

April 18, 2022

First Focus on Children Responses to the Centers for Medicare and Medicaid Services Request for Information: Access to Coverage and Care in Medicaid & CHIP

Submitted via cmsmedicaidaccessffi.gov1.qualtrics.com

Objective 1.1: What are the specific ways that CMS can **support states in achieving timely eligibility determination and timely enrollment** for both modified adjusted gross income (MAGI) and non-MAGI based eligibility determinations? In your response, consider both eligibility determinations and redeterminations for Medicaid and CHIP coverage, and enrollment in a managed care plan when applicable.

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.¹ 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.² 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. Consequently, meaningful outreach and enrollment resources and efforts that are culturally and linguistically appropriate (for example, in native language and plain language) and community based, as well as "no wrong door" policies continue to be vital to improving children's access to care under Medicaid and CHIP. CMS must work in close partnership across HHS as well as with other agencies such as DOE to connect and activate existing community-based and family-led organizations and projects to deliver enrollment services "where families are." This type of whole-of-government partnership with community-based and family-led organizations also ensures that diverse community health workers and peer-to-peer support can best reflect the communities in which they are situated and are best suited to offer culturally and linguistically appropriate enrollment services.

Children and parents tend to share the same insurance status, meaning that if a parent is uninsured, so is their child. The shared aspect of coverage between parents and children means that reducing access to parents will subsequently reduce access of their children.³ A comprehensive body of research highlights the powerful effect of increases in parental access to insurance coverage on their children's access to insurance coverage. In

¹ 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>.

² 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

³ Leighton Ku and Matthew Broaddus, *Coverage of Parents Helps Children, Too*, Center on Budget and Policy Priorities (October 2006), available at: <https://www.cbpp.org/sites/default/files/atoms/files/10-20-06health.pdf>

fact, from 2013–2015, 710,000 children who were already income-eligible for Medicaid gained coverage, despite the fact that these children’s eligibility for coverage did not change under the Affordable Care Act.⁴ This is due in large part to parents gaining coverage under the Medicaid expansion and realizing that their children had been eligible for Medicaid all along. 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 in low-income families received at least 1 annual well child visit.⁵ These findings reiterate the importance of parental coverage in ensuring that children can get the care they need to learn, grow, and thrive.

Objective 1.3: In what ways can CMS support states in addressing barriers to enrollment and retention of eligible individuals among different groups, which include, but are not limited to: people living in urban or rural regions; people who are experiencing homelessness; people who are from communities of color; people whose primary language is not English; people who identify as lesbian, gay, bisexual, transgender, queer, or those who have other sexual orientations or gender identities (LGBTQ+); people with disabilities; and people with mental health or substance use disorders? Which activities would you prioritize first?

Early Childhood Continuous Eligibility

Having uninterrupted health care coverage from birth to age 6 allows children to have consistent access to well-child visits, vaccinations, and specialty care. During these first five years, children need regular, routine checkups so that any social, emotional, or developmental delays are detected early and before beginning school. Medicaid and CHIP specifically provide comprehensive coverage for children through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit — with little or no cost to families.

A child who churns in Medicaid and/or CHIP will experience gaps in both coverage and access to care that can be detrimental to their development; even a short gap in coverage can harm a child by reducing their access to necessary care. If a coverage gap is prolonged, families may face expensive medical bills or may put off their child’s care due to high out-of-pocket costs. Maintaining Medicaid and/or CHIP coverage through age 5 provides children with a long-term medical “home,” where care is coordinated, efficient, and consistent. Continuous eligibility will also ensure children have access to the same provider networks and benefits. Churning or fluctuating from Medicaid and/or CHIP to private coverage due to income changes forces families to search for new in-network providers and navigate new cost-sharing rules, burdening families and complicating a child’s access to necessary care.

Children who are Black, Latino, or multi-racial are more likely to be enrolled in Medicaid/CHIP, and providing continuous eligibility until age 6 would ensure these children are entering school on the same ground as their white peers. Furthermore, families with a low income, who have less education, or who are Black or Hispanic are more likely to have changes in income within a year that would change a child’s eligibility for Medicaid/CHIP, increasing the likelihood of churn. These families may already be struggling to make ends meet and allowing their children to churn in and out of Medicaid/CHIP may cause irreversible, lifelong harm.

