HEALTH CAPITAL Topics
Volume 5, Issue 8
August 2012
Jessica C. Burt, Esq., MHA - Senior Research Associate • Kati V. Williams - Editor

Update on Pediatrics

As healthcare reform initiatives place increased emphasis on primary and preventive care, the healthcare industry is likely to experience increased demand for pediatric services in the coming years. The healthcare marketplace continues to experience dramatic change as the business of healthcare becomes increasingly competitive and providers face decreases in reimbursement and changes in utilization levels. Despite their historically low compensation (as compared to other physician specialties), in recent years, pediatricians have seen increases in compensation levels, including salary increases and other amenities, e.g., sign-on bonuses and resident stipends.[1] With the new payment structures and models of care being implemented under the *Patient Protection and Affordable Care Act* (ACA), reimbursement rates are also expected to rise, potentially signaling a "*new day*" for these, as some have described, often undervalued providers.

Pediatricians provide primary care services to infants, children, teenagers, and young adults, tracking their growth to adulthood, from birth to 21 years of age, providing prevention-based services to healthy children and medical care to those who are seriously or chronically ill.[2] Pediatricians have been increasingly involved in the prevention, early detection, and management of behavioral, developmental, and functional social problems that affect children and adolescents.[3] General pediatricians must work with pediatric subspecialists, pediatric surgical specialists, as well as physical therapists, nutritionists, psychologists, social workers, and teachers to provide for the health and emotional needs of children.[4]

In 2010, there were a total of 77,500 pediatricians in the U.S., comprised of 57,830 pediatric primary care practitioners and 19,670 pediatric subspecialists.[5] Of the total 72,223 pediatricians providing patient care in 2010, approximately 42,832 (59.31 percent) provided patient care in an office-based setting, approximately 12,214 (16.91 percent) practiced in a hospital-based setting, and approximately 4,178 (5.78 percent) practiced as part of another professional activity, such as administration; medical teaching; and, research.[6] Pediatrics is currently the third largest specialty field, representing 6.73 percent of total active physicians and 18.98 percent of total primary care physicians, including specialists and subspecialists.[7] The pediatric workforce has increased approximately 165.9 percent between 1975 and 2010, with a current per capita ratio of 26 pediatricians per 100,000 population.[8] Female physicians now comprise a growing majority of the field, with the number of male pediatricians decreasing.[9] Although the pediatrician workforce has steadily grown, there is a pronounced geographic maldistribution of pediatricians, which is expected to worsen as new graduates become increasingly less likely to practice in rural areas.[10] In an attempt to address this disparity, the ACA introduced a number of provisions designed to incentivize workforce growth in rural and otherwise underserved areas, as discussed in this month's *HC Topics Provider Supply Series*.

In addition to workforce demographics, the scope of practice for pediatricians has changed, with growing roles for mid-level providers, such as nurse practitioners (NPs) and physician assistants (PAs). Physician practices with a payor mix that includes a higher proportion of reimbursement from Medicaid than Medicare, such as pediatric and family medicine practices, are more likely to employ NPs or PAs.[11] The increased role of NPs and PAs in the provision of pediatric services may also provide a level of competition to pediatricians and family medicine physicians, both in the provision of services and in the recruitment of qualified mid-level providers.[12] As the demand for primary care providers continues to increase, NPs may provide support to primary care physicians and may help offer a solution to the provider shortage. Similarly, PAs may provide a clinical supplement to physicians by "*performing diagnostic, therapeutic, preventive, and health maintenance services*."[13]

Reimbursement for pediatric services is generally lower than that of other physician specialties, which typically provide a higher number of services and procedures for which they receive *ancillary services and technical component* (ASTC) revenue, while pediatricians perform far more cognitive functions than procedures, which are subject to lower reimbursement.[14] This trend is seen in both the commercial and government health insurance settings, the latter of which usually consists of Medicaid for pediatric patients, which serves more than 30 million children nationwide.[15]

Historically, Medicaid reimbursement for children's services has been substantially less than Medicare's reimbursement.[16] As a result, Medicaid reimbursement

(Continued on next page)

rates place fiscal pressures and challenges on pediatricians.[17] However, effective in 2013, the ACA requires states to pay Medicaid payments to primary care physicians (including pediatricians) at the same rate as is paid by Medicare.[18] Additionally, the ACA's optional expansion of Medicaid may bring additional revenue for providers as more patients enroll and federal funding increases. The June 28, 2012 U.S. Supreme Court decision (SCOTUS) to make the ACA's *Medicaid Expansion* optional for states and the resulting impact on providers is further discussed in this month's *HC Topics* article, *Medicaid Expansion: A Fiscal Decision to Ensure Access to Care*.

