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April 18, 2022

VIA ELECTRONIC SUBMISSION

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Request for Information on Access to Care and Coverage for People Enrolled in Medicaid and CHIP

On behalf of the American Academy of Pediatrics (AAP), a non-profit professional organization of more than 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents, and young adults, I write in response to the Request for Information (RFI) from the Centers for Medicare & Medicaid Services (CMS) regarding Access to Care and Coverage for People Enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Our comments have also been endorsed by the Pediatric Policy Council, which consists of the Academic Pediatric Association, the American Pediatric Society, the Association of Medical School Pediatric Department Chairs, and the Society for Pediatric Research.

Children make up the single largest group of people who rely on Medicaid and CHIP; more than 39 million children currently rely on Medicaid and CHIP coverage, including children with special health care needs and those from low-income families. Medicaid also provides comprehensive prenatal care to pregnant women, enabling millions of pregnant women to have healthy pregnancies and thereby helping millions of children get a healthy start. Unlike many private health insurance plans, Medicaid guarantees specific benefits designed especially for children. Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits are the definitive standard of pediatric care, covering an array of services like developmental, dental, vision and hearing screenings, and allowing health problems to be diagnosed and treated appropriately and as early as possible. Children enrolled in Medicaid are more likely to get medical check-ups, attend more days at school, graduate, and enter the workforce than their uninsured peers.

The AAP applauds CMS for your comprehensive and person-centered approach to defining access to care and to understanding the barriers to access for individuals enrolled in Medicaid and CHIP. As you have outlined in this RFI, eligible children and families must be able to enroll in coverage, to rely on that coverage being there for them when they need it, and then to use that coverage to get the care they need. **Those elements must be actively monitored, and policy to ensure elements are working well must be enforced.**

Medicaid acts a safety net for those who live in poverty, work in occupations where employers do not offer health care and experience a variety of health problems. Medicaid also plays a disproportionately large role in covering people of color.

According to the Kaiser Family Foundation, Medicaid covers about three in ten Black, American Indian and Alaska Native (AI/AN), and Native Hawaiian or Other Pacific Islander (NHOPI) nonelderly adults and more than two in ten of Hispanic nonelderly adults, compared to 17% of their White counterparts. Medicaid and CHIP play an even larger role for children of color, covering more than half of Hispanic, Black, and AI/AN children and nearly half of NHOPI children, compared to 27% of White children.¹ Consequently, the ways in which Medicaid/CHIP policies are contemplated, communicated, and implemented have direct equity implications. To truly achieve CMS' equity agenda, Medicaid and CHIP must be improved.

Medicaid is designed to provide broad coverage to eligible children, yet barriers remain that prevent some eligible children from enrolling in the program, and some enrolled children from accessing the care that they critically need. In some areas, this can be true even of access to primary care, especially for children with complex medical conditions who may require specialized diagnostic or treatment services that are not readily available from providers in their geographic area or even in their state. Families seeking needed but readily unavailable care may have to travel for hours to find a qualified pediatric specialist. Referring clinicians struggle to get the necessary prior authorization to allow their patients to seek such care. Overall, the process is cumbersome and unreliable for patients, families, and providers, contributing to delays in care.

As a state/federal partnership, Medicaid allows each state substantial discretion to determine eligibility, benefits, definitions of medical necessity, provider payments, networks, and quality data reporting. And while federal law and regulations have attempted to standardize Medicaid in certain areas, excessive state variation has led to policy fragmentation with uneven and inconsistent access. In the words of Dr. Jamila Michener, the state-by-state design and implementation of Medicaid policy “produces unequal politics and deepens already yawning racial, class, and geographic disparities in the United States.”²

A child's access to the care they need, when and where they need it, should not be contingent on where they live. The Academy believes an active federal role in the review and oversight of children's access to care is crucial. Therefore, we urge CMS to establish, clarify, and enforce minimum essential standards for state Medicaid and CHIP programs related to children's access to care.

The Academy has long urged CMS to do more to fulfill its obligation under Section 1902(a)(30)(A) of the Social Security Act to ensure access for children insured under the Medicaid program to necessary medical services based on the recommendations in its Medicaid policy statement.³ This “Equal Access” provision of the Act states that Medicaid plans must “provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to ensure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and services are available to the general population in the geographic area.”

The Academy's Principles of Child Health Financing policy statement outlines a vision for a comprehensive health care system for children.⁴

¹ Guth, M. and Artiga, S. (2022, March 17). *Medicaid and Racial Health Equity*. KFF. Retrieved April 5, 2022, from <https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/>

² Michener, J. (2018). Medicaid, Political Life, and Fragmented Democracy. In *Fragmented Democracy: Medicaid, Federalism, and Unequal Politics* (pp. 1-18). Cambridge: Cambridge University Press. doi:10.1017/9781108224987.001

³ COMMITTEE ON CHILD HEALTH FINANCING; Medicaid Policy Statement. *Pediatrics* May 2013; 131 (5): e1697–e1706. 10.1542/peds.2013-0419

⁴ Mark L. Hudak, Mark E. Helm, Patience H. White, COMMITTEE ON CHILD HEALTH FINANCING *Pediatrics* Sep 2017, 140 (3) e20172098; DOI: 10.1542/peds.2017-2098: <https://pediatrics.aappublications.org/content/140/3/e20172098>

- All children, adolescents, and young adults from birth to the age of 26 years who reside within our borders, regardless of income, family composition, or immigration status, should be covered by an affordable, quality health insurance plan that allows access to comprehensive essential care.
- The foundation for medical necessity for children should be based on the comprehensive, fully inclusive set of services provided by the EPSDT benefit embodied in Medicaid as well as the preventive care recommendations in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*.
- Accessible health insurance coverage should pose minimal enrollment and renewal burdens, commence with the minimal waiting period needed to verify eligibility, offer continuous eligibility for a minimum of 12 months, and be portable across states.
- Insurance coverage options should ensure access to an adequate pediatric primary, specialty, and subspecialty network that includes dental, behavioral, and mental health services.
- Essential coverage also enables care coordination and care management by pediatric primary and specialty medical homes to ensure excellent outpatient management of children with chronic and complex conditions and to ensure linkages to age-appropriate public, community, and employer-based programs.
- For children to receive accessible, continuous, comprehensive, and coordinated care from the medical home, payment for services must be adequate and timely.
- Ensuring access to health insurance and providing timely access to and payment for necessary health care services for children should be a shared responsibility of parents and/or families, employers, and state and federal government agencies.

These principles closely align with the *Strategic Vision for Medicaid and The Children's Health Insurance Program (CHIP)* published by CMS leadership⁵, which highlights a proactive policy agenda focused on three key areas: 1) Coverage and Access; 2) Equity; and 3) Innovation and Whole-person Care. Additionally, the principles honor the unique abilities of states to optimize and strengthen care delivery infrastructure to meet the demographic and health needs of their constituents. We applaud CMS for this bold vision statement, in addition to the expressed intent of the RFI to solicit broad input on approaches that CMS and states can adopt to understand, measure, and improve Medicaid access with a more uniform methodology and in ways that account for multiple factors that can impact access.

As CMS considers policies and procedures to improve Medicaid and CHIP, we urge you to remember an essential core principle: **Children are not little adults**; they require services and care specifically suited to their unique developmental needs. Because of their continuous growth and development, children need timely access to a full set of pediatric and age-appropriate and family centered services. Missed screenings, diagnoses, and treatments can result in life-long health consequences that generate extensive and avoidable costs.

Additionally, children's growth and development of brain structures builds slowly over time in response to their environment but continues throughout adolescence and into their mid-twenties. Social drivers of health such as adequate nutrition, safe and affordable housing, exposure to typical experiences, nurturing caregiving, sleep, safety, and absence of violence are all key components of healthy brain and mental development, in addition to learning emotional and behavioral regulation. Consequently, the "value equation" of children's

⁵ A Strategic Vision for Medicaid And The Children's Health Insurance Program (CHIP)", Health Affairs Blog, November 16, 2021. DOI: 10.1377/hblog20211115.537685

health care is more complex than that of adults and should be considered as CMS considers all policies in Medicaid and CHIP: more upfront investment yields better health outcomes and long-term savings.

Our members identified several barriers that stand in the way of achieving the Academy's Principles of Child Health Financing, especially as it relates to ensuring equal access for children enrolled in Medicaid and CHIP. The Academy acknowledges that CMS does not have the current statutory authority to implement some of the changes delineated below. Nevertheless, as the agency considers ways to improve how Medicaid and CHIP serve children and families, our comments reflect the Academy's vision of how the programs *should* work to meet their full potential.

The experiences of our members, in addition to specific recommendations CMS can take to mitigate these barriers to access, are outlined below and broken into the following categories:

1. Improving Access to Care
2. Ensuring Adequate Payment
3. Reducing Administrative Burden
4. Data Collection and Monitoring
5. Streamlining Eligibility and Enrollment
6. Promoting Continuous Coverage

Our detailed comments in each of these areas are below. Some of the top priorities we recommend CMS act on are included here:

- Establish **minimum essential standards** for state Medicaid and CHIP programs related to access to care. CMS must also articulate the available methods for federal and state enforcement of these minimum essential standards. Further, CMS must use the available methods for federal enforcement.
- To fully realize the Administration's bold vision to eliminate health disparities and achieve health equity, it is imperative to **provide adequate—and equitable—payment for Medicaid providers** to support Medicaid enrollees' equitable access to high-quality care.
- Use every authority possible to **increase children's access to mental health services**.
- Establish federal network adequacy standards for children, especially those with special health care needs, serious or chronic health conditions, limited English proficiency, and those who are experiencing mental health or other challenges. These standards must **ensure that provider networks include the full range of pediatric primary, ancillary, specialty, and subspecialty providers who typically care for children** to ensure access to all covered benefits.
- CMS must **take a child-specific approach to define and measure access to care in Medicaid and CHIP**. Children represent nearly half of all Medicaid enrollees, and their needs and experiences are different from those of other populations. This understanding must be reflected in the way that the programs are designed, that measures are defined and outcomes are assessed, and in program evaluation.
- Similarly, a whole-child framework requires Medicaid and CHIP to **integrate and coordinate with other essential resources** that meet needs relating to housing and food security, literacy, education, mental health, and others. A framework to understand whole-child and whole-person access to care must recognize and strive for seamless coordination between medical and non-medical resources.

- **Reduce administrative barriers** like prior authorization and strengthen oversight of Medicaid payers to ensure transparency and compliance with current federal regulations.
- Conduct meaningful **outreach and enrollment** and institute “no wrong door” policies to improve children’s coverage.
- To minimize gaps in enrollment due to transitions between programs, **prioritize continuous eligibility** policies that reduce administrative churn, including state 1115 waiver requests to provide multi-year continuous eligibility for children.
- To truly achieve health equity, **the voices, experiences, and expertise of diverse stakeholders, especially children and families, must be meaningfully included** in the process to design, implement, and monitor Medicaid and CHIP policies and practices.

Improving Access to Care

According to CMS, Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) protection is designed to “assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.”⁶ Additionally, the Supreme Court’s 2015 decision in *Armstrong v. Exceptional Child Center, Inc.* concluded it is the responsibility of the federal government to enforce the equal access provision found in Section 1902(a)(30)(A), which requires that state Medicaid provider payments be “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”

Despite these statutory protections and affirmative court rulings, the unfortunate truth is that Medicaid and CHIP coverage does not always ensure enrollees’ access to care. Too many barriers remain that prevent some children from accessing the care that they critically need, including, but not limited to:

- Implementation of EPSDT benefits, including limits on service availability and utilization
- Shortages of pediatric subspecialists nationwide or regionally
- Insufficient provider participation in Medicaid and CHIP including providers who do not accept Medicaid or CHIP at all, providers who are not accepting additional Medicaid/CHIP patients into their panel, and providers who accept Medicaid and CHIP but have long wait times
- Language access and culturally appropriate care
- Inadequate support for the medical home to enable after-hours care with a trusted care team

When children see providers who know their medical and family history and can monitor their physical and socio-emotional development, they are more likely to have better overall health, be up to date on immunizations, perform better in school, and receive care in the most cost-effective way.⁷ Moreover, child health is a strong predictor of adult health. Addressing health and development during childhood—from birth through adolescence—leads to improved health and wellbeing throughout the lifespan and extending well beyond health care needs. Conversely, the inability to access health care services threatens the physical, mental, and social health and well-being of children and their caregivers.⁸ All children, regardless of their zip code, must have access to the full range of age-appropriate health care providers, subspecialists, and facilities. It is the federal government’s responsibility to monitor the implementation of Medicaid programs and ensure *all* enrolled children have access to the full range of providers and services they need.

In the RFI, CMS solicits feedback on “how to establish minimum standards or federal ‘floors’ for equitable and timely access to providers and services, such as targets for the number of days it takes to access services. These standards or “floors” would help address differences in how access is defined, regulated, and monitored, and enforced across delivery systems, value-based payment arrangements, provider type, geography, language needs, and cultural practices.

We urge CMS to establish minimum essential standards for state Medicaid and CHIP programs related to access to care. Further, we urge CMS to clearly articulate the available methods for enforcing these minimum essential standards. Our specific comments and recommendations related to improving access to care are below:

⁶ <https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html>

⁷ Murphey, David. “Health Insurance Coverage Improves Child Well-Being.” *Child Trends*, May 2017. https://www.childtrends.org/wp-content/uploads/2017/05/2017-22HealthInsurance_finalupdate.pdf.

⁸ AAP Blueprint for Children, 2016 <https://www.aap.org/en-us/Documents/BluePrintForChildren.pdf>

Developing and Enforcing Minimum Essential Standards

It is crucial that CMS considers the unique needs of children as the agency contemplates the development of minimum essential standards. Children must have access to a sufficient range of pediatric providers with the training and expertise to provide appropriate, high-quality, and cost-effective care, including mental and behavioral health care, for children who are generally healthy as well as those with the most complex and chronic conditions. Provider networks must ensure access to needed pediatric providers regardless of the state in which a child lives. Children with serious, chronic or complex health conditions, including children with special health care needs, must have in-network access to a range of pediatric providers, including primary, specialty and subspecialty care physicians (such as pediatric medical subspecialists and pediatric surgical specialists); pediatric nurse practitioners; pediatric mental health providers; other pediatric clinicians; and children's hospitals to ensure that their particular health conditions are appropriately addressed by clinicians and facilities with pediatric training and capacity.

EPSDT/Bright Futures

The definition of medical necessity under EPSDT is much broader than the definition used in private health insurance: Medicaid must cover "necessary health care, diagnostic services, treatment and other measures...to correct or ameliorate defects and physical and mental illness and condition...if they correct, compensate for, or improve or prevent a condition from worsening...even if that condition cannot be prevented or cured."

The preventive health care services of EPSDT closely align with the AAP *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Fourth Edition*.¹⁰ The EPSDT set of services ensures access to care commensurate with each child's medical needs including age-appropriate physical health, mental health, and developmental care services across the pediatric continuum³ and provides a useful and relevant framework for making a determination of pediatric medical necessity. States are required to provide all medically necessary services mandated by EPSDT regardless of whether those services are part of the individual state's Medicaid program, including for Medicaid Managed Care.¹³ This federal treatment requirement and EPSDT's definition of medical necessity are intended to ensure uniform and comprehensive access to needed care for children and adolescents covered within the Medicaid program across the nation.

Despite robust federal requirements to promote and protect children's health, state compliance with EPSDT is often deficient and presents an ongoing challenge for parents, providers, and healthcare advocates. States and Managed Care Organizations (MCOs) use varying definitions of medical necessity that can ultimately lead to inappropriate coverage denials and limits on services. Additionally, while MCOs must provide all benefits offered under the state plan, they can establish their own provider network qualifications, contract terms, and payment rates (within parameters required by the terms of the contract with the State). Geographic variation in provider access, which can be driven by both the breadth of an MCO's network and the availability of providers in a given geographic area, can also affect the type, quality, and utilization of services used by beneficiaries.

Unequal access to pediatric oral health services is a prime example of how EPSDT is not reaching its full potential. Under EPSDT, all children enrolled in Medicaid, should have coverage for dental services. Covered dental services must, at a minimum, include dental care needed for relief of pain, infection, restoration of teeth, maintenance of dental health (provided at as early an age as necessary), and medically necessary orthodontic services.⁹ While states are required to adopt a periodicity schedule specific to pediatric dental

⁹ Section 1905(r)(3) of the Social Security Act. See also, CMS, Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children's & Adolescents, September 2013, available at <https://www.medicaid.gov/medicaid/benefits/downloads/keep-kids-smiling.pdf>

services detailing the recommended intervals at which enrolled children should receive dental check-ups, a 2016 report from the Office of the Inspector General (OIG) determined that not all states are ensuring fee schedules and payment policies align with the state's periodicity schedule, leading to a majority of children in 4 states not receiving required dental services.¹⁰

In 2018, CMCS released an Informational bulletin saying "states should review their Medicaid and CHIP payment policies for incongruities with their pediatric dental periodicity schedules and correct any identified issues" to prevent misalignments between pediatric dental periodicity and fee schedules.¹¹ However, this communication lacked any true enforcement mechanism, and access to dental care for children enrolled in

Medicaid and CHIP continues to vary greatly at the state, local, and plan level.

