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Centers for Medicare & Medicaid Services  
Department of Health and Human Services

Via email to: [FFEcomments@cms.hhs.gov](mailto:FFEcomments@cms.hhs.gov)

**RE: General Guidance on Federally-facilitated Exchanges**

Dear Mr. Larsen,

As organizations that share a strong commitment to the health of our nation's children, we thank you for the opportunity to comment on the May 16, 2012 "General Guidance on Federally-facilitated Exchanges."

#### **OVERVIEW**

Children have much at stake in the development of federally-facilitated Exchanges (FFEs). The FFEs are expected to serve as an important source of coverage and access for many of the nation's children, as well as their parents. We encourage the Administration to ensure that FFEs offer coverage options and access to needed care for children and pregnant women that is high quality and meets their unique needs.

In addition, FFEs will have a vital role in the implementation of a simple, unified application and enrollment process to achieve the Affordable Care Act's (ACA) goal of ensuring that people are enrolled in health coverage and do not experience gaps in coverage. A seamless and simplified system is extremely important for the nation's children, many of whom will be in families that must navigate multiple coverage and affordability programs under the ACA. In fact, an estimated 75 percent of parents who qualify for subsidized Exchange coverage are expected to have children who qualify for Medicaid and CHIP.<sup>1</sup> Without effective coordination between Exchanges and Medicaid/CHIP, children could easily get lost in the bureaucratic shuffle if their families must navigate a layered system that falls far short of the ACA's intent.

Before addressing these issues and others in the more detailed comments below, we would like to make a cross-cutting recommendation that HHS revise its guidance and policies to provide more detail on how it will ensure appropriate oversight of Partnership model FFEs. It is helpful that the guidance reiterates that the federal government is ultimately responsible for the elements of Exchange implementation performed by the state partner. Given that the ultimate responsibility for the FFE will fall on HHS, it is critical that the agency require states to demonstrate a core competency and willingness to enforce the ACA consumer protection provisions, such as

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<sup>1</sup> Estimates by the Urban Institute.

network adequacy, non-discrimination provisions, accreditation, etc. Therefore, HHS must articulate its plan for monitoring state performance, promptly correcting any problems and revoking the Partnership, if necessary.

## **SPECIFIC COMMENTS BY GUIDANCE SUBSECTIONS**

### **Plan Management in a Federally-facilitated Exchange**

*Addressing child-only plans* – The FFE guidance makes no reference to child-only plans and how they will operate under an FFE even though they are a potentially important source of coverage for children. With many families in complex coverage situations, Exchanges will need to offer plans that address a variety of family coverage needs. For example, child-only plans will be vital for families where parents may have access to employer-sponsored coverage but dependent coverage is unavailable. HHS should clarify how FFEs (both Partnership and full FFEs) will ensure child-only plans are available, sufficient, and affordable for the children who need them.

*Defining and meeting a strong standard for pediatric and maternal network adequacy* – We are extremely concerned about the lack of meaningful network adequacy standards for Qualified Health Plans (QHPs) under FFEs. Currently, the guidance suggests that the FFE will simply “verify” a state review in states that have adopted minimum federal standards. However, those standards, as articulated in the final regulation on state Exchange establishment (§155.302), do not provide a strong framework for children's or pregnant women's access to care. Furthermore, the FFE guidance does not provide the criteria that the FFEs will use in reviews of network adequacy data submitted by QHPs in their applications in those states that do not meet the minimum federal standards. The FFE review criteria must be clarified and strengthened to ensure that the network adequacy verification and review process does not effectively render the FFEs' QHP network adequacy standards meaningless.

