December 17, 2015

Andrew Slavitt, Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9937-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

Re: CMS-9937-P. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017

Dear Mr. Slavitt:

On behalf of the more than 220 member children’s hospitals across the country, the Children’s Hospital Association (CHA) appreciates the opportunity to comment on the Notice of Benefit and Payment Parameters for 2017 (Notice). We focus our comments below on several key aspects of the Notice that we believe must be improved to ensure that children have access to the services and providers they need when they need them.

Children’s hospitals have a unique perspective of children’s health care needs and the delivery of pediatric care. They play a critical role in preventing uninsured and under-insured children from falling through the cracks in the nation’s health care system. From healthy children in need of preventative care to those with complex conditions and in need of a specialized medical home, all children benefit from the pediatric training, clinical care, research and child health advocacy that take place in the nation’s children’s hospitals. While all children’s hospitals provide local care, they also excel in specialty care, meaning that children throughout large geographic regions have access to pediatric specialists, services and technology not found in community or adult hospitals.

Nearly one million children are enrolled in Qualified Health Plans (QHPs) to date, making Exchange coverage an increasingly important component of children’s coverage overall, and helping to bring the rate of uninsured kids to historic lows. It is absolutely imperative that children’s QHP coverage and access to care is strengthened as implementation moves forward and a growing number of children enter the Exchange market.

We particularly wish to highlight our concerns and recommendations regarding the provisions in the Notice on network adequacy and essential community providers (ECP):

- **Pediatric network adequacy standards** – Network adequacy metrics must be appropriate for pediatric health care. The new standards proposed in the Notice fail to ensure that QHP provider networks will have a sufficient range of pediatric providers with the training and expertise to provide appropriate, high-quality and cost-effective care for children who are generally healthy, as well as those with the most complex and chronic conditions.

- **ECP children’s hospitals** – We are extremely concerned and disappointed that CMS has decided against the disaggregation of children’s hospitals from the ECP “hospital” category and strongly urge you to move forward to propose this disaggregation. The current grouping of children’s hospitals with other ECP hospital types allows issuers to contract with lower cost hospitals that do not have the capacity to provide the specialized care that children need, rather than with the children’s hospital in their service area.

Champions for Children’s Health
Our comments and recommendations relate to these issues and others that are critical to the health and well-being of children covered by both federally-facilitated (FFEs) and state-based Exchanges (SBEs).

**Standards Applicable to Navigators, Consumer Assistance Tools and Programs and Non-Navigators Assistance Personnel (§155.205, 155,210, 155.215)**

We are extremely pleased that CMS proposes to require Navigators and other consumer assistance personnel to provide targeted assistance to underserved and/or vulnerable populations. We encourage CMS to develop a basic set of criteria/parameters for what would be considered an underserved and vulnerable population. The criteria would provide Exchanges with a framework, to help ensure that certain populations, such as children and youth with special health care needs (CYSHCNs), do not fall through the cracks and are targeted for the critical information and assistance that Navigator and other consumer assistance programs provide.

ECPs could provide a potential starting place for a targeting framework, as they are specifically geared and equipped to care for the same vulnerable and underserved populations, including children, who are the focus of the proposed consumer assistance requirements. We would suggest that consumer assistance programs should look at their populations in need of care provided by an ECP, beginning with children and adults with serious, complex or chronic conditions. These populations face immediate, often daily, challenges navigating the health care system and may need intensive guidance, support and assistance to also navigate their insurance coverage choices.

For example, a family of a child with spina bifida might need intensive assistance to identify appropriate in-network pediatric providers and understand the specific health plan limitations related to coverage of wheelchairs, their replacement and related costs. They also might need assistance understanding the variation among plans for coverage of a range of therapies – both numbers of visits and cost sharing requirements. For these families, a one-size-fits-all approach to consumer education and outreach is not appropriate and could, in fact, lead to inadequate coverage with lifelong consequences for the child and huge financial consequences for the family. It is absolutely critical that consumer education and information materials specifically address their health care challenges. We look forward to working with you to ensure that consumer assistance personnel have the training and information/educational resources necessary to guide these families to the most appropriate coverage for them and their child.