Forgone routine oral health services may have lifelong consequences for children, as oral health care covers a range of health promotion and disease prevention concerns, including dental caries; periodontal (gums) health; proper development and alignment of facial bones, jaws, and teeth; other oral

From a pediatrician in New York:

"A new patient presented to my practice with significant caries in his molars, a moderate fever, and a mild headache. The clinician who saw him worried that this combination in this otherwise healthy boy who was new to our care meant that he might have a brain abscess. We sent him to the ED for a head CT and indeed, this young man, a Medicaid enrollee, had a brain abscess that required surgery, antibiotics, and recovery in the ICU. Good quality, timely preventive dental care would have prevented this very costly and potentially fatal problem."

diseases and conditions; and trauma or injury to the mouth and teeth. It is crucial that CMS work to develop stronger enforcement mechanisms to ensure children enrolled in Medicaid and Medicaid-expansion CHIP programs have access to all EPSDT services, including oral health care.

Our specific recommendations are below:

Recommendation: Federal payers and regulators of health care services for children should exercise their full authority to ensure that children, adolescents, and young adults have access to a uniform standard of essential pediatric health care benefits across all geographies. If, and to the extent that, existing statutory authority cannot achieve this goal, new legislative solutions should be enacted.

Recommendation: CMS should provide clear regulatory guidance that identifies EPSDT benefits as the standard for pediatric health benefits. Ensuring that all children enrolled in Medicaid and CHIP receive EPSDT as the standard of pediatric health care requires ensuring (1) adherence with current preventive care and

¹⁰ Office of Inspector General. (2016). *Most Children With Medicaid In Four States Are Not Receiving Required Dental Services*. Retrieved April 5, 2022, from <https://oig.hhs.gov/oei/reports/oei-02-14-00490.pdf>

¹¹ CMCS. (2018, May 4). *CMCs Informational Bulletin - Aligning Dental Payment Policies and Periodicity Schedules in the Medicaid and CHIP Programs*. Retrieved April 5, 2022, from <https://www.medicaid.gov/federal-policy-guidance/downloads/cib050418.pdf>

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immunization recommendations, as well as (2) the application of a robust definition of medical necessity across payers, so that all treatments children need are received, and that needed care is delivered in a timely way. In addition, payment for services must be set at appropriate levels to ensure clinicians are accessible to provide such treatment (see "Ensuring Adequate Payment" section for more recommendations on the link between payment and access to care).

Recommendation: Preventive care and wellness benefits for children, adolescents, and young adults should be consistent with current recommendations in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*.¹² In accordance with the Affordable Care Act (ACA) and other federal provisions, preventive and wellness benefits, including immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) and the AAP, should be exempt from any cost sharing.

Recommendation: CMS should develop a standardized definition of medical necessity to apply to Medicaid and CHIP, including a specific standard of pediatric medical necessity to be applied on a case-to-case basis. Such a definition would ensure that children and others can access needed health benefits meaningfully and consistently. AAP recommends the following definition of pediatric medical necessity: **"health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals or organizations, such as [those represented by] the AAP, in order to promote optimal growth and development in children and youth and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities."** This definition should appropriately reflect the needs of children in allowing medical professionals flexibility in prescribing health services that consider the evolving needs of the individual child. Furthermore, each state's process for determining medical necessity should rely on the expertise of pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. All payers should ensure that in the process of making decisions on the basis of medical necessity, the physical, mental and behavioral health, and developmental care needs of the child are fully considered and that appropriate comprehensive benefits are available to address the full range of these needs.

Recommendation: All health care benefits should be sufficient in the type, amount, frequency, duration, setting, and scope to enable care that achieves the best clinical outcome for the condition(s) under treatment. At minimum, access to all needed services under EPSDT would include all mandatory and optional benefits outlined in the AAP statement "Scope of Health Care Benefits for Children from Birth Through Age 26."¹³ These benefits should not be subject to limits such as prior authorization requirements or caps on the number of screenings performed during a visit. Of course, EPSDT ensures that all medically necessary services children need are provided, even if they are not included in a state's plan.

Recommendation: Develop appropriate benefits that address the needs of pregnant people. Pregnant people should be afforded the full range of maternity care (preconception, prenatal, labor, delivery, and postpartum) recommended in the Guidelines for Perinatal Care issued jointly by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. This would closely align with and further inform the information CMS has provided to states about postpartum coverage extension options and improving maternal health outcomes.¹⁴

¹² <https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx>

¹³ COMMITTEE ON CHILD HEALTH FINANCING, Scope of Health Care Benefits for Children From Birth Through Age 26. *Pediatrics* January 2012; 129 (1): 185–189. 10.1542/peds.2011-2936

¹⁴ CMS. (2022). SHO# 21-007 re: Improving maternal health . Retrieved April 5, 2022, from <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf>

Recommendation: Provide pharmacy benefits appropriate for children and broad enough to pay for medicines and specialized nutritional products required for children with special health care needs and for children with rare diseases. State Medicaid Pharmacy and Therapeutics committees should populate and operate a pediatric formulary with the recognition that less expensive (usually generic) drugs may not be as effective as alternative but more costly (usually brand name) drugs of the same class in all patients under all circumstances. Pharmacy benefits should acknowledge that many medications are appropriately prescribed to children in the absence of a pediatric label indication or dosing information. Optimally, states should mandate that all Medicaid MCOs operating in the state adopt the same state pediatric Medicaid formulary to ensure continuous and consistent treatment of patients (especially those with special health care needs or rare diseases) because they often transition between Medicaid insurers.

Ensuring Timely Access to Appropriate Quality and Expertise

Federal network adequacy standards are needed that ensure access for children, especially those with special health care needs, serious or chronic health conditions, limited English proficiency, and those who are experiencing mental health or other challenges. These standards must ensure that provider networks include the full range of pediatric primary, ancillary, specialty, and subspecialty providers who typically care for children to ensure access to all covered benefits. Provider networks must be capable of providing services for all levels of complexity, including for rare conditions, without administrative or cost barriers for consumers.

Considerations for ensuring timely access to appropriate quality and expertise for children include the following:

Does the generalist(s) or specialist(s) network contain physicians who have pediatric expertise? Are they able to diagnose and treat the condition?

Certain plans may consider access to adult specialty or subspecialty care as meeting a network adequacy standard, when in fact adult care may not be appropriate for children. For example, while an adult general surgeon might be able to perform appendectomies safely on teenage patients, the same is not the case for a patient under the age of ten. Compared to adults, radiology services for children may require adjustment of equipment and contrast dosing. To put it plainly: an adult specialist who agrees to see pediatric patients is not the same as a pediatric specialist.

Research continues to demonstrate the positive outcomes and quality impacts of care provided by pediatric medical subspecialists and surgical specialists, versus adult specialists and subspecialists for the pediatric population.¹⁵ Factors such as lower

From a pediatrician in California:

“Our wait time for a Developmental-Behavioral Pediatrician is now over a year because of the acute workforce shortage. This leads to massive delays in diagnosis of autism and other conditions, which delays treatment and results in poorer outcomes.”

¹⁵ Chowdhury MM, Dagash H, Pierro A. A systematic review of the impact of volume of surgery and specialization on patient outcome. *Br J Surg*. Feb. 2007; 94(2):145-161

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complication rates, shorter lengths of stay, and better outcomes for disease-specific conditions highlight the need for unfettered access to pediatric specialists and subspecialists.

Additionally, in many areas of the country access to pediatric specialty or subspecialty care might require services that should only be provided by pediatric subspecialists or a children's hospital in another state, such as for surgery to correct a pediatric heart condition, retinopathy of prematurity screening, neonatology consultations, dermatologic assessment, or critical care medicine. Furthermore, medical complexity in children consists of a lot of individually rare conditions, meaning it may sometimes be difficult to find a pediatric specialist with the necessary expertise. For example, one of our members reported the need to send a hospitalized child from Buffalo to Philadelphia because the specific procedure, embolization of a pulmonary lymphatic malformation, was only available in Philadelphia. That child is alive today, and back living in Buffalo, because they were able to receive care in Philadelphia.

Is the clinician or practice accepting new patients with the child's insurance plan(s)?

Accepting Medicaid or CHIP insurance coverage is necessary but not sufficient. The practice must also be accepting new patients with that specific insurance plan. If a primary care pediatrician is forced to choose between an 18-24 month wait to see a developmental specialist in state, but no wait time when referring out of state, they'll likely choose to refer out of state to ensure promptness of care.

Does the provider already have a network of supplemental services needed to assist delivering the service?

Sometimes a health insurance carrier may require that a child whose "network" is based out of one hospital system needs to see a specialist in another hospital system. Problems can arise if a child needs specialized services but pediatric expertise, appropriate medical equipment, or both are unavailable through a single in-network hospital or practice. For example, a child's medical needs may require imaging studies using equipment only available from a hospital where neither the technologist performing the study nor the radiologist reading the study has pediatric training. Access to a reputable, well-trained pediatric specialist with significant experience is less valuable when there is not the necessary pediatric medical equipment needed to provide vital care.

Additionally, larger children's hospitals with dedicated staff to help coordinate care, such as social workers, care coordinators, Medicaid service coordinators, nursing agencies, and therapists may be better suited to take on children with medical complexities. In many instances, those institutions might be out of state from where the child and family currently reside. A child- and family-centered approach would require that Medicaid programs allow children to receive this full suite of services in a coordinated way, even if some of the services may be available individually in the child's home state or in-network.

Recommendation: Ensure that the provider networks of all Medicaid fee-for-service programs and all Medicaid MCOs contain the following components:

1. Sufficient numbers of providers trained in primary care and subspecialty pediatrics, as well as pediatric surgical specialists.
2. Sufficient numbers of physicians and other licensed providers of oral health, mental health, developmental, behavioral, and substance-abuse services so that medically necessary services are accessible within a reasonable length of time.
3. When possible, a minimum of 1 hospital that specializes in the care of children.
4. Imaging facilities that specialize in the care of children, including hospital services if freestanding facilities are not able to appropriately meet the needs of pediatric patients.

5. Vendors of durable medical equipment and home health care agencies that have experience caring for children, especially those with special health care needs.

In addition to the above, we encourage CMS to develop a robust and multifaceted test of network adequacy that considers these minimum thresholds in the context of true access, including the impact of locations of care, wait times for care, etc. Additional comments on these issues follow later in this letter.

Recommendation: CMS should coordinate with HRSA and other agencies across HHS, as well as through a whole-of-government approach, to support workforce development that ameliorates serious shortages of pediatric subspecialists that are impeding access to care for young people and can manifest through long wait times, long distances traveled to receive care, and forgone care. In addition to the Pediatric Subspecialty Loan Repayment Program, incentives should address high educational debt burden and relatively lower salaries that serve as barriers to training in pediatric subspecialties and encourage clinicians to train and practice in under-resourced areas.

Recommendation: License an MCO as a pediatric Medicaid provider only if its comprehensive pediatric network can provide children with quality care across the full continuum of care and hold that MCO accountable.

Recommendation: CMS should require a minimum standard for network adequacy, in whatever format utilized, which plans must meet and which states may additionally build upon.

Recommendation: Ensure that all children have timely access to appropriate services from qualified pediatric medical subspecialists and pediatric surgical specialists who are needed to optimize their health and well-being, in both fee-for-service care and the managed care setting. Managed care plans should use clinicians with appropriate pediatric training and expertise. There should be no financial barriers to access to pediatric specialty care.

Recommendation: Managed care plans should ensure access within the plan to tertiary-care centers appropriate for children, as well as an appropriate number and mix of geographically accessible pediatric-trained physician specialists.

Recommendation: The referral process for pediatric specialty clinicians (pediatric medical subspecialists, pediatric surgical specialists, and pediatric behavioral mental health specialists) should be developed by health plans in collaboration with pediatricians, pediatric specialty clinicians, and families. The criteria for referrals may include age of patient, specific diagnoses, severity of conditions, and logistic considerations (eg, geographic access and cultural competence).

Recommendation: Implement dedicated planning and oversight when MCOs contract for care delivery to children with special health care needs (including children with complex and/or rare diseases, children with behavioral/mental health conditions, and children and youth in foster care).

Geographic Proximity and Improving Care Across State Lines

When we asked what key priorities should be considered to ensuring equal access for children enrolled in Medicaid/CHIP, our members repeatedly identified geographical proximity as a major barrier. This is especially true for children with medical complexity, as the pediatric specialists and other specialized services required to treat the unique needs of a child are not located in a child's home state. In fact, the care a child requires for their very specialized condition—which may only affect a small number of children—is often only available in one or two locations in the entire country. A recent Medicaid and CHIP Payment and Access Commission (MACPAC) report finds that, “Children who qualify for Medicaid on the basis of a disability have a

higher share of out-of-state inpatient hospital stays than other eligibility groups. These children are also more likely to access care outside of the hospital-referral region where they reside.”¹⁶

In some instances, a family that lives on the border between two states would have a much shorter drive to a facility located out of state than an in-state clinician or facility located 100 or more miles away. Lack of reliable transportation and direct costs such as lodging and food, and ancillary costs such as childcare (if the family has more than one child) and missed work, and lack of resources may make it difficult to travel to a distant care provider within a state.

While Medicaid may cover some transportation services under the Non-Emergency Medical Transportation (NEMT) benefit, that transportation traditionally covers only the patient and the parent, not additional children or family members. Additionally, implementation of NEMT may create barriers and challenge timely access because of restrictions or limitations in scheduling and availability of approved local transport contractors. In addition, we have seen a troubling trend in recent years of states seeking to waive NEMT. While these waivers are often for adults (but may affect 19- and 20-year-olds), transportation remains a vital part of the ability of patients to access needed care.

Consequently, pediatricians may be more inclined to refer to the out of network/state providers if it would cut down on travel time for the family, thereby decreasing cost of transportation, fewer missed work hours for the parent/caregiver, and less school time missed for the child.

Children do not choose where to reside, and their living situation might change throughout the year. They may live with parents, stepparents, grandparents, with other caregivers or in foster care. They may split their year between several residences, or they may be homeless. These situations where children have a current address that is different from their primary address may increase the need for pediatricians to refer out-of-state.

Recommendation: Implement policies and procedures to ensure equitable and prompt payment to providers and facilities for pediatric services rendered to Medicaid patients outside their home state or outside of their managed care organization’s network. When payment rates differ among the child’s home state and the state where care is received, we recommend that the accountable Medicaid program use the higher payment rate to account for differences in regional costs and to ensure specialty care is available.

Recommendation: Strongly encourage states to streamline their enrollment and screening requirements for out-of-state Medicaid providers. Several states already accept the home state enrollment of the provider and/or providers’ Medicaid enrollment. If more states used this approach, it would cut back significantly on the administrative burden on providers and result in more timely care for children.

Recommendation: Consider funding multidisciplinary, regional mobile units for both subspecialty and mental health care for children in rural areas to meet patients closer to where they live.

Recommendation: Develop a template for a single case agreement and encourage state/health plan use.

Recommendation: Dedicate federal funding to states to mitigate other patient barriers (lodging, food, transportation) to improve access to out-of-state care.

Recommendation: Direct states to prioritize the needs of children and families, including through referrals to out-of-state and out-of-network care, especially when the out of state option is significantly closer and/or more clinically appropriate.

¹⁶ Medicaid Payment Policy for Out-of-State Hospital Services, MACPAC, January 2020, page 2. <https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid-Payment-Policy-for-Out-of-State-Hospital-Services.pdf>

Prioritizing Whole-Person Care

The AAP envisions patient- and family-centered care coordination for all children, relying on the medical home as a foundation for an effective and efficient system of care delivery.¹⁷ Care coordination goes beyond case management to connect plans of care from various subspecialists, navigate insurance coverage for services, prescriptions, and medical equipment, and foster linkages to home and community-based services ranging from home health aides to nursing and dyadic or family-centered care. To ensure optimal outcomes for children and youth, especially those with complex medical needs, coordination is required among multiple care systems and individuals. Such coordination must take into consideration the continuum of health, education, early child care, early intervention, nutrition, mental/behavioral/emotional health, community partnerships, and social services (as well as payment for these services) needed to improve the quality of care for all children and youth including those with special health care needs, while acknowledging the importance of language and culture in achieving desired outcomes.¹⁸ Coordination of care across settings allows the comprehensive and holistic needs of the child and family to come first.

