether payment is real. While Medicaid payments may be two-thirds of Medicare payments, they can also take twice as long to arrive. The opportunity cost of having revenue tied up due to a Medicaid “computer glitch” is not insubstantial for small and independent practices. Random sampling of claims for payment accuracy and timeliness can discourage unfair payer practices that can lead to access issues.

For more contours of pediatric practice, CMS may also wish to consider the frequency of utilization of different types of service per pediatrician and service location. The vast majority of services provided to children are ambulatory, and pediatrics is a high volume practice. For example, in Northern New England from 2007-2010, there were 2.8 office visits per child per year -- that is, 2,800 office visits annually per 1,000 insured children. About 21% of these visits were well child checks, with other visits mainly being sick visits. There were also 359 ED visits (range, 223-635) per 1,000 insured children per year. In contrast, there were 11.7 medical discharges annually per 1,000 insured children (range among various hospital service areas, 6.3-17.8) and 5.2 mental health discharges per 1,000 (range, 1.2-11.6). Medicaid payments support healthy Medicaid practices.
Source: 2008 AAP Socioeconomic Survey of Pediatric Practices. This large-scale mailed survey collected financial, operations and productivity benchmark data from 2,946 FAAPs. In addition, it should be noted that Survey findings suggest a median practice size of 3.5 full-time equivalent physicians, with three nurses included in a total of eight non-physician staff per practice. Staff-to-physician ratio increases with practice size, averaging 3.4 staff per physician in solo and 2-physician practices to 3.8 in pediatric group practices with over 5 physicians. A median of approximately 4,000 visits per physician was reported by pediatricians for multi-specialty groups, compared to 4,500 visits for solo and 2-physician pediatric practices and 5,000 or more for pediatric group practices.

B. Strengthen the National Immunization Infrastructure though Reform of the Vaccines for Children (VFC) Program

Immunization is fundamentally a public health function that requires the vast majority of the population to be immunized to prevent the spread of disease. This is because the evidence is strong that children achieve higher immunization rates when private-sector medical homes participate fully, in concert with a variety of government-funded clinics, in the effort to ensure that all children receive all vaccines recommended by the Advisory Committee on Immunization (ACIP) of the Centers for Disease Control and Prevention (CDC). CMS should encourage the US immunization infrastructure by requiring reporting for immunization administration rates, and undertaking the other policy recommendations in this section. Overall, we urge CMS to require the inclusion of immunization administration payments in every State access analysis.

There is no greater value in the health care system than immunization, but inadequate provider payments for immunizations imperil the public health goal of achieving high rates of population immunity against a host of infectious agents. In many states, practices receive vaccine under the Vaccines for Children (VFC) Program. From a business perspective, the only mechanism for pediatricians to recoup practice costs associated with vaccine inventory, administration, documentation, and family education is through billing vaccine administration CPT codes. Currently, Medicaid programs across the country pay less than 100% of Medicare for vaccine administration codes, an amount insufficient to offset the practice expense associated with vaccines. This financial loss is compounded by the fact that CMS has not interpreted the VFC act to allow usage of the CPT code 90461 for vaccines that contain more than one antigen. Hence, CMS refuses to pay pediatricians appropriately for the additional documentation and counseling expense associated with administering “supershots” such as Pentacel (Dtap-IPV-Hib, a 5 antigen vaccine). If a practice gives Pentacel to a Medicaid patient, a practice can only bill 90471 x1. In contrast, if Pentacel is given to a patient with private insurance, insurance pays for correct coding (90460 x1 and 90461 x4).

This refusal has led to jarring choices for pediatricians. Pediatric practices are forced to make decisions regarding what services can be provided to Medicaid children based on how they are being paid for vital preventive care. One practice in Kentucky has reported wrenching choices that are directly attributable to the decision by the state to revert to paying $3.30 per vaccine administered to uninsured children covered by VFC. Due to this tremendous cut in payment, the practice has terminated its participation in the VFC program. While the pediatricians in the practice will continue to see patients, Medicaid and uninsured patients are instructed to go to the health department for their vaccines. Other offices in the area are doing the same.

The Academy urges CMS to take logical steps to strengthen immunization infrastructure. First, CMS could track immunization administration as part of its required access analysis and rule that CPT code 90461 may be used when administering products provided through VFC. Second, the Academy urges CMS to require States to follow Advisory Committee on Immunization Practice (ACIP) recommendations for access to vaccines. This is particularly important for young adults (19-21) who have not yet lost Medicaid coverage but have aged out of the VFC program. The
broadest use of a vaccine should be covered; that is, payment should be allowed for a vaccine as long as it is “permissible” even if its use is not formally “recommended.” This occurs when ACIP recommendations are broader than FDA-approved package labeling.