**Annual Eligibility Redetermination §155.335(j)**

We continue to be concerned about automatic re-enrollment hierarchies that do not take into account enrollees’ health care needs and are solely focused on ensuring minimal disruptions or changes to cost sharing requirements. As we noted in our comments on the 2016 Notice, these types of hierarchies could possibly protect families from unexpected expenses, but could have other serious implications for children, particularly children with serious, complex and chronic conditions. Specifically, automatic re-enrollment into a new plan may result in different benefits and provider networks from the previous plan year.

Until all plans are subject to certain strong, common standards for benefits and provider networks, these types of processes must be undertaken very carefully to avoid costly and dangerous fragmentation. It is vital that enrollees have access to clear and accurate information on benefits and networks, before they are enrolled in a new plan.

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We are pleased that CMS is beginning to explore ways to improve consumer experience and enable them to make more informed choices about their health plan through the introduction of “standardized options.” We hope that this is a first step toward strengthening the overall Essential Health Benefits (EHB) package, particularly the pediatric services category, to ensure that children and families have access to medically necessary, age-appropriate services regardless of their plan choice. Our specific comments regarding the proposal are below.

First, we wish to reiterate our ongoing concern that the current benchmark approach for determining the EHBs fails to ensure that children have access to a pediatric-appropriate set of benefits. Children are not little adults and require health care benefits distinct from those provided for adults. As noted in a Sept. 30, 2015 letter from 36 allied organizations to the Center for Consumer Information and Insurance Oversight (CCIIO), an informal review of states’ proposed benchmark plan documents revealed numerous instances of inadequate coverage for children. The review found gaps in key aspects of coverage for children with special health care needs, such as coverage for auditory services, wheelchairs, and even, well-child visits.

Therefore, we emphasize several key recommendations, which we and allied children’s organizations have previously shared with you, to strengthen coverage for pediatric services and habilitative services and devices under the EHB:

- The pediatric EHB category must provide adequate coverage for children representative of all of their health needs. At a minimum, the pediatric benefits in the state benchmark plans should be comparable to the Children’s Health Insurance Program (CHIP) benefit package. CHIP benefits are specifically tailored to children and meet their continuous, and changing, growth and developmental needs. States should be required to assess the pediatric benefits that are included and excluded from their selected benchmark and use their CHIP benefits to supplement as needed.

- CMS should delineate a minimum set of services and devices that are covered under the habilitative services and devices benefit. We, again, applaud CMS on the establishment of a uniform definition of habilitative services and devices and separate limits for habilitative and rehabilitative services, if such limits are imposed. However, our benchmark plan review highlighted in the Sept. 30 letter to CCIIO clearly indicates the need for further guidance from CMS.

- CMS should clarify that the habilitation benefit must not be subject to age restrictions or arbitrary limits (e.g., number of visits per year), which are not based on medical necessity. CMS should also prohibit the imposition of financial requirements (such as copayments or coinsurance) on habilitative services and devices that are more restrictive than those for other benefit categories and may impede access to necessary care.

In addition, we wish to highlight several areas where the proposed standardized options could be strengthened:

**Single provider tiers**
We are encouraged that CMS is considering the inclusion of a single provider tier as part of its plan standardization. We know that tiered provider networks are confusing to consumers and can result in unanticipated out-of-pocket expenses.
and delayed care when a specialist or specialty facility is in a higher cost sharing tier. We are concerned, however, that absent strong network adequacy standards, issuers may exclude some providers that they otherwise would have placed in a higher tier in a multi-tiered network. Therefore, it is critical that the QHP network adequacy standards ensure that enrollees, including children and adults with serious, chronic or complex health conditions have access to the full range of providers for all covered services in that single tier.

Furthermore, we seek clarification of what constitutes a provider tier as the proposed plan options allow for higher cost sharing for specialty visits. For example, under the silver standard plan option, the cost sharing for a primary care visit would be $30 whereas cost sharing for a specialist visit would be $65. We caution that any cost sharing differentials that might impede or discourage utilization of needed specialty care may discriminate based on health status in violation of the Section 1557 nondiscrimination protections. Again, it is imperative that children and adults with health care challenges have access to a full range of providers for all covered services.

