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January 14, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244
Submitted electronically to http://www.regulations.gov

Re: CMS-2408-P - Medicaid and Children's Health Insurance Plan (CHIP) Managed Care

Dear Ms. Verma,

On behalf of over 220 children's hospitals across the country, the Children's Hospital Association (CHA) appreciates the opportunity to provide comments on the proposed rule to make changes to existing Medicaid managed care regulations. Since almost two-thirds of children covered by Medicaid are enrolled in comprehensive risk-based managed care, the proposed rule has implications for children's hospitals and children's health.

Though children's hospitals account for only 5 percent of hospitals in the United States, they provide 47 percent of the hospital care required by children covered by Medicaid. Children's hospitals are regional centers for children's health, providing care across large geographic areas and serving Medicaid children across state lines. Children's hospitals serve the majority of children with serious illnesses and complex chronic conditions and most children in need of major surgical services. In addition, children's hospitals are engaged in efforts to promote delivery system changes, efficiency and cost savings in Medicaid.

As you know, more than 50 percent of the beneficiaries on Medicaid are children, necessitating a review of the new proposed policies to ensure they work for children, in addition to the broader Medicaid population. We appreciate your review of current rules and believe that some of the proposed rule provisions will strengthen Medicaid managed care requirements. We also want to thank you for not changing some of the current regulatory provisions that are important to children and other Medicaid and CHIP beneficiaries. However, we also believe there are several aspects of the proposed rule that could go farther to protect children's access to needed care and meet their unique health and developmental needs. We provide more detailed comments below on the proposed rule provisions and our comments on the 2015 proposed Medicaid and Children's Health Insurance Program managed care rule (CMS-2390-P) for your consideration more broadly.[1]

Specifically on the CMS proposed changes in this rule, we strongly encourage CMS to address the unique needs of the pediatric population by refining the proposed managed care requirements to:

- Ensure adequate provider networks for children, particularly children with serious, chronic or complex conditions

[1] See July 27, 2015, Letter to Andrew Slavitt re: CMS-2390-P - 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

- Support appropriate provider payments to ensure access for children
- Address quality of care for children
- Maintain Data Reporting Requirements

Ensure Adequate Provider Networks for Children
We appreciate CMS' acknowledgement in the proposed rule of the differences between pediatric and adult health care systems by continuing to require states to develop network adequacy standards for both pediatric and adult specialists, primary care, dental and behavioral health providers. However, we are concerned that the rule does not give states more specific parameters for the definition of pediatric specialists to ensure that network standards appropriately assess children's access to all pediatric specialty services covered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

In addition, while we agree with CMS that time and distance standards are not always the most appropriate quantitative metric to measure network adequacy, we are very concerned about the outright elimination of these standards as a floor for state network adequacy assessment. Children must have timely access to a full range of providers that are in their community, including specialty providers when available. The elimination of the requirement that states use time and distance as the foundational component of their network adequacy standards could deny many children the care they need when they need it.

However, as we stated in our comments on the 2015 proposed rule, network adequacy quantitative standards for pediatric specialty care must go beyond time and distance, given the regionalization of that care. Time and distance metrics alone cannot account for the many children who travel long distances and across state lines to receive necessary care from appropriate pediatric specialty providers, including hospitals equipped to meet their unique tertiary and quaternary medical needs. A recent study in the June 2018 issue of Health Affairs[2] found that nearly half of pediatric specialty hospitalizations took place outside of adult-focused distance standards. Similarly, an earlier CHA analysis found that approximately 50 percent of children nationwide would not have access to the services of an acute care children's hospital if adult Medicare Advantage time and distance standards are used.

Clearly, a basic floor of time and distance standards must be the foundation for a more comprehensive, multi-faceted set of quantitative standards to assure that children have in-network access to the full range of covered services to which they are entitled under EPSDT. Absent basic, appropriate and multi-faceted quantitative parameters for pediatric specialty network assessment, children with serious, chronic or complex health may experience significant gaps in care, which could have long-term implications for their future well-being and potential.

The following recommendations are intended to strengthen the proposed rule to ensure that children enrolled in Medicaid managed care plans have access to timely access to all covered services to which they are eligible under EPSDT and that those services are provided by clinicians with the appropriate pediatric expertise.