For children and youth, and especially for those with special health care needs, high-quality care must support family members, who provide the bulk of day-to-day care and advocacy for the child. All public and private payers should invest in providers, families, and communities to achieve better short-term health outcomes and to stimulate changes that will result in sustained improvement in the long-term life course. Some metrics of quality outcomes pertinent to pediatrics reflect enhancements to the family's ability to support the child. Parents, for example, indicate that a meaningful outcome of a health intervention is reducing the number of school days and workdays that an illness, injury, or condition cause to be missed within the family.^{19 20}

A payer that covers both a parent and a child has important timely data about the family unit that may allow the medical home to optimize a child's comprehensive care. Likewise, continuous real-time sharing of data about patient populations between payers and practices can be a powerful way to help both groups respond to health needs in a timely way. Social determinants of health (including parental and socioeconomic factors) largely shape many adverse conditions and experiences affecting vulnerable children. Some childhood adverse conditions begin during fetal development; some are associated with preterm birth. Other conditions involve situations, actions, and deficiencies that cause children to become medically, behaviorally, or emotionally complex. Many social determinants of health culminate with children reaching maturity in socioeconomic conditions and habitual behavior patterns associated with lifelong chronic and expensive adult conditions.²¹

Relevant parental factors include the parents' or caregivers' employment status; past and present physical, mental health; use of tobacco and other substances; previous experience with and attitudes toward medical care; and competencies as parents or caregivers. Knowledge of these parental factors may allow the medical home to tailor medical care and parental education to prevent or mitigate those adverse childhood experiences that are predictable yet potentially modifiable. These same factors also influence whether a parent creates and maintains a relationship with a pediatric medical home for their child. Some payers already incentivize pregnant mothers to remain engaged with their prenatal care, such as by providing portable safe

¹⁷ COUNCIL ON CHILDREN WITH DISABILITIES and MEDICAL HOME IMPLEMENTATION PROJECT ADVISORY COMMITTEE, Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems. *Pediatrics* May 2014; 133 (5): e1451–e1460. 10.1542/peds.2014-0318

¹⁸ Turchi RM, Mann M. Building a medical home for children and youth with special health care needs. In: Hollar D, ed. *Handbook of Children With Special Health Care Needs*. New York, NY: Springer-Verlag; 2013:399–418

¹⁹ Anderson B, Beckett J, Wells N, Comeau M. The eye of the beholder: a discussion of value and quality from the perspective of families of children and youth with special health care needs. *Pediatrics*. 2017;139(suppl 2):S99–S108

²⁰ COUNCIL ON SCHOOL HEALTH; The Link Between School Attendance and Good Health. *Pediatrics* February 2019; 143 (2): e20183648. 10.1542/peds.2018-3648

²¹ Bitsko RH, Holbrook JR, Robinson LR, et al; EdS. Health care, family, and community factors associated with mental, behavioral, and developmental disorders in early childhood—United States, 2011–2012. *MMWR Morb Mortal Wkly Rep*. 2016;65(9):221–226

sleepers and play yards or coupons for infant products for those who attend nearly all their prenatal visits; those with the data and resources should also incentivize parents to engage appropriate services on their own behalf and engage with a comprehensive, coordinated medical home for their children. Resources should also be deployed when necessary to provide or subsidize essential transportation for necessary encounters.

Recommendation: A key factor that impedes delivery of quality care is a lack of appropriate, affordable, community-based family services and supports.²² In addition, a lack of appropriate pediatric-oriented medical, surgical, mental health, substance use, and other therapeutic services within a geographic area or a payer's network of providers can impose a significant barrier. Payers, public and private, should invest in the necessary infrastructure to support the pediatric medical home and medical neighborhood.²³

Recommendation: When appropriate, allow pediatricians and pediatric practices to provide care to adult parents and caregivers, with adequate payment and without excessive administrative burden. For example, pediatricians regularly administer the flu vaccine to parents, grandparents, and other caregivers who accompany a child to an office visit. Similarly, pediatricians regularly conduct myriad screenings for new parents, including anxiety, postpartum depression, social determinants of health, domestic and family violence, family substance use, and more. Caring for a parent-child dyad or a child within the family context can lead to the best health outcomes, but often comes with payment denials and other administrative burdens.

Recommendation: Where they exist, payers should support community-based efforts that identify children and adults in high-risk families, provide care coordination, and measure results in housing, education, employment, and engagement with the health system.

Recommendation: Establish adequate payment to a practice or facility that coordinates care of infants and children with complicated physical and/or mental health conditions (eg. pay for care coordinators, social workers, extended office hours, home visitations, dental care, durable medical equipment, etc.).

Recommendation: Allow for payment for coordination of care services outside of face-to-face encounters that optimize care. This is especially important for children with special health care needs as well as for care needed to transition from pediatric to adult care when an individual may most benefit from having both adult and pediatric care teams providing care in consultation. Examples of these services include providing reminders and other outreach to patients and coordination and communication with medical subspecialists, surgical specialists, mental health specialists, therapists, educators, and community resources.

Recommendation: Payment should be proportional to the specific services provided in this regard by the medical home and should consider the complexity of the patient panel. It is essential to understand that complexity relates not only to patient-specific medical and psychological factors but also, and especially in pediatrics, factors specific to parents and caregivers as well as overarching household and social factors, such as food and nutrition insecurity, housing insecurity and quality, neighborhood and household violence, poverty, immigration status, and need for legal services.

Recommendation: Coordination payments could be made as enhanced fee-for-service payment or as supplemental per-member per-month payment. Supplemental per-member per-month methodology can also enable providers to establish and maintain health information technology and collect data for quality improvement and population health initiatives. However, any type of "bonus" or supplemental payment must

²² Bachman SS, Comeau C, Long TF. Statement of the Problem: health reform, value-based purchasing, alternative payment strategies, and children and youth with special health care needs. *Pediatrics*. 2017;139(suppl 2):S89–S98

²³ Jonathan Price, Mary L. Brandt, Mark L. Hudak, COMMITTEE ON CHILD HEALTH FINANCING, Suzanne K. Berman, Kenneth M. Carlson, Angelo P. Giardino, Lawrence Hammer, Kimberly Heggen, Stephen A. Pearlman, Beena Gaiind Sood; Principles of Financing the Medical Home for Children. *Pediatrics* January 2020; 145 (1): e20193451. 10.1542/peds.2019-3451

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be adequate to support the services needed; for example, a \$1-\$2 per-member per-month payment for a 1,000 patient panel would fall far short of covering the salary costs of a clinical team member like a Care Coordinator. Payers should pay fairly for existing CPT codes that apply to care management of children with chronic and/or complex medical and behavioral conditions.

Recommendation: CMS should foster interagency collaboration and coordination to promote whole-person care and eliminate siloes. The recent joint letter from Secretaries Becerra and Cardenas regarding school-based health centers serves as a model of this type of collaboration.²⁴ Whole-person planning and programming also requires broad stakeholder input including patients, families, and providers.

Improving Access to Pediatric Mental Health Care

Children's emotional and behavioral health were in crisis before the COVID-19 pandemic, and the public health emergency has acutely exacerbated these challenges. The pandemic highlights preexisting disparities in morbidity and mortality, access to health care, quality education, affordable housing, adequate nutrition, and safe environments, which create more challenges and stressors for many families and communities. Studies have found higher rates of anxiety, depression, and post-traumatic symptoms among children during the pandemic, especially among young people of color.

This is why AAP, along with the American Academy of Child and Adolescent Psychiatry and the Children's Hospital Association, declared a [National State of Emergency in Children's Mental Health](#).²⁵ The challenges facing children and adolescents are so widespread that we are naming the situation exactly what it is, a national emergency for children and adolescents. We must identify strategies to meet these challenges through innovation and action, using state, local and national approaches to improve the access to and quality of care across the continuum of mental health promotion, prevention, and treatment. And we must tackle the disproportionate impact of the pandemic on young people in communities of color who face inequities resulting from structural racism.

Suicide is the second leading cause of death of youth ages 10-24 in the U.S. and rates have been rising for decades.²⁶ Between March and October 2020, the percentage of emergency department visits for children with mental health emergencies rose by 24 percent for children ages 5-11 and 31 percent for children ages 12-17.²⁷ The CDC also found a more than 50 percent increase in suspected suicide attempt Emergency Department visits among girls ages 12-17 in early 2021 as compared to the same period in 2019.²⁸ Given this growing crisis, AAP and the American Foundation for Suicide Prevention, in collaboration with experts from the National Institute of Mental Health, released the [Blueprint for Youth Suicide Prevention](#)—an educational resource to support clinicians in identifying strategies to support youth at risk for suicide. The blueprint represents the first major interdisciplinary effort to infuse suicide risk reducing strategies into pediatric care and youth community settings.²⁹

²⁴ <https://www.hhs.gov/sites/default/files/school-based-health-services-letter.pdf>

²⁵ <https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/>

²⁶ <https://wonder.cdc.gov/controller/datarequest/D76>

²⁷ Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1675–1680. DOI: [http://dx.doi.org/10.15585/mmwr.mm6945a3external icon](http://dx.doi.org/10.15585/mmwr.mm6945a3external%20icon)

²⁸ Yard E, Radhakrishnan L, Ballesteros MF, et al. Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021. *MMWR Morb Mortal Wkly Rep* 2021;70:888–894. DOI: <http://dx.doi.org/10.15585/mmwr.mm7024e1>

²⁹ <https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/>

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Last spring, the AAP, joined by 29 other leading organizations, released a comprehensive set of Child and Adolescent Mental and Behavioral Health Principles³⁰ that, if enacted in policy, would increase access to evidence-based prevention, early identification, and early intervention; expand mental health services in schools; integrate mental health into pediatric primary care; strengthen the child and adolescent mental health workforce; increase insurance coverage and payment; extend access to telehealth; support children in crisis; and address the mental health needs of justice-involved youth. We recommend the principles document to you as consider all policies related to coverage and access to care for children and families.

Additionally, the Academy's recent response to a Senate Finance Committee Request for Information on Barriers to Accessing Mental Health Care³¹ highlights several policy themes that CMS should prioritize when considering improving access to mental health care:

- 1) Support the development of sustainable funding models that allow for integration of mental health practitioners in a pediatric primary care practice, including PMHCA programs;
- 2) Allow providers to bill for time spent coordinating care and provide funding for care coordinators or navigators who help families navigate the mental health system, with no patient cost sharing;
- 3) Increase payment rates for mental/behavioral health care;
- 4) Allow providers to bill non-specific codes when a child does not have a diagnosable condition but has significant mental health needs that require care;
- 5) Stand up a trauma-informed support system that children and families as well as pediatricians can access when children are in crisis; and
- 6) Review how EPSDT is implemented in states to support access to mental health services and provide guidance to states on Medicaid payment for evidence-based mental health services for children including those that promote integrated care.

Children and adolescents with behavioral health needs often face waiting times of several weeks, or even months, to get an appointment (even in large cities with more developmental and behavioral pediatricians or child psychiatrists than most parts of the country), and this wait time often extends to months for children whose preferred language is not English. While more providers are needed to address the mental health needs of the pediatric population, payment rates for these services are a key barrier to both building the workforce and building practices. Many providers choose to work in cash-only practices that do not accept insurance because payment rates for mental health services are so low, especially for patients enrolled in Medicaid/CHIP.

Policies and models that expand the capacity of front-line pediatric and family medicine clinicians to respond to the mental health needs of children and adolescents, such as the HRSA Pediatric Mental Health Care Access Program and models that integrate a mental health or developmental specialist within a primary care practice, such as the Primary Care Behavioral Health Consultation model (PCBH), should also be supported. Unfortunately, billing for these models of integrated care often trigger a co-pay, co-insurance, or deductible for families. That should be eliminated as it serves as a barrier to access for families.

Medicaid is designed to meet children's unique needs, particularly through its EPSDT benefit. Together, the Medicaid equal access provision and the EPSDT benefit should ensure that children have timely access to needed care, including mental health services.

³⁰ See full comments at: <https://downloads.aap.org/DOFA/CAMH%20Principles%202021%20Final%2005-04-21.pdf>

³¹ See full comments at: <https://downloads.aap.org/DOFA/AAP%20Comments%20Senate%20Finance%20RFI%20Nov%202021.pdf>

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However, state Medicaid programs implement EPSDT and medical necessity determinations differently, a challenge exacerbated by the proliferation of contracts with Medicaid managed care plans with varied benefit designs and coverage limitations. CMS should review how EPSDT is implemented in the states to support access to prevention and early intervention services, as well as developmentally appropriate mental health services across the continuum of care. Specific assessment of mental health network adequacy and access to services should be included in future rulemaking regarding Medicaid enrollees' access to care through fee-for-service and managed care programs. In addition, to address the real and perceived barriers to payment for mental health care for children by Medicaid, CMS should **provide guidance to states on Medicaid payment for evidence-based mental health services for children including trauma-informed care and those that promote integrated care.**

Additionally, despite enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and its subsequent expansions to Medicaid managed care, CHIP, and the health insurance marketplaces, there has been a persistent need to improve oversight and compliance with the requirements of MHPAEA. Further, MHPAEA still needs to be expanded to children and adolescents enrolled in Medicaid fee-for-service arrangements. While new compliance measures included in recently passed legislation are promising, many children and adolescents still face barriers in accessing mental health and substance use disorder treatment due to insurance discrimination that singles out these services. Increased oversight is needed to ensure that insurers are complying with mental health parity laws to promote broader mental health insurance networks.

Recommendation: Pediatricians routinely report that the Medicaid payment rates to care for children with complex mental health needs are inadequate to maintain an inpatient or outpatient clinic setting. Payment rates for mental/behavioral health care must be improved. Medicaid payment rates for pediatric mental, emotional, and behavioral health services should be increased to 100% of Medicare levels or higher for similar services.

Recommendation: Geographic "carve-outs" that limit where patients can receive behavioral health services (for example, contracts for a given city or county) should be eliminated. Carving out mental health services takes care out from the medical home and away from the primary care clinician.

Recommendation: Group visits, secure text check-ins, short video check-ins, virtual, or audio-only visits with a care team can be part of an effective treatment model and should be adequately paid for. Restrictions on yearly maximum visits should be eliminated.

Recommendation: Setting and provider type restrictions that prevent behavioral health services from being delivered in primary care settings should be eliminated. This includes eliminating same-day billing restrictions and other structural barriers like prior authorization, required behavioral health diagnoses, limits to appropriate care such as the number of screening tools used per encounter, and other limits to episodes of care.

Recommendation: Prior authorizations for mental health medications should be removed. As children churn on/off Medicaid and CHIP and between MCOs, the prior authorization process delays and disrupts care for children and families, including for those who have been on medications for years. In particular, "fail first" and step therapy policies should allow for override by a mental health or primary care provider who knows a child's history and experience with medications.

Recommendation: Federal, state, and local policymakers should collaborate with schools and community partners to provide mental/behavioral health services. Pediatricians and other clinicians need to be able to work with children where they are located and paid for their time spent working directly with school mental health providers.

Language Access

Immigrant children represent the fastest growing segment of the US population. One in every 4 children in the United States, approximately 18.6 million children, lives in an immigrant family.³² As a result of changes in federal policy such as public charge and increases in immigration enforcement, immigrant families have faced discrimination in accessing health care. In fact, children of immigrant families are nearly twice as likely to be uninsured compared to children of nonimmigrant families.

Even when immigrant children and families can access health care providers, they face further obstacles when language barriers prevent effective communication between pediatricians, children, and families on medical issues. Although many immigrant children speak English, their parents may not, creating a barrier that can prevent families from accessing needed health services and/or causing inadequate communication with health care providers. Without access to qualified medical interpreters in health care settings, language barriers can place English-speaking children in the difficult position of interpreting between health care providers and their family members.³³

The Academy has previously recommended that all health facilities have access to trained interpreter services and that CMS require Medicaid to provide full payment for these services for patients with LEP.³⁴ Similarly, we strongly supported previous efforts by the Obama Administration to ensure meaningful access for individuals with limited English proficiency because they help to prevent discrimination and improve the quality of care for children and families. When in-person interpreter services are not possible, remote interpretation serves as a crucial tool for providers to improve communication with patients and families³⁵ and we encourage the Department to maintain the current standards for remote video interpreting.

Patients and families with LEP need adequate language resources and access to language professionals—including posted signs in multiple languages, written materials, live interpreters (preferably in-person, but also remote video and telephonic interpreters), and dedicated translators of written instructions. Such services are not only crucial for equitable care but have been demonstrated to improve patient care outcomes and satisfaction.³⁶ For example, a pediatrician from South Carolina shares the successful experience of a hospital with full-time, in-person interpreters, where parents and pregnant women often drive more than an hour to seek medical care for themselves and their children because they know they will have an in-person interpreter, which they know will improve their capacity to support their own health and well-being. In one instance, a child with severe visual impairment and limited English proficiency was able to connect to primary pediatric care only because the interpreter recognized that he did not have a medical home and called a case manager to facilitate connection to care.

