State Health Insurance Exchanges  
Key Issues for Children’s Health Care  
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State policymakers need to consider the unique needs of children when making decisions on the scope, structure, and plan participation of the Exchanges.

Exchanges will work for children if:

- Continuous care and coverage for children is ensured
- Health plans are required to contract with all essential community providers, including children’s hospitals
- A comprehensive pediatric benefit is included in the essential health benefits package
- Pediatric providers are included in Exchange governance and policymaking entities
- Network adequacy standards for health plans ensure that children have reasonable access to the providers they need
- Health plans are required to conduct meaningful negotiations for adequate payment rates for all necessary services
- Pediatric quality measurement, reporting and improvement are a high priority for Exchanges and health plans

Continuity of Care

Continuous care and coverage for children must be ensured even when a child's provider leaves a network or the child moves back and forth between subsidized Exchange coverage and Medicaid or the Children’s Health Insurance Program (CHIP). Children, especially children with special health care needs, can be greatly affected by even small gaps in care and coverage. Children with ongoing health concerns and their families 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.

To achieve continuity of care and coverage, states should:

- Establish common pediatric provider network standards between the Exchange and Medicaid and CHIP or require the Exchange to set pediatric network adequacy standards that overlap 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 change plans or move between public and private coverage.

- Adopt a broad definition of primary care providers under the Exchange network adequacy standard. Children, particularly children with complex or chronic medical conditions, often receive primary health care services through the pediatric subspecialist who...
is treating their underlying condition. For these children, a pediatric subspecialist is just as critical as a general pediatrician. In many cases, the subspecialist serves as the medical home for the child.

- **Require qualified health plans (QHPs) to cover all medically necessary services that are provided by essential community providers, including children’s hospitals that are eligible to participate in the 340B Drug Discount Program.** Unless QHPs cover all necessary services, children who move from Medicaid to a QHP will be at risk of losing coverage for critically needed services that they had received through the Medicaid Early and Periodic Screening, Treatment and Diagnosis (EPSDT) benefit.

- **Implement 12-month continuous eligibility.** Continuous eligibility would ensure that children maintain their current coverage and providers for an entire year, regardless of a change in income or family circumstance.

**Essential community providers**

QHPs must be required to contract with all essential community providers, including children’s hospitals eligible to participate in the federal 340B Drug Discount Program, that serve low-income and medically-underserved populations. Essential community providers, which include but are not limited to children’s hospitals and other entities specified in Section 340B, play a particularly important role in the care of low-income and critically or chronically ill and disabled children. These children require a broad range of medical, habilitative and rehabilitative services throughout their lives, which the essential community provider provision in the ACA is intended to address.

**Essential Health Benefits**

A comprehensive pediatric benefit must be included in the essential health benefits package. The benefit must include 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 particularly important that the benefit package include coverage for ancillary services utilized by 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.

**Governance**

Pediatric providers should be included in Exchange governance and policymaking entities. Pediatric providers, including subspecialists, offer a critical perspective on insurance coverage, health benefits, health plan purchasing, health care delivery, and important public health issues pertaining
to children. Many pediatric providers also have important insights about the challenges of moving between public and private coverage. These perspectives are invaluable to the design and implementation of an Exchange structure that effectively meets the health care needs of children and their families.

Therefore, states should:

- Include a pediatric provider on their Exchange governing boards
- Clarify conflict of interest requirements related to Exchange governance structures to allow health care providers to serve on governance boards. Specifically, unless a health care provider represents a particular health plan, that provider would not have a conflict of interest under the legislative intent of the ACA.
- Include pediatricians, pediatric subspecialists and others who care for children with complex and chronic conditions in the list of required entities for stakeholder consultation. Exchanges, and most importantly, covered families and children, will benefit from the input by providers who can directly address the impact of policy and programmatic changes on children’s health and health care.

**Network adequacy**

**Network adequacy standards for QHPs must ensure that children have reasonable access to the providers they need.** To prevent adverse selection and ensure there is fairness in the Exchange, all plans must meet the same network adequacy standards.

