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## **Medicaid Policy Statement**

COMMITTEE ON CHILD HEALTH FINANCING

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American Academy of Pediatrics

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## POLICY STATEMENT

# Medicaid Policy Statement

### COMMITTEE ON CHILD HEALTH FINANCING

#### KEY WORDS

Medicaid, Child Health Insurance Program, benefits, coverage, financing, payment, eligibility, outreach, enrollment, managed care, quality improvement

#### ABBREVIATIONS

AAP—American Academy of Pediatrics  
AARA—American Recovery and Reinvestment Act  
ACA—Patient Protection and Affordable Care Act  
CHIP—Children's Health Insurance Program  
CMS—Centers for Medicare and Medicaid Services  
CPT—*Current Procedural Terminology*  
DHHS—Department of Health and Human Services  
EHB—essential health benefits  
EPSDT—Early and Periodic Screening, Diagnosis and Treatment  
FMAP—federal medical assistance percentage  
FPL—federal poverty level  
HMO—health maintenance organization  
MCO—managed care organization  
MOE—maintenance of effort  
PCMH—patient-centered medical home

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## abstract

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Medicaid insures 39% of the children in the United States. This revision of the 2005 Medicaid Policy Statement of the American Academy of Pediatrics reflects opportunities for changes in state Medicaid programs resulting from the 2010 Patient Protection and Affordable Care Act as upheld in 2012 by the Supreme Court. Policy recommendations focus on the areas of benefit coverage, financing and payment, eligibility, outreach and enrollment, managed care, and quality improvement. *Pediatrics* 2013;131:e1697–e1706

### HISTORY OF MEDICAID PROGRAM

The Medicaid program was enacted in 1965 as Title XIX of the Social Security Act with funding streams derived from both federal and state governments. All states have participated in this voluntary program since Arizona joined in 1982. Federal law designates which groups of people must be eligible for Medicaid enrollment and what core medical benefits must be provided. Each state may then expand eligibility criteria, enhance benefits, contract with managed care organizations (MCOs) to administer the Medicaid program, and apply for waivers to develop specialized programs for particular populations. For instance, states have had the option to enroll children whose families have an income at or below 200% of the federal poverty level (FPL) in Medicaid, although only 6 states had chosen to do so by 1997 when the State Children's Health Insurance Program (CHIP) was enacted by Congress as Title XXI of the Social Security Act.

By 2009, total Medicaid enrollment had grown to include 34.2 million infants, children, and adolescents younger than 21 years. Medicaid provided benefits to 39% of the US pediatric population and covered 48% of all births. In 2009, Medicaid payments to providers for all age groups had expanded to \$326.0 billion.\* Although children younger than 21 years represented 53% of all Medicaid enrollees, they

\*These figures differ from the Medicaid data provided by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary<sup>1</sup> for several reasons. The higher CMS estimate of total Medicaid costs for fiscal year 2009 of \$380.6 billion includes nonprovider expenses such as disproportionate share hospital payments, administration costs, the Vaccines for Children Program, and other adjustments. Calculated costs per participant also differ for 3 reasons: (1) CMS uses estimated "person-year equivalents" (50.1 million) for fiscal year 2009 rather than "ever participants" (62.9 million unique participants covered by Medicaid for at least 1 month) as the basis for the calculation; (2) the AAP considers 19- and 20-year-old participants to be children, whereas CMS considers them to be adults; and (3) CMS segregates both children and adults who are blind and/or disabled into a separate "disabled" category.

accounted for only 29% of all Medicaid provider payments. In 2009, Medicaid expenditures averaged \$2630 per child younger than 21 years compared with \$6459 per adult between the ages of 21 and 64 years and \$11 812 per senior citizen 65 years or older.<sup>2</sup>