When language services are lacking, patient care suffers. In one study, 80% of health care providers reported encountering patients with LEP.³⁷ Without language services, families may be forced to resort to harmful alternatives to a licensed, qualified, medical interpreter: they may rely on inadequate second language skills, recruit untrained bilingual staff or strangers *ad hoc*, incorrectly assume patients understand English, or place children in the uncomfortable and unethical position of interpreting for their parents. Inadequate language

³² Children of Immigrants Data Tool. <https://datatool.urban.org/charts/datatool/pages.cfm#>.

³³ COUNCIL ON COMMUNITY PEDIATRICS; Providing Care for Immigrant, Migrant, and Border Children. *Pediatrics* June 2013; 131 (6): e2028–e2034. 10.1542/peds.2013-1099

³⁴ See full comments at: <https://downloads.aap.org/DOFA/1557%20RFI%20Comment%20Letter%20Final.pdf>

³⁵ Lion KC, Brown JC, Ebel BE et al. Effect of Telephone vs Video Interpretation on Parent Comprehension, Communication, and Utilization in the Pediatric Emergency Department: A Randomized Clinical Trial. *JAMA Pediatr.* 2015;169(12):1117-1125. doi:10.1001/jamapediatrics.2015.2630

³⁶ Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Serv Res.* 2007;42(2):727-754. doi:10.1111/j.1475-6773.2006.00629.x

³⁷ Proctor K, Wilson-Frederick SM, Haffer SC. The Limited English Proficient Population: Describing Medicare, Medicaid, and Dual Beneficiaries. *Health Equity.* 2018;2(1):82-89. doi:10.1089/heq.2017.0036

resources can ultimately lead to negative, costly, and sometimes deadly consequences. For example, one New England Journal of Medicine article discusses cases of medication being placed in the ear instead of taken by mouth, resulting in paralysis and a \$71 million lawsuit.³⁸

Recommendation: Direct states to provide full payment for trained interpreter services, including telephonic/video interpreters, for children and families with LEP. This will assist in thorough and accurate communication between physician and patient, increased accuracy of diagnosis and more appropriate treatment plan, and increased patient and family understanding of and adherence to treatment, thus avoiding adverse clinical consequences.

Recommendation: Ensure that MCOs (these may be either HMOs or provider-sponsored networks) provide educational materials to families that are culturally effective and written at literacy levels and in languages used by Medicaid recipients. The use of audiovisual aids should be encouraged.

Recommendation: Create minimum essential standards across electronic health records (EHRs) that allow clinicians to indicate the unique language needs of multiple caregivers (e.g., father requires Spanish interpreter; mother requires ASL interpreter) since these are not always the same for both caregivers and EHRs are not designed with children and family structure in mind.

The Role of Telehealth in Ensuring Access to Care

The use of telehealth technologies by primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists has the potential to transform the practice of pediatrics. As identified above, issues related to access, network adequacy, and pediatric workforce create significant barriers for children enrolled in Medicaid and CHIP from being able to receive the care that they critically need.

It is appropriate in the pediatric context for network adequacy standards documenting access to care to include care provided via telehealth technologies. However, it should never be acceptable for calculations of network adequacy to depend in any significant way on telehealth to meet a network adequacy standard. For the best access to subspecialty pediatric services, children need guaranteed access to face-to-face care that could then be supplemented by telehealth services. To deliver child- and family-centered care, the flexibility to offer telehealth services should always be balanced with safety, quality, licensing, and certification standards, and must take place within the context or within the support of a medical home.³⁹

These services include a continuum of remote and in-person care options, such as audiovisual, audio-only (telephone), store and forward, portal interactions, and remote patient monitoring (particularly for children with complex or chronic illness). Telehealth is particularly important for children and youth with special health care needs who experience significant barriers to receiving necessary care. Mental and behavioral health services are especially amenable to remote care and can also be provided as an extension of the medical home. Each of these modalities provides necessary care when the physician and patient cannot meet in person, or they can be used as an adjunct to in-person services. Under-resourced communities can also have improved access to pediatric care, which requires adequate resource support for infrastructure to allow for equitable implementation.

Telehealth can decrease disparities in access to care by extending pediatric expertise and best practices to children no matter where they are located. However, the modality is not equally accessible by all populations.

³⁸ Flores G. Language Barriers to Health Care in the United States. *N Engl J Med*. 2006;355(3):229-231. doi:10.1056/NEJMp058316

³⁹ COMMITTEE ON PEDIATRIC WORKFORCE; The Use of Telemedicine to Address Access and Physician Workforce Shortages. *Pediatrics* July 2015; 136 (1): 202–209. 10.1542/peds.2015-1253

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Addressing barriers such as language, digital literacy, disability, and access to and payment for technology infrastructure will be required to avoid furthering disparities.⁴⁰

Recommendation: Physicians who deliver health care services through telehealth, as well as referring clinicians and participating facilities, should receive adequate payment for their services to increase the availability of pediatric health care services for all children. Payment for telehealth care should be at parity with in-person visits, including transmission or facility fees to account for the costs of supporting technology.

Recommendation: CMS should provide guidance on the use of telehealth, outlining current authority and rules around use and payment under Medicaid, particularly for children with medical complexity.

Recommendation: Ensure coverage of telehealth care by the pediatric medical home as well as pediatric medical subspecialists and surgical specialists, without defaulting to telehealth care vendors that do not provide access to a medical home.

Recommendation: Confirm coverage of and ensure payment for audio-only telehealth visits. Medicaid enrollees, particularly those who are elderly, live in rural areas, or who are non-native English speakers, may be less likely to complete video visits.⁴¹ Patients in certain racial or ethnic groups may be more likely to participate in audio-only visits compared with video visits,⁴² raising the importance of this policy towards improving health equity. Additionally, under-resourced providers serving Medicaid patients may find it easier and less cost-prohibitive to offer audio-only visits rather than video visits. Video visits may require potential up-front infrastructure costs, as well as recurring maintenance and staff training to use the software effectively, none of which are necessary for audio-only visits.⁴³

Recommendation: Currently, all physicians practicing intra- and interstate must comply with state licensing and other practice rules in every state in which they practice, including via telehealth.⁴⁴ Regulatory and licensing authorities should partner with medical organizations and other health care stakeholders to overcome administrative, financial, and legislative barriers to implement telehealth and expand patient access to health care.

Recommendation: State and local governments should develop appropriate licensing structures to support the practice of telehealth across jurisdictions.

Recommendation: CMS should mandate state Medicaid programs to cover electronic consultations between primary care and subspecialty care, with payment to both the primary care and the subspecialists, as is done in Medicare. This asynchronous service is even more essential for pediatric care, given the limited number of pediatric subspecialists and the geographic maldistribution of these pediatric subspecialists. Electronic

⁴⁰ SECTION ON TELEHEALTH CARE, COMMITTEE ON PRACTICE AND AMBULATORY MEDICINE, COMMITTEE ON PEDIATRIC WORKFORCE, Telehealth: Improving Access to and Quality of Pediatric Health Care. *Pediatrics* September 2021; 148 (3): e2021053129. 10.1542/peds.2021-053129

⁴¹ Seizing The Moment For Telehealth Policy And Equity", Health Affairs Blog, September 13, 2021. DOI: 10.1377/hblog20210909.961330

⁴² Woo Baidal JA, Chang J, Hulse E, Turetsky R, Parkinson K, Rausch JC. Zooming toward a telehealth solution for vulnerable children with obesity during coronavirus disease 2019. *Obesity* (Silver Spring). 2020;28(7):1184–1186

⁴³ Houston, R., & Ralls, M. (2022, March 31). *The doctor will hear you now: Audio-only telehealth and the promise of access, equity, and engagement in Medicaid - CHCS blog*. Center for Health Care Strategies. Retrieved April 8, 2022, from <https://www.chcs.org/the-doctor-will-hear-you-now-audio-only-telehealth-and-the-promise-of-access-equity-and-engagement-in-medicaid/>

⁴⁴ Hansen MB, Klatt T. The interstate medical licensure compact: what physicians should know. *S D Med*. 2015;68(2):81pmid:25423771

consultations have been demonstrated to reduce unnecessary visits to subspecialty care and to reduce wait time for subspecialty visits,⁴⁵ both of which are needed in pediatrics.

Recommendation: Increase and financially support ongoing and future research, including demonstration projects, to study the effectiveness of telehealth to address workforce needs, expand patient access to care, improve quality of care, reduce health care costs, and ensure patient/family and pediatric clinician satisfaction.

Recommendation: Design grants that address key barriers that prevent both primary care practices in underserved areas and serving children with complex medical needs and pediatric subspecialists in larger academic centers from implementing subspecialty telehealth care. Such barriers may include technology costs, staff support, equipment maintenance, and technology upgrades, as well as costs associated with lost revenue due to inadequate payment.

Recommendation: Create loan repayment programs for pediatric subspecialty providers that incentivize the provision of telehealth services to rural and underserved areas by including telehealth as a means of reaching rural areas.

Access to Gender-Affirming Care

In the United States, it's estimated that around 150,000 youth identify as transgender and gender diverse (TGD), which is when an individual's gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth.⁴⁶ TGD youth often confront stigma and discrimination, which contribute to feelings of rejection and isolation that can adversely affect physical and emotional well-being. They also lead youth to experience disproportionately high rates of homelessness, physical violence and harassment (at home, at school, and in the community), substance use, and high-risk sexual behaviors. In addition, suicide rates are much higher in TGD youth than their peers. In addition to experiencing these everyday challenges, there continues to be a national coordinated effort to discriminate against this already vulnerable population.

In 2021, more than 250 bills were introduced in state legislatures to discriminate against the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) community, with many focusing specifically on transgender and gender-diverse youth.⁴⁷ Most of these bills are intended to prohibit pediatricians and other physicians from providing gender-affirming care to TGD youth. As a result of these efforts, more than 45,000 of these TGD youth were at risk of losing access to evidence-based, medically necessary health care.

The AAP recommends that transgender and gender-diverse youth (TGD) “have access to comprehensive, gender-affirming, and developmentally appropriate health care that is provided in a safe and inclusive clinical space.”⁴⁸

⁴⁵ Barnett ML, Yee HF Jr, Mehrotra A, Giboney P. Los Angeles Safety-Net Program eConsult System Was Rapidly Adopted And Decreased Wait Times To See Specialists. *Health Aff (Millwood)*. 2017 Mar 1;36(3):492-499. doi: 10.1377/hlthaff.2016.1283. PMID: 28264951.

⁴⁶ Williams Institute. (2021, October 12). *Age of individuals who identify as transgender in the United States*. Retrieved April 5, 2022, from <https://williamsinstitute.law.ucla.edu/publications/age-trans-individuals-us/>

⁴⁷ <https://www.hrc.org/campaigns/the-state-legislative-attack-on-lgbtq-people>

⁴⁸ Rafferty J; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH; COMMITTEE ON ADOLESCENCE; SECTION ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH AND WELLNESS. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. *Pediatrics*. 2018 Oct;142(4):e20182162. doi: 10.1542/peds.2018-2162. Epub 2018 Sep 17. PMID: 30224363.

Recommendation: All state Medicaid agencies and contracted MCOs should provide gender-affirming care for transgender, gender diverse, and nonbinary individuals, including access to mental health services and medical and surgical therapy as and when appropriate.

Special Considerations for Children in Foster Care

Children in foster care have complex health needs because of the adverse childhood experiences they have encountered, such as abuse, neglect, witnessed violence, and parental substance use disorders. Children and young people in foster care have a history of complex trauma and need access to services and support to help them heal and thrive when they enter the system. More than one-quarter of children in foster care have a mental health diagnosis and they are more likely to experience developmental delays and speech/language disorders than their peers.⁴⁹ Fetal alcohol syndrome, a condition in which early diagnosis and therapeutic services are critical, is common among children in foster care, but often not recognized or misdiagnosed.⁵⁰ Children with a history of foster care are 1.5 times more likely to report oral health problems as compared to their counterparts.⁵¹

Title IV-E of the Social Security Act provides federal funding for child welfare assistance for low-income children who have been removed from their homes. Children receiving assistance under Title IV-E are automatically eligible for Medicaid. However, children who are not eligible for Title IV-E services, because, for example, they receive in-home services or have family income above the established eligibility standard, are not automatically eligible for Medicaid, although many are eligible through another pathway.⁵²

Effective Medicaid coverage is vital to ensuring access to care and long-term wellbeing for this vulnerable population. In addition, Medicaid coverage serves as a key resource and assurance for families adopting a child with special needs from foster care, who otherwise might not be able to serve as adoptive parents without comprehensive Medicaid coverage and the EPSDT benefit. Additionally, black children, American Indian/Alaska Native children, and children who identify as LGBTQ+ are disproportionately represented in the foster care population.^{53 54} This overrepresentation makes Medicaid critical for achieving equity: it can either furnish the children with the services that they need, or it can be yet another point of systemic failure for these children.

While there are concerns about continuity of coverage and receipt of timely and appropriate care for all children enrolled in Medicaid, these issues are especially relevant for children involved in the child welfare system. Beneficiaries face an array of different state eligibility policies regarding documentation and prior out-of-state foster care placements. In addition, there may be gaps in needed care if a condition goes unidentified as a child moves between homes or duplication of services because a provider is unaware that a screening or assessment has been conducted.

⁴⁹ Bilaver LA, Havlicek J, Davis MM. Prevalence of Special Health Care Needs Among Foster Youth in a Nationally Representative Survey. *JAMA Pediatr.* 2020;174(7):727–729. doi:10.1001/jamapediatrics.2020.0298

⁵⁰ Ira J. Chasnoff, Anne M. Wells, Lauren King; Misdiagnosis and Missed Diagnoses in Foster and Adopted Children With Prenatal Alcohol Exposure. *Pediatrics* February 2015; 135 (2): 264–270. 10.1542/peds.2014-2171

⁵¹ COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE, *Pediatrician Guidance in Supporting Families of Children Who Are Adopted, Fostered, or in Kinship Care.* *Pediatrics* December 2020; 146 (6): e2020034629. 10.1542/peds.2020-034629

⁵² <https://www.macpac.gov/wp-content/uploads/2015/06/Intersection-of-Medicaid-and-Child-Welfare.pdf>

⁵³ Administration for Children and Families, Children’s Bureau, “Child Welfare Practice to Address Racial Disproportionality and Disparity” (Washington, D.C.: U.S. Department of Health and Human Services, April 2021), available at https://www.childwelfare.gov/pubPDFs/racial_disproportionality.pdf

⁵⁴ Stevens, G. and Shi, L., “Effect of Managed Care on Children’s Relationships with their Primary Care Physicians,” *Archives of Pediatric and Adolescent Medicine* 156, no. 4 (2002), available at <https://jamanetwork.com/journals/jamapediatrics/fullarticle/191765>.

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Improving Access to Care

Recommendation: As a primary source of support for children and youth in foster care, Medicaid plays an important role in ensuring appropriate services are available to support the health and wellbeing of enrollees. To enable children and young people to remain in family and family-like settings to the greatest degree possible, services must be readily available in home and community settings, and not only in inpatient or residential settings. This requires adequate coverage as well as adequate payment rates for service providers.

Recommendation: The care received by children in foster care is often fragmented due to placement changes within the child welfare system or churn in and out of that system. CMS should work to advance policies that promote seamless enrollment into Medicaid for children in foster care that endures while the child remains in the child welfare system, continues for at least one year beyond their placement in foster care or until they attain age 26, allows for care across county and state lines, and involves accessible EMR information with adequate privacy protection.

Ensuring Adequate Payment

Payment can be a significant driver of physician participation in the Medicaid program and, as a result, in how easily children enrolled in Medicaid and CHIP can establish care within a medical home. A well-implemented and adequately funded medical home not only is the best approach to optimize the health of the individual patient, but also can function as the most effective instrument for improving population health. For children with complex medical needs to receive accessible, continuous, comprehensive, and coordinated care from the medical home, payment for services must be timely and adequate.⁵⁵

Medicaid fee schedules and capitated payments to primary care and subspecialty physicians are significantly lower than payments for comparable services from Medicare and private insurance companies. Low Medicaid payment rates, delayed or unpredictable payments, and confusing or burdensome payment policies and paperwork are primary reasons that physicians limit participation in the program, leaving patients facing barriers to access for primary care and subspecialty health care services.⁵⁶ Even at academic medical centers that serve as “safety nets” for uninsured or underinsured patients, reduced access for children enrolled in Medicaid may manifest as significantly longer wait times for subspecialty care.⁵⁷

In a report by the State Health Access Data Assistance Center (SHADAC) to the Medicaid and CHIP Payment and Access Commission (MACPAC), only 70.8% of providers were accepting new Medicaid patients, compared to 85.3% accepting Medicare and 90% accepting private insurance.⁵⁸ Access was worse among certain specialty

providers—only 35.7% of psychiatrists were accepting new Medicaid patients, compared to 62.1% accepting Medicare and 62% accepting private coverage.

