Dec. 1, 2016

Kevin Counihan
Director & Marketplace Chief Executive Officer
Center for Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: 2018 Draft Letter to Issuers in the Federally-facilitated Marketplaces (FFM)

As organizations dedicated to improving the health and well-being of children, adolescents, and pregnant women, we thank you for the opportunity to comment on the Draft 2018 Letter to Issuers in the Federally-facilitated Marketplaces (Letter).

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. Specifically, we urge CCIIO to:

• Ensure that the Essential Health Benefits (EHBs) guarantee access to medically necessary, age-appropriate coverage
  o Define the pediatric EHB category so health plans provide age-appropriate coverage for children that is representative of all of their health needs1
  o 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
  o Avoid the sole use of time and distance metrics when assessing network adequacy in relation to pediatric specialty care
  o Clarify that network adequacy standards should apply to providers in the lowest cost-sharing tier of plans with tiered networks
  o 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; Section 3 (Network Adequacy)

CHAPTER 2: QUALIFIED HEALTH PLAN AND STAND-ALONE DENTAL PLAN CERTIFICATION STANDARDS. [Section 3. Network Adequacy]

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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 (PEDIATRICS, January 2012, VOLUME 129 / ISSUE 1).
Network breadth

We believe 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 network breadth classification system to identify plans that utilize integrated delivery systems can be a valuable consumer assistance tool. However, we believe that the proposed definition in the Letter 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 must include all necessary providers of covered services, including primary and specialty care, particularly for children and adults with serious, chronic or complex condition. 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 other services 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. 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, higher out-pocket costs due to the tiering of specialty providers, and lack of transparency in coverage 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 to ensure that children have 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, such as that provided by pediatric subspecialists, pediatric surgical specialists, pediatric nurse practitioners, other pediatric ancillary providers, and children’s hospitals, in order to address their particular health conditions.

CCIIO should expand the assessment of pediatric access to 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, such as pediatric physical therapy, occupational therapy, and speech therapy; pediatric audiology services; and pediatric optometry. Facility access assessments must include pediatric hospitals in addition to adult acute hospitals as proposed in the Letter. 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 network must be assessed. The tiering of certain specialty providers into higher cost tiers is problematic because it places unanticipated costs onto families of children enrolled in the plan who may need care from a 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 enrolled children, 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. 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. The Letter does not specify the actions that CCIIO will take when it is determined that enrollee access to higher cost specialty providers is limited. 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 needed providers 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.
Thank you for your attention to the concerns of the pediatric community. If you have any questions regarding these comments, please contact Jan Kaplan (jan.kaplan@childrenshospitals.org or 202-753-5384) with the Children’s Hospital Association.

American Academy of Pediatrics
Children’s Hospital Association
Family Voices
First Focus
National Association of Pediatric Nurse Practitioners