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Improving access by reducing medicaid-to-medicare payment disparities: congenital heart disease and beyond

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Approximately 25% of all babies born in the United States with a congenital heart defect will have a lesion requiring surgical intervention within the first year of life[1–3]. Though survival has improved in the past decades, only 75% of affected infants will survive the first year, with mortality disproportionally occurring in the first 28 days of life[4]. In this issue, Schlatterer et al. implicate impaired autonomic functioning, measured via heart-rate variability and assessed pre-operatively, with evidence of MRI-evaluated brain injury[5]. The results provide insight into mechanisms of brain injury in neonates with unique cardiac physiology and, if validated in larger studies, may provide clinicians with another means of gauging pre-operative injury in patients with critical congenital heart disease. Neurologic sequelae are frequent consequences of critical congenital heart disease[6–8]. One study in patients with univariate heart defects demonstrated significant lower psychomotor and mental developmental indices at 1 year, with neurologic complications persisting up to 5 years[9–11]. These long-term risks necessitate neurodevelopmental and cardiology follow-up through the patient's life, which in turn requires consistent health insurance coverage.

Health insurance coverage is strongly associated with improved survival and outcome in patients with congenital heart conditions[5,12]. Uninsured infants with these lesions exhibit 3 times the mortality risk of babies with private insurance[13]. In the United States, insurance "coverage" does not equate to access to medical care, as being insured does not guarantee healthcare unless a provider accepts that particular insurance plan. Differences between being eligible for insurance, enrolled in insurance and ultimately obtaining care are all points where children are vulnerable to being lost to the healthcare system[14].

Medicaid is the largest insurer of children and, for enrolled patients, access to a physician strongly relates to payment, which are critical revenue sources to maintain the finances of pediatric practice[15–17]. On average, Medicaid – which insures over 38 million children nationwide, pays 72% of Medicare rates, the largest insurer of adults[15,18,19]. These payments differ based on type of medical care rendered. For example, payment for primary care is paid at 66% of Medicare reimbursement, while for services such as specialist care, the Medicaid-to-Medicare Payment Ratio is 82%[20]. Substantial state-based variation also exists in payments, with a range of 33%–127% of Medicaid rates nationwide[20]. Sadly, the current lower payment scale for patients enrolled in Medicaid compared to Medicare or private insurance represents a historical de-valuation of children and a misunderstanding of the importance of care provided by pediatricians. Further, as Medicaid covers a disproportionately higher percentage of Black/African-American and Latino children compared to the population, lower reimbursement may be viewed as a systemic form of health inequity, which several states have attempted to rectify with pilot programs utilizing Medicaid health equity incentive payments[21].

The traditional rationale for lower payment rates, beginning at the founding of the Medicaid program in 1965, was rooted in the belief that children as a population were healthier overall compared to adults, and in a disease-focused model of healthcare delivery, required less medical care[22]. This historical framework no longer applies. One-fifth of children now have special healthcare needs, and the incidence of chronic disorders such as obesity, Type 2 diabetes, and mental health issues are rising[23–25]. As technology progresses, children with previously fatal diseases are now surviving, resulting in a greater population of medically complex children[23]. Further, as US healthcare moves away from a fee-for-service model to a system prioritizing preventive care, pediatric services provide the greatest value in healthcare[26]. Pulse oximetry screening for congenital cyanotic heart lesions as described in Schlatterer et al. is estimated to cost only $6.28 cents per infant, in return for identifying more than 1100 previously undiagnosed cases annually[27,28]. Pediatric immunizations are estimated to save $68.8 Billion per child cohort[29]. Even more cost-effective is the pediatrician's role in mitigating social factors which influence children's health across their lifespan[30,31]. Unfortunately, despite greater recognition of the importance of these issues, little progress has been made in the fundamental inequity in payments between the largest insurer of children and the Medicare, the largest insurer of adults[18].

Passage of the Affordable Care Act in 2010, temporarily created "Medicaid Parity," or equivalency in primary care payments for both Medicaid and Medicare physicians for 2013 and 2014, creating a natural experiment to evaluate the impact of such a payment increase on healthcare access for children. Originally conceived as an incentive for doctors to provide care to patients who were newly insured via Medicaid's new qualifying income threshold to 138% of the federal poverty level, this parity created increases in appointment availability without differences in wait times across 10 states evaluated[32]. Within pediatrics, a study by Tang et al. demonstrated that surveyed pediatricians increased Medicaid participation during the 2- year period by 3–6 percentage points, depending on metric, with the largest gains in the average percentage of Medicaid patients assigned to each

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pediatric provider[33]. Yet despite these encouraging results, only 15 states continued the payment equivalency once federal support waned[34].

Federal movement toward Medicaid parity with Medicare has been piecemeal and unacceptably slow, hindered by a lack of prioritization of children's needs and those of low-income individuals and families. Throughout the COVID pandemic, as the nation better understood the power and role of vaccination in preventing disease, Congress introduced the Strengthening the Vaccines for Children Program Act of 2021[35]. In addition to fixing long-standing weaknesses in pediatric immunization delivery, the bill proposed incentives for pediatricians participating in the Vaccines For Children Program and established payment parity solely for vaccine administration through 2022[35]. The bill also increased the Medicaid Federal Medical Assistance Percentage - which determines the payment level the federal government provides to states to support Medicaid - by 1% through 2022. However, even this limited approach to payment equivalency was removed from the proposal. Even more ambitious, the proposed Kid's Access to Primary Care Act would align Medicaid and Medicare reimbursement rates for outpatient primary and subspecialty care, and track results of the payment increases on pediatric healthcare access. However prospects for congressional action of the legislation are uncertain[36,37].

Currently, federal efforts seem oriented toward increasing Medicaid and insurance enrollment, and not on payment levels. For example, 4.4 million people are potentially eligible for Medicaid, but are not eligible because they reside within the 14 states have not expanded Medicaid under the Affordable Care Act[38,39]. Remedies to insure this population include restoring federal matching funds to entice these 14 states to expand Medicaid at limited state cost, as proposed in the Build Back Better Plan[40]. Other plans include extending subsidies for those who live in non-expansion states and earn between the individual state's Medicaid threshold and 100% of the federal poverty level[40]. There is specific concern for uninsured families who fall in to the "Family Glitch," which are employees whose employer-sponsored insurance for an individual meets the affordability threshold of the Affordable Care Act, but for whom family coverage is excessively costly – a group estimated at 6 million Americans[38,41]. Pediatricians must remind policymakers that, similarly to Medicaid Expansion under the Affordable Care Act, these laudable efforts to increase Medicaid enrollment will not translate to delivery of medical care without movement toward comparable Medicaid and Medicare payments.

As we aim to provide health insurance to these uninsured children and adults, we must remind legislators that what was true a decade ago remains true today. Caring for children with complex underlying conditions, such as those addressed by Schlatterer et al. requires multiple primary care and pediatric specialists. Access to that care must align strongly with payment incentives to safeguard the care children need to thrive. The historical assumptions upon which the two-tiered payment between Medicaid and Medicare no longer apply. Parity in payment and the wider access it brings is what kids deserve.

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AUTHOR CONTRIBUTIONS

S.S. wrote the first draft of the manuscript and made substantial contributions to this manuscript. H.L.B. reviewed several drafts of the manuscript and made substantial contributions including assisting with re-drafting the paper, and revising it critically for important intellectual content. Both authors gave final approval of the submitted manuscript to be published.

COMPETING INTERESTS

The authors declare no competing interests.

ADDITIONAL INFORMATION

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