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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: CMS-2439-P. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality

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 to make changes to existing Medicaid managed care regulations. With more states enrolling children in Medicaid managed care, it is important that Medicaid managed care is as strong as possible in the areas of access to care, network adequacy, adequate payment and reimbursement and quality assurance. We appreciate CMS' focus on children enrolled in managed care in the proposed provisions and strongly support many of the efforts outlined in the rule. We also strongly suggest that CMS consider changes to ensure sufficient support for children's access to timely and needed care and not finalize any policies that could negatively impact that care.

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. Though children's hospitals account for only 5 percent of hospitals in the United States, they account for about 45 percent of all hospital days for children on Medicaid. Children's hospitals are regional centers for children's health, providing care across large geographic areas and serving Medicaid children across state lines. In addition, children's hospitals serve the majority of children with serious illnesses and complex chronic conditions and most children in need of major surgical services.

The care delivered by pediatric providers, including children's hospitals, needs to be valued. This means that these providers 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. Low Medicaid base rates are coupled with additional payments to address this underpayment and are critical in allowing children's hospitals to continue providing care to millions of children across the country. In Medicaid managed care, 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 who provide care to millions of children across the country.

We appreciate CMS's review of the managed care rule and its efforts to strengthen Medicaid managed care for Medicaid beneficiaries, including children. In our comments, we outline considerations for CMS in the areas of access, state directed payments, in lieu of services and settings (ILOSs), quality assessment and review and the quality rating system.

Ensuring Access to Care for Children in Managed Care

Appointment Wait Time Standards

Medicaid plays 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 care they need in a timely manner and in the right setting. These barriers are particularly acute for children and youth with serious and complex needs, including systemic problems causing issues in access to pediatric specialty services and behavioral health care. Ensuring that children covered under Medicaid receive appropriate care when they need it is important in advancing the health of millions of children across the country.

We commend CMS's proposed appointment wait time standards and the effort to align them with the standards for marketplace plans. It is an important step in moving the Medicaid program forward and improving access to care for Medicaid beneficiaries, including millions of children. We also appreciate CMS' acknowledgement of the differences between pediatric and adult health care systems by requiring states to develop network adequacy standards for both pediatric and adult appointments in the areas of primary care and outpatient behavioral health.

We would like to highlight the current youth mental health crisis and the effects it has had on mental health care for children. We appreciate CMS' focus on outpatient behavioral health in the proposed appointment wait time standards and recognize that additional support needs to be applied to behavioral health care, especially as it related to pediatric behavioral health. There is a significant mental health care workforce shortage, and the demand for pediatric mental health care has only increased with the current youth mental health crisis. In relation to its focus on outpatient mental health, we urge CMS to consider the increasing needs that exist for pediatric behavioral health so that the proposed standards for pediatric behavioral health can be met.

We also encourage CMS to consider the inclusion of provider protections along with these wait time standards. This is critical to ensure that providers are partners in these standards and that the standards do not create disincentives to providers participating in the Medicaid program. We would also like to highlight that some providers may be more affected than others with additional standards in place. More specifically, these standards might be particularly difficult for individual or smaller practices to meet due to workforce constraints. Providers should be able to comply with these additional standards, in order for the goal of increased access to Medicaid to be achieved.

In addition, these proposed wait time standards must be coupled with additional support for the Medicaid program. We support CMS's efforts to improve access to care through these proposed standards for MCOs, however, policies that could result in providers being penalized due to workforce shortages does not address the systemic issues within the Medicaid program that lead to inadequate provider networks. It is imperative that underlying Medicaid payment issues are addressed in order to further strengthen the pediatric health care workforce so that providers are able to comply with these standards. This support is especially important regarding the need for adequate reimbursement for Medicaid providers who care for the most vulnerable children and provide costly specialty care to millions of children. Appropriate reimbursement of pediatric care that is being provided to children covered under Medicaid will have a direct impact on access to care and the ability of providers to be able to meet additional standards put in place by CMS.

