POLICY STATEMENT

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 and the medical home in the delivery of services, managed care can be effective in increasing access to a full range of health care services and clinicians. A carefully designed and administered managed care plan can minimize patient under- and overutilization of services, as well as enhance quality of care. Therefore, the American Academy of Pediatrics urges the use of the key principles outlined in this statement in designing and implementing managed care programs for newborns, infants, children, adolescents, and young adults to maximize the positive potential of managed care for pediatrics. These principles include the following: Pediatrics 2013;132:e1452–e1462

- Access to primary care pediatricians
- Access to pediatric specialty services
- Appropriate eligibility and treatment authorization
- Effective quality improvement and management
- Adequate financing and payment

INTRODUCTION

Faced with persistent escalation in health care costs, employers, state Medicaid programs, the State Children’s Health Insurance Program (CHIP), and other purchasers of health care continue to study and often reconfigure managed care plans to find the most efficient strategies that provide access to quality health care while controlling costs. As a means of coordinating the delivery and financing of health care services, managed care plans have advanced different configurations that may include selective contracting with clinicians, medical management (ie, utilization management), gatekeeper functions, and different payment methodologies. Newer models and market changes have led to further changes, such as integrated delivery systems (IDSs), accountable care organizations (ACOs), payment incentives based on quality indicators, and clinician and payer consolidations. Additionally, clinicians and payers, including managed care organizations, have begun to explore ways to achieve better outcomes for children and families through coordinated care initiatives such as accountable care organizations, patients medical home, and integrated delivery systems. This document provides an update to the Academy’s 2006 policy statement, “Guiding Principles for Managed Care Arrangements for the Health Care of Infants, Children, Adolescents, and Young Adults.”

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care plans, are in the midst of adjusting to the mandated components of the Patient Protection and Affordable Care Act (ACA; Pub L No. 111-148, 2010). As the delivery and financing of health care services continues to face profound challenges, diligent and focused efforts are needed to ensure that managed care plans serve the varied health care needs of neonates, infants, children, adolescents, and young adults (hereinafter referred to as children) and their families.

The effects of managed care on children’s access to services and actual health outcomes are not yet clear. Some studies report positive effects (lower emergency department use and higher outpatient use; reduced costs, especially for hospitalizations), but also report concerns regarding access to care and satisfaction. Other studies suggest no statistically significant differences in self-reported outcomes for children enrolled in managed care versus traditional health plans.

The effectiveness of managed care in linking more low-income children to a medical home is uncertain. The proportion of Medicaid-enrolled children 0 to 20 years of age registered in managed care plans increased from 52.2% in federal fiscal year 2000 to 69.6% in federal fiscal year 2008. Medicaid program shifts from fee-for-service to managed care plans have had little consistent effect on the health care use pattern by children and satisfaction with care received.

States that have expanded Medicaid and CHIP managed care programs for children with special health care needs have reported mixed results in terms of access to care and utilization.

The American Academy of Pediatrics (AAP) urges the use of the following principles outlined in this statement in designing and implementing managed care for children:

- Access to primary care practitioners (PCPs)
- Access to pediatric specialty services
- Appropriate eligibility and treatment authorization
- Effective quality improvement and management
- Adequate financing and payment

It is important to monitor the short- and long-term effects of cost-containment measures on the quality and outcome of medical services for children. The financial arrangements inherent in managed care plans often include discounted charges and modified fee schedules, performance incentives, capitation, case rates, and bundled or global fees. Utilization management techniques used by managed care plans include precertification, concurrent review and discharge planning, care coordination, case management, preauthorization, formulary management, and physician practice profiling in comparison with selected benchmarks. Accountability links financial consideration and utilization in addition to quality measures and patient satisfaction. Managed care plans are also incorporating evidence-based review, comparative effectiveness (also known as patient-centered outcomes research), value-based benefits, and tiered-level benefits to manage access to services. 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.

