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January 14, 2019

VIA ELECTRONIC SUBMISSION

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

RE: CMS-2408-P; Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care

Dear Administrator Verma:

On behalf of the American Academy of Pediatrics (AAP), a non-profit professional organization of 67,000 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, I write to submit comments on the proposed rule by the Centers for Medicare & Medicaid Services (CMS) regarding changes to the Medicaid and Children's Health Insurance Plan (CHIP) managed care regulatory framework. We read the proposed rule with great interest, as it will have far-reaching effects on children and families who are served in Medicaid and CHIP. We strongly believe that any source of children's coverage must ensure access to timely, affordable, high-quality and age-appropriate health care that meets their unique needs, and Medicaid and CHIP are no exception.

We understand that this proposed rule was published in response to concerns expressed by states regarding the "administrative burden" associated with the current requirements promulgated in the final managed care rule on April 25, 2016. We are pleased that in considering proposed changes to the rule, the Department has left in place most provisions that protect children and families, including those relating to enrollee rights and protections, program integrity, and sanctions for noncompliance with contract requirements.

However, the Academy is deeply concerned with the proposed changes the rule makes to network adequacy standards and disseminating information to enrollees. When considered in conjunction with the Department's proposed rule to roll back the Medicaid Access Rule, these changes could leave children, particularly those with serious, chronic, or complex medical needs, with reduced access to the care they need. We urge CMS to reconsider these provisions before issuing a final rule.

Our specific comments are below.

The Importance of Children’s Access to Care

Children make up the single largest group of people who rely on Medicaid; nearly 36 million children receive Medicaid coverage, including children with special health care needs and those from low-income families. Medicaid also provides comprehensive prenatal care to pregnant women, allowing millions of pregnant women to have healthy pregnancies and helping millions of children get a healthy start. Unlike many private health insurance plans, Medicaid guarantees specific benefits designed especially for children. Medicaid’s Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits are the definitive standard of pediatric care, covering an array of services like developmental, dental, vision and hearing screenings, and allowing health problems to be diagnosed and treated appropriately and as early as possible. Simply put: Medicaid works for America’s children. In fact, children in Medicaid are more likely to obtain medical check-ups, attend more days at school, graduate and enter the workforce than their uninsured peers.¹

When children see providers who know their medical history and can monitor their physical and socio-emotional development, they are more likely to have better overall health, be up-to-date on immunizations, perform better in school and receive care in the most cost-effective way.² Moreover, child health is a strong predictor of adult health. Addressing health and development during childhood—from birth through adolescence— leads to improved life outcomes in many areas. Conversely, the inability to access health care services threatens the physical, mental, and social health and well-being of children and their caregivers.³ The AAP believes that all children, regardless of their zip code, must have access to the full range of age-appropriate health care providers, subspecialists, and facilities.

Proposed Changes to Section 438.68 (Network Adequacy Standards)

Under current regulations, states must establish network adequacy standards for Medicaid managed care entities. At a minimum, states must develop time and distance standards for:

- Primary care, adult and pediatric
- OB/GYN
- Behavioral health
- Specialist, adult and pediatric
- Hospital
- Pharmacy
- Pediatric dental
- Additional provider types when it promotes the objectives of the Medicaid program, as determined by CMS, for the provider type

¹ <https://www.macpac.gov/wp-content/uploads/2015/11/EXHIBIT-41.-Use-of-Care-among-Non-Institutionalized-Individuals-Age-0%E2%80%9318-by-Primary-Source-of-Health-Coverage-2015-MEPS-data.pdf>

² https://www.childtrends.org/wp-content/uploads/2017/05/2017-22HealthInsurance_finalupdate.pdf

³ <https://www.aap.org/en-us/Documents/BluePrintForChildren.pdf>

We believe this framework helps ensure children in Medicaid have access to the providers, care and services they need. We strongly support the current rule’s requirements that network adequacy determinations include, for children, access to pediatric primary care. Additionally, we urge CMS to include a requirement that access to *pediatric medical subspecialists* and *pediatric surgical specialists* be required. Pediatric subspecialists provide specialized care to children, many of whom have complex medical conditions or require long-term, coordinated care for chronic illnesses. Nationwide, critical shortages of pediatric subspecialists prevent children from getting the care they need. The result is that families face long wait times to get appointments with subspecialists or must travel long distances to access needed health care, and primary care pediatricians have difficulty referring out to subspecialists. The AAP continues to support the inclusion of pediatric medical subspecialists and pediatric surgical specialists as a requirement of all network adequacy documentation.