Third, the Academy would urge CMS and CDC to work together to address vaccine stock issues. Currently, Medicaid-insured children cannot be immunized by private vaccine stock for influenza vaccine, even though this vaccine is typically available for six weeks or more prior to acquisition of vaccine stock by VFC in the same state. Many children require two doses of vaccine a month apart. When pediatric providers do not receive their first shipment of influenza vaccine until mid-October, it is virtually impossible to successfully reach all children in a pediatrician’s practice and protect them by the time influenza arrives. The VFC program discourages, or in the case of some grantees, simply forbids, the borrowing of payable flu vaccine to administer to patients in the office.

To improve access to vaccine generally, the Academy would urge CMS to consider use of the following metric to gauge VFC versus private influenza vaccination disparity. Most immunization metrics show very good congruence between privately-insured and Medicaid-enrolled children, often with less than a 5% disparity. Occasionally, in fact, children covered by Medicaid may even reflect higher rates of immunization than children covered under commercial PPO contracts. But coverage of flu vaccine for Medicaid children is consistently around 15% lower than commercial. This issue transcends regions and Medicaid programs. Unlike maintaining adequate stocking of basic childhood vaccines, timely delivery of adequate supplies of VFC flu vaccine to pediatric practices is completely beyond the pediatrician’s control. Large pharmacy chains typically receive influenza vaccine before more remote rural practices. In addition, flu vaccine must be preordered six months prior to receipt, and identifying how many VFC infants vs. three year olds who could get Flumist vs. teen asthmatics who need injectable – in a practice with shifting demographics – is challenging. These challenges should be recognized to encourage measurement of access to and utilization of medically necessary care.

The Academy provides in-depth background on vaccines and the impacts that vaccination have on pediatric practices below, but initially, and with respect, strongly urges CMS to include immunization administration as a required component of any access plan analysis. Pediatricians

9 Ibid.
10 One pediatrician provides more colorful contours regarding the challenges flu vaccine presents: “Flu vaccine preorder is like ‘The Price Is Right’ on prednisone: If you order too much, it goes bad (and for payable vaccine, you’re out the $); if you order too little, you usually can’t order more until everyone else has gotten all of their initial pre-order. Some years providers may order 500 doses of VFC but only get a fraction of them until very late in the season. Other years a practice may not get their full order at all. Some states’ VFC programs (like Kansas) do not begin to distribute VFC vaccine to pediatric offices until the state has received its entire order from the distributor -- November or later -- when private vaccine arrived 3 months earlier. Our [rural Tennessee] practice does not start giving flu vaccine until we have ALL 6 types (baby, regular, and Mist for both VFC and private) because it is very difficult to explain to families, ‘We only have vaccine for our paying patients right now’ – this sounds like TennCare discrimination. We have had families leave our practice when we told them this. This access issue is 100% bureaucratic and can only be changed if CDC’s VFC program changes its policies and instructs its grantees to do the same.”
have struggled for years with VFC’s low payment rates and high administrative burden while also achieving significant successes at strengthening herd immunity. Given that federal and state governments have placed a high priority on improving immunization rates, it is only rational for CMS to adopt the Academy recommendations that seek to maintain the strength of our immunization infrastructure.

Although pediatricians have universally embraced immunization as a core competency, recently the pressures of a rapidly increasing number of vaccines, tight financing, and increased time spent counseling about parental concerns are making pediatricians question their ability to continue to offer immunization services. The number of vaccines recommended for routine use in children has doubled over the last 15 years. The demands on pediatric practices to deliver the current standards of immunization practice have increased substantially as a result.

