

Ensuring Adequate Marketplace Provider Networks: What's Needed for Children

Pediatric-specific network adequacy standards should be developed and monitored to ensure that children enrolled in Qualified Health Plans (QHPs) have access to needed services in a timely way.

- Pediatric provider networks in the marketplaces should include a full range of primary, specialty, and ancillary pediatric providers, and ensure coordination and continuity of care among all providers.
- Pediatric-specific network adequacy standards (related to timeliness, quantity and types of providers, and monitoring), should be developed with input from pediatric health researchers and providers, and families in order to ensure that children have access to needed services without unreasonable delay.
- Pediatric provider networks must be continually assessed to identify gaps in access to care, accompanied by a plan to remedy those gaps and monitor access to care in those areas.

Network adequacy standards and assessments should assure access for children with special health care needs or limited English proficiency.

- Pediatric provider network standards for QHPs should specifically reflect the challenges that especially vulnerable populations, such as children with special health care needs, including those with complex conditions or limited English proficiency, face in securing the care they need when they need it.
- Network adequacy standards must require an appropriate distribution of pediatric specialists. Limited or tiered networks that create barriers to appropriate care or substantial disruptions of care and provider relationships can be catastrophic to the development and health of children with special health care needs.
- Provider networks must include providers who offer services in the appropriate languages to serve the population. Children's health could suffer if parents are unable to find linguistically and culturally appropriate providers for their families.

QHPs should provide easy access to essential community providers that care for children.

- States—through insurance regulation and marketplace policy—should ensure that QHPs have an adequate network of essential community providers (ECPs).¹ QHPs must be required to contract with, and provide adequate payment to, all pediatric ECPs including, but not limited to, children's hospitals and school-based health centers. A robust pediatric ECP network will assure access to these especially qualified providers with expertise in the care of low-income and critically or chronically ill and disabled children.
- Pediatric ECPs are uniquely positioned to provide critically important support services that address the health care access barriers these children face, including language services, social service interventions, and outreach. Adequate reimbursement for these services must be assured as well.

Children, particularly those with chronic and complex conditions, must have access to out-of-network providers at no additional cost if no network provider is accessible for needed services in a timely manner.

- Children must be able to access the pediatric specialty care they need even when the QHP network has an insufficient number or type of provider to provide the needed care. Children with complex or chronic conditions may need specialty care from a type of provider not in a QHP network, given the shortage of certain types of pediatric specialists nationwide, and the possibility of narrow provider networks in some plans.
- Children must be able to access those providers at no additional cost and do so in a timely manner when it is determined that the care is appropriate.
- QHP policies and rules for accessing out-of-network care and the process for appeals of denials of requests for out-of-network care must be made clear to consumers.

Provider networks that overlap with Medicaid/CHIP can help promote continuity of care for children who move between the Exchange and public coverage.

- Inevitably, some children will move between marketplace and Medicaid/CHIP coverage as their family income or other characteristics change. States should establish network standards that require or encourage aligned or overlapping pediatric provider networks with Medicaid/CHIP to allow for continuity of care for children who move between public and private coverage.²

Dental provider networks for children must be assessed and any deficiencies addressed.

- Dental provider networks must be adequate to assure that oral health services will be accessible to children without unreasonable delay.
- All dental provider networks must be assessed, including those in the stand-alone dental plans that are offered in the marketplaces, as rigorously as medical care provider networks for children.
- Marketplaces should have an initial standard for dental provider network adequacy and have a system to monitor access to dental care for children. At a minimum, dental plans should be required to demonstrate the steps they will take to maintain a network that has the number and types of providers needed to assure timely access to oral health services for children.
- States should continue to study the issue of meaningful dental network adequacy standards specific to their localized conditions.

Network adequacy standards and assessments should be transparent.

- The state's network adequacy standards, assessment procedures, and data documenting QHP compliance with those standards, should be clear and transparent to the public.
- Assessment results and data on QHP network adequacy (e.g., wait times, numbers, and types of providers) for children should be publicly disclosed, as well as health plan accreditation status and Consumer Assessment of Health Care Providers and Systems survey results for children, including the child access to care survey and the survey for children with chronic conditions.
- QHPs should be required to report publicly on the impact of their provider networks on children's access to care.

Network Adequacy Background

Child health advocates will need to direct their advocacy toward multiple decision-makers, including state regulators, marketplace officials, and insurance issuers, to encourage the development of appropriate provider networks for children by health plans in the marketplaces. Those efforts must be in collaboration with pediatric health service researchers, pediatric providers and consumers with experience and expertise in pediatric care delivery. The responsibility for determining network adequacy standards generally rests within state insurance departments or other regulatory agencies, but marketplaces will play a crucial role in “certifying” that a health plan’s network meets those standards. In states with a partnership or federally facilitated marketplace, federal officials will review and enforce network adequacy standards.³

Background

Federal statute and regulation requires QHPs to have a provider network that has “sufficient number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.” Nonetheless, there is no federal standard for how provider networks are assessed for adequacy or efficiency as a condition of QHP certification nor are there specific federal standards for appropriate pediatric provider networks.⁴

What is a Robust Pediatric Provider Network?