In response to comments submitted on the 2015 proposed rule, CMS declined to set specific benchmarks for time and distance (for example, 30 miles or 30 minutes). Instead, it allows each state to develop its own standards that may vary based on provider type and differ by geographic area. Under that approach, the current time and distance standards act as a floor and are not overly prescriptive. They allow states the flexibility to experiment with other innovative network adequacy metrics, so long as they comply with the universal standard outlined by CMS in 2015.

In the AAP’s previous comments on the 2015 proposed rule,⁴ we applauded CMS for its recognition that network adequacy is a foundational component of a health plan’s ability and capacity to provide services and for proposing standards for network adequacy. While the current time and distance standards are not perfect for ensuring the needs of children are met, the Academy supported the inclusion of an objective, universal federal network adequacy standard that acted as a floor for states in reporting data and monitoring access.

The NPRM revises §438.68(b)(1) and (b)(2) by deleting the requirements for states to set time and distance standards and adding a weaker requirement that states set a “quantitative minimum” access standard for specified health care providers. According to CMS, quantitative standards that states may elect to use include, but are not limited to, minimum provider-to-enrollee ratios; maximum travel time or distance to providers; a minimum percentage of contracted providers that are accepting new patients; maximum wait times for an appointment; hours of operation requirements (for example, extended evening or weekend hours); and combinations of these quantitative measures.

The Academy is concerned that absent a required standard for network adequacy that acts as a floor, pediatric access may be unintentionally limited, and children may be inadvertently harmed. Children are at particular risk from the proposed dilution of the network adequacy standard because in most of the states that contract with Managed Care Organizations (MCOs) (35 of the 39), at least three quarters of all Medicaid children are enrolled in MCOs.⁵ While CMS “encourages states to use the quantitative standards in combination – not separately – to ensure that there are not gaps in access to and availability of services for enrollees,” encouragement

⁴ <https://downloads.aap.org/DOFA/AAP2015MCOComments.pdf>

⁵ <https://www.kff.org/medicaid/report/states-focus-on-quality-and-outcomes-amid-waiver-changes-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2018-and-2019/>

alone will not guarantee that states are utilizing standards that monitor children's access to medically necessary services. Moreover, eliminating a federal floor enables states to establish standards that do not ensure appropriate access to all medically necessary pediatric care.

Indeed, such plans may consider access to adult specialty or subspecialty care as meeting a network adequacy standard, when in fact adult care may not be appropriate for children. Research continues to demonstrate the positive outcomes and quality impacts of care provided by *pediatric* medical subspecialists and surgical specialists, versus adult specialists and subspecialists for the pediatric population.⁶ Factors such as lower complication rates, shorter lengths of stay, and better outcomes for disease specific conditions highlight the need for unfettered access to *pediatric* specialists and subspecialists.

Moreover, the time and distance requirement took effect for contract rating periods starting July 1st of this year, meaning there has been less than 6 months of operational experience with the current policy. Additionally, all states already specify some level of travel standards for primary care.⁷ As such, the proposal to eliminate these standards for the sake of easing administrative burden seems far-reaching.

Furthermore, CMS also proposes to revise § 438.68(b)(1)(iv), which requires states to establish time and distance standards for "specialist, adult and pediatric." CMS believes it is "inappropriate" to define "specialist" at the federal level, and therefore clarifies that states have the authority to define "specialist" in whatever way they deem most appropriate for their programs. As a result, states could exempt their contracting MCOs from demonstrating adequate access to entire groups of specialists, like neonatologists, oncologists, or cardiologists.⁸

Narrow networks threaten to disrupt existing relationships families have with their medical homes and limit access to primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, replacing such care with available adult specialists and subspecialists. For example, while an adult general surgeon might be able to perform appendectomies safely on teenage patients, the same is not the case for a patient under the age of ten. An adult specialist who agrees to see pediatric patients is not the same as a pediatric specialist.