Cost-efficient health care delivery should be driven by performance-incentive programs focused on improved quality of care, actual clinical outcomes, and patient satisfaction, rather than policies that create barriers to care or discourage a willingness to provide services for children with special health care needs. It is well understood that inadequate physician payment can be a significant barrier to physician service access. Attention should be paid to the relationship of payment on access to care and the quality of care that children and adolescents receive. Additionally, market consolidations by managed care plans need to be reviewed in light of the effects on pediatrics and pediatricians, including, but not limited to, coverage benefits and access to pediatricians, pediatric medical subspecialists, and pediatric surgical specialists (unless otherwise indicated, use of the term pediatrician includes PCPs, pediatric medical subspecialists, and pediatric surgical specialists).

By including the precepts of primary care in the delivery of services, managed care can be instrumental in encouraging clinicians to provide access to a full range of evidence-based and evidence-informed pediatric health care services within a medical home. Children who received care in medical homes were less likely to have unmet medical and dental needs and were more likely to receive comprehensive pediatric care. Managed care plans can be instrumental to support the intent and desired outcomes of a medical home. A medical home provides care that is accessible, family centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. The guidelines for care delivered in this environment are well illustrated in Bright Futures, as recommended in the ACA.

Medically necessary health interventions that are evidence based or evidence informed are intended to prevent, diagnose, detect, treat, ameliorate, or palliate the effects of a physical, mental, genetic, or congenital condition, injury, or disability...
that lies outside the range of normal variation. Managed care organizations frequently use medical management guidelines to make coverage determinations. Payers are now looking at value-based benefits, comparative effectiveness, or patient-centered outcomes research to support their medical management and benefits coverage. However, adult-oriented policies frequently cannot be applied to the decision about a child’s health care. Many of these “evidence-based” studies are not developed with a pediatric focus, are derived from best-case actuarial data, or are proprietary. The implementation of medical management guidelines that do not address the unique needs of children may adversely affect the health and well-being of pediatric patients, especially those with special health care needs. The development of medical management guidelines and comparative effectiveness studies used to determine benefits coverage should be reviewed regularly to substantiate their validity and reliability in the pediatrics environment. In addition, as part of ACA implementation, each state will establish its own determination of essential health benefits. Therefore, the effect of variability of benefits coverage, which may exist among states because of state determination of essential health benefits, needs to be studied.

Just as fee for service can result in overutilization, payment structures in managed care plans can result in misutilization of appropriate services and reduced quality of care. Underutilization could result from underfunded pediatric services, including inadequately funded primary care capitation or payments and restrictions or limited access to pediatric medical subspecialists, pediatric surgical specialists, and tertiary care centers. Other access restrictions could block the use of necessary related services that improve outcomes or enhance quality of life, such as behavioral/mental health services, reproductive health services, social work services, developmental evaluation, occupational and physical therapy, vision screening, hearing screening, and speech and language therapies. Many services are, in fact, safety-net services, such as those of school-linked clinics and services of other public entities. To guard against inappropriate utilization and restricted access to necessary services, approaches to managed care must include a definition of medical necessity that addresses the unique needs of children and adolescents, specifically addressing the needs of those who have a functional impairment, chronic condition, or significant and multiple risks. Annual public reporting or monitoring should be considered to inform consumers of the quality of their health care benefits, with specific attention to recognized state or national benchmarks, required medical loss ratios, enrollment retention, and so forth. When a state has mandated participation in Medicaid managed care plans, it must implement rigorous regulatory oversight to ensure that eligible children have access to high-quality health services in a medical home and that pediatricians are adequately paid to provide these services. In addition, in states in which Medicaid enrollees are required to use a Medicaid managed care plan or enroll in state insurance exchanges as proposed by the ACA, beneficiaries should have the freedom to choose among 2 or more managed health care plans. In areas where only 1 managed care plan is available, particularly rural areas, families should be able to choose their individual physicians, and every effort should be made to allow Medicaid patients to remain in the care of their medical home. Medicaid provisions in the Balanced Budget Act of 1997 (Pub L No. 105-33) require adequate safeguards in every state implementation plan to ensure access to and delivery of quality health care for children.