Over the last 15 years, there has been a dramatic shift in the immunization landscape. In addition to an increased number of diseases that can now be prevented with immunization, the number of available combination vaccines has also increased. Along with the traditional measles-mumps-rubella (MMR) and diphtheria-tetanus-acellular pertussis (DTaP), combinations are now available for DTaP-Hib, DTaP-Hep B, DTaP-Hib-IPV, DTaP-HepB-IPV, MMR-varicella, and others (listed below).
<table>
<thead>
<tr>
<th>Vaccine</th>
<th># of components</th>
<th>IA codes reported</th>
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</thead>
<tbody>
<tr>
<td>HPV</td>
<td>1</td>
<td>90460</td>
</tr>
<tr>
<td>Influenza</td>
<td>1</td>
<td>90460</td>
</tr>
<tr>
<td>Meningococcal (MCV4)</td>
<td>1</td>
<td>90460</td>
</tr>
<tr>
<td>Pneumococcal (PCV13)</td>
<td>1</td>
<td>90460</td>
</tr>
<tr>
<td>Hib</td>
<td>1</td>
<td>90460</td>
</tr>
<tr>
<td>IPV</td>
<td>1</td>
<td>90460</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>1</td>
<td>90460</td>
</tr>
<tr>
<td>Td</td>
<td>2</td>
<td>90460 and 90461</td>
</tr>
<tr>
<td>HepB-Hib (Comvax)</td>
<td>2</td>
<td>90460 and 90461</td>
</tr>
<tr>
<td>DTaP or Tdap</td>
<td>3</td>
<td>90460, 90461 and 90461</td>
</tr>
<tr>
<td>MMR</td>
<td>3</td>
<td>90460, 90461 and 90461</td>
</tr>
<tr>
<td>MMRV</td>
<td>4</td>
<td>90460, 90461, 90461, and 90461</td>
</tr>
<tr>
<td>DTaP-IPV (Kinrix)</td>
<td>4</td>
<td>90460, 90461, 90461, and 90461</td>
</tr>
<tr>
<td>DTaP-Hib (Trihibit)</td>
<td>4</td>
<td>90460, 90461, 90461, and 90461</td>
</tr>
<tr>
<td>DTaP-Hib-IPV (Pentacel)</td>
<td>5</td>
<td>90460, 90461, 90461, 90461 and 90461</td>
</tr>
<tr>
<td>DTaP-HepB-IPV (Pediarix)</td>
<td>5</td>
<td>90460, 90461, 90461, 90461 and 90461</td>
</tr>
</tbody>
</table>

Increase in Counseling & Documentation. Given that physicians are a trusted source of information, spending time with parents to address their vaccine concerns at well child visits is an appropriate use of scarce pediatrician time. But costs also accrue with these conversations and resulting administration of vaccines. Per the Current Procedural Terminology code description, counseling about a vaccine includes:

- Obtaining information on potential contraindications to receiving a particular vaccine(s)
- Reviewing/discussing the relevant CDC Vaccine Information Statement(s) (VIS)
- Reviewing/discussing risks and benefits of specific vaccine(s)
- Obtaining informed consent for each vaccine(s) administered
- Addressing all other patient/parent concerns and questions related to vaccines and immunization administration

The October 2009 American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) recommendations indicate that there are 7 minutes of physician vaccine counseling time for code 90460 and 5 minutes of physician vaccine counseling time for code 90461. This is in addition to the counseling provided for other topics during a well child visit.

With passage of the 1994 National Childhood Vaccine Injury Act, providers are required to provide a Vaccine Information Statement (VIS) with every dose of vaccine given and must document federally required pieces of information in the chart as well as the state registry (eg,
manufacturer, product name, lot number, expiration date, date of VIS, name and address of person administering the vaccine). Documentation is typically done by component, so a combination vaccine may need to be recorded 3 times in a child’s record. Documentation of discussions, particularly if a vaccine was refused, also must be recorded. All of this takes physician time.

**Development of the New CPT Codes.** Previously, the pediatric immunization administration codes (90465-90468) paid a provider per vaccine and were separated by route of administration (oral, nasal, injection). Despite CDC and AAP preference for combination vaccines, which lessen the number of injections a child must receive, individual vaccines are paid relatively higher than combination vaccines. And under this system, a pediatrician discussing MMR and autism or the latest outbreak of whooping cough (pertussis) and need for Tdap updates was not being adequately paid for the amount of time spent counseling for each component.

The AAP worked with the American Medical Association CPT Editorial Panel to propose new codes that would address the increased time spent counseling. The Academy then worked through the RUC to appropriately value the new CPT codes. The new CPT codes, 90460 and 90461, replaced codes 90465-90468 and are reported based on the number of vaccine components rather than the number of injections/administrations. A comparison of the old and new immunization administration (IA) codes is below.

<table>
<thead>
<tr>
<th>New codes</th>
<th>Deleted codes</th>
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<tr>
<td>90460 and 90461</td>
<td>90465-90468</td>
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<tr>
<td>Reported “per”</td>
<td>Component</td>
</tr>
<tr>
<td>Age restriction</td>
<td>18 years and younger</td>
</tr>
<tr>
<td>Counseling</td>
<td>Required by physician or other qualified health care professional</td>
</tr>
<tr>
<td>Routes of administration</td>
<td>All routes of administration</td>
</tr>
<tr>
<td></td>
<td>Codes differ based on route of administration (e.g., injectable vs. intranasal)</td>
</tr>
</tbody>
</table>

Through the RUC process, valuation recommendations were developed and forwarded to CMS for inclusion on 2011 RBRVS. These new codes, if paid according to their RBRVS published values, encourage provision of immunizations in the most cost efficient and accessible setting: the patient’s medical home.