Other Network Adequacy Considerations:

We commend CMS for proposing an additional access standard through the proposed wait time standards, specifically in the areas of primary care and outpatient mental health for children. We also urge CMS to explore other areas where gaps in access to care are present, including specialty and out-of-state pediatric care where access issues are especially present. For specialty care, children often have issues in finding providers that can meet their needs and face long wait times for appointments. Access issues for specialty care also lead children and their families travelling out of state to reach the providers they need.

For specialty care, we believe it is important to apply the marketplace appointment wait time standard of 30 days for non-urgent appointments to both fee-for-service (FFS) and managed care in Medicaid. Physician specialty care usually results in long wait times for children, and this particularly harms children with complex medical conditions that require pediatric specialty care more often. Implementing an appointment wait time standard that aligns with that required of marketplace plans will be a step forward in reducing gaps in access to care for pediatric physician specialty services.

It is critical that CMS addresses the various barriers that prevent children enrolled in managed care from accessing the providers they need. This includes narrow MCO networks that do not include adequate pediatric capacity, particularly specialty care (which is often hospital-based) and outpatient behavioral health services. Another issue is MCO gatekeeping and utilization management practices that steer patients away from specialized children's hospitals, even when they are in-network. These contribute to access issues that children and their families face when trying to receive specialty care. Addressing access and network adequacy issues through a variety of policy changes, including the proposed appointment wait time standards, is critical in removing these barriers to care. We encourage CMS to continue prioritizing access to care issues for children covered under Medicaid going forward.

Out-of-state care for children should also be prioritized, as there are gaps in access in this area as well. Many children have to travel to a children's hospital outside of their home state because the care they require may not be available within their state. This often includes the need for specialty care. We encourage CMS to focus on addressing out-of-state care for children, and hope that efforts to address access issues in specialty care leads to more insight on how to address issues in access, consistency and timeliness of approval for out-of-state care as well.

We also want to emphasize the need for added 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 have reported 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. In addition to CMS's efforts to review state implementation of EPSDT, we also encourage collaborating with Medicaid stakeholders, including children's hospitals and other pediatric providers in those efforts.

Secret Shopper Surveys

We commend CMS on the proposed requirement for states to use independent entities to conduct annual secret shopper surveys. This is a good step in improving state monitoring of plan compliance with wait time standards and determining the accuracy of information located in provider directories. These secret shopper surveys will be important in identifying gaps in access for pediatric care in addition to ensuring that children and families have access to accurate provider directories.

Provider Payment Analysis

We support the proposed provider rate analysis requirements 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 throughout the 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 children. 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."[1] The lack of intermediate level 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 shine a light on gaps in access 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 comparative services reimbursed under Medicare and the rates do not necessarily take into consideration children and their needs. Further, we do not know that 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 additionally request that CMS continue to examine what works for children and what does not. 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. In some cases, these services are more often supported by children's hospitals in their communities as

[1]Mental Health Care in the United States: The Case for Federal Action (U.S. Senate Committee on Finance, March 2022),
https://www.finance.senate.gov/imo/media/doc/SFC%20Mental%20Health%20Report%20March%202022.pdf.

other health care systems discontinue this care as a result of financing falling short. We would like to work with CMS to examine what access standards and payment benchmarks may be most appropriate for this critical care for children.

The Importance of State Directed Payments for Children and Children's Hospitals

Children's hospitals are the highest Medicaid hospitals and provide critical pediatric care to millions of children covered under the Medicaid program. Though children's hospitals account for only 5 percent of hospitals in the United States, they account for about 45 percent of all hospital days for children on Medicaid. They also play an important role in providing care for out-of-state children, who may require more specialty care that is unavailable in their home state. In addition, children's hospitals serve the majority of children with serious illnesses and complex chronic conditions and most children in need of major surgical services.

