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

The Massachusetts Chapter

Executive Director
Cathleen Haggerty
860 Winter Street
Waltham, MA 02454
781-895-9852
Fax 781-895-9855
chaggerty@mcaap.org

Immediate Past President
Carole Allen, M.D., FAAP
Somerville, MA
617-629-6391
callen@mcaap.org

President
Gregory Hagan, M.D., FAAP
Cambridge, MA
617-665-3600
gnhagan@challiance.org

Vice President
James Perrin, M.D., FAAP
Boston, MA
617-726-8716
jperrin@partners.org

Treasurer
Peter Kang, M.D., FAAP
Boston, MA
617-355-8235
Peter.Kang@children's.harvard.edu

Secretary
John O'Reilly, M.D., FAAP
Springfield, MA
413-794-7448
joreilly@mcaap.org

District Representatives

District 1
Alan Kulberg, M.D., FAAP

District 2
Michelle Dalal, M.D., FAAP

District 3
Mark Vining, M.D., FAAP

District 4
Walter Rok, M.D., FAAP

District 5
Shailesh Shah, M.D., FAAP

District 6
Eric Sleeper, M.D., FAAP

District 7
Kathleen Conroy, M.D., FAAP

District 8
Allison Brown, M.D., FAAP

District 9
Eric Fleegler, M.D., FAAP

District 10
Michael McManus, M.D., FAAP

Counsel
Edward Brennan, Esq.
Norwell, MA
(781) 982-9143

Payment Reform and Child Health—Massachusetts Agenda 2011

The Massachusetts Chapter of the American Academy of Pediatrics (MCAAP), representing more than 1600 primary care and subspecialty pediatricians in the Commonwealth, understands the need for reform to address the spiraling cost of healthcare in Massachusetts. We are committed to a system that delivers highest quality care to children at sustainable cost. In order to assure optimal health outcomes over time, and in order to achieve real savings for the Commonwealth over the long-term, our first order of business must be to guarantee optimal health for children.

The crisis in health care is not driven by the cost of medical care for children.

Increasingly, the cost of health care compromises the fiscal health of the Commonwealth, as well as the bottom line for businesses large and small, municipalities, and individuals across the state. The burden of rising health care costs in the Commonwealth threatens every other category of state spending. Costs associated with the Medicaid program, in particular, threaten to overwhelm the state budget.

But children's health services comprise a very small portion of total health care expenditures, and thus contribute relatively little to the burden of rising cost. Historically, health care expenditures for patients under the age of 18 have constituted less than 10% of total health care expenditures for the nation as a whole.[1] In the Medicaid program nationwide, children make up fewer than half (49%) of Medicaid recipients and account for only 20% of Medicaid expenditures. In Massachusetts, children comprise an even smaller segment of the Medicaid population: In FY07, fewer than 1/3 of Medicaid recipients were children, accounting for less than 20 % of total Medicaid expenditures.[2] The recent dramatic increase in Medicaid enrollment and spending are driven by the recession and the extension of universal coverage to adults, not by increased costs incurred by the pediatric population. Due to adverse risk selection, costs per insured child in the Medicaid population may well be higher than costs attributable to the 65% of children in Massachusetts who have some form of private insurance (FY07)[3] **Health services for children do not drive the cost crisis.**

Reform proposals and potential risks to child health

Precisely because child health plays such a relatively small role in overall health care expenditures, it would be easy to overlook the unique health needs of children as changes are instituted. And indeed, care for children has often been overlooked in the past by large organizations--managed care entities, large hospital systems and policy-making bodies--because it is dwarfed in terms of cost and size by adult care. In the context of current reform deliberations, there is great risk that this will happen again, to the detriment of child health in Massachusetts.

It would be tragic and short-sighted if changes to the state's health care delivery and payment systems, however sorely needed, had the unintended consequence of undermining the health and well being of children and families in the Commonwealth. We must take great care that the interests of children and families are not overlooked as fundamental change occurs.

