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Financing Childhood Health Supervision Services in the 21st Century

ABBREVIATION. NSECH, National Survey of Early Childhood Health.

Pediatricians view their communities with a unique perspective, being the only professionals who interact consistently with preschool children and their parents when providing early childhood health supervision services. This supplement, reporting the findings of the National Survey of Early Childhood Health (NSECH), is a landmark publication that improves our understanding of early childhood health supervision services. The findings indicate marked variability in health supervision visits: the topics and amount of time devoted to counseling or anticipatory guidance, the types of services, and the overall quality of the services. Although many factors influence this variability, including varying recommendations among governmental organizations and professional societies and a lack of consistent physician training, fiscal considerations also exert a powerful effect. This commentary explores how fiscal policies compromise the quality of the early childhood health supervision services and suggests financing approaches to promote the delivery of high-quality services.

Currently, several fiscal policies aimed at containing health care expenditures compromise the delivery of quality pediatric health supervision services. These include family out-of-pocket expenses for health supervision services in the form of higher copayments and deductibles, excluding health supervision services from the benefits covered in the insurance plan, and reducing physician payments for pediatric services. These policies are counterproductive, increasing "downstream" expenditures while doing nothing to moderate the more powerful drivers of health care expenditures: hospital costs, pharmaceuticals, new medical technologies, and home health care. Inadequate pediatrician reimbursement in both the private and public health care sectors produces compensatory mechanisms that have an adverse impact on health supervision services. Inadequate reimbursement is like a viral respiratory pathogen that reduces lung compliance, interferes with the normal respiratory function, and causes an increase in respiratory rate to maintain tidal volume

and adequate oxygenation. It disrupts the functioning of the health care delivery system because pediatricians respond to lower per-unit-of-service payments by increasing the number of patient visits. They may increase the number of children being cared for in the practice, which leads to working longer hours and shortening the visit appointment times, especially for health supervision visits. The ability of pediatricians to reduce their own expenses is often limited because of rising overhead costs related to staff salaries and health benefits, health plan administrative requirements, office rent, communications and new technology infrastructure, and regulations such as the Health Insurance Portability and Accountability Act. Although some degree of increased productivity is desirable, pressure to shorten visit times can affect the quality of service, patient compliance, and satisfaction. Available evidence documents that low Medicaid physician payments reduce access to pediatricians and increase per capita Medicaid expenditures.¹⁻³ The findings of the NSECH demonstrate that current financing is not promoting the quality of early childhood health supervision services that is needed for optimal health outcomes. Any effort to improve the delivery of early childhood health supervision services must address the problem of inadequate pediatrician reimbursement in both public and private sectors.

There are a number of steps that pediatricians can take to ameliorate the problem of low reimbursement. Pediatricians should stop the widespread practice of undercoding their services. Too often, primary care pediatricians are submitting claims at the 99213 level when it is more appropriate to use a 99214 or 99215 Current Procedural Terminology code. Increasing the relative proportion of bills submitted at the 99214 to 99213 by 10% to 20% will markedly increase revenue. In addition, more pediatricians need to use the modifier 25 in billing for an acute problem addressed during a preventive care visit, and more pediatricians need to use time as the key factor when an acute-care visit is extended for more intensive counseling.

State American Academy of Pediatrics chapters should advocate that health plans pay for these modifiers and counseling codes as well as for formal developmental assessments. Health plans should also provide financial incentives to primary care physicians who provide higher quality health supervision services and achieve better health supervision-related outcomes such as higher up-to-date immunization rates. Unfortunately, many insurance plans are not responsive to this approach because they are under intensifying pressure to contain premium increases and are attempting to reduce outlays and services that do not have clear short-term offsets in downstream medical expenditures. What may be

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needed are alternative approaches that do not rely on health plans to fund these health supervision services appropriately.

Who should finance these child health supervision services? Who benefits from enhancing the quality of these services? In addition to the patient and family, society, as a whole, benefits greatly when these early childhood services help parents of all children promote language and healthy emotional development, protect children from vaccine-preventable disease, identify developmental problems early, and prevent serious injuries. Society benefits when pediatricians identify parental and family problems such as maternal depression, alcohol and substance abuse, and domestic violence and make referrals to programs that address these problems. When a larger proportion of children enter kindergarten ready to learn and we reduce the need for special education services, the public education system benefits. When the prevalence of child abuse and domestic violence is reduced, the number of children who require out-of-home placements decreases and local and state departments of social services and the juvenile justice system benefit.

We need financing approaches that recognize the value of these health supervision services to both the individual and society. A recent Institute of Medicine report entitled *Assuring Access and Availability: Financing Vaccines in the 21st Century* recommends a vaccine financing restructuring using principles that could be extended to include the broader array of child health supervision services.⁴ One possible approach is a federally funded mandate for health supervision services on all health plans combined with a voucher system for uninsured children. Pediatric primary care physicians who meet specific standards, including the documentation of both care processes and outcomes, would be eligible for the program. All health plans would be required to pay physicians for health supervision services at the federally set "minimum rate" or higher. Health plans could pay higher than the minimum rate to attract outstanding primary care physicians to participate in their plans. Although health plans would be required to provide the enhanced health supervision services, they would receive federal funds to pay for these services. The families of uninsured children would receive a voucher for these services that "certified" primary care physicians who meet the specified standards could submit for reimbursement.

Another way that the government could encourage physicians to improve their delivery of child health supervision services is to provide additional tax incentives and or credits for purchasing and maintaining clinical information systems used to ensure that all children receive quality health supervision services. There are many precedents for using federal funds and tax incentives to support critical sectors of the economy. Examples include tax incentives to develop renewable energy sources, the oil depletion allowance to encourage oil exploration and drilling, and farm credits, supports, and subsidies. Why should our tax policy not recognize that early childhood health supervision services are a worth-

while investment in our future human capital? At a minimum, a new major federally funded research initiative should be dedicated to assessing the effectiveness of health supervision services on a wide range of outcomes.

It is hoped that the findings of the NSECH will stimulate a public discourse on the role of the federal government in financing vaccines and other child health supervision services. If we cannot ensure that every child in the United States has quality health insurance, then perhaps we can agree that, in addition to an education, every child should receive health supervision services and immunizations.

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Mommy, Who Is My Doctor?

ABBREVIATION. NSECH, National Survey of Early Childhood Health.

Mommy, who is my doctor? Every child deserves an answer to this question. We would hope that a parent can respond with the name of the child's primary care pediatrician, who, together with his or her colleagues, provides the services called for in well-accepted definitions of primary care. The Institute of Medicine has defined primary care as the delivery of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.¹ One of us defined primary care >30 years ago (and 2 of us were among the first primary care trainees) as having 4 essential elements: first contact, integration of service, continuity, and family focus.² Continuity is considered by many to be the most essential component of quality primary health

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