AMERICAN ACADEMY OF PEDIATRICS

Committee on Child Health Financing

Guiding Principles for Managed Care Arrangements for the Health Care of Newborns, Infants, Children, Adolescents, and Young Adults

ABSTRACT. By including the precepts of primary care in the delivery of services, managed care can be a tool to increase access to a full range of health care clinicians and services. On the other hand, managed care can result in underutilization of appropriate services and reduced quality of care. Therefore, the American Academy of Pediatrics urges the use of the principles outlined in this statement in designing and implementing managed care for newborns, infants, children, adolescents, and young adults for several reasons. This policy statement replaces the 1995 policy statement, "Guiding Principles for Managed Care Arrangements for the Health Care of Infants, Children, Adolescents and Young Adults," and outlines the key principles of managed care for newborns, infants, children, adolescents, and young adults.

ABBREVIATIONS. AAP, American Academy of Pediatrics; PCP, primary care pediatrician.

Faced with unprecedented growth in health care costs, employers, state Medicaid programs, the State Children's Health Insurance Program, and other purchasers of care have turned from traditional fee-for-service reimbursement to managed care plans in an attempt to find the most efficient strategies that provide access to quality health care while controlling costs. During this period of change in the delivery and financing of health care services, new and expanded efforts are needed to strengthen managed care systems that serve newborns, infants, children, adolescents, and young adults (hereinafter referred to as children) and their families.

The American Academy of Pediatrics (AAP) urges the use of the principles outlined in this statement in designing and implementing managed care for children for several reasons–disruptions in pediatrician-patient relationships; barriers to appropriate pediatric referrals and delays in treatment authorization[1]; limited quality-of-care measures appropriate for children[2]; lack of pediatric risk adjustment payment mechanisms[3]; limited coordination with public health, education, and social services systems[4]; and a general paucity of research on children in managed care.[5] Concern also has been raised about the adverse effects of shifting resources from providing medical services to generating excessive profit in for-profit health care plans. Many of the same criticisms also can be made of traditional fee-for-service plans.

Managed care plans typically use certain cost and utilization management features. (A glossary of managed care terms is in the AAP publication, *A Pediatrician's Guide to Managed Care*.[6]) It is important to monitor the effects of cost-containment measures on the quality and outcome of medical services for children. The financial arrangements often include capitation, discounted charges and fee schedules, and performance incentives. The features of utilization management generally include precertification, concurrent review and discharge planning, care coordination, case management, preauthorization, and physician practice profiling. These financial and utilization incentives and disincentives should be structured to preserve and, when appropriate, extend access to comprehensive and coordinated preventive, acute, and chronic care for all children.

By including the precepts of primary care in the delivery of services, managed care can be a tool to increase access to a full range of health care professionals and services within a medical home.[7] On the other hand, managed care can result in underutilization of appropriate services and reduced quality of care. Such underutilization could result from patient and physician disincentives to appropriate utilization and restrictions on access to pediatric medical subspecialists and pediatric surgical specialists and tertiary care centers. Other access restrictions could block the utilization of necessary related services, such as mental health, social work services, developmental evaluation, occupational and physical therapy, vision screening, hearing screening, and speech and language therapies, as well as school-linked clinics and other public health service clinicians.

When a state has mandated participation in Medicaid managed care plans, it must implement rigorous regulatory oversight to ensure the quality and financial viability of participating managed care plans. In addition, in states where enrollment in managed care plans is mandatory, Medicaid beneficiaries should have the freedom to choose among 2 or more managed health care plans and participating public and private clinicians.[8] In areas where only 1 managed care plan is available, particularly rural areas, families should be able to choose their individual physicians.[7] Medicaid provisions in the Balanced Budget Act of 1997 (PL 105–33) require adequate safeguards in every state implementation plan to ensure access and delivery of quality health care to children.[9]

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The AAP seeks to work in partnership with families, other health and health-related professionals, federal and state governments, employers, and the managed care industry to implement the following principles of managed care for children. These principles about access to primary and specialty pediatric services, treatment authorization, quality of care, and financing and reimbursement are intended to maximize the positive potential of managed care and to minimize negative effects on health care for children.[10]