CMS should encourage states to apply for waivers that provide multi-year coverage for young children.

Reducing Barriers to Limited English Proficient Communities

⁴ 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>

⁵ 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>

According to a report from the Assistant Secretary for Planning and Evaluation, among the remaining uninsured are 2.2 million people who live in households where no English is spoken and 3.2 million live in households with at least one non-English language spoken.⁶ Given that these data exclude undocumented immigrants, they are likely a significant undercount. Overall, there are more than 25 million limited English proficient (LEP) individuals living in the United States.⁷ The Kaiser Family Foundation has also found that, compared to an uninsured rate of 9% for nonelderly citizens, 26% of lawfully present immigrants lack health insurance, topped by 42% of undocumented immigrants.⁸ U.S. citizen children with at least one immigrant parent have an uninsured rate more than double that of their peers. Achieving the Biden administration's equity and coverage goals requires CMS to invest significant resources addressing LEP and immigrant communities' access to Medicaid and CHIP.

Both applicants and eligibility workers spend significant time addressing the cases of LEP and immigrant applicants for Medicaid due to the lack of in-language resources. Few states have developed applications in languages other than English, and of those, they are primarily in Spanish. When LEP people apply for Medicaid or CHIP with English-language applications, they may end up submitting incomplete or unresponsive information if they do not understand the questions correctly. Some applicants may skip questions or intentionally enter incorrect information if they become stuck, for example; this leads to delays in coverage as workers resolve the issues. CMS should work with states to increase the number of applications available in multiple languages. It should also work with states to hire more workers from linguistic minority communities to process those applications and ensure machine-translation tools are not used in reviewing them.

CMS should assist states draft Medicaid and CHIP applications, both in English and other languages, that are written in a culturally competent manner for populations with low literacy in the U.S. health and economic systems. It should focus test template applications with a diverse array of potential applicants, including from immigrant and limited English proficient communities. It should also review applications for potential to eliminate or reduce questions. This will not only help applicants, particularly immigrant and LEP households who may have complex eligibility scenarios, avoid errors but will make the application less intimidating. For example, applicants with multi-generational large households may feel intimidated by filling out duplicative information for each household member, and there may be opportunities to cut down on repeating questions in those situations.

CMS should also review training for call-center intake workers. In some states, these workers are not given cultural competency or policy training, leading to miscommunication or incorrectly filled out applications that are then delayed for processing as errors are resolved by eligibility workers. The federal marketplace call center has improved its performance in this area over time, including addressing problems with interpretation services and in-language glossaries for health and health insurance terms. CMS should draw best practices from other call centers to help states improve the performance of their Medicaid and CHIP intake staff to avoid delays due to errors.

CMS should also ensure that eligibility workers have proper and clear training about the eligibility of different types of immigrants for different types of coverage. Given the very complex nature of immigrants' eligibility for Medicaid and CHIP, with variations by immigration status, state of residence, age, pregnancy status, and length of time in the U.S., it is too easy for an under-trained worker to incorrectly deny coverage. Immigrants may be similarly unaware of their incorrect denial or lack the resources to pursue an appeal. CMS should consider establishing, in partnership with state agencies, help lines staffed by policy experts for complex

⁶ Issue Brief No. HP-2021-21 "Reaching the Remaining Uninsured: An Evidence Review on Outreach & Enrollment Strategies." <https://aspe.hhs.gov/reports/reaching-remaining-uninsuredoutreach-enrollment>. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. October, 2021.

⁷ Jie Zong and Jeanne Batalova, "The Limited English Proficient Population in the United States in 2013," Migration Policy Institute, July 2015. <https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states-2013>

⁸ "Health Coverage of Immigrants," Kaiser Family Foundation, April 2022. <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/>

determination scenarios, such as mixed-status families, or for developing events, such as Ukrainian and Afghan arrivals. While local agencies usually have policy staff or consultants, having additional, responsive resources may reduce unnecessary appeals.

