October 28, 2011

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, SW

RE: CMS-9989-P; ESTABLISHMENT OF EXCHANGES AND QUALIFIED HEALTH PLANS – PROPOSED RULE

On behalf of the Association of Maternal & Child Health Programs (AMCHP), I am pleased to offer the below comments on the Centers for Medicare and Medicaid Services’ Proposed Rule on Establishment of Exchanges and Qualified Health Plans (CMS-9989-P), published in the Federal Register on July 15, 2011 (the “Proposed Rule”). AMCHP is the national organization representing state and territorial maternal and child health program directors whose mission is to improve the health and well-being of all women, children, and families, including children and youth with special health care needs.

Exchange Governing Boards (§155.105(c), §155.110(c)(3))
Exchange governance structures should be free of conflicts of interest, and boards should be comprised of majority consumer representatives, including individuals who represent the interests of children and families. We believe that the final rule should specifically prohibit the appointment of board members or employment of staff that are affiliated in any way with individual insurers. AMCHP strongly encourages that HHS specify the types of representation on the exchange boards include state Title V Maternal and Child Health (MCH) leaders and other key stakeholders (e.g. family groups representing children with special health care needs) be appointed as members of the Exchange Governing board.

Also important to Exchange governance will be ex officio representation from Medicaid and Children’s Health Insurance Program (CHIP) state offices. This will help to ensure that Medicaid and CHIP programs – including “no wrong door” eligibility screening and enrollment for such programs – are successfully integrated into Exchange operations. This integration will be particularly important for children in families who may move between eligibility for Medicaid/CHIP and private insurance.

Stakeholder Consultation (§155.130)
AMCHP is pleased that the regulation added other entities including, public health experts as one of the groups with whom the Exchanges should consult. AMCHP agrees that the inclusion of these groups will provide diverse input and will be informative. We hope that policymakers will work to assure that the consultation with public health experts includes state MCH programs and that the Exchanges also be encouraged to consult with state and local maternal and child health organizations, representatives of families of children with special health care needs and other entities that specialize in the care of children with disabilities.
Functions of the Exchange (§155.200)
Exchanges will pay a central role in the process of determining an individual’s eligibility for enrollment in a qualified health plan, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP and basic health plans (BHP). States should be encouraged to actively engage with state Title V MCH programs in providing guidance to the development and strengthening of outreach and enrollment processes to as unique needs of maternal and child health populations are considered in the development of a single streamlined and coordinated eligibility and enrollment process, and that where relevant, eligibility for other public health programs (e.g., Children with Special Health Care Needs programs, high risk prenatal care coordination, Early Intervention (Part C of IDEA), WIC child nutrition programs, Family Planning, etc) is considered and integrated into these systems.

Consumer assistance should be well-coordinated, easy to find and use, and designed to provide a broad range of culturally-appropriate assistance to families, including those who have children with special health care needs, limited English proficiency, low literacy, and mixed immigration status. To ensure that families are well served, Navigators with a variety of expertise and especially those that are consumer and community-based nonprofit organizations, must be included. Community health, education and outreach workers with existing relationship in culturally diverse communities should be incorporated into Navigator outreach efforts. Exchanges should also be encouraged to provide Navigator grants to existing entities that already serve the navigator function, such as Family-to-Family Health Information Centers.

We also note that the regulation encourages the Exchanges to use the call centers as a conduit to any other state programs as appropriate. With this in mind, AMCHP strongly encourages the Exchanges to assure that the websites and call centers are linked to statewide 1-800 help and hotline numbers required by Title V programs. These Title V funded numbers are designed to link women, children and their families to programs and services and offer a prime opportunity to closely coordinate with other state programs.

Treatment of a Direct Primary Care Medical Home (§156.245)
With regard to coverage provided by a QHP issuer through a direct primary care medical home, HHS should adopt or incorporate standards and criteria already developed, such as those listed in Guidelines for Patient-Centered Medical Home (PCMH) Recognition and Accreditation Programs, issued in March 2011. Those guidelines build on the Joint Principles of the Patient-Centered Medical Home, developed and adopted in February 2007 and endorsed by a number of physician organizations, including the American Academy of Family Physicians and the American Academy of Pediatrics. The guidelines describe elements considered essential for effective PCMH recognition programs and state that programs should attempt to assess all of the primary care domains outlined by the Institute of Medicine—comprehensiveness, coordination, continuity, accessibility, and patient engagement and experience.

Establishment of Exchange Network Adequacy Standards (§155.1050)
The Proposed Rule needs to be strengthened significantly to ensure that the needs of children, including children and youth with special health care needs who often require a full array of
ancillary services, are met. Ideally, HHS should encourage state Exchanges to set pediatric network adequacy standards that overlap with Medicaid and CHIP. Common or overlapping provider networks would allow children to maintain continuity of care and providers if they were to move between public and private coverage. The provider networks must also ensure meaningful access to providers of obstetric and gynecological services important to promoting healthy pregnancies and healthy births and gynecologic health in adolescents. This must include a sufficient number of providers able to prescribe the full range of FDA-approved contraceptive drugs and devices and the outpatient services associated with their use.