**Deductible-exempt services**

We also are pleased that certain services, including primary care, specialty visits, and generic drugs, are exempt from the deductible in the silver and gold plans. The exemption of these services from deductibles reduces financial barriers to needed care and encourages enrollees to seek care when they need it. In particular, CYSHCNs, including those with complex health conditions, need access to services on a regular basis to enable them to achieve an optimal level of health and development. This proposal, with the following clarifications and refinements, can help ensure that the financial barrier of a deductible does not impede that access:

- The “set of EHBs” that are addressed in the standardized options should separate pediatric services from those for adults. Families with relatively healthy children, as well as those with children who suffer from serious, chronic or complex conditions, face unique challenges with respect to both plan decisions and financial implications of care. Furthermore, children interact with their provider more frequently for routine care as well as sickness and chronic care as they have developmental issues that must be addressed concurrently.

- CMS should clarify that the deductible exemption applies to the full range of pediatric preventive services, including those provided by a pediatric specialist. Children with chronic or complex medical conditions visit their medical specialists more frequently and may rely on them for their well-child and other preventive screenings, including immunizations. In addition, children with complex or other special health conditions may have other care needs that prevent them from receiving recommended well-child and preventive screenings according to approved guidelines and schedules. The final rules should clarify that the deductible exemption applies regardless of when or where the recommended preventive service is delivered.

- The deductible exemption should apply to habilitative services, not solely rehabilitative services. As proposed, habilitative speech, physical and occupational therapies are not included in the standardized options. Coverage of habilitative services and devices is a critically important benefit for children who may suffer from a condition at birth (such as cerebral palsy, autism or spina bifida) or from an illness or injury that prevents normal skills development and functioning. Standardized cost sharing structures for these services should be incorporated into the options to both inform consumer plan choice and convey the potential financial impact of using these important therapies.

- CMS should clarify which types of specialist visits would be exempt from the deductible and if there are any limits on the number of visits that would be allowed under the exemption. Again, this clarification should distinguish between adult and pediatric specialists.
- CMS should consider switching to a copayment for specialty drugs and identify ways to minimize the application of coinsurance overall. Coinsurance is a confusing concept for many consumers and does not allow them to accurately determine their costs of care. It also could deter families from seeking timely care, which could have long-term financial and health implications. Furthermore, the use of coinsurance rather than copayments for specialty drugs in the silver plans could be considered discriminatory under Section 1557 as it imposes higher costs on enrollees who are sicker. As CMS notes in the preamble, copayments “are more transparent and make it easier for consumers to predict their out-of-pocket costs.”

Finally, we encourage CMS to use the standardized option as a mechanism to begin the process of increasing standardization of plan documents, beyond the required Summary of Benefits and Coverage. As noted in the Sept. 30 letter to CCIIO, our informal review of EHB benchmark plan documents revealed confusing, missing or conflicting information about covered services, limits, and exclusions. Standardization will facilitate federal and state review, approval and oversight of plans and help ensure that consumers can access the information that they need to make informed decisions regarding their coverage.

Network Adequacy §156.230

We are pleased that CMS is moving forward to establish specific network adequacy standards for QHPs in the FFEs and that regulators, either the state or the FFE, would be responsible for prospectively applying the standards to the QHPs. This is an important step forward in strengthening provider networks and ensuring that all enrollees have access to the services promised to them through their health plan. We strongly urge CMS to require all states, not just those with FFEs, to adopt specific network adequacy standards that incorporate our following recommendations specific to pediatric-appropriate networks.

We remain seriously concerned that the new standards in the Notice will not ensure that QHP provider networks have a sufficient range of pediatric providers with the training and expertise to provide appropriate, high-quality and cost-effective care for children who are generally healthy as well as those with complex or chronic conditions. Therefore, we urge you to review our recommendations in two recent letters to the department⁴, as well as the consensus document, “Safeguarding Access to Medically Complex Care for Children by Requiring Health Plans and Exchanges to Develop Adequate Provider Networks,” which articulate the components of strong standards that would meet children’s health and developmental needs.