Except for a few special programs (eg, family planning services, American Indian/Alaskan Native populations, administrative costs), the federal government funds a different proportion of each state's Medicaid budget.<sup>3</sup> This federal medical assistance percentage (FMAP) for each state is based on a formula that relates the 3-year rolling average per capita income in the state to that for the entire United States. By law, the minimum and maximum FMAPs are 50% and 83%, respectively.<sup>3</sup> Before the passage of the 2009 American Recovery and Reinvestment Act (ARRA: Pub L No. 111-5), the FMAP varied across states from 50% to 76%. Under ARRA and other FMAP "extension legislation" (Education, Jobs, and Medicaid Assistance Act of 2010 [Pub L No. 111-226]), FMAPs temporarily increased through June 2011 (eg, to a range of 62%–85% in the second quarter of fiscal year 2010). These enhanced FMAPs transiently decreased state Medicaid expenditures for fiscal year 2009 through fiscal year 2011. However, with the sunset of ARRA FMAP legislation and more Medicaid beneficiaries due to continued poor economic conditions and other factors, state Medicaid costs increased sharply in fiscal year 2012 and are expected to continue to climb through fiscal year 2019.<sup>†</sup>

<sup>†</sup>Beginning in 2020, the federal government will still fund 90% of the additional costs associated with newly eligible participants under the ACA. If the ACA Medicaid expansion were to be adopted by all states, the Congressional Budget Office had estimated that the total increased cost of the Medicaid program attributable to Medicaid expansion from 2014 to 2019 would be \$564 billion dollars, of which \$500 billion, or 89%, would have been funded by the federal government.<sup>3</sup>

## IMPACT OF THE ACA AND THE 2012 SUPREME COURT DECISION ON THE MEDICAID PROGRAM

Passage of the Patient Protection and Affordable Care Act (ACA)<sup>‡</sup> in 2010<sup>4</sup> profoundly changed the Medicaid program through its expansion of Medicaid eligibility to all legal residents younger than 65 years with individual or family incomes at or below 138% of the FPL.<sup>§</sup> Hence, the ACA not only added a large population of adults (ages 19 through 64) who became newly eligible for Medicaid, but in many states, the expansion also increased the number of eligible children (through age 18) by mandating a higher minimum income eligibility.<sup>||</sup> The ACA directed the federal government to fund Medicaid expansion in full through 2016 and then at lower but still significant levels thereafter (tapering to 90% funding by 2020). The landmark Supreme Court decision upheld the constitutionality of the ACA

<sup>‡</sup>Encompassing the Patient Protection and Affordable Care Act and the amendment law associated with that act, the Health Care and Education Reconciliation Act (Pub L No. 111-152).

<sup>§</sup>The ACA established a new national floor of Medicaid coverage at 133% of the FPL with a standard 5% of income disregard that constituted part of a simplified modified adjusted gross income calculation designed to harmonize means-tested eligibility (Medicaid disregards the first 5% of one's income before calculating the proportion to the FPL). The ACA had mandated a minimum income level for Medicaid eligibility at 138% of the FPL beginning in 2014.

<sup>||</sup>The number of children newly eligible for Medicaid in a given state as a result of the change in qualifying FPL will depend on that state's current choice of percentage of FPL as the eligibility criterion for Medicaid for older children as well as that state's implementation of and enrollment within CHIP. There are currently 2.8 million children below 138% of the FPL who are not currently insured by Medicaid or by CHIP. In addition, an unknown number of children with family incomes between 100% and 138% of the FPL who are currently insured by CHIP would rollover to Medicaid coverage and about 4.3 million children with family incomes between 100% and 138% of the FPL who are now covered by private insurance would potentially be eligible for Medicaid.

with respect to the contested "individual mandate" for every American to obtain health insurance by a 5 to 4 margin.<sup>5</sup> However, the Court also struck down as unconstitutional an enforcement provision of the ACA that would have allowed the Department of Health and Human Services (DHHS) to withhold all federal Medicaid funding from states that declined to participate in Medicaid expansion. By a 7 to 2 majority, the Court ruled that this provision constituted undue coercion on states by the federal government; in a remedy, however, the Court upheld the constitutionality of the Medicaid expansion as an individual state option.

