

July 3, 2023

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & 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) & Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P)**

Dear Administrator Brooks-LaSure,

As organizations that share a strong commitment to the health of our nation's children, we appreciate the opportunity to provide comments in response to two proposed rules issued by the Centers for Medicare & Medicaid Services (CMS), *Ensuring Access to Medicaid Services & Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality*. More than 50% of our nation's children currently rely on Medicaid/CHIP coverage,<sup>1</sup> including children with special health care needs and those from low-income families. As CMS seeks to improve access to care in Medicaid/CHIP, the unique needs of children must be considered. We appreciate CMS' focus on children's access to care and strongly support many of the provisions and goals outlined in these proposed rules.

The unfortunate truth is that Medicaid/CHIP coverage does not always equate to sufficient access to care. Too many barriers remain that prevent some children from accessing the care that they critically need, including traveling long distances to get care, waiting weeks or months to get an appointment with a clinician, getting care from clinicians with less specific training, or going without care altogether. Overall, the process can be cumbersome and unreliable for patients, families, and providers, contributing to delays in care.

Our organizations have long urged CMS to do more to fulfill its obligation under Section 1902(a)(30)(A) of the Social Security Act to ensure sufficient access for children enrolled in Medicaid/CHIP. As such, we applaud the agency for proposing these groundbreaking regulations, which make sweeping changes to improve children's access to care and health care quality in both Medicaid Managed Care and Medicaid Fee-For-Service (FFS). Though CMS has proposed separate rules to define and oversee enrollee access to care in Medicaid FFS and Medicaid Managed Care delivery systems, we strongly urge CMS to adopt a unified approach to mitigate and further prevent disparities in access to care for children in these different delivery systems. Medicaid enrollment should guarantee access to care regardless of the delivery system a state has implemented. As such, we are responding here to both proposed rules. Our comments below highlight our general support for key policy changes that are included in one or both proposed rules. We also provide recommendations for additional actions to strengthen the proposed rules for children.

**Network Adequacy**

Children are not little adults; they require services and care to meet their ever-changing developmental needs. It is imperative children receive timely preventive care, well-child visits, and screenings to identify health conditions, developmental delays, and other challenges early so that they can access needed treatment

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<sup>1</sup> CMS. (2023). *Medicaid & Chip Enrollment Data—February 2023*. Retrieved June 14, 2023, from <https://www.medicare.gov/medicaid/national-medicare-chip-program-information/medicaid-chip-enrollment-data/index.html>

services to achieve and maintain their highest level of functioning. Barriers to needed services can delay treatment and intervention initiation, contributing to poorer outcomes for children and families and greater long-term costs to the health care system.

In general, we support the new standards for appointment wait times and the use of secret shopper surveys and enrollee experience surveys to monitor network adequacy more closely. The spirit of the rule represents a significant and welcome improvement in the way access is defined and monitored, which has the potential to improve health outcomes for children and families. We particularly appreciate CMS differentiating between "adult" and "pediatric" care in the proposed wait time standards and including geographic location to highlight the importance of supporting out-of-state care for children.

However, ensuring that children have access to the services and benefits delineated in Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is impossible without a sufficient, appropriately trained, adequately compensated pediatric workforce that participates in Medicaid FFS and in contracted MCO networks. Children enrolled in Medicaid may technically be eligible for an extensive list of services, but due to the limited number of pediatricians and other pediatric clinicians in a state Medicaid program or an MCO's network, families often struggle to find providers or face long appointment wait times. For example, children in mental health crisis seek services in an already inadequate and under-resourced system, leaving far too many on lengthy program waitlists or "boarding" in emergency departments until an appropriate placement or services become available.

Overall, the proposed rules seek to further align Medicaid network adequacy standards for pediatric primary care, pediatric outpatient behavioral health services, and OB/GYN services with those in the Marketplace. Notably, the current proposal does not align with the Marketplace specialty visit appointment time standard (30 business days) and the Marketplace time-and-distance standards. These proposed wait time standards are a crucial first step to improving access to care, though such standards alone cannot immediately address the long-term workforce shortages.<sup>2</sup> In addition to enforcing meaningful wait time standards, CMS must collaborate across HHS and with external stakeholders to address systemic underinvestment in pediatric care and historic workforce shortages through a combination of workforce incentives, payment reforms, and appropriate network adequacy oversight.

We offer the following recommendations to strengthen the network adequacy component of the proposed rules:

- **We support CMS expanding the timeliness standards proposed in the Managed Care rule at § 438.68 to all children enrolled in Medicaid FFS.**
- **We recommend CMS expand the proposed timeliness standards to include pediatric specialty care (30 business days).**
- **At a minimum, CMS should align the maximum wait time thresholds and time and distance standards for pediatric primary care, pediatric behavioral health care, pediatric specialty care, and OB/GYN services with those set to go into place in the Marketplace in 2025.**

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<sup>2</sup> Hu, Ju-Chen, Janet R Cummings, Xu Ji, and Adam S. Wilk. "Evaluating Medicaid Managed Care Network Adequacy Standards And Associations With Specialty Care Access For Children." Health Affairs, June 2023.  
<https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01439>.

