Centers for Medicare and Medicaid Services

Vision

The Centers for Medicare and Medicaid Services (CMS) is one of the most important federal agencies that impacts the health of U.S. children. CMS manages Medicaid, the Children’s Health Insurance Program (CHIP), and the insurance marketplaces, which, combined, help finance the care of close to 40 million children in the country. These federal and state partnerships have a huge impact on families. Medicaid’s rate of growth is the lowest of any health program in the country. Its per-child costs are also the lowest of any quality insurance structure in the United States. Medicaid includes the appropriate pediatric benefit—the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT)—which covers medically necessary services for each child and is especially critical for children with special health care needs and their families. CMS is currently embarking on a challenging implementation of the new Merit-Based Incentive Payment System (MIPS) in Medicare, but the agency could also leverage its vast Medicaid and CHIP resources to ensure that every eligible child is enrolled and receives comprehensive access to EPSDT services, and ultimately, that all children get the right care in the right place at the right time.

Recommended Administrative Actions

Ensure that insurance offers children appropriate benefits. CMS should require the adoption of state-level requirements that covered benefits in Medicaid and stand-alone CHIP programs meet the ACA requirements for essential health benefits, which include preventive care, acute care, critical care, pediatric surgical care, behavioral health services, and oral health care. CMS should specifically clarify that such benefits packages should adhere to Bright Futures. This national health promotion and prevention initiative includes guidelines that provide theory-based and evidence-driven guidance for all preventive care screenings and well-child visits. CMS should also confirm that all future updates of Bright Futures are self-executing in the context of private insurance coverage. Because children often lack access to oral health care, CMS should provide detailed guidance specific to pediatric dental benefits in CHIP and the ACA marketplaces and allow for flexibility to provide cost-effective risk-based pediatric dental benefits. In addition, medical foods should be explicitly covered by all public and private insurers. CMS should work with the Department of Defense to strengthen and harmonize benefits provided by TRICARE. Lastly, CMS should ensure that state Medicaid programs cover out-of-state services when medically necessary.

Facilitate enrollment in health insurance for eligible children. More children have health insurance than ever before thanks to Medicaid and CHIP, but they do not always get the benefits of the programs to which they are entitled. Millions of children are eligible for Medicaid or CHIP but are simply not yet enrolled. If all eligible children were enrolled in the appropriate plans, the percentage of children who lack insurance could be cut by over 40 percent. CMS must act to further streamline enrollment and retention rules and work with states to simplify their eligibility procedures and boost outreach to ensure that every eligible child is enrolled in quality, affordable health insurance for which they are eligible. Appropriate support for presumptive eligibility and increased periods of continuous eligibility for children would also decrease the uninsurance rate. CMS should also coordinate efforts with HRSA, which funds the Family to Family Health Information Center (F2Fs) Program. These centers help families of children with special health care needs navigate the health care system, including state Medicaid programs.

Expand CHIP coverage for pregnant women. While states have the option of covering pregnant women under their CHIP programs, only 17 do so. CMS should work with states to identify barriers to uptake of the CHIP options for covering pregnant women and to expand access to prenatal care for eligible women.
Integrate mental and behavioral health into pediatric primary care. As many as one in five children in the United States will experience a diagnosable mental disorder, but only 20 to 25 percent of affected children receive treatment. There are countless more children who face mental and behavioral impairments that do not meet the criteria for a diagnosis, or who are not accessing developmentally appropriate assessment and diagnosis, whose needs are not being met by the current system. Primary care physicians treat one-third of children and adolescents with mental health conditions. Shortages of mental health professionals including those with early childhood and adolescent expertise—and, specifically, of child and adolescent psychiatrists—necessitate greater primary care clinician involvement in mental health care. The next administration should provide federal support for innovative state or regional models of behavioral health integration in pediatric primary care settings, such as child psychiatry access programs. As noted, it should also eliminate inappropriate behavioral health carve-outs, which prevent children from getting the care they need, and support payment policies that promote co-location of care and same-day billing of medical and mental health services.

Ensure that children receive mental health and addiction services regardless of insurance. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act was intended to protect children and their families from insurance discrimination on the basis of mental health and substance use disorders. That law—and successor legislation applying the same protections to Medicaid managed care and CHIP—were supposed to end long-standing discriminatory practice by insurers. Unfortunately, that has not proven to be the case. CMS should aggressively investigate and enforce provisions relating to treatment limitations and financial cost-sharing, including and especially within Medicaid managed care and CHIP, and work with Congress to expand these protections to fee-for-service Medicaid. This must include stronger protections for network adequacy and greater education of the provider community about the obligations of insurers under parity and what constitutes a violation of parity. In addition, CMS should work with states and private insurers to specifically cover multigenerational therapies to address infant-early childhood mental health issues.

Actively address downstream impact of MACRA on children. Changes in Medicare are often adopted and applied to Medicaid programs and to private payer contracts. Thus, even though few children are enrolled in Medicare, the new MIPS and Alternative Payment Models (APMs) programs in Medicare have the potential to impact health care payments for all children insured by Medicaid, CHIP, and private payers. CMS should consider the downstream impact that implementing MIPS will have on children and work with pediatric providers while implementing it to avoid later issues.

