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July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Medicaid Program; Ensuring Access to Medicaid Services (CMS–2442–P)

Dear Administrator Brooks-LaSure:

On behalf of over 220 children's hospitals across the country, the Children's Hospital Association (CHA) appreciates the opportunity to provide comments on the proposed rule entitled, "Medicaid Program: Ensuring Access to Medicaid Services." We strongly support CMS' goal and proposed policies to strengthen access to care for children under Medicaid and CHIP and ask you to consider additional steps to ensure all children can access medically necessary care in a timely manner.

Medicaid is the single largest health insurer for children in the United States and serves as the backbone of children's health care. Children are about half of all Medicaid beneficiaries, but they account for less than 20 percent of program spending. The program provides affordable coverage with pediatric-appropriate benefits for children in low-income families and children with special health care needs and chronic or complex conditions.

Medicaid is the foundation for the pediatric health care system, including children's hospitals. Medicaid is essential to children's hospitals' ability to deliver care to any child who needs it, especially children with complex medical conditions and cancer. Medicaid, on average, provides health insurance coverage for half of children's hospitals patients and for some children's hospitals patient mix, closer to three-quarters. This makes children's hospitals the largest Medicaid hospitals and a critical funding source for the care they provide to our nation's children.

Children's hospitals are a vital safety net for all children, treating children across the country who are uninsured, underinsured, and enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Although children's hospitals account for only 5 percent of hospitals in the United States, they provide 45 percent of the inpatient hospital care required by children covered by Medicaid.

Children's hospitals are also regional centers for children's health, providing care across large geographic areas and serving Medicaid children across state lines. Children's hospitals serve the majority of children with serious illnesses and complex chronic conditions and most children in need of major surgical services. In addition, children's hospitals are engaged in efforts to promote delivery system changes, quality improvement, efficiency and cost savings in Medicaid.

The care that pediatric providers, including children's hospitals, deliver needs to be valued, and they should receive adequate payment for the services they provide to ensure children can access all health care needs. Medicaid rates are generally well below Medicare rates, which are below commercial insurance rates. Medicaid base rates with additional payments to address this underpayment are critical to ensure that children's hospitals can continue to provide care to millions of children across the country. Supplemental and state directed payments help bridge the gap caused by low Medicaid reimbursement, although they do not completely solve the underfunding problem. These payments are a critical means of payment for children's hospitals that provide care to millions of children across the country.

To improve Medicaid support for children's access to care, CHA, along with other pediatric providers advocate for federal policymakers to ensure:

- **Adequate payment to support access to needed care for children**. Children's hospitals, pediatricians and other pediatric providers serve a large number of patients covered by Medicaid and CHIP. Adequate Medicaid payment is critical in ensuring children can access care.

- **Federal incentives to ensure access to care for children and the pediatric workforce.** This will also help address the children's mental health crisis since Medicaid is the primary payer for behavioral health services.

- **Considerations for children.** Any Medicaid payment policy changes should consider the impact on children and the providers who rely on the program to sustain their missions.

We ask you to keep these goals in mind as you finalize this proposed rule and take additional actions to better support children's access to needed care under Medicaid and CHIP.

Our specific comments on the Medicaid access proposed rule are below.

Access Standards

Medicaid and CHIP play a vital role in supporting healthy development for millions of children. Unfortunately, too many of these children face barriers that prevent them from accessing the right care in the right setting at the right time. These barriers are particularly acute for children and youth with serious and complex needs, including systems issues regarding access to pediatric specialty services and behavioral health care, some of which may still be included in FFS.

In response to your question in the proposed rule preamble, we urge CMS to apply the access standards, including wait times, secret shopper, and enrollee experience surveys requirements, included in the proposed Medicaid managed care rule to FFS under this rule as well. The standards should align across different delivery systems and public payers, particularly since there are several states that have not used Medicaid managed care to provide care to beneficiaries, including children. All children and youth deserve robust access to medically necessary services, regardless of the delivery system their state has chosen to adopt.