Our specific recommendations follow:

Pediatric-specific network adequacy metrics

We urge you to review our prior comments regarding the importance of developing specific network adequacy standards for children⁵ as you develop state minimum and federal default metrics for network adequacy. Children are a unique population requiring special consideration because the providers of their care are different than those for adults. In particular, CYSHCN must have access to pediatric specialty and subspecialty care, such as that provided by pediatric subspecialists, pediatric surgical specialists, and children’s hospitals, in order to address their particular health and

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⁵ See Nov. 19 letters.
developmental conditions. A strong pediatric network adequacy standard, as well as a robust process for the review of issuer compliance with that standard, is critical to their care and well-being.

Pediatric-specific standards would allow for an assessment of provider networks that is based on the inclusion of trained and experienced in-network pediatric providers capable of providing appropriate care, from well-baby care to care for CYSHCNs, including those with serious, chronic or complex conditions. Inadequate and limited networks that do not include this range of providers may result in care delays with poor medical outcomes that ultimately cost insurers and consumers more. Standards must:

- Ensure that QHP networks are capable of providing pediatric services for all levels of complexity, including for rare conditions, without administrative or cost barriers for children and families
- Only allow out-of-network arrangements as an exception for extremely rare services or when timely access to the type of provider a child needs cannot be assured
- Not allow a child to be penalized by the health plan through extra cost sharing or administrative hurdles in the rare circumstance when that child must use an out-of-network provider

We agree that network assessments must be based on strong objective measures and urge CMS to adopt pediatric-appropriate metrics that take into consideration geographic challenges and the entire range of children’s health care needs. The recent proposed rule for Medicaid managed care plans and the Children’s Health Insurance Program (CHIP), Medicaid and Children’s Health Insurance Program (CHIP) Programs: Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions to Third Party Liability, represents a good first step in the development of pediatric-specific metrics. In addition, the National Association of Insurance Commissioners’ (NAIC) Network Access and Adequacy Model Act (Model) includes some promising provisions that could strengthen children’s access to in-network pediatric providers.

We are pleased that CMS will seek to align the QHP standards with those under Medicaid and by the NAIC, given the movement of families and children between public and private coverage. However, we are concerned that both the Medicaid managed care proposed rule and the NAIC Model do not fully assure that provider networks will be appropriate for children. For example, the Medicaid managed care rule includes certain provisions, such as the use of Medicare Advantage distance standards, which are not appropriate for the assessment of network adequacy related to pediatric specialty care. We refer you to our comment letter on the proposed Medicaid managed care rule for our recommendations to further strengthen the standards for Medicaid managed care plans and CHIP. We also highlight needed refinements to the NAIC Model below and remind you that aligned standards will only be effective if they prevent fragmented and delayed care and ensure children access to the full range of providers for all covered services. We urge you to establish a work group of pediatric health care experts to develop a comprehensive set of pediatric measures that could be applied across programs.

In the interim, to ensure that QHP networks meet the needs of children in the 2017 plan year, we strongly recommend that states be required to utilize an appropriate set of metrics that represent the state’s population (child and adult) and

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geographic diversity, as well as health care practices. We suggest that the NAIC standards be adapted for use by states to measure QHP networks with the following refinements (indicated by abc and [ ]):

- Provider-covered person [child and adult] ratios by [pediatric and adult] specialty [and subspecialty]
- Primary care [pediatric and adult] provider professional-covered [child and adult] person ratios
- Geographic accessibility of [pediatric and adult] providers
- Geographic variation and [pediatric and adult] population dispersion
- Waiting times for an appointment with participating [pediatric and adult] providers[, including specialists and subspecialists]
- Hours of operation
- The ability of the network to meet the needs of covered persons, which may include low income persons, children and adults with serious, chronic or complex health conditions or physical or mental disabilities or persons with limited English proficiency
- Other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care
- The volume of technological and specialty care services available to serve the needs of covered persons [children and adults] requiring technologically advanced or specialty care services