Further, limiting access to academic medical centers and children's hospitals will be harmful for children with special health care needs (CSHCN). In this context, it is not uncommon for Medicaid enrollees to require medically necessary services that may not be available in the state or panel as currently established by the MCO. For example, in many areas of the country, access to pediatric specialty or subspecialty care might require services that should only be provided by pediatric subspecialists or a children's hospital in another state, such as for surgery to correct a pediatric heart condition, retinopathy of prematurity screening, neonatology consultations, dermatologic assessment, or critical care medicine. We urge CMS to take efforts to ensure

⁶ <https://www.aap.org/en-us/advocacy-and-policy/state-advocacy/Documents/PediatricVAdultSubspecCare.pdf>

⁷ <https://www.commonwealthfund.org/blog/2018/provider-networks-and-access-medicare-managed-care-look-federal-and-state-standards>

⁸ <https://www.aap.org/en-us/advocacy-and-policy/state-advocacy/Documents/PediatricVAdultSubspecCare.pdf>

existing physician-patient relationships are maintained whenever possible as network adequacy standards are implemented. Additionally, plans should make appropriate transitions to in-network care in any new network.

The AAP believes that plans should be required to ensure that children have appropriate access to all pediatric primary, specialty, and subspecialty care they need. As such we request that CMS return to require a minimum standard for network adequacy, in whatever format utilized, which plans must meet and which states may additionally build upon.

Access to Telehealth Can Not Replace Adequate Networks

In justifying its rollback of standardized network adequacy standards outlined in the NPRM, CMS argues that “in some situations, time and distance may not be the most effective type of standard for determining network adequacy and some states have found that time and distance analysis produces results that do not accurately reflect provider availability.” To illustrate this point, CMS alludes to the use of telehealth, which would apply other criteria than time and distance to measure availability. CMS cites a 2017 Brookings/Schaefer Center report which states that in some clinical areas, “telemedicine could make proximity measures obsolete, or counterproductive.”⁹

The AAP believes that pediatric telehealth care may provide cost-effective opportunities to meet the unique needs of children, particularly in underserved areas.¹⁰ It is appropriate in the pediatric context for network adequacy standards documenting access to care to include care provided via telehealth technologies, but it should never be acceptable for calculations of network adequacy to depend in any significant way on telemedicine to meet a network adequacy standard. For the best access to subspecialty pediatric services, children need guaranteed access to face-to-face care that could then be supplemented by telehealth services. The flexibility to include explicit telehealth services should always be balanced with safety, quality, licensing and certification standards, and must take place within the context or in support of a medical home.

In pediatrics, a medical home is not a building, but an approach to providing comprehensive primary care in which a care team works in partnership with a child and child’s family to assure that all the medical and non-medical needs of the patient are met and that care is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children and adolescents, including children and adolescents with special health care needs.¹¹ The use of telemedicine care by virtual health care providers, such as those linked to retail-based clinics, entrepreneurs, or insurers whose business model is to provide health care services to patients via smart phone, laptop, or video-consult kiosk without a previous physician-patient relationship, previous medical history, or hands-on physical examination (other than what

⁹ Hall, Mark, A. and Ginsburg, Paul, B. A Better Approach to Regulating Provider Network Adequacy (September 2017). Available at <https://www.brookings.edu/wp-content/uploads/2017/09/regulatory-options-for-provider-network-adequacy.pdf>.

¹⁰ AAP Policy Statement: The Use of Telemedicine to Address Access and Physician Workforce Shortages <http://pediatrics.aappublications.org/content/136/1/202>

¹¹ AAP Policy Statement: Patient- and Family-Centered Care and the Pediatrician's Role <http://pediatrics.aappublications.org/content/129/2/394>

can be accessed via the technology), can undermine the basic principles of the medical home model.

While we agree that telehealth care may require a different approach to measurement, the appropriateness of time and distance standards to determine the adequacy of providers who furnish care in physically specified locations is a separate issue. We believe that fragmented care delivered outside the medical home model should be avoided. In isolation, the use of virtual telemedicine care represents the antithesis of the medical home model of quality pediatric care: care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. Telehealth care should augment, and not substitute for, a robust in-person network of pediatricians, pediatric medical subspecialists and surgical specialists, and other health care providers.

Proposed Changes to Section 438.10 (Information to Plan Enrollees)

We are concerned with two of the changes the NPRM makes related to information relayed to enrollees. Under the 2015 rule, CMS requires notice to enrollees of a provider's termination within 15 days of a covered plan's receipt or issuance of the termination notice. CMS proposes changes to §438.10(f)(1) that would lengthen the time period governing when a managed care plan must notify enrollees that their physician has left the network to within 30 days of actual termination. This change substantially limits a parent's ability to find another network provider in the plan for their child, which could inadvertently impact continuity of care. Such a notification is of particular importance for CSHCN, who may require additional time to find a specialist or subspecialist with specific expertise in their unique conditions.