- The final rule should clarify for states that no single quantitative standard will be sufficient to assess the adequacy of pediatric specialty networks. Instead, state standards should include time and distance as well as a broad set of measurable criteria, along with any other requirements that the state deems appropriate to assure access to all covered services by appropriate in-network pediatric specialty providers. In particular, plan networks should be required to take into account the regionalization of specialty care for children with serious,

[2] See Children's Hospital Association. Implications of adult network adequacy standards on children's access to pediatric specialty care, June 2018.

chronic or complex conditions for each type of pediatric specialty covered under the contract to meet the requirements of the EPSDT benefit.

- When developing quantitative criteria, states should incorporate the following, without relying on a single metric alone to avoid a false assessment of adequacy: enrollee ratios by specialty; geographic accessibility, with appropriate adjustments for geographic differences and for the regionalization of specialty care to assure access to all covered services; geographic population dispersion; wait times by specialty, based on provider hours and availability; the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care, diagnostics or ancillary services; and minimum appropriate providers available to meet the needs of children with special health care needs.

- We strongly agree that stakeholders are key players in the development of appropriate network adequacy standards and urge CMS to require, rather than "encourage," states to consult with a broad range of interested parties. Specifically, as states develop standards for pediatric specialty care, they should consult with a spectrum of individual pediatric specialty societies and provider/facility types, caregivers, child health advocates, and health plans with particular experience with children enrolled in Medicaid or CHIP.

- Oversight, including regular audits of plans' provider networks, is absolutely critical to ensuring that children have access to timely care and the providers they need, particularly pediatric specialists. Therefore, we continue to support the inclusion of the 2015 final rule's access and timeliness requirements and considerations, as well as a range of important oversight mechanisms, including but not limited to §438.66 State Monitoring Requirements; §438.206 Availability of Services; §457.1230 CHIP Access Standards; and §438.207 Medicaid Assurance of Adequate Capacity and Services. In order to ensure that the state pediatric specialty network standards accurately assess children's access to the most appropriate providers for their care, CMS must implement strong, ongoing monitoring and analytical strategies. Similarly, state standards must include network gap analysis and timely mitigation requirements. Furthermore, all standards development, implementation, and auditing procedures must be nimble enough to adapt to changes in health care delivery and population needs.

Support Appropriate Provider Payments to Ensure Children's Access to Care

We encourage CMS to work with states within existing rules to best support adequate payments to ensure the best access to care and quality outcomes for children. As you know, Medicaid is a dominant payer for children's hospitals, accounting for nearly 40 percent of net revenue from all payers and more than half of inpatient visits. However, most children's hospitals are paid below the cost of care for their Medicaid patients. Children's hospitals often receive supplemental payments from states to fill the gaps between Medicaid base rates and the costs of care. Even with Medicaid supplemental payments, children's hospitals are currently reimbursed 80 percent of the cost of care. Adequate Medicaid payment is important to ensuring access for the over 30 million children covered by the program. Adequate Medicaid payment is critical to children's hospitals remaining financially viable, allowing them to continue to provide comprehensive care, advanced pediatric medicine and provide a wide range of subspecialty services and equipment. As we transition away from supplemental payments under Medicaid managed care, we need to ensure appropriate Medicaid payments to fill significant gaps in reimbursement.

Directed Payments

We support the new directed payment options for states, especially as they transition away from providing supplemental payments under their managed care contracts to more appropriately reimburse providers under the new CMS rules. In the 2016 rule, CMS allowed states to direct certain managed care plan's expenditures under the contract. In this proposed rule, CMS would allow two new directed payments by states to managed care plans, in addition to those previously allowed. Under the proposed rule, states would

be allowed to require plans to pay at least the fee-for-service (FFS) rates in the state plan, excluding supplemental payments, and to adopt cost-based, Medicare-equivalent, commercial-payer equivalent, or another market-based rate. This flexibility will help providers transition away from supplemental payments and explore new ways gaps in Medicaid payment could be addressed.

