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## *Children's Hospital Association Consensus Statement*

### **Safeguarding Access to Medically Complex Care for Children by Requiring Health Plans and Exchanges to Develop Adequate Provider Networks**

#### **Safeguarding Children's Access to Care**

- Children are a unique population. To appropriately address the health care needs of all children, regardless of age<sup>1</sup>, network adequacy standards must be specifically evaluated with respect to any insurance product that is offered in the commercial marketplace or by state or federal governments, and which purports to provide services to children. This includes traditional insurance products, managed care products, coverage offered through Medicaid and/or the Children's Health Insurance Program (CHIP), and products sold on the new health care Exchanges.
- Network adequacy should be evaluated for two specific subpopulations of children:
  - First, plans should demonstrate that adequate primary care access is available and affordable for all children that are generally well. The NCQA HEDIS measures and others are a good starting place for evaluating access and performance of well-child networks. It should be noted that there have historically been significant problems with access to dental and mental health services for generally well children. Health plans should demonstrate that they can provide adequate and affordable access to pediatric-appropriate specific services, using the Medicaid Early Periodic Screening Diagnostic and Treatment benefit as a model.
  - Second, network adequacy must be specifically evaluated for children with more complex or chronic health care needs (children with special health care needs). For example, a recent Health Affairs<sup>2</sup> article found that 10 percent of children enrolled in Medicaid and/or CHIP account for approximately 70 percent of the resource utilization in pediatrics. As such, payers should demonstrate that their networks are adequate and are affordable for the subpopulation of children that represents the majority of their anticipated pediatric spending in any given year.

This consensus statement focuses on the subpopulation of children with special health care needs, which is defined in simple terms as the top 10 percent of utilizers in the most recent rate year.

#### **Essential pediatric community providers<sup>3</sup>**

In order to serve children adequately, networks must include one or more pediatric hospital providers that are in the geographic area and maintain comprehensive pediatric specialty services. At a minimum, these hospitals should have the capacity to provide neonatal services, critical and intensive care, surgical, emergency/trauma services, and the relevant

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<sup>1</sup> This consensus statement addresses the provision of health care services to children of all ages, including adolescents.

<sup>2</sup> G. Kenney, J. Ruhter, and T. Selden, "Containing Costs and Improving Care for Children in Medicaid and CHIP," Health Affairs 28:6 (2007): w1012- w1036 web exclusive.

<sup>3</sup> The following requirements could be readily supplemented or refined based on the historic experience of existing insurance products for the population of children and adolescents with special health care needs.

range of ancillary supports, such as occupational, physical, and speech therapy services; specialized pharmacies; anesthesia; durable medical equipment; and linguistically and culturally responsive providers/services.

- Public and private insurance products should provide access to the full range of pediatric subspecialty services typically required to care for sick children of all ages. This should include, but not be limited to, access to pediatric cardiology, neurology, nephrology, developmental medicine, psychiatry, gastroenterology, orthopedics, pulmonology, oncology and radiology. In general, public and private insurance plans should demonstrate that the specialists in question have been trained and credentialed or have substantial experience treating children.
- Network adequacy should be evaluated in consideration of providing access to an appropriate pediatric facility—which may be in another state. It may be necessary for children to travel significant distances and to other states to receive treatment. Therefore, if an appropriate pediatric specialty hospital is not available in the immediate geographic area, arrangements should be made to refer the patient to an appropriate facility in the same or different state, at no greater out-of-pocket expense.
  - Health plans should specifically contract with these providers “in network”; it is unacceptable to allow payers to contract for the majority of services required on an out-of-network or single-case agreement basis.
- Plan networks should be designed to provide services for all levels of complexity, including for rare conditions, without administrative or cost barriers for consumers. In plans with tiered provider networks, pediatric specialty care providers should be in no higher than the second least expensive tier. When pediatric specialty care is predominantly provided in one or two provider settings, those settings should be in the lowest cost tier. Consumers must be informed of cost sharing requirements associated with the tiers.
- Pediatric provider networks should be stable, and public and private insurers should be required to inform consumers well in advance of any significant changes to their networks. Transitional coverage should be mandated for care that is “in process” (active treatment) at the time that network changes are being made.
- Children with special health care needs require a network that can support an appropriate transition to adult care providers. The network must include adult providers who are able to provide for their unique needs or pediatric and/or adolescent specialists who are able to provide specialized care through young adulthood.