Pediatricians have the critical expertise necessary to guide efforts to maintain and strengthen the health of children as new systems of care evolve in Massachusetts.

The published literature describing models for Accountable Care Organizations (ACOs) all stress that primary care must form the very core of any ACO structure if the model is to result in high quality care with reasonable cost. This forms the essence of real, high value health care for children.

The American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA)—together representing some 350,000 primary care physicians—recently released a document entitled "Joint Principles for Accountable Care Organizations". [4] The pediatric community in Massachusetts endorses the important principles delineated in that document.

In recognition of the unique needs of children in the larger health care system, it is critical to assure that there is real, substantive input from the pediatric community in the organization, regulation and oversight of ACOs. Further, mechanisms for resource allocation within any ACO must guarantee fair treatment for children, families and the community of practitioners who provide pediatric care.

ACOs are a long-term investment that should strengthen vital and effective systems for pediatric primary care.

Primary care for children within a child and family-centered medical home is essential for high quality and cost efficient care. Re-invigorating and re-organizing the medical care of children around the medical home model must be the central focus, if we hope to maintain high quality services for children and contain costs.

However, the **pediatric** medical home is quite different from an adult-centered medical home in many ways. [5, 6] The care of children and youth with special health care needs may, in some respects, resemble the model of care that is envisioned for adult medicine, but the bulk of pediatric primary care aims to optimize **long-term outcomes** for **well** children. The real value of these distinctive services must be recognized and these services must be appropriately resourced.

We must maintain a robust system of Pediatric surgical and specialty care.

If ACO's are to manage the full continuum of care for all members, they must be capable of providing access to a full range of pediatric services. We must maintain a robust system of PEDIATRIC surgical and specialty care, accessible to all children across the Commonwealth, provided in community and tertiary hospitals with a demonstrated commitment to children. Children will at times require highly specialized care, available in a limited number of venues. ACOs must have systems in place to provide timely access to needed care that cannot be delivered within the context of a specific ACO's routine affiliations.

Improved communication and coordination among primary care pediatricians, pediatric subspecialists and surgeons will improve care and help manage costs. ACOs must encourage, not hinder, this communication.

Developmental and behavioral health services are central to the health of children

For children, perhaps to a much greater extent than for the adult populations, true cost savings in the near- and long-term require appropriate resourcing of developmental and behavioral health services. The current system does a poor job of addressing these needs. Developmental, behavioral and mental health care are under-resourced and unnecessarily fragmented by "carve outs" that discourage collaborative care between pediatricians and mental health providers.

The Commonwealth has made great strides in recent years through the implementation of the Massachusetts Child Psychiatry Access Program and the Children's Behavioral Health Initiative. ACOs must support these initiatives and other efforts that will improve behavioral health services and outcomes for children and families.

If we continue to shortchange the critical areas of developmental and behavioral health, we will not reduce costs for the Commonwealth. Continued underfunding of these services for children and adolescents inevitably generates far greater future costs in the areas of education, adult mental health services and the criminal justice system.

Existing public health initiatives and services critical to child health must not be compromised by payment reform.

Massachusetts has long championed innovative programs to support the health of children. We must be sure that these critical efforts are not undermined. Specific existing public health initiatives, such as regionalization of neonatal medicine and pediatric trauma care must be preserved. We must retain the ability to pursue promising new initiatives that require statewide or regional cooperation. We must not compromise the viability and vitality of pediatric research endeavors and institutions. The structure and purview of any ACOs should facilitate the development of new innovations and collaborative efforts, rather than creating barriers to relationships that benefit child health.

Global Payments and Child Health

Current payment models in Pediatrics encourage fragmented and often episodic care. There is little financial incentive to provide collaborative care, to focus on children with special health care needs or to incorporate complex issues of child development or behavioral health into routine practice

Initiation of global payments in the context of an inefficient system characterized by perverse incentives would amplify rather than mitigate problems of quality and cost. We must avoid the real possibility of further undermining the very primary care providers who are so critical to making these changes work.