The new codes became effective on January 1, 2011. Since that time, pediatricians have reported many implementation problems to the Academy. Although the Health Insurance Portability and Accountability Act (HIPAA) mandates that covered entities recognize new CPT codes when they become active; CMS has ruled that VFC can not recognize 90461. This interpretation undermines the intent of Medicaid and the Vaccines for Children program does not address the issues outlined herein, and ignores real costs incurred by pediatric practices associated with the acquisition, storage, monitoring, loss, and insurance of vaccines and in some states, property tax assessments.
2011 Comparison of relative value units (RVUs) for the new and old IA codes

<table>
<thead>
<tr>
<th></th>
<th>wRVUs</th>
<th>NF PE RVUs</th>
<th>PLI RVUs</th>
<th>Total NF RVUs</th>
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</thead>
<tbody>
<tr>
<td>90460</td>
<td>0.17</td>
<td>0.50</td>
<td>0.01</td>
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</tr>
<tr>
<td>90461</td>
<td>0.15</td>
<td>0.18</td>
<td>0.01</td>
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<tr>
<td>90465</td>
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<td>0.49</td>
<td>0.01</td>
<td>0.67</td>
</tr>
<tr>
<td>90466</td>
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<tr>
<td>90467</td>
<td>0.17</td>
<td>0.49</td>
<td>0.01</td>
<td>0.67</td>
</tr>
<tr>
<td>90468</td>
<td>0.15</td>
<td>0.18</td>
<td>0.01</td>
<td>0.34</td>
</tr>
</tbody>
</table>

wRVU = work relative value unit
NF PE RVU = non-facility practice expense relative value unit
PLI RVU = professional liability insurance relative value unit
Total NF RVUs = total non-facility relative value units

Vignettes of payment under the old and new codes

<table>
<thead>
<tr>
<th>Vignette #1</th>
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<tbody>
<tr>
<td>CPT Codes</td>
<td>RVUs</td>
<td>RVUs</td>
</tr>
<tr>
<td>DTaP-Hib-IPV</td>
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<td>0.67</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep B</td>
<td>90466</td>
<td>0.36</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>90468</td>
<td>0.34</td>
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<tr>
<td>Pneumococcal</td>
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<tr>
<td>TOTAL RVUs</td>
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<td>TOTAL PAYMENT</td>
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<table>
<thead>
<tr>
<th>Vignette #2</th>
<th>2010</th>
<th>2011</th>
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</thead>
<tbody>
<tr>
<td>CPT Codes</td>
<td>RVUs</td>
<td>RVUs</td>
</tr>
<tr>
<td>DTaP</td>
<td>90465</td>
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<td>Hib</td>
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<tr>
<td>TOTAL RVUs</td>
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<td>4.76</td>
</tr>
<tr>
<td>TOTAL PAYMENT</td>
<td>$83.24</td>
<td>$161.73</td>
</tr>
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</table>

administration is a cause for grave concern about pediatricians’ abilities to financially sustain immunizations of children on Medicaid.

We urge CMS to reconsider its decision regarding payment for 90461 for vaccines administered through VFC programs, and also respectfully urge CMS to require states to include immunization administration rates in all access analyses due to the value of the intervention.

C. Appoint an Empowered Federal Ombudsman

The AAP would respectfully urge CMS to establish a federal ombudsman to field and act on provider and beneficiary complaints. Providers should be able to submit data to CMS proving that Medicaid-eligible patients do not have access to health services to the same extent as patients with private health insurance. Currently, the Rule contemplates Medicaid administrators submitting data and reports to CMS to convince CMS that patients have access and that providers are paid fairly. Pediatricians harbor deep concern that states—many of which have been recalcitrant actors repeatedly paying too poorly to guarantee access—will act differently simply because they must report their deficient rates. The system that has resulted from State-set rates has repeatedly disclosed rates in the past. Nonetheless, Medicaid programs systemically undervalue children compared to adults by paying on average only two-thirds what Medicare pays for the same primary care service. Beneficiaries, pediatricians and other providers need CMS to act on deficient access issues, and not passively accept State analyses of Medicaid access as an acceptable status quo.