Legal scholars generally agree that the narrowly written Court decision did not invalidate other changes made by the ACA to the Medicaid program that pertained to existing populations.<sup>6</sup> The constitutionality of 3 provisions in particular has special importance for the pediatric population. First, Section 2001(b) of the ACA imposes a "maintenance of effort" (MOE) requirement that disallows states from restricting eligibility or reducing benefits for current child Medicaid beneficiaries until 2019. Second, Section 2001(a) (5) (b) expanded Medicaid eligibility for children under 19 by raising the minimum qualifying family income level to 138% of the FPL. Third, the ACA required states to improve outreach to and simplify enrollment of any person currently eligible for Medicaid.<sup>6</sup>

Many children now covered by Medicaid lose health insurance as they become young adults, so that how states choose to respond to the opportunity afforded by the ACA to participate in the adult Medicaid expansion can have a great impact on many pediatric patients. It is likely that additional negotiations will ensue in the future between the secretary of the federal DHHS and state Medicaid agencies that have initially

signaled reluctance to pursue full-scale Medicaid expansion.<sup>6</sup>

This revision of the American Academy of Pediatrics (AAP) Medicaid Policy Statement advocates for the provision and funding of children's services in the Medicaid program and highlights changes in or new opportunities for state advocacy efforts as a result of the passage of the ACA and the 2012 Supreme Court decision.

The AAP continues to voice strong support for the Medicaid program and over the years has offered a continuing series of recommendations aimed at enhancing care and improving outcomes for children.<sup>7</sup> In particular, the AAP has long advocated innovative approaches to care (such as pediatric medical homes) that aim to achieve better health outcomes while reducing costs of care. The AAP stands ready to support newer population health-based programs (eg, Medicaid accountable care organizations) that seek to attain those same objectives. AAP members have been integral providers in both regular Medicaid and in state-specific Medicaid waiver programs and consequently have working experience with reform efforts of varying success.

## BENEFITS AND MEDICAL HOME

Beyond a core set of mandated benefits, federal guidelines provide states with wide discretion in benefit design. The AAP recommends that all state Medicaid agencies:

1. Provide all children at a minimum the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit and all other mandatory and optional benefits as outlined in the AAP statement "Scope of Health Care Benefits for Children From Birth Through Age 26."<sup>8</sup> Ensure that the medical necessity definitions used by each state for

purposes of justifying medical services covered by Medicaid payment are consistent with the EPSDT policy. Furthermore, each state's process for determining medical necessity should rely on the expertise of pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. Ensure that in the process of making decisions on the basis of medical necessity, the medical, behavioral health, and developmental care needs of the child are fully considered and that appropriate comprehensive benefits are available to address the full range of these needs.<sup>9</sup>

Develop appropriate benefits that address the needs of pregnant women. Pregnant women should be afforded the full range of maternity care (preconception, prenatal, labor, delivery, and postpartum) recommended in the Guidelines for Perinatal Care issued jointly by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. Detail the full scope of pediatric Medicaid benefits in consumer brochures, on Web sites, and, most importantly, in state plan documents and managed care contracts. State agencies should provide a clear comparison of pediatric Medicaid benefits and networks among managed care plans so that families can choose a plan that is most appropriate for the needs of their child(ren).

2. Provide pharmacy benefits appropriate for children and broad enough to pay for medicines and specialized nutritional products required for children with special health care needs and for children with rare diseases. State Medicaid Pharmacy and Therapeutics committees should populate and operate a pediatric formulary with the recognition that less expensive

(usually generic) drugs may not be as effective as alternative but more costly (usually brand name) drugs of the same class in all patients under all circumstances. Pharmacy benefits should acknowledge that many medications are appropriately prescribed to children in the absence of a pediatric label indication or dosing information. Optimally, states should mandate that all Medicaid MCOs operating in the state adopt the same state pediatric Medicaid formulary to ensure continuous and consistent treatment of patients (especially those with special health care needs or rare diseases) because they often transition between Medicaid insurers.

