



American Academy of Pediatrics



**TESTIMONY OF
SUSAN KRESSLY, MD, FAAP
PRACTICING PEDIATRICIAN
AMERICAN ACADEMY OF PEDIATRICS**

before the

COMMITTEE ON SMALL BUSINESS

SUBCOMMITTEE ON REGULATIONS AND HEALTHCARE

UNITED STATES HOUSE OF REPRESENTATIVES

JUNE 24, 2009

Department of Federal Affairs
601 Thirteenth Street, N.W.
Suite 400 North
Washington, D.C. 20005
202-347-8600 / 800-336-5475 / Fax 202-393-6137

Thank you very much, Chairwoman Dahlkemper and Members of the Committee. Thank you for your leadership and representation of the Third District of Pennsylvania. Many children in northwest Pennsylvania have been helped by the votes you have cast in favor of reauthorization of the Children's Health Insurance Program and the American Recovery and Reinvestment Act. Without these measures, many children would be without Medicaid. The Academy also applauds you for your innovative attempt to find solutions to our health IT funding quandaries.

I am honored to represent the American Academy of Pediatrics before you today. My name is Susan Kressly and I am a practicing pediatrician in Warrington, Pennsylvania. I have a strong interest in health information technology as it relates to pediatrics and I am a member of the Academy's Council on Clinical Information Technology. In addition to serving on the Council's immunization task force, I serve on the Child Health workgroup of the Certification Commission on Health Information Technology. I would like to extend my sincere thanks to this Committee for allowing me this opportunity to represent children, who represent nearly one-third of America's population, but from whom you don't hear, because they cannot vote. I am grateful for the opportunity to give them a voice.

I am also here today to speak for pediatricians. Sixty percent of pediatricians practice in small businesses. We are distinct from other doctors because the major government program that pays for the health care of children is Medicaid, not Medicare. Medicaid has a major impact on child health. It pays for 40% of births in the United States, and covers 30 million children. Medicaid faces fiscal problems, but not because of the children that are covered by the program. While more than 50% of the people covered by Medicaid are children, these children account for less than 25% of its cost. Most Medicaid dollars are spent on the care of disabled adults and adults in nursing homes.

Pediatricians provide the best care that we can for our patients, and many of us use a variety of tools to improve care. But pediatricians find it very hard to purchase health IT systems on our own. A real factor in our inability to afford these expensive technologies is the payment rates that pediatricians receive. Surveys by the American Academy of Pediatrics show that payment rates under Medicaid average around 70% of Medicare. In other words, the average pediatrician providing a service for a patient covered by Medicaid receives only about two thirds of the payment received by a provider for the same service for a patient covered by Medicare.

The Academy greatly appreciates the funding included for pediatricians to purchase health IT in the American Recovery and Reinvestment Act or ARRA, and Academy member surveys show that the funding has the potential to reach around two-thirds of pediatricians. However, small pediatric practices, that is, the same small businesses on which this Committee focuses its work, are disadvantaged by the health IT funding infrastructure established by the law because of the low payment rates under Medicaid and also because of the disparities between the ARRA requirements for practices that are paid by Medicaid and those that are paid by Medicare.

First, the funds in ARRA flow differently for Medicaid and Medicare. ARRA requires practices under Medicaid, including pediatric practices, to demonstrate that they meet a specific case mix

threshold for Medicaid to pay incentives. ARRA does not require this for practices receiving Medicare payments. The Academy thinks that pediatricians whose patient panels are made up by 20% Medicaid, CHIP, and uninsured patients should be eligible for HIT funding under the ARRA legislation.

Second, the meaningful use standard in the statute also poses problems. Medicare rules will require “meaningful use” of health IT in order for a practice to qualify for Medicare incentives. A meaningful use standard also applies to Medicaid, but under the statute, it appears that states can create their own rules for what meaningful use means within their own Medicaid programs. As a result, within a brief time, we could have one Medicare definition of meaningful use and fifty-six different definitions of meaningful use in the various state and territorial Medicaid programs. One-third of doctors practice near state lines, meaning that they would need to qualify for HIT payments under ARRA according to two or more state meaningful use rules. Such variances will undermine the purpose of adopting health IT within the Medicaid population, that is, to improve and to measure the quality of health care for all, including children. To improve quality, we must develop data sets that can be compared. A structure that undermines state-to-state uniformity makes that much less likely. Therefore, we urge you to advocate for a repeal of state Medicaid programs’ ability to modify the definition of meaningful use from a national standard.