12-Month Continuous Eligibility for Children in Medicaid and CHIP for all Kids and Youth

Children in low-income families should be continuously covered under Medicaid or CHIP for a full year. Many families experience some income fluctuation, but their income does not change substantially or for the long term. Keeping children covered leads to improved health status and well-being, promotes health equity, and alleviates the impact of seasonal work, overtime, and variable work hours on low-income families. For states, continuous coverage for 12 months reduces administrative costs and labor while helping to promote more efficient health care spending. When children with chronic conditions have consistent access to medications and their medical home, and when all children can access care when needed without interruptions, health care costs go down. CMS should encourage and incentivize all states to implement 12-month continuous eligibility.

Eliminate Barriers to Health Coverage for Children in Immigrant Families

All children should have access to health care, regardless of their immigration status. The COVID-19 pandemic and its economic fallout have affected our nation's children and every child and family needs support to recover. Until Congress eliminates structural barriers in our immigration system and other systems to protect all children's healthy development, including the five-year waiting period for those with legal permanent status to access certain federal programs and determinations of public charge for children, CMS should encourage and incentivize states to eliminate the five-year bar for children and people who are pregnant.

Expand CHIP income eligibility to 300% of Poverty in All States

The CHIP income eligibility level varies across the country. Some states provide CHIP for children in families at or just above 300% of the federal poverty level (FPL) and some states have an eligibility level as low as 175% (North Dakota). Current rules don't allow states to expand their CHIP eligibility level even if their legislature and governor want to. CMS should encourage states to utilize the state plan amendment process to raise their CHIP eligibility level.

Eliminate Waiting Periods for CHIP

Currently, 12 states enforce waiting periods for children who apply to a CHIP. These waiting periods require children to "go bare" without any insurance through CHIP even though they meet income and other eligibility requirements. These waiting periods are an archaic standard that means children are uncovered while they are growing, developing, and, over the last two years, living through a pandemic. CMS should eliminate the state option for waiting periods.

Enroll All Eligible Children

The majority of uninsured children in this country are eligible for Medicaid or CHIP but are not enrolled. Approaches to improve enrollment should include a combination of ways to enroll, retain, and renew coverage, including expanded outreach to families with children, such as enhanced use of culturally competent navigators, community health workers, and parent mentors; enrollment at key moments and places such as at birth and during enrollment in WIC, Head Start, early childhood, and education programs; simplified paperwork and elimination of bureaucratic barriers; and allowance of presumptive and express lane eligibility and a streamlined renewal of coverage. CMS should incentivize states to take up all options, including Express Lane, to enroll all eligible kids.

Objective 2.1: How should states monitor **eligibility redeterminations**, and what is needed to improve the process? How could CMS partner with states to identify possible improvements, such as leveraging managed care or enrollment broker organizations, state health insurance assistance programs, and marketplace

navigators and assisters to ensure that beneficiary information is correct and that beneficiaries are enabled to respond to requests for information as a part of the eligibility redetermination process, when necessary? How could CMS encourage states to adopt existing policy options that improve beneficiary eligibility redeterminations and promote continuity of coverage, such as express lane eligibility and 12-month continuous eligibility for children?

CMS should engage in formal conversations with state Medicaid offices and state budget officers about these specific options. CMS should be prepared to show the administrative and per member/per month cost savings when 12-month, or longer, continuous eligibility is applied to Medicaid recipients. Data shows that continuous coverage can reduce monthly/yearly Medicaid costs, so states could negotiate lower rates with MCOs.⁹ In order for states to see the benefit of offering 12-month continuous eligibility, Medicaid and state budget offices should receive in-depth cost savings estimates for their states from CMS. The same could be said for Express Lane. Data shows that South Carolina saved \$1.6 million in administrative costs when they implemented Express Lane.¹⁰ State budget officers would likely find that a compelling argument and probably have no idea it exists. Including key Medicaid staff and budget office staff in these ongoing conversations could entice more states to take up the already existing options. It won't be easy, but with consistent conversations and sharing data that show how their particular state will benefit fiscally and kids will benefit in terms of health outcomes, could be what is needed to bring states on board.

