January 31, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2393–P
P.O. Box 8016
Baltimore, MD 21244
Submitted electronically to http://www.regulations.gov

Re: Comments for Medicaid Program; Medicaid Fiscal Accountability Regulation; *Federal Register, Vol. 84, No. 222, November 18, 2019 [CMS–2393-P]*

Dear Administrator Verma,

As organizations dedicated to promoting the health of our nation's children and pregnant women, we urge the Centers for Medicare and Medicaid Services (CMS) to withdraw the proposed Medicaid Fiscal Accountability Regulation (MFAR) and instead work with patients and their families, clinicians, hospitals, states, and other Medicaid stakeholders to develop policy that will ensure efficiency and transparency while protecting access to Medicaid services.

If finalized, the MFAR would trigger insecurity and instability for state Medicaid programs and state budgets by injecting uncertainty into how states can finance the state share of their Medicaid expenditures, and how they pay providers. We are concerned that the rule could result in significant funding deficits, leading to major limitations to states' Medicaid programs or putting states in the difficult position of choosing between health care, education, infrastructure, and other essential services.

Furthermore, we are troubled that the proposed rule includes virtually no analysis of the likely harmful impact on beneficiaries, providers, and states. Although there is no evaluation of how the rule will affect access to care for children, pregnant women, or families, major provisions of the rule would be effective on publication, forcing states to begin making changes that would likely have a major impact on state budgets and Medicaid resources and payments. Resultant reductions in Medicaid eligibility, benefits, and access to services could cause serious and irreversible harm to the tens of millions of children, pregnant women, and others who rely on the program for their health care.

We caution CMS not to make sweeping changes that may seriously harm beneficiaries without first collecting necessary information and data, after which we recommend CMS work with stakeholders including our organizations in developing targeted, well-designed policies as necessary.

Meaningful Access to Care Improves Health Outcomes

Medicaid is a vital health care program for children, pregnant women, and other vulnerable populations. Not only is Medicaid the single largest health insurer for children in the United States, but it is also tailored to meet the unique needs of children through its foundational Early and Periodic Screening,

Diagnostic, and Treatment (EPSDT) benefit, which is particularly important for children with special health care needs. Children enrolled in Medicaid are more likely to get check-ups, miss less school, graduate and enter the workforce than their uninsured peers.[1] Simply put: Medicaid coverage works for children. Medicaid also provides comprehensive prenatal care to pregnant women, enabling millions of pregnant women to have healthy pregnancies and prevent instances of preterm birth, low birthweight, and other complications in infants.

Child health is a strong predictor of adult health. Access to the full range of timely care and support throughout childhood keeps kids healthier, reduces symptoms of concurrent issues, and has been shown to lead to positive outcomes in long-term and short-term health, education, future productivity and earnings.[2] Conversely, the inability to access health care services threatens the physical, mental, and social health and well-being of children and their caregivers.[3] Our organizations believe that all children, regardless of their zip code, must have access to the full range of age-appropriate health care providers, subspecialists, and facilities.

We are extremely concerned that the proposed rule does not include a meaningful analysis of how the policy changes would impact access to care, particularly for children and pregnant women. Challenges and barriers to access to care within the Medicaid program already exist. For example, compared to their privately insured peers, children with Medicaid or CHIP coverage have more difficulty making appointments, seeing specialists, and are more likely to go to the ER due to lack of access or availability with their usual source of care.[4] Although not all unmet need can be attributed to a lack of provider access, it is a significant factor in these concerns. Uncertainty about the stability of states' financing and supplemental payment arrangements could lead to dramatic provider payment reductions, elimination of optional benefits, and narrowing of eligibility criteria. We are dismayed that CMS has not taken steps within its authority to ensure equal access in the Medicaid program,[5] and instead is proposing new policy likely to create new barriers to access and exacerbate existing ones.