If a state does not choose to establish common network standards with Medicaid and CHIP, it is critical that the Exchange establish specific standards under which QHP issuers would be required to maintain: (1) sufficient numbers and types of pediatric providers to assure that services are accessible without unreasonable delay; (2) arrangements to ensure reasonable proximity of participating providers, including providers accepting new patients; (3) an ongoing monitoring process to ensure sufficiency of the network for enrollees; and (4) a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner.

QHPs should also be required to publicly disclose data related to their network adequacy (e.g., wait times, distance traveled for appointments, etc.). Exchanges must develop their network adequacy standards utilizing data collected through the consumer needs assessment recommended above, which will collect information about the health status/conditions and demographics of the population served by the plan. HHS approval of Exchange standards should be based on quantitative guidelines developed by the Department to address timeliness, proximity, and provider capacity, at a minimum.

**Essential Community Providers (§156.235)**

We applaud HHS for recognizing the importance of essential community providers in meeting the needs of various communities throughout the country and in particular, the needs of those individuals who are the most underserved. Essential community providers, which include but are not limited to those entities specified under section 340B (a)(4) of the Public Health Service Act, play a particularly critical role in the care of low-income and critically or chronically ill and disabled children. These children (as well as underserved and low-income adults) require a broad and diverse range of medical, habilitative, and rehabilitative services throughout their lives that the essential community provider provision in the ACA is intended to address.

To ensure that children have access to quality services when they need them, we strongly recommend that HHS require QHPs to specifically contract with pediatric-appropriate providers, including pediatric subspecialists, children’s hospitals, and all essential community providers identified in Section 340B. Those providers should also include other federally-recognized health care models that are solely dedicated to the needs of children, such as school-based health centers.

To ensure that this blanket contracting requirement does not inhibit the use of network design to incentivize high quality care, HHS can require QHPs to collect and report on common quality measures, including maternal and child health measures. A common set of measures applicable
to children and pregnant women that can be used across states would be a useful tool for Exchanges, states, and HHS in assessing pediatric quality in the QHPs. The initial core measures recommended under the Children’s Health Insurance Program Reauthorization Act could be a useful starting point.

**Special Enrollment Periods (§155.420)**

For special enrollment periods, the Rule proposes limiting an existing enrollee of a QHP to be able to change plans only within levels of coverage. HHS recognizes that limiting enrollees to a specific level would pose a challenge for an enrollee in a catastrophic plan that becomes pregnant. AMCHP fully support a women’s ability to change plans should she become pregnant while enrolled in a catastrophic plan. Therefore, we request that pregnancy be made an exceptional circumstance under §155.420, which would trigger a special enrollment period, so that a woman enrolled in a catastrophic plan is able to gain coverage that offers maternity care.

Under the ACA insurers in the Exchange are permitted to sell catastrophic plans to young adults under age 30 and those unable to afford other insurance. Unlike other plans in an Exchange, catastrophic plans are not required to cover maternity care and beneficiaries must meet a high deductible before most claims are paid. In effect, catastrophic plans would require a woman who becomes pregnant to pay for most or all of her maternity services out of pocket, possibly causing women to delay or forego maternity care critical to ensuring a healthy pregnancy.

In 2007 the average cost for maternity care for an uncomplicated vaginal delivery was $7,737. Given that 50% of pregnancies in the US are unplanned and that three quarters of unplanned pregnancies occur in women ages 29 and younger, many young women may find themselves enrolled in a catastrophic plan, unexpectedly pregnant, and unable to afford maternity care. A delay in accessing prenatal care leads to immense health, emotional and societal costs. In 2004, singleton infants born to mothers who received late or no prenatal care were nearly twice as likely to be low birth weight. Unplanned pregnancy has been associated with low birth weight, which accounts for 10% of all healthcare costs for children, and is a major predictor for infant mortality.

**Stand Alone Dental Plans (§155.1065)**

Oral health promotion and prevention is critical to reducing disease burden and increasing quality of life. Failure to provide access to preventive dental care almost always results in quick fixes that are short lived and high priced. The regulation codified the requirement that the Exchange allow limited scope stand-alone plans to be offered furnishes at least the pediatric essential dental benefit. We urge HHS to explicitly clarify that insurance reforms and consumer protections should be applied equally to stand alone dental plans and QHPs to assure families parity in benefits, cost and access to dental care within the exchange.
Again, thank you for the opportunity to comment on the proposed rule on Establishment of Exchanges and Qualified Health Plans. We hope you have found our comments helpful. Should you have any questions, please contact AMCHP’s Associate Director of the National Center for Health Reform Implementation, Carolyn Mullen at cmullen@amchp.org.

Sincerely,

Michael Fraser, PhD
Chief Executive Officer

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