Feb. 25, 2014

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RE: 2015 Draft Letter to Issuers in the Federally-facilitated Marketplace (FFM)

As organizations that share a strong commitment to the health of our nation’s children and pregnant women, we appreciate the opportunity to comment on the Draft 2015 Letter to Issuers in the Federally-facilitated Marketplace. We applaud you for your ongoing and dedicated efforts to create, and continually refine, the marketplaces to meet the needs of a diverse population in need of coverage and access to care. The challenge of controlling consumer costs while providing access to quality, coordinated and comprehensive health care is a difficult one, and we look forward to continuing to work with you on those efforts in the coming months and years. We have a unique perspective of children and pregnant women’s health care needs and the delivery of care to children and pregnant women, including those with complex or chronic conditions. We, therefore, respectfully submit the following comments and recommendations that we believe will strengthen the qualified health plan (QHP) requirements to ensure that they meet the health care needs of all children and pregnant women, especially those who face difficult health challenges.

We are pleased that the 2015 draft letter to issuers reflects some strengthening of standards for QHPs in the areas of provider networks and enforcement of non-discrimination requirements. However, we believe that these standards should be further strengthened, as detailed below, to fulfill the promise of the Affordable Care Act (ACA) that children and families have appropriate coverage, as well as timely and quality health care.

Chapter 2, Section 3. Network Adequacy

We reiterate our concerns that we have shared with you in previous comment letters regarding the lack of a strong federal standard for health plan network adequacy and applaud your intent, as stated in this draft letter, to articulate time, distance, and other standards for provider networks in future rulemaking. We respectfully urge you to include robust network adequacy standards that are specific to pediatric health care as part of those future guidelines, and we look forward to working with you on their development.

Children, particularly children and youth with complex or chronic health conditions, must have access to a full array of primary and specialty care and ancillary services. A strong pediatric and perinatal network adequacy standard, as well as a robust process for the review of issuer compliance with that standard, is critical to their care and well-being. In our previous comments\(^1\) we provided recommendations for a strong pediatric network adequacy standard:

- Every QHP must include in their pediatric provider networks pediatric primary care providers, a complete range of pediatric subspecialists (e.g., pediatric neurologists, oncologists and

\(^1\) See March 15, 2013 Letter to Marilyn Tavenner Re: March 1, 2013 Letter to Issuers on Federally-facilitated and State Partnership Exchanges
neonatologists); pediatric habilitative/rehabilitative therapy providers (e.g., occupational, speech and physical therapists); pediatric home care; pediatric mental health and substance abuse professionals; pediatric vision and dental care providers; and pediatric pharmacists. It is especially important that networks include providers who offer care coordination services (e.g., medical homes) to ensure that children, particularly those with serious and chronic conditions, have their acute and chronic medical, functional and psychosocial needs comprehensively addressed. Furthermore, each QHP must provide meaningful access to providers of obstetric and gynecological services important to promoting healthy pregnancies and births and gynecologic health in adolescents.

- Marketplace network adequacy standards and assessments must include procedures to monitor, identify, and address pediatric provider network gaps or access barriers, including wait times and transportation complexities.

- QHPs must be required to allow a child or a pregnant woman to obtain a covered service from an out-of-network provider at no additional cost if no network provider is accessible for that service in a timely manner. Furthermore, QHPs should include in their applications a description of their procedures for approving out-of-network care, as well as specialty care, and be required to describe those procedures in all consumer information. CMS must review those procedures to ensure they will not impede consumers’ timely and appropriate access to out-of-network and specialty care.

- Pediatric and perinatal experts representing a wide range of disciplines should be consulted on the identification of metrics specific to children and pregnant women’s access to care.

We also urge you to strengthen and clarify how you will determine that a network is “sufficient in number and types of providers to assure that all services will be accessible to enrollees without unreasonable delay.” We are pleased that CMS has adopted some new approaches for 2015 that will strengthen the review criteria in the FFMs to determine whether a plan’s provider network meets these standards. In particular, we are pleased that the new criteria requires issuers to submit provider lists for each QHP to CMS, which will evaluate the lists to determine whether the network meets the “reasonable access” and “without unreasonable delay” standards.