Medicaid is a dominant payer for children's hospitals. However, most children's hospitals are paid below the cost of care for their Medicaid patients. Medicaid rates are generally well below Medicare rates, which are below commercial insurance rates. As a result, children's hospitals often receive supplemental payments from states to fill the gaps between Medicaid base rates and the costs of care. Even with Medicaid supplemental payments, children's hospitals are currently reimbursed 79 percent of the cost of care. Adequate Medicaid payment is critical to children's hospitals remaining financially viable, allowing them to continue to provide comprehensive care, advanced pediatric medicine, community supports and provide a wide range of subspecialty services and equipment.

State directed payments are a critical payment stream in Medicaid managed care that provide children's hospitals with funding to mitigate the financial challenges caused by low Medicaid base rates. For some children's hospitals, directed payments help to fill gaps in payment by an estimated 20%. These payments are critical to the ability of children's hospitals to fulfill their missions and provide needed access to care for children.

There are current workforce constraints that also need to be taken into consideration when implementing policy related to Medicaid payment. The pediatric health care workforce has faced capacity challenges, and this has been especially present in pediatric behavioral health. The youth mental health crisis has caused additional strains on the workforce and children's hospitals, with the demand for pediatric behavioral health services increasing now more than ever and resulting in numbers of children boarding in children's hospitals waiting for needed care. To support the pediatric health care system and improve the role of Medicaid for children, policies that reduce the investment in children's health care under Medicaid and CHIP should not be adopted. It is critical that the Medicaid program is supported to the fullest extent possible, and additional support in Medicaid payment is imperative in that support.

Limits for SDPs

We strongly support the proposal to codify the Average Commercial Rate (ACR) as the SDP payment ceiling for hospitals. This proposal would preserve a critical funding source for children's hospitals that rely on SDPs to fill in the cost gaps for providing Medicaid services to children. The

ACR mirrors the current state of SDPs being paid to children's hospitals, so maintaining this practice will ensure that this critical funding source is not further reduced.

We do not support Medicare rates being applied as the payment ceiling for SDPs. Implementing Medicare rates as the SDP expenditure limit would result in significantly lower SDPs for hospitals that rely on these payments to fill Medicaid payment gaps. Children's hospitals are the highest Medicaid hospitals and provide pediatric specialty care, which is costly. Currently, SDPs assist with the Medicaid payment gaps these hospitals face, giving them the ability to continue running their facilities. If funding through these SDPs were to be reduced, the financial strain on children's hospitals would be much higher. Lower SDPs would be detrimental to the pediatric care system and could result in even more access challenges for children.

In addition, as mentioned by CMS in the proposed rule's preamble, the ACR is a more appropriate benchmark to apply to SDPs because the population covered under commercial insurance aligns better with the population covered under Medicaid managed care. Also, Medicare is not a good benchmark for pediatric services since many times there are not pediatric services reimbursed under Medicare and the rates do not necessarily take into consideration children and their needs. As a result, having Medicare rates as the SDP limit would not be appropriate and would likely result in inappropriate reimbursement for the pediatric services that are being provided in children's hospitals. Therefore, the ACR would be the appropriate limit to apply to SDPs as opposed to applying the Medicare rate.

We do not support CMS's consideration to impose any other limits on the total amount of SDP expenditures. These proposed limits would reduce the level of SDPs, which would add to the current financial burden these hospitals face. As stated above, children's hospitals are high Medicaid providers and therefore already face payment gaps due to low Medicaid base rates and providing specialty care. Children's hospitals rely on SDPs to help fill those gaps in payment, and a managed care expenditure limit would significantly reduce a critical source of funding for these hospitals. Any further reductions in SDP funding would result in access to care issues for the millions of children who are covered by Medicaid and receive essential health care through children's hospitals.

Financing

We do not support the proposed requirement for states to collect attestations from providers stating that they do not participate in a hold harmless arrangement. This issue is currently being litigated and therefore, we believe this proposal would be premature to consider within this proposed rule. We urge CMS to withdraw this provision from the rule and reconsider it once this issue is no longer being legally contested.

SDP Reporting Requirements

Children's hospitals are major care providers for children on Medicaid, with Medicaid covering half of children's hospitals patients and for some children's hospitals patient mix, closer to three-quarters. In addition, children's hospitals account for about 45 percent of all hospital days for children on Medicaid. As a result, children's hospitals face payment losses from low Medicaid reimbursement rates which are often partially compensated by state directed payments in managed care.