3. Ensure that all children have timely access to appropriate services from those qualified pediatric medical subspecialists and pediatric surgical specialists who are needed to optimize their health and well-being.
4. Ensure that Medicaid provider networks are sufficient to guarantee that children who transition from pediatric to adult care providers do not experience disruption in services.
5. Adopt periodicity schedules as defined in the AAP guidelines.<sup>10</sup> Immunization schedules should also be consistent with national guidelines as periodically revised by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the American Academy of Pediatrics, and the American Academy of Family Physicians.<sup>11</sup>

New or continuing efforts in which the AAP and its members can participate that can result in enhanced benefits for children enrolled in Medicaid programs include the following:

1. Develop and then facilitate the implementation of a working pediatric medical home model that

incorporates Bright Futures guidelines<sup>12</sup> and treatment services as codified in EPSDT.

2. Work with Medicaid and private insurance companies to standardize parameters for the medical home concept.<sup>13,14</sup> The wide variation in both panel size and family demographics encountered across pediatric practices suggests that a variety of models may be needed.
3. Develop and direct a program that educates parents, patients, and physicians about the advantages of a pediatric medical home.<sup>15</sup>
4. Partner with AAP state chapters, other pediatric health care providers, and families with children who are Medicaid beneficiaries to monitor and recommend improvements to state Medicaid programs and to the Centers for Medicare and Medicaid Services (CMS).
5. Assist parents, patients, and physicians to understand the full scope of Medicaid benefits.

## FINANCING AND PAYMENT

Medicaid fee schedules and capitated payments to primary care and subspecialty providers are significantly lower than payments for comparable services from Medicare and private insurance companies. Low Medicaid payment is the primary reason that physicians limit participation in the program with resulting barriers to patient access for primary care and subspecialty health care services.<sup>16–22</sup> Even at academic medical centers that serve as “safety nets” for uninsured or underinsured patients, reduced access may be reflected by significantly longer wait times for subspecialty care.<sup>23</sup> Hence, the initial intent of Title XIX to provide truly equal access to quality primary and subspecialty care has not been fulfilled. Other documented reasons why providers decline or

limit participation in Medicaid include delayed or unpredictable payments, confusing or burdensome payment policies and paperwork, and nonadherence to scheduled visits.<sup>17,18,22</sup>

Although the MOE provision in the ACA proscribes states from restricting their current Medicaid eligibility rules until 2019 for children, states may choose instead to reduce their expenses by limiting nonmandatory services for adults, trimming payments for services, revoking any higher payments to specific groups of physicians, and cutting hospital payments. States have voiced alarm that high unemployment rates and increasing numbers of families enrolled in Medicaid will critically affect their budgets. In addition, as the US population ages, the growing number of seniors who become eligible for Medicare will also swell the ranks of seniors dually eligible for Medicaid coverage. The CMS Office of the Actuary has estimated that if each state fully implemented the ACA Medicaid expansion, state Medicaid expenditures would more than double over the decade from 2009 to 2019, from \$132.3 billion to \$313.3 billion.<sup>24</sup> To the extent that any state chooses to participate in the ACA Medicaid expansion, it will be vital that federal and state governments not compromise necessary coverage for children nor fail to provide adequate payment for pediatric care. In addition, states must be cognizant that ACA discontinued federal disproportionate share hospital payments to all states, anticipating that Medicaid expansion to the adult population would provide replacement revenue for safety net hospitals. Hence, states that choose not to participate in Medicaid expansion may risk the viability of some safety net hospitals.

In 2011, Medicaid payments for evaluation and management services across all states averaged ~64% of the

Medicare rates and lagged even farther behind payments by private insurers.<sup>25</sup> The ACA provides federal funding to Medicaid programs and state-financed Medicaid managed care plans to pay eligible physicians at Medicare rates for certain evaluation and management services, preventive care, and immunization administration during 2013 and 2014 (but not subsequently), including well-child (“checkup”) codes (*Current Procedural Terminology* [CPT] codes 99381–99385; 99391–99395). Payment at this level should be sustained beyond 2014 and expanded to include all Medicaid services. This will require intense federal and state-specific advocacy.