However, we believe that the network adequacy review still must be strengthened, beginning with the establishment of clear and measurable metrics to evaluate whether networks, in fact, provide reasonable access to the full range of services that a consumer, particularly a child, may need. We urge CMS to:

- Refine the reasonable access review to ensure that there is an adequate representation of pediatric, obstetric and gynecological providers in the networks. As proposed, the review of provider types does not include an assessment of the breadth and type of hospital systems or other provider types to ensure that they are adequate to meet the health care needs of specific populations, such as children and pregnant women. At a minimum, CMS should use a basic access metric that includes more specificity regarding the types and quantity of providers in QHP networks, as well as benchmarks for timeliness of appointments.

- Clarify how it will determine whether a QHP network fails to meet the standard of providing access to care without unreasonable delay. Neither the draft letter nor the underlying regulation define “unreasonable delay,” and there are no criteria or metrics included in the draft letter that identify how a QHP network will be assessed in relation to this standard.
• Require QHPs to publicly disclose data related to their network adequacy (e.g., wait times, numbers and types of pediatric providers) for all populations, including children. In addition, QHPs must have a documented plan to identify access barriers, including wait times, and steps to address those barriers.

In addition, we urge you to include in the assessment of provider networks a review of their alignment with those in a state’s Medicaid and Children’s Health Insurance Programs (CHIP). We know that CHIP provider networks, in particular, are designed with children in mind, and those networks can serve as a model for the QHPs. Furthermore, common or overlapping provider networks would allow children and pregnant women to maintain continuity of care and providers if they move between public and private coverage. Children with ongoing health concerns and their families often have a strong reliance on a particular provider, and a change in provider networks or coverage can be catastrophic to their development and health.

We were pleased that the March 2013 Letter to Issuers indicated that CMS would monitor the sufficiency of networks via consumer complaints and data collection from issuers. We urge the agency to continue to make the collection and analysis of consumer complaints a priority as barriers to care resulting from narrow networks will be a strong indicator that improvements are needed. We ask that you provide additional clarification about the process you will use to inform consumers of their options to file complaints, the approach you will take to track and address individual consumer concerns, and the specific remedial procedures that will be required of issuers when their networks are found to be insufficient. We also ask that information about consumer complaints and plan remedies be made public. Finally, we urge CMS to monitor provider networks throughout the coverage year through consumer complaints and other data collection methods. Based on those findings, the agency should be prepared to require issuers to broaden their QHP networks during the coverage year to ensure consumers have adequate access to health services.

Chapter 2, Section 4. Essential Community Providers

Several types of essential community providers (ECPs) offer vital services to children and their families, including FQHCs, children’s hospitals and others. The unique role of children’s hospitals in the care of very sick children is the reason why we continue to seek a requirement that QHPs include them as ECPs in their provider networks. Though we believe that the 2015 draft letter improves the review criteria for the inclusion of ECPs in QHP networks, we continue to have serious reservations about the general approach. Our concerns and recommended changes of the standard are delineated below. We respectfully urge you to consider these changes to the standard in upcoming rulemaking.

The 30 percent standard for ECP participation in QHP networks should be considered a floor rather than the standard, and QHPs should be encouraged and incentivized to move beyond that standard to ensure that all ECPs are in networks.

The increase in the standard for ECP participation in provider networks from 20 percent in 2014 to 30 percent in 2015 does not guarantee a representative mix of ECPs nor does it ensure an adequate quantity of ECPs in the networks. Though the draft letter depicts the 30 percent standard as a minimum threshold, most plans will achieve that standard and go no further.