Despite an exemption for grandfathered plans, the ACA is intended to enhance access and benefits coverage. A grandfathered health plan is an existing plan on the market when the ACA was signed into law in March 2010. Grandfathered plans are exempt from several provisions of the ACA as long as the grandfathered plan has not made any significant changes, such as raising premiums or eliminating benefit categories. Insurance plans that undergo such changes forfeit their grandfathered status and are subject to the full scope of ACA provisions. ACA provisions affecting children and adolescents include the following:

- All nongrandfathered health insurance plans are required to cover all well-child visits, including physical examinations; immunizations; screenings for hearing, vision, developmental, and behavioral health; and anticipatory guidance in accordance with Bright Futures guidelines.
- Nongrandfathered health insurance plans are required to provide this benefit without copayments or other cost sharing for individual policy years and group plan years, effective September 23, 2010.
- Effective January 1, 2014, new health insurance plans operating under state health insurance exchanges must provide a package of essential benefits, the scope of which must be equal to benefits provided under a “typical” employer-sponsored plan. However, essential health benefits may vary from state to state.
1. Access to Appropriate PCPs
   a. Choice of primary care physicians for children must include pediatricians.

   As the medical specialty concerned with the physical, mental, and social health of children from birth to young adulthood, pediatricians understand the constantly changing functioning status of their patients’ growth and development. Numerous studies support the significant relationship between primary care and health outcomes.15

   b. PCPs should serve as the child’s primary care provider and ensure the delivery of comprehensive preventive, acute, and chronic care services. In areas in which pediatricians are not available, access to pediatric consultation is important. Access to pediatric care/consultation should be available 24 hours a day, 7 days a week, or there should be appropriate coverage arrangements.

   c. The primary care medical home (PCMH) implies, first and foremost, care coordination (ie, the PCMH manages all referrals that 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, including but not limited to cystic fibrosis, juvenile rheumatoid arthritis, renal disease, cancer) if the subspecialist is willing to assume responsibility for care coordination within the context of the patient/family-centered medical home. Managed care plans should support development of the patient/family-centered medical home by pediatricians and pediatric medical subspecialists for the pediatric population covered under their plans, particularly children with special health care needs. Children with special health care needs should be defined as those who “have a chronic physical, developmental, behavioral, or emotional condition and who require coordinated health and related services of a type or amount beyond that required by children generally.”16 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). Managed care plans can assist the PCP in identifying and fostering linkages to available resources.

   d. Adolescents, young adults, and other individuals from more vulnerable populations may need multiple sources of care available to ensure that adequate services are provided.

2. Access to Pediatric Specialty Services
   a. When children need the services of pediatric medical subspecialists or other health care professionals, managed care plans should use clinicians with appropriate pediatric training and expertise. Pediatric-specialty clinicians include pediatric medical subspecialists, pediatric surgical specialists, and behavioral mental health specialists, who should have completed an appropriate fellowship in their area of expertise and are certified by specialty boards if certification is available. There should be no financial barriers to access to pediatric specialty care above and beyond customary health plan requirements for specialty care.

   b. Managed care plans should ensure access within the plan to tertiary-care centers appropriate for children, as well as an appropriate number and mix of geographically

- Preexisting condition exclusions are banned for children up to 19 years of age who are enrolled in nongrandfathered plans (effective September 23, 2010).
- Coverage is extended to young adults under a parent’s health insurance plan to 26 years of age if the plan provided dependent coverage (effective September 23, 2010).
- All private insurance plans are barred from rescinding coverage, except in the case of fraud or misrepresentation by the enrollee.
- Private insurance plans are barred from imposing lifetime dollar limits on coverage for “essential health benefits.”
- Plan enrollees in all nongrandfathered plans are allowed to choose a participating pediatrician as the child’s primary care physician.

Judicial challenges regarding the constitutional nature of the ACA have been resolved. The AAP now 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 of access to primary and specialty pediatric services, treatment authorization, coordination of care, and financing and payment are intended to maximize the positive potential of managed care for the benefit of children and guide pediatricians and those providing care to children and adolescents, as well as families, payers, policy makers, and managed care plans.

PRINCIPLES OF MANAGED CARE FOR CHILDREN

1. Access to Appropriate PCPs
   a. Choice of primary care physicians for children must include pediatricians.
accessible pediatric-trained physician specialists.

c. The referral process for pediatric specialty clinicians (pediatric medical subspecialists, pediatric surgical specialists, and pediatric behavioral mental health specialists) should be developed by health plans in collaboration with pediatricians, pediatric specialty clinicians, and families. The criteria for referrals may include age of patient, specific diagnoses, severity of conditions, and logistic considerations (eg, geographic access and cultural competence).

d. Access to specialty services within the managed care organization can be expedited by creating a “presumptive authorization” category (eg, no preauthorization needed for diagnoses including but not limited to hernia, strabismus, appendicitis, and diabetes).

e. Managed care plans must foster and financially support care coordination, such as interdisciplinary communication with the pediatric patient’s medical home, including the PCP, pediatric medical subspecialists, pediatric surgical specialists, mental health professionals, and any other professional service providing medical care.

