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May 18, 2010

The Honorable Kathleen Sebelius  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Sebelius:

The American Academy of Pediatrics (AAP), a non-profit professional organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, congratulates you on the recent enactment of the Patient Protection and Affordable Care Act (PPACA). The Administration now faces the herculean task of implementing this landmark law, and the AAP looks forward to working closely with you to ensure that the health of every child is improved.

One of the earliest PPACA provisions to take effect creates Section 2713 of the Public Health Services Act, Coverage of Preventive Health Services. This vital provision requires all health plans to cover, with no cost-sharing, “with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration,” meaning the services outlined in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*.

In drafting regulations, the Department of Health and Human Services must address clinical, payment, and administrative/informatics issues associated with pediatric preventive health care. These three topics form a three-legged stool essential to support effective implementation of the provision. **Neglecting any one of these three components will undercut the provision's benefits for children.**

The attached document sets out the key issues in implementation. We look forward to working closely with you to ensure that these regulations support patient and family health and pediatric providers' ability to serve our nation's children and youth well. If the AAP can provide further assistance, please do not hesitate to contact Cindy Pellegrini or Robert Hall in our Washington, DC office at 202/347-8600 or [cpellegrini@aap.org](mailto:cpellegrini@aap.org)/[rhall@aap.org](mailto:rhall@aap.org).

Sincerely,

Judith S. Palfrey, MD FAAP  
President

The American Academy of Pediatrics (AAP) appreciates the opportunity to provide background information toward the development of effective regulations implementing provisions of the Patient Protection and Affordable Care Act (PPACA) related to coverage of preventive health services for children.

One of the earliest PPACA provisions scheduled to take effect creates Section 2713 of the Public Health Service Act, Coverage of Preventive Health Services. This vital provision requires all health plans to cover, with no cost-sharing, “with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration,” meaning the services outlined in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*.

Clinical, payment, and administrative/informatics aspects of this requirement must all be addressed in detail in order for this provision to fulfill its potential to create a revolutionary leap forward in pediatric health. If any of these categories is left unaddressed, or if significant questions remain unanswered, there will be the potential for loopholes to be created that will leave many children outside the protections of this provision. The AAP urges you to take into account the following issues as you develop regulations to implement Section 2713.

### **Clinical Issues**

In defining the services covered by Section 2713 as “..with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration,” Congress was clearly referring to *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. *Bright Futures* was updated most recently in 2008 and offers the only existing comprehensive clinical guidelines for pediatric preventive health care. Development of the current third edition was led by the AAP in partnership with the Health Resources and Services Administrations’ Maternal and Child Health Bureau. Its development was an evidence-informed, active collaboration with a wide range of organizations, including those representing other physician providers, nurses, insurance companies, mental health providers, dentists, school health, families and consumer groups, and many others. Representatives from the Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, and the Indian Health Service also contributed to the development of these national guidelines.

Perhaps the best-known aspect of *Bright Futures* is the schedule of “well child visits” it establishes – 31 visits between birth and age 21 years – also known as the “periodicity schedule.” Guidance for these visits is divided between Health Supervision and Anticipatory Guidance. Health Supervision covers medical history, observation of the parent-child interaction, surveillance of development, physical examination, and immunizations. Anticipatory Guidance comprises the rich array of topics on which pediatricians are expected to give parents guidance to prevent illness and promote health.

These topics help parents address nutrition, physical activity, behavioral issues, discipline, safety and injury prevention, and much more.

*Bright Futures* well child visits follow the periodicity schedule and reflect both essential components for each visit and family and/or community-specific components that are included when appropriate. Essential components include, but are not limited to:

- solicitation of parental and youth concerns
- identification of children with special health care needs
- a complete physical examination
- measuring and plotting Body Mass Index (BMI)
- immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)
- universal screening (including but not limited to developmental screening, autism specific screenings, oral health risk assessment)
- selective screening based on risk assessment
- use of screening tools, including behavioral and mental health screens
- anticipatory guidance
- family/community specific components determined by:
  - parent or child concerns
  - private, confidential time with adolescent patients
  - problems discovered
  - treatment, referrals (as needed) and follow-up plans

These health supervision visits are a crucial aspect of serving as a medical home for pediatric patients. Having created the medical home concept in the 1960s, the AAP was deeply gratified by the attention to and promotion of the medical home in the PPACA. By crafting a strong regulation to effectuate Section 2713, HHS can advance the medical home for all children and affirm that *Bright Futures* services are a core component.

