Payment Reform Proposal for the Children's Health Care System in Washington

Submitted by the Washington Chapter of the American Academy of Pediatrics

Vision

We look forward to the day when:

- Every child in Washington is healthy and able to succeed in learning;
- Our state has achieved the "Triple Aim" of (1) expanding access to health services, (2) controlling costs and (3) improving health outcomes; and
- Every child has a Medical Home that meets the national standard of care.

Key Challenges & Reforms

Our goal is to work with the State to achieve this vision and fulfill the promise of the Cover All Kids law. Forty-six percent of Washington's 1.7 million children are covered by Apple Health for Kids. Washington's system to pay providers who care for these children must be improved and fully aligned with the Triple Aim. This requires a paradigm shift to redesign the current system that lacks open access to care, coordinated care, a preventive approach to health and a quality efficient, cost effective delivery system.

Problems with the Status Quo

1. **More than 100,000 of Washington's children are still uninsured.** Although our state has made enormous progress since the Cover All Kids law was passed in 2007, more needs to be done to streamline enrollment and reach out to enroll children who still lack coverage. A representative sample of 125 pediatricians out of 1,000 Washington pediatricians completed a survey in 2012, which indicated that if Medicaid Payment Reform led to reimbursement equal to private insurance or UMP (Uniform Medical Plan), they would provide open access to new Medicaid patients as clinic capacity allows.

2. **The current payment system is inequitable**. Today, pediatricians and other primary care physicians are paid for caring for children enrolled in Apple Health for Kids at just 59% of the rates paid for the care of children of State employees under the Uniform Medical Plan. This is inequitable in light of the fact that children enrolled in Apple Health for Kids are more likely to face health disparities and generally require a higher intensity of care. According to the Health Care Authority,

8.3% of children on Medicaid (who are members of Apple Health for Kids) have poor to very poor health status as compared to 1.1% of children with private commercial insurance.

3. **The inequity in rates reduces access to care for the very children who most need services.** Insurance coverage only works if there are health care providers available throughout the state to provide the comprehensive services children need. At the current payment rate, many providers cannot afford to keep their practices open to new Apple Health patients. The legislature recognized the need to increase rates when it passed the Cover All Kids law in 2007, and included funds in the budget to increase provider rates to 90% of the rates paid by the Uniform Medical Plan. That decision meant many more providers in rural communities and low-income urban and suburban areas could open their practices to children enrolled in Apple Health for Kids. However, as the 2008 recession cut state revenues, the State rescinded those increases. Now fewer providers are able to accept Apple Health patients, because the payment they receive does not cover the cost of delivering care. A representative sample of 125 pediatricians out of 1,000 Washington pediatricians completed a survey in 2012 which indicated 27% of respondents limited access to care for new Medicaid patients.

4. **Key preventive services are not adequately covered.** Washington is one of a small handful of states that has not incorporated the entire preventive services listed in the Bright Futures recommendations in its provider payment system (Bright Futures is the standard developed by the American Academy of Pediatrics for well-child care in children of all age groups). As a result, screenings for developmental delays, autism, and behavioral health concerns are not covered, and reimbursement for immunizations for children in Apple Health is less than 25% of what private insurers pay. There is no funding to address the childhood obesity epidemic. These shortcomings in our health system have a direct impact on our children's ability to learn, and on the future costs of our health system.

5. **The State's payment system has not kept pace with new technology and best practices for care management.** New tools like electronic medical records and secure email are increasingly being used to improve communications between providers and their patients. Primary care physicians must have the ability to exchange critical information with specialists, hospitals, and insurance plans to improve the coordination of services and quality of care. The State has yet to acknowledge the value of care management services by paying for them, and does not mandate bi-directional flow of information or administrative transparency regarding quality and cost data. Care management in the efficient Medical Home

system of care has been established as the best method to decrease emergency department utilization and contain costs.

6. **The current reimbursement system is not aligned with the State's policy to encourage the development of Patient Centered Medical Homes.**[1] The Cover All Kids law explicitly recognizes the importance of connecting families with Medical Homes, where teams of well-qualified health care providers work with parents to safeguard the health of their children and contain costs. However, the current payment system does little or nothing to assist practices in achieving the national standards for Medical Homes.

