Dec. 1, 2016

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200 Independence Avenue, S.W.
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RE: 2018 Draft Letter to Issuers in the Federally-facilitated Marketplaces

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 Draft 2018 Letter to Issuers in the Federally-facilitated Marketplaces (Letter). Children’s hospitals play a critical role in preventing uninsured and under-insured children from falling through the cracks in the nation’s health care system and have a unique perspective of children’s health care needs and the delivery of pediatric health care, particularly for children with serious, chronic or complex conditions. While all children’s hospitals provide local care, they also excel in specialty care. As a result, 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). The coverage provided to those children must ensure access to timely, affordable and high quality age-appropriate care that meets their unique developmental needs. Our comments below focus on ways to strengthen benefits and provider networks for children so they have better access and care through QHPs and other forms of commercial insurance.

First, we respectfully reiterate several key recommendations that we have provided to you as the implementation of the Affordable Care Act has progressed (most recently in our comments on the Notice of Benefit and Payment Parameters for 2018 and the 2017 Draft Letter to Issuers in the Federally-facilitated Marketplaces). Specifically, we urge CCIIO to:

- Ensure that the Essential Health Benefits (EHBs) guarantee access to medically necessary, age-appropriate coverage
  - Define the pediatric EHB category so health plans provide age-appropriate coverage for children that is representative of all of their health needs
  - Delineate a minimum set of services and devices that are covered under the habilitative services and devices benefit

- Adopt a network adequacy standard that ensures children in-network access to all providers of covered services
  - Avoid the sole use of time and distance metrics when assessing network adequacy in relation to pediatric specialty care
  - Clarify that network adequacy standards should ensure access to providers in the lowest cost-sharing tier of plans with tiered networks

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1 At a minimum, the definition should be based either on the benefits provided in a state’s CHIP plan or on the American Academy of Pediatrics’ Scope of Health Care Benefits for Children.
Disaggregate children’s hospitals from other types of essential community provider (ECP) hospitals to ensure provider networks are sufficient to meet children’s needs.

We also offer the following comments and recommendations focused on the new proposals in Chapter 2; Sections 3 (Network Adequacy) and 4 (Essential Community Providers) and their implications for children’s health and health care.

**CHAPTER 2: QUALIFIED HEALTH PLAN AND STAND-ALONE DENTAL PLAN CERTIFICATION STANDARDS**

**Section 3. Network Adequacy**

*Network breadth*

As we noted in our comments on the 2018 NBPP and 2017 draft Letter, we support efforts to increase transparency about health plan networks for enrollees. We believe that the proposed pilot of a network breadth indicator is a good first step and urge you to move forward with an additional network breadth classification system that separates adult and pediatric acute care hospitals, as well as the most commonly utilized pediatric specialists. This additional classification will help families choose plans that include the pediatric specialty providers they may need to care for their child in the event he or she suffers a serious or complex medical event.

We also agree that additional specificity in the classification system to identify plans that utilize integrated delivery systems can be a valuable consumer assistance tool. However, we believe that the Letter’s proposed definition of integrated care should be strengthened with additional criteria that ensure the seamless provision of health care services, from the perspective of the patient and family, across the entire care continuum. Plans with integrated delivery systems should include all necessary providers of covered services, including primary and specialty care, particularly for children and adults with serious, chronic or complex conditions. They also must have mechanisms in place to coordinate the efforts of providers, irrespective of institutional, departmental, or community-based organizational boundaries. Specifically, they must:

- Provide comprehensive care management of inpatient and outpatient hospital services, behavioral health, and transitions to care in other settings, in addition to primary care services
- Coordinate access to the full range of pediatric specialty and subspecialty medical services, including services that are located in other geographic areas if medically necessary
- Have a system to make referrals to community and social support services, as appropriate
- Provide patient and family support
- Use health information technology to link services, as feasible and appropriate

Finally, QHPs with integrated delivery systems must be held accountable for the quality, comprehensiveness and accessibility of their provider networks. We urge CCIIO to be assertive in its review of QHP integrated systems and to use consumer testing to assess the ability of the networks to fully meet the age-specific needs of enrollees.

*Specialty Access*

We applaud CCIIO for its proposal to assess consumer access to higher cost specialty providers and urge the agency to begin these assessments in the current plan year. We agree that children’s access to appropriate specialty providers is being negatively impacted by the growing trend of narrow, limited and tiered networks throughout the market. For
example, we are increasingly aware of issuers that are contracting with 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, or they are including children’s hospitals only in more expensive tiered offerings. When a network includes providers without the requisite pediatric training or places pediatric specialty providers in a higher cost-sharing tier, families may be referred to inappropriate providers who, by their own admission, do not have the experience to provide the services needed. Lack of pediatric specialty care in networks, lack of transparency in coverage, and higher out-of-pocket costs due to the tiering of specialty providers put children and their families at financial risk and threaten children’s long-term quality of life.