It is increasingly apparent that many QHPs were able to meet the 20 percent threshold in 2014 while creating narrow provider networks that either exclude some ECPs outright or include them only in more expensive offerings. We are now seeing how these narrow networks may impede children’s access to appropriate care. For example, several of the QHPs in Washington State’s marketplace have excluded Seattle Children’s Hospital from their provider networks. This exclusion leaves children enrolled in these
plans without access to many specialty services, such as level IV neonatal intensive care and heart, liver and intestinal transplantation, for which this hospital is the only regional provider. Recently, the hospital identified 125 patients who lost contracted access to the hospital's services when their coverage became effective on Jan. 1. The hospital treated these patients, whose ailments ranged from craniofacial disorders to a neck mass, to give families time to work with issuers and better understand their new benefits. To date, the hospital has incurred tens of thousands of dollars in administrative costs associated with the extra work required to care and negotiate payments for these patients.

We are pleased that some states, including Connecticut and Minnesota, have recognized the important role that ECPs play in meeting the health care needs of low-income and very sick children. Connecticut has adopted a high threshold for inclusion of ECPs in QHP networks that all but guarantees full access to needed services. Minnesota has taken a unique and promising approach through the enactment of legislation that requires pediatric hospitals and their affiliated clinics to be designated as ECPs. The legislation is intended to ensure pediatric hospitals have the ability to participate in all product offerings on Minnesota’s marketplace so all families can access primary and specialty pediatric care.

These types of stronger ECP contracting standards are critical if the health care needs of these children and others who require specialized care will be met under the ACA.

**The second requirement of the proposed ECP standard, which requires the offer of a contract to one ECP within each category, does not ensure that children, particularly children with serious medical conditions, will have access to the unique care that they need.**

We urge you to modify this standard so ECPs can fulfill their mission as envisioned by the ACA by:

- Establishing a separate category for children’s hospitals rather than grouping them with other types of hospitals. The current grouping of children’s hospitals with other hospitals in the “hospital” category allows issuers to contract with lower cost 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. However, when children are suffering from serious acute or chronic conditions, the variability of their illnesses and conditions requires the refined clinical capabilities of pediatric specialty care found in children’s hospitals. The children’s hospital role is to provide all services that a child may need so that other community hospitals and the families in the community have the assurance of access when they cannot care for a child with a high acuity or a chronic, complex condition. Nationally, transfers from other hospitals equal 11 percent of children’s hospital admissions, compared to 2 percent for general acute care hospitals; this is part of the reason children's hospitals have an acuity level double that of general hospitals. The role regional children’s hospitals play in the lives of very sick children is precisely the kind of provider the ECP provision in the ACA intends to guarantee.

  CMS should consider whether other types of ECPs provide services that are specialized enough to warrant their own categories. For example, the category “Other ECP Providers” includes hemophilia treatment centers (HTCs) that provide specialized services to children. Hemophilia is almost always diagnosed at a young age and the majority of those with the diagnosis receive some treatment from HTCs. Grouping HTCs with other types of clinics and providers means that children with hemophilia may not receive adequate care.

- Requiring QHPs to contract with at least one ECP in each category, rather than simply demonstrate that they have offered contracts in “good faith” to at least one ECP in each category. An offer without a contract does nothing to ensure that the QHP network has the appropriate mix of

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2 Children’s Hospital Association, [What is a Children’s Hospital?](http://www.childrenshospital.org)
providers even when it meets the 30 percent ECP participation standard established in this draft letter.

- Strengthening the “good faith offer” standard if it is retained. First, an offer should only be considered to be in “good faith” if it includes a competitive offer of reimbursement rates that is comparable to other commercial product rates and is for all covered services. Furthermore, the contract must not allow issuer practices that can impede children’s access to needed specialty care, such as complicated and stringent prior approval requirements for care provided through an ECP or another specialty provider.

In many states, issuers have offered ECPs extremely low reimbursement rates, in contradiction with the “generally applicable payment rate” standard established in the final rule on the Establishment of Exchanges and Qualified Health Plans. ECPs are also being tiered into less attractive and more expensive plans or are being offered contracts for a limited set of services rather than the full complement of services otherwise covered by the plan. Taken together, these practices will undermine the ability of ECPs to continue to serve the millions of children and families who depend on them for quality care.