II. Other Policy Considerations

Beyond the Academy’s three specific policy recommendations above, other policy issues that the Academy finds important for comment in the Rule must also be addressed. First, the Academy is concerned that the Rule does not require states to improve payment as a first logical step to realizing the equal access provision of the Medicaid statute. By not advocating for payment equity, the Rule does not leverage preliminary findings from 2013-2014 that support the proposition that payments at Medicare rates improve access. The Rule states: “even if access issues are discovered … states may be able to resolve those issues through means other than increasing payment rates.” Such an approach devalues recent evidence as well as peer-reviewed reports in the academic literature that strongly link payment rates and access.11 Allowing state Medicaid and MCO plans to pursue other unspecified and untested approaches will only perpetuate existing access inequities for Medicaid beneficiaries.

Second, we are deeply concerned that the Rule does not by its terms compel Medicaid MCOs to disclose payments and access measure and metrics, even though the majority of children covered by Medicaid are enrolled in managed care plans. According to the Medicaid Statistical Information System (MSIS), 22.8 million (70%) of 32.8 million Medicaid enrollees through age 20 were enrolled in some pre-paid plan (HMO/medical, dental, behavioral health, primary care

11 See Polsky, Ibid.
case management, or some other form of Medicaid managed care). The Academy would urge CMS to make payments, access measures, and performance metrics of each state Medicaid or Medicaid MCO plan transparent and open to the public for study and review. This would be consistent with the transparency that CMS has afforded the records of Medicare payments and outcomes metrics. Perpetuation of the secrecy that currently cloaks Medicaid MCO data is a disservice to patients and taxpayers.

Third, the Rule requires providers to convince their state Medicaid programs that the programs should pay more reasonable rates. With respect, providers have been trying to do this since 1965 and have generally not succeeded. During the late 1990's, for instance, North Carolina Medicaid reached payment rates of 100% of Medicare. Since then, payment has fallen and access, especially for adults with disabilities, patients with dental problems, patients with mental health needs, and adolescents, has declined to unacceptable levels. Pediatricians are very frustrated that while CMS establishes a very thorough method for determining Medicare payment rates, it implements an entirely different payment system for Medicaid even though CMS provides the majority of funding for the program. Despite continuous efforts by providers to enforce the equal access provision over the fifty-year existence of the Medicaid program, provider payments still average two-thirds of the Medicare rate in many states. CMS should assure that Medicaid payment is at least equivalent to Medicare payment to reverse the systematic undervaluation of children, pregnant women, adults with disabilities, and their providers. The proposed Medicaid payment system has become highly complicated, and this level of complexity would be avoided if health care services rendered to Medicaid patients by providers were simply paid at least at Medicare rates.

Fourth, access to the comprehensive services recommended in Bright Futures is the accepted standard for pediatric care. CMS can most effectively determine whether access to pediatric primary care services is appropriate through two screens:

(A) CMS should determine within each state Medicaid and Medicaid MCO plan if payment is rendered for both a well-child checkup and for other elements of the Bright Futures suite of services, including screenings and vaccinations, if provided on the same day. Many plans limit the number of paid vaccines per day or may not pay for vaccines if billed with a code for a well child checkup visit on the same day. While such limitations may be reasonable for the Medicare population, they are neither appropriate nor practical for pediatric primary care. The Academy urges CMS to conduct a systematic review of Medicare’s Medically Unlikely Edits (MUEs) algorithms and modify or rescind an algorithm in consideration of best practices in pediatrics.

(B) CMS should query state Medicaid and Medicaid MCO plans about whether they have enforced any timing restrictions or quantitative caps on recommended EPSDT and other necessary services for children. An example of timing restriction is the disallowance by Medicaid plans of payment for a second EPSDT visit if it occurs within 365 days of the prior visit. The Academy finds no justification for this arbitrary restriction and notes that it unnecessarily complicates best practice. There is no reason why four consecutive EPSDT visits
that occur at intervals of 11 months, 15 months, and 10 months for the convenience of the family would result in denied payments for two of the four visits. Nevada Medicaid has arbitrarily set a cap of two CPT code 99215-level office visits in the primary care setting per calendar year. If a patient has had already two high-level office visits, the physician must decide whether to refer issues properly handled in the primary care setting to a specialist, or delay care until the next calendar year, when the clock starts anew and payment will not be denied.

Fifth, access to a children’s hospital with comprehensive services is critical for all children and youth. Hospital access must include the full gamut of inpatient and outpatient services (e.g., medical and surgical subspecialists, therapists, nutritionists, and imaging) and to inpatient pediatric mental and behavioral health services. Hospital access must be defined as access “through all doors,” not just the emergency department doors.13

Sixth, the confluence of two small networks does not necessarily create a network adequate to address pediatric needs. Access to services is sometimes controlled by multiple agencies and health plans, each with its own agenda. For example, dental services for special needs children must often be provided in a facility setting under anesthesia. This requires the participating dentist to find an in-network hospital or outpatient surgical center and an in-network anesthesia provider. Often these networks do not intersect with the result that the child cannot receive the service despite what appear on paper to be robust medical and dental networks.