It is critically important that each QHP participating in a marketplace have robust pediatric provider networks that can meet the unique needs of the children enrolled in that plan. Children must have timely access to a full range of primary, specialty and ancillary pediatric providers to ensure that they receive comprehensive and medically and developmentally appropriate care. The networks must include pediatric primary care providers, pediatric specialists (e.g., pediatric neurologists, oncologists), pediatric habilitative/rehabilitative therapy providers (e.g., occupational, speech and physical therapists), pediatric home care services, 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. In addition, 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.

How are Provider Networks Developed and Assessed?

Although there is no one single accepted standard or metric for determining pediatric provider network adequacy, some methodologies may be particularly appropriate for this population. For example, pediatric networks can be developed and assessed using provider-to-patient ratios for pediatric primary and specialty care, rural/urban geographic accessibility standards (including geo-mapping, mapping of mid-level clinician availability and telehealth capabilities), appointment waiting times standards, hours of operation, hospital access, and the location of medically underserved populations relative to providers,⁵ among other methods.

There are unique and challenging provider network issues for children with chronic or complex conditions. Given the severity of illness and the regional basis of most pediatric specialty care in the United States, these children and their families commonly travel long distances, sometimes to other states, to access the care they require. Furthermore, the availability of many specialty pediatric therapists (e.g. speech therapists, occupational therapists) is limited in rural areas and it is not uncommon for children with complex or chronic conditions who live in these areas to travel substantial distances to access their services. Therefore, for pediatric specialty providers, wait times may be a more meaningful metric of network adequacy than simple geographic distribution or driving distances.

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NOTES:

¹ CCIIO has created a non-exhaustive database of ECPs at <http://hab.hrsa.gov/affordablecareact/ecp.html>; Note: Children's hospitals are the only ECP providers eligible under Section 340b of the Public Health Service Act that care solely for children, though other eligible entities also care for children, including federally qualified health centers, rural health centers, Ryan White Clinics, etc. For the complete list of eligible entities under Section 340b, see <http://www.hrsa.gov/opa/eligibilityandregistration/index.html>; See also CMS "Frequently Asked Questions on Essential Community Providers," May 13, 2013), <http://ccio.cms.gov/resources/files/ecp-faq-20130513.pdf>.

² For a description of Medicaid managed care network adequacy requirements by state, see Appendix 8 of "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey," Kaiser Commission on Medicaid and the Uninsured (July 2011), <http://www.kff.org/medicaid/8220.cfm>.

³ See Corlette, S., Volk, J. & Lucia, K., "Plan Management: Issues for State, Partnership, and Federally Facilitated Health Insurance Exchanges," The Center on Health Insurance Reforms at Georgetown University Health Policy Institute and National Academy of Social Insurance, (May 2012), <http://www.nasi.org/research/2012/plan-management-issues-state-partnership-federally-facilitat>; and S. Rosenbaum, "The QHP Certification Process in Federally-Facilitated Exchanges: Network Adequacy and Essential Community Providers" Health Reform GPS (March 27, 2013), <http://healthreformgps.org/resources/the-qhp-certification-process-in-federally-facilitated-exchanges-network-adequacy-and-essential-community-providers/>.

⁴ Additional network adequacy background and framework can be found in: "Plan Management Function: Network Adequacy White Paper" Adopted by the NAIC Health Insurance and Managed Care (B) Committee on June 27, 2012, http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf; NCQA, "Network Adequacy & Exchanges," (February 2013), http://www.ncqa.org/Portals/0/Public%20Policy/Exchanges&NetworkAdequacy_2.11.13.pdf; and FamiliesUSA, "Consumer-Friendly Standards for Qualified Health Plans in Exchanges: Examples from the States," (January 2013); <http://familiesusa2.org/assets/pdfs/health-reform/Consumer-Friendly-Standards-in-Exchange-Plans.pdf>.

⁵ Quest Analytics, "Leveraging Vetted Network Adequacy Assessments (Fast-Track Your State Programs)," (July 2012), http://www.statereform.org/sites/default/files/white_paper_leveraging_network_adequacy_for_state-based_programs.pdf; and Talbot, J. http://www.statereform.org/sites/default/files/white_paper_leveraging_network_adequacy_for_state-based_programs.pdf; and Talbot, J. A., Coburn, A., Croll, Z. and Ziller, E., "Rural Considerations in Establishing Network Adequacy Standards for Qualified Health Plans in State and Regional Health Insurance Exchanges," *The Journal of Rural Health* (2013), <http://onlinelibrary.wiley.com/doi/10.1111/jrh.12012/abstract>.