Funding Uncertainty Will Impede Access to Care

If finalized as written, the proposed rule would result in considerable uncertainty for state budgets and weaken the flexibility necessary for states to adequately finance their Medicaid programs and pay providers serving Medicaid beneficiaries. Medicaid programs are fundamental components of states' economies.[6] The proposed rule would apply arbitrary, poorly defined standards and make substantive changes to longstanding rules that could disallow or restrict states' Medicaid financing arrangements , causing states to scramble to fill funding gaps. States have little flexibility to fill sudden gaps in funding and each state is likely to approach deficits differently. In addition to its impact on Medicaid, this could result in a ripple effect that touches other important state-financed programs and budget line items like education or public health initiatives. If faced with a loss of federal funding, states might reduce the

[1] https://www.macpac.gov/wp-content/uploads/2015/11/EXHIBIT-41.-Use-of-Care-among-Non-Institutionalized-IndividualsAge-0%E2%80%9318-by-Primary-Source-of-Health-Coverage-2015-MEPS-data.pdf
[2] https://www.cbpp.org/sites/default/files/atoms/files/1-19-18health-factsheet-children.pdf
[3] https://www.aap.org/en-us/Documents/BluePrintForChildren.pdf
[4] https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-42.-Measures-of-Access-to-Care-among-Non-Institutionalized-Individuals-Age-0%E2%80%9318-by-Primary-Source-of-Health-Coverage-2018.pdf
[5] https://www.macpac.gov/publication/methods-for-assuring-access-to-covered-medicaid-services-rescission/
[6] https://www.macpac.gov/subtopic/medicaids-share-of-state-budgets/

number of enrollees, benefits covered, or cut spending in other areas to make up the difference, resulting in a direct negative impact on children's access to care.

Medicaid payment levels for children's providers are already low, with Medicaid paying 72 percent of what Medicare paid in 2016.[7] Medicaid payments do not cover the full cost of providing care and low payment rates are often cited as a reason for limited provider participation in the Medicaid program.[8] Disruptions to funding streams could magnify existing obstacles to recruiting and retaining pediatric specialists or subspecialists into the program, and would likely create additional, distinct challenges for rural and safety net providers that rely heavily on supplemental payments to provide care and keep their doors open.

We are also concerned that this rule is being considered while the number of uninsured children is rising, and when CMS is proposing to roll back federal oversight and monitoring of beneficiary access through a rescission of the Medicaid Access Rule.[9] The combined effects of inadequate access monitoring, uncertainty of Medicaid financing, and instability created for state budgets could be devastating for children, pregnant women, and families who rely on Medicaid. CMS must seriously consider the potential impact of any proposed policy changes through the unique perspective of children's health and closely examine the potential consequences on children.

CMS should first collect necessary data and information before working with stakeholders, including states, providers, beneficiaries and their families, and organizations representing them, in developing reasonable, targeted policies to address any problems related to financing and provider payments that are identified (to the extent new polices are necessary and not already addressed by existing statutory and regulatory authority). A data-driven impact analysis specifically looking at children's access to health care services would be an essential element of this process.

Thank you for your consideration of these comments. We look forward to working with CMS to strengthen the Medicaid program and ensure access to care for the millions of children that rely on Medicaid. If you have any questions or would like additional information, please contact Stephanie Glier at the American Academy of Pediatrics, at 202-347-8600 or sglier@aap.org.

Sincerely,

American Academy of Pediatrics
Children's Defense Fund
Children's Hospital Association
Family Voices
First Focus on Children
Georgetown Center for Children and Families
March of Dimes
National Association of Pediatric Nurse Practitioners

[7] https://www.urban.org/sites/default/files/publication/88836/2001180-medicaid-physician-fees-after-the-aca-primary-care-fee-bump_0.pdf
[8] https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/MAX_IB11_PhysicianParticipation.pdf
[9] https://downloads.aap.org/DOFA/Final--%20SKG%20Access%20Rule%20Rescission%20Comments.pdf