

The Honorable Kathleen Sebelius  
Secretary, US Department of Health and Human Services  
200 Independence Ave., SW  
Washington, DC 20201

April 30, 2010

Dear Secretary Sebelius:

We the undersigned organizations, representing primary care pediatricians, pediatric subspecialists, pediatric surgical specialists, and children's hospitals want to thank you for your commitment to pediatric providers in health reform. The signing of Public Law 111-148 represents a great legislative achievement, and the inclusion of Sec. 1202's Medicaid payment reform in *The Health Care and Education Affordability Reconciliation Act of 2010* (Public Law 111-152) for pediatric medicine lays the groundwork for improving access to general pediatric, pediatric subspecialty and pediatric surgical specialty medicine for children. This section also reflects legislative intent to make children's access to needed medical care a priority.

Children with Medicaid coverage need the services of all types of pediatricians. Unlike the situation for adult patients, many pediatric subspecialties are undersubscribed and facing serious workforce issues. The difficulties in obtaining reimbursement and the low rates of return on billing are significant disincentives to correcting this problem and negatively impact access for children in Medicaid. General pediatricians and pediatric subspecialists provide 57% of all office visits paid for by Medicaid on behalf of persons ages 0-21.<sup>1</sup> Additionally, a higher proportion of children with Medicaid have chronic illnesses requiring pediatric subspecialty services than do non-Medicaid patients.<sup>2</sup> As a result, pediatricians are intimately familiar with the Medicaid system. Pediatricians, pediatric subspecialists and pediatric surgical specialists are the physician group that interacts with the Medicaid program more than any other organized physician group.

As you begin the implementation process, we would appreciate the opportunity to work with you to clarify that the Medicaid payment provisions of Sec. 1202 include a new payment floor for both general pediatrics and pediatric subspecialists, that payment increases should also apply to procedure codes, that payment increases should apply to codes for which Medicare publishes relative value units, and that updated immunization codes are referenced appropriately. These steps will help us best meet the needs of children.

**Pediatric subspecialty is included in Sec. 1202.** We believe Sec. 1202, by referencing services provided by physicians with a primary designation in pediatric medicine, includes those services provided by pediatric subspecialists. The section is entitled "Payments to Primary Care

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<sup>1</sup> Genevieve M. Kenney, Joel Ruhter, and Thomas M. Selden, "Containing Costs And Improving Care For Children In Medicaid And CHIP," HEALTH AFFAIRS ~ Web Exclusive, September 17, 2009, pages w1025-w1036.

<sup>2</sup> ELECTRONIC ARTICLE: Deborah Shatin, Regina Levin, Henry T. IreysDagger, and Virginia Haller, "Health Care Utilization by Children With Chronic Illnesses: A Comparison of Medicaid and Employer-insured Managed Care," PEDIATRICS Vol. 102 No. 4 October 1998, p. e44. :

Physicians,” but the language of the section states that payment floors apply to “payment for primary care services ... furnished ... by physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine...” Clearly, pediatric subspecialists should not be excluded by this definition because they have a primary specialty definition of “pediatric medicine.” The use of pediatric medicine, rather than general pediatric medicine, further indicates the intent to include both general and subspecialty pediatrics. Additionally, it is essential to the goals surrounding health reform that sick infants, children, adolescents and young adults have access to all pediatric specialty services, including those provided by neonatologists, pediatric intensivists and pediatric hospitalists, among others, who may, in many cases, serve as the attending physicians for patients. This is particularly true for patients who rely on Medicaid to meet their health care needs.

For these reasons, we strongly urge that regulations or other administrative actions taken to implement Sec. 1202 should clarify that pediatric subspecialists are deemed eligible for inclusion in this provision.

Some subspecialty pediatric groups are also concerned that they may be excluded due to the fact that their members are certified by a non-pediatric specialty society or Board. Pediatric neurologists, pediatric mental health experts, pediatric ophthalmologists, and others may fall into this category. Children need access to the services provided by these pediatric physicians, especially when very sick, and thus excluding these physicians from the opportunity to receive fair payment for their services will trickle down to the detriment of the sickest children. We urge you to not exclude these pediatricians from eligibility for payment under Sec. 1202 in drafting the regulation.

**Exclusion of Procedure Codes.** We believe that the \$8.3 billion investment to increase Medicaid payment to 100% of Medicare made in Sec. 1202 will significantly improve access to care. Currently, Medicaid pays 66% of Medicare on average,<sup>3</sup> with some states paying as little as 33% of Medicare for some Evaluation and Management (E&M) codes.<sup>4</sup> During these difficult economic times, as more children and families are relying on Medicaid for care, states are cutting already inadequate provider payment rates in an attempt to balance budget shortfalls. The federal government’s investment in Medicaid payment reform will enable pediatric physicians and surgeons, many of whom have been forced to cap or even cut their Medicaid caseload due to low Medicaid payment, to continue to treat Medicaid and CHIP enrollees.