We believe beginning with a focus on primary care and outpatient mental health makes sense for children and ask you to explore other access gap areas, such as pediatric physician specialty services, for future work. We also believe more must be done to support out-of-state care across the board and hope that the findings from the focus on the services prioritized by CMS start to provide more information about out-of-state care and how we can better support children, particularly as CMS looks more at specialty care.

A good first step would be to include the marketplace specialty care wait time requirement of 30 days for non-urgent appointments for children. We believe that this should be applied in FFS or managed care delivery systems. Physician specialty care often requires long wait times, sometimes for clearly needed care for children with complex conditions so this should be prioritized going forward and examined more closely on aspects that are unique to children.

We also request more focus on the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for children. Children's hospitals and other pediatric providers report inconsistent implementation of this critical benefit for children. Gaps in access to services are particularly acute when looking at mental health services and ensuring early identification and prevention all the way through treatment. Children's hospitals report lack of access to the intermediate level of care, such as intensive outpatient, day programs and partial hospitalization, that can prevent hospitalizations and help children transition back home after more intensive treatment. We know CMS is undertaking an effort to review state implementation of EPSDT and we strongly encourage including Medicaid stakeholders, including children's hospitals and other pediatric providers, into this effort.

We thank CMS for proposing the existing access standards on primary care and outpatient mental health with a specific focus on children as children's hospitals and many pediatric providers requested in response to your request for information last year. We hope the standards for outpatient mental health and primary care help children access needed care before a crisis.

We ask that in the final rule the accountability and enforcement steps are specifically outlined to ensure these standards result in real improvement in access to care for children and not just reporting gaps that then are not addressed. Lastly, access standards alone will not result in improvements for children. Medicaid support for providers caring for children needs to be increased to retain more pediatric Medicaid providers and entice new providers to participate.

Payment Rate Transparency

We believe adequate payment is critical to supporting children's access to medically necessary care. Section 1902(a)(30)(A) of the Act requires States to "assure 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 extent that such care and services are available to the general population in the geographic area." We support CMS' efforts in this rule to take steps to address payment for pediatric services and the commitment to examining where we are and where we need to be to best support access to needed care for our nation's children. We hope this is a first step in supporting actions across the country that can raise the level of access we want to see under the Medicaid and CHIP programs for children. Currently, a pediatrician treating a child enrolled in

Medicaid receives only 66% of what is paid for a Medicare enrollee.[1] And on average, Medicaid reimburses, including supplemental payments, children's hospitals only 79% of the cost of care provided.[2]

Appropriate payment rates support access by increasing provider participation in the Medicaid program. Appropriate rates also support long-term financial stability and quality of care for providers—like children's hospitals—that serve a large number of patients covered by Medicaid and CHIP. Notably, although children's hospitals account for only 5% of hospitals in the United States, they provide nearly half of all pediatric hospital care covered under Medicaid. Sadly, Medicaid rates generally fall below those of other payers. The Medicaid program cannot expect to ensure meaningful and timely access to high-quality services while paying substantially less than other payers, so much so that providers must take a financial loss with every Medicaid patient they serve.

We support CMS' efforts to begin to get a better handle on payment rates provided by Medicaid programs across the country. We strongly support the requirement for states to publicly report all FFS rates for Medicaid services. Transparency is a good first step in identifying further steps that need to be taken to better support pediatric providers and children's access to needed care. We also strongly support the reporting of rates that differ for children and by geographic location. We look forward to this reporting providing more information on the support for Medicaid services for children currently provided, whether provided in their home state or in other states.

Comparative Rate Analysis

We support the comparative rate analysis requirements in the proposed rule as a first step in reviewing Medicaid rates for primary care, obstetrical and gynecological and outpatient mental health services versus what is provided under Medicare. Conducting this analysis will provide systematic information on Medicaid payment rates for these services and how they compare to Medicare levels.