In addition to traditional Medicaid, the *Children's Health Insurance Program* (CHIP) is an important method of access for a large segment of pediatric patients. The program is largely a federally funded Medicaid program designed to help states expand health insurance to children whose families earn too much for traditional Medicaid, but not enough to afford private/commercial health insurance.[19] As of 2011, approximately 7 million children had enrolled in CHIP since its inception, which Congress established in 1997 to cover uninsured, low-income children not eligible for Medicaid.[20] Despite the success of CHIP, in 2010, approximately 65 percent of uninsured children were eligible for CHIP, but were not enrolled.[21] When the ACA's individual mandate goes into effect in 2014, growth in CHIP enrollment will likely increase the demand for pediatric services.

The ACA also encourages the use of new medical models to drive quality and patient-centered care delivered to pediatric patients. The *Pediatric Medical Home (PMH)* concept is designed to improve the coordination of patient care and thereby improve quality.[22] In addition to covered fee-for-service payments, participating providers would also receive a per-member, per-month *medical home* fee, which would serve to compensate pediatricians for services they have long provided to patients, including: telephone and email follow-up with patients and their families; patient education and support; and, consultation and coordination of care with specialists and other providers.[23]

Based on the pediatric industry trends above, the industry is likely to experience an increase in demand for services in future years, driven by a focus on primary and preventive care, as well as expanded access to healthcare through insurance coverage. In order to succeed, providers must continue to adapt to changing market conditions, including: the increased demand for services despite a diminishing supply of providers; increasing operations and administrative practice costs; increasing competition for services; shifting reimbursement; and, the ever-increasing stringency of regulatory requirements for providers. Despite the various market pressures projected for pediatric providers, the ACA's increased focus on primary care and preventive services suggest that pediatricians will likely experience continued growth in reimbursement and increased demand for their services going forward.

1 "Low Reimbursement Depresses Compensation," HealthLeaders Media, http://www.healthleadersmedia.com/print/HOM-227373-4625/Low-reimbursement-depresses-compensation (Accessed 8/7/2012).
2 "Occupational Outlook Handbook 2008-09 Edition: Physicians and Surgeons," by the Bureau of Labor Statistics, 2009, http://www.bls.gov/oco/pdf/ocos074.pdf (Accessed 10/06/2009).
3 "The Official ABMS Directory of Board Certified Medical Specialists, Volume 3," Marquis Who's Who, 1994, p. xxiii-xxv.
4 "Chapter I.1 Pediatric Primary Care," by Melinda J. Ashton, MD, Case Based Pediatrics for Medical Students and Residents, May 2002, http://www.hawaii.edu/medicine/pediatrics/pedtext/s01c01.html (Accessed 8/17/2012).
5 "Physician Characteristics and Distribution in the US 2012 Edition," American Medical Association, 2012, p. 289.
6 Ibid., p. 67.
7 Ibid., p. 289.
8 Ibid., p. 460.
9 "Attempting to Meet Our Nation's Pediatric Workforce Needs" By Scott A. Shipman, 39 Pediatric Annals 2 (February 2010), p. 92.
10 Ibid., p. 91-92.
11 "Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants in Physician Offices," By Melissa Park et al., National Center for Health Statistics, NCHS Data Brief, No. 69, August 2011.
12 Ibid.
13 "The Role of Nurse Practitioners in Reinventing Primary Care," By Mary D. Naylor and Ellen T. Kurtzman, Health Affairs, Vol. 29, No. 5, May 2010, p. 898; "Physician Assistant (PA)," MedlinePlus, US National Library of Medicine, July 27, 2012, http://www.nlm.nih.gov/medlineplus/ency/article/001935.htm (Accessed 8/13/2012).
14 "Low Reimbursement Depresses Compensation," HealthLeaders Media.
15 Ibid.; "Medicaid Facts: California," American Academy of Pediatrics, June 2011, http://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/access-to-care/Medicaid%20Fact%20Sheets/California.pdf (Accessed 8/7/2012).
16 "The Adequacy of Physician Reimbursement for Pediatric Care Under Medicaid" By Margaret McManus, Pediatrics, 87, 6, (1991), p. 909, 911.
17 "Low Reimbursement Depresses Compensation," HealthLeaders Media.
18 "Section-by-Section Analysis with Changes Made by Title X and Reconciliation included within Titles I-IX," Democratic Policy Committee, http://dpc.senate.gov/healthreformbill/healthbill96.pdf (Accessed 5/24/2010).
19 "What is SCHIP," American Medical Association, http://www.ama-assn.org/resources/doc/rfs/schip.pdf (Accessed 8/17/2012).
20 "Medicaid & CHIP," Kaiser Family Foundation, http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=61&rgn=6 (Accessed 8/7/2012); "Coverage Counts: Supporting Health and Opportunity for Children" Trendwatch, American Hospital Association, 2007, p.5-6.
21 "Who and Where Are The Children Yet To Enroll In Medicaid And The Children's Health Insurance Program?," By Genevieve M. Kenney, et al., Health Affairs, Vol. 29, No. 10, October 2010.
22 "Attempting to Meet Our Nation's Pediatric Workforce Needs" By Scott A. Shipman, 39 Pediatric Annals 2 (February 2010), p. 91; "Can Patient-Centered Medical Homes Transform Healthcare Delivery?" By Melinda K. Abrams et al., The Commonwealth Fund, March 27, 2009, http://www.commonwealthfund.org/From-the-President/2009/Can-Patient-Centered-Medical-Homes-Transform-Health-Care-Delivery.aspx (Accessed 8/30/12).
23 "Can Patient-Centered Medical Homes Transform Healthcare Delivery?" By Melinda K. Abrams et al., The Commonwealth Fund, March 27, 2009, http://www.commonwealthfund.org/From-the-President/2009/Can-Patient-Centered-Medical-Homes-Transform-Health-Care-Delivery.aspx (Accessed 8/30/12); "The Medical Home for Children: Financing Principles" By The Committee on Child Health Financing, American Academy of Pediatrics, January 2012, http://www.medicalhomeinfo.org/downloads/pdfs/MHfinanceprin.pdf (Accessed 8/30/12), p. 1.