The AAP proposes the following recommendations for federal and/or state action:

1. Ensure that Medicaid payments to providers for the goods and services involved in caring for children not only pay for the related work and practice expenses but also provide a sufficient return to make continued operation of a practice or facility economically feasible. In a broader context, payments should be sufficient to enroll enough providers and facilities so that, as required by federal law, Medicaid patients have “equal access” to care and services as do nongovernmentally insured patients in that geographic region. Failure to provide this fair level of payment will lead to continued early attrition of current pediatric providers as well as failure to attract physicians to pursue careers in primary or subspecialty pediatric care. To achieve this aim, the AAP recommends the following:
  - a. Increase base Medicaid payment rates for all CPT codes, including pediatric specific CPT codes (eg, well-child checkup,



counseling, and developmental assessment), to all providers to the 2012 or 2009 regional Medicare fee schedule rate, whichever is higher, or, in the case of preventive services without a Medicare payment, to a rate calculated by applying Medicare fee schedule methodology to the published values of work, practice expense, and professional liability insurance relative value units adjusted for the geographic region. These payment rate principles should be made permanent (ie, extended beyond the 2014 termination date) with the minimum level of payment per CPT code established as the greater of the 2012 Medicare actual or calculated rate or the current year's rate.

- b. Establish a methodology to provide additional fair payment to a practice that recognizes the extra resources that might be invested on behalf of its Medicaid patients to promote wellness (eg, to pay for more vigorous outreach to increase participation rates with well-child checkups) and to provide care coordination of infants and children with complicated physical and/or mental health illnesses (eg, to pay for care coordinators, social workers, extended office hours, home visitations, dental care, durable medical equipment, etc). At present, fee-for-service payments (even if increased to Medicare rates) and current Federally Qualified Health Center payments do not fully pay for these extra resources.
  - c. Reward practices that meet or exceed AAP-approved predefined quality and performance metrics with incentive payments.<sup>26</sup>
  - d. Require Medicaid managed care plans to determine payment based on the principles outlined in (a) and (b) so that pediatric providers and patient-centered medical home (PCMH) programs are appropriately compensated. Similarly, require managed care plans to make providers eligible for additional incentive payments, as in (c), if, for instance, providers demonstrate improved outcomes, reduction of total Medicaid costs, and robust efforts to transition children with special health care needs to adult care. Provide input to Medicaid managed care plans about possible designs and implementations of structured incentive programs based on quality and performance parameters advocated by the AAP.
  - e. Explore the feasibility of adjusting fee-for-service or capitated payments to a provider on the basis of a risk-adjustment mechanism that accounts for the extra costs associated with caring for children with chronic conditions and other key pediatric diagnoses among the children in the provider panel.
  - f. Establish a mechanism within state Medicaid agencies and Medicaid MCOs for rapid adjustment of fee-for-service or capitated payments to providers for recommended new vaccines and other new technologies that rapidly achieve translation from clinical trials to standard clinical practice.
  - g. Require that paperwork in support of claims is not unduly burdensome and that clean claims are paid within 30 to 45 days of submission, so that practices can meet their cash flow obligations.
2. Oppose the conversion of Medicaid financing to an annual allotment or block grant programs with a fixed budget. Block grant proposals typically result in cost shifting from federal to state budgets and do not reduce overall health costs or improve quality of care. In fact, institution of block grants in combination with revocation of the MOE provision in ACA would likely restrict eligibility and reduce benefits for children to result in the loss of the individual child's guarantee to access Medicaid services. Recently, the concept of using "per capita caps" to control Medicaid expenditures has resurfaced, but ultimately, this mechanism of funding poses the same risks for children as do block grants.
  3. Work with the AAP to study the feasibility of implementing pediatric-specific accountable care organizations through carefully structured demonstration projects.<sup>27,28</sup>
  4. Pay primary care physicians for behavioral health services that physicians are qualified and competent to provide. Eliminate carve-outs for behavioral health coverage.
  5. Mandate that states perform an in-depth assessment of the fiscal viability of any health plan before contracting with that plan to administer a Medicaid program and conduct annual audits to verify continued fiscal stability of the health plan. Require states that contract with MCOs to publish their physician payment methodologies and rates for each child eligibility group on an annual basis.
  6. Advocate for federal and state agencies to partner with organizations, such as the AAP, to educate