We emphasize that time and distance metrics should not be used to assess a network’s adequacy in relation to pediatric specialty care, though we believe they are a generally appropriate measure of a network’s primary care capacity. A CHA analysis has found that approximately 50 percent of children nationwide would not have access to the unique services provided by a children’s hospital under the current Medicare Advantage minimum distance standards, given the regional nature of that care, particularly tertiary and quaternary pediatric care. The use of this metric would place children who need the specialty care provided by a children’s hospital at risk of delayed services or compel them to seek care in settings ill-equipped to address their unique pediatric service needs.  

Therefore, we strongly recommend against the use of the Medicare Advantage distance metrics as the federal default standard for pediatric provider networks. Furthermore, states should not be allowed to use it as their sole metric for the assessment of QHP networks overall. Instead, we believe that QHPs should be able to demonstrate that their networks are adequate and affordable for the subpopulation of children that represented the majority of the plan’s pediatric spending in any given year, using a broad representative set of pediatric-appropriate metrics.

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Narrow and tiered networks
We are extremely troubled by the statement in the preamble to the Notice, “It is not our intent in establishing these default standards to prohibit certification of plans with narrow networks or otherwise impede innovation in plan design. Instead, we intend to establish a minimum floor consistent with the levels generally maintained in the market today, so that generally a very small number of plans would be identified as having networks deemed inadequate.” We strongly urge CMS to clarify in the final notice that QHPs with networks deemed inadequate would be considered discriminatory under Section 1557 of the ACA because they would deny enrollees access to needed services. Such plans must not be certified. We remind CMS that all QHPs must be able to demonstrate that their enrollees have access to a full range of providers for all covered services, from primary care to specialty and subspecialty care for children and adults with complex medical needs.

We agree with CMS that innovation in plan design is an important vehicle to advance delivery system reform that can meet the goals of the Triple Aim – better care, smarter spending, and healthier people. However, we remind you that the growing trend toward narrow, limited and tiered networks is creating serious barriers to children’s access to the care they need when they need it. These network designs can place unanticipated costs and stress on families when a needed pediatric provider is not in the network, and may deter families of children with serious medical needs from enrolling in that plan. Families and referring physicians are increasingly frustrated and fearful about harm to children and hospitals face additional administrative and financial burdens to negotiate special arrangements with issuers as a result of the confusion and fragmented care caused by these narrow and tiered networks.

Even narrow networks must assure access to trained and experienced providers for all covered services, including pediatric specialty and subspecialty care. However, a recent survey of children’s hospitals finds that three-quarters of responding hospitals were excluded from at least one QHP in their service area in 2015; 25 percent of those hospitals were excluded from at least one-half of the QHPs and some were excluded from all QHPs.8 We know from recent experience in Seattle, and now in Houston9, that narrow networks that exclude children’s hospitals directly impact children’s access to care. Currently, almost 500 families who rely on Texas Children’s Hospital for care have been struggling to determine how they are going to continue to access that care in a timely manner, let alone afford to pay higher costs associated with out-of-network care.

We also urge CMS to apply network adequacy standards to the lowest cost sharing tier of any tiered network to ensure that it includes the full range of pediatric specialists and subspecialists, as well as an appropriate pediatric tertiary care facility. The tiering of certain specialty providers into higher cost tiers is problematic because it places unanticipated costs onto patients enrolled in the plan who may need care from a provider in a higher cost sharing tier. It also could deter patients with serious medical needs from that plan or product. Furthermore, tiered networks that place children’s hospitals or other pediatric specialists in a higher cost tier may violate the nondiscrimination protections of Section 1557 of the ACA as the services offered by those providers are necessary for enrollees of a specific age group (i.e. children). Not only would this plan design potentially result in adverse selection, it would impose undue burdens on enrolled children. We know that some states have already adopted requirements to protect consumers from possible discrimination in the design of tiered networks and we suggest those standards as possible models to consider.10