Second, we are concerned that an offer will be considered in good faith if it “includes terms that a willing, similarly-situated, non-ECP provider would accept or has accepted” (page 23). We know that ECPs by their very nature are different from non-ECPs. Furthermore, children’s hospitals, in particular, are different from other non-ECP providers because of the specialty and regional care they provide. An offer to an ECP cannot be considered in the same context as an offer to a non-ECP provider given the unique, and sometimes more costly, services that ECPs provide.

- Requiring issuers to submit a narrative that specifically explains how their ECP network will provide adequate services for medically underserved children and children with special health care needs in their service area. The specific requirements for that narrative should include the ways that the issuer will monitor children’s access to care and address identified gaps.

- Eliminating the option for issuers to submit a narrative justification in place of meeting the ECP standard. The ECP requirements in the ACA were designed to ensure that children and families have access to the trusted providers in their communities that are uniquely positioned to meet their health care needs. Allowing issuers to bypass this requirement via a written justification compromises this critically important aspect of the ACA’s promise.

CMS should release a list each year of the ECPs that have contracts with the QHPs in each service area and make the list public on the CCIIO website and available to consumers through Healthcare.gov.

Consumers and providers must be able to easily access the information they need about the QHP provider networks on the marketplace website. We continue to hear from ECPs that do not know if they are in the networks of some QHPs and are beginning to see patients who were not aware that the network did not include that provider until they sought care. In some instances, plans continued existing contracts without notifying the providers. In other situations, the plans did not approach the providers to include them in network and simply excluded them. As a result, providers may not know if they are in network until they have to check the insurance coverage for a particular patient. A public list, combined with an improved website design, will improve the consumer experience during the enrollment process and will enable them to make the most appropriate choices when a health issue arises.
Chapter 2, Section 5. Accreditation

We continue to be pleased that CMS will require issuers to display their accreditation status on the marketplace website but are also concerned that the information may not be helpful to consumers. As we stated in our Aug. 16, 2013 comment letter, we believe the website must include clear and simple explanations about the meaning of the terms “Accredited by NCQA,” “Accredited by AAAHC,” “Accredited by URAC,” “Accredited by NCAA and URAC,” etc., and “Not yet accredited.” We also urge CMS to provide more complete information regarding the actual accreditation level of a plan, rather than categorizing plans as “Accredited” regardless of their accreditation level (e.g., “Excellent,” “Commendable,” “Accredited”). Furthermore, navigator and other consumer assistance entity training should include a module on the differences between the various accreditation levels. Families must have full information about the accreditation status of health plans, along with an explanation of what the status levels mean, in order to make decisions that are not simply based on a plan’s cost.

Finally, we believe it is critical that more specific information be displayed on the marketplace website to enable families to choose the health plan that will best meet their child’s needs. First, issuers must be required to report both adult and child CAHPS results, including the child CAHPS version of the access to care survey and the survey for children with chronic conditions. The specific domains identified in the CAHPS survey (e.g., access to care, communication, etc.) provide a strong framework with which to assess patients’ and caregivers’ experiences.

Chapter 3, Section 1. Discriminatory Benefit Design: 2015 Approach

The non-discrimination provisions of the ACA are intended to protect some of the most vulnerable health care consumers, including children. Therefore, it is imperative that they are enforced fully in the marketplaces.

We, again, reiterate our comments in our March 15, 2013 letter on the importance of ongoing issuer monitoring and compliance reviews by CMS to identify discriminatory practices and wording in benefit templates and other plan design features. Federal review will provide greater consumer protections than might occur under state insurance regulatory reviews. Should CMS continue to rely on state enforcement, we believe it is critical that the agency issue guidance that establishes clear standards for the breadth of plan elements that states must review for discriminatory effect, including but not limited to covered benefits and drug formularies; provider networks; visit limits; and utilization management.

We also reiterate our continued concern that there is no definition of “discrimination” in the context of benefit design delineated in federal guidance. We urge CMS to develop and promulgate a definition of “discrimination” that applies to all types of marketplaces and does not vary among states to allow the agency to evaluate health plans uniformly and transparently. The absence of a standard definition of discrimination also leaves both insurers and consumers uncertain about which benefit designs are allowable and when federal enforcement action is necessary or possible.