Finally, the Academy strongly supports CMS’s statement that, “To the extent that individuals in the state obtain access to a particular type of service through out-of-state providers, including through telemedicine or telehealth, or to the extent that individuals in a geographic area generally obtain services through out-of-state providers, the state will need to consider such providers in reviewing access to care.” Academy fellows have repeatedly raised the real issue of cross-state access for children in their care, especially for children and youth with special health care needs (CYSHCN), who may live in states with historically high-volume, out-of-state use of services.

13 For example, for many years, East Tennessee Children’s Hospital (ETCH) was in-network (for facility and most specialists) for one Medicaid Managed Care Organization (MCO) only for patients admitted through the emergency department. This led to a scenario whereby, for example, a child with a severe asthmatic attack might need to be admitted to the children’s hospital for management. The same child presenting early to the pediatrician’s office could not be admitted directly as an inpatient, even though this would save the resources of an emergency department visit. Another problem with this structure is that, at discharge, an asthmatic patient may need, for example, a pulmonology appointment, cystic fibrosis testing and an x-ray. Once the child was designated as an established outpatient (either immediately or 30 days afterwards), the pulmonologist would be considered “out of network” and no longer approved. This structure had severe impacts on access for the child, requiring the patient to establish care with a different pulmonologist who was not familiar with the hospital course. The structure also led to concerns of patient abandonment, in which Medicaid patients may not understand why a prior subspecialist can no longer care for the child. Patients may reasonably choose to visit the local out-of-network ER to bypass the in-network requirement so they can see the local pediatric specialist and renew the 30 day single-case agreement, rather than traveling 3 hours to the next nearest in-network children’s hospital (especially if they lack adequate transportation). Cystic fibrosis testing and x-ray are outpatient tests done at a hospital facility; because ETCH was not in-network for “elective” (i.e. non-emergency) outpatient services, they were not be permitted. This was unfortunate particularly given that many community hospitals, while “in network,” are not experienced at doing specialty lab/image testing on young patients and can produce lower quality results. These lead to treatment delays while tests are repeated, leading to increased parental anxiety and increased physician medico-legal risk (further promoting “defensive medicine” and higher expense).
Such high volumes should themselves be indicative of access issues that the State should address through higher Medicaid payments.

III. Specific CMS Requests for Feedback

Further aspects of the Academy’s response relate to specific requests for comment from CMS.

Documentation of Access to Care and Service Payment Rates (§ 447.203). CMS has finalized the provision to require that states make access data reviews available to the public and to CMS for review. The Academy strongly supports this provision.

CMS has stated that, “Currently, there are no national standards to demonstrate access for each Medicaid covered service that would take into account differences in state geographic locations.” The Academy would strongly disagree, because Medicare rates can serve as an efficient and effective proxy to demonstrate access to care. Also, these rates are modified by geography through each code’s Geographic Practice Cost Index modifier.¹⁴

The Academy strongly supports the inclusion of dental services in any Medicaid payment analysis, as this will better force states to confront and publicize oral health access deficiencies more transparently. CMS accomplishes oral health access disclosure under the Rule by requiring states to publish dental rates as a “primary care service.” While many oral health services are not truly primary care, it is critical that access to oral health improve in the pediatric Medicaid population. Every effort should be made to improve access to these services.

The Rule also requires that states establish a mechanism for ongoing beneficiary input and that states log the volume and nature of responses to beneficiary input. In addition, CMS has added a requirement that states establish and maintain a similar provider feedback mechanism, and recommends use of a state’s Medical Care Advisory Committee (MCAC).¹⁵ The Academy strongly supports these structures.

The Rule also contemplates beneficiary complaints triggering access reviews, however it is unclear from the Rule the weight to be granted to beneficiary complaints, and has no gauge of emphasis on preventive versus acute service complaints. The Academy would urge that any complaint from a beneficiary should trigger a federal access review following a mandatory access review initiated by a State. AAP would respectfully note that health literacy is correlated with income, and is lower in lower-income populations on average.¹⁶ Additionally, children are uniquely dependent on adults to access the health system for them. Unfortunately, adults with lower health literacy tend to over-utilize the health system to treat acute health issues rather than prevent health issues, meaning that they present their families to the health system with greater

¹⁵ See 42 CFR 431.12
Also, “Adults living below the poverty level had lower average health literacy than adults living above the poverty threshold.” See https://nces.ed.gov/pubs2006/2006483.pdf.
morbidity burdens. The Academy would urge CMS to require that a balancing be included in any access analysis to focus on utilization of preventive services, as especially in the pediatric context, prevention should constitute the vast majority of service utilization. Due to the general lack of understanding of the breadth of the Early and Periodic Diagnosis Screening and Treatment (EPSDT) benefit, CMS and states should treat beneficiary complaints with deep respect and prioritize them appropriately. A family unable to access care who has successfully navigated the Medicaid system to file a complaint will generally need immediate aid, and not just an application to file a complaint with a possibility of later adjudication.