CMS should also encourage states to apply for waivers that provide multi-year coverage for young children.

Objective 2.3: What actions could CMS take to promote continuity of coverage for **beneficiaries transitioning** between Medicaid, CHIP, and other insurance affordability programs; between different types of Medicaid and CHIP services/benefits packages; or to a dual Medicaid-Medicare eligibility status? For example, how can CMS promote coverage continuity for beneficiaries moving between eligibility groups (e.g., a child receiving Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] qualified supports who transitions to other Medicaid services such as home and community based services [HCBS] at age 21, etc.); between programs (Medicaid, CHIP, Basic Health Program, Medicare, and the Marketplace); or across state boundaries? Which of these actions would you prioritize first?

CMS should encourage states to apply for waivers that provide multi-year coverage for young children. Specifically, continuous coverage from birth through the age of 5 allows children to have consistent access to well-child visits, vaccinations, and specialty care. During these first five years, children need regular, routine checkups so that any social, emotional, or developmental delays are detected early and before beginning school. Medicaid and CHIP specifically provide comprehensive coverage for children through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit — with little or no cost to families.

Additionally, coverage between Medicaid and CHIP should be seamless, so children who move between beneficiary groups experience no gaps in coverage. Maintaining seamless Medicaid and/or CHIP coverage through age 5 provides children with a long-term medical “home,” where care is coordinated, efficient, and consistent.

Objective 3.1: What would be the most important areas to focus on if CMS **develops minimum standards** for Medicaid and CHIP programs related to access to services? For example, should the areas of focus be at the national level, the state level, or both? How should the standards vary by delivery system,

⁹ Leighton Ku, PhD, MPH, Erika Steinmetz, MBA and Tyler Bysshe, MPH, “Continuity of Medicaid Coverage in an Era of Transition,” Milken Institute of Public Health, George Washington University, November 2015.

http://www.communityplans.net/Portals/0/Policy/Medicaid/GW_ContinuityInAnEraOfTransition_11-01-15.pdf

¹⁰ Jennifer Edwards & Rebecca Kellenberg, “Case Study of South Carolina’s Express Lane Eligibility Processes,” Health Management Associates, Nov. 2013. <https://www.healthmanagement.com/wp-content/uploads/Final-South-Carolina-ELE-Case-Study-ASPE-03062014.pdf>

value-based payment arrangements, geography (e.g., sub-state regions and urban/rural/frontier areas), program eligibility (e.g., dual eligibility in Medicaid and Medicare), and provider types or specialties?

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.”¹¹

We urge CMS to develop stronger enforcement mechanisms to ensure children enrolled in Medicaid and Medicaid-expansion CHIP programs have access to all EPSDT services. Despite robust federal requirements to promote and protect children’s health, state compliance with EPSDT is often deficient, varies across states, 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 soft 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.

To ensure that the inclusion of the full range of services are covered, the HHS Secretary must be required to develop a standardized definition of medical necessity, including a specific standard of *pediatric medical necessity* to be applied on a case-to-case basis, to assure that children and others can access essential health benefits meaningfully and consistently. In line with the AAP, the pediatric definition of medical necessity should be as follows: “health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals, such as the AAP, to promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities.”¹²

Objective 3.3: How could CMS consider the **concepts of whole person care or care coordination** across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs when establishing minimum standards for access to services? For example, how can CMS and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination?

Children and youth are currently facing a mental health crisis, which has been exacerbated by the pandemic. While the mental health challenges of COVID-19 have affected children of all backgrounds, they have disproportionately impacted children of color. Unfortunately, the increased demand for mental health services coincides with a severe lack of resources for children and teens. There are many ways to address the workforce shortage, but from a provider standpoint, the integration of behavioral health services with primary care would allow more children to access necessary mental health treatment, and would also emphasize prevention and early intervention. The average delay between the onset of mental health symptoms and treatment is 11 years, so prevention and early intervention are especially important.

