American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

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June 15, 2009

The Honorable Edward M. Kennedy
Health, Education, Labor and Pensions Committee
US Senate
Dirksen Senate Office Building Room 428
Washington, DC 20510

Dear Chairman Kennedy:

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

The Academy is very appreciative of your clear efforts to prioritize children's health throughout the bill. The Academy's highest priorities for health reform may be achieved if the legislation were to become law. These priorities include coverage for all children, age-appropriate benefits for children in a medical home, and appropriate payment rates to allow access to covered services. If children have access to comprehensive health services, we can prevent many of the expensive morbidities of adulthood.

However questions remain regarding the operation of the structures set forth in the legislation. Of particular note, it does not appear certain that families are mandated to purchase coverage for their children. Thus, we may not achieve coverage of all children as a result of health reform. Similarly, we are concerned that "Gateway" plans are not required to cover medically necessary services for children, even though the bill takes a significant step forward in mandating that Bright Futures preventive services be available with "first dollar" coverage in such plans. Finally, it is unclear how existing public program payment rates would be impacted by the legislation, especially if Medicaid programs across the country absorb significant new populations under already strained budgets.

We look forward to working through these issues as the legislative process unfolds and have listed more specific comments below. We are concerned that while many children may be helped by your efforts, we should not pass up this opportunity to help all children in the US. We greatly appreciate your consideration of the needs of children and look forward to continuing to work with you to ensure that the life success of every child is our nation's highest priority.

Sincerely yours,

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

DTT:rh

AAP Comments to Affordable Health Choices Act

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

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

Sec. 2708. Coverage of Preventive Services.

All Gateway plans appear required to cover immunizations recommended by the Advisory Committee on Immunization Practices and Bright Futures well child care with no more than minimal cost sharing (Sec. 2708(a)(2) and (3)). This requirement represents a major step forward in recognizing that the preventive needs of children are significantly different than adults and the Academy strongly commends the Committee for the inclusion of this provision.

Sec. 2709. Extension of Dependent Coverage.

The legislation requires that group and individual plans allow young adults to be covered as dependents until age 26. This provision will aid many adolescents and young adults in obtaining coverage. Pediatricians recognize that these young people are far from invincible, desperately need health insurance, and often simply can not afford the high price of insurance as they start their own careers and/or families. This is particularly important for older adolescents with special health care needs who may find it difficult to find an adult practice that meets their needs.

Title IV – Health Care Workforce

The Academy commends the Committee for including significant improvements to work force law that will directly impact pediatric populations. The Committee's support for pediatric primary care, pediatric subspecialty care and pediatric surgical specialty care, will greatly

improve the development of the future workforce. In particular, the Academy lauds the recognition in Sec. 436 that primary care physicians frequently provide mental health services for adolescents and younger children and these physicians should thus be eligible for mental and behavioral health education and training grants. The availability of this training coupled with the ability to bill for these needed services is a leap forward in the care of children and adolescents. Academy members often report that they have difficulty in using codes for conditions such as depression. Additionally, the Academy commends the Committee for its recognition in Sec. 437 that health plans should assure patient access to culturally competent care, a core component of the concept of the medical home in pediatrics. Finally, we welcome the recognition of the significant pediatric oral health work force deficiencies in Secs. 433 and 434.

The Academy also commends the Committee for the following:

- Funding increases for National Health Services Corps (Sec. 173).
- Emergency Medical Services for Children program reauthorization (Sec. 176).
- Community Transformation Grants program to promote preventive health (Sec. 321). The Academy commends the Committee's focus on healthier schools and age levels as well as the Committee's understanding of the unique needs of special populations and age groups.
- Reauthorization of the Sec. 317 immunization program and inclusion of a grant program to improve immunization rates (Sec. 324).
- The significant focus on children in the bill's quality and delivery system research sections (sec. 399JJ(d)(3) as set forth by Sec. 204).
- The Committee's significant focus on children in health care quality measure development, quality improvements, the expansion of children's quality demonstration

projects, the focus on medical homes for children, the attention paid to transitions for adolescents to adult care, as well as the Committee's recognition of the needs of children in comparative effectiveness research (Secs. 203, 211, 212, and 219).

- The inclusion of pediatric-specific provisions in the establishment of grants for the design and implementation of regionalized systems of emergency care, as well as increased research on emergency medicine (Sec. 214).
- The Committee's support of the wellness fund and reauthorization of the two prevention task forces (Secs. 302 and 303).
- The Committee's focus on the oral health care needs of children (sec. 313).
- The dental sealant program (sec. 314) and the addition of oral health issues to the Pregnancy Risk Assessment Monitoring System and the National Health and Nutrition Examination Survey.

