Re: Children’s health priorities for the 2017 Letter to Issuers in the Federally-facilitated Marketplaces

Dear Mr. Slavitt:

As organizations that share a strong commitment to the health of our nation’s children, we would like to take this opportunity to applaud you for your ongoing and dedicated efforts to create and continually refine the Marketplaces to meet the needs of a broad and diverse population in need of coverage and access to care. We write to you today because we believe that additional refinements are necessary to ensure that the Marketplaces will work for children. Nearly one million children are enrolled in QHPs to date, making Marketplace coverage an increasingly important component of children’s coverage overall, and helping to bring the rate of uninsured kids to historic lows at just 6 percent in 2014. We ask that you consider our recommendations to improve children’s coverage and address them in upcoming guidance to issuers, including the Letter to Issuers in the Federally Facilitated Marketplaces (Letter). We also look forward to providing comments to you on these issues in response to the proposed 2017 Notice of Benefits and Payment Parameters, which we understand is now under review by the Office of Management and Budget.

First, we would like to thank you for two critically important improvements to requirements for health plans that were included in the 2016 Notice on Benefits and Payment Parameters, which will help children access high-quality health care where and when they need it:

- The establishment of a uniform definition of habilitative services and devices and separate limits for habilitative and rehabilitative services. These are vitally important first steps to ensuring that children have access to the full range of services they need to attain and maintain their highest developmental potential.

- The commitment to propose stronger requirements in the 2017 NBPP for health plan contracting with children’s hospital essential community providers (ECPs).

Second, we share with you the priority areas for children’s health care coverage and access where improvement is still needed. We urge you to incorporate our recommendations in this year’s guidance for health plans related to:

- Pediatric-appropriate benefits

- Improved pediatric network adequacy standards

- Cost-sharing for out-of-network care
• Care transitions that work for very sick children
• Pediatric quality improvement
• Language access

PEDIATRIC-APPROPRIATE BENEFITS

We urge CMS to strengthen the requirements for health plan coverage of the pediatric services and habilitative services and devices categories of the essential health benefits (EHBs). Children are not little adults and require a set of health care benefits distinct from those provided for adults. As noted in the 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 found gaps in coverage of well-child visits. To ensure that the EHBs support, rather than impede children’s healthy development, we urge CMS to address the following issues in this year's guidance to issuers:

• Definition of pediatric services
  We request that CMS further define the pediatric categories to ensure adequate coverage for children that is representative of all of their health needs. At a minimum, plans should be required to ensure that their pediatric benefits are comparable to the CHIP benefit package.

As we have previously articulated to the Department of Health and Human Services (HHS)¹, we strongly believe that the pediatric EHB category should be defined based on the comprehensive services under Medicaid’s Early and Periodic screening, Diagnosis and Treatment (EPSDT) benefit. As the next best alternative, we have suggested that HHS define this benefit using services from states’ 2014 Children’s Health Insurance Program (CHIP) plan. Both EPSDT and CHIP plans have a robust benefits package that assures children receive all the services they need to maintain and improve their health as they grow and develop². In contrast, studies³ have documented the significant gaps in pediatric services covered by plans subject to the EHB requirement, especially when compared to the child-appropriate benefits under CHIP. Furthermore, our own review of EHB benchmarks highlights some surprising, and alarming, apparent gaps in pediatric coverage.

• Coverage of habilitative services and devices
  • CMS should delineate a minimum set of services and devices that are covered under the habilitative service and devices benefit. We applaud CMS on the inclusion of provisions in the 2016 NBPP that establish a uniform definition of habilitative services and devices and separate limits for habilitative and rehabilitative services, if limits on services are imposed. These

1 See October 16, 2014 Letter to Secretary Sylvia Burwell on the Department’s approach to revisions to the EHBs for 2016
2 See American Academy of Pediatrics, Scope of Health Care Benefits for Children From Birth Through Age 26
3 See: Government Accountability Office (GAO), Children's Health Insurance: Coverage of Services and Costs to Consumers in Selected CHIP and Private Health Plans in Five States (March 2015)
Health Affairs: The ACA’s Pediatric Essential Health Benefit Has Resulted In A State-By-State Patchwork Of Coverage With Exclusions (Sept. 2015)
The Wakely Consulting Group, Comparison of Benefits and Cost Sharing in Children’s Health Insurance Programs to Qualified Health Plans (July 2014)
advances in the coverage of habilitative services and devices are an important step toward ensuring that children with special health care needs can achieve and maintain function at the highest level possible. However, as we note in our Sept. 30 letter to CCIIO, coverage of habilitation not only varies significantly among the state benchmarks, but often does not meet children’s developmental needs. The review clearly indicates the need for further guidance from CMS. At a minimum, guidance to issuers should specify the following coverage parameters:

- The habilitative services benefit includes, but is not limited to: physical and occupational therapy, speech-language pathology, behavioral health services, audiology, rehabilitation medicine, and developmental pediatrics.
- The habilitative devices benefit includes, but is not limited to: durable medical equipment (e.g., wheelchairs and related accessories), orthotics, prosthetics, low vision aids, hearing aids, augmentative communication devices that aid in hearing and speech, and other assistive technologies and supplies.

○ 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. As we note in our Sept. 30 letter to CCIIO, a child may need habilitative services for a longer period of time than rehabilitative services as it may be difficult to measure progress for a child who is developing a skill for the first time or to determine the limits of the child’s capacity. Furthermore, children will need frequent replacements of devices, such as wheelchairs, glasses, auditory aids, orthotics, prosthetics, and augmentative communications devices as they grow and develop.

○ CMS should require an exceptions process for individuals who need habilitative services that exceed a plan’s coverage, similar to that required for Multi-State Plans. While an exceptions process must not replace access to a full scope of habilitative services, a clearly delineated and simple appeals procedure must be available for families when a particular service is in dispute for any reason. We also encourage CMS to require plans to track requests for exceptions and their outcomes and report that information to CMS.

• Transparency standards for plan documents.
We recommend that the 2017 guidance to issuers standardize requirements for all plan documents, beyond the required Summary of Benefits and Coverage. As noted in the Sept. 30 letter to CCIIO, our informal review of health 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.

IMPROVED PEDIATRIC NETWORK ADEQUACY STANDARDS

Essential community providers (ECPs)
As we noted previously, we are extremely pleased that CMS recognizes the unique role that children’s hospitals play in the care of children and intends to propose stronger requirements for QHP contracting with children’s hospital ECPs. We look forward to working with CMS to enact requirements that will ensure that QHPs contract with at least one children’s hospital ECP in their service area so vulnerable children have access to the specialty care they provide.
On the other hand, we urge you to reconsider the use of a minimum percentage threshold for ECP participation in plans. A minimum percentage standard does not guarantee 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.

**Pediatric network adequacy**

We urge CMS to move forward to ensure that QHP networks include the full range of pediatric primary, ancillary, specialty and subspecialty providers who typically care for children to ensure access to all covered benefits. We respectfully remind you that children’s unique health and developmental needs cannot be addressed through adult-focused network adequacy standards and ask that you review the principles for pediatric network adequacy articulated in Safeguarding Access to Medically Complex Care for Children by Requiring Health Plans and Exchanges to Develop Adequate Provider Networks, which has been endorsed by more than 70 national, state and local organizations.

The 2016 NBPP and Letter indicated that CMS intends to base its network adequacy standards for QHPs on those adopted by the National Association of Insurance Commissioners (NAIC). We urge you to consider the final revised NAIC standards with a critical eye as we believe that those standards must be strengthened to meet the unique needs of children. Necessary improvements to those standards include, but are not limited to:

- **Networks should be assessed using a broad set of objective pediatric-specific measures that are consistent across carriers and developed with the input of experts in pediatric health care.** It is especially important that network adequacy is assessed based on the inclusion of in-network pediatric providers with the requisite training and expertise to provide needed care, not on the number of providers in a network. This clarification is particularly important in pediatrics to ensure that networks include pediatric specialists and subspecialists who are equipped to care for children with serious, chronic or complex conditions.

- **QHPs that utilize tiered networks must be required to ensure that children and adults enrolled in those plans have access to the full range of primary, specialty, tertiary and quaternary care through in-network providers in the lowest cost-sharing tier.** We are very concerned that tiered networks — networks that assign different levels of consumer cost-sharing to different tiers of providers — are being designed in a discriminatory fashion. For example, children’s hospitals, which specialize in the care of children with more complex needs are increasingly placed into higher cost-sharing tiers, forcing children and families who need specialty care to pay significantly higher out-of-pocket costs. Not only do those plans run the risk of being insufficient for children with specialized health care needs, they may also violate non-discrimination protections under the Affordable Care Act. Therefore, it is imperative that all network adequacy standards are applied to the lowest cost-sharing tier of any tiered network so that tier includes a full range of providers for all covered services. 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 as possible models to consider.