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8 See Survey of Children’s Hospital Inclusion/Exclusion From Health Plan Provider Networks.
9 See Insurer cutbacks squeeze patients out of high-end care. Thousands are left furious, terrified after PPO plans dropped, Jenny Deam, Houston Chronicle, Dec. 5, 2015.
Network design transparency
Consumers must have clear information regarding narrow and tiered provider networks, including information about cost sharing responsibilities associated with each tier, out-of-network care, and appeals processes for denied services. The full transparency of issuers’ provider selection standards is critical, given that many narrow and tiered networks seem to be designed on the basis of cost, rather than quality. Issuers often identify networks that exclude specialty providers as “high-value” or “high-performing,” implying that provider quality has been considered in the development of the network. In the event that quality is a factor in network design, consumers and providers should have information regarding the quality measures that were used. By the same token, if quality measures have not been used to create the network, it is critical that families, providers and regulators are made aware of the basic methods that were used to create the network, which may be centered on lower cost providers.

Consumer information is absolutely critical to informed decision-making and awareness of out-of-pocket expenses that may be incurred as a result of care decisions. This information must be provided during plan selection to enable families with CYSHCNs to choose the most appropriate plan to meet their child’s needs. However, robust consumer information must not be used as a substitute for an adequate provider network.

Furthermore, there must be stringent, ongoing oversight and intervention by CMS and states to ensure that plan design does not effectively deny families the value of the premium they have paid and coverage for all benefits promised under the plan. We emphasize that it may be necessary to periodically review and modify the specific measures and standards for plans to reflect changes in practice patterns, demographics and other factors. In order to ensure that the standards accurately assess children’s access to the most appropriate providers for their care, CMS must implement strong, ongoing analytic strategies. State and federal oversight of QHP networks must include procedures to monitor, identify, and address pediatric provider network gaps or access barriers, including wait times and transportation complexities. The standards development and implementation process must be nimble enough to adapt as health care delivery and population needs change.

Notice of Network Change; Continuity of Care §156.230(e)(1) and 156.230(e)(2)

We commend CMS for recognizing the need for consumer notification and a transition period of care when their provider is discontinued from a plan network and urge the agency to require similar requirements for the SBEs. It is especially important that the care of a very sick child not be disrupted during the course of care as a result of a provider network change. The ending of the plan’s contractual relationship with their pediatric provider should not result in fragmented care that threatens a child’s health and well-being or in higher costs to the family through out-of-network cost sharing rates.

Families of children with serious, chronic or complex conditions face some unique challenges when a provider they rely on is no longer in-network or they change plans. For example, they may have difficulty finding a new plan that includes the range of pediatric specialists and subspecialists necessary, particularly given the regionalization and specialization of tertiary and quaternary pediatric care. We offer the following suggestions to further strengthen the continuity of care protections for children and their families:

- The definition of “serious acute condition” must be refined to include pediatric-specific conditions
- The 90-day continuity of care transition period should be the minimum, rather than the maximum, length of time allowed for enrollees to continue treatment with their current provider. Children with chronic or complex conditions develop a strong reliance on their pediatric providers and disruption of care at any stage in their treatment can have
detrimental lifelong consequences.

- New enrollees in the midst of an active course of treatment should be able to continue that treatment with their current providers for up to 90 days, even if those providers are not in their new plan’s network

**Essential Community Providers §156.235**

**Disaggregation of children’s hospitals from other hospital types §156.235(a)(2)(ii)**

We are extremely concerned and disappointed that CMS has decided against the disaggregation of children’s hospitals from the ECP “hospital” category and we strongly urge you to move forward to propose this disaggregation. We believe the originally intended disaggregation noted in the Final *[Notice of Benefit and Payment Parameters for 2016]* accurately recognized the unique capabilities and expertise located in children’s hospitals. The current grouping of children’s hospitals with other hospitals allows issuers to contract with lower cost hospitals that do not have the capacity to provide the specialized care that children need, rather than with the children’s hospital in their service area.