Raising Medicaid payment rates to adequate levels, reducing administrative burden to enroll and participate in Medicaid programs, and increasing certainty of payment can increase physician and hospital capacity and improve access for children

A Georgia pediatrician recently closed her solo practice, which saw 70% Medicaid patients, during the height of the COVID-19 pandemic because the business model was “unsustainable.”

A Virginia pediatric practice recently closed their panel to additional Medicaid patients because clinic locations are unable to pay their overhead costs and break even if more than 15% of their payments are from Medicaid.

enrolled in Medicaid.⁵⁹ After adjusting for state demographic characteristics SHADAC found that every 1 percentage point increase in the Medicaid to Medicare fee reimbursement ratio was associated with a 0.78

⁵⁵ Principles of Financing the Medical Home for Children. Jonathan Price, Mary L. Brandt, Mark L. Hudak, COMMITTEE ON CHILD HEALTH FINANCING. *Pediatrics* Jan 2020, 145 (1) e20193451; DOI: 10.1542/peds.2019-3451: <https://pediatrics.aappublications.org/content/145/1/e20193451>

⁵⁶ AAP Survey of Pediatrician Participation in Medicaid, CHIP and VFC. Elk Grove Village, IL: American Academy of Pediatrics; 2012

⁵⁷ Bisgaier J, Polsky D, Rhodes KV. Academic medical centers and equity in specialty care access for children. *Arch Pediatr Adolesc Med.* 2012;166(4):304–310 PMID:22147760

⁵⁸ MACPAC. (2019). *Physician acceptance of new Medicaid Patients*. Retrieved April 5, 2022, from <https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf>

⁵⁹ Medicaid Policy Statement, COMMITTEE ON CHILD HEALTH FINANCING, *Pediatrics* May 2013, 131 (5) e1697-e1706; DOI: 10.1542/peds.2013-0419

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percentage point increase in provider acceptance.⁶⁰ Another study demonstrated that the short-term increase in Medicaid payments for primary care services in 2013-14 resulted in greater physician participation in the Medicaid program.⁶¹

Many pediatric practices, institutions, and organizations have encountered barriers to appropriate payment for care and corresponding barriers to access care for their patients. These barriers exist irrespective of geography, political leadership or will.

In total, the administrative burden and cost associated with attempting to recoup adequate payment for services rendered, coupled with extreme variations between state policies, make it difficult for our members to ensure children can receive timely care. This impedes the ability of our members and other clinicians to accept more Medicaid patients, particularly among small practices, and threatens the viability of practices serving areas with a higher proportion of patients enrolled in Medicaid coverage.

Considering that the Medicaid program disproportionately covers the health care services of marginalized populations,⁶² **inadequate provider payment contributes to structural racism and other inequities in health care. To fully realize the Administration's bold vision to eliminate health disparities and achieve health equity, it is imperative to provide adequate payment for Medicaid providers to support Medicaid enrollees' equitable access to high-quality care.**⁶³

Establishing Minimum Standards for Medicaid Payment

Patients across the country have faced barriers to timely access to necessary care due to inadequate Medicaid payment rates. In fact, several AAP state chapters have been engaged in state policy related to the equal access provision under Title XIX of the Social Security Act. The Florida Chapter of AAP sued the state Medicaid agency over insufficient payment rates in 2005, which resulted in a 2016 settlement that led to improved payment and access to care.⁶⁴ The Michigan Chapter of AAP was a co-plaintiff in a similar suit that was settled in 2007, which resulted in the state raising Medicaid payment for EPSDT related codes by 47%.⁶⁵

Legal action at the state level does not guarantee a permanent solution. In 2002 the Oklahoma Chapter of AAP sued the state Medicaid agency over insufficient payment rates. While the plaintiff's affirmative ruling was eventually overturned on appeal, subsequent legislation created a physician's advisory committee and led the state to raise Medicaid payments rates to be 100% of Medicare.⁶⁶ Unfortunately, even the substantial efforts involved in litigation, legislation, and technical advice has not fully ensured adequate payment to support equal access; rates were cut again when the state economy took a downturn. Each year, pediatricians and other primary care physicians in Oklahoma reargue the same points to maintain physician participation in Medicaid, especially in the rural areas of the state and the poorer areas of cities.

We share these examples to illustrate that many pediatric practices, institutions, and organizations have encountered barriers to appropriate payment for care delivered to patients and corresponding barriers to

⁶⁰ <https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf>

⁶¹ Tang, S. S., Hudak, M. L., Cooley, D. M., Shenkin, B. N., & Racine, A. D. (2017). Increased Medicaid Payment and Participation by Office-Based Primary Care Pediatricians. *Pediatrics*, 141(1). doi:10.1542/peds.2017-2570

⁶² Michener, J. (2022, January 20). *A racial equity framework for Assessing Health Policy*. Commonwealth Fund. Retrieved April 5, 2022, from <https://www.commonwealthfund.org/publications/issue-briefs/2022/jan/racial-equity-framework-assessing-health-policy>

⁶³ Allen, H. L. (2022, February 25). Eliminating health disparities will require looking at how much and how Medicaid pays participating providers. Milbank Memorial Fund. Retrieved April 4, 2022, from <https://www.milbank.org/quarterly/opinions/eliminating-health-disparities-will-require-looking-at-how-much-and-how-medicaid-pays-participating-providers/>

⁶⁴ <https://fcaap.org/wp-content/uploads/2016/04/2016-04-05-Settlement-Agreement-Reached-in-Florida-Medicaid-Case-FINAL.pdf>

⁶⁵ <https://www.pubintl.org/cases-and-projects/michigan-medicaid-westside-mothers-v-olsezewski/>

⁶⁶ <https://www.pubintl.org/cases-and-projects/okaap-v-fogarty/>

access for their patients irrespective of geography or political leadership or will. **The experiences from AAP chapters highlight the need for CMS to take a standardized approach to enforcing the equal access provision; a national solution is called for.**

Recommendation: Increase base Medicaid physician payment rates to 100% or higher with the Medicare Physician Fee Schedule for all CPT codes, including pediatric-specific CPT codes (eg, well-child checkup, anticipatory guidance, immunization counseling, and developmental assessment). In the case of services without a Medicare payment, a rate should be calculated by applying Medicare fee schedule methodology to the published values of work, practice expense, and professional liability insurance relative value units adjusted for the geographic region, or through comparison with typical payment rates among commercial health plans for the same services. Establishing a minimum payment for services that are common in pediatrics but not covered by Medicare is essential.

Recommendation: Establish a methodology to provide additional fair payment to a practice that recognizes the extra resources that might be invested on behalf of its Medicaid patients to promote wellbeing (eg, to pay for more vigorous outreach to increase participation rates with well-child checkups) and to provide care coordination of infants, children, and youth with complicated physical and/or mental health illnesses (e.g. to pay for care coordinators, behavioral health integration, social workers, extended office hours, home visitations, dental care, durable medical equipment, etc).

Recommendation: Reward practices that meet or exceed AAP-approved predefined quality and performance metrics (such as AAP's Bright Futures Guidelines) with incentive payments.

Recommendation: Ensure appropriate payment for telehealth encounters as well as asynchronous care (eg, secure email and text) to facilitate optimal function of the medical home and to improve patient and family satisfaction. These interactions may occur between the patient and family and the medical home or between the medical home and specialty care providers. This care yields the greatest value when it is delivered within the medical neighborhood because it facilitates more timely access to care, promotes continuity and thereby enhances quality, and avoids inappropriate use of urgent care or emergency departments. Payers should recognize this greater value by incentivizing patients and families to coordinate care through the medical home.

Recommendation: Establish a mechanism for rapid adjustment of fee-for-service or capitated payments to providers for recommended new vaccines and other new technologies that rapidly achieve translation from clinical trials to standard clinical practice.

Recommendation: Vaccines, including the influenza vaccine, provided by the Vaccines for Children program and the Centers for Disease Control and Prevention are properly viewed as an important type of "in-kind" financing. As such, they should be supplied in a way that is as timely and adequate as monetary financing. In particular, release of annual influenza vaccine to accessible medical homes should be prioritized. Delayed delivery relative to other venues, such as pharmacies and retail-based clinics, results in lost opportunities for families to engage the medical home and potentially benefit from other interventions or health education at the same time.

Recommendation: Pay for the administration of immunizations, including for the counseling associated with administration of multiantigen vaccines, as well as for standalone vaccine counseling. Payments for vaccines should be 125% or higher of the current Centers for Disease Control and Prevention private sector price list and payment for immunization administration should be 100% or higher of the Medicare rate for each vaccine administration CPT code. As of the date of this response, new codes for standalone vaccine counseling are under development and after publication, Medicaid should pay 100% or higher of the Medicare rate for such codes.

Assessing the Sufficiency of Rates

The AAP recommends that CMS assess the adequacy of state payment rates in comparison to Medicare rates for the same services, where applicable. The AAP respectfully urges CMS to also require states to acquire concurrent analogous data about access metrics for pediatric populations insured by non-Medicaid payers, particularly by commercial plans offered through the health insurance marketplaces and by large employers. CMS should require an in-depth analysis of impact on access metrics as well as an analysis over time for any state that implements payment rates lower than Medicare or commercial payers and should take compliance actions to increase payment to adequate rates if access is harmed.

Unique Value of Pediatric Care

The Center for Medicare & Medicaid Innovation (CMMI) has a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through improvement to our health care system. Unfortunately, the narrow focus of these demonstration programs on short-term quality improvement and cost savings has largely excluded models to improve payment and delivery of pediatric care, where the timeline for impact is outside of the budget window and the measurable effects spread beyond direct health care costs to school readiness, educational attainment, workforce participation, and safety net program use.

For example, early developmental screening, including socio-emotional screening with appropriate follow up and intervention, can mitigate the development of adolescent mental health and substance abuse issues, ameliorating both the harm and the cost of these issues. High rates of immunization among children save substantial dollars each year, and models should continue to promote and support high rates of immunization. Addressing the needs of children in the context of their family and community settings improves the efficacy of services and health outcomes of children and families, as well as making important services including preventive health services more accessible for children. This requires strategies such as providing early child development support in primary care pediatric practices, implementing two-generation strategies like maternal depression screenings, and integrating school-based health and other community resources into the pediatric medical neighborhood. Having shared accountability for a population of children and making efforts to coordinate care, to reduce duplication, and to provide timely and effective care for children will lead to healthier adults. Consequently, the “value equation” of children’s health care is more complex than that of adults and should be considered as CMS considers payment policies in Medicaid and CHIP.

Moreover, children and pregnant individuals continue to face significant challenges outside of the health care setting that prevent them from achieving optimal health. For example, one in five US children lives in poverty. This is of deep concern, not only because poverty jeopardizes the ability of families to meet essential needs, but also because poverty creates familial stress, makes adverse childhood experiences (ACEs) more likely, and can marginalize or exclude children from healthy growth trajectories and readiness to learn before entering kindergarten. The research on social determinants of health, resiliency, ACEs, and toxic stress all makes clear that healthy child development is dependent upon safety, stability, security, and nurturing in the child’s home environment.⁶⁷ As CMS explores how Medicaid and CHIP can advance broader health system reform, the agency should consider how integrated health systems could better address ACEs, resulting in decreased chronic illness burden, including mental health issues, as children reach adulthood. This includes coverage of trauma-informed care services, including all necessary screenings, diagnosis, office-based management,

⁶⁷ COUNCIL ON COMMUNITY PEDIATRICS, Poverty and Child Health in the United States. *Pediatrics* April 2016; 137 (4): e20160339. 10.1542/peds.2016-0339

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counseling, case management, community collaboration, and home visiting.⁶⁸ Investing in these services for children mitigate negative health outcomes and the significant economic burden of ACEs, thereby leading to long-term savings.⁶⁹

Thus, a comprehensive understanding of what is unique about pediatrics must be woven into the design of a new framework that defines and measures access in Medicaid and CHIP, including the implementation, the goals and measurement of outcomes, as well as the timeframe to expect return on investment or cost-savings. This framework should also help develop or support accountable resources in communities such as programs involving social services that meet needs relating to housing and food security, literacy, mental health, and others. In short, an ideal access framework should support seamless coordination between medical and “non-medical” resources.

⁶⁸ THE COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE, COUNCIL ON COMMUNITY PEDIATRICS, COUNCIL ON CHILD ABUSE AND NEGLECT, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, Trauma-Informed Care. *Pediatrics* August 2021; 148 (2): e2021052580. 10.1542/peds.2021-052580

⁶⁹ Miller, T. R., Waehrer, G. M., Oh, D. L., Purewal Boparai, S., Ohlsson Walker, S., Silverio Marques, S., & Burke Harris, N. (2020). Adult health burden and costs in California during 2013 associated with prior adverse childhood experiences. *PLOS ONE*, 15(1). <https://doi.org/10.1371/journal.pone.0228019>

Reducing Administrative Burden

When we asked our members to identify barriers that impede children enrolled in Medicaid and CHIP from accessing the care that they need, we found that administrative burden was the most common response. Overall, our members expressed frustration that administrative processes can oftentimes be long, confusing, and difficult, leading to vast inefficiencies and even life-threatening delays in care. We were told repeatedly that the coordination of care is time consuming, cumbersome, and oftentimes impossible due to denied claims.

Prior Authorization

Prior authorization (PA) was identified as the most onerous issue for our members as it relates to children enrolled in Medicaid and CHIP. This includes duplicative requirements for clinical information exchange, burdensome paperwork requirements to refer the patient to another provider, refusal of out-of-state care services necessary for children with complex medical needs, and unnecessary reauthorization intervals that are impractical or harmful.

From a pediatrician in Texas:

“Variations in prior authorizations for pharmaceuticals that are on our Medicaid preferred drug list drive me up the wall. For instance, a medication to treat a child with ADHD is not allowed to be prescribed in a primary care setting for young children without input from a child and adolescent psychiatrist. Currently, the waitlist for a child and adolescent psychiatrist in our area is 9 months. I have done my due diligence by becoming an expert in this area because of our workforce shortage, but an arcane prior authorization requirement by the state limits me from providing best practice clinical care.”

While the prior authorization process itself is both unclear and arduous for patients and providers, it also can create life-threatening delays in care. The delay of waiting for prior authorization before a child can see an appropriate specialist or waiting for a successful appeal of an original decision, can mean the difference between ameliorating a child’s condition or exacerbating it. Our members also report problems communicating with Medicaid MCOs when families are seeking second or third opinions for rare conditions. The MCOs often disagree with the determination that the patient must go out of network to get quality care, and sometimes try to refer pediatric patients to adult subspecialists because they are in network.

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In an attempt to identify barriers to medication access and affordability in pediatric, adolescent and young adult oncology patients, a survey of pediatric oncology investigators at all 38 NCI Community Oncology Research Program (NCORP) sites within the Children's Oncology Group (COG) was completed.⁷⁰ The results were disheartening: the majority of respondents cited prior authorization as a serious barrier to appropriate care, including as a cause of poor health outcomes.

A separate, single institution study found that 2.5% of outpatient pediatric hematology and oncology clinic visits triggered a PA request. This translated to one medication PA per day and 46 minutes of provider time consumed per request.⁷¹ The authors found that 98.5% of the PA requests were ultimately approved. Thus, they reasoned that the PA process in pediatric oncology was not

necessary to ensure that “the right patient gets the right care at the right time,” the stated goal of the PA process. Further, there is likely a significant opportunity cost imposed on the healthcare system given the considerable time spent by healthcare providers on the PA process. In a post hoc analysis of this experience, when the data were limited to oncology patients newly diagnosed within the study period who received any chemotherapy, they found that 61% required at least one medication PA. The authors concluded that the medication PA process represented an opportunity to improve patient care while reducing wasteful spending by encouraging payers and providers to collaborate on developing mutually agreed upon sources that define medical necessity.

Moreover, there is no reason for pharmacy benefit managers to deny coverage for appropriate medications. Payers should not use arbitrary step-based medication approval practices or force changes to a patient's stable and effective medication plans because of cost-based formulary changes. Formulary changes mid-year that are based solely on medication costs end up requiring children who are well-managed on their current medication to switch medications and go through a new adjustment period. This is especially concerning in the treatment of children and adolescents with ADHD, who frequently require many months of treatment optimization after formulary changes.