### **Out-of-network requirements**

Children should not be penalized by the health plan if their care is provided by an out-of-network provider because there is no provider available within network that is capable of providing a covered benefit.

- When out-of-network care is received, cost sharing and other requirements for the consumer should be the same as if the plan was contracted and in-network.
- Plans should demonstrate that they maintain an adequate and timely approval process for out-of-network services, utilize appropriate pediatric clinical standards in evaluating requests, and have an appeals process for denied services. Regulators should assure that the insurance company does not impose additional barriers to access, including onerous prior authorization processes.
- Out-of-network arrangements should only be used as an exception for extremely rare services.
- Single case agreements are not an acceptable alternative to plans having a generally adequate pediatric network.

- Payers should be required to reimburse hospitals the reasonable and customary value for services that are provided on an out-of-network basis.

### **Monitoring requirements**

The insurer should proactively address access to pediatric specialty services when filing provider network information.

- Monitoring agencies, such as state insurance departments, should establish reporting requirements that specifically address access to care for children with special health care needs. Plans should expressly report on the utilization of services by this population, including the nature of the services, their location, and the extent to which these services were provided outside the contracted networks.
- Plans should report on all existing externally benchmarked, risk-adjusted pediatric quality and outcomes standards utilized in their contracts with hospitals and subspecialty networks. In addition, plans should identify which of these standards were used to determine the relative quality of the limited or tiered network plans they are intending to market in the event those types of networks are established.

*This statement was approved by the Children’s Hospital Association Leadership Committee on Advocacy and Policy and further endorsed by the following children’s hospitals, state children’s hospital associations, and allied organizations (as of Oct. 16, 2014)*

### **Children’s Hospitals and State Associations**

Arkansas Children’s Hospital, Little Rock, AR  
 California Children’s Hospital Association, CA  
 Loma Linda University Children’s Hospital, Loma Linda, CA  
 Miller Children’s & Women’s Hospital Long Beach, CA  
 Children’s Hospital Los Angeles, CA  
 Children’s Hospital Central California, Madera, CA  
 UCSF Benioff Children’s Hospital Oakland, CA  
 Children’s Hospital of Orange County, Orange, CA  
 Lucile Packard Children’s Hospital Stanford, Palo Alto, CA  
 Rady Children’s Hospital San Diego, CA  
 Children’s Hospital Colorado, Aurora, CO  
 Connecticut Children’s Medical Center, Hartford, CT  
 Yale-New Haven Children’s Hospital, New Haven, CT  
 Children’s National Health System, Washington, DC  
 Florida Association of Children’s Hospitals, FL  
 Chris Evert Children’s Hospital at Broward Health Medical Center, Fort Lauderdale, FL  
 Golisano Children’s Hospital of Southwest Florida, Fort Myers, FL  
 Joe DiMaggio Children’s Hospital, Hollywood, FL  
 Wolfson Children’s Hospital, Jacksonville, FL  
 Baptist Children’s Hospital, Miami, FL  
 Miami Children’s Hospital, FL  
 All Children’s Hospital Johns Hopkins Medicine, St. Petersburg, FL  
 St. Joseph’s Children’s Hospital of Tampa, FL  
 Tampa General Hospital, FL  
 Children’s Healthcare of Atlanta, GA