A network that does not include a children’s hospital will not have adequate capacity or the capability to provide the complete spectrum of care that children may need. As we have noted in numerous prior communications, a CHA analysis of children’s hospital service lines and beds demonstrates the unique capacity and capabilities of children’s hospitals and reinforces the importance of establishing network adequacy standards that ensure that children, in fact, have access to the services provided by an ECP children’s hospital.

Children’s hospitals are a vital safety net for all children, treating uninsured, underinsured, and publicly and privately covered children across the country. They have the experience and expertise to appropriately treat vulnerable and low-income children in need of tertiary and quaternary care, as evidenced by the volume of services they provide. They have pediatric specialists and subspecialists with the specific clinical training to meet the needs of children from birth into adulthood for a full range of conditions.

Pediatricians, family practice physicians, and adult community hospitals refer their patients to ECP children’s hospitals for treatment of everything from complicated fractures to complex congenital heart conditions, because of the expertise of those working in the hospital. To illustrate this point, we share the case of a two-year-old child who was in need of hernia repair surgery. The child was referred to an in-network outpatient surgery clinic, rather than the local ECP children’s hospital because that hospital was not in the plan’s network. However, the surgical center told the child’s family that it did not have providers with the appropriate pediatric training and would not treat a two-year-old. The center informed the family that the only provider in the community equipped to care for their young child was the children’s hospital. Ultimately, the child was treated on an in-network basis at the children’s hospital with good outcomes.

According to the preamble to the proposed Notice, CMS does not believe that there are enough ECP children’s hospitals in the HHS ECP database to provide issuers with sufficient contracting flexibility. However, we believe that, in fact, the database does not accurately indicate the availability of children’s hospitals across the nation. A review of the 2017 draft database found that approximately 60 children’s hospitals are categorized correctly as children’s hospitals; however, at least 115 ECP children’s hospitals are not identified as such. Given that there are at least 190 acute care ECP children’s hospitals

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hospitals nationwide, there are clear discrepancies in the database. Further direct communication to CMS regarding this analysis is forthcoming. We urge you to review this new data and move forward to strengthen the requirements for QHPs to contract with ECP children’s hospitals by disaggregating them from other types of ECP hospitals. We look forward to working with you to ensure that the ECP provisions of the ACA meet their promise of ensuring that vulnerable populations, including children, have access to the care they need when they need it.

**QHP satisfaction of ECP provider participation standard §156.235(a)(2)(i) and §156.235(b)(2)(i)**

We reiterate our strong belief that CMS should reconsider the use of a minimum percentage threshold for ECP participation. A minimum percentage standard does not guarantee that QHPs will contract with a representative mix of ECPs nor does it ensure an adequate quantity of ECPs in the networks. Regardless of the established minimum, most plans will achieve that standard and go no further without, necessarily, addressing ongoing gaps in networks.

We are also opposed to the proposal in the Notice to count contracted or employed full-time equivalent (FTE) practitioners at a single location toward a QHP’s satisfaction of the ECP participation threshold. Rather than strengthening access to ECPs, we believe this approach would severely weaken access. The intent of the ECP provisions is to ensure that vulnerable and low-income populations, including children, have access to facilities specially equipped to provide a comprehensive set of services that meet the language, cultural, environmental, and sociodemographic needs of targeted populations. Counting individual practitioners within those facilities towards the ECP standard is completely counter to the underlying goal of ensuring geographic access, as well as access to a broad range of provider types. For example, an issuer could meet the 30 percent minimum threshold by contracting with three of ten MD FTEs in an area, even though most or all of the FTEs are gastroenterologists and/or from the same facility.

Furthermore, we are concerned that this provision poses an administrative and costly burden on the facility as well as on issuers. For example, it is not clear how and if both credentialed and non-credentialed clinicians should be counted. Furthermore, the facility, not the clinicians, typically contract with the issuer. Given that a children’s hospital’s in-network status is not always known until a child seeks care, it may be close to impossible to determine if contracted practitioners are in-network and should be counted by the hospital. In addition, issuers would need to count the credentialed vs. non-credentialed FTEs for purposes of meeting their ECP threshold, which creates an additional administrative process for them.