We commend CMS for establishing a specific methodology to evaluate issuer compliance with the current essential health benefit (EHB) non-discrimination standards. We agree that outlier analysis on cost-sharing, as well as on prior approval and step therapies for prescription drugs, will help identify potential discriminatory practices by issuers. We recommend that CMS also conduct outlier reviews of prior authorization requirements for medical treatments, particularly in pediatric and specialty care settings. Further, we reiterate our recommendation that CMS also conduct reviews of benefit explanations and exclusions that condition receipt of benefits on an enrollee’s age (such as lower age limits on eyeglasses for children) or might limit duration and scope of certain benefits (such as
habilitation), which would be discriminatory against children in need of a range of services. As we have articulated in previous communications\(^3\) to HHS, we believe the current approach to habilitation coverage is resulting in arbitrary limits that could be considered discriminatory against children who need these services to reach their full potential.

Finally, CMS should indicate how consumers may complain and secure remedies of potentially discriminatory practices by issuers. It is critical that families understand their rights to appeal a benefit decision and that CMS has a system in place to assure remediation of any violations identified.

**Chapter 3, Section 2. Prescription Drugs**

We are pleased that CMS is considering policies to help with transitions of care, including continuity of access to specialists for individuals who are in the midst of a course of care. The draft letter specifically notes that continuity of care is a concern for patients undergoing cancer treatments, and we want to emphasize that continuity of care also is a serious concern for children and pregnant women with serious or lifelong medical conditions in families with fluctuating incomes. Children with special and complex health care needs typically have strong relationships and a reliance on their pediatric specialists. As we discussed earlier, disruption of care and provider relationships that could result from churning could be catastrophic to the development and health of these children. Likewise, because of the time-limited nature of pregnancy-related Medicaid coverage, pregnant women with chronic health conditions could experience serious disruptions in care as they cycle on and off Medicaid or CHIP. Again, we believe alignment of robust pediatric and perinatal provider networks inside and outside of the marketplace and with Medicaid and CHIP is the best approach to address continuity of care concerns for children and pregnant women. At a minimum, issuers should be required to allow children and pregnant women with chronic or complex conditions to maintain their provider for a transitional time period when a change of provider would cause undue hardship. Issuers must also coordinate coverage and develop transition plans that include readiness reviews to ensure uninterrupted access to medically necessary services. The “Bridge” approach adopted by California and considered by Tennessee is another promising strategy that would enable individuals to maintain their provider if they move between public and private coverage.

**Chapter 6, Section 1. Provider Directory**

We are pleased that CMS is creating more stringent QHP network directory standards for 2015. The ability of patients and their families to select QHPs that might include existing relationships with a medical home, necessary pediatric, obstetric or gynecological medical or surgical subspecialists, and/or other needed health care services and providers, is dependent upon the availability of an accurate, real-time provider directory at the time of plan selection. Such a real-time directory will allow families to make informed choices when choosing between various plan options in the marketplace. We encourage all efforts to ensure that these provider directories are not simply updated but represent real-time information on the providers currently participating in the QHP network.

We appreciate this opportunity to share our views regarding the 2015 Draft Letter to Issuers in the Federally-facilitated and State Partnership Marketplace. We look forward to working with you on the development of sound pediatric provider network standards and metrics, as well as other aspects of marketplace implementation, to ensure that children have access to timely and quality care and that coverage under the ACA meets the unique health care needs of children, pregnant women, and their

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\(^3\) See Dec. 24, 2012 letter to Sec. Sebelius on the proposed rule, Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation (CMS-9880-P)
families. If we may provide further information or otherwise be of assistance, please contact Jan Kaplan at 703-797-6084 or jan.kaplan@childrenshospitals.org.

Sincerely,

AIDS Alliance for Women, Infants, Children, Youth & Families
American Academy of Pediatrics
Association of Maternal & Child Health Programs
Children’s Defense Fund
Children’s Dental Health Project
Children’s Hospital Association
Family Voices
First Focus
Georgetown University Center for Children and Families
March of Dimes
National Association of Pediatric Nurse Practitioners