Second, the rule would relax the frequency with which paper provider directories must be updated if contractors offer mobile-enabled directories. §438.10(h)(3) requires that information in a paper directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days of receiving updated provider information. The NPRM relaxes these requirements if the managed care plan offers a mobile-enabled, electronic directory. In justifying this change, CMS cites research that 64 percent of U.S. adults living in households with low incomes own smartphones, and that lower-income adults are more likely to rely on a smartphone for access to the Internet, because they are less likely to have an Internet connection at home.

The AAP strongly opposes the proposed changes to §438.10(h)(3). Even if a majority of low-income households own smartphones, a large plurality (at least 36 percent, according to the Department) do not. The agency also assumes that everyone who owns a smartphone knows how to navigate complex plan websites to obtain provider directory information or read such information in electronic format. The Academy believes all information should be required to be provided at a literacy level appropriate for families and based on the expressed information sharing preference of families at enrollment and re-enrollment. As such, we urge CMS to reconsider the inclusion of this provision in the final rule.

The Proposed Rollback of the Medicaid Access Rule Exacerbates Our Concerns

The Department's proposed changes in the Medicaid Managed Care NPRM coincide with the proposed rollback of the Medicaid Access Rule, which exacerbates our concerns related to children's access to care. On March 23, 2018 CMS proposed to weaken the federal requirements for states to document whether fee-for-service Medicaid payments to providers are sufficient to ensure beneficiary access to covered care and services in the Medicaid program. The proposal would also exempt states from current regulatory requirements to document that access will not be diminished when they propose rate reductions for any services covered under Medicaid.

According to CMS, this rule is being proposed in response to "state concerns over the administrative burden associated with the current requirements." However, it is the responsibility of the federal government to enforce the Medicaid equal access provision, which requires that state Medicaid provider payments be sufficient to ensure comparable access to care with other forms of insurance. The recently released proposed rule relinquishes the federal government's responsibility to monitor access to care for children enrolled in Medicaid and would also make it easier for states to reduce provider payment rates in FFS, which could lead to less provider participation in the program and diminished access to services for children and families.

It is important to note that while the NPRM specifically addresses access monitoring and exemption for payment rate changes in Medicaid FFS delivery systems, this rule has implications for Medicaid managed care. Within federal regulations, states have broad flexibility to establish provider payment rates and methodologies. Under a circumstance where states and MCOs utilize FFS provider payments as a benchmark for their own payments, this proposed rule would allow for similar cuts to MCO provider rates without an examination of the resultant impact on access to care. Specifically, lower FFS rates could support lower actuarially sound capitation payments to MCOs, and lower FFS rates could enable MCOs to lower their network provider payment rates correspondingly. The resulting impact will be felt not just by states that qualify for exemption under the arbitrary 85% threshold in the proposed rule, but by all states. Further, many states also carve services out of managed care contracts, so that even children enrolled in MCOs may access certain services through fee-for-service, such as prescription drugs, mental health services, and long-term services and supports.

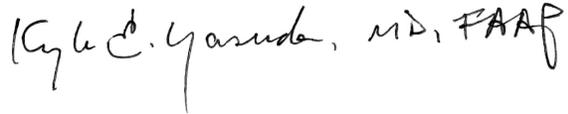
The Academy submitted comments¹² on the proposed rule strongly urging CMS to withdraw the proposal, and to instead strengthen the current access monitoring regulations. In anticipation for the release of the final rule in 2019, we repeat our concerns that these changes could leave children, particularly those with serious, chronic, or complex medical needs, with reduced access to the care they need. The Academy reiterates a call for CMS to revise its proposed rule on access monitoring to instead strengthen requirements that ensure appropriate access to care in the Medicaid program.

In conclusion, we thank the Department for the opportunity to submit comments on the proposed rule regarding changes to the Medicaid and CHIP managed care regulatory framework. We urge CMS to reconsider the proposed changes to network adequacy standards and disseminating

¹² <https://downloads.aap.org/DOFA/MedicaidAccessComments.pdf>

information to enrollees, which may unintentionally harm access to pediatric care and inadvertently harm children. If you have any further questions, please don't hesitate to contact Nick Wallace in our Washington, D.C. office at 202-347-8600 or nwallace@aap.org.

Sincerely,

A handwritten signature in black ink that reads "Kyle E. Yasuda, MD, FAAP". The signature is written in a cursive, slightly slanted style.

Kyle E. Yasuda, MD, FAAP
President