Given its potential negative impact on access to care and the burdensome nature of operationalizing this proposal, we believe it runs counter to the ACA’s goals of increased access and lower costs and should be deleted.

**Patient Safety Standards for QHP Issuers §156.1110**

We are pleased that CMS is moving forward to strengthen patient safety standards for the QHPs and support the alignment of the stronger standards with others geared toward the reduction of patient harm. We wish to emphasize the importance of ensuring that the standards reflect all populations, including children served by the QHPs and contracted hospitals. We urge CMS to consider the uniqueness of children’s health care needs, their health care delivery system, pediatric quality measures, and children’s health care safety initiatives as it implements §156.1110.

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We also believe that patient safety standards and initiatives must be integrated into the larger quality realm to reflect the objectives established in the National Quality Strategy. In pediatrics, the key aspects of quality improvement, measures development, and patient safety evaluation and management are found in the Pediatric Quality Measures Program (PQMP), the pediatric measures work at the National Quality Forum, and the Child Health Patient Safety Organization (PSO), a component of the Children’s Hospital Association.

The Child Health PSO, like all PSOs, plays a critical role in helping hospitals improve patient safety through reporting, analysis, and data-sharing mechanisms. The Child Health PSO, unlike other PSOs, is uniquely focused on children’s hospitals and was established in recognition of the specific challenges of caring for the pediatric population. It should serve as a model for hospital patient safety programs that are comprehensive, involve patients and families, and include appropriate expertise for the specific populations served by the hospital.

Specifically, hospitals that serve children must include pediatric expertise in the design, implementation and monitoring of their patient safety programs and ensure that safety guidelines originally developed for adult populations are appropriate for and/or are modified for children. For example, a system to ensure medication safety for children must include the capacity for weight-based dosing.

We strongly encourage CMS to turn to the Child Health PSO, the PQMP, and other similar child-focused endeavors for their expertise and reach to assist with and support pediatric-appropriate implementation of the patient safety initiatives under §156.1110. These would include:

- Hospitals’ implementation of a patient safety evaluation system. Child Health PSO and other PSOs currently provide assistance to their participating hospitals to develop such policies.

- Alignment and coordination with other non-PSO evidence-based initiatives that reduce preventable harm and hospital readmission and improve care coordination and health care quality. Only under these circumstances would exceptions to a requirement that QHPs work with PSOs to reduce patient harm be acceptable.

- Minimum standards for the reporting of adverse events through the Agency for Healthcare Research and Quality Common Formats that preserve the PSO privilege and confidentiality protections while driving critical data collection for pediatric quality and safety improvement.

In addition, we are pleased that the patient safety standards under §156.1110(a)(2)(i)(B) require QHP issuers to ensure that hospitals have implemented a comprehensive person-centered discharge program. It is critical that hospitals that serve children demonstrate that their discharge planning programs reflect the needs of the populations (e.g., by age group and sub-populations (e.g., by level of complexity) served by the hospital. Features of a comprehensive discharge planning program that may be more unique in hospitals serving children include the structure and function of the child’s family and social environment, ongoing coordination with other settings (such as schools), development of goals for the child following discharge, and recognition of the child’s developmental stage and milestones to be achieved. Discharge planning is a key component of care transitions that improves outcomes for patients transitioning between acute hospital and post-acute care. Disruptions in care for children, particularly children with special health care needs, can lead to lifelong consequences that affect a child’s quality of life and generate extensive and avoidable costs.

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13 Most recently extended through the Medicare Access and CHIP Reauthorization Act of 2015.
We thank you, again, for this opportunity to comment on the proposed Notice. CHA and our members look forward to continuing to work with you to ensure that the insurance coverage offered though the Exchanges best meets the health care needs of all children, especially those children who face difficult health challenges. If you have any questions regarding this letter or other Exchange-related issues, please contact Jan Kaplan at the Children’s Hospital Association at 202-753-5384 or jan.kaplan@childrenshospitals.org.

Thank you,

[Signature]

M. James Kaufman, PhD
Vice President, Public Policy