Academy must strive for right balance in business partnerships

Dr. Berman

The Academy has worked with the private sector for years. We now have opportunities to expand and increase those relationships. So, how do we balance maintaining our integrity and accountability with our desire to obtain support from industry for important Academy activities?

The fact is, public-private partnerships to address community problems have become an accepted model of community action. We can not afford to isolate the Academy from the business community because of concerns about perceived conflict of interest, especially when we are taking every precaution to avoid such a conflict.

The Academy's relationship with industry was discussed at the 2000 Annual Chapter Forum, the February Board meeting and district, section and committee meetings. Some of the fundamental questions raised included: Is the Academy too dependent on advertising revenue from our publications? Should industry representatives be allowed to distribute AAP materials purchased by their companies to pediatricians and residents as part of their "detailing" activity? Should the Academy invest in "for profit" business ventures in order to generate revenue to support core AAP activities? Should the Academy and its Center for Child Health Research contract to do industry-sponsored research in order to generate revenue for core support and other projects? Should the Academy seek industry funds to support our own research agenda?

These are only a few of many important but complex questions. And answering these questions will not be easy. Many of our members feel passionately about these issues. Some are urging that we minimize industry financial support. This means AAP staff and programs would need to be marketed contracted to a level that could be supported on dues, publication subscriptions and sales (without including advertising in those publications), charitable donations and government grants.

Other members urge that we work with industry to fund an expansion of AAP staff and programs that improve the health of the underserved. Those programs include CATCH grants, as well as programs that address concerns of pediatricians such as reimbursement, new government regulations (Health Insurance Portability and Accountability Act), and managed care contracting.

Our challenge is to find the middle ground based on a realistic view of what the Academy can and should do. We have to focus our limited resources. We have to be willing to discontinue activities, even beneficial ones, when other needs are higher priorities.

In searching out this middle ground, let's consider what I call the "Three E's." Those are, the need to empower children and their families, to be entrepreneurial, and to be ethical.

The medical homes we provide are partnerships that empower the patient and family to take responsibility for their own health and well being. Electronic communication, including the latest advances in telemedicine, will be important tools to empower families. Direct-to-consumer advertising of prescription drugs and other forms of advertising need to be assessed in the context of a society in which access to information on the Web and choice are becoming a "right" of citizenship. Gone forever are the days when physicians can control the flow of information to their patients/families.

The future success of the Academy will reflect our own entrepreneurial efforts to generate revenue to sustain our programs. However, we need to think and act strategically so we don't divert our energy to marginal endeavors. We can't just chase whatever business opportunity presents or whatever grant dollars are available. We still have to balance our mission with our ability to fund our work. For example, how do we balance our desire to use the Web to make publications (such as our Red Book and Neonatal Resuscitation Program materials) available to pediatricians working in developing countries with our need to generate revenue from our own publishing business?

Finally, the Academy's ethical standards should be clear and well-communicated in order to maintain the public's trust and respect. These standards should deal with such issues as conflict of interest and protection of the rights of patients and families, including privacy and confidentiality. We currently are working in collaboration with the AMA on updating our ethical policies. We can't afford to ignore reality. We need to explore all options to fund our programs, as long as those options don't compromise us in any way. Finding that perfect balance is a challenge we can and must meet.

Steve Berman, M.D., FAAP
President, American Academy of Pediatrics

Medicaid

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the advantage of adjusting for practices that lack the capacity to take new patients of any type.

By both measures, providers in states in the lower quartiles of Medicaid payments in terms of (1) overall payments for primary care services (Norton S. "Recent Trends in Medicaid Fees, 1993-1998." Urban Institute,1998), and (2) payments for three commonly used primary care codes (98391, 98123 and 9124) for children (American Academy of Pediatrics Medicaid Reimbursement Survey, 1998/99) have substantially lower participation rates (See Table). Among the lowest participating states, as measured by the proportion of primary care providers in private office-based settings who accept all Medicaid patients, are California (33%), New Jersey (37%) and Michigan (38%) — all states in the lowest quartile by payment rate.

By any standard, these low rates are very likely to impact access to having a primary care provider and needed services.

A multivariate regression analysis further demonstrates the interactions among payment rates, administrative concerns, capitated managed care and ratio of child health care providers in the state. In addition to low payments, higher paperwork concerns, larger share of capitated than (reduced) fee-for-service Medicaid patients and greater ratios of children per child health care physician also contributed significantly to provider unwillingness to accept Medicaid patients to the same extent they accept non-Medicaid patients.

By demonstrating a clear relationship between low payment, administrative burden, capitated managed care and impeded participation by primary care pediatricians in private office-based settings, these data raise concerns about equal access to physician offices by Medicaid children and system capacity to care for an estimated 6.4 million children currently eligible to enroll in Medicaid expansion and SCHIP programs.

Medicaid to Medicare Fee Ratio and Participation by Primary Care Pediatricians in Private Office-based Settings

<table>
<thead>
<tr>
<th>State Medicaid Payment Indicator</th>
<th>Medicaid-to-Medicare Fee Ratio</th>
<th>Full Pediatrician Participation in 2002</th>
<th>Relative Pediatrician Participation in 2002</th>
<th>Patients Accepting All Medicaid Patients to % Pediatricians Accepting All Non-Medicaid Patients</th>
<th>Patients Accepting All Medicaid Patients</th>
<th>Patients Accepting All Medicaid Patients Accepting All Non-Medicaid Patients</th>
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<td>Quartile</td>
<td>Quartile Average</td>
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<tr>
<td>I) Medicaid-to-Medicare Fee Ratio for Primary Care Services in 1998 (Norton, 1999)</td>
<td>1st</td>
<td>42.4%</td>
<td>46.77%</td>
<td>69.24%</td>
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<td>2nd</td>
<td>60.2%</td>
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<td></td>
<td>3rd</td>
<td>73.0%</td>
<td>62.93%</td>
<td>85.92%</td>
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<td>4th</td>
<td>93.1%</td>
<td>68.11%</td>
<td>93.74%</td>
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<tr>
<td>II) 1998/1999 Medicaid-to-Medicare Fee Ratio for 99391, 99213, 992141, Weighed by 1999 Utilization2, 3</td>
<td>1st</td>
<td>47.2%</td>
<td>51.15%</td>
<td>72.46%</td>
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<td>2nd</td>
<td>62.2%</td>
<td>56.15%</td>
<td>78.20%</td>
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<td>3rd</td>
<td>70.2%</td>
<td>69.43%</td>
<td>90.04%</td>
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<td>4th</td>
<td>88.9%</td>
<td>65.08%</td>
<td>90.58%</td>
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</table>

Notes:
1 Primary care pediatricians in private-office based settings include nonresident primary care pediatricians in solo, group and multispecialty group practices, staff-model HMOs and private hospitals.

2000 Red Book erratum

The following erratum should be noted in the AAP 2000 Red Book:

P 406: Under the heading "Care of Exposed Persons," line 5, change after to before as follows:

Change: The routine use of mumps vaccine is not advised for persons born after 1956 ...

To: The routine use of mumps vaccine is not advised for persons born before 1956 ...

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