However, while Medicare parity for E&M services covered under Medicaid will improve access to care, we encourage you to use the authority at your disposal to apply the payment increase to E&M **and** procedure codes. The inclusion of procedure codes is particularly important in regards to access to pediatric subspecialists and pediatric surgical specialists. While subspecialists and surgical specialists do bill for some E&M codes, many of the services they provide are billed under the procedure code designation.

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<sup>3</sup> Medicaid to Medicare Fee Index 2008, Kaiser Family Foundation State Health Facts, (<http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4>)

<sup>4</sup> American Academy of Pediatrics’ 2007/2008 Medicaid Reimbursement Survey, (<http://www.aap.org/research/medreimpdf0708/ny.pdf>).

**Exclusion of Codes Not Paid for by Medicare.** Section 1202 appears to set a payment floor only for those E&M codes that are recognized for payment by the Medicare program. Thus, E&M codes to which Medicare assigns values, but does not recognize for payment appear to be excluded. The following is a list of the E&M codes that are not recognized for payment by the Medicare program:

99241-99245 (Outpatient consultation) [new policy starting 1/1/10)  
99251-99255 (Inpatient consultation) [new policy starting 1/1/10)  
99288 (Physician direction of EMS)  
99339-99340; 99374-99380 (Care plan oversight)  
99358-99359 (NF2F prolonged physician services)  
99360 (Physician standby service)  
99363-99364 (Anticoagulant management)  
99366-99368 (Medical team conferences)  
99381-99397 (Preventive medicine services)  
99401-99404 (Preventive medicine counseling, individual)  
99408-99409 (Alcohol/substance abuse structured screening)  
99411-99412 (Preventive medicine counseling, group)  
99420 (Health risk assessment)  
99429 (Unlisted preventive medicine service)  
99441-99444 (Telephone and online medical evaluation services, physician)  
99450 (Basic life and/or disability exam)  
99499 (Unlisted E/M service)

While most of the codes on this list have Relative Value Update Committee (RUC)-recommended Relative Value Units (RVUs) published on the Medicare physician fee schedule (PPS), the PPS “Status Indicator” column indicates that “while RVUs are shown, they are not paid under the Medicare program.” If the E&M codes not paid for under the Medicare program are excluded from the payment floor as generated by the new law, pediatric providers may not receive payment increases for key services that are clearly valued by CMS. As is clear from the list above, these services are exactly the types of services, such as “well child care codes” (i.e., 99381-99397 (Preventive medicine services)), that the new law purports to value. By excluding these codes, children’s access to the preventive services the legislation is trying to promote will be limited.

As the health care delivery system transitions from predominantly fee-for-service driven payment models to paying for more coordinated, patient- and family-centered care, we urge you to include the services for children valued by Medicare, even if Medicare does not provide payment for them. This will ensure that pediatric physicians and surgeons will benefit from the increased payment for services essential to the provision of care in the medical home, such as outpatient consultation, inpatient consultation, care plan oversight and preventive medicine services and counseling. Medicare clearly recognizes that pediatricians and other non-Medicare providers spend time on these services, and thus they have values associated with them. They should be valued under Section 1202.

**Immunization Codes.** Subsection JJ2 of Section 1202, Services Related to Immunization Administration for Vaccines and Toxoids, is also important to children. Several of the codes cited in the new law will be modified by the end of 2010. When the codes are released by the end of this year, two codes will replace the first four codes listed in the legislation. **The new codes will result in more efficient, quality care since they will incentivize pediatricians to use combination vaccines and to administer fewer immunization “sticks.”** We urge CMS to update the codes designation in Subsection JJ2 to reflect the updated codes.

We want to thank you again for all of your efforts on behalf of children and pediatricians. However, moving forward, significant work needs to be done to effectively develop and implement the provisions included in Section 1202 of HR 4872 so that the needs of children are appropriately valued. We can not afford to treat children in Medicaid as a fraction of adults in Medicare. We look forward to working with you over the coming months to implement the entirety of health reform to the greatest benefit of children.

Sincerely,

American Academy of Ophthalmology  
American Academy of Pediatrics  
American Association for Pediatric Ophthalmology and Strabismus  
American Association of Neurological Surgeons  
American College of Rheumatology  
American Pediatric Society  
American Society of Pediatric Nephrology  
American Thoracic Society  
Association of Medical School Pediatric Department Chairs  
Child Neurology Society  
Children’s Specialty Care Coalition  
Congress of Neurological Surgeons  
Council of Pediatric Subspecialties  
National Association of Children’s Hospitals and Related Institutions  
North American Society for Pediatric Gastroenterology, Hepatology and Nutrition  
Pediatrix Medical Group, Inc.  
Society for Pediatric Research