Payment models based on “shared savings” and methods of risk adjustment for child health services must be defined in ways that are relevant and appropriate to the needs of children.

Outcomes and savings associated with pediatric care must be measured in terms that are relevant to the children that we care for. **The data are clear, the “return on investment” for preventative child health services is great, but the time horizon is long-term**. Obvious examples include: Childhood immunizations, developmental and behavioral interventions, obesity prevention and accident prevention. These efforts are at the core of pediatric medicine, providing measurable savings to the health care system and to society as a whole. **The value of child health services cannot be measured in terms of “short-term shared” savings, but rather by the value of benefits that accrue over years.**

Risk adjustment for Pediatric care requires validated methodologies that account for biologic and environmental risk factors that affect child health.

While risk adjustment methodology is becoming somewhat more reliable for adult populations, in pediatrics there are no validated risk adjustment methodologies currently available. Children differ from adults both physiologically and epidemiologically. For example, children with chronic illness tend to suffer from many different conditions, each of relatively low prevalence. Adults, in contrast, tend to suffer from a smaller number of more uniform and high prevalence conditions. These differences, together with smaller population size, confound statistical analysis.

Furthermore, non-medical determinants of health in children (e.g., poverty and associated factors such as poor nutrition, exposure to domestic violence and other toxic stressors) have profound influence on long-term health outcomes. While adults may benefit greatly from modifiable lifestyle changes and improvements in their personal choices, children are entirely dependent upon the stability of their environment and the choices of others. Meaningful pediatric risk adjustment must take these factors into account.

The lack of relevant and validated risk adjustment methodologies for pediatrics raises serious questions about the validity of proposed global payments models. If risk cannot be accurately determined, how can resources be allocated fairly?

This lack of appropriate risk adjustment methodologies in pediatrics places child health at risk as we move to implement systems based on global payments and ACOs. Historically, when adult and pediatric systems were forced to compete for resources within the context of a capitated system of care, children lost access to many of the resources that they needed. During the managed care experience in the 1990s capitated payments were generally distributed in ways that reinforced historical biases and inequities in resource allocation. “Funds flow” worked to the disadvantage of primary care generally, and to the detriment of pediatrics in particular. As we move forward with this second iteration of capitated medicine, it is crucial that there be a well-defined mechanism for fair allocation of global payments. If the Commonwealth mandates global payments, it must also ensure fair play. If the Commonwealth hopes to achieve real cost savings, we cannot systematically disadvantage child health services. Our commitment to quality cannot be triaged in the rush to contain cost.

A focus on quality will maximize the value of child health services in the Commonwealth, while reining in the cost of care.

Citizens of the Commonwealth are justifiably proud of our precedent-setting guarantee of health care access for all. Even as that groundbreaking legislation was being passed, observers noted that the critical issue of cost had merely been deferred for a later date. As efforts play out to achieve meaningful and over-due cost containment and payment reform, we must resist the effort to defer another critical and integrally related issue: quality.

The effort to reign in cost should perhaps be better termed an effort to improve value. And value cannot be measured exclusively in terms of a dollar amount. We could easily cut costs and have worse outcomes. Our goal must be to improve cost and quality. Quality and cost must be addressed simultaneously, if we are to maximize real value in the care of children.

The need for a careful, deliberate approach: Cost containment that creates value will take time, expertise, careful evaluation and collaboration with pediatricians, the front line providers of child health care in the Commonwealth.

Many pediatricians in the Commonwealth work in small groups or as solo practitioners. From the perspective of practice infrastructure and practice culture, these smaller, independent practices will be faced with particular challenges that hinder an easy transition to an integrated global payment system. They will be especially vulnerable if change is rapid and forced. As a result, at the current time, there should be no statewide mandate.

Change must be undertaken in a deliberate fashion, informed wherever possible by the evidence and experience developed by specialists in child health. At all stages of the process, there must be substantive, on-going representation from the pediatric community.

We add the voice of the pediatric community to others calling for careful, deliberate and incremental implementation of any health payment reform legislation. Pilot programs should be initiated and evaluated, so as to inform the larger effort.