¹¹ “Early and Periodic Screening, Diagnostic, and Treatment,” Centers for Medicare and Medicaid Services.

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

¹² Essential Contractual Language for Medical Necessity in Children. Committee On Child Health Financing. Pediatrics Aug 2013, 132 (2) 398-401; DOI: 10.1542/peds.2013-1637. <https://pediatrics.aappublications.org/content/132/2/398>

CMS should also 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 those that promote integrated care.

Additionally, parity for mental health services and compliance with parity laws needs to be emphasized. CMS should prioritize oversight and compliance with the requirements of federal insurance parity laws to ensure broader mental health insurance networks that can meet the increased needs of children and adolescents.

Navigators Funding should also be available for primary care practices to hire care coordinators or navigators who help families navigate the often-complex mental health care system. Systems for care linkages and follow-ups, including referral to outpatient and community behavioral health centers should be created. Payment should also be provided for time spent addressing social drivers of health, such as nutrition, safety, transportation, and housing, which often impact mental health.

We ask CMS to use every authority possible to increase children's access to mental health services, such as improving access to evidence-based prevention, early identification, and early intervention; expand mental health services in schools; integrating mental health into pediatric primary care; strengthening the child and adolescent mental health workforce; increasing insurance coverage and payment; extending access to telehealth; supporting children in crisis; addressing the mental health needs of justice-involved youth; and improving access to peer support networks.

In addition, we urge CMS to:

Continue to expand postpartum Medicaid coverage

Currently, Medicaid coverage for postpartum mothers only lasts for 60 days in many states. For postpartum mothers struggling with a substance use disorder, and especially mothers that have given birth to a newborn with prenatal substance exposure, 60 days of coverage is simply not enough to address their specific needs. One study found that opioid overdose deaths among postpartum mothers decline during pregnancy, but peak in the 7 to 12 months postpartum, which does not overlap with the 60-day coverage period. Another study found that expanded Medicaid does in fact increase coverage for postpartum women.¹³ Postpartum visits in Colorado, a state that expanded Medicaid, were 50 percent higher than in Utah, a state that has yet to expand the program.¹⁴ We appreciate CMS' implementation of the provision of the American Recovery Act that gives states the option to extend postpartum Medicaid coverage to 12 months, and we urge CMS to do everything possible to encourage states to take up this option.

Encourage coordination of systems around families

Children and families impacted by opioids have needs that fall under the jurisdiction of a range of state departments, offices, and programs, and some of the most successful efforts to provide prevention and

¹³ Schiff, Davida M et al. "Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts." *Obstetrics and gynecology* vol. 132,2 (2018): 466-474. doi:10.1097/AOG.0000000000002734

¹⁴ Gordon, Sarah H., et al. "Effects Of Medicaid Expansion On Postpartum Coverage And Outpatient Utilization: The effects of Medicaid expansion on postpartum Medicaid enrollment and outpatient utilization. Comparing Colorado, which expanded Medicaid, and Utah, which did not." *Health Affairs* 39.1 (2020): 77-84.

services to families involve coordination among these different entities. Some of these stakeholders include mental and behavioral health providers; physical health providers; the child welfare system; economic supports including housing, TANF, and WIC; and family courts. Rarely is federal or state funding directed for purposes of this coordination. Without coordination and buy-in from families, communities, and local practitioners, success is much less likely for families and programs.¹⁵ One example of a state program utilizing this coordinated approach is the Children and Recovering Mothers (CHARM) Team in Vermont, which is an interdisciplinary and cross-agency team that coordinates care for pregnant and postpartum mothers with a history of opioid use disorder and their babies. This is a program supported by the federal government through the Substance Abuse and Mental Health Services Administration, and some of the indicators of success include starting prenatal care early in pregnancy, engaging in SUD treatment and counseling, the provision of family and social supports, and creating plans of safe care.

We ask CMS to encourage this type of care coordination in states through regulation, payment, and other assistance to states.