It is important to note that *Bright Futures* establishes guidelines, not a rigid checklist of activities for health care providers. While every family should expect that a health supervision visit will include a comprehensive examination and anticipatory guidance, the specifics may vary depending upon the child, family, and community. Physicians must have the flexibility to meet each child and family's needs appropriately.

#### **HHS Regulations Should:**

- State explicitly that *Bright Futures* health supervision visits are the guidelines referred to in Section 2713.
- Affirm explicitly that coverage for these services is required under the new law.
- State clearly that all components of pediatric well child visits (including immunization administration, health supervision, anticipatory guidance), in accordance with the *Bright Futures* periodicity schedule, must be free of financial barriers, including copayments and deductibles.
- Encourage insurance companies to remove other barriers or disincentives for physicians in providing comprehensive *Bright Futures* services to their patients

and families.

### **Payment Issues**

The Academy welcomes the goal of the PPACA: true reform of the U.S. health care system. By changing the health system from a model of disease treatment to prevention, the PPACA has the potential to dramatically improve both the health care system and the health of our nation's children and families. Section 2713 is central to this effort for both children and adults as adult disease often has its roots in childhood, and can be most effectively prevented or mitigated with interventions during that period. In order to be effective, however, preventive health care must be *valued*, meaning quite literally that its priority must be reflected in payment rates. Unless prevention is valued, little will change.

Therefore, the Academy urges you in the strongest possible terms to address pediatricians' profound concern that the elimination of cost-sharing, and particularly of copayments, has the potential to have a negative impact on children's access to services. Simply put, copayments currently pay for many well child visits because insurers frequently bundle well child visits and services as part of other pediatric care. If HHS allows insurers to simply eliminate copayments without paying for the preventive services delivered at a visit, children will likely receive fewer well visits and access will decrease. Failing to address this issue could have the tragic result of undermining both the letter and spirit of Section 2713.

Beyond the impact on children's access to preventive services, losing the revenue stream from copayments could be devastating to pediatric practices. For almost all pediatric practices, well baby/well child copayments paid with the caregiver's funds represent a key revenue stream. Too many pediatric practices are already in precarious financial circumstances due to the low payments provided by public and private insurers, and this additional burden could make the difference in their viability. Pediatricians throughout the country report that private insurers commonly ignore and fail to reimburse for established CPT codes for many pediatric services, including immunization administration, developmental and autism screening, hearing and vision screening. Combined with generally dismal Medicaid payment rates, these burdens could make it impossible for many pediatric practices to absorb a loss in payment from current cost-sharing. The value of copayments should be incorporated into payers' reimbursement levels to physicians and other health care providers.

It is very encouraging that the federal government is taking positive steps to increase Medicaid payment rates for preventive services (embodied in Evaluation and Management Codes) through Section 1202 of the Health Care and Education Reconciliation Act of 2010. While this historic step is certainly welcome, it is ironic that payment rates for the very services guaranteed by Section 2713 will not be included in the Medicaid payment floor increase, because the Medicaid payment rate increase in the section appears to include only those services paid for by Medicare. Medicare does not currently pay for those CPT Codes which denote well child care (99381-99385; 99391-

99395), even though it recognizes values for the work that pediatricians and other providers bring to bear when they perform these services. Because close to 15,000 children have Medicare coverage due to their end stage renal disease or disability, it is not defensible for Medicare to fail to clearly pay for these services.

Nevertheless, Medicare does publish the values for these codes, as well as a status indicator of “I” (Invalid; Medicare uses another code to report this service) or “N” (Noncovered under the Medicare program.) The Academy greatly appreciates the publication of these status indicators because the RVUs associated with the CPT codes can then be referenced in pediatric practice contracts with private and other public payers. In effect, by publishing the RVUs, pediatricians can be paid even for well child visits for which Medicare does not pay. While the Academy appreciates these efforts, a superior model would be for Medicare to publish the RVUs *and commit to pay* for these services. Another improvement would be for the regulations implementing Section 2713 to require private insurers to follow CPT guidelines, which would greatly increase access to preventive services for children. This could help insurers achieve their 85/80% medical loss ratio and have the added benefit of investing in prevention in a significant way for children, and thus, the future of the country.