States should consult with pediatric health services researchers, providers, and consumers, including families of children with special health care needs, to develop appropriate pediatric-specific standards related to timeliness, quantity and types of providers, and monitoring. Based on that input, states should establish specific Exchange certification standards that require all QHP provider networks to:

- Include pediatric primary care providers, a complete range of pediatric subspecialists (e.g., pediatric neurologists, oncologists), and pediatric habilitative/rehabilitative therapy providers (e.g., occupational, speech and physical therapists), home care services, mental health and substance abuse professionals, vision and dental care providers, and pharmacists
- Overlap or share networks with Medicaid/CHIP to allow children to maintain continuity of care and providers if their situation changes and they move between public and private coverage
- Maintain sufficient numbers and types of pediatric providers to assure that services are accessible without unreasonable delay
• Ensure that a child can 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

• Undergo ongoing monitoring to ensure sufficiency of the network for children and families, including the identification of access barriers and steps to address those barriers

• Publicly disclose data related to their network adequacy (e.g. wait times, numbers and types of pediatric providers) for all populations

• Document wait times for children and improvement plans if benchmarks are not met

Provider payment

QHPs should be required to conduct meaningful negotiations for adequate payment rates for all necessary services provided by essential community providers, including children’s hospitals, as well as ancillary services provided by pediatric specialty and ancillary service providers. Adequate and fair payment policies for all providers are a key component of efforts to improve access and address provider shortages, particularly for children in need of specialty services.

• Adequate payment must be provided for the support services intended to address health care access barriers that are uniquely characteristic of essential community providers, such as language services, social service interventions, outreach and others. Reimbursement for those services is critical to provider capacity and essential community providers’ ability to fulfill their mission of providing care to those with inadequate access.

• Adequate payment must be provided for all components of patient-centered medical homes for high-need individuals, as well as primary care medical homes. The medical home model that encompasses a broad spectrum of services is particularly effective for children with complex and chronic medical conditions. Existing children’s hospital medical home programs for these children have documented higher quality of care, reduced costs, and improved outcomes and quality of life for enrolled children and their families. However, public and private insurers do not reimburse children’s hospitals in full for many of the services that are essential to these programs. QHP coverage of these programs would allow their expansion and replication in both the private and public markets.

• States should use pediatric-specific access standards to monitor adequacy of provider payment. The Exchange should work with children’s providers and other pediatric experts to develop appropriate access standards and require QHPs to publicly disclose data related to the access measures.

Quality

It is critical that state Exchanges build the infrastructure to comply with nationally developed standards for pediatric measure reporting, as required under the ACA\(^1\). It is also critical that Exchanges and QHPs play an active role in health care quality improvement

\(^1\) Federal guidance, as required under the ACA, on quality standards and measurement is expected in 2012
that address children’s unique health care needs. Exchange and QHP-based incentives can drive the development of delivery reforms that improve quality while controlling costs, such as medical homes, accountable care organizations and other integrated care models.

Role of Exchanges in ensuring high-quality pediatric care, including continuous quality improvement and measurement

- Ensure that pediatric-appropriate quality measures are included in quality and cost ratings for QHPs. Those measures must address the care provided to children with different needs and across different care settings.

- Engage with pediatric providers to identify QHP pediatric quality standards and measures, as well as plan rating metrics, starting with the CHIPRA core measures.

- Align QHP pediatric quality standards and measures with those in the state’s Medicaid program, the private insurance market outside the Exchange, and across QHPs.

- Choose plans to participate in the Exchange based on a set of high quality standards that address clinical, network adequacy and delivery reform models that can meet the health care needs of children, particularly those with complex and chronic conditions. For example, Exchanges could require plans to contract with providers that participate in medical home models, accountable care organizations or other integrated and coordinated care systems.

- Involve pediatric providers, consumers and other pediatric stakeholders in the design of payment models that reward plans for continuous quality improvement and other quality and patient safety activities, such as the use of health IT.

- Develop certification standards for QHPs that reward plans that collaborate with pediatric providers in the design of innovative delivery and payment reforms and contract with pediatric providers that are participating in delivery models that promote coordinated care.

- Collect consistent and regular data to assess the effectiveness of new delivery systems in controlling costs and improving health outcomes.

Role of QHPs in ensuring high-quality pediatric care, including continuous quality improvement and measurement

- Contract with pediatric providers that have demonstrated continuous quality improvement.

- Encourage providers to implement integrated and coordinated care models that improve patient experience and outcomes and lower costs, such as medical homes and accountable care organizations, through incentivizing payment policies and other contractual agreements.

- Include providers in the design of payment and other contractual incentives aimed at encouraging continuous quality improvement and delivery innovation.
• Design payment structures that cover the costs of the full spectrum of primary, specialty, and ancillary services, including care coordination and management

• Include information about pediatric coordinated and integrated delivery systems in consumer and patient marketing materials

For more information about state implementation of Exchanges that works for children’s health care, contact Jan Kaplan at (202) 753-5384.