Support family-centered treatment and care

Families with children impacted by substance use must be afforded the opportunity to recover in environments that work best for their families and meet their needs. Family-centered treatment programs include children and other family members in the treatment process, provide family-based clinical care, and provide supportive and community-based services including child care, transportation, home visiting, mental health services, employment training, housing, and linkages to other financial aid and human services programs.¹⁶ Numerous states have implemented family-centered treatment programs and have seen positive outcomes including that participating mothers were more likely to receive prenatal and postpartum behavioral health care, findings of child maltreatment were less common in participating families, and the length of NICU stays for babies born with prenatal substance exposure were shorter for families in these programs. However, access to these programs is limited because they are not widespread and sustained throughout the country.

One example of such a program is the Boston Medical Center's Supporting Our Families Through Addiction and Recovery (SOFAR) program, which establishes a medical home in its pediatric primary care clinic for parents in recovery and their children and provides these families with ongoing support to enhance child development and parent recovery.¹⁷

Another example is Yale New Haven Hospital's treatment of Neonatal Abstinence Syndrome (NAS), which is a non-pharmacological approach and instead focuses on soothing the infant's symptoms while encouraging the mother-infant bond. This approach typically includes rooming together post-delivery and modification of the environment to support attachment and provide a soothing environment for the infant. Such non-pharmacological approaches are associated with better outcomes for both infants' short term and long-term health, as well as mothers' recovery outcomes in the near and long-term and attachment between mother and child, which is fundamental to building a healthy parent-child relationship.

Family-based residential treatment can also be beneficial for postpartum parents and their families. This type of treatment allows parents to receive substance use treatment in a location where their children and family live alongside them, thus preventing the children from being removed to foster care. One example of family-

¹⁵ Substance Abuse and Mental Health Services Administration. A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. HHS Publication No. (SMA) 16-4978. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016. Available at: <http://store.samhsa.gov/>.

¹⁶ Seibert, Julie, et al. "State policy levers for expanding family-centered medication-assisted treatment." *Washington, DC: Office of the Assistant Secretary for Planning and Evaluation* (2019).

¹⁷ SOFAR (Supporting Our Families through Addiction and Recovery)," Boston Medical Center. <https://www.bmc.org/pediatrics-primary-care/sofar>

based residential treatment services is provided by LUND in Vermont, which provides residential treatment for substance use and mental health issues for pregnant and parenting women in addition to other family support and wrap-around services.¹⁸

We ask CMS to encourage the use of family-centered treatment and care through regulation, payment, and other assistance to states.

Objective 3.5: What are specific ways that CMS can support states to **increase and diversify the pool of available providers** for Medicaid and CHIP (e.g., through encouragement of service delivery via telehealth, encouraging states to explore cross-state licensure of providers, enabling family members to be paid for providing caregiving services, supporting the effective implementation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, implementing multi-payer value-based purchasing initiatives, etc.)? Which of these ways is the most important?

If children receive continuous coverage, 12 months or multi-year, providers may be more likely to take patients with Medicaid or CHIP as they won't doubt if they will be paid for their services and they can build a medical home with their patient.

Additionally, future consideration should be given to the role of telehealth in network adequacy and we urge CMS to consider telehealth as *a supplement to*, rather than a substitute for, appropriate in-network providers. During the coronavirus pandemic, telehealth emerged as a vital health care service delivery tool for providers, patients and families. It will continue to be critical to providing necessary care beyond the pandemic. Pediatric providers have implemented a range of telehealth technologies to meet the needs of their patients ranging from texting families the results of COVID-19 tests, conducting aspects of well-child visits, delivering behavioral health services and providing in-hospital consultative care via telehealth.

There is also a dire shortage of practitioners specializing in mental and behavioral health to care for infants, children, adolescents, and young adults. Prior to the pandemic, in 2020, SAMHSA estimated that 4.5 million additional behavioral health practitioners are needed to address the needs of children with serious emotional disturbances and adults with serious mental illness, including an additional 49,000 child and adolescent psychiatrists. The gap between currently available child and adolescent providers including developmental-behavioral pediatricians and what is needed to provide evidence-based mental and behavioral health care for this population is stark.