To this, we add our perspective that children represent a particularly vulnerable population that will be disproportionately affected by miscalculations and unintended consequences. It is imperative that special effort be made to remain attentive to the needs of children. For any global payment system that is established, it will be critical that mechanisms for "mid-course corrections" are in place, in order to respond to the inevitable unintended consequences of payment reform.

---

1. U.S. Department of Health and Human Services, Agency for Health Care Research and Quality: MEPS (Medical Expenditure Panel Survey) Statistical Briefs 253-256, August 21, 2009
http://meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2006&Table=HCFY2006%5FPLEXP%5F%40&VAR1=AGE&VAR2=SEX&VAR3=RACETH5C&VAR4=INSURCOV&VAR5=POVCAT06&VAR6=MSA&VAR7=REGION&VAR8=HEALTH&VARO1=4+17+44+64&VARO2=1&VARO3=1&VARO4=1&VARO5=1&VARO6=1&VARO7=1&VARO8=1&_Debug=
and
http://www.meps.ahrq.gov/mepsweb/data_stats/Pub_ProdResults_Details.jsp?pt=Statistical%20Brief&opt=2&id=915

2. Henry J Kaiser Family Foundation, Kaiser Commission on Medicaid and the uninsured and Urban Institute estimates based on 2007 MSIS ad CMS 64 data. http://facts.kff.org/chart.aspx?ch=465

3. Henry J Kaiser Family Foundation, Kaiser Commission on Medicaid and the uninsured and Urban Institute estimates based on 2007 MSIS ad CMS 64 data. http://www.statehealthfacts.org/chfs.jsp?rgn=23&rgn=1

4. http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/private/healthplans/payment/acos/20101117.Par.0001.File.tmp/AAFP-ACO-Principles-2010.pdf

5. The Academic Pediatric Association Task Force on the Family-Centered Medical Home, The Family-Centered Medical Home: Specific Considerations for Child Health Research and Policy, Academic Pediatrics 2010; 10:211–7.

6. Massachusetts Chapter of the American Academy of Pediatrics, Medical Home White Paper, 2009. http://www.mcaap.org/

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Payment Reform and Child Health--Massachusetts Agenda 2011

Executive Summary:

- **Rising health care costs are not primarily driven by the cost of health care for children. However, high cost conditions in the adult population originate during childhood.**
- **Payment reform must not compromise child health. Children represent a particularly vulnerable population that would be disproportionately affected by miscalculations and unintended consequences.**
- **A focus on quality will maximize the value of child health services in the Commonwealth, while reining in the cost of care.**
- **Pediatricians can provide critical input to maintain and strengthen the health of children as new systems of care evolve in Massachusetts.**
- **The "return on investment" for preventative child health services is great, but the time horizon is long-term. The value of child health services cannot be measured in terms of short-term "shared savings", but rather by the value of benefits that accrue over years.**
- **Primary care must be at the center of any Accountable Care Organization (ACO) structure if the model is to result in high quality care with reasonable cost containment.**
- **Accountable Care Organizations are a long-term investment that should strengthen effective systems for Pediatric primary care. ACOs must provide access to the full range of child health services.**
- **Developmental and behavioral health services are essential to the provision of Accountable Care for Children.**
- **ACOs need a robust system of Pediatric surgical and specialty care.**
- **Public health initiatives critical to child health, such as regionalized care of critically ill newborns or pediatric trauma, must not be compromised by payment reform.**
- **We must maintain the viability and vitality of pediatric research endeavors and institutions.**
- **Validated risk adjustment methodologies do not yet exist for pediatric care.**
- **Meaningful risk adjustment must take into account the many non-medical determinants of child health. (e.g., poverty and associated factors such as poor nutrition, exposure to domestic violence and other toxic stressors.)**
- **Cost containment that creates value will take time, expertise, careful evaluation and collaboration with pediatricians, the front line providers of child health care in the Commonwealth.**