New Supplemental Payments Transition Period

We support the proposed rule's new transition period of 3 years when Medicaid populations or services are initially moving from FFS to managed care. This transition period will allow states and providers time to explore how to best ensure access for Medicaid beneficiaries without existing supplemental payments, which today are partially filling the gap between the costs of care and Medicaid payment. We encourage CMS to work with states to explore other ways to address payment for Medicaid services, so children and other beneficiaries are able to access needed services from Medicaid providers.

Address Unique Needs of Children in Quality Rating Systems

The proposed rule revises current requirements for states that are developing their own Quality Rating System (QRS) to provide them additional flexibility. Specifically, the proposed rule requires that an alternative state QRS must generate ratings, which are "substantially comparable to the federal QRS to the extent feasible, taking into account such factors as differences in covered populations, benefits, and stage of delivery system transformation." The proposed rule notes that CMS will develop sub-regulatory guidance on this alternative and requires mandatory performance measures in the QRS. We believe the states should have some degree of flexibility in the rating systems development and support CMS' proposal to include mandatory performance measures in the QRS. However, we strongly encourage CMS to ensure that the guidelines developed for alternative QRS support the ability to examine the performance of Medicaid managed care plans across states.

While supportive of efforts to align plan rating systems, we request that CMS ensure pediatric-specific ratings are available. We are encouraged that CMS expects to coordinate with those measures selected for the Scorecard initiative, which draws upon the Child Medicaid Core set. Those ratings should use underlying measures important and relevant to children and their caretakers. It is challenging to create a QRS for Medicaid managed care plans that is informative and useable for consumers who are shopping for a health plan. At the same time, we remind CMS that one-half of Medicaid beneficiaries are children and it is particularly important that any QRS is appropriate and adequate to reflect the care provided to children, including all subpopulations of children (e.g. children with medical complexity). Therefore, we ask you to consider children's unique needs as you develop the CMS quality rating system and associated guidance.

Any rating systems must address all of the populations served and address the care provided by a range of providers. We are concerned that combining measures into a star rating system may not adequately reflect the needs of certain patient populations, such as children with medical complexity. Aggregate ratings that do not address or mask the quality of care for critical sub-populations and relevant quality domains may result in insufficient information to guide the choice of plans as well as the prioritization of quality improvement efforts by plans. In addition, ratings information needs to be clear and useable for a variety of consumers who will value certain services and quality improvement efforts differently. For example, a low-income, childless adult will search for a different plan than a parent of a child with severe asthma. Likewise, the pediatric population is heterogeneous, and a parent with a child diagnosed with cerebral palsy may look for the quality of a plan's specialty services, which may not be as important to a parent with a child who only needs standard preventive care.

We also remind CMS that any QRS should be dynamic and improved upon over time. In particular, we continue to be concerned about the limited scope of measures that address pediatric health care and outcomes and the impact of those limitations on the adequacy of plan quality ratings for children, particularly children with medical

complexity. We urge CMS to carefully test, evaluate, and refine the rating methodology over time, particularly as new measures become available that better capture the needs of the various subpopulations served by Medicaid, including children and are supported by new evidence to the extent possible. As CMS explores measures to include in the QRS, we strongly encourage participation of pediatric quality experts, several from children's hospitals are actively involved in CMS' current measures work and associated workgroups, to ensure that measures selected work for children. CHA would be happy to help identify pediatric experts to participate.

Maintain Data Reporting Requirements

We are pleased that the proposed rule maintains the requirement that states collect and validate encounter data from plans and provide this data to CMS and clarifies that the required data includes "allowed amount and paid amount" of claims. We need better Medicaid data in general, and on children in particular. Therefore, the rule's continuation and strengthening of current data reporting requirements is a step in the right direction. As we look at alternative payment models and additional ways to improve pediatric care, including specialty care, this data from health plans will be critical to efforts to identify gaps in care and the most effective and efficient ways to provide care.

We appreciate the opportunity to provide comments on the proposed regulation. We look forward to working with CMS to advance the needs of children, particularly as CMS finalizes and implements the managed care regulation. If you have questions or need additional information, please contact Aimee Ossman at (202) 753-5333 or aimee.ossman@childrenshospitals.org.

Sincerely,

M. James Kaufman, Ph.D.
Vice President, Public Policy