3. Eligibility and Treatment Authorization

a. Managed care plans must provide appropriate written, oral, and Web-based information and counseling to current and potential beneficiaries that allow informed patient choice of a managed care organization, network options for primary care physicians, relevant pediatric medical subspecialists and pediatric surgical specialists, and pediatric hospital and ancillary services.

b. Families should receive education at the time of enrollment to help them understand fully their health plan benefits (including limitations on the amount, duration, and scope of services; cost-sharing requirements; and participating health care professionals). Carriers with multiple managed care plans should provide a clear comparison of pediatric benefits and networks across managed care plans so that families can choose a plan most appropriate for their needs. Materials should be clear, in lay language, and easy for all families to understand.17 Materials should be available in the patient’s/family’s primary language.

c. Subsequent to enrollment, health insurance benefits for pediatrics must be clearly defined. Managed care plans must provide details on the scope of pediatric benefits in consumer brochures, Web sites, and, most importantly, in plan evidence of benefit coverage documents and managed care contracts.

d. 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 served by the managed care plan. The roster of the provider network should be continuously updated by the managed care plan to reflect newly participating physicians as well as deletion of nonparticipating providers. The parent’s/patient’s choice of pediatrician as well as the required copayments should be listed on the patient’s insurance card.

e. Managed care plans should provide accurate and current online patient eligibility data, timely authorization review, and real-time claims adjudication with real-time payment information available to clinicians and patients.

f. Managed care plans need to make every effort to provide timely and accurate verification of eligibility to the physician and should not retroactively rescind payments on the basis of the plan’s error. Plans must be bound by their confirmation of eligibility, and physicians are to be held harmless and be fully compensated when services are provided after the plan’s verification of eligibility.

g. The treatment authorization process for elective services initiated by the PCP should efficiently facilitate timely appropriate referral for specialty consultations, hospital inpatient and outpatient care, and other treatments. Emergency-based services should not require previous authorizations.

h. Plans should provide timely responses to treatment authorization requests (including 24-hour access and approvals in the case of emergencies) on the basis of the nature and urgency of the patient’s needs. Managed care plans should allow member access to emergency care consistent with the “prudent layperson” standard.17 Plans are urged to make transparent their processes for authorizations and are encouraged to evaluate and share studies on the effects of previous authorizations on patient access, costs, and quality of care.

i. 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 third-party reviewer of the same specialty or, if not available, by a physician experienced in
the treatment of the pediatric illness.

j. Before making any determination that any item or service furnished to a person younger than 26 years is not medically necessary, the managed care plan should consider whether an item or service (1) is appropriate for the age and health status of the person, and (2) is supported by evidence-based or evidence-informed clinical practice guidelines developed for children’s health care services that are endorsed or approved by appropriate medical professional societies or governmental public health agencies. Managed care plans should describe the process by which physicians are to provide justification for medical necessity. Referral to a panel of third-party reviewers with pediatric expertise may be the option of last resort.

k. Pharmacy benefits must be appropriate for children and recognize that off-label use of medications is often necessary for children, including compounded medications, which are often necessary to meet the unique needs of children. (Off-label use may be defined as using an approved drug to treat a disease that is not indicated on the label or varying from the indicated dosage, regimen, or patient population.)

l. Health plans need to recognize and reward the unique skills of pediatricians in addressing pediatric mental health issues and remove barriers to mental health care, as outlined in the AAP and American Academy of Child and Adolescent Psychiatry joint paper “Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration.” Pediatric primary care clinicians have substantial opportunities to affect the mental health of children: preventing mental health problems by guiding parents in behavior management; identifying mental health symptoms as they emerge; intervening early, before symptoms have evolved into disorders; facilitating referral of children and their family members when mental health or substance abuse specialty services are needed; and collaborating with child and adolescent psychiatrists in caring for children with severely impairing mental health and substance abuse disorders. Managed care plans are called on to implement parity in mental health benefits, including diagnostic parity for pediatricians and procedural parity for child and adolescent psychiatrists. By addressing the administrative and financial barriers that primary care clinicians and children’s mental health professionals currently encounter in providing behavioral, mental, and brain health services to children and adolescents, managed care plans can improve access, collaboration, and coordination for pediatric mental health care. PCPs should be recognized as often the best equipped to provide initial mental health therapeutic and counseling services for children and their families.