A robust pediatric provider network is critical for children's access to appropriate and necessary care, particularly for children and youth with complex or chronic health conditions. These children often require a full array of primary and specialty care and ancillary services and a meaningful network adequacy standard under the FFE framework is critical to their care and well-being. Furthermore, 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. We strongly recommend HHS adopt a more robust standard for what constitutes network adequacy for plans seeking to participate in an FFE by:

- Requiring the FFEs to confirm that the QHP provider networks include the full range of pediatric providers, including primary care and subspecialties, habilitative and rehabilitative care, home care, mental health and substance abuse services, vision and dental care, and pharmacy. Provider networks should

also include the full range of maternal health care providers, including obstetric and gynecological providers. In states without a robust pediatric or maternal network standard, the FFEs should develop one, ideally working with the department of insurance.

- Clarifying the criteria, with input from pediatric and maternal and child health experts, that the FFEs will use in their review of network adequacy data submitted by QHP applicants in those states that do not have their own minimum standards. HHS should also clarify the FFE process for monitoring the effectiveness of QHP networks for timeliness and provider capacity, at a minimum. QHPs should be required to publicly disclose data related to their network adequacy (e.g. wait times, numbers and types of providers) for all populations, including children and pregnant women.
- Requiring QHPs to allow a child or 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.
- Aligning full FFE and Partnership model FFE pediatric provider network standards with Medicaid and CHIP. Common or overlapping provider networks would allow children to maintain continuity of care and providers if their situation changes and they move between public and private coverage. Children with ongoing health concerns 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. Likewise, disruptions in health care coverage during pregnancy, especially for women carrying high-risk pregnancies, could jeopardize the health of the mother as well as the child, increasing the risk of prematurity or other adverse birth outcomes.

***Contracting with essential community providers*** – We are concerned about the lack of strong contracting requirements related to essential community providers in this guidance. HHS should set a more stringent standard for the FFE-certified QHPs that requires the QHPs to contract with all essential community providers identified in section 340B (a)(4) of the Public Health Service Act. Those providers include children's hospitals and other federally-recognized health care models that are solely dedicated to the needs of children, such as school-based health centers. Essential community providers play a particularly important role in the care of low-income and critically or chronically ill and disabled children. These children require a broad and diverse range of medical, habilitative and rehabilitative services throughout their lives, which the essential community provider provision in the ACA is intended to address.

***Ensuring that benefits meet the needs of children and are non-discriminatory*** – We are disappointed not to see a federal essential health benefits standard proposed for the FFEs, since we believe a federal benefit standard is required under the ACA. We urge

you to develop a national standard for the FFEs that includes a comprehensive pediatric benefit with a “medical necessity” definition, similar to Medicaid’s EPSDT standard, which is based on children’s unique health care needs. The benefit must also include a definition of habilitation that ensures access to all necessary services to attain and maintain function. Coverage of services that allow children to maintain function is critical for children with severe disabilities who may need those services to prevent them from regressing in function, such as during a plateau in treatment. It is also critical that the benefits cover necessary ancillary services for children with special health care needs, such as physical, speech and occupational therapy, home health care, durable medical equipment and personal care, which are typically limited by commercial plans or not covered at all.

In addition, we strongly urge HHS to establish uniform, robust, and transparent enforcement structures to assure compliance with the non-discrimination provisions of the ACA (Section 1302 of the ACA §§1302(b)(4)(B), (C), and (D)). Specifically, HHS should establish clear processes to assure that QHPs – in designing their benefits – do not engage in discriminatory practices based on age, disability, or expected length of life and take into account the unique needs of women and children. Furthermore, the FFE appeal process must include avenues for individuals who have been subject to discriminatory practices to have a venue in which to address their concerns.

### **Accreditation and Quality Reporting**

*Ensuring phased-in accreditation and quality reporting does not compromise children’s health care quality* – We are concerned that the initial open-market approach to QHP certification in the first year of FFE operations could compromise child health care quality. The proposed phase-in for accreditation of QHPs means that a plan may operate in the Exchange without basic safety and quality standards in effect. We are also concerned that families may not have adequate information about the differences between an accredited and unaccredited plan and may simply choose a plan based on cost. Since the Exchange marketplace should foster competition based on quality as well as cost, we urge you to consider an expedited process for accreditation. In the absence of an expedited accreditation process, HHS should clarify how consumers will be educated about the differences between an accredited and unaccredited plan so they can make the best choice for their family.