- physicians about programmatic changes in Medicaid fee-for-service or managed care environments (eg, pay-for-performance and PCMH programs). Physicians should understand the quality and cost control objectives of new initiatives and the linkage between fully documenting achievement of these goals and payments to physician practices.
7. Pay for the administration of immunizations (including multiantigen vaccines) and for counseling using the current CPT code set. Payments for vaccines should be at least 125% of the current Centers for Disease Control and Prevention private sector price list and payment for immunization administration should be, at minimum, 100% of the Medicare rate for each vaccine administration CPT code.
  8. Ensure, wherever possible, the availability of at least 2 financially viable Medicaid MCOs in every region to allow for patient choice. Requests for proposals for organizations to serve as Medicaid third-party administrators and the ensuing selection process should be fully transparent.
  9. Explore innovative methods to establish trust funds to support graduate medical education specific to the provision of primary and subspecialty care for Medicaid participants that will help maintain a qualified pediatric provider workforce.
  10. Require Medicaid to provide full payment for trained interpreter services for patients with limited English proficiency. This will assist in thorough and accurate communication between provider and participant, increased accuracy of diagnosis and more appropriate treatment plan, and increased participant understanding and adherence to treatment, thus avoiding adverse clinical consequences.

11. Pay for observational care, urgent care, day medicine services, and necessary interhospital transport services, including transport of neonates from tertiary or quaternary neonatal or pediatric intensive care units to step-down convalescent units.
12. Implement policies and procedures to ensure equitable and prompt payment to providers and facilities for pediatric services rendered to Medicaid patients out of state. States should work together and with the federal government to achieve uniform and seamless processes to pay for these services.
13. Require all payers to report financial data on an annual basis so that the medical loss ratios (the percentage of total funding that is spent on patient care functions) are clearly delineated and transparent to the public.
14. Require states to develop clear and transparent rules and regulations related to ACA provisions for recovery audit contracting processes. Each state must ensure that physicians who are licensed and have practiced in the state supervise the work of certified professional coders with expertise in pediatric primary and subspecialty care. Key stakeholders, including physicians and the public, must have direct input in the process to avoid flawed statistical analysis. Payment errors due to both undercoding and overcoding should be included in a final reconciliation report. A clear and fair appeals procedure that is accomplished in a timely manner must be part of the formal recovery audit contracting process.

## ELIGIBILITY

The AAP endorses the ACA-mandated expansion of Medicaid eligibility to

include all children who live in families with an income below 138% of FPL.<sup>¶</sup> The AAP recommends that states implement the following additional measures to facilitate enrollment of children eligible for Medicaid or CHIP benefits:

1. Remove the 5-year waiting period for eligible children and/or pregnant women who are lawfully residing in the United States consistent with the provisions of the CHIP Reauthorization Act (Pub L No. 111-3).
2. Identify uninsured children who are not financially eligible for Medicaid and if possible facilitate enrolling them in CHIP.
3. Ensure that children who are moved by the state into a foster care program are tracked and immediately enrolled in and covered by Medicaid until age 21 using the Chafee option.<sup>#</sup> In 2014, if chosen by the foster child alumna, Medicaid coverage becomes mandatory under the ACA until age 26.
4. Ensure that newborn infants eligible for Medicaid are assigned to a specific plan immediately after birth so that timely provision of services in the first few months of life is not impeded by anticipated difficulties in payments of claims.

## OUTREACH, ENROLLMENT, AND RETENTION

The AAP recommends that states strengthen their outreach, enrollment, and retention efforts to enroll all eligible uninsured children in Medicaid, CHIP, or exchange coverage.

<sup>¶</sup>For fiscal year 2012, the FPL thresholds are \$15 415 for a single adult and \$31 809 for a family of 4, with the exception of Alaska and Hawaii, where thresholds are 25% and 15% higher, respectively.