4. Quality Improvement and Management

a. Managed care plans should be transparent and provide written standards that pertain to access to primary care, referrals to specialty physician and other recommended services, the referral process, and protocols for service.

b. Pediatricians, pediatric medical subspecialists, pediatric surgical specialists, and behavioral mental health specialists should have an active role in developing quality improvement mechanisms and patient-centered outcomes research programs. Any cost-containment process, pay-for-performance program, tiered benefits, differential physician payments, or value-based benefit design should be reviewed in light of the effects on pediatric access and quality of care.

c. Managed care plans have developed a broad and diverse clinical database related to utilization of services. As a result, managed care plans should participate in patient registry development and thoughtful quality outcomes research based on the principles articulated in the AAP policy statement “Principles for the Use and Development of Quality Measures.” Health care payers are in a unique position to collaborate with the pediatric community to develop and implement changes that systematically advance children’s health care. Managed care plans should actively engage pediatricians in both community and hospital settings in outcomes research and quality improvement efforts, such as developing patient registries or working toward a single national pediatric database similar to the Medicare Part B database. Quality management should include appropriate peer review, with pediatric cases reviewed by pediatricians.

d. Use of patient-centered outcomes research studies is increasing as payers look to assess treatments and costs to determine the ideal course of treatment, medication, or medical device for certain conditions. With the establishment of the Council for Comparative Effectiveness Research as part of the American Recovery and Reinvestment Act passed in February 2009, private payers, including
managed care payers, have enhanced comparative effectiveness efforts. Also, the Patient-Centered Outcomes Research Institute was established through the 2010 ACA and was created to conduct research to provide information about the best-available evidence to help patients and health care clinicians make more informed decisions. These efforts support incorporation of outcomes-based research to benefit design. Managed care plans are encouraged to share clinical and financial data along the continuum of care to allow for assessment of access, quality, and cost of care. Managed care plans using pediatric comparative effectiveness and patient-centered outcomes research studies for coverage determinations need to make all research public and available for comment by organized medicine and specialty societies. For pediatric comparative effectiveness research, pediatricians, and pediatric specialists must be part of the review.

e. Plans should promote recommended preventive services, early identification, and treatment of health problems in children by providing benefits coverage and appropriate payment to physicians for all recommended screenings and assessments. These measures should be included in incentive programs to physicians as part of pay-for-performance programs.

f. Plans should report a uniform standard set of encounter data in compliance with the Health Insurance Portability and Accountability Act (Pub L No. 104-191 [1996]).

g. States should publish uniform data for health plans that offer consumers and purchasers the opportunity to evaluate and compare performance, including relevant financial information, among competing plans. The measures reported by states on a managed care plan’s performance should emphasize quality standards, such as access to care, patient satisfaction, and health outcomes.

h. Managed care contracts shall exclude prohibitions that restrict information and advice that physicians provide about a patient’s medical options, including, but not limited to, advice on noncovered treatment options and information about the patient’s plan and competing health plans.

i. Managed care plans are encouraged to work collaboratively with pediatricians, pediatric specialists, the AAP, and AAP chapters to develop and/or enhance quality-improvement activities that can benefit all children.

j. Managed care programs should collaborate with their clinicians and community resources to identify appropriate family practice and internal medicine medical homes that provide optimal care for children with special health care needs as they age out of the pediatric medical home and transition to adult care.