Protect adolescent confidentiality. It is absolutely essential for adolescents to be assured of confidentiality when they seek sensitive medical services like contraception, pregnancy tests, and treatment for sexually transmitted infections. Without a guarantee of confidentiality, they are unlikely to seek timely care for their health care issues. Yet, this confidentiality can be violated by billing practices and the health insurance claims process (e.g. Explanation of Benefits documents that are sent to the policy holder, including parents). CMS, in coordination with the Department of Labor, which oversees Employee Retirement Income Security Act (ERISA) plans, should work with the states to ensure that insurance coverage processes do not impede the ability of providers to deliver essential health care services to adolescents on a confidential basis.

Clarify the primary care exception rule. The Medicare program is clear—under the primary care exception rule (PCER)—that a physician can bill for up to four individuals in continuity care clinics in teaching hospitals, but it is unclear if the same applies to Medicaid. Most state agencies state that they follow the Physicians at Teaching Hospitals (PATH) guidelines, which only apply to Medicare. CMS should explicitly inform state Medicaid directors that pediatric providers qualify for the PCER, as well to ensure appropriate financing of pediatric training.

Address the impact of the “Two-Midnight Rule” on children. Children often arrive at hospitals with care needs that are addressed intensively, leading to rapid improvement. CMS should closely examine the impact of the “Two-Midnight Rule” with respect to children. The rule would require a Medicare patient to stay in the hospital for two nights to qualify for inpatient status. Downstream uptake of this rule could impact pediatrics. Currently, the rule undermines the medical judgment of the treating physician in determining the most appropriate course of care for their patients. Pediatric providers are concerned that, if the rule is applied to private insurers and other payers like Medicaid and CHIP, access to care for the most vulnerable populations of children could be limited even further.

Children with medically complex conditions. Children with special health care needs, in particular those with medical complexity, deserve access to the highest quality care in a medical home. The next administration must seek to improve patient care for these children. In addition, CMS should work to assure that children in need of home care services can access those services under the EPSDT benefit.

Health information technology (HIT). CMS should work to increase the regulatory uniformity of pediatric health information technology across states. Current electronic health records systems are not designed for the needs of children or pediatricians. CMS should require the inclusion of children covered by stand-alone CHIP programs in Health Information Technology for Economic and Clinical Health (HITECH) Act incentive payment case-mix calculations.

Support payment for primary care interventions. CMS should consider financing innovative primary care interventions for children that can have a significant impact on child health and
development. For instance, the Reach Out and Read program provides developmentally appropriate children's books to families in the primary care setting to encourage family reading and child literacy.

**Recommended Congressional Actions**

*Preserve the fundamental nature of Medicaid.* Medicaid is the largest health insurance program for children in the United States, but is under constant debate in Congress. Congress should cease efforts to block grant Medicaid, implement a per capita cap, or otherwise shift significant costs to states. These changes would represent a step backward in federal funding to states and states would invariably cut payments, limit services, or bureaucratize enrollment to decrease the burden on state budgets. Medicaid must remain a guaranteed source of coverage.

*Expand access to care by reauthorizing CHIP.* Since its bipartisan beginning in 1997, CHIP has worked hand-in-hand with Medicaid to cut the child uninsured rate approximately in half. CHIP currently finances insurance for eight million children in working families that earn too much to qualify for Medicaid but too little to afford private health insurance. Simply put, the benefits, affordability, and networks available in CHIP surpass other available options. Current federal funding for CHIP is slated to expire at the end of fiscal year 2017. If this is allowed to happen, it would disrupt coverage for millions of children and jeopardize their health. To ensure maximum stability for children, Congress should enact a long-term extension by the spring of 2017. Long-term funding will give stability to states and encourage them to implement innovations for their programs. Such an extension should also include provisions that increase participation among eligible children in CHIP and Medicaid, as eligible but unenrolled children constitute a large majority of children who remain uninsured.

*Apply Bright Futures requirement to all insurance.* The ACA references the Bright Futures recommendations as a standard for access and design of age-appropriate health insurance benefits for infants, children, adolescents, and young adults. Congress should explicitly require that all private insurance, Medicaid, CHIP, and other insurers cover all Bright Futures services for children.

*Ensure that children have access to providers under the Medicaid program.* Children are, too often, left behind by low Medicaid payment policies. On average, Medicaid pays about 70 percent of Medicare rates for a given service. Low Medicaid payments impede the ability of pediatric providers to accept more Medicaid patients, to implement medical home enhancements such as employing care coordinators, and to create unnecessary access barriers for children enrolled in the Medicaid program. Congress should extend the Medicaid payment equity provision of the ACA and enact legislation to apply the equal access rule to Medicaid managed care.

*Promote efforts to fully vaccinate all children.* The Vaccines for Children (VFC) program is a successful program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. Multi-antigen vaccine administration is regulated by the VFC program. The current CMS interpretation of the VFC statute promotes suboptimal pediatric care and threatens child welfare. CMS disallows the use of CPT code 90461 for multi-component vaccines and only allows CPT code 90460 for the first components. As a result, pediatricians are sending VFC children elsewhere for their vaccinations or are, in some instances, reverting to the use of less-effective single-antigen vaccines. These practices fracture the medical home and decrease vaccination rates, endangering entire communities. Congress should clarify the VFC statute in order to promote vaccine usage.