More support is needed for children's behavioral health services along the entire continuum of care, from more support in pediatricians' offices to more intensive treatments for children with more severe needs. Low payments under Medicaid for these services are directly impacting access for kids. The Senate Finance Committee's March 2022 report on mental health concludes that "accessing outpatient psychiatric appointments has presented longstanding challenges, as many children wait an average of one month before being seen by a psychiatrist, in part due to low participation rates by these providers in Medicaid."[3] The lack of an intermediate level of care between the physician office and the hospital is a huge issue for children who need intensive outpatient behavioral health services, partial hospitalization and other step-down services. High-acuity behavioral patients may end up stuck in the hospital setting because, for a Medicaid patient with significant behavioral needs, there is no available option for step-down programs. Intensive outpatient programs can help prevent hospitalizations, but also help the child transition back to home. Some of these programs currently do not take Medicaid at all or limit the placements for children covered by Medicaid. We hope this focus on outpatient mental health services will help

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[1] "Medicaid Facts," American Academy of Pediatrics, January 2017.

[2] Annual Benchmark Report, Children's Hospital Association, 2020.

[3] "Mental Health Care in the United States: The Case for Federal Action," p12, U.S. Senate Committee on Finance, Washington, D.C., March 2022.

shine a light on gaps and result in additional support for our kids who desperately need care in a timely manner to prevent crisis.

We do note, however, that Medicare is not the perfect benchmark, especially as you consider pediatric services. Some services may not have services reimbursed under Medicare and the rates don't necessarily take into consideration children and their needs. Further, we don't know if Medicare levels will be sufficient in some cases to support children's access to care and the pediatric provider workforce. Therefore, we support this as a first step and request that CMS continue to examine what works and what does not for children. We should not assume that Medicare in all cases is the correct payment benchmark for children's services.

We would also support examining payment for physician specialty services as a next step. For children, often the longest wait times and access issues are for pediatric physician specialty care and in some cases these services are being more often supported by children's hospitals in their communities as other health care systems discontinue this care as the financing falls short. We would like to work with you to examine what access standards and payment benchmarks may be most appropriate for this critical care for children.

State Analysis for Rate Reduction or Restructuring

We support the two-tiered analysis process for states when a rate reduction or restructuring is proposed to ensure access is maintained. We support the additional analysis requirements if a state's rates are less than 80% of Medicare. We hope this can be increased in time to be at least 100% of Medicare. At the very least, we do not believe children's services should be paid less than what adult services are under the Medicare program. Given our earlier comments on Medicare as the comparison, we do want to point out that it is not the perfect comparison for children's services, including for NICU services as one example. We hope the additional procedural requirements will result in states keeping their rates at least stable, but per our earlier comments this alone will not result in the necessary support for services for children.

We also want to clarify what is meant by "restructure". We want to confirm that this would not include any type of rate increase. We would not want to disincentivize positive changes that states want to undertake.

Home and Community-based Services

Medicaid is the primary payer for home and community-based services (HCBS) and plays a significant role in providing children with special health care needs, including those with chronic or complex medical conditions, the long-term services and supports they need to live at home with their families. Even with EPSDT, many children with special health care needs also rely on HCBS, often covered under waiver programs. Waiver programs provide coverage for services that are not otherwise available through the Medicaid program (including EPSDT). This can include habilitative services, respite services or other services that can help prevent institutionalization. Waivers and EPSDT are often used together to provide a comprehensive benefit for children with disabilities who would otherwise need the level of care provided in an institutional setting. This enables those children to remain in their homes and communities while receiving medically necessary services and supports. The HCBS waiver services essentially "wrap-around" the EPSDT benefit.

The problem of HCBS waiver lists is well-documented and affects many people with disabilities, including children. Although the comparison of waiting lists across states is problematic, we do know that many states have waiting lists in place that impact children, including those who are medically fragile, technology-dependent or have intellectual or developmental disabilities. We are concerned about the long waits that children and their families experience and recommend that CMS explores how to incentivize and support improved state capacity for these services. Without these services, children unnecessarily end up in institutions and isolated from their families and communities. That isolation negatively affects them, their families and the trajectory of the rest of their lives. Providing the HCBS services and supports that children need now can set them up for adulthood so they can be engaged in their communities and workplaces.

