June 10, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

RE: CMS–9942–NC; Request for Information Regarding Provider Non-Discrimination

Dear Administrator Tavenner:

The American Academy of Pediatrics (AAP), a non-profit professional organization of 62,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, appreciates the opportunity to provide comments in response to the Request for Information (RFI) regarding provider non-discrimination, issued by the Departments of Labor, Health and Human Services (HHS), and Treasury on March 12, 2014.

The AAP advocates that all children receive high-quality, accessible, family-centered, continuous, coordinated, and comprehensive care in a medical home. To this end, the AAP believes that insurance payment schedules must cover the fixed and variable costs of providing care that is deemed medically-necessary by a child’s physician, and that payment rates should be adequate to support a robust pediatric workforce that can care for the present and future health and developmental needs of children in the United States. Without adequate coverage and payment, there is significant risk that families will be unable to access the full scope of services and care needed to maintain and promote the optimal health of their children.

The comments that follow reflect the AAP’s interpretation of the ACA’s provider non-discrimination provision and our commitment to improving access to quality, comprehensive, evidence-informed, and timely care for children in the United States. Thank you.

Sincerely,

James M. Perrin, MD, FAAP
President
JMP/IK
American Academy of Pediatrics (AAP or the Academy) Comments in Response to U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS); [CMS–9942–NC]; Request for Information Regarding Provider Non-Discrimination; Federal Register/Vol. 79, No. 48; March 12, 2014 (RFI)

The AAP supports safe, comprehensive, team-based, quality care for all children provided in a medical home. The AAP believes that any health care professional who actively participates in the care of children must demonstrate appropriate education, training, skills, and ongoing competencies in pediatric health care within his or her scope of practice to ensure that the highest standards of care are met for our nation’s children. Patient safety and quality of care are the primary concern of the AAP with respect to provider non-discrimination rules.

The Medical Home
The concept of the medical home was first introduced to the health care field by the Academy in the 1960s. The AAP developed the medical home model for delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children, including children and youth with special health care needs. A family-centered medical home is not a building, house, hospital, or home health service, but rather an approach to providing comprehensive primary care. By its very nature, the medical home’s design and function is to promote a systems approach to care that is benchmarked by quality and safety.

Children with Special Health Care Needs (CSHCN)
Children are not small adults, and insurance provider networks and network standards crafted around the health care needs of adults will not adequately meet the unique needs of children. This is especially true for CSHCN. CSHCN are defined by the Maternal and Child Health Bureau (MCHB) as “those who have one or more chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.” Unlike adults, children navigate the health care system through their parents and families. States and issuers must involve families in provider network planning and adequacy oversight.

Pediatric Benefits and Networks
All children must have access to a comprehensive array of primary care, specialty care, and ancillary services. Insurance provider networks must be required to include pediatricians as well as a complete range of pediatric medical subspecialists, pediatric surgical specialists, and pediatric behavioral and mental health specialists within a given geographic area so that every child has and can maintain access to his/her medical home and specialty care in a timely manner. In addition, issuers must maintain provider networks and payment rates that create adequate access to pediatric-specific services such as habilitative and rehabilitative care, mental health and substance abuse treatment, vision, dental care, hearing services, others. The AAP Policy Statement Scope of Health Care Benefits for Children from Birth Through Age 26 defines the benefits that should be included in a given health plan.

Issuers must be required to include Essential Community Providers (ECPs) in their plan networks. These providers of services to low-income and medically underserved communities
are uniquely important to children, including CSHCN, who may be accessing care and services at many different locations within the health care system. Federal 2015 guidance for plans in federally facilitated marketplaces suggests QHPs can meet the ECP inclusion requirement if 30% of available ECPs in each plan’s geographic area are included in a given network—this should be considered a minimum standard and should not suggest a plan meets network adequacy requirements. Plans should include all ECPs in a given geographic area. Of particular note, children’s hospitals—both those that are free standing and those within a hospital—must be included in networks to ensure children receive the specialty care they need. Essentially, children’s hospitals are the only facilities that can provide needed services for children with rare conditions and optimal care for children with more common conditions. Administrative procedures for obtaining out-of-network care should not be burdensome for families.

**Mental and Behavioral Health**
Children with mental health and substance use disorders have long faced discrimination in access to services and costs associated with those services. Treating conditions related to the brain and the providers who treat those conditions as different from those of the body is a form of discrimination and it is particularly problematic for children since most mental health conditions present in adulthood manifest themselves in youth. Therefore, screening and early intervention in children is critical. Mental/behavioral health carve-outs are programs that contract directly with managed behavioral health organizations, separately from the remaining health care benefits package. Mental health carve-outs in public and private insurance are a significant barrier to access to mental health care for many children, and the practice of mental health carve-outs serves as a form of discrimination against children with mental health conditions and their providers.

**Care Coordination and the Medical Home**
It is critically important that issuers’ provider networks include professionals who provide care coordination services to ensure that all children, particularly CSHCN, have their needs addressed and that services are coordinated through the child’s medical home. Should a needed pediatrician, pediatric medical subspecialist, pediatric surgical specialist, or pediatric behavioral health specialist not be available and accessible in-network, children must have access to obtain covered services from out-of-network pediatricians, pediatric medical subspecialists, pediatric surgical specialists, or pediatric behavioral specialists at in-network out-of-pocket rates and in a timely manner. In rural and frontier areas where children face geographic barriers to access the services of a pediatric medical subspecialist or pediatric surgical specialist, a child must have access to an adult medical subspecialist or surgical specialist trained to address the child’s condition, at no extra cost and in a timely manner.

**Pediatric Providers and Children**
All issuers should provide significant family education regarding physicians and other providers and services considered in-network as well as the appropriate steps required to obtain out-of-network care. Similarly, network directories must be updated in real time, and information on the current status of a physician’s panel should be included in that directory (ie, whether the physician is accepting new patients, whether a referral is required to see the physician, etc). Any measurement of “good faith efforts” by issuers to contract—either with physicians or with ECPs—should only include competitive offers of payment rates that are comparable to other
insurance plan payment rates for similarly covered services. Pediatricians in a number of areas have reported being offered contracts with significantly lowered payment rates. Such contract offerings should not constitute good faith efforts to ensure network adequacy.

**Network Adequacy**

Issuer network adequacy standards and metrics should be transparent and made readily available to the public. Network adequacy must be continually monitored using both data from issuers as well as feedback from the public. A clear appeals process as well as a process for filing complaints by enrollees unable to gain access to care in-network must be established, and data from these processes should be made publically available. States should have the authority to require issuers to broaden networks if they are found to be out of compliance with network adequacy standards.

The AAP appreciates the complexity of this issue and hopes that the regulations promulgated to enforce this provision of the ACA ensure access to appropriate, timely, comprehensive, quality care for all children. The AAP thanks you for the opportunity to provide comments. Should you have questions, please contact Ielnaz Kashefipour at ikashefipour@aap.org or 202-724-3302.