PRINCIPLES OF MANAGED CARE FOR CHILDREN

1. Access to Appropriate Primary Care Pediatricians

a. Choice of primary care clinicians for children must include pediatricians.

b. Primary care pediatricians (PCPs) should serve as the child's medical home[11] and ensure the delivery of comprehensive preventive, acute, and chronic care services. They should be accessible 24 hours a day, 7 days a week, or have appropriate coverage arrangements.

c. The PCP should assume the role of the care coordinator (ie, the physician who ensures that all referrals are medically necessary). The function of the PCP might be transferred to a pediatric medical subspecialist for certain children with complex physical and/or mental health problems (eg, those with special health care needs, such as children with cystic fibrosis, juvenile rheumatoid arthritis) if the specialist assumes responsibility and financial risk for primary and specialty care. For certain physical, developmental, mental health, and social problems, the PCP may seek the assistance of a multidisciplinary team with participation by appropriate public programs (eg, Title V Program for Children with Special Health Care Needs).

d. Families should receive education at the time of enrollment to help them understand fully how managed care arrangements work for their individual policies.

2. Access to Pediatric Specialty Services

a. When children need the services of a physician specialist or other health care professionals, plans should use clinicians with appropriate pediatric training and expertise. Pediatric-trained physician specialists, including pediatric medical subspecialists and pediatric surgical specialists, should have completed an appropriate fellowship in their area of expertise and be certified by specialty boards in a timely fashion if certification is available. These physicians and other health care practitioners should be engaged actively in the ongoing practice of their pediatric specialty and should participate in continuing medical education in this area.

b. There should be no financial barriers to access for pediatric specialty care above and beyond customary plan requirements for specialty care.

c. Plans should contract with the appropriate number and mix of geographically accessible pediatric-trained physician specialists and tertiary care centers for children.

d. Referral criteria for pediatric specialty clinicians should be developed. These criteria may include age of patient, specific diagnoses, severity of conditions, and logistic considerations (eg, geographical access and cultural competence).

e. Processes for approving referrals to pediatric medical subspecialists and pediatric surgical specialists should be developed by health plans working collaboratively with PCPs and pediatric medical subspecialists and pediatric surgical specialists.

f. Access to specialty services can be expedited by creating a "presumptive authorization" category (eg, no preauthorization needed for diagnoses such as hernia, strabismus, appendicitis, and diabetes.)

g. Pediatric medical subspecialists and pediatric surgical specialists including mental health professionals, should routinely communicate with the pediatric patients' primary care pediatrician.

3. Treatment Authorization

a. Families and pediatricians should be fully informed of the plan's participating clinicians. This should include an up-to-date listing of the plan's participating health care professionals whose practices are currently open to patients insured by the managed care plan. Identification of primary care pediatricians and required copayments should be listed on the patient's insurance card.

b. The treatment authorization process, which is initiated by the PCP, should encourage and facilitate timely appropriate referral for specialty consultations, hospital inpatient and outpatient care, and other treatments.

c. Plans should provide timely responses to treatment authorization requests, based on the nature and urgency of the patient's needs, including 24-hour access and approvals in the case of emergencies. Pediatricians should challenge managed care contracts that require them to certify all emergency department visits. Managed care plans should not restrict access to emergency care consistent with the "prudent layperson" standard.[12]

d. Plans should provide a timely appeals process that includes direct discussions between the reviewing panel, the patient's pediatrician and the relevant specialists and, if appropriate, an external review by an independent panel of pediatricians experienced in the treatment of the patient's illness.

e. To make any determination about the medical necessity of any item or service to be furnished to a person younger than 21 years, the medical director of the managed care plan should consider whether an item or service: 1) is appropriate for the age and health status of the person; 2) will prevent or ameliorate the effects of a condition, illness, injury, or disability; 3) will aid the overall physical and mental growth and development of the person; 4) will assist to achieve or maintain maximum functional capacity for performing daily activities; and 5) relies on medical practice guidelines that are endorsed or approved by appropriate medical professional societies or governmental public health agencies.[13]