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

Sec. 161 Individual Responsibility.

It is unclear from this section whether there is a mandate for children to be covered as the section discusses a responsibility on the part of "individuals," and whether the penalties for the lack of coverage apply to "any individual who did not have in effect qualifying coverage." The Academy has endorsed a mandate structure with appropriate subsidies to achieve universal coverage for children, but we are uncertain whether all children would be covered as a result of this section. Additionally, it is unclear how children in non-traditional circumstances, such as foster care, may be impacted by this provision.

Sec. 3101 Affordable Choices of Health Benefit Plans,
Sec. 3111 Support for Affordable Health Coverage and

Sec. 3112 Small Business Health Options Program Credit.

Gateways as established in the legislation are implemented at the state, sub-state or regional level and plans purchased through these structures appear to offer assistance to families at or below 500% of the FPL. Given the need to constrain cost in this legislation, perhaps the subsidy levels should be initially targeted at those families below 300%, who have significant difficulty affording the high costs of insurance. The Academy appreciates the Committee's recognition that families face significant costs in affording insurance, and the provision to subsidize some of the costs of insurance, even to families at higher incomes, should support more children in middle-income families in obtaining coverage.

Sec. 3111(b)(6). Indexing.

The limitation of premium growth to the medical component of the consumer price index in section 311(b)(6) could represent a precipitous decrease in funding available for health services in out years under Gateway plans. If the improvement in health outcomes due to the Committee's new emphasis on quality reporting and the medical home fails to rein in cost growth, this provision could have large ramifications on child health access under a reformed health system and should be approached with significant caution.

We also hope that the Committee recognizes the importance of our children's hospitals and the enormous amount they have done to save the lives of the sickest and most vulnerable of our citizens. It is laudable to shift focus to prevention but we must not do it at the expense of treatment and care aspects of the healthcare system.

Sec. 3101(m). Rewarding Quality Through Market-Based Incentives.

It appears that the fees paid by the Gateway plans would be impacted by required "pay for reporting/performance" models based on Medicare's Physician Quality Reporting Initiative and

the core measure set established in the Children's Health Insurance Program Reauthorization Act sec. 401 quality provisions, but beyond this it is unclear whether plans would negotiate commercial payment rates with pediatricians, as plans currently do in other private sector plans. The Academy has prioritized increases in Medicaid and Children's Health Insurance Program (CHIP) payment rates to be at least Medicare for health reform and hopes that modifications could be made to this section to clarify that physician payment rates offered by new Gateway plans would be commercial rates.

Sec. 3116(a)(5). Qualified Individual

It appears that those eligible for Medicaid but unenrolled could be excluded from eligibility for the public plan. This could be detrimental to children who are eligible but not currently enrolled in Medicaid.

Sec. 201 National Strategy.

The Academy lauds the focus on quality that this new program would bring to national health policy. The Academy would urge the Committee's consideration of including children's health quality on a par with management of chronic disease (presumably in adults) in the Secretary's priority setting, as strong data associates the onset of chronic disease, especially obesity, type 2 diabetes, and mental health disorders, with health habits developed in childhood. Additionally, the development of common quality measures (See Sec. 399HH(b)(2)(A)) may inadvertently leave children behind, as measure development in Medicare has long received significantly more funding and support than such development in pediatric programs within Medicaid and CHIP. The Academy would also urge the Committee to direct the Secretary to include the coordination of CHIP and Medicaid program data, to the extent practicable, in the Strategic Plan developed under this section.

Sec. 202 Interagency Working Group on Health Care Quality.

Similarly, we would urge the Committee to consider whether connections to representatives of Governors' offices or Medicaid/CHIP Directors and other applicable state agencies could be established with the working group.

Sec. 212(c). Requirements for Health Teams.

The Academy commends the Committee for inclusion of this section and is interested in the Committee's consideration of the following thoughts. The Academy believes that, in the context of children's health, the legislation should acknowledge the historic roles of HRSA and the Maternal and Child Health Block Grant in the development of the medical home. Thus, while this section appears to establish medical home structures in private coverage, and Medicare already contains a large demonstration project, Medicaid statute retains no specific medical home flexibility or authority. We urge the Committee to consider a medical home structure in the Medicaid program that would focus on that program's largest population - children. The section should also clarify the important role of care coordination, particularly for the 15% of children with special health care needs. Addition of such care coordination is not expensive, is our best hope for cost containment and has been shown effective in cutting down on hospitalizations and assisting parents returning to work.