The AAP most recently expressed its concerns to CMS about administrative burden in response to the Patients Over Paperwork RFI in 2019.⁷² Some recommendations specifically related to prior authorization are reiterated below.

Recommendation: All industry stakeholders (eg, private payers, public payers, and vendors) should standardize and automate prior authorization processes and requirements across the healthcare system in

More than 60% of pediatric oncology investigators cited prior authorizations as reasons for delays to their patients' receipt of chemotherapy and supportive care medications as prescribed. Half of all respondents felt that prior authorization-induced delays in receiving supportive care had negative clinical consequences.

⁷⁰ Kelly, Michael J. MD, MPH, MS; Sung, Lillian MD, PhD; Dickens, David S. MD, FAAP. Barriers to Medication Access in Pediatric Oncology in the United States, *Journal of Pediatric Hematology/Oncology*: May 2019 - Volume 41 - Issue 4 - p 286-288

⁷¹ David Dickens and Brad H. Pollock, “Medication Prior Authorization in Pediatric Hematology and Oncology,” *Pediatric Blood & Cancer*, 64; DOI:10.1002/pbc.26339.

⁷² Full comments can be found at:

<https://downloads.aap.org/DOFA/AAP%20Comments%20on%20CMS%20Reducing%20Admin%20Burden%20RFI%20Final%2008.12.2019.pdf>

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order to minimize restrictions that prohibit timely access to medically necessary health care services. Timely mechanisms for prior authorizations should also be established.

Recommendation: Prior authorization of medications that are being used on a chronic basis should be eliminated. The Secretary, in consultation with pediatricians, could establish a list of mutually agreed upon, medically necessary therapeutic and supportive care medications that would not require prior authorization.

Recommendation: Access to specialty services can be expedited by creating a “presumptive authorization” category (eg, no preauthorization needed for diagnoses including but not limited to hernia, strabismus, appendicitis, and diabetes).

Recommendation: Eliminate the need for prior authorization of emergency care and require state Medicaid services be covered after appropriately administered out-of-state emergent care.

Recommendation: In conjunction with states, create a registry of pediatric providers for certain disease conditions or therapists who specialize in caring for medically complex children to eliminate the need for prior authorization.

Other Administrative Burdens

In addition to prior authorization, our members identified several other substantial administrative burdens impacting their ability and willingness to participate in Medicaid. One theme that emerged was the lack of uniformity regarding paperwork and approval processes, in addition to varying levels of state enforcement of MCO compliance with federal rules and regulations.

Federal regulations require state Medicaid agencies that contract with Medicaid MCOs to post certain information on their websites (or ensure that the information is posted on the websites of the MCOs). However, a recent 13-state scan of Medicaid agency websites found that most fell far short of including basic information about MCO enrollment and performance for children and pregnant individuals. No state posted information on receipt of EPSDT services (other than dental care) by children enrolled in each MCO. And none of the 13 states posted enrollment, EPSDT, or child and maternal health quality data disaggregated by race and ethnicity.⁷³

Children are at particular risk when states and plans fail to meet the bar set by federal managed care regulations because in nearly all the states that contract with MCOs (35 of 39), at least three quarters of all children covered by Medicaid are enrolled in MCOs. State Medicaid agencies that are responsible for contracting with and monitoring the performance of the MCOs are often under-resourced relative to the task at hand. With such limited resources, state agencies’ focus on the possible savings from managing the care of high-cost populations means that children’s primary and preventive care often takes the back seat in both MCO contracting and oversight.⁷⁴

This lack of oversight—coupled with a lack of uniformity among Medicaid managed care plans—creates an undue burden on pediatric practices. Pediatricians want to focus their time and practice resources on caring for patients, not addressing managed care concerns.

⁷³ Corcoran, A., Hurler, E., Schneider, A., Buschmann, J., Clark, M., & Osorio, A. (2021, September 9). *Transparency in Medicaid managed care: Findings from a 13-state scan*. Center For Children and Families. Retrieved April 4, 2022, from <https://ccf.georgetown.edu/2021/09/09/transparency-in-medicicaid-managed-care-findings-from-a-13-state-scan/>

⁷⁴ Guyer, J., Boozang, P., and Toups, M., “Moving to the Vanguard on Pediatric Care: Recommendations for the MassHealth 1115 Waiver Renewal” (Washington DC: Manatt Health, November 2020), available at <https://www.manatt.com/insights/white-papers/2020/moving-to-thevanguard-on-pediatric-care-recommend>.

One pervasive administrative complexity that burdens our members is related to MCO prospective attribution. When a patient enrolls in Medicaid, oftentimes they do not select a specific MCO or primary care provider. While many states auto-assign patients to a plan or provider, the current selection process is arbitrary, and many barriers exist when trying to switch between MCOs. Some of our members have been automatically assigned patients who live 5 hours away or who are over the age of 26. In many circumstances, coverage churn

From a pediatrician in North Carolina: “When we transitioned to managed care in 2021, enrollees were given the opportunity to choose a plan but many children and families were auto-assigned. Unfortunately, many of my patients were auto-assigned to a plan that did not contract with the major hospital in our region of the state. As a result, children could be seen in the emergency room but could not access hospital-based care otherwise, including referrals to subspecialists and other routine hospital care.”

leads to existing patients being automatically assigned to an MCO that does not consider their pediatrician in-network, leading to discontinuities in care or lack of payment. It is essential that CMS enforce rules and regulations to improve the process and oversight of patient attribution, including improving algorithms to better assign patients by geography/age, developing easier methods for patients to switch Medicaid plans, and paying providers even when they are considered “out of network” for at least 1 visit or through an illness episode. To best support team-based care and the pediatric medical home, assignments should also be connected to a specific tax ID, not to a specific clinician.

In total, ongoing issues with Medicaid managed care are a disincentive for pediatricians to

participate in the Medicaid program; CMS has the opportunity to make meaningful changes to alleviate these burdens. The AAP Policy Statement, “Guiding Principles for Managed Care Arrangements for the Health Care of Newborns, Infants, Children, Adolescents, and Young Adults,” lays out key principles for policymakers to consider when designing and implementing managed care programs to maximize the positive potential of managed care for pediatrics.⁷⁵ We encourage CMS to consider all the recommendations outlined in the policy statement, and we highlight several key recommendations below:

Recommendation: All payers and managed care plans should share clinical and financial data along the continuum of care to allow for assessment of access, quality, and cost of care. Managed care plans using pediatric comparative effectiveness and patient-centered outcomes research studies for coverage determinations need to make all research public and available for comment by organized medicine and specialty societies. For pediatric comparative effectiveness research, pediatricians and pediatric specialists must be part of the review.

Recommendation: All payers and managed care plans need to make transparent all policies and procedures regarding coverage and payment determinations, including fee schedules and claims edits. The AAP urges that

⁷⁵ Guiding Principles for Managed Care Arrangements for the Health Care of Newborns, Infants, Children, Adolescents, and Young Adults. COMMITTEE ON CHILD HEALTH FINANCING. Pediatrics Nov 2013, 132 (5) e1452-e1462; DOI: 10.1542/peds.2013-2655: <https://pediatrics.aappublications.org/content/132/5/e1452>

AAP Comments: Access to Care in Medicaid and CHIP
Reducing Administrative Burden

any changes affecting payment to the pediatrician be provided in writing and in advance to provide timely notification and allow time for review/appeal/negotiation by the pediatrician.

Recommendation: Medicaid managed care plans must be required to determine payment based on the principles outlined the AAP's Medicaid Policy Statement so that pediatric providers and patient-centered medical home (PCMH) programs are appropriately compensated.⁷⁶

Recommendation: Paperwork in support of claims must not be unduly burdensome and clean claims must be paid within 30 to 45 days of submission, or whenever the state requires.

Recommendation: Streamline the credentialing process by Medicaid and MCOs, including for providers seeking interstate credentials.

Recommendation: Expand telephone and internet access to enable timely prior authorization of care and appropriate processing of appeals, including 24/7 daily access and holiday access.

Recommendation: Payers using fee-for-service payments should consistently adhere to CPT definitions of services. Pediatricians waste administrative resources encoding the same service differently for different payers. Resultant errors in billing can reduce revenue. In addition, variant coding enfeebles a practice's ability to conduct internal analyses of its services.

Recommendation: For Medicaid programs to be responsive to the needs of both patients and providers, it is essential that the programs be subject to either competition among at least 2 and when possible 3 MCOs in a region or to regulation that is regularly updated to reflect continuing input from patients and providers.

Recommendation: State Medicaid agencies should maintain a child health dashboard that contains MCO specific performance data and is easily accessible. At a minimum, this performance data should include EPSDT screenings and treatment, Child Core Set metrics, and all information already required to be posted by federal regulations. The dashboard should include a data hub with links to relevant structural information about each MCO with which the state contracts.

Recommendation: CMS should monitor and enforce state Medicaid agency compliance with the minimum transparency requirements in its regulations. This would help reset state and MCO expectations about transparency.

Recommendation: CMS should add a child health dashboard as a measure to the State Administrative Accountability pillar of its Medicaid & CHIP Scorecard. The child health dashboard should include performance information on EPSDT screenings and treatment and Child Core Set metrics specific to each MCO in each state.

Recommendation: Ensure clinical information is readily shared across electronic health records (such as bidirectional immunization registries), including when care is taking place across state lines, by promoting health record interoperability.

⁷⁶ Medicaid Policy Statement. COMMITTEE ON CHILD HEALTH FINANCING. Pediatrics May 2013, 131 (5) e1697-e1706; DOI: <https://doi.org/10.1542/peds.2013-0419>; <https://pediatrics.aappublications.org/content/131/5/e1697>

Data Collection and Monitoring

It is critical that stronger pediatric-specific standards are established in Medicaid and CHIP. Children are a unique population, and their providers are different than those for adults. Pediatric providers have specific training, experience and expertise that equips them to meet the physical, mental, and developmental health needs of all children, including those who have serious, complex, or chronic health conditions or special health care needs.

Pediatric-specific standards would allow for an assessment of provider networks to ensure the inclusion of trained and experienced in-network pediatric providers capable and available to provide appropriate care—from well-baby care to care for children and youth with special health care needs, including those with serious, chronic, or complex conditions. Inadequate and limited networks that do not include this range of providers may result in care delays with poor health outcomes that ultimately cost insurers and enrollees more.

To meet these goals and ensure that children can get timely and age-appropriate care, network adequacy standards must be developed for the full range of board-certified pediatric specialties and subspecialties.⁷⁷ The standards also must ensure that networks include one or more appropriate pediatric hospital providers and reflect the fact that teams of pediatric specialists are typically concentrated near children's hospitals, underscoring the regional nature of pediatric specialty care for high-acuity and/or complex conditions.

Monitoring State Performance Against Minimum Standards

CMS developed regulations to enforce Medicaid's "Equal Access" provision, effective April 2016, that require states to develop and submit to CMS an Access Monitoring Review Plan (AMRP) that specifies the data elements the state will use in assessing beneficiary access to care in a Medicaid fee-for-service setting. While the AAP supported the incremental steps advanced by these regulations, we remain concerned that specific data requirements and standards for states were not included, and that the regulations lacked clear enforcement mechanisms. Further, the AAP remains disappointed that CMS did not enforce the submission of updated AMRPs from states in 2019, leaving stakeholders and the broader public in the dark about whether and how states are taking any actions to improve the access challenges they identified in their initial 2016 reports.

In general, the Academy favors the creation of a standardized national core set of measurements for access with additional measures developed by states and programs as may be needed, based on their unique characteristics. A national core set is crucial to enable comparison of metrics across geographic locations and across programs in the same location, to assess the impact of innovations and models such as those implemented in 1115 waivers, and to determine those states and/or programs that most need targeted intervention to improve access. Differences in geography, population, and density and distribution of health care providers and facilities can independently affect access metrics. State Medicaid agencies should participate in constructing an initial set of access metrics, **but the Academy recommends that CMS determine a national floor for proposed thresholds.**

⁷⁷ Including, but not limited to, access to Pediatric Allergy/Immunology, Hospital Medicine, Dermatology, Neurology, Surgery, Adolescent Health, Child Abuse and Neglect, Hospice and Palliative Care, Transport, Urgent Care, Otolaryngology, Developmental-Behavioral Pediatrics, Cardiology, Critical Care, Emergency Medicine, Endocrinology, Gastroenterology, Hematology-Oncology, Infectious Diseases, Nephrology, Pulmonology, Rheumatology, Obesity, Sports Medicine, Plastic Surgery, Neurological Surgery, Genetics, Ophthalmology, Anesthesiology, Orthopedics, Radiology, and Urology.

Access metrics will likely be compiled and monitored by state Medicaid agencies. Nevertheless, the Academy firmly believes that these data should also be transmitted in real time to CMS and other federal bodies (e.g., MACPAC, Congressional Committees, the Government Accountability Office) capable of independent oversight and analysis. AAP recommends that CMS exercise its statutory authority to require Medicaid MCOs to report all core and supplemental access metrics. As noted above, reporting of Medicaid claims data, other data, and access metrics data to the state Medicaid agency by Medicaid MCOs may not be uniform across all states. In addition, metrics of access by state Medicaid or Medicaid MCO plans should be openly available and transparent to the public and researchers in the same way as are Medicare data.

As previously noted, the *Armstrong* decision concluded that it is the responsibility of the federal government to enforce the equal access provision found in Section 1902(a)(30)(A). Therefore, it is CMS' statutory obligation to assess whether children have access commensurate to others in their geographic area. In addition to a standardized national core set that allows for state-to-state comparisons, the Academy urges CMS to review and approve (or disapprove) access to care thresholds suggested by state Medicaid agencies that will consider the specific context of the state. These thresholds must be informed by understanding the analogous access metrics in the commercially insured pediatric population in the state or geographic region of comparison. The AAP believes that in many areas, access to needed health care services by children and youth enrolled in Medicaid and CHIP already falls significantly below access for children and youth insured by private payers.

CMS should also closely monitor access to care as a means of tracking compliance with federal minimum standards. Specifically, all states should be required to track the percentage of enrollees who have access to a primary care physician and who have access to needed pediatric subspecialists. **Rather than a sole reliance on time and distance to assess potential access, we recommend a comprehensive, multi-faceted set of quantitative standards specific to pediatrics.** Those measurable factors include, but are not limited to, wait times; enrollee ratios by specialty; geographic accessibility; geographic population dispersion; and minimum appropriate providers available to meet the needs of children with special health care needs, including those with limited English proficiency, and diverse cultural and ethnic backgrounds. It is vital that CMS track access issues, including unsuccessful referrals and unsuccessful attempts to provide appropriate medications due to formulary restrictions.

From a pediatrician in South Carolina:
“I have been trying to arrange psychiatric care for a child enrolled in Medicaid for months. Despite hours of attempts/phone calls/emails from me and my practice care coordinator to find an appropriate specialist, the child has still been unable to access the needed care.”

CMS should also ensure access measures are updated regularly and adequately reflect provider availability. For example, a specialist that travels one day per month to an alternative location should not be counted as a full-time equivalent at both locations. Rolls of specialists must be updated at least annually and not include physicians who are deceased, retired, or moved out of state.

Beyond measures of potential access, CMS should assess utilization of care to identify disparities and barriers to access to care. Medicaid-insured children and youth require comprehensive access to primary care medical homes, specialty/subspecialty physician services, hospital emergency rooms, children's hospitals, pediatric dentists, outpatient/inpatient mental and behavioral health, home health services, durable medical equipment, and pharmacy. Access to all of these health care services is routinely tracked by most state Medicaid and Medicaid

MCO plan by analysis of claims data. In general, the medical literature confirms that the social determinants of health affect Medicaid-insured children and youth more adversely than those insured by commercial payers. Hence, it can be anticipated that utilization in many of these categories of end resort (ED visits, hospital admissions) that reflect a greater acuity or complexity of medical need will be higher than in the general pediatric population. Utilization data must be interpreted after appropriate pediatric-specific risk adjustment. Any finding of lower utilization in certain categories (pediatric dentists, primary care medical home, and pediatric specialty/subspecialty physician) raises concerns about diminished access to these critical services due to network limitations, transportation barriers, or other social impediments

Once thresholds metrics are determined, the Academy recommends that CMS issue compliance actions to states and plans that do not meet these thresholds and facilitate appeals processes for beneficiaries and providers who raise access issues. CMS should also take steps within its authority to address those root causes of access disparity that CMS can ameliorate under its authority.