<sup>#</sup>A Medicaid option, known as the Chafee option, allows states to extend Medicaid to former foster children but only up to age 21. Currently, there are 21 states that use the Chafee option to provide health care coverage to former foster youth (Chafee Foster Care Independence Act of 1999).

1. Use multiple sites and replicate other effective strategies as have been implemented in CHIP to maximize and maintain enrollment of individuals eligible for Medicaid.
2. Optimize coordination of Medicaid, CHIP, and exchange program outreach through the use of streamlined eligibility determination, redetermination and enrollment processes including the use of short and easily understood common application forms, and expanded use of online enrollment. Once a child is enrolled, coverage should continue for 12 months.
3. Consider using the medical home to enroll patients and provide a fair payment for the administrative expense of this procedure.
4. Adopt practices that result in a “no wrong doors” approach to enrollment. All venues for Medicaid, CHIP, and exchange program enrollment should be able to evaluate an applicant’s eligibility for any of these programs and to process the appropriate application.
5. Advocate support for federal policies to provide incentives to states to increase enrollment and retention in Medicaid and to continue those incentives for CHIP programs.

## MANAGED CARE

In recent years, fiscal and policy considerations have encouraged states to contract with MCOs to administer the Medicaid program. As of fiscal year 2009, an estimated 61% of Medicaid beneficiaries 0 through 20 years of age were enrolled in a Medicaid health maintenance organization (HMO).<sup>2</sup> The AAP recommends that all MCOs should adopt a pediatric medical home model for all children that adequately addresses their needs, including those with special health care needs. Network adequacy should be determined

by periodic evaluation of the number of Medicaid providers whose panels are open to all new Medicaid patients.<sup>29</sup>

The AAP recommends that states adopt the following minimum set of practices and standards in their approach to Medicaid MCOs:

1. Ensure that MCOs (these may be either HMOs or provider-sponsored networks) provide educational materials to families that are culturally effective and written at literacy levels and in languages used by Medicaid recipients. The use of audiovisual aids should be encouraged.
2. Provide appropriate written, oral, and Web-based information and counseling to Medicaid eligible patients that allow informed patient choice of MCO-based network options for primary care physicians, pediatric medical subspecialists and pediatric surgical specialists, and pediatric hospital and ancillary services.
3. Assign Medicaid participants to an MCO that allows retention of the patient’s medical home.
4. Recognize that pediatricians are primary care physicians who are eligible for pediatric patient assignment in all default enrollment systems.
5. Ensure that the provider network of all Medicaid MCOs contains the following components:
  - a. Sufficient numbers of providers trained in primary care and subspecialty pediatrics, as well as pediatric surgical specialists.
  - b. Sufficient numbers of physicians and other licensed providers of oral health, mental health, developmental, behavioral, and substance-abuse services so that medically necessary services are accessible within a reasonable length of time.

- c. When possible, a minimum of 1 hospital that specializes in the care of children.
  - d. Vendors of durable medical equipment and home health care agencies that have experience caring for children, especially those with special health care needs.
6. License an MCO as a pediatric Medicaid provider only if its comprehensive pediatric network can provide children with quality care across the full continuum of care and hold that MCO accountable.
  7. For Medicaid programs to be responsive to the needs of both patients and providers, it is essential that the programs be subject to either competition among at least 2 and when possible 3 MCOs in a region or to regulation that is regularly updated to reflect continuing input from patients and providers. Provider service networks (not-for-profit organizations created and governed by providers) should be evaluated and approved on a level playing field with HMOs.
  8. Require that Medicaid administrative processes such as site visits and audits are simplified to minimize the burden for providers and office staff. Results of these processes should be available as a report card and transparent to prospective Medicaid enrollees.
  9. Implement dedicated planning and oversight when MCOs contract for care delivery to children with special health care needs (including children with complex and/or rare diseases, children with behavioral/mental health conditions, and foster care children).
  10. Establish an All Payer Claims Database and require MCOs to participate fully in reporting encounter



data. This would allow health policy analysts and researchers in government, academia, and the private sector to examine regional patterns of utilization, access to care, and quality of care and inform efforts to construct “best practice” models of care.