- **Special attention must be paid to the oversight of, and information dissemination regarding, both narrow and tiered networks, many of which seem to be designed on the basis of cost, rather than quality.** The exclusion of certain specialty providers, such as
children’s hospitals, from a network, or the tiering of those providers into higher cost tiers, is extremely problematic for families with children. Limited and tiered networks place unanticipated costs onto children and families and may deter families of children with serious medical needs from enrolling in that plan. Furthermore, we are concerned that some plans may identify networks that exclude specialty providers as “high-value” or “high-performing,” and thus, imply that provider quality has been considered in the development of the network. In the event that quality is a factor that is used in the design of a network, families should have information regarding the quality measures that were used.

**COST-SHARING LIMITS FOR OUT-OF-NETWORK CARE**

We believe that the clarification in the final 2016 NBPP that insurers have the option to count cost-sharing for out-of-network care toward annual out-of-pocket limits is an important first step in protecting families from exorbitant expenses. However, we strongly believe that a child who must receive out-of-network care because there is no in-network provider with the appropriate expertise and training should not be penalized financially for doing so. In those circumstances, out-of-network services should be considered as if they were provided in-network and out-of-pocket cost sharing limits should apply.

**CARE TRANSITIONS THAT WORK FOR VERY SICK CHILDREN**

While the 2016 NBPP provisions on care transitions for new enrollees are a good first step, we believe that these provisions should be strengthened. At a minimum, we believe that QHPs should be required, rather than encouraged, to offer new enrollees transitional care for a minimum of 30 days for an ongoing course of treatment.

We also encourage CMS to address other continuity of care situations that may arise, such as when a provider’s network status changes. Continuity of care is an extremely important issue for children with chronic or complex health (including behavioral health) conditions who often have long-standing relationships with their providers. Those providers are specially equipped to treat the child’s condition and address their unique developmental needs. Disruptions in care can be catastrophic for these children. Therefore, all consideration must be given to ensuring continuity of provider to the extent possible. In the event a change in provider cannot be avoided, including a change in the provider’s network tier, there must be a child-centered transition plan to address the range of the child’s needs. At a minimum, children should be allowed to see their current provider for at least 90 days or until a course of treatment is completed at in-network cost-sharing levels. We look forward to working with you to strengthen requirements for care transitions under all types of circumstances.

**PEDIATRIC QUALITY IMPROVEMENT (QIS)**

We are concerned that the 2015 NBPP did not delineate specific performance measures for QHPs and did not address the need to ensure that measures are appropriate for all sub-populations of individuals, including children. It is essential that CMS includes measures in the QIS that represent the needs and quality of care provided to our most vulnerable children in evaluating and rating QHPs as soon as such measures become available through the Pediatric Quality Measures Program (PQMP) and other efforts. We encourage CMS to work closely with National Quality Forum, as well as other quality initiatives, to ensure that QIS measures adequately reflect the needs of all children – from those who are generally healthy to those with medical complexity. Those measures and related QIS standards should be applicable to all QHPs.
LANGUAGE SERVICES

We applaud you for including language access requirements in the 2016 NBPP and recommend that these be retained in 2017 and moving forward. In particular, we strongly support continuing to require taglines in 15 languages on all critical documents and websites of Marketplaces, issuers, agents and brokers. Qualified language access services are essential to communication with families when a child’s parents or guardians have limited English proficiency. In addition, we believe that American Sign Language and Braille should be a component of all language access services to ensure that children and families with hearing or vision impairment can access clinical information. These services must be available throughout the health care enrollment process, as well as when health care services are provided to ensure that children receive the coverage and care they need.

We thank you, for your ongoing efforts to improve coverage and access of children and families in the Marketplaces. We look forward to continuing to work with you to ensure that the QHPs meet the health care needs of all children, especially, those children who face difficult health challenges. If you have any questions regarding this letter, please contact Jan Kaplan (202-753-5384) at the Children’s Hospital Association.

American Academy of Pediatrics
Autism Speaks
Children’s Defense Fund
Children’s Dental Health Project
Children’s Hospital Association
Community Catalyst
Family Voices
First Focus
Georgetown University Center for Children and Families
March of Dimes
National Association of Pediatric Nurse Practitioners
National Health Law Program
National Hispanic Medical Association

Cc:
The Honorable Sylvia Matthews Burwell, Secretary
US Department of Health and Human Services

The Honorable John Koskinen, Commissioner
US Department of the Treasury

The Honorable Thomas Perez, Secretary
US Department of Labor