Proposed Solutions

1. **Bring Apple Health for Kids to parity with rates paid and services covered by the Uniform Medical Plan (UMP) for the care of children of state employees.**
    a. A 2012 survey completed by 126 Washington pediatricians revealed 99% would provide open access to new Medicaid patients if payment were equal to UMP.
    b. Parity allows the state's clinics to recruit new physicians by bringing payments in line with what other states provide; this would build capacity to care for more than 100,000 children without health insurance or a physician.
    c. Services covered by UMP include all Bright Futures standards of well-child/preventive care, including for vision, developmental, mental health and autism screening as well as annual well-child visits through age 18. This will improve health outcomes and meet health quality measures

Evidence to support establishing equity in payment rates

When the State of Colorado recently increased reimbursement rates, the percentage of pediatricians accepting Medicaid rose from 20% to 96%. Ninety percent of parents reported they have little or no trouble getting appointments for their children when needed. (2)

When payment for the behavioral health screens was incorporated in the rate structure in Massachusetts, the number of screens performed increased from 16.6% of Medicaid well child visits to 53.6%, and the early identification of potential mental health problems increased by 25.8%.

In Longview, Child and Adolescent Clinic has provided Developmental Screening with funds provided by grant awards at four designated well-child visits in the first three years, and in

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[1] *The term Patient Centered Medical Home is also often referred to as a "health home" or simply as a "medical home." It is inclusive of preventive and primary medical, dental, and behavioral health and related services.*

2011 has referred 111 children to a community-based 0-3 year program for early intervention of thus identified developmental delays.

In 2007, Cowlitz County ranked 37th out of 39 counties for the poorest oral health outcomes (cavity free children) for Medicaid children under 6 years of age because there was no reimbursement to pediatricians for prevention and the early intervention of application of fluoride varnish plus parent oral health education. Within two years after Medicaid provided incentive reimbursement for fluoride varnish application, Cowlitz County ranked 2nd out of 39 counties for cavity free children.

2. Establish baseline quality measures and health care utilization cost benchmarks.

The Cover All Kids law directs the Health Care Authority to "establish a concise set of explicit performance measures that can indicate whether children enrolled in the program are receiving health care through an established and effective Medical Home, and whether the overall health of enrolled children is improving."

To meet this mandate, the Health Care Authority should track quality measures and report the percentage of children statewide who:

- Are current in their well child examinations
- Are fully immunized
- Receive developmental screenings at each prescribed well child visit
- Receive vision and hearing screening at each prescribed well child visit
- Have Body Mass Index (BMI) measured at each well child visit (and a care plan developed when indicated)
- Have an Asthma Action Plan and appropriate preventive medication prescribed when indicated
- Receive oral health preventive services and education at every prescribed well child visit
- Have poor or very poor health status
- Have access to culturally appropriate care, including interpreters where indicated

Note that a Healthy People 2020 Objective is to "Increase the proportion of children, including those with special health care needs, who have access to a medical home." Additional measures outlined by the Healthy People 2020 Objectives includes core outcome measures such as: (a) Families of children with special health care needs (CSHCN) will participate in decision-making at all levels and will be satisfied with the services they receive; (b) CSHCN will receive regular, ongoing comprehensive

care within a medical home; and (c) All children will be screened early and continuously for special health care needs.

Evidence to support baseline quality measures and evaluation of cost savings

"In a study of 7 patient-centered medical home demonstrations caring for children and adults, Fields et al showed that annual reductions in hospitalizations ranged from 6% - 40% and a decrease in emergency department (ED) visits ranging from 7.3% - 29%, suggesting improvements in quality, and annual cost savings ranging from $71 to $640 per patient."[2] A representative sample of 125 pediatricians out of 1,000 Washington pediatricians completed a survey in 2012 which indicated that more than 75% would provide all Bright Futures standards of care if payment were covered by Medicaid.

> *In Olympia, Beth Harvey, M.D., FAAP saw a 5-year-old for a Bright Futures preventive well-child examination and noticed a large spleen. Lab work revealed a rare systemic disease that affects the kidneys. As the disease was caught early, the child stands a chance of avoiding hypertension and the need for a kidney transplant.*

3. Encourage primary care practices to achieve Medical Home certification. [3]

This should meet the standards developed by the National Committee on Quality Assurance (NCQA).

a. Provide certified Medical Home with a cost containment and quality care incentive payment of $3 per member per month to support the additional staff and infrastructure required to continue to provide open access and deliver effective and cost efficient care within the Medical Home.
b. Create a "Glide Path" for practices that have yet to achieve certification as a Medical Home with incentive payments of $2 per member per month in order to meet benchmarks for the transformation to the Medical Home model of care, and obtain Medical Home certification. This would be modeled after Connecticut's Glide Path program.
c. To help primary care providers function as Patient Centered Medical Homes, 25 states have implemented a variety of payment policy changes and other reforms in Medicaid and the Children's Medicaid Program. Nineteen of these 25 states

[2] *Fields D, Leshen E, Patel K. Analysis and commentary. Driving quality gains and cost savings through adoption of medical homes. Health Affairs(Millwood) 2010; 29(5) 819-826.*
[3] *Washington State Medical Home Leadership Network, "Medical Home Recognition and Accreditation for Pediatric Practices and Providers in Washington State" Fall 2012.*

pay providers per member per month fees for care management services and to perform the functions of a PCMH. [4]