We provide the following comments on the scope and methodology of the proposed assessment to ensure that children have timely access to the specialty providers they need.

- **The adoption, and proactive enforcement, of comprehensive network adequacy standards specific to children’s health care needs must be a top priority.** We respectfully remind CCIIO that inadequate access to appropriate specialty providers is an indication of an inadequate network and the absence of effective network adequacy standards. We urge CCIIO to require QHPs to have provider networks that are capable of providing pediatric services for all levels of complexity, including for rare conditions, without administrative or cost barriers for children and families.

  As we have noted in previous comment letters, children are not little adults and must have access to providers with the training and expertise to meet their unique developmental needs. In particular, children with serious, chronic or complex health conditions, including children with special health care needs, must have in-network access to pediatric specialty and subspecialty care providers, including pediatric ancillary providers and children’s hospitals, to address their particular health conditions.

- **CCIIO should expand the assessment of pediatric access to include the full range of pediatric specialty and subspecialty providers.** QHPs must be held accountable for children’s access to the full range of pediatric specialties, including but not limited to the general specialty areas identified in the Letter (e.g., pediatric cardiology, endocrinology, infectious disease, nephrology, etc.), as well as pediatric behavioral/mental health and rehabilitative and habilitative services (e.g., pediatric physical therapy, occupational therapy, and speech therapy), pediatric audiology services, and pediatric optometry. The assessments of health care facility access must include pediatric hospitals in addition to adult acute hospitals as proposed. Active monitoring of children’s access to these providers is essential to their future development and well-being.

  **Children’s access to pediatric specialists in tiered provider networks must be assessed.** The tiering of certain specialty providers into higher cost-sharing tiers is problematic because it places unanticipated costs onto families with a child who may need care from a specialty provider in a higher cost-sharing tier. It also could deter families of children with serious medical needs from enrolling in a given plan or product. Not only would these plan designs potentially result in adverse selection and impose undue financial burdens on families, they may run the risk of violating the non-discrimination protections of Section 1557 of the ACA.

- **The assessment of a QHP network should not be based on comparisons with other QHPs in the service area in the absence of strong network adequacy standards and certification that the other QHPs have met those standards.** We oppose the proposal to assess QHP specialist networks relative to other QHPs in the service area unless all QHPs are required to meet pediatric-appropriate network adequacy standards. Given the growing trend toward narrow networks, it is possible that few or no QHPs will have adequate pediatric specialty access, rendering a comparison between QHPs meaningless. Instead, we urge CCIIO to base the assessments on pediatric patients’ actual experiences with access to timely and appropriate in-network care.
• **Access assessments must be accompanied with action when warranted.** We urge CCIIO to delineate the specific steps that issuers must take in the event the consumer access assessment indicates an inadequate network, including the identification of needed specialists to fill network gaps. Again, we remind CCIIO that out-of-network arrangements should be allowed only as an exception for extremely rare services or when timely access to a needed specialist cannot be ensured. Furthermore, QHPs should not be permitted to impose out-of-network cost-sharing if the most appropriate specialist for a child is not in the plan’s network or is not available in a timely fashion.

**Section 4. Essential Community Providers**

We urge CCIIO to continue to allow issuers to write in essential community providers (ECPs) that are not included in the non-exhaustive database for 2018. We also urge CCIIO to strengthen its mechanisms to inform providers about the release of the annual ECP petition and database. It is imperative that there is a full and accurate accounting of available ECPs in a service area given their role as key providers of health care for underserved and vulnerable populations.

Many ECPs are still learning about the annual petition process and database as CCIIO expands its outreach and communications mechanisms. CCIIO’s current reliance on stakeholders, including professional membership associations such as CHA and the American Hospital Association, to inform providers about the petition and database is all the more reason to expand, not limit, the mechanisms to identify ECPs. While we look forward to continuing our collaboration with CCIIO to secure a strong response to the ECP petition, we urge you to establish more formal communication streams to ECP providers via Federal Register notices, direct emails from CMS, and other avenues. Until those formal structures are established, issuer write-in capability should continue as a critical fail-safe for those providers who may be inadvertently left off the list.

Thank you, again, for the opportunity to provide comments on the draft Letter. If you have any questions about our comments, please contact Jan Kaplan at 202-753-5384 or jan.kaplan@childrenshospitals.org.

Sincerely,

M. James Kaufman, PhD
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