

October 31, 2011

Secretary Sebelius
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

**Re: CMS-9989-P; Establishment of Exchanges and Qualified Health Plans;
Proposed Rule**

Dear Secretary Sebelius:

As organizations committed to the health and wellbeing of children and families, we appreciate this opportunity to comment on the Proposed Rule establishing Exchanges and Qualified Health Plans. We are pleased to see that the Proposed Rule recognizes the unique needs and circumstances families may face as they seek to find health care coverage for themselves and their children. However, given the unique relationship that children in particular have with the health care system, we, the undersigned organizations, believe that there are steps that can be taken to strengthen this regulation and ensure that children and youth receive the care they need when their families purchase qualified health plans in the Exchanges. Our suggestions are below.

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 (§155.105(c), §155.110(c)(3)).

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. The majority of board members on any Exchange should be consumer representatives (e.g., patients, parents, caregivers, small business owners, human resource personnel)¹, and should also include members who represent the unique perspective of children and families, including immigrant families and their children and children and youth with special health care needs. Pediatric providers, including subspecialists, and families who use pediatric services will offer a critical perspective on insurance coverage, health benefits, health plan purchasing, health care delivery, and important public health issues pertaining to children. Many pediatric providers, as well as families, will also provide key insights, drawn from their own experiences, about the challenges of moving between public and private coverage.

In addition, health care providers should not be among the entities that are identified as having a potential conflict of interest. The intent of the conflict of interest standard is to ensure that the membership of the governing board appropriately represents consumer interests. Unless a health care provider is affiliated with or represents a particular health

¹ The term “consumer” should be read to include all individuals who purchase, benefit from, and/or represent those who purchase and benefit from the health insurance products made available through Exchanges.

plan, the provider would not pose a conflict of interest and would, as stated previously, offer a unique and important perspective to the governing board.

All consumer assistance tools, including notices, should be designed and coordinated to meet the needs of a diverse range of consumers, including children with special health care needs and families with mixed immigration status, limited English proficiency, and/or cultural or physical barriers to coverage and care (§155.205, §155.210, §155.230).

Experience with Medicaid and CHIP has demonstrated how important community-based outreach and application assistance are in reaching and enrolling eligible children. The Proposed Rule does not provide a specific definition of consumer, but it is important to recognize the diversity of those who will be “qualified individuals” and “qualified employers or employees” and to provide tools and coordinated assistance to meet their needs. States should be required to conduct a consumer needs assessment that will inform the design, operation, and evaluation of the state’s proposed consumer assistance tools, including the call center, website, Navigator program, and outreach initiatives. Moreover, consumer assistance tools should be coordinated with and/or linked where appropriate to other existing statewide consumer assistance tools and information lines that are designed to assist families in accessing health care and other support services. 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. Exchanges should be encouraged to provide Navigator grants to existing entities that already serve the navigator function, such as Family-to-Family Health Information Centers.²

The use of a single, streamlined application accessible through “no wrong door” will ensure that all children and families will be determined eligible for the coverage option that matches their circumstances (§155.405).

We strongly support the “no wrong door” concept and use of a single, streamlined application that provides access to all coverage options: Medicaid, CHIP, the Basic Health Plan (if applicable), and the Exchange. It is equally important that individuals and families have multiple ways to apply, including in-person assistance particularly considering that not all individuals and families will be well served through an online, self-service model. However, technology should be employed to the greatest extent possible and explicitly enabled for mobile devices (which are often more available than computers to low-income families and/or minority groups). The online eligibility and seamless enrollment systems should provide specific, dedicated functionality, with appropriate levels of security and access, for Navigators to assist families.

² Family-to-Family Health Information Centers, located in every state and the District of Columbia, are funded through the Health Resources and Services Administration to help families whose children have special health care needs to navigate the health care system.

Open enrollment, special enrollment, and disenrollment procedures should minimize gaps in coverage and avoid disruptions in access to a usual source of care (§155.410, §155.420).

Given the large numbers of people that will be enrolled and the potential for confusion about options and requirements under the individual mandate, it is recommended that the initial enrollment period be longer than the proposed five-month period. Additionally, coverage effective dates should be expedited to avoid gaps in coverage and disruptions in access to care. In particular:

- A delay of up to five weeks following enrollment before coverage starts is not acceptable, particularly given the advanced state of technology to be used in managing eligibility and enrollment. The coverage gap is not optimal for any population, but is particularly problematic for children, especially children with special health care needs whose development and health can be greatly affected by even small gaps in coverage. The final regulation must address the potential gap for children who may cycle off of Medicaid and into a qualified health plan. We recommend that retroactive eligibility/coverage be required for all children to protect them from coverage gaps.
- To avoid imposing additional financial costs on families, reasonable notice for families wishing to dis-enroll from their plan should be 24 hours in a real-time environment.
- Generally speaking, triggering events are not associated with changes in health status, thus the prohibition against movement among levels of coverage is unnecessary to avoid adverse selection.
- To encourage early prenatal care and prevent prematurity, low-weight births, and other adverse birth outcomes, a pregnancy should trigger a special enrollment period so women enrolled in a catastrophic plan can switch to more comprehensive coverage.
- Changes in provider networks should trigger a special enrollment period to ensure that children and families, particularly children and youth with special health care needs, do not lose their usual source of care.

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. We fully support a women’s ability to change plans should she become pregnant while enrolled in a catastrophic plan. Additionally 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.

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 (§156.245). 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.

Exchanges should establish standards, subject to HHS approval, that ensure that the provider networks of Qualified Health Plans (QHPs) include a robust panel of pediatric providers, including primary care pediatricians, a complete range of pediatric subspecialists (e.g., pediatric neurologists, oncologists), habilitative/rehabilitative therapy providers (e.g., occupational, speech and physical therapists), home care services, pediatric mental health and substance abuse professionals, and pediatric vision and dental care providers (§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.

Qualified Health Plans (QHPs) should be required to contract with all essential community providers, where available, that serve low-income and medically-underserved populations (§ 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.

Our organizations commend the Department for producing a draft rule that establishes a strong basis for establishing exchanges. We urge you to consider making the improvements detailed above. If our organization may be of further assistance, please contact Robert Hall at 202-347-8600 or rhall@aap.org. We look forward to continuing to work with you to ensure that the Exchanges provide appropriate coverage for all children and families.

Sincerely,

Academic Pediatric Association
American Academy of Family Physicians
American Academy of Ophthalmology
American Academy of Pediatrics
American Pediatric Society
Ascension Health
Asian & Pacific Islander American Health Forum
Association of Maternal and Child Health Programs
Association of Medical School Pediatric Department Chairs

Children's Health Fund
Easter Seals
Epilepsy Foundation
Family Voices
First Focus
Georgetown Center for Children and Families
March of Dimes
National Alliance to Advance Adolescent Health
National Assembly on School-Based Health Care
National Association of Children's Hospitals
Society for Pediatric Research
Voices for America's Children
ZERO TO THREE