Beyond an automatic access analysis triggered by any beneficiary complaint, CMS and States should also reach out to important groups that bolster access to Medicaid services for vulnerable populations. To establish an “early warning system” regarding access beneficiary challenges, CMS and states should work with their family-to-family health information centers, which are federally funded and serve as health system navigation hubs for children and families with special health care needs. Additionally, interaction with Title V programs should also provide important patient-oriented information to flag, and hopefully provide an early warning sign re: CYSHCN and access. Finally, AAP state chapters are acutely aware of access challenges in every state and CMS should reach out to these organizations to find the best avenues and strategies to adequately gauge unmet need in the pediatric population whose care is financed by Medicaid. States should be encouraged to consult with these organizations as well.

CMS has stated that it is “not currently proposing national standards to be applied across all service categories or uniformly for all states,” but invites comment regarding “whether a core set of measures or thresholds should be applied to Medicaid, and, if so, what those specific measures or thresholds would be.” The Academy would respectfully urge swift reconsideration of this decision and implementation of Medicare payment as an appropriate national standard floor for Medicaid payment rates.

CMS has stated that a formal federal process will not be established to receive and respond to access complaints. However, CMS invites comment regarding, “the feasibility of requiring a state level formal hearings process where access to care concerns will be independently heard by a hearings officer.” The Academy would strongly support this structure if it is meant to apply to a federal hearings process.

CMS suggests that states refer to their MCAC as one possible avenue for State/provider liaison. The Academy strongly supports this proposal and would urge that any Medicaid rate change be analyzed by the MCAC prior to implementation.

The Academy respectfully disagrees that the term “modified” in the context of rate changes should be left to state discretion. Even though CMS suggests that “modified” means “reduced,” it eviscerates that standard by stating that such cuts only trigger scrutiny if they occur “in circumstances when the changes could result in access issues.” CMS goes on to state, “To the extent that states are unsure whether a change could result in access issues, we will work with states individually to make a determination.” The Academy firmly believes that any cut in rates

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17 http://health.gov/communication/literacy/quickguide/factsliteracy.htm
18 See Bright Futures generally.
should trigger scrutiny, especially as health costs have again begun trending upward at double
digit rates. Cuts represent not only a significant decrease by their very nature, but in the context
of medical inflation, failure to increase payments in line with medical inflation may be
functionally equivalent to a significant payment reduction.

In the context of 42 CFR §447.205 (“Public Notice of Changes in Statewide Methods and
Standards for Setting Payment Rates”), the Academy strongly supports the CMS decision to
remove the term “significant” from the provider’s determination of a “change in payment
methods and standards” that would trigger the public notice requirement under the Rule.

CMS has solicited comment whether it should allow for exemptions to the scope of required
access reviews mandated under § 447.203(b)(5), including whether to permit streamlined
approaches to measuring access to care based on specific circumstances within states. For
instance, CMS notes it has particular interest in whether states with higher percentages of
beneficiaries enrolled with managed care organizations should be exempt from conducting the
ongoing access data reviews and/or the rate reduction monitoring procedures and what threshold
for such exemptions would be appropriate. We understand that many states carve out certain
services from managed care capitation rates and continue to pay for those services through FFS.
We also understand that many of the individuals who remain in state FFS systems may have
complex care needs. We note that states already have significant flexibility within the final
provisions of the rule to choose measures within their access monitoring review plans that are
tailored to state delivery systems. This could allow, for instance, a state with high levels of
managed care enrollment to focus on specific care needs of the populations that remain in FFS
after a managed care transition. The Academy would respectfully urge that any further access
analyses focus on the neediest populations and adhere to the benefit of CYSHCN.

IV. Excerpted AAP Policy

The Academy has analyzed access to care for children in Medicaid for decades because the
Medicaid program is a keystone of financing care for the most vulnerable children in the United
States. As a result, the Academy has generated numerous policy statements to address Medicaid
and other payment issues. For ease of consideration by CMS, this comment excerpts relevant
Academy policy below:

Medicaid Policy Statement, Pediatrics, May 2013,
http://pediatrics.aappublications.org/content/131/5/e1697/.
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. ...It is necessary to ensure that Medicaid payments to providers for the goods and
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.