Leveraging T-MSIS Data to Monitor Access

Most of the measurements referenced in Appendix A can be made using claims data owned by the Medicaid plan. Quantification of pediatric primary care, medical subspecialty, and surgical specialty providers is crucial to assess access and several nuances merit amplification. Using credentialing information, state Medicaid and Medicaid MCOs plans may or may not be able to list in-network physicians who have reported that they are board-certified in pediatrics or subboard-certified in a pediatric medical subspecialty or pediatric surgical specialty. However, physician self-attestation is the least reliable method of ascertainment of specialty certification. The Academy recommends that Medicaid plans work with pediatric and surgical specialty and subspecialty boards (e.g., American Board of Pediatrics, American Board of Surgery, American Board of Medical Specialists) to obtain rosters of board- and sub-board-certified physicians.

State Medicaid and Medicaid MCO plans can cross reference unique identifiers contained in these lists (e.g., NPI numbers; specific training information) against their internal credentialing data to determine the number of boarded pediatricians and sub-boarded pediatric medical subspecialty and pediatric surgical specialty physicians within their networks. Current pediatric expertise of every physician identified through this process should additionally be vetted through simple inspection of the distribution of ages of Medicaid beneficiaries in that physician's recent claims data. For instance, a physician certified in pediatric and adult cardiology who has not seen a Medicaid patient less than 16 years old in the past year cannot be counted as an access point for pediatric patients in need of cardiology care. In certain areas of the country, a significant percentage of a pediatric specialist's effort may be devoted to primary care. In that case, that provider's available FTE effort to provide subspecialty care is less than 1 and can be calculated from the ratio of codes billed under specialty taxonomy to primary care taxonomy in claims data. Finally, many pediatric physicians work part-time. Claims data over the past 6-12 months should be inspected for each provider and compared to his or her peers to assign an FTE equivalent to every provider to determine the depth of the provider network (i.e., the functional number of pediatric providers by specialty and subspecialty).

There will be differences in metrics among state and MCO plans due solely to differences in geographic distribution of patients and providers. Differences in distribution of Medicaid- and non-Medicaid-insured children and youth in a defined geographic region may also contribute to differences in access metrics between the two groups.

Recommendation: Managed care plans have developed a broad and diverse clinical database related to utilization of services. As a result, managed care plans should participate in patient registry development and thoughtful quality outcomes research based on a set of existing quality measures that promote child health

and can be used for value-based payment.⁷⁸ Health care payers are in a unique position to collaborate with the pediatric community to develop and implement changes that systematically advance children's health care. Managed care plans should actively engage pediatricians in both community and hospital settings in outcomes research and quality improvement efforts, such as developing patient registries or working toward a single national pediatric database like the Medicare Part B database. Quality management should include appropriate peer review, with pediatric cases reviewed by pediatricians.

Recommendation: Managed care plans are encouraged to share clinical and financial data along the continuum of care to allow for assessment of access, quality, and cost of care. Managed care plans using pediatric comparative effectiveness and patient-centered outcomes research studies for coverage determinations need to make all research public and available for comment by organized medicine and specialty societies. For pediatric comparative effectiveness research, pediatricians, and pediatric specialists must be part of the review.

Recommendation: Plans should promote recommended preventive services, early identification, and treatment of health problems in children by providing benefits coverage and appropriate payment to physicians for all recommended screenings and assessments. These measures should be included in incentive programs to physicians as part of pay-for-performance programs.

Recommendation: Plans should report a uniform standard set of encounter data in compliance with the Health Insurance Portability and Accountability Act.

Recommendation: States should publish uniform data for health plans that offer consumers and purchasers the opportunity to evaluate and compare performance, including relevant financial information, among competing plans. The measures reported by states on a managed care plan's performance should emphasize quality standards, such as access to care, patient satisfaction, and health outcomes.

Monitoring and Improving Pediatric Access to Home and Community-Based Services

Children with Medicaid are entitled to home health care services, including private duty nursing and personal care services, through EPSDT. However, their receipt of sufficient quality services is highly variable. Because long-term services and supports (LTSS) are infrequently covered by private health insurance, state Medicaid programs may provide some services through wraparound coverage for families not categorically eligible for Medicaid through Home and Community-Based Services (HCBS) waivers, Section 1115 waivers, and other state-specific mechanisms. However, even in states where such services are available, there are often gaps in covered populations and children are placed on waiting lists despite the requirements of the Americans with Disabilities Act and the *Olmstead v LC* Supreme Court decision.

Differing HCBS benefit and eligibility standards for children at the state and health plan levels confuse pediatricians and families alike. No national standards exist related to the number of HCBS hours that should be approved based on medical or psychosocial complexity. Additionally, while children are guaranteed HCBS under Medicaid's EPSDT benefit, state accountability is currently limited to individual lawsuits at the state level, meaning that children's access to care faces inappropriate variation across states. As CMS considers ways to improve the availability and quality of HCBS for the Medicaid population, it should start with basic oversight mechanisms to evaluate the current state of access to pediatric home care, including utilization of services, pediatric waiting lists, whether HCBS providers have pediatric-specific training, and current racial and ethnic disparities that lead to inequities.

⁷⁸ <https://publications.aap.org/aapnews/news/6941>

AAP Comments: Access to Care in Medicaid and CHIP Data Collection and Monitoring

A substantial challenge in delivering HCBS to children and youth with special health care needs is the limited workforce of home health care providers, and the even further shortage of home health care providers with pediatric training. Of note, geographic disparities exacerbate this challenge as certain areas of the country, including rural areas, are particularly under-resourced with fewer home health care providers available. Low reimbursement rates for pediatric home care, compounded with low wages for home care workers overall, contribute significantly to this existing workforce shortage. Ensuring that children have access to the necessary services and benefits outlined above is impossible without a sufficient, appropriately trained, adequately compensated workforce of pediatric home and community-based care providers. Children enrolled in Medicaid may technically be eligible for an extensive list of services, but due to the limited workforce, families often struggle to find providers for them at home. This often leads to either prolonged hospitalizations and/or overburdened family caregivers. CMS must work to address these workforce gaps in tandem with other stakeholders through a combination of workforce incentives, payment reforms, network adequacy oversight, integration of home health within child-focused health care systems, expanding the use of telehealth for pediatric home care, and aligning pediatric home care with adult home care.⁷⁹

Receiving sufficient HCBS that help a child acquire, improve, or retain a skill or level of functioning can mean the difference between talking and not talking, walking and not walking, or needing special education and being able to join a regular classroom. A successful framework for HCBS will also acknowledge that most adolescents who rely on HCBS will transition into young adults who continue to need these services. Similarly, a successful approach will incorporate the expertise of pediatricians, pediatric HCBS providers, and family caregivers of children and youth who rely on HCBS. The Academy recently outlined legislative proposals to transform pediatric HCBS in a letter to Congress, including expanding benefits and eligibility and strengthening the pediatric HCBS workforce.⁸⁰

CMS is requesting specific feedback on ways to promote a more standardized effort to monitor access in LTSS, including HCBS. The scant measures available to evaluate the quality of home health care services are limited to adult populations. The CMS Home Health Compare program has no pediatric-specific items,⁸¹ and national surveys on home health care typically do not include children.⁸² As a result, state managed care contracts for LTSS lack pediatric-specific measures to evaluate the quality of care provided.⁸³

While the AAP believes it is generally appropriate to prioritize validated, evidence-based quality measures, there are no current pediatric measures that meet these standards and no structure in place to develop such measures. CMS should prioritize expert input on the evidence needed for measures of pediatric HCBS. Future surveys and data reporting requirements in this area should include patients younger than age eighteen to enhance our understanding of pediatric utilization nationally and by state, to understand how state-based waiver eligibility affects utilization. Future research should include rigorous evaluation of the current state of home nursing quality, including the development of pediatric-specific measures that consider the family context, to support future interventions designed to improve access and training.⁸⁴ In addition, future research

⁷⁹ Foster CC, Agrawal RK, Davis MM. Home Health Care For Children With Medical Complexity: Workforce Gaps, Policy, and Future Directions. Health Affairs. 2019;38(6). Available from: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05531>

⁸⁰ See full comments at: <https://downloads.aap.org/DOFA/Final-%20AAP%20HCBS%20Access%20Act%20Comments.pdf>

⁸¹ Medicare.gov. Home Health Compare: about Home Health Compare data.

Centers for Medicare and Medicaid Services; <https://www.medicare.gov/homehealthcompare/Data/About.html>

⁸² National Center for Health Statistics. About the National Home and Hospice Care Survey. NCHS. Available from: http://www.cdc.gov/nchs/nhhcs/about_nhhcs.htm

⁸³ Honsberger K, Holladay S, Kim E, VanLandeghem K. How states use Medicaid managed care to deliver long-term services and supports to children with special health care needs: a 50-state review of Medicaid managed care contracts. National Academy for State Health Policy; 2018 Nov. Available from: <https://nashp.org/wp-content/uploads/2018/12/MLTSS-and-CYSHCN-Issue-Brief-Final.pdf>

⁸⁴ Foster et al. Home Health Care For Children With Medical Complexity: Workforce Gaps, Policy, and Future Directions. Health Affairs. 2019;38(6). Available from: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05531>

should incorporate the parent or caregiver proxy voice to reflect their critical role in supporting children and youth who rely on HCBS.

In the immediate term, CMS should prioritize expert input on the evidence needed for pediatric measures of HCBS. Stakeholder input into this should include home health agencies and providers, patient and family advocates, and pediatricians. CMS can make use of existing expert consensus to begin incorporating the available assessments into the national approach to quality measurement for HCBS and to inform the evidence development needed to yield validated pediatric quality measures.

Recommendation: Issue standardized guidance regarding implementation of the ACA's concurrent care requirement for pediatric hospice programs (Section 2302).

Recommendation: Enable family members to be paid for providing caregiving services. Compensation must include important wage and benefit mandates that appropriately acknowledge the skill, services, and care being provided by families.

Fair Hearings, Appeals, and Grievances

The Academy recommends that hearings of complaints and appeals on pediatric care access issues should include input from family representatives as well as a pediatric medical subspecialist or surgical specialist with expertise in the specific area of care under review. If a complaint or appeal is unresolved by a Medicaid MCO, the Academy also recommends that CMS establish a patient-friendly procedure so that patients, parents, and providers can bring the complaint or appeal to a central state agency and/or state-appointed ombudsmen. In addition, patients, parents, and providers should be able to register their complaint or appeal to a federal call center or ombudsman office so that these complaints and appeals can be tracked and, if necessary, be adjudicated centrally. A national database will provide valuable insight into variations in access across state Medicaid and Medicaid MCO plans that can be used to refine a national standard set of pediatric-specific impediments to accessing medically necessary care.

Recommendation: Plans should provide timely appeals processes that include direct discussions between the reviewing panel, the patient's pediatrician, and the relevant specialists and, if appropriate, an external review by an independent third-party reviewer of the same specialty or, if not available, by a physician experienced in the treatment of the pediatric illness.

Recommendation: Before making any determination that any item or service furnished to a person younger than 26 years is not medically necessary, the managed care plan should consider whether an item or service (1) is appropriate for the age and health status of the person, and (2) is supported by evidence-based or evidence-informed clinical practice guidelines developed for children's health care services that are endorsed or approved by appropriate medical professional societies or governmental public health agencies. Managed care plans should describe the process by which physicians are to provide justification for medical necessity. Referral to a panel of third-party reviewers with pediatric expertise may be the option of last resort.

Streamlining Eligibility and Enrollment

Over the last fifty years, our country has made tremendous progress ensuring children have access to comprehensive, high-quality, and affordable health coverage. From 1984 to 2016, the percentage of uninsured children declined from 29 percent to 4.5 percent. Improvements in outreach and enrollment processes, in addition to coverage expansions under Medicaid, CHIP, and the ACA, are largely credited for the decrease in children's uninsurance rates. But over the last few years that progress slowed, stalled, and then reversed course. According to 2020 data from the US Census Bureau, 4.4 million children (5.7%) under age 19 lack the health coverage they need to survive and thrive.⁸⁵

Millions of uninsured families never receive coverage because they don't know help is available, doubt they qualify, and do not apply for coverage. The Urban Institute estimates that 57.4 percent of the uninsured children in 2018 were eligible but not enrolled in Medicaid or CHIP.⁸⁶ This includes many children with disabilities, for whom coverage is necessary to not only improve health outcomes and quality of life, but also to mitigate tremendous financial strain and medical debt for their family to simply acquire medically necessary therapy, durable medical equipment, or home health care. Studies have shown that interventions to enroll children based on eligibility in other means-tested programs (SNAP, WIC, etc) would capture 70% of those children who are eligible but are not otherwise currently enrolled in Medicaid or CHIP.⁸⁷ Consequently, meaningful outreach and enrollment resources and "no wrong door" policies continue to be vital to improving children's access to care under Medicaid and CHIP.

The AAP offers the following recommendations to increase resources to improve outreach and enrollment and streamlining eligibility for children and families.

Recommendation: Automatically grant Medicaid eligibility when children or adults participate in the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF). As part of that process, identifying SNAP and TANF recipients who have employer sponsored insurance would help Medicaid programs promptly enroll eligible people without incurring health care costs already covered by employers.

Recommendation: Incentivize states to take up Express Lane Eligibility to expedite and simplify enrollment in Medicaid and CHIP by relying on findings from other agencies' eligibility determinations. These agencies and programs should extend to include SNAP, WIC, TANF, housing assistance, and others.

Recommendation: Adjust eligibility determination periods to facilitate automatic enrollment when people file their tax returns. Qualify people as financially eligible for Medicaid and CHIP if prior-year federal income tax returns show sufficiently low income to qualify.

Recommendation: Automatically enroll newborns into Medicaid if there is no proof of other coverage. This includes automatic enrollment in the mother's Medicaid plan unless the parent or parents choose a different plan for their child.

⁸⁵ US Census Bureau. (2021, September). *Current population reports - usatrade.census.gov*. Retrieved April 13, 2022, from <https://usatrade.census.gov/content/dam/Census/library/publications/2021/demo/p60-274.pdf>

⁸⁶ Haley, J. M., Kenney, G. M., Pan, C. W., Wang, R., Lynch, V., & Buettgens, M. (2020, October). *Progress in children's coverage continued to stall out in 2018*. Urban Institute. <https://www.urban.org/research/publication/progress-childrens-coverage-continued-stall-out-2018>.

⁸⁷ Crocetti, Michael et al. "Characteristics of children eligible for public health insurance but uninsured: data from the 2007 National Survey of Children's Health." *Maternal and child health journal* vol. 16 Suppl 1,0 1 (2012): S61-9. doi:10.1007/s10995-012-0995-x

Recommendation: Ensure that newborn infants eligible for Medicaid are assigned to a specific plan immediately after birth so that timely provision of services in the first few months of life is not impeded by anticipated difficulties in payments of claims.

Recommendation: Allow states to experiment with longer periods of continuous eligibility (eg, birth to age five), with sufficient federal funding.

Recommendation: Streamline Medicaid/CHIP enrollment and renewal procedures by allowing self-declared income, using passive renewal procedures, eliminating face-to-face renewal encounters, and improving communication with families regarding renewal procedures.

Recommendation: Consider using the medical home to enroll patients and provide a fair payment for the administrative expense of this procedure.

Recommendation: Support federal policies that provide incentives to states to increase enrollment and retention in Medicaid/CHIP.

Addressing Barriers to Enrollment for Immigrant Populations

Although Medicaid and CHIP are important sources of coverage for low-income children, some noncitizens are ineligible because they are undocumented or have fewer than five years of US residence. These eligibility restrictions contribute to large disparities in coverage rates. In 2020 about 33 percent of undocumented children and 18 percent of documented immigrant children were uninsured, compared with only 4 percent of citizen children.⁸⁸ The Academy believes that all children from birth to the age of 26 years who reside within our borders, **regardless of immigration status**, should be covered by an affordable, quality health insurance plan that allows access to comprehensive essential care. State-based coverage expansions of non-citizen children have shown to decrease the child uninsured rate and increase access to care.⁸⁹

Additionally, while Medicaid expansion was intended to expand access to more adults, research has shown that covering more parents, caretakers, and other adults helps increase children's coverage rates.⁹⁰ As a result, state decisions to forgo expansion also act as a further impediment to covering all children. More than 2 million uninsured adults who live below the poverty line are denied health care because their states did not expand Medicaid. Latino children and families are disproportionately impacted by their state's decisions not to expand Medicaid. In 2019, nearly all non-expansion states had Latino child uninsured rates higher than the national average for Latino children (9.3 percent). This coverage disparity means that out of every 100 school aged Latino children living in non-expansion states, 17 are uninsured compared to just seven out of every 100 living in expansion states – a difference of 10 children.⁹¹

Research also demonstrates that when parents have health insurance, children are more likely to get the care they need. Increases in adult Medicaid eligibility levels were associated with a greater likelihood that children

⁸⁸ Henry J. Kaiser Family Foundation. Health coverage of immigrants. KFF; 2020 Mar 18: <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/> Google Scholar

⁸⁹ Lipton, B. J., Nguyen, J., & Schiaffino, M. K. (2021). California's health4all kids expansion and health insurance coverage among low-income noncitizen children. *Health Affairs*, 40(7), 1075–1083. <https://doi.org/10.1377/hlthaff.2021.00096>

⁹⁰ Hudson, J. L., & Moriya, A. S. (2017). Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects On Their Children. *Health Affairs*, 36(9), 1643-1651. doi:10.1377/hlthaff.2017.0347, available at <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0347>

⁹¹ Whitener, K., Snider, M., Corcoran, A., (2021, June 29). *Expanding Medicaid Would Help Close Coverage Gap for Latino Children And Parents*. Center For Children and Families. <https://ccf.georgetown.edu/2021/06/29/expanding-medicaid-would-help-close-coverage-gap-for-latino-children-and-parents/>.