### **Payment Transparency**

Medicaid's equal access provision 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." However, Medicaid fee schedules and capitated payments to primary care and subspecialty clinicians are significantly lower than payments for the same services from Medicare and private insurance companies.<sup>3</sup> Consequently, low Medicaid payment rates, delayed or unpredictable payments, and confusing or burdensome payment policies and paperwork are the main drivers that ultimately limit provider participation in the program, leaving patients with inadequate access for primary care and subspecialty health care services.<sup>4,5</sup>

Making payment rates in both FFS and managed care more transparent to policymakers, providers, patients, and advocates is an important first step towards enforcement of the equal access provision. These requirements will ensure stakeholders have more accurate information related to payment and create the opportunity for them to raise concerns to State Medicaid agencies and MCOs when inadequate payment impedes access to care for beneficiaries.

While we support these proposed changes, we remain concerned that the 80 percent benchmark outlined by CMS severely undervalues pediatrics and will not meaningfully address inadequate payment to Medicaid providers. Notably, proposed § 447.203(c) in the Access rule develops a process for State access analyses that would **only** be required whenever a State submits a SPA proposing to reduce provider payment rates or restructure provider payments.

Our recommendations to further strengthen payment transparency are below:

- **The proposed 80 percent fee ratio threshold proposed by CMS at § 447.203(c)(1)(i) should be increased to 100 percent of Medicare. CMS should require the more extensive access analysis outlined in § 447.203(c)(2) when a proposed rate reduction would take Medicaid payment below 100 percent of Medicare.**
- **The proposed Medicaid-to-Medicare fee ratio threshold should become a federal floor for all SPA and waiver approvals for the specified physician and outpatient services, not just for proposed rate reductions.**
- **CMS should require any state below a 100% Medicaid-to-Medicare fee ratio for pediatric primary care and pediatric behavioral health services to demonstrate on an annual basis that they are fully meeting the equal access provision for children enrolled in Medicaid. This requirement should apply to both FFS and managed care delivery systems.**
- **CMS should require all states, including those with a Medicaid-to-Medicare fee ratio above 100%, to complete the more extensive access analysis outlined in § 447.203(c)(2) to establish a baseline measure of access to care for Medicaid beneficiaries. Such analysis should include FFS as well as**

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<sup>3</sup> Medicaid-to-Medicare Fee Index, 2019, Kaiser Family Foundation. <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/>

<sup>4</sup> AAP Survey of Pediatrician Participation in Medicaid, CHIP and VFC. Elk Grove Village, IL: American Academy of Pediatrics; 2012

<sup>5</sup> Bisgair J, Polsky D, Rhodes KV. Academic medical centers and equity in specialty care access for children. Arch Pediatr Adolesc Med. 2012;166(4):304–310pmid:22147760

**managed care, enabling comparison of access within and across delivery systems. This baseline analysis should serve as a comparison point for future access monitoring.**

### **Home and Community-Based Services (HCBS)**

Children enrolled in Medicaid are entitled to home health care services, personal care services, and private duty nursing services through EPSDT. Despite this right, and the resulting state obligation to provide medically necessary home health care, access to and the quality of nursing and personal care through EPSDT falls short.

Private health insurance rarely covers pediatric home health care. For families of children not categorically eligible for Medicaid, some states include pediatric access through certain Home and Community-Based Services (HCBS) waivers, Section 1115 waivers, and other state-specific mechanisms. Even in states where such services are available, there are often gaps and children are placed on waiting lists despite the requirements of the Americans with Disabilities Act and the *Olmstead v. L.C.* Supreme Court decision. Overall, children's access to HCBS is disparate and varied across states, shifting the state obligation to provide pediatric home health care to, in most situations, unpaid family caregivers.

We support CMS creating new HCBS safeguards in the proposed rules. If finalized, the proposed changes would improve HCBS by strengthening monitoring and oversight, standardizing quality measures and reporting requirements, better supporting the direct care workforce, and prioritizing person-centered planning.

To better serve the unique needs of children who rely on HCBS, we offer the following recommendations:

- **CMS should ensure 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.**
- **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.**
- **CMS should explicitly mention paid family caregivers as part of the payment adequacy provision and/or the definition of direct care workforce.**
- **The proposed HCBS quality measure set should have pediatric specific metrics.**

### **Medicaid Advisory Committees**

The proposed improvements to the Medicaid Advisory Committee (MAC) system at § 431.12 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.

- **CMS must ensure that families of children 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 by States for their participation in these processes, including providing transportation assistance/reimbursement,**

**childcare, financial reimbursement (for room, board, and any missed work), and varying meeting times and locations to allow participation of enrollees during working hours.**

### **Strengthening Implementation of EPSDT**

According to CMS, Medicaid's 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."<sup>6</sup> Despite robust federal statutory requirements to promote and protect children's health, state compliance with EPSDT is highly variable even within a state, often deficient in covered services, and presents an ongoing challenge for parents, providers, and child health advocates. All children, regardless of their zip code, must have timely access to the full range of medically necessary and age-appropriate services.