5. Financing and Payment

a. Payment 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 26 Years,” with the periodicity of visits and procedures described in the AAP statement “Recommendations for Preventive Pediatric Health Care” and the current edition of the Bright Futures, as well as “The Medical Home for Children: Financing Principles.” The methods used for pediatric health care payment should consider age, chronicity and severity of underlying health problems (case mix, risk, or severity adjustment), service area market, and geographic considerations. Payments to the PCMH for chronic condition management should support the additional visits and time spent on care plan development and complex disease management, as reflected in Current Procedural Terminology (CPT) codes for care plan oversight, non-face-to-face care, complex and transitional care, telephone care, and E-mail consultations, as well as recommended pediatric services provided by nonphysician professionals. The payment structure should encompass recognition of all CPT and Healthcare Common Procedure Coding System codes based on their relative value units (RVUs), the complexity of the physician’s patient panel mix, expanded care-management responsibilities, after-hours accessibility, new quality-improvement activities, and up-front investments and support for infrastructure.

b. Managed care plans need to make transparent all policies and procedures regarding coverage and payment determinations, including fee schedules and claims edits. Any changes affecting payment to the pediatrician must be provided in writing and in advance to provide timely notification and allow time for review/appeal/negotiation by the pediatrician. There must be a specified time period for repayment requests applied equally to payers and clinicians, and payment offsets on future claims to adjust contested claims already paid by managed care plans should be prohibited.
c. Appropriate payment for immunizations should be based on the actual cost incurred by the practice and should include a reasonable margin to encourage provision of these services within the medical home. Actual cost calculation should include the purchase price, applicable taxes, shipping/handling charges, and total additional costs associated with vaccine inventory management, including but not limited to finance costs, immunization registry reporting, vaccine administration, personnel costs, and factors for inventory control, loss prevention, inventory shrinkage, and vaccine storage (including specialized refrigerators/freezers, temperature controls, and alarms). Fee schedules and health plan coverage benefits for immunizations must be updated in a timely manner and made effective retroactive to the date new recommendations for new vaccines are published by the AAP or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

d. Payment for physician services for newborn care should be separately identified as unique and distinct from maternal services and should ensure adequate and clearly identified payment to attending physicians who provide care for newborn infants to ensure consistent and continuous coverage for the neonatal period and for subsequent pediatric care.

e. 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 risk-adjusted rating groups, a pediatric diagnostic classification system, or a combination of these. As risk-adjustment techniques are developed by payers, it is necessary to incorporate a pediatric focus and involve PCPs and pediatric specialists experienced in private practice in their design. Contract provisions about carved-out services, outlier payment, stop-loss provisions, reinsur ance or shared-risk arrangements for individual children, and aggregate plan loss or profits should be clearly identified. Any additional services (meaningful use reporting, attestations to facilitate data correction, and so forth) to be covered under the capitation rate must be subject to mutual agreement by the health plan and the contracting physician.

f. When primary care is 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, immunizations, hospitalization, emergency services, transplant services, and, in the case of adolescents, pregnancy and other reproductive health services.

g. All recommended preventive services, including pediatric immunizations, must be covered as first-dollar coverage and not be subject to deductibles and/or copayments or any other cost-sharing mechanism under the health plan. Payment for preventive care services needs to be in full and not be bundled or considered incidental to the office visit. Appropriate payment can be accomplished by paying for each service reported separately at a level that reflects the total RVUs of all the reported services.

h. Health plans paying pediatricians for pediatric care on a fee-for-service schedule should use the most current Resource-Based Relative Value Scale as the basis for their fee schedule. The American Medical Association/Specialty Society Relative Value Scale Update Committee RVU values are appropriate for PCPs, pediatric medical subspecialists, and pediatric surgical specialists. A single multispecialty, regionally adjusted conversion factor applied to the current-year RVUs (ie, at least 100% of the current year Medicare resource-based relative value scale reimbursement rate) should be incorporated. Medicaid fees should be set at a rate that is at least 100% equivalent to those in Medicare. Health plans should use the most current version of CPT codes and adhere to CPT guidelines regarding the use of codes.

i. In all payment systems and methodologies, pediatric services within the context of the medical home should be appropriately assessed to ensure that pediatric primary and specialty services are not undervalued in terms of practice expense, professional liability, and physician work. Financial incentives to encourage use of the medical home must be paramount, and there should not be financial incentives by the managed care plan to encourage use of nonmedical home service offerings, such as retail-based clinics and/or urgent care centers.