Evidence to support the value of the Medical Home model of care

Pioneered in concept by the American Academy of Pediatrics, the concept of providing family-centered care through Medical Homes has been tested for more than 20 years. One of the longest-running national studies measuring children's access to Medical Homes is the National Survey of Children's Health, a telephone survey conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics. This survey continues to demonstrate that access to a Medical Home increases the likelihood that children will receive preventive care and have fewer unmet health care needs.[5]

The five features of a medical home used in this National Survey are as follows: having a usual source of care; a personal physician or nurse; receiving all needed referrals for specialty care; receiving help in coordinating care; and family centered care. Nearly all of Washington's pediatric practices would try to offer these five features of the Medical Home if they could afford to add additional staff to the Medical Home team.

Key outcomes of a large national survey on Medical Homes in 2007:

- Children without a Medical Home were almost four times as likely to have an unmet health care need as were children with a Medical Home and three times as likely to have unmet dental needs as were children with a Medical Home.

- Children whose health was reported as fair or poor were only half as likely to have a Medical Home as those whose health was rated to be excellent or very good.

- Hispanic children were more than three times more likely to be without a Medical Home than white children;

- African American children were more than twice as likely to be without a Medical Home as white children.

- Children in poverty were three and half times more likely than non-poor children to lack a Medical Home.

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[4] *M. Takach, "About Half of the States Are Implementing Patient Centered Medical Homes for their Medicaid Populations," Health Affairs, November 2012 31(11):2432-40.*

[5] *Strickland B, Jone J, Ghandour R, Kogan, and Newacheck, The Medical Home: health care access and impact for children and youth in the United States. Pediatrics 2011; 127; 604.*

A representative sample of 125 pediatricians out of 1,000 Washington pediatricians completed a survey in 2012 regarding Medical Homes and the ability to provide their established patients 24/7 care management. Only 62% could afford the staff to provide 24/7 care management, and only 30% could afford staff to provide after-hours care in their facilities.

Cost Savings

Roughly 30 percent, or approximately $700 billion, of the $2.5 trillion in annual health care spending in the U.S. is estimated to be unnecessary.[6] The marketplace recognizes the potential for return on investment in the Medical Home, in the form of both quality and cost improvements.

Success of previous Medical Home demonstrations across the U.S. has prompted investments in publicly and privately funded Medical Home programs, with anticipation of future savings and better patient care. For example, WellPoint predicts that its new Medical Home program could reduce its projected medical costs in 2015 by up to 20 percent based on analysis of its current Medical Home pilot projects.[7] United Healthcare estimates that its new efforts will save twice as much as they cost.[8]

> *A Kaiser Family Foundation report released in November 2012 shows "modest state costs for implementing the Medicaid expansion under the Affordable Care Act compared to significant increases in federal funds, allowing some states to see net budget savings even as millions of low-income uninsured Americans gain health coverage."*

To evaluate anticipated cost savings (to be measured from payment records) HCA should record utilization cost benchmarks including:

- Decline in emergency department utilization rates
- Decline in days of hospitalization

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[6] *Reid, R. J., Fishman, P. A., Yu, O., Ross, T. R., Tufano, J. T., Soman, M. P., & Larson, E. B. (2009). A patient centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation. American Journal of Managed Care, 15(9), e71-e87.*

[7] *Wellpoint. (2012, June 6). Wellpoint Press Releases. Retrieved June 14, 2012, from http://ir.wellpoint.com/phoenix.zhtml?c=130104&p=irol-newsArticle&ID=1703173&highlight=*

[8] *United Health Care Services, Inc.: Shifting from Fee-for-Service to Value-Based Contracting Model.*

In Spokane, Chris Olson, M.D., FAAP was performing a Medical Home Bright Futures preventive well-child examination when he detected a Wilm's tumor of the kidney. This early diagnosis saved the child's life and minimized the required treatment.

In Bellingham, Peter Filuk, M.D., FAAP saw a 9-month-old baby for a Bright Futures preventive well-child examination. During the exam Dr. Filuk discovered an abdominal mass the size of a baseball. It was determined to be a Neuroblastoma. With this early identification, surgery was possible and the infant was able to avoid chemotherapy and radiation therapy. "I truly believe this is a perfect story of how Medical Home preventive well-child care can save a life and help a family," says Dr. Filuk.

An incentive program to achieve medical home certification would be patterned after the CMS Electronic Medical Record Meaningful Use Program and would be funded by Medicaid and Medicaid Managed Care organizations utilizing medical loss ratio funds. [9]

[9] *Michael J. McCue and Mark A. Hall, "Insurers' Responses to Regulation of Medical Loss Ratios," The Commonwealth Fund, December 5, 2012.*