## QUALITY IMPROVEMENT AND PROGRAM INTEGRITY

The AAP recommends that, as appropriate, CMS and the AAP, or state Medicaid agencies and state AAP chapters, should work collaboratively to develop and/or enhance quality-improvement activities that can benefit all children.

1. CMS should encourage collaboration among the Agency for Healthcare Research and Quality, the National Committee for Quality Assurance, the National Quality Forum, the AAP, and the CHIP Reauthorization Act Pediatric Healthcare Quality Measures Centers of Excellence. These organizations can evaluate current quality and performance measures with a goal of recommending modifications or achieving consensus around new measures that pertain to pediatric patients, including children with special health care needs. These measures should align with the recommendations outlined in the AAP policy statement “Principles for the Development and Use of Quality Measures.”<sup>26</sup>
2. States should require health plans to use the core set of pediatric quality improvement measures that were created as part of the CHIP Reauthorization Act. These measures quantitate access to care, utilization of services, effectiveness of care, patient outcomes, and satisfaction of both patients and providers related to preventive, primary, acute, and chronic care for children. States should develop mechanisms for public reporting of these measures

that allow Medicaid beneficiaries to compare outcomes among MCOs. Consistent with federal statute, states should require that all Medicaid programs provide access to quality primary and subspecialty pediatric care that is equal to that achieved through private payers (“equal access” mandate).

3. At a minimum, states should establish Medicaid Advisory Committees whose membership includes pediatric primary care and subspecialty providers. These committees can advise state Medicaid agencies on issues related to the identification, implementation, and evaluation of quality measures and improvement programs as well as issues related to eligibility, enrollment, formulary, network adequacy, access, and medical necessity. To achieve maximal benefit, each state Medicaid agency should employ a physician with pediatric expertise who can continuously assist the agency with these issues as they relate to pediatrics.
4. Federal and state agencies should work with the AAP to develop tools and measures to monitor potential changes in the quality of pediatric care and the outcomes of the pediatric population. These tools and measures will be helpful in evaluating the effect of PCMHs and the impact of reform on children with special health care needs.
5. States should assume central responsibility for key administrative procedures that pertain to all Medicaid providers. These procedures could include meaningful provider assessment, education (eg, fraud and abuse training), and credentialing activities that would apply for all payers within the Medicaid or CHIP programs.
6. States should report results of peer review and reviews of medical records in a timely manner to

providers, plans, and beneficiaries consistent with applicable federal and state laws related to confidentiality, peer review privilege, and care review privilege.

7. States should monitor enrollment patterns and develop prospective means to assess reasons for changes in enrollment to ensure that MCOs do not encourage children with a high level of need to switch to other plans.
8. States should provide timely, meaningful, linguistically and culturally appropriate summaries of quality and performance measure and programs to beneficiaries to guide their choice of Medicaid plan.

## CONCLUSIONS

By 2019, if the ACA Medicaid expansion were to be implemented by all states, 16 million additional individuals would gain insurance coverage through Medicaid and CHIP. Regardless of state variations in participation in the ACA Medicaid expansion, Medicaid will remain as the largest single insurer of children.<sup>30</sup> Additional legal proceedings and federal/state negotiations may clarify how DHHS will implement Medicaid expansion in the new adult population. In the meantime, the AAP supports state chapter advocacy efforts to expand Medicaid to the newly eligible population. Although AAP chapters might not take the lead in advocacy, they can provide pediatric expertise to coalition efforts and highlight the positive effects expansion will have on young adults.

To date, governmental health policy on both state and federal levels has not adequately met the medical, behavioral, and developmental needs of children. The ACA has provided a framework to redress some of these deficiencies. The AAP, through its network of chapters, sections, committees, councils, and staff and in partnership with other

allied organizations, can collaborate with both federal and state agencies to monitor implementation of those aspects of the ACA that promise to enhance the care and outcomes of children and young adults and perhaps suggest refinements for future regulations. Success in these endeavors will not only enhance the health and well-being of the children for whom pediatricians care but also will enrich our

ability to provide the quality of care to which we aspire.

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