**Relevant Recommendations:**

- Increase base Medicaid payment rates for all CPT codes, including pediatric specific CPT codes (e.g., 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.

- 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.

- 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.

- 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.

- 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 (e.g., 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 (e.g., 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.

**Principles of Health Care Financing, Pediatrics, Nov. 2010,**
http://pediatrics.aappublications.org/content/126/5/1018.

The payment structure for comprehensive care should encompass recognition of relevant Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, optimal community-based care coordination, current quality-improvement activities, and up-front investments and support for medical home infrastructure, including health information technology.
Payment policies should recognize and reward clinicians who provide population-based prevention and who promote continuous and coordinated care, including care coordination between generalists and specialists. Payment should be discouraged for clinics that provide episodic care for minor conditions.

**Guiding Principles for Managed Care Arrangements for the Health Care of Newborns, Infants, Children, Adolescents, and Young Adults, Pediatrics, Aug. 2013, [http://pediatrics.aappublications.org/content/132/5/e1452](http://pediatrics.aappublications.org/content/132/5/e1452).**

Cost-efficient health care delivery should be driven by performance-incentive programs focused on improved quality of care, actual clinical outcomes, and patient satisfaction, rather than policies that create barriers to care or discourage a willingness to provide services for children with special health care needs. It is well understood that inadequate physician payment can be a significant barrier to physician service access. Attention should be paid to the relationship of payment on access to care and the quality of care that children and adolescents receive.

Payers are now looking at value-based benefits, comparative effectiveness, or patient-centered outcomes research to support their medical management and benefits coverage. However, adult-oriented policies frequently cannot be applied to the decision about a child’s health care. Many of these “evidence-based” studies are not developed with a pediatric focus, are derived from best-case actuarial data, or are proprietary. The implementation of medical management guidelines that do not address the unique needs of children may adversely affect the health and well-being of pediatric patients, especially those with special health care needs.

The methods used for pediatric health care payment should consider age, chronicity and severity of underlying health problems (case mix, risk, or severity adjustment), service area market, and geographic considerations. Payments to the Patient Centered Medical Home (PCMH) for chronic condition management should support the additional visits and time spent on care plan development and complex disease management, as reflected in Current Procedural Terminology (CPT) codes for care plan oversight, non-face-to-face care, complex and transitional care, telephone care, and E-mail consultations, as well as recommended pediatric services provided by nonphysician professionals. The payment structure should encompass recognition of all CPT and Healthcare Common Procedure Coding System codes based on their relative value units (RVUs), the complexity of the physician’s patient panel mix, expanded care-management responsibilities, after-hours accessibility, new quality-improvement activities, and up-front investments and support for infrastructure.

Managed care plans need to make transparent all policies and procedures regarding coverage and payment determinations, including fee schedules and claims edits. Any changes affecting payment to the pediatrician must be provided in writing and in advance to provide timely notification and allow time for review/appeal/negotiation by the pediatrician. There must be a specified time period for repayment requests applied equally to payers and clinicians, and payment offsets on future claims to adjust contested claims already paid by managed care plans should be prohibited.
Appropriate payment for immunizations should be based on the actual cost incurred by the practice and should include a reasonable margin to encourage provision of these services within the medical home. Actual cost calculation should include the purchase price, applicable taxes, shipping/handling charges, and total additional costs associated with vaccine inventory management, including but not limited to finance costs, immunization registry reporting, vaccine administration, personnel costs, and factors for inventory control, loss prevention, inventory shrinkage, and vaccine storage (including specialized refrigerators/freezers, temperature controls, and alarms).

All capitated rates should be adjusted for case-mix differences based on age, geographic location, modifiers for children with special health care needs, outlier risk adjusted methods, more risk adjusted rating groups, a pediatric diagnostic classification system, or a combination of these. As risk adjustment techniques are developed by payers, it is necessary to incorporate a pediatric focus and involve PCPs and pediatric specialists experienced in private practice in their design.

In all payment systems and methodologies, pediatric services within the context of the medical home should be appropriately assessed to ensure that pediatric primary and specialty services are not undervalued in terms of practice expense, professional liability, and physician work. Financial incentives to encourage use of the medical home must be paramount, and there should not be financial incentives by the managed care plan to encourage use of nonmedical home service offerings, such as retail-based clinics and/or urgent care centers.

Thank you for your attention to the views of the American Academy of Pediatrics.
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).

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. 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.”

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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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 pediatric- 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.7

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

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