Ohio House Finance Subcommittee on Health and Human Services

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By

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Pediatrix Medical Group

Chairman Romanchuk, Vice Chair Sprague, Ranking Member Sykes and members of the committee, my name is Dr. Ben McDonald and I am a Columbus-based neonatologist. Thank you for the opportunity to appear before you today.

My practice in Columbus includes Riverside Methodist Hospital, Mount Carmel St. Ann's, Dublin Methodist Hospital and Nationwide Children's Hospital. Across Ohio our physicians provide care to newborns at eighteen (18) hospitals. In 2016, our physicians cared for nearly 21,000 newborns in Ohio, of which over 4,500 were high-risk newborns.

Neonatologists are the frontline primary care physicians for critically ill newborns admitted to the Neonatal Intensive Care Unit (NICU) within hospitals. Neonatologists are trained as pediatricians, and then go on to complete three (3) additional years of training to care for the sickest and smallest of infants that are born. Although a pediatrician can treat common health problems of newborns, a neonatologist is specially trained to care for the most critical and high-risk newborns. If a newborn is born premature, has a serious illness, injury, or birth defect, a neonatologist may assist at the time of delivery and manage the subsequent care of the newborn. If a problem is identified before a baby is born, a neonatologist may consult with an obstetrician regarding the care of the baby.

Request Your Support for Budget Amendment Resolving Disparity

I am here today seeking resolution of a budget matter: one that involves a disparity in Ohio Medicaid compensation when it comes to paying for neonatal critical care services. More specifically, we seek your favorable consideration of increasing the neonatologist Medicaid reimbursement up to the Medicare rate (or at least to the average Ohio Medicaid rate).

Since at least 2005, our neonatal services have been undervalued relative to the average Ohio Medicaid rate. This is especially unfair when one considers the population and acuity that we are dealing with here. Neonatologists participate in a statewide voluntary consortium of perinatal clinicians known as the Ohio Perinatal Quality Collaborative (OPQC) whose aim is to reduce preterm births and improve birth outcomes across Ohio. I'll speak in a minute to some of the initiatives undertaken by OPQC, but neos across Ohio have developed and implemented clinical initiatives that have decreased costs to the state and improved care, which is exactly the type of value-based behavior that policy makers are seeking. We can find no rationale behind the reimbursement methodology that undervalues our services. As legislators we need your help today to resolve this disparity.

Ohio Perinatal Quality Collaborative (OPQC)- Recent Initiatives

I mentioned earlier that Ohio has a statewide voluntary consortium of perinatal clinicians known as the Ohio Perinatal Quality Collaborative (OPQC) whose aim is to reduce preterm births and improve birth outcomes across Ohio. Let me say at the outset that having a collaborative like this in Ohio is commendable. As a national group, we participate in other similar statewide collaborative and have experienced the positive impacts that can be made through such a partnership.

OPQC has several past and current projects that address both preterm birth and infant mortality in an effort to promote the best outcomes for Ohio's mothers and babies. One of the most recent initiatives of OPQC focused on delivering optimal care for Neonatal Abstinence Syndrome or (NAS), which is the medical term used for babies that are born dependent on opiates. These infants can develop symptoms right at birth, but more commonly after 2 to 3 days, and in some situations, 1 to 2 weeks later. They generally present with neurologic related symptoms. They can experience a constellation of symptoms such as sweating, sneezing, nasal stuffiness, fever and rapid respiratory rates. Intestinal symptoms may also occur**.** In its most severe form, an infant with NAS may develop seizures. These babies are opiate dependent secondary to maternal drug use and/or abuse. There are a variety of ways opiates are used during pregnancy. Women may become dependent on prescription pain medicine, either before or during pregnancy, for legitimate medical pain control. More commonly, pregnant women may be undergoing treatment for opiate addiction with drugs such as Methadone or Subutex. The more unfortunate cases involve pregnant women abusing street heroin and potentially other drugs. OPQC voluntarily worked to improve the care of newborns suffering from NAS by reducing variation in identification and treatment. After the early stages of this project, 52 participating Level 2 and Level 3 NICUs across Ohio were able to show a reduction in length of treatment from 16.3 to 14.3 days; and reduction in length of stay from 20.3 to 19 days. This resulted in better care for newborns at a lower cost to Ohio taxpayers.

Neonatologists- Impact on Infant Mortality

As you may know, preterm birth is the leading cause of infant mortality in Ohio. Infant mortality and prematurity are conditions that are devastating for families, and incur significant health care costs. Being born prematurely has lifelong impact. I mentioned other state collaboratives and impact upon infant mortality earlier so I thought that I might mention South Carolina's Perinatal Collaborative which consisted of all of the Level III NICUs working together to implement certain clinical measures designed to improve outcomes. The result has been significant improvement in South Carolina's infant mortality ranking and clinical outcomes for pre-term infants. We have the same opportunity here in Ohio and with your support we look forward to increased efforts.

Continuous Quality Initiatives and Medicaid Rates for Neonatologists

One resource that Pediatrix Medical Group has developed over the years is our electronic health record, BabySteps®, which is currently used in more than 250 NICUs and includes a clinical information database comprised of more than a million newborns representing 18 million patient days. We were way ahead of the curve in developing this Electronic Health Record**.** We have used this database to enhance our bedside services by evaluating our care and implementing changes that have had measureable and

significant benefits to our patients. For instance, as a result of our ability to better chart and follow the care we provide, our system has led directly to a program that has significantly reduced the number of premature infants burdened with the terrible disability of blindness or severe vision impairment-known as Retinopathy of Prematurity or (ROP). We do not seek nor do we receive extra funding for this and similar programs. The computer systems required to capture and maintain this growing database have real dollar costs. One concern that we have is the ability to continue such private-sector, quality initiatives that create best practices and even competition among practices without an increase to our Medicaid reimbursement.

Poor Compensation, Recruitment and Hospital-Based Practices

My last main point today relates to our very real recruitment challenges. The fact that Ohio's Medicaid compensation for neonatology services ranks near the bottom certainly presents challenges when we are trying to recruit physicians to Ohio. Our group recruits neonatologists from across the country, and often, what we see, is that our Ohio doctors have some sort of connection to Ohio whether family or perhaps training here. Without this family or education connection, we have a tough time recruiting quality physicians to practice in Ohio. In the environment under which we operate today, adequate reimbursement is a critical factor in continuing to provide quality-driven initiatives and excellent access to care.

Competition for recruits is only intensifying, and my personal opinion is that more neonatologists coming out of fellowship will consider the payment rates for Medicaid in a particular state as they weigh their ability to earn income. Please keep in mind that as neonatologists we take all patients regardless of their payment source, unlike office-based practices which can limit or cap the percentage of Medicaid patients they will serve. In this regard, other states will have a distinct advantage over Ohio, with two-thirds of the states averaging 75% of Medicare or higher for reimbursement of hospital-based neonatal and pediatric services. This compares to an average reimbursement of just 41% of Medicare for the same services in Ohio.

In closing, thank you again for the opportunity to provide this testimony today. Healthcare is rapidly changing and we believe there are some clinical and other initiatives that Ohio can undertake to improve the health outcomes of its newborns. We look forward to working with you and your colleagues as a state and even national resource. Mr. Chairman, with your permission, I would be happy to answer any questions that you or the committee members may have.