*Pass legislation to improve the care of medically complex children.* The Advancing Care for Exceptional (ACE) Kids Act, if properly designed and implemented, could provide access to a strong medical home for medically complex children, begin to remedy barriers to access in Medicaid across state lines, and improve data collection in Medicaid.

*Establish systematic and comprehensive data collection efforts in all care models.* Medicare data are now easily accessible for research and inform system reform efforts across the country. Yet, state Medicaid data are often non-comparable due to the structures established in individual programs. Data collection, aggregation, and analysis are necessary predicates for children to fully participate in health system reform efforts whether arising from fee-for-service or managed care models. Congress must act to ensure that data from state Medicaid programs can be systematically and appropriately utilized in a timely manner.

*Expand access to care through telehealth services.* Every child deserves access to care in a medical home and care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. Yet, too many children lack access to such a medical home, particularly those who live in underserved areas and who have special health care needs. Telehealth care has the potential to provide cost-effective opportunities to meet the patient’s needs, including the unique needs of children. The next administration should encourage the passage and implementation of the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act (S. 2428 in the 114th Congress) and the Expanding Capacity for Health Outcomes (ECHO) Act (S. 2873 in the 114th Congress). Incorporating these models into the pediatric medical home could help ensure child access to appropriate and coordinated care.

*Ensure child access to mental and behavioral health care.* Nationwide, there are significant shortages of providers to treat children with mental health concerns. Congress should pass the Children's Access to Mental Health Services Act (H.R. 5462 in the 114th Congress), which provides an enhanced federal match for state Medicaid administrative expenses. This match enables states to create the necessary infrastructure to develop and
implement organized behavioral health access programs for children. Congress should also address payment and insurance design that serve as barriers that prevent pediatric providers from seamlessly providing or collaborating with other medical professionals to provide mental health services to children.

**Expand the number of pediatric providers.** Medicare's graduate medical education (GME) program provides essential support for pediatric GME programs located outside of freestanding children's hospitals. The program, however, has an arbitrary statutory cap on the number of Medicare-funded GME slots that hampers the nation's ability to meet the need for pediatric providers. Congress should expand the number of Medicare GME slots and ensure equitable distribution to pediatrics to support the pediatric pipeline. In addition, to incentivize provision of care to children on Medicaid, Congress should explore loan repayment for physicians who serve a significant share of low-income patients.

**Maintain coverage for youth in the juvenile justice system.** The period when a juvenile reenters the community after being incarcerated is a critical time to prevent recidivism. Connection with appropriate medical, mental health, and substance abuse care is absolutely necessary. Yet, states often completely terminate a juvenile's Medicaid coverage while they are in the juvenile justice system. Federal law should facilitate easier access to services upon reentry by requiring states to merely suspend, rather than terminate, a juvenile's Medicaid coverage when he or she is incarcerated.

**Medicaid parity for Puerto Rico.** In general, under federal law, the percentage of funds that the federal government provides to Puerto Rico's Medicaid program is capped at 55 percent, despite lower incomes and higher rates of poverty than the U.S. mainland. Enhanced funding provided to Puerto Rico under the ACA will cease at the end of fiscal year 2017. Since 40 percent of Puerto Rico residents rely on Medicaid for health insurance, Congress must address the impending shortfall to prevent devastating cuts to services and eligibility.

**Fix the foster care "glitch."** In passing the Affordable Care Act, Congress intended to extend health care coverage eligibility to all individuals up to age 26. However, because of what is understood to be a “glitch” in federal law, this eligibility is being denied to youth who age out of foster care in one state but subsequently reside in a different state. If the administration fails to address this issue administratively, Congress should pass legislation that clarifies eligibility to age 26 across state lines for youth who age out of foster care.

### Funding Priorities

**Enrollment.** CMS should continue funding for outreach and enrollment in communities for CHIP, Medicaid, and marketplace plans. CMS should encourage states to coordinate enrollment efforts with community based programs in order to reach children and families where they are.

**Health Information Technology.** CMS should waive requirements for pediatricians to have a certain percentage of their case mix financed by Medicaid to qualify for health information technology (HIT) incentive payments. Pediatricians have the lowest penetration of HIT of any medical specialty and hurdles to qualify in Medicaid are not comparable to those in Medicare.

### About this Document

This document is an excerpt from **Blueprint for Children: How the Next President Can Build a Foundation for a Healthy Future** (http://aap.org/blueprint), which was produced by the American Academy of Pediatrics in September 2016 and has also been endorsed by the following organizations: the Academic Pediatric Association, the American Pediatric Society, America’s Promise Alliance, the Association of Medical School Pediatric Department Chairs, Family Voices, the National Association of Pediatric Nurse Practitioners, the Pediatric Policy Council, the Society for Adolescent Health and Medicine, the Society for Pediatric Research and ZERO TO THREE.