Blank Children's Hospital, Des Moines, IA  
Ann & Robert H. Lurie Children's Hospital of Chicago, IL  
Kosair Children's Hospital, Louisville, KY  
Mt. Washington Pediatric Hospital, Baltimore, MD  
Boston Children's Hospital, MA  
Children's Hospital of Michigan, Detroit Medical Center, MI  
Helen DeVos Children's Hospital, Grand Rapids, MI  
Children's Hospitals and Clinics of Minnesota, Minneapolis, MN  
Gillette Children's Specialty Healthcare, St. Paul, MN  
Children's Mercy Hospitals and Clinics, Kansas City, MO  
SSM Cardinal Glennon Children's Medical Center, St. Louis, MO  
St. Louis Children's Hospital, MO  
Children's Hospital & Medical Center, Omaha, NE  
New Jersey Council of Children's Hospitals, NJ  
Children's Specialized Hospital, Mountainside, NJ  
University Medical Center of Southern Nevada, Las Vegas, NV  
Blythedale Children's Hospital, Valhalla, NY  
Ohio Children's Hospital Association, OH  
Akron Children's Hospital, OH  
Cincinnati Children's Hospital Medical Center, OH  
Nationwide Children's Hospital, Columbus, OH  
Dayton Children's Hospital, OH  
ProMedica Toledo Children's Hospital, OH  
The Children's Hospital of Philadelphia, PA  
Children's Hospital of Pittsburgh of UPMC, PA  
South Carolina Children's Hospital Collaborative, SC  
MUSC Children's Hospital, Charleston, SC  
Palmetto Health Children's Hospital, Columbia, SC  
McLeod Children's Hospital, Florence, SC  
Children's Hospital – Greenville Health System, Greenville, SC  
Children's Hospital Alliance of Tennessee, TN  
Children's Hospital at Erlanger, Chattanooga, TN  
Niswonger Children's Hospital, Johnson City, TN  
East Tennessee Children's Hospital, Knoxville, TN  
Le Bonheur Children's Hospital, Memphis, TN  
Monroe Carell Jr. Children's Hospital at Vanderbilt, Nashville, TN  
Dell Children's Medical Center of Central Texas, Austin, TX  
Children's Health System of Texas, Dallas, TX  
Cook Children's Health Care System, Fort Worth, TX  
Texas Children's Hospital, Houston, TX  
Covenant Children's Hospital, Lubbock, TX  
Children's Hospital of San Antonio, TX  
Primary Children's Hospital, Salt Lake City, UT  
Seattle Children's Hospital, WA  
Children's Hospital of Wisconsin, Milwaukee, WI

### **Allied Organizations**

Alliance of Dedicated Cancer Centers

- City of Hope Comprehensive Cancer Center, Duarte, CA
- USC Norris Cancer Hospital, Los Angeles, CA
- Sylvester Comprehensive Cancer Center, Miami, FL
- H. Lee Moffitt Cancer Center & Research Institute, Tampa, FL
- Dana-Farber Cancer Institute, Boston, MA
- Roswell Park Cancer Institute, Buffalo, NY
- Memorial Sloan-Kettering Cancer Center, New York, NY
- The Ohio State Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Solove Research Institute, Columbus, OH
- Fox Chase Cancer Center, Philadelphia, PA
- The University of Texas MD Anderson Cancer Center, Houston, TX
- Seattle Cancer Care Alliance, Seattle, WA

American Academy of Child and Adolescent Psychiatry  
 American Association for Marriage and Family Therapy  
 American Association for Thoracic Surgery  
 American Congress of Community Supports and Employment Services  
 American Music Therapy Association  
 American Occupational Therapy Association  
 American Speech-Language-Hearing Association  
 American Thoracic Society  
 Association of Medical School Pediatric Department Chairs  
 Autism Health Insurance Project - California  
 Autism Speaks  
 California School-Based Health Alliance  
 Cancer Support Community  
 Child Neurology Foundation  
 Child Neurology Society  
 Children Now - California  
 Children's Defense Fund  
 Children's Defense Fund - California  
 Children's Partnership  
 Epilepsy Foundation  
 Family Voices  
 First Focus  
 Leukemia & Lymphoma Society  
 Los Angeles Trust for Children's Health  
 March of Dimes  
 Maternal and Child Health Access - California  
 National Alliance to Advance Adolescent Health  
 National Association of Pediatric Nurse Practitioners  
 National Association of School Nurses  
 National Marrow Donor Program  
 New England Alliance for Children's Health  
 Pediatric Congenital Heart Association  
 Pediatric Orthopaedic Society of North America  
 Society of Developmental-Behavioral Pediatrics  
 Society of Thoracic Surgeons

The Arc of the United States  
United Cerebral Palsy  
United Spinal Association