In addition, there are a range of payment and coding issues associated with pediatric health supervision visits that should be addressed by regulations. The AAP is deeply concerned that Section 2713 does not through the letter of the law bar payers from engaging in inappropriate bundling of certain services, or the elimination of separate payments that currently exist for some services recommended in *Bright Futures*. If increasing numbers of services are bundled into the health supervision visit payment without increases in that payment level, pediatricians will face an untenable mandate to do more with less. Such a development would certainly violate the spirit of the PPACA in prioritizing and rewarding preventive health services.

Finally, payment considerations should also support the medical home. The medical home, a concept originally established under the auspices of the AAP as a collaboration between pediatricians and families caring for children with special health care needs, is best effectuated through payments that reflect the medical services provided in an office visit; care coordination provided by a spectrum of specialists and other service providers; and any quality improvement efforts and infrastructure support. As noted above, the medical home is not a place, but an approach to care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective, delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care. Medical homes have clear benefits for families, pediatricians and payers. Documented benefits include reduced hospitalizations, reduced length of stay in hospital, reduced emergency department utilization, reduced prescription of unnecessary medications, and increased family and provider satisfaction. *Bright Futures* is an important tool in implementing pediatric medical home practices.

While many medical home models of payment exist, the Academy has endorsed payment models that supplement the fee-for-service model, including models that add a pay for performance payment or a reasonable capitation fee to supplement fee for service payments. Supplemental payment, also promoted strongly by the PPACA, directs physicians to meet patients' needs through a range of activities, including non-face-to-face care like telephone consultation and electronic communications. Studies have demonstrated conclusively that incentivizing this approach yields improved patient outcomes and can also reduce costs by helping to keep patients healthy. In implementing the guarantee of *Bright Futures* services without cost-sharing, we urge you to consider how the regulations impact the profusion of medical home demonstration projects across the United States as established by public and private payers.

### **HHS Regulations Should:**

- Require insurers to follow CPT guidelines for payment of well child services, as well as separate payment for all services that are appropriately reported under current CPT guidelines.
- Bar insurers from passing on to physicians and other health care providers the cost of eliminating cost-sharing. Children's access to preventive services will be harmed if physicians and other health care providers are required to absorb the elimination of cost-sharing by payers.
- Recognize that payment should support the medical home. Communication within the medical home occurs face-to-face in the visit, by telephone or by electronic media. To enhance access, meet the needs of the family, and encourage care that is comprehensive and family-centered, mechanisms for reimbursing all aspects of professional services and communications must be addressed.

### **Administrative/Informatics Issues**

In crafting regulations, HHS should address a number of administrative/informatics issues that will be vital to the successful implementation of Section 2713. First and foremost, definitions are crucial to the scope and reach of Section 2713. The AAP has identified three issues that must be defined appropriately in regulations: covered entities, cost-sharing, and *Bright Futures*.

Section 2713 states that *Bright Futures* services must be covered by "A group health plan and a health insurance issuer offering group or individual health insurance coverage..." The Administration should clarify through regulatory language that this mandate applies to all payers both within and outside exchanges: plans regulated under the Employee Retirement Income Security Act (ERISA); plans regulated by the states; plans offered through the individual market; and all public programs, including Medicaid, the Children's Health Insurance Program, and Tricare.

Cost-sharing must also be defined in a comprehensive fashion. Plans should not be permitted to require copayments, apply *Bright Futures* services to deductibles, or charge higher premiums for plans covering these services.

The *Bright Futures* guidelines must also be defined specifically and appropriately. In addition to stating explicitly that these are the guidelines referred to in Section 2713, the regulations should make clear that the requirements will transfer to any future editions issued. As noted above, the third edition of *Bright Futures* was released in 2008; a fourth edition is already being contemplated. This would also comport with the next section of the PPACA which references to-be-published guidelines for preventive services for women. It seems clear that Congress intended for the science to be updated as new information educates clinicians both in the pediatric and adult female populations. Creating structures to modify which preventive services women and children receive in the United States without cost-sharing will allow the provision to better stand the test of time.