We acknowledge that CMS is undertaking additional review of EPSDT implementation and will provide state Medicaid programs with updated guidance by June 2024 in accordance with the Bipartisan Safer Communities Act.<sup>7</sup> Our organizations look forward to understanding the findings of the landscape analysis and working with CMS to strengthen children's access to care.

However, this core guarantee for children can't wait: CMS must take steps now to strengthen EPSDT.

- **We urge CMS to incorporate stronger assessments of EPSDT implementation into both proposed rules.**
- **When submitting CMS-416 data, managed care states should be required to stratify their data at the MCO level, in addition to its aggregate statewide results. CMS should also strengthen data transparency by posting both the statewide and MCO-specific data to a publicly available website, which will allow stakeholders to compare MCO performance.**

Our organizations tremendously appreciate the hard work by CMS to craft a thoughtful, comprehensive regulatory approach to improving access to care in Medicaid and CHIP. If our organizations can be of any further assistance, please do not hesitate to contact Stephanie Glier, Director, Federal Advocacy at the American Academy of Pediatrics at [sglier@aap.org](mailto:sglier@aap.org).

Sincerely,

American Academy of Pediatrics  
Children's Hospital Association  
Family Voices  
First Focus on Children  
Georgetown Center for Children and Families  
National Association of Pediatric Nurse Practitioners  
Academic Pediatric Association  
AIDS Alliance for Women, Infants, Children, Youth & Families  
American Academy of Child and Adolescent Psychiatry  
American Pediatric Society

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

<sup>7</sup> CMCS. Informational Bulletin: Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth. August 18, 2022. <https://www.medicaid.gov/federal-policy-guidance/downloads/bhccibo8182022.pdf>

American Physical Therapy Association  
Association of Asian Pacific Community Health Organizations (AAPCHO)  
Center for Law and Social Policy (CLASP)  
Educare Learning Network  
March of Dimes  
National Federation of Families  
Primary Care Development Corporation  
Start Early  
The National Alliance to Advance Adolescent Health  
Youth Villages

*State Organizations*

Alabama Arise  
Alabama Chapter of the American Academy of Pediatrics  
Arizona Chapter of the American Academy of Pediatrics  
California Chapter 1 of the American Academy of Pediatrics  
Children's Advocacy Alliance of Nevada  
Children's Institute, OR  
Colorado Chapter of the American Academy of Pediatrics  
Colorado Children's Campaign  
Common Good Iowa  
DC Chapter of the American Academy of Pediatrics  
Family Connection of South Carolina  
Family Voices of New Jersey  
Family Voices of North Dakota  
Florida Chapter of the American Academy of Pediatrics  
Health Action New Mexico  
Idaho Voices for Children  
Illinois Chapter of the American Academy of Pediatrics  
Indiana Chapter of the American Academy of Pediatrics  
Iowa Chapter of the American Academy of Pediatrics  
Kansas Action for Children  
Kansas Chapter of the American Academy of Pediatrics  
Kentucky Chapter of the American Academy of Pediatrics  
Louisiana Partnership for Children and Families  
Maine Chapter of the American Academy of Pediatrics  
Maryland Chapter of the American Academy of Pediatrics  
Massachusetts Chapter of the American Academy of Pediatrics  
Minnesota Chapter, American Academy of Pediatrics  
Missouri Chapter of the American Academy of Pediatrics  
NC Child, NC  
Nebraska Chapter of the American Academy of Pediatrics  
Nevada Chapter of the American Academy of Pediatrics  
New Jersey Chapter of the American Academy of Pediatrics

New Mexico Pediatric Society  
New Mexico Voices for Children  
New York State Chapter 2 of the American Academy of Pediatrics  
New York State Chapter 3 of the American Academy of Pediatrics  
North Carolina Pediatric Society  
Ohio Chapter of the American Academy of Pediatrics  
Orange County Chapter of the American Academy of Pediatrics  
Partnerships for Action, Voices for Empowerment (PAVE), WA  
Pennsylvania Chapter of the American Academy of Pediatrics  
Pennsylvania Health Access Network  
Pennsylvania Partnerships for Children  
Raising Illinois Prenatal-to-Three Coalition  
Raising Special Kids, AZ  
Rehabilitation and Community Providers Association (RCPA), PA  
Rhode Island Chapter of the American Academy of Pediatrics  
Rhode Island KIDS COUNT  
Shriver Center on Poverty Law, IL  
South Carolina Chapter, American Academy of Pediatrics  
SPAN Parent Advocacy Network, NJ  
Stanford Sierra Youth & Families, CA  
Tennessee Chapter of the American Academy of Pediatrics  
Texas Pediatric Society  
The Children's Agenda, NY  
The Children's Partnership, CA  
The Parents' Place of Maryland  
Virginia Chapter of the American Academy of Pediatrics  
Wisconsin Chapter of the American Academy of Pediatrics  
Wyoming Chapter of the American Academy of Pediatrics