CMS could help alleviate some of this shortage by helping schools access Medicaid coverage for mental health services provided there and investing in school-based mental health models to meet children where they are. Additionally, peer-to-peer support networks can play a role in connecting youth to mental health services and treatment, and CMS should examine ways that it can encourage and pay for the use of these networks.

Objective 4.1: What should CMS consider when developing an **access monitoring approach that is as similar as possible** across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care programs) and programs (e.g., HCBS programs and dual eligibility in Medicaid and Medicare) and across services/benefits? Would including additional levels of data reporting and analyses (e.g., by delivery system or by managed care plan, etc.) make access monitoring more effective? What type of information from CMS would be useful in helping states identify and prioritize resources to address access issues for their beneficiaries? What are the most significant gaps where CMS can provide **technical or other types of**

¹⁸ See <https://lundvt.org/about-lund/>.

assistance to support states in standardized monitoring and reporting across delivery systems in areas related to access?

CMS should require consistent and comparable data reporting across states. Particularly important are requiring and posting accurate data that reflect in a timely way, how many children by age, race, ethnicity, and location are enrolled, applied for and denied coverage, disenrolled, and have actual access to physical, oral, and mental health care and treatment. State advocates, policymakers, health provider organizations, and state legislators could use this data to pinpoint outreach to unenrolled children, enroll additional providers, and guide patients to care.

All children must have timely access, without administrative or financial barriers, to the full range of age-appropriate health care providers, including pediatric and perinatal specialists, subspecialists, and facilities. Children require developmentally appropriate and timely care from in-network primary, specialty, subspecialty, and ancillary pediatric providers with the training and expertise to care for children, regardless of where they live, even when those providers are in another state or region. Administrative requirements should not create obstacles for children and families in accessing the health care they need. It is imperative children receive preventive care, well-child visits, and developmentally appropriate screenings to identify challenges early and that they continue to access needed treatment services to achieve and maintain their highest level of functioning. Longer lag times between symptom onset and treatment due to challenges accessing needed services may not only result in poorer outcomes, but also in greater costs to patients and the health care system.

Federal network adequacy standards are needed that assure 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. In addition, standards must assure that all provider networks include perinatal providers to ensure timely access to maternity and newborn care.

Objective 4.2: What **measures of potential access**, also known as care availability, should CMS consider as most important to monitor and encourage states to monitor (e.g., provider networks, availability of service providers such as direct service workers, appointment wait times, grievances and appeals based on the inability to access services, etc.)? How could CMS use data to monitor the **robustness of provider networks across delivery systems** (e.g., counting a provider based on a threshold of unique beneficiaries served, counting providers enrolled in multiple networks, providers taking new patients, etc.)?

It is critical that quantitative network adequacy metrics enhance, rather than impede, children's timely access to the most appropriate provider for the care they need on an in-network basis. We support the use of time and distance metrics as a generally appropriate measure of a network's pediatric primary care capacity. However, time and distance cannot account for the many children who travel long distances and across state lines to receive necessary care from appropriate pediatric specialty providers, including children's hospitals equipped to meet their unique tertiary and quaternary medical needs. A study in the June 2018 issue of *Health Affairs*¹⁹ found that nearly half of pediatric specialty hospitalizations took place outside of adult-focused distance standards. Similarly, an earlier Children's Hospital Association analysis found that approximately 50% of children nationwide would not have access to the services of an acute care children's hospital if adult Medicare Advantage time and distance standards are used. The use of time and distance standards as the sole

¹⁹ Colvin, Jeffrey D., et al. "Hypothetical network adequacy schemes for children fail to ensure patients' access to in-network children's hospital." *Health Affairs* 37.6 (2018): 873-880.

metric for network adequacy would place children at risk of delayed services or may lead them to care in settings ill-equipped to address their pediatric service needs.