Regarding the proposed provider-level data reporting through the Transformed Medicaid Statistical Information System (T-MSIS), we ask CMS to explore ways that additional context (such as the information mentioned above) can be included to accompany the dollar amounts being reported. Children's hospitals receive significant funding through SDPs, however, this is because they are high Medicaid providers and also face significant Medicaid shortfall. It is imperative that this additional context is provided to demonstrate the reason for the reported SDP amounts being paid to providers that would be reported through this provision.

In Lieu of Services and Settings

In Lieu of Services and Settings (ILOSs) are innovative alternatives for states to address health-related social needs (HRSNs) for children and families through Medicaid managed care. We recognize the importance of addressing HRSNs for children and families covered under Medicaid, who are likely to be disadvantaged regarding social needs such as housing, income, food security, etc. We support the use of ILOSs as a means of improving child health outcomes and to further expand health equity for all children.

If ILOSs continue to be expanded through the Medicaid program, additional support has to be incorporated simultaneously in order to accommodate that expansion. Medicaid resources are finite, and reimbursement remains inadequate for many of the health care services currently being provided through managed care. If ILOSs are to be truly expanded, additional support must also be provided to ensure that the already limited resources for the Medicaid program are not further reduced. If the Medicaid program continues to expand what it offers beneficiaries, the infrastructure needed to support the program must also be expanded to support the full capacity of Medicaid.

Quality Assessment and Review

Managed Care State Quality Strategies

Assessing the quality of Medicaid services being furnished through managed care is critical in improving the delivery of these services. We support CMS's provision to set forth requirements for states to draft and implement a written quality strategy for services furnished through managed care.

Regarding these provisions, we encourage CMS to pose requirements for states to include pediatric-specific measures in their written quality strategies. Children are not little adults and require quality initiatives specific to their unique needs. This also includes having pediatric quality measures in place that can accurately assess children's health outcomes. It is critical that child-specific health data is captured through these strategies so that states are able to identify access and quality issues in pediatric care, separate from but in addition to adult care. These quality strategies can then be utilized to ensure that children enrolled in Medicaid managed care are receiving quality health care and their needs are being met.

Medicaid Managed Care Quality Rating System (MAC QRS)

Establishing and Modifying a Mandatory Measure Set for MAC QRS

We commend CMS for its efforts to improve the Medicaid Managed Care Quality Rating System (MAC QRS) to provide beneficiaries and their caregivers with an online resource to compare Medicaid and CHIP managed care plans. This is important in allowing children and their families to be able to view which plans fit their child's health care needs best. We also support CMS efforts to better align state requirements for Medicaid managed care quality rating systems with those of marketplace plans.

In addition, we commend CMS for its inclusion of pediatric measures in the proposed mandatory measure set for states' MAC QRSs. It is critical that the methodology for the plan quality ratings is inclusive of pediatric health measures to ensure that the QRS is an accurate source of plan information for children and families.

We encourage CMS to further review the pediatric measures included in the measure set proposed to ensure that they capture accurate health outcomes for children. For example, we are concerned with the Asthma Medication Ratio (AMR) quality measure that has been proposed. This measure is not designed to support outcome measurement in the pediatric population. Although the ACR includes children in the measurement, it would not result in an accurate depiction of asthma adherence for the pediatric population.

We urge CMS to consider an alternative measurement that would better capture asthma outcomes for children to ensure that children and families are seeing accurate quality ratings for plans through the QRS. This will help them to choose the plan that better fits their child's health care needs.

In conclusion, we appreciate your work to improve Medicaid managed care and the significant impact it has on children's health and hospitals. We look forward to working with you to further improve Medicaid managed care so that children's hospitals can continue to provide critical care to the millions of children covered by Medicaid. Please contact Milena Berhane at milena.berhane@childrenshospitals.org or (202) 753-5521 with any questions.

Sincerely,

Aimee Ossman
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