j. In light of evolving payment methodologies, continuation of high-quality services for children must be ensured, and primary care physicians should be protected against undue financial risk as well as arbitrary assignment to tiered or differential payment levels. Risk levels for office-based PCPs should be on an
aggregate, not individual, basis and should be adjusted based on case-mix analysis. Any payment incentives, including shifting of risk to the clinician by the managed care plan, need to be fully transparent and supported by data and resources for the clinician to manage the risk and make informed clinical and financial decisions.

k. Mandatory clinician participation in all service offerings by the managed care plan carrier should be prohibited, and physicians need to be allowed to determine their level of participation and acceptable risk, individually or as a physician group, within the health plans.

l. 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 beneficiaries of CHIP or Medicaid and require the federal and state governments to guarantee clinician payments if plans become insolvent.

m. Plans should use pediatric quality measures that assess the current status and improvements of care over some relevant time frame. Quality measures on structure, process, health, and functional outcomes need to be based on current acute, chronic, mental, dental, and preventive pediatric care standards, in accordance with the principles promulgated in the AAP policy statement “Principles for the Use and Development of Quality Measures.”19 As physician payment begins to be tied more closely to patient outcomes through pay-for-performance programs, the reporting of CPT category II codes will be necessary to qualify for supplemental payments.20

n. Many of the responsibilities for managing the care of pediatric inpatients are being coordinated between hospitals and physicians as part of IDSs with a variety of payment methodologies: prospective payment, case rate methodologies, or bundled or global fee arrangements. Pediatricians and pediatric medical and surgical specialists are encouraged to work closely with hospitalists, hospital quality assurance managers, case managers, medical directors, and administrators to improve care management and resource utilization continuously and make process changes that are outcome driven. Managed care organizations, ACOs, and health plans could be very influential in enhancing this aspect of health care.

o. To ensure timely and appropriate payment, plans should make available electronically pertinent patient information, including, but not limited to, patient eligibility status and current contact information, benefits, and benefit limitations.

p. Financial incentives are needed to support the medical home infrastructure, including adoption of health information technologies. Despite the benefits to patients and payers attributable to implementation of information technologies, physicians, especially those in private practice, bear the risks and costs of implementation and maintenance as well as associated upgrades but do not see a return on their capital outlay.29

q. Managed care plans developing IDSs and ACOs should be aligned with the recommendations by the AAP.30,31 The AAP fostered the concept of the medical home and is a staunch advocate for comprehensive essential health care needs of children. The AAP wholeheartedly recommends that managed care plans, ACOs, and IDSs adopt a medical home model for children that adequately addresses the needs of all children, including those with special health care needs.

CONCLUSIONS

Managed care will continue to evolve until the approaches used to finance and deliver health care more consistently meet the needs of patients, clinicians, employers, and society overall. During this evolution in managing health care, specific and consistent attention must be given to the direct relationships between clinician payments, access to care, the quality of care provided, and health outcomes for children as well as patient satisfaction. Primary care physicians, adult and pediatric, are the backbone of managed care systems and key to IDSs. Much of the focus in today’s health care reform environment and in managed care has focused, with good reason, on controlling health care costs. In addition to controlling costs, managed care is also in a position to enhance access to and quality of care. To achieve the greatest value in health care for children, payers, employers, and clinicians must all consistently focus on enhancing access to health care, improving outcomes, increasing quality and safety, and achieving greater patient/family participation and satisfaction with their care. Many debilitating adult conditions begin in childhood. Pediatricians need the tools and support of the health care delivery system to ensure the health and readiness of tomorrow’s adult population. Comprehensive,
coordinated, value-based care with cost control may have great effects and may be best demonstrated in pediatric health care.

LEAD AUTHOR
Thomas Long, MD, FAAP

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COMMITTEE ON CHILD HEALTH FINANCING, 2012–2013
Thomas Long, MD, FAAP Chairperson
Molly Droge, MD, FAAP
Norman “Chip” Harbaugh, MD, FAAP
Mark Helm, MD, FAAP
Mark Hudak, MD, FAAP
Andrew Racine, MD, FAAP

Budd Shenkin, MD, FAAP
Iris Snider, MD, FAAP
Patience White, MD, FAAP
Earnestine Willis, MD, FAAP

STAFF
Ed Zimmerman
Lou Terranova


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COMMITTEE ON CHILD HEALTH FINANCING

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