As to the exact wording of the section, the Academy would suggest a change to the language in Sec. 212(c)(2)(D) to "evidence-based/informed" which would recognize the evidence level of expert opinion. Additionally, while pediatricians are hoping to purchase and implement the use of information technology systems in their offices, they are limited in their ability to do so due to multiple issues. First, pediatricians often find it difficult to locate health IT systems with pediatric functionality. Additionally, the tight margins in pediatric practices, as well as the lower

level of future funding for a significant portion of pediatricians due to the ARRA 20% Medicaid case mix threshold, create financial barriers for pediatricians that other physicians do not experience. Funding should flow to practices with a 10% Medicaid and CHIP case load. While pediatricians are committed to improving patient care through the purchase and appropriate use of health information technology, fewer pediatricians have purchased such systems. As a result, requiring that implementation and maintenance of health IT systems to qualify for "Health Team" status could have the unintended consequence of leaving pediatrics and children behind in legislative attempts to advance the medical home, a concept originally developed by pediatricians in their care of children with special health care needs.

Further, the Academy is interested in, and somewhat concerned regarding the structure of the Health Teams supporting the Medical Home. The concept of a community organization that would "share" resources such as care coordinators that focus on chronic care management is appropriate. However it is unclear from the legislation whether the care team should direct the funds that are distributed to the medical home. The Academy is eager for more clarification regarding the details of the role Health Teams will have in payment decisions. Additionally, it is longstanding Academy policy that the Medical Home should have the primary responsibility of caring for patients. Health teams should provide support to the Medical Home. The Health Team must act as more than a disease management organization directly providing care to the patient. The Medical Home should provide clinical outcome data to the Health Team but to provide a care plan on each patient to the Health Team would be burdensome to practices and would not add much value for the patient. The Medical Home should have ultimate responsibility for coordinating the care, not the Health Team. This emphasis on care coordination by the Medical Home could be reflected in amending the language in Sec. 212(c)(2)(D)(3) to require primary

care providers to implement a multidisciplinary team approach similar to that required of the Health Team in Sec. (c)(2).

Title VI – Improving Access to Innovative Medical Therapies.

The Academy urges the Committee to include needed clinical study incentives and other protections for children when drafting the Biologics Price Competition and Innovation section of the bill. With clearly defined approaches to ensuring that all biological products that are used in children are studied in children, we can continue the progress made with drugs in biologics. We look forward to providing comments on final language for this section when released.

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

Sec. 3103(h). Essential Health Care Benefits.

While the Academy is deeply appreciative of the first dollar coverage of immunizations recommended by ACIP and the well child services recommended in the Bright Futures Guidelines (Sec. 2708(a)(2) and (3)), the Academy has significant concern with the ability of the Medical Advisory Council (MAC) to limit coverage for medically necessary pediatric benefits. While pediatric benefits are listed as one of the groups of benefits that must be examined by the MAC (Sec. 3103(h)(9)), it is unclear what the tests of "medical and scientific validity" would produce for children. Greater clarification of this standard and what it would create might ease some of these concerns, but the Academy urges the Committee in the strongest terms to exempt medically necessary pediatric benefits from the purview of the MAC. Too many times pediatricians and other child advocates have found that they are consulted too late or serve as "one member of fifteen" on committees or structures focused on adults. These odds almost always disadvantage children and diminish their needs. We are hopeful that the MAC process

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

Sec. 3111(h) No Federal Funding, and Sec. 3116(a)(2)(A) Eligible Individual.

The limitation on subsidies and eligibility to undocumented families may have significant ramifications for families with children unable to produce documentation regarding their residency. Pediatricians try to provide health services for all children who come into their practices and Academy policy calls for health insurance to be available to all children in the United States. Therefore, this provision may have a significant negative impact on some families' ability to purchase health insurance for their children.

Sec. 185. Health Information Technology Enrollment Standards and Protocols.

The Academy hopes to accomplish three modifications to the new health information technology components in federal law so that children can benefit to the same degree as adults as a result of the funding. In particular, the Academy would greatly appreciate a modification of the threshold case mix level in the Medicaid program to 10% of combined Medicaid and CHIP patients in a pediatric panel. Additionally, the Academy believes that the term "meaningful use," in the Medicaid context, is fraught with uncertainty as current law appears to allow each state to set forth its own definition. This could lead to 56 different meaningful use standards in State and Territorial Medicaid programs as applied to children, greatly decreasing the likelihood of better data collection and quality improvement.