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Streamlining Eligibility and Enrollment

in low-income families received at least 1 annual well child visit.⁹² These findings reiterate the importance of parental coverage in ensuring that children can get the care they need to learn, grow, and thrive.

Recommendations to improve access to Medicaid/CHIP for immigrant populations are below:

Recommendation: Remove the 5-year waiting period for eligible children and/or pregnant women who are lawfully residing in the United States consistent with the provisions of the CHIP Reauthorization Act (Pub L No. 111-3).

Recommendation: Eliminate the discrimination against undocumented children by allowing them access to the Medicaid/CHIP program if they meet other eligibility criteria. Ensure that children with asylum claims pending and those with Special Immigrant Juvenile Status are eligible for Medicaid and CHIP in all states.

Recommendation: Encourage all states to take advantage of the option to cover documented immigrant children through provisions in the Immigrant Children Health Insurance Act provisions of the CHIPRA legislation.

Recommendation: Allow youth who are considered “lawfully present” under the Deferred Action for Childhood Arrivals (DACA) program to qualify for Medicaid, CHIP, or tax credits in the marketplace.

Recommendation: Eliminate confusion by clarifying that youth granted Special Immigrant Juvenile Status (SIJS), but who do not yet have a green card, are eligible for ACA Marketplace coverage, Medicaid, and CHIP.

Recommendation: Conduct robust outreach efforts targeted to immigrants to encourage immigrants to access programs they are eligible for.

Recommendation: Create communications tools that acknowledge inequities in health literacy, helping families to better understand their own eligibility and resources.

Recommendation: Invest in community health workers, prioritizing bilingual, bicultural community health workers for immigrant and refugee families.

⁹² Venkataramani, M., Pollack, C. E., & Roberts, E. T. (2017). Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services. *Pediatrics*. doi:10.1542/peds.2017-0953, available at <http://pediatrics.aappublications.org/content/pediatrics/early/2017/11/09/peds.2017-0953.full.pdf>

Consistent Coverage

Despite the importance of Medicaid and CHIP, serious issues must be addressed to stabilize coverage for the people they serve. We know that interruptions in coverage worsen health outcomes and lead to avoidable hospitalizations or emergency room care for mental health disorders, asthma, and diabetes. Coverage gaps also raise the average monthly cost of Medicaid and result in higher avoidable administrative costs for states, health care providers, and health plans. As CMS considers strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs, continuous eligibility policies that reduce administrative churn should be prioritized.

A recent MACPAC analysis found that 8.5 percent of children enrolled in Medicaid lost coverage and re-enrolled within 12 months in states without continuous eligibility, compared to only 6 percent of children enrolled in Medicaid in states that implemented continuous eligibility.⁹³ Moreover, the analysis highlighted

From a pediatrician in Texas:

“Many of the children in my practice have parents who are agricultural workers or work in oil fields. Most of the time these families’ income levels are below the Medicaid income eligibility limit. However, if there is a particularly busy season a family’s income can easily jump in a short amount of time. I’ve had patients lose Medicaid coverage because a periodic income check was run during one of those unusual income surge periods. That means my patients miss out on scheduled appointments and can’t have the ability to pick up prescribed medications.”

that the negative impacts of churn disproportionately affect Black/Latino populations. Research also demonstrates the high rates of churn among postpartum individuals, which in turn can drive the increasing rates of maternal morbidity and mortality.⁹⁴

Almost half of the states have taken up the option to provide 12-month continuous eligibility for children, but progress at the state level has stalled. If Congress were to permanently expand this provision to all states for both Medicaid and CHIP, administrative costs for states would be reduced and health providers and

plans would more readily maintain continuity of care management, which is vital to keeping children healthier. Similarly, while the American Rescue Plan Act gave states the option to extend postpartum coverage for 12 months, this policy too will result in a patchwork of coverage from state to state. Congress permanently extending this provision to apply to all states would likewise improve health outcomes for people who give birth while reducing administrative costs.

Most importantly, policies such as these that promote continuous coverage lessen financial stress and offer timely access to needed care for children on Medicaid and CHIP and their families. Continuous coverage also

⁹³ <https://www.macpac.gov/wp-content/uploads/2021/09/Associations-Between-State-Eligibility-Processes-and-Rates-of-Churn-and-Continuous-Coverage.pdf>

⁹⁴ Daw JR, Kozhimannil KB, Admon LK. High Rates of Perinatal Insurance Churn Persist After the ACA. Health Affairs Forefront. September 2019

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better enables assessments of the quality of care delivered under Medicaid/CHIP, as persons with gaps in coverage are typically excluded from quality improvement data. The full and accurate assessment of quality of care that would be made possible if more individuals had continuous coverage would promote greater accountability of MCOs and Medicaid programs overall. Conversely, lack of continuous coverage could negatively impact the data collected in the Child Core Set,⁹⁵ painting an inaccurate picture of how well Medicaid and CHIP are performing.

The federal government has significant experience working with states to strengthen eligibility, enrollment, and coverage practices. For example, when Congress enacted CHIPRA in 2009, it included incentives for states that met enrollment targets and adopted five of eight simplification policies.⁹⁶ Additionally, CMS's Coverage Learning Collaborative was established with the goal of spreading best practices to address common challenges and pursue innovations in Medicaid and CHIP policies and operations as well as broader state health coverage efforts.⁹⁷

From a pediatrician in Missouri:
“Some of my patients have lost Medicaid coverage because they couldn’t understand the paperwork, or didn’t get their information back to the state within ten days.”

The Academy supports legislative efforts to expand these policies to all states and encourages CMS to approve state 1115 waiver requests to promote continuity of coverage by providing multi-year continuous eligibility for children. Under existing authorities, CMS can work to incentivize and require reporting on streamlined eligibility and enrollment practices, both in terms of specific policies (ie, use of presumptive eligibility) as well as process measures (ie, percentage of applications processed in 7 days).⁹⁸ CMS can also improve the eligibility redetermination process by requiring states to report on specific metrics and make that information publicly available—including call center statistics during, and continuing after, the unwinding of the public health emergency-related continuous coverage protection—and work with and incentivize states to enact policies that promote continuity of coverage for children and families.

Our specific recommendations to improve continuity of coverage for children and families are below:

Recommendation: Identify uninsured children who are not financially eligible for Medicaid and if possible, facilitate enrolling them in CHIP and subsidized coverage on the Exchanges.

Recommendation: Optimize coordination of Medicaid, CHIP, and exchange program outreach using streamlined eligibility determination, redetermination and enrollment processes including the use of short and easily understood common application forms, and expanded use of online enrollment. Once a child is enrolled, coverage should continue for at least 12 months.

⁹⁵ CMS. (2022). 2022 core set of children's health care quality measure ... Retrieved April 5, 2022, from <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-child-core-set.pdf>

⁹⁶ Kaiser Family Foundation . (2012). State adoption of coverage and enrollment options in the children's health insurance reauthorization act of 2009. Retrieved April 5, 2022, from <https://www.kff.org/wp-content/uploads/2013/01/8146.pdf>

⁹⁷ <https://www.medicaid.gov/resources-for-states/medicaid-and-chip-mac-learning-collaboratives/index.html>

⁹⁸ Tricia Brooks, A. G., & 2022, M. (2022, March 17). Medicaid and chip eligibility and enrollment policies as of January 2022: Findings from a 50-state survey. KFF. Retrieved April 5, 2022, from <https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/>

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Promoting Consistent Coverage

Recommendation: Navigators/assisters could help families understand the new set of options available if an enrollee's eligibility has changed. Efforts should consider families together rather than as separate individuals.

Recommendation: Ensure that Medicaid provider networks are sufficient to guarantee that children who transition from pediatric to adult care providers do not experience disruption in services.

Recommendation: Create additional safeguards and layers of review before disenrolling children with special health care needs (including children with complex and/or rare diseases, children with behavioral/mental health conditions, and foster care children).

Recommendation: Prevent disruptions in children's coverage and care when families move across state lines. Establish a window of reciprocal Medicaid coverage across state lines to ensure children maintain needed coverage during a transition like a move.

Recommendation: Decrease or eliminate enrollment fees and eliminate "lock-out" periods after disenrollment from Medicaid or CHIP for failure to pay premiums.

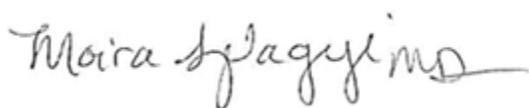
Recommendation: Eliminate the 4-week gap in coverage for children transitioning from CHIP to marketplace coverage.

Recommendation: Eliminate waiting periods for enrollment into CHIP after loss of employer-based insurance.

Recommendation: Auto-enroll youth leaving the juvenile justice system into Medicaid or CHIP and extend coverage for former juvenile justice youth up to age 26 to align with available coverage for children aging out of the foster care system.

The AAP appreciates this opportunity to submit comments on this RFI. If you have any questions, please do not hesitate to contact Stephanie Glier in our Washington, D.C. office at 202-347-8600 or sglier@aap.org.

Sincerely,

A handwritten signature in black ink that reads "Moira Szilagyi MD". The signature is written in a cursive, flowing style.

Moira Szilagyi, MD, PhD, FAAP

President

MAS/nw

Appendix A: Potential Pediatric Access Measures. Recommended in 2015

Recommendations to CMS in response to 2015 Access RFI

The Academy proposes as a starting point the measure set below. Most of the measures in the set are similar to those proposed for adults but are modified to be relevant to the specific needs of children and youth as indicated by the bold italicized emphasis. A few novel proposed measures pertaining to the number and types (new, established) of visits per primary care and subspecialty physician will provide additional information about the relative availability of each physician in the network to Medicaid beneficiaries. In particular, a comparison of new to established visit ratios across subspecialties will provide important information about access to services above and beyond just counting providers who self-report to be accepting new patients.

The AAP suggests modifications to extant measures to reflect considerations specific to children and youth. For each metric that involves counting providers, additional analysis needs to be performed over the Medicaid plans in a geographic region to determine adequacy of access. For instance, suppose there are 100,000 total children (40,000 Medicaid-insured; 60,000 insured by a non-public payer) in a given geographic region. National standards suggest that ten pediatric cardiologist are necessary to provide adequate access to care for all pediatric patients. Suppose further that each of 4 Medicaid plans has 10,000 beneficiaries who are children and youth. If each Medicaid plan has 2 pediatric cardiologists in-network, it might appear that each plan achieves the threshold for access to pediatric cardiology. However, if each plan counts the same two pediatric cardiologists as its in-network providers, in reality there is only 1 cardiologist for 20,000 Medicaid-insured children and youth. Compare this to the possibility – should all 10 cardiologists participate in all non-public payer plans – that there is 1 cardiologist for each 6,000 children insured by those plans. Full comprehension of some access metrics requires integration of data across Medicaid and non-Medicaid plans in a given region and comparison to what can be determined to be regional, state, or national metrics for non-Medicaid insured children and youth.

- Number of in-network **pediatricians** in a **certified medical home** (e.g., by National Committee of Quality Assurance or a state agency) accepting any and new Medicaid patients
- Number of in-network **pediatricians** accepting any and new Medicaid patients
- Number of in-network **pediatric** medical subspecialty and surgical specialty board- certified physicians **by subspecialty** accepting any and new Medicaid patients
- Number of **pediatric** home health and DME companies accepting any and new Medicaid patients
- Number of in-network dentists accepting any and new **pediatric** Medicaid patients
- Number of **child** psychiatrists, **child** psychologists, **child** social workers, and **child** mental health counselors/therapists accepting any and new Medicaid patients
- Number of in-network **children's** hospitals
- Number of in-network inpatient mental/behavioral health facilities that care for any and new Medicaid-insured **children and youth**
- Number of in-network outpatient mental/behavioral health clinics/centers that care for any and new Medicaid-insured **children and youth**
- Number of complaints by primary care **pediatricians** about difficulty in securing authorization for specialty or subspecialty care or in identifying an in-network **pediatric medical subspecialty or surgical specialty** physician for Medicaid **children and youth**
- Number of complaints by emergency room physicians and other specialists/subspecialists in identifying a **pediatric medical home** or an appropriate **pediatric specialty/subspecialty provider** to which to refer a Medicaid-insured child or youth for follow-up
- Number of complaints by mental and behavioral health providers (psychiatrists, psychologists, mental health counselors/therapists) about difficulty in referring Medicaid-insured **children and youth** to a **pediatric medical home**.

- Number of retail and specialty pharmacies accepting any and new Medicaid-insured **pediatric** patients
- Number of retail and specialty pharmacies providing non-pharmacy care to Medicaid- insured **children and youth**

The AAP proposes three new measures of access for children and youth. Again, metrics should be compared to normalizing data for children and youth insured by payers other than Medicaid. The first ratio pinpoints within a specialty or subspecialty which providers more readily accept new Medicaid-insured children and youth. The second ratio viewed across specialties/subspecialties provides insight into which specialties are most difficult for Medicaid- insured children and youth to access. Both sets of data can inform general or targeted interventions to improve access.

- Number of visits by Medicaid-insured **children and youth** per unit time per in- network primary care and **pediatric medical subspecialty or surgical specialty** board- certified physician
- Ratio of new to established patient visit codes for Medicaid-insured **children and youth** per in-network primary care and **pediatric medical subspecialty or surgical specialty** board-certified physician
- Ratio of out-of-network referrals for each **pediatric medical subspecialty and surgical specialty** to in-network visits

Measures for Beneficiary Reported Access

The Academy also suggests several modifications and amplifications of the proposed adult measures in this category to reflect the needs of children and youth through the full developmental spectrum. Modification of proposed measures to reflect considerations specific to children and youth:

- Percentage of **children and youth** attributed to a primary care provider in a certified **pediatric medical home**
- Number of complaints by Medicaid-insured **children or youth** or their parents/guardians about difficulty in obtaining recommended care in a **pediatric medical home**
- Number of complaints by Medicaid-insured **children or youth** or their parents/guardians about difficulty in obtaining dental services from a **pediatric** dentist
- Number of complaints by Medicaid-insured **children or youth** or their parents/guardians about difficulty in obtaining care from a **pediatric medical or surgical physician** as recommended by a primary care provider, emergency room physician, or **pediatric subspecialist or surgical specialist**
- Number of complaints by Medicaid-insured **children or youth** or their parents/guardians about difficulty in obtaining care from a **pediatric mental or behavioral health professional or a substance abuse treatment center** as recommended by a primary care provider, emergency room physician, or **pediatric subspecialist or surgical specialist**
- Number of complaints by Medicaid-insured **children or youth** or their parents/guardians about difficulty in obtaining services from a **pediatric DME or pediatric home health agency** as recommended by a primary care provider, emergency room physician, or **pediatric subspecialist or surgical specialist**
- Number of complaints by Medicaid-insured **children or youth** or their parents/guardians about difficulty in obtaining recommended pharmacy services including filled prescriptions for long acting removable contraceptives in female adolescents or young adults
- Number of complaints by Medicaid-insured **children or youth** or their parents/guardians about difficulty in obtaining timely vaccinations as recommended by ACIP
- Number of complaints by Medicaid-insured **children or youth or their parents/guardians** about difficulty in obtaining information from state or MSO call center

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Appendix A: Potential Pediatric Access Measures (2015)

- Average wait time from initial first request by patient or primary care provider to appointment with pediatric provider or subspecialist
- Average time from first request for authorization of services on behalf of Medicaid-insured children or youth to disposition (approval or denial)

The AAP recommends several new measurements of access appropriate for children and youth. These concentrate on access to preventive services either directly (by quantifying numbers of medical home visits and assessing adherence to immunization schedules) or indirectly (through quantification of emergency room visits).

- Percentage of **children and youth** who have had one or more visits to a **pediatric medical home** in the past 12 months
- Percentage of **children and youth** by age group with the number of preventive visits as recommended by Bright Futures
- Percentage of **children and youth** who are up-to-date with immunizations as recommended by ACIP or Bright Futures
- Average number of emergency room visits per Medicaid-insured **child or youth** in the most recent 12 months