(Continued on next page)

HCC
HEALTH CAPITAL CONSULTANTS

(800) FYI - VALU

Providing Solutions in the Era of Healthcare Reform

Founded in 1993, HCC is a nationally recognized healthcare economic financial consulting firm

- **HCC Home**
- **Firm Profile**
- **HCC Services**
- **HCC Experts**
- **Clients Projects**
- **HCC News**
- **Upcoming Events**
- **Contact Us**
- **Email Us**

HEALTH CAPITAL CONSULTANTS (HCC) is an established, nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, Missouri, with regional personnel nationwide. Founded in 1993, HCC has served clients in over 45 states, in providing services including: valuation in all healthcare sectors; financial analysis, including the development of forecasts, budgets and income distribution plans; healthcare provider related intermediary services, including integration, affiliation, acquisition and divestiture; Certificate of Need (CON) and regulatory consulting; litigation support and expert witness services; and, industry research services for healthcare providers and their advisors. HCC's accredited professionals are supported by an experienced research and library support staff to maintain a thorough and extensive knowledge of the healthcare reimbursement, regulatory, technological and competitive environment.

Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, serves as President of **HEALTH CAPITAL CONSULTANTS** (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Intuition of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, the latest of which include: "*The U.S. Healthcare Certificate of Need Sourcebook*" [2005 - Beard Books], *"An Exciting Insight into the Healthcare Industry and Medical Practice Valuation"* [2002 – AICPA], and *"A Guide to Consulting Services for Emerging Healthcare Organizations"* [1999 John Wiley and Sons].

Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious "*Shannon Pratt Award in Business Valuation*" conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows.

Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the Senior Vice President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience, and has participated in the development of a physician-owned multi-specialty MSO and networks involving a wide range of specialties; physician-owned hospitals, as well as several limited liability companies for the purpose of acquiring acute care and specialty hospitals, ASCs and other ancillary facilities; participated in the evaluation and negotiation of managed care contracts, performed and assisted in the valuation of various healthcare entities and related litigation support engagements; created pro-forma financials; written business plans; conducted a range of industry research; completed due diligence practice analysis; overseen the selection process for vendors, contractors, and architects; and, worked on the arrangement of financing.

Mr. Zigrang holds a Master of Science in Health Administration and a Masters in Business Administration from the University of Missouri at Columbia, and is a Fellow of the American College of Healthcare Executives. He has co-authored *"Research and Financial Benchmarking in the Healthcare Industry"* (STP Financial Management) and *"Healthcare Industry Research and its Application in Financial Consulting"* (Aspen Publishers). He has additionally taught before the Institute of Business Appraisers and CPA Leadership Institute, and has presented healthcare industry valuation related research papers before the Healthcare Financial Management Association; the National CPA Health Care Adviser's Association; Association for Corporate Growth; Infocast Executive Education Series; the St. Louis Business Valuation Roundtable; and, Physician Hospitals of America.

Anne P. Sharamitaro, Esq., is the Vice President of **HEALTH CAPITAL CONSULTANTS** (HCC), where she focuses on the areas of Certificate of Need (CON); regulatory compliance, managed care, and antitrust consulting. Ms. Sharamitaro is a member of the Missouri Bar and holds a J.D. and Health Law Certificate from Saint Louis University School of Law, where she served as an editor for the Journal of Health Law, published by the American Health Lawyers Association. She has presented healthcare industry related research papers before Physician Hospitals of America and the National Association of Certified Valuation Analysts and co-authored chapters in "*Healthcare Organizations: Financial Management Strategies*," published in 2008.