We realize and appreciate that this funding could have flowed only through Medicare, but we also believe children and pediatricians should not have to overcome more barriers than adults and their health care providers to reap the benefits that health IT can provide. The Academy believes that the case mix threshold standard should be repealed so that the Medicaid and Medicare health IT incentive infrastructures are comparable. If that is not possible, the case mix threshold for Medicaid should be lowered as far as possible to provide incentive payments to as many Medicaid providers as possible.

Congress and the Obama Administration have made significant strides in recognizing the need to support pediatric health IT outside of ARRA. Title IV Section 401 of CHIPRA will act as a catalyst for pediatric health information technology by making available \$25 million over five years to develop a pediatric electronic health record format and also to measure and improve the quality of pediatric care. We stand ready to work with the Agency for Healthcare Research and Quality to assure that implementation of this legislation will help children.

Many resources have already been applied to forming useful quality measures for adults. Unfortunately, most of those measures do not apply to children. In addition, many quality measures for pediatrics are based on preventing rather than reducing disease, and thus comparisons and analyses that must be performed must be population-based and over long-term before real gains can be demonstrated. Such widespread and long-term benefits include: reductions in morbidity, mortality and quality of life due to improved immunization rates, violence and accident prevention, prevention of mental health disorders, obesity reduction and more. These subtler, longer-to-realize benefits can lead to huge and measurable savings of healthcare dollars for our country, but will take innovative and dedicated leaders to craft

appropriate quality initiatives and measures and it will require technologies and an infrastructure based on individual practices to track data over longer periods of time. Adult quality measures and programs do not and will not provide these measures of child health care quality over the long haul. . We need additional resources to do what is right for our children today and the country tomorrow.

We are all thankful that the Children's Health Insurance Program or CHIP reauthorization became law, and we must be realistic regarding shrinking state Medicaid budgets. Without robust funding assistance, Medicaid providers, including pediatricians, may not be able to adopt health IT as quickly as the national healthcare system needs or as intended by ARRA.

We would also urge you to consider at least two other issues: what we can do now to improve child health, and how we can think outside of the box for the future to improve child health.

There has been much talk about interoperability as HIT becomes more widely adopted. There is already a meaningful use project that exists in pediatrics that is just waiting to have more available resources. I am referring to the State Immunization Information Systems. Standards have been well-defined to create bi-directional, real-time information exchange between various stakeholders using existing technology. There have been many people dedicated to this mission, yet year-after-year states have not been able to upgrade their systems to keep up with the available EHR technology and the cutting edge standards have yet to be implemented in all but a few states. This is a "shovel ready" project that has huge implications for public/private health exchange of information, preventing misuse of healthcare dollars from inappropriate or duplicate immunizations, and that has immediate value to each and every practicing pediatrician.

We urge the Administration to also "think outside the box" while making decisions regarding topics to invest in with ARRA health IT funds. Health IT should be about innovation and we should take this opportunity to harness new ideas to best effect. One option we would urge the Administration to explore is embedding into approved health IT systems much more than Computerized Physician Order Entry or electronic Decision Support. We would suggest that systems link to databases of pediatric knowledge so that physicians can practice the best quality medicine, but also so that the families of patients can become better educated during their healthcare encounters. In the pediatric realm, this would involve links to leading sources of pediatric information that could be customizable for pediatric conditions. Ideas like these would help leapfrog patient care and educate family members about how to stay healthy and decrease over-utilization of unnecessary health services.

In conclusion, as the Small Business Committee continues its debates and discussion around implementing incentives for the adoption of health information technology systems under the ARRA, please keep in mind the special needs of the children and pediatric practices. Pediatric practices often operate under tighter margins, are not directly supported by the Medicare system, and have more burdensome restrictions on receiving ARRA incentives than do providers who receive Medicare payments. To provide the best health care for children and to help pediatricians

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June 24, 2009

leverage the best that health information technology has to offer to support that care, we need partners and incentives that will allow us to reach that goal.

Thank you very much for the opportunity to testify before you today.