4. Quality Assurance

a. Health plan coverage policies (including limitations on the amount, duration, and scope of services; cost-sharing requirements; and participating health care professionals) should be clear, simply written, and easy for all families to understand.[14] Written standards should be established for access to primary care, referrals to specialty services, referral process and protocols for service. Plans also should designate a special department from which potential enrollees can obtain information on the plan.

b. Pediatricians, pediatric medical subspecialists, and pediatric surgical specialists should have an active role in developing quality assurance mechanisms and ensuring quality of care in any cost-containment process.[11]

c. Quality management should include appropriate peer review,[11] with pediatric cases reviewed by pediatricians.

d. Plans should create incentives to promote early identification of health problems among children.

e. Plans should report a uniform standard set of encounter data in compliance with the Health Insurance Portability and Accountability Act.

f. States should publish uniform data that offer consumers and purchasers the opportunity to evaluate and compare performance, including financial characteristics, among competing plans.

g. Gag clauses should be excluded from all managed care contracts.

5. Financing and Reimbursement

a. Reimbursement methods should be developed that cover all the health care needs of children as defined by the AAP policy statement, "Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents, and Young Adults Through Age 21 Years,"[15] and the periodicity of visits and procedures in AAP statement "Recommendations for Preventive Pediatric Health Care."[16] The methods used for pediatric health care reimbursement also should consider age, chronicity, and severity of underlying health problems (case mix, risk, or severity adjustment) and geographic considerations.

b. Reimbursement for physician services for newborn care should be separately identified as unique and distinct from maternal services and should ensure clearly identified payment to physicians and continuous coverage not only for the neonatal period, but also for subsequent pediatric care.

c. 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 rate cells/groups, a pediatric diagnostic classification system, or a combination of these. Because pediatric risk-adjustment techniques are not well-developed, contract provisions about carved-out services, outlier payment, reinsurance or shared-risk arrangements for individual children and aggregate plan loss or profits should be included.

d. Capitated contracts should include fee-for-service carve-outs for unexpected or high cost services, including but not limited to neonatal and routine newborn hospital care, pregnancy services, immunizations, and emergency services.[17]

e. No copayments should be applied to preventive services.

f. Medicaid managed care plans reimbursing pediatricians for pediatric care on a fee-for-service schedule should use the Resource-Based Relative Value Scale physician fee schedule as the basis for their fee schedule. The work values approved by the Health Care Financing Administration are appropriate for primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists. A single multispecialty conversion factor that equates to at least 100% of the Medicare Resource-Based Relative Value Scale reimbursement rate also should be incorporated. Fees should be set at a rate that is at least 90% of the usual, customary, or reasonable fee or equivalent to those in Medicare, whichever is higher.[7,18]

g. Financing arrangements for all pediatric services should be made to ensure that pediatric services are not undervalued in terms of practice expense, professional liability, and physician work values.

h. To ensure continuation of high-quality services for children, primary care physicians should be protected against undue financial risk. Risk levels for primary care office-based pediatricians should be on an aggregate, not individual, basis and be adjusted based on case-mix analysis.

i. Federal requirements for capitation should apply to all managed care plans. Federal and state governments should preapprove all contracts with managed care plans in which enrollees are primarily insured by the State Children's Health Insurance Program or Medicaid and require the federal and state governments to guarantee clinician payments if plans become insolvent.

j. Plans should use quality-of-care measures for children, including assessments of structure, process, and health and functional outcomes (eg, compliance with pediatric preventive standards including, but not limited to, immunization rates and referrals for chronic physical and mental health problems).

k. To ensure timely and appropriate reimbursement, plans should make available electronically pertinent patient information, including but not limited to, patient eligibility status and current patient mailing address.

CONCLUSION

The AAP recommends that careful attention be devoted to the design, implementation, and evaluation of managed care plans that serve children, including children with special health care needs. The AAP seeks to collaborate with managed care plans to adopt these guiding principles to ensure access to high-quality pediatric services.

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