April 7, 2017

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via email to HealthyChildrenandYouth@cms.hhs.gov

Subject: CMS Pediatric Care Improvement Request for Information

Dear Administrator Verma,

Thank you for the opportunity to provide feedback on a topic very important to the membership of the Pediatric Orthopaedic Society of North America (POSNA). We are the largest professional body in the United States caring for the musculoskeletal needs of the nation's children. As such, we experience the effects of the broad swathe of healthcare coverage upon our charges. As CMS and CHIP provide healthcare coverage to more than 1 in 3 children in the U.S., nearly all of us in POSNA are intimately involved with your agency and have firsthand understanding of the challenges involved in covering so many children. We are aware of your many successes, but we would like to suggest improvement to some elements of the programs.

In preparation of this RFI, the membership of POSNA was queried as to their suggestions and observations to improve the healthcare coverage yet decrease costs. A grave concern of our membership is the prospect of reduced enrollment in CMS and CHIP programs for the nation's neediest children. We strongly support maintaining and expanding Medicaid. This would allow more children to receive quality healthcare and benefit from having stable, dependable coverage. We stand in opposition to any move that could curtail these important programs. Kurt Newman, MD, CEO of Children's National Health System in Washington DC, summarized the Kaiser Family Foundation's research in his Washington Post op-ed on February 14, 2017 by stating "Children make up 50 percent of today's Medicaid population but account for just 20 percent of Medicaid spending." He argued that as more adults, seniors and disabled individuals are enrolled in Medicaid, children in general are competing for an ever shrinking share of a funding pool. Just as Medicare was created solely to cover the healthcare costs of the elderly, he posits that the nation needs to develop a separate program to cover children. Having a federally run program for children, in the image of Medicare, would set specifications for care across states, thus stabilizing eligibility requirements and standards of care. Currently, access to care is impeded by variable, often low, reimbursement. Rates set by individual states for Medicaid/CHIP programs, often make caring for children unprofitable. A federal government program for childhood

health could guarantee reimbursement at an equitable rate compared to Medicare across all 50 states. We recognize that more covered lives and higher reimbursements will increase the expense to the system. However, we emphasize that this is an investment to prevent higher medical costs and health-related unemployment for our country's future adult population.

An integral part of any efficiently running system is self-monitoring and feedback. We propose that the Medicaid/CHIP programs set aside funding for pediatric healthcare outcomes studies to determine which treatment options truly improve long-term results. The funds should also support disease/condition registries, allowing for the study of substantial multicenter groups of patients, particularly for uncommon maladies. The data derived from this investment would drive evidence-based practices for different conditions, thus, improving treatment efficacy and cost savings.

Our member surgeons also wish to address the need for better preventative health outreach. Benjamin Franklin's truism about fire safety "an ounce of prevention is worth a pound of cure" is arguably applicable to pediatric healthcare. For example, there is an increasing rate of rupture of the anterior cruciate ligament of the knee, which occurring at ever younger ages. Studies have shown that proper training can help young athletes protect themselves from injury. This will both decrease the direct costs of treatment and indirect consequences of knee injury, such as developing premature arthritis. We also believe in the value of public service announcements and educational programs designed to draw attention to devastating injuries caused by lawn mower accidents, all-terrain vehicles, improper seatbelt usage, and firearms. These serve the purpose of protecting children, leading to fewer injuries and the substantial costs involved in treating them. The National Highway Traffic Safety Administration analyzed the circumstances surrounding fatal teen driver motor vehicular accidents and found that 10 percent were distracted drivers. Further study by the American Automobile Association Foundation for Traffic Safety found that 58 percent of all teen driver accidents were due to distraction. A multifaceted educational and instructional program could help to reduce those numbers substantially. We should note that costs for these devastating, yet often preventable injuries, could continue over the victims' lifetime. For a child rendered paraplegic, the effects of these accidents are evident in the need for ongoing care and lack of future earning potential. The opportunity to make an impact, when one third of the nation's children are an accessible audience, is phenomenal and should not be squandered.

We also feel that programs designed to identify and treat those children with vitamin D deficiency or obesity will have a lasting benefit. Costs are comparatively low as compared to treatments of the conditions' consequences, such as fractures and limb deformity. Both can be identified at routine well-child health visits and can be addressed with a combination of medications and parental education. In the case of obesity, the Centers for Disease Control and Prevention note the startling finding that obesity rates in the US double from 9 percent in young children to 21 percent in teenagers. Besides obesity's musculoskeletal childhood issues (i.e., slipped hips and pathologic bowleggedness), its long term associated health implications are extremely debilitating and costly. Tackling these issues is emblematic of interdisciplinary cooperation and education between pediatric orthopaedic surgeons and pediatricians. Pursuing this concept, we champion increased pediatric musculoskeletal education for healthcare students in nursing, pediatrics, and family health, to emphasize earlier diagnosis of conditions such as slipped capital femoral epiphysis (SCFE), developmental hip dysplasia, pediatric compartment syndromes associated with trauma, and infantile bone and joint infections (osteomyelitis and septic arthritis). These are conditions that if treated early need limited surgery and have good outcomes; if treated late, such conditions require multiple surgeries over one's life time, extensive

therapy and often result in permanent disability. Other areas of overlapping preventative health include programs to emphasize prenatal vitamins and prenatal health, to lower the rate of birth defects, such as myelomeningocele (due to low maternal folate), and caudal regression syndrome (linked to maternal diabetes).

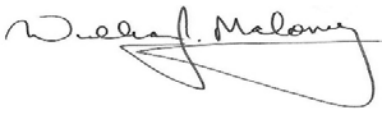
One of the biggest challenges we face as pediatric orthopaedists is the child that is not fully rehabilitated following a trauma or a surgical intervention. Often, rehabilitative services are not available to the extent needed to effect full recovery, and therefore children will be unable to return to regular activities, or the outcome of a surgery will not achieve its expected goal. Bundling services such as occupational therapy and physical therapy into the care pathway of a specific surgical procedure or injury would guarantee a patient's access to these needed services.

For the near future, we suggest more partnerships between the government and healthcare systems, such as the Partners for Kids (PFK) in Ohio. That program bridges the state's 5 Medicaid Managed Care Plans and the actual care of approximately 330,000 children, through an accountable care organization structure. The PFK is paid on a capitated basis, yet most of the member physicians are paid on a fee-for-service basis. Network members are reimbursed at a rate of 105% of usual Medicaid fees, and are therefore incentivized to treat the clientele. The PFK has a network of health navigators that work to streamline care for complex patients and their families. The partnership further incentivizes its member physicians, for example, to increase adolescent well-visits. It is of a scale that is can create community-based health programs, such as school based asthma therapy. Where such partnerships can be created, we feel they will help not just the individual child, but improve the health of the community as a whole.

Thank you again for the opportunity to present our thoughts and concerns. Our presidential line stands ready to respond to any questions you may have.

Sincerely,

James McCarthy, MD
President, Pediatric Orthopaedic Society of North America



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