Rather than a sole reliance on time and distance, with our child health advocacy partners, we recommend a comprehensive, multi-faceted set of quantitative standards specific to pediatrics. Those measurable factors include, but are not limited to, wait times (as proposed in the Notice for behavioral health providers, but applied to all pediatric specialties); 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.

An objective federal network adequacy standard must also include strong oversight and monitoring of networks to identify and address pediatric provider network gaps or barriers to access. Provider networks must include oral health providers who treat children and mental health providers for children and families.

Objective 4.4: How should CMS consider requiring states to report standardized data on **Medicaid fair hearings, CHIP reviews, managed care appeals and grievances, and other appeal and grievance processes** that address enrollment in coverage and access to services? How could these data be used to meaningfully monitor access?

CMS should require states to report data on Medicaid fair hearings, CHIP reviews, managed care appeals and grievances, and other appeal and grievance processes that address enrollment in coverage and access to services. These data should include all demographic information, dates, time frames, decisions, and final outcomes.

Objective 5.1: What are the opportunities for CMS to **align approaches and set minimum standards for payment regulation and compliance** across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care) and across services/benefits to ensure beneficiaries have access to services that is as similar as possible across beneficiary groups, delivery systems, and programs? Which activities would you prioritize first?

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.

Objective 5.4: Some research suggests that, in addition to payment levels, administrative burdens that affect payment, such as claims denials and provider enrollment/credentialing, can discourage provider acceptance of Medicaid beneficiaries. What actions could CMS take to encourage states to **reduce unnecessary administrative burdens that discourage provider participation in Medicaid and CHIP** while balancing

the need for program integrity? Which actions would you prioritize first? Are there lessons that CMS and states can learn from changes in provider enrollment processes stemming from the COVID-19 Public Health Emergency?

As per our earlier answers, encouraging and incentivizing states to cover children and youth with multi-year coverage and twelve month continuous coverage will encourage provider participation and decrease state administrative costs.

Other Feedback

CMS should support legislation in Congress to require 12-month continuous eligibility in Medicaid and CHIP and permanent funding for CHIP.

CMS can expand access to Medicaid and CHIP by encouraging more states to take up the option to cover lawfully present pregnant people and children. To date, despite the availability of matching funds, 17 states do not cover lawfully present children, 17 are not covering lawfully present pregnant people, and an additional 14 are not covering all pregnant people regardless of status.²⁰ These states span the political spectrum, presenting opportunities for expansion given the right incentives. CMS should highlight the positive health outcomes for children and families if more states chose to do so, such as the connections to maternal and mental health.

CMS should also determine that Deferred Action for Childhood Arrivals (DACA) and Special Immigrant Juvenile Status (SIJS) recipients are lawfully present for Medicaid eligibility purposes for those states that have taken up the option. DACA recipients have been ineligible since HHS arbitrarily deemed them not lawfully present for the purposes of the Affordable Care Act, Medicaid and CHIP coverage.²¹ While applicants for SIJS are considered lawfully present, because of the unanticipated green card backlog, recipients of that status are not. These exclusions present the best opportunity for CMS to expand eligibility for a predominantly uninsured community of color without waiting on congressional or state action.

Medicaid acts as a safety net for people who live in poverty, work in occupations where employers do not offer health care and experience a variety of health problems. Together, Medicaid and CHIP serve 60% of children in the United States - and play a large role for children of color, covering more than half of Hispanic, Black, and AIAN children and nearly half of NHOPI children, compared to 27% of White children.²² 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. To truly achieve equity, the voices, experiences, and expertise of diverse stakeholders, especially youth and families, must be meaningfully included in partnership to design, implement, and monitor Medicaid and CHIP policies and practices.

²⁰ "Health Care Coverage Maps," *National Immigration Law Center*, <https://www.nilc.org/issues/health-care/healthcoveragemaps/>

²¹ "Frequently Asked Questions: Exclusion of Youth Granted 'Deferred Action for Childhood Arrivals' from Affordable Health Care," *National Immigration Law Center*, Sept. 25, 2013. <https://www.nilc.org/issues/health-care/acadacafaq/>

²² 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/>