Similarly, we are very concerned about the two-year delay in implementation of quality reporting and display requirements. This delay means that plans will not be held accountable for quality of care in the way that the ACA intended and families will not have the tools they need to choose health plans based on quality during that phase-in period. We urge you to solicit input from pediatric and perinatal quality experts during this rulemaking process and to require all health plans inside and outside Exchanges to report on a common set of federal pediatric and perinatal quality measures. We strongly encourage you to use the pediatric and perinatal core set measures recommended

under the Children's Health Insurance Program Reauthorization Act, as well as the perinatal measures found in the Medicaid adult core set. Coordinating measures across Medicaid, CHIP, and the Exchange will minimize administrative burdens and simplify reporting by health plans and states. Furthermore, it will also provide a larger data pool for use by researchers and policymakers by allowing for direct comparison between Medicaid, CHIP and the Exchanges.

### **Eligibility for Insurance Affordability Programs and Enrollment in the Individual Market**

We are deeply concerned that it is the nation's children who will most frequently suffer without a simple, user-friendly eligibility and enrollment systems consistent with the ACA's goal of creating a "no wrong door" enrollment system. As also suggested by the final Exchange and Medicaid rules (§435.1200 and §155.302), the FFE guidance allows FFEs to either 1) determine Medicaid and CHIP eligibility; or 2) assess applicants for Medicaid and CHIP eligibility and transmit information to the State Medicaid and CHIP agency to make the final determination. The decision to allow FFEs to adopt a "handoff" approach could lead to the fragmentation of eligibility systems, an issue of particular importance to the nation's children because they often reside in families that will be required to navigate both Exchange subsidies and Medicaid or CHIP.

While we do not support splitting eligibility responsibilities, we believe, at minimum, that strong safeguards should be in place to ensure that consumers are enrolled in the appropriate source of coverage in a streamlined fashion. For example, we encourage HHS to ensure that the extent to which states can duplicate components of eligibility determinations already undertaken by an FFE are minimized. To this end, state Medicaid agencies should not be allowed to ask individuals to provide information they already have provided to an FFE, nor should Medicaid agencies be allowed to re-verify data that an FFE already has verified. Moreover, states that want the FFE to merely conduct an assessment of potential Medicaid and/or CHIP eligibility should not be allowed to elect this option until they can demonstrate that their Medicaid agency (or an agency acting on its behalf) has the capacity to conduct such determinations in full accordance with ACA rules and requirements.

### **Stakeholder Input**

We appreciate your stated commitment to work closely with local stakeholders on the implementation of full FFEs, as well as on the Partnership Exchanges. We also urge you to specifically reach out to organizations and providers serving children, as well as pregnant women, particularly those with expertise and experience with serious or chronic health care needs and complex family coverage scenarios. We also seek further clarification on the mechanisms HHS will use to ensure that all aspects of FFE design and implementation are transparent. Since information transparency will be critical to

maximum stakeholder involvement, we strongly recommend that HHS provide public notice and access to the following for each state in a full or Partnership FFE:

- Partnership Exchange blueprint
- Documentation of how the FFE is operationalized in the state (e.g. stakeholders involved, Memorandums of Understanding between federal and state agencies, basic performance data on call centers and other federal functions)
- Plan and process for engaging state-level stakeholders on each aspect of the FFE (plan management, consumer assistance, eligibility and enrollment, etc), including public hearings, convening of advisory and work groups, etc.

Thank you for considering these comments and recommendations as you continue your challenging work to provide gateways to health coverage that work best for our nation's children, pregnant women, and their families.

Sincerely,

American Academy of Pediatrics  
Children's Defense Fund  
Children's Hospital Association  
The Children's Partnership  
Family Voices  
First Focus  
Georgetown University Center for Children and Families  
March of Dimes  
National Assembly on School-Based Health Care  
Voices for America's Children