Military families are particularly affected. They can encounter vastly different Medicaid programs each time they are required to move across state lines. This is a particular challenge for the many families with children with complex or chronic medical conditions who rely on Medicaid HCBS. A 2018 report from the TRICARE for Kids Coalition found that 3.4 million children of veterans depend on Medicaid and an additional 200,000 children of active service and retiree families with TRICARE coverage—roughly 10% of children covered by TRICARE—also rely on Medicaid, many due to serious medical conditions requiring the specialized pediatric "wrap-around" programs provided by the program.[4] These children with medical complexities or disabilities face numerous challenges accessing the specialized pediatric home and community-based services they need, including home health aides, personal care assistants, day health services, habilitation and respite care to support the child and family in the home. Those challenges range from starting out at the bottom of state Medicaid waitlists following each location transfer to accessing a new network of providers. A 2015 report from the Military Compensation and Retirement Modernization Commission (MCRMC) found that state HCBS services are often unavailable to military families as these families may never reach the top of a state's waiting list for Medicaid services because they are often moved from state to state.

CMS should ensure that the payment adequacy provisions apply to 1905(a) home health care and personal care services, including private duty nursing. CMS should also work with states to help ensure underlying payment rates for HCBS are sufficient to ensure meaningful access.

While we support the general goal of ensuring the direct care workforce is paid fairly, we are concerned the provision that requires 80% to be spent on compensation takes too limited a view of what it takes to deliver these services and supports. Children's hospitals report that the highest quality and reliable providers in their states are the ones that invest in information systems, training and other infrastructure. The children in these states that access these services have very complex needs (i.e. kids with trachs and vents). We worry that the 80% requirement could further strain access to high quality agencies. We ask CMS to consider other supports, like training, that could be included in the 80%. One hospital reports that currently only 25% of their patients that need these services are able to access them. CMS should explicitly mention paid family caregivers as part of the 80% and/or the definition of direct care workforce.

[4] "America's Military Readiness and the Essential Role of Medicaid," Tricare for Kids Coalition, Washington, D.C., 2018.

We support additional accountability as it relates to waiting lists and quality measures. CMS should require information from state HCBS waiting lists to include break outs by age to capture the number of children on waiver waiting lists. The proposed HCBS quality measure set should have pediatric specific metrics that are meaningful for the population of children using home and community-based services.

Medicaid Advisory Committees

The proposed improvements to the Medicaid Advisory Committee (MAC) system have the potential to transform the operation of state Medicaid programs, making them more attuned and responsive to the lived experiences of enrollees. This includes the requirement for states to create a new Beneficiary Advisory Group (BAG), comprised entirely of individuals with lived experience in Medicaid, that will provide direct feedback to the state Medicaid agency *and* participate in the MAC.

We recommend that CMS ensure that families of children currently enrolled in Medicaid, especially those with disabilities and medical complexity, are included and represented on each MAC and BAG as those with critical lived experience. Families should also be appropriately compensated for their participation in these processes. Given children make up a large portion of the Medicaid population, we would like to see more focus on inclusion of children and families in the BAG and pediatric providers, including pediatricians, pediatric specialists, children's hospitals and other state groups focused on children's unique needs, in the MAC.

We thank you for all your work to best support the millions of children who rely on Medicaid. It will take all Medicaid stakeholders working together to make real progress in ensuring our nation's children have timely access to medically necessary care. Please call on us if there is anything we can do to help support the advancement of the policies included in this proposed rule. If you have any questions, please contact Milena Berhane at milena.berhane@childrenshospitals.org or (202) 753-5521.

Sincerely,

Aimee Ossman
Vice President, Policy
Children's Hospital Association