Beyond these definitions, HHS should explain through the regulatory process how the department plans to measure and monitor private insurers' compliance with Section 2713. Both plans and providers deserve clear guidance, access to technical assistance, and resources to answer questions or report possible violations. HHS should dedicate specific resources to educating plans about these requirements and addressing the inevitable questions that will arise.

Finally, Section 2713 presents a unique opportunity to integrate appropriate preventive care guidelines into electronic medical records (EMRs), health information exchange (HIE), and personal health records (PHRs). Ambulatory EMRs are typically designed to address the needs of the adult population. Adult-oriented EMRs usually cannot be easily adapted to meet the special requirements of pediatric care. However, EMRs that support child health care will by definition meet the needs of adolescents as they transition to adult care, which makes them useful for all ages. Recognizing the priority that Section 2713 places on preventive care, all EMRs designed for use with children and adolescents should include *Bright Futures*. This could also be achieved by the use of "web-services" for accessing programs such as *Bright Futures* rather than requiring each EMR to have these programmed into the system. Requiring these EMRs to include or access *Bright Futures* in order to meet both the Medicare and Medicaid "Meaningful Use" standard for 2013 would also greatly improve efforts to measure quality and support research. As with all EMR functionality, it is important to remember that this needs to be done in a manner that supports physician workflow.

Health Information Exchange products are being used to exchange and consolidate information from EMRs. Standards for managing and displaying conflicting consolidated data from multiple EMRs are in the early stages of development. For example, HIEs can state that a child is both allergic and non-allergic to the same medication. "Problem list" inconsistencies, where the same problem is described in different ways, also plague HIEs. Similar inconsistencies will exist for *Bright Futures* data sent to HIEs unless steps are taken to address these challenges.

Personal Health Records are beginning to be more widely used. The ability of parents and adolescents to use PHRs to support the use of *Bright Futures* to improve accuracy, efficiency and involvement needs further development. The use of PHRs to replace HIEs

as a “source of truth” for managing the conflicting information from multiple EMRs (see above) is just beginning to be discussed but offers great promise for resolving this problem. PHRs also can solve patient-identification issues that are a significant challenge for HIEs.

**HHS Regulations Should:**

- Clarify that all payers (those covered by ERISA, all state-regulated group plans and plans in the individual market, as well as Medicaid, CHIP, Tricare, etc.), both within and outside Exchanges, must pay for the full cost of providing all *Bright Futures* services
- State that coverage is attached to the current version of *Bright Futures*, i.e. the third edition as of this writing but to convey to any future updates.
- Define cost-sharing comprehensively. Plans should not be permitted to require copayments, apply *Bright Futures* services to deductibles, or charge higher premiums for plans covering these services. As stated above, insurers should be prevented from passing on the cost of eliminating cost-sharing to physicians and other health care providers.
- Include language to address the mechanisms that HHS will use to monitor plans' compliance with these provisions and systems for institutions, providers or patients encountering questions or potential violations.
- Support the use of *Bright Futures* in EMRs in a manner that supports physician workflow;
- Support incentives for the creation and use of web services for *Bright Futures* in conjunction with EHRs and PHRs;
- Require the Meaningful Use requirements for 2013 to include *Bright Futures* for EMRs used for child and adolescent healthcare;
- Support research into standard methodologies for reconciling data inconsistencies in HIEs regarding problem lists and *Bright Futures*;
- Support incentives for parents and adolescents to adopt PHRs that contain *Bright Futures*.

Again, thank you for the opportunity to offer the AAP's perspective on priorities for the implementation of Section 2713. If the Academy can provide additional assistance, please contact Cindy Pellegrini or Robert Hall in our Washington, DC office at 202/347-8600 or [cpellegrini@aap.org](mailto:cpellegrini@aap.org)/[rhall@aap.org](mailto:rhall@aap.org). We look forward to working with you to use the PPACA to improve the health of all our nation's children.