The Children’s Hospital Association believes that existing federal guidelines related to the inclusion of essential community providers (ECPs) in Marketplace provider networks must be strengthened to ensure that low-income, medically underserved children have access to the full spectrum of primary, specialty and ancillary providers they need when they need them. In order to serve children adequately, networks must include one or more pediatric hospital providers, if available, that are in the geographic area of the Marketplace and maintain comprehensive pediatric specialty services.

Children’s hospitals across the country are actively engaged in their local communities to improve the health of the pediatric population. They are a vital safety net for all children, treating uninsured, underinsured, and publicly and privately covered children across the country. Although children’s hospitals are less than 5 percent of all hospitals in the U.S., they account for 45 percent of all pediatric inpatient days. Children’s hospitals serve the majority of children with serious illnesses and complex chronic conditions and most children in need of major surgical services. Children’s hospitals provide almost all of the care for children with cancer, cardiac conditions, cystic fibrosis and spina bifida.

Children’s hospitals have a unique perspective of children’s health care needs and the delivery of pediatric health care, particularly for children with chronic conditions and children with medical complexity. We understand the challenge of controlling costs while providing access to quality, coordinated and comprehensive health care. We are very concerned that the current federal requirements for network adequacy and ECPs are ambiguous and are exacerbating the trend toward narrow and tiered networks that exclude or limit ECPs. This trend has already resulted in Marketplace plans that do not have contracts with the children’s hospital in their service area. Instead, those plans have contracted with lower cost community hospitals that do not have the capacity to provide the specialized care that children need. In addition, some issuers are including children’s hospitals only in more expensive offerings. Lack of pediatric specialty care in networks, lack of transparency in coverage, burdensome pre-authorization processes, and high cost sharing put children and their families at financial risk and threaten children’s long-term quality of life.

Therefore, we recommend revisions to federal rules for the Marketplaces to require QHPs to contract with all ECPs, including children’s hospitals, where available. Please see the Association’s Consensus Statement, “Safeguarding Access to Medically Complex Care for Children by Requiring Health Plans and Exchanges to Develop Adequate Provider Networks” (June 2014) for a full set of recommendations related to the inclusion of children’s hospitals in public and private plan networks.

In the event that federal guidelines are not strengthened to require QHP contracting with all ECPs, we recommend, at a minimum, the following improvements to the current CMS and Office of Personnel Management standards:

- **The use of a minimum percentage threshold for ECP contracting should be reconsidered and replaced.** Ideally, QHPs should be required to contract with all ECPs, as Congress intended. The current 30 percent standard for ECP participation in provider networks does not guarantee a representative mix of ECPs nor does it ensure an adequate quantity of ECPs in the networks.

  In the event that a fixed minimum percentage for ECP participation is retained, it must be significantly increased with incentives to issuers to encourage them to move beyond that standard.

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1 These recommendations were shared with CMS in the Association’s Feb. 24, 2014 Letter to Marilyn Tavenner regarding the 2015 Draft Letter to Issuers in the Federally-facilitated Marketplace.
- **Children’s hospitals should not be grouped with other types of hospital ECPs under the current approach, which requires the offer of a contract to one provider within each ECP category.** The grouping of children’s hospitals with other hospitals in the “hospital” category allows issuers to contract with lower cost hospitals that do not have the capacity to provide the specialized care that children need, rather than with the children’s hospital in their service area.

Children’s hospitals should be in a separate category, rather than grouping them with other types of hospitals. When children are suffering from serious acute or chronic conditions, the variability of their illnesses and conditions requires the refined clinical capabilities of pediatric specialty care found only in children’s hospitals.

Non-children’s hospitals have little capacity to provide the continuum of care that very sick children need and that children’s hospitals provide. A recent analysis by the Children’s Hospital Association of the availability of pediatric specialty services in 13 states shows a distinct concentration of capacity in children’s hospitals—the children’s hospitals provide, on average, more than six-fold the number of selected pediatric services than seen in non-children’s hospitals, and have more than 25-fold the number of pediatric designated beds. Furthermore, a survey of our member hospitals located in three states indicates that children’s hospitals see greater than 60 percent of all occurrences for 21 different pediatric services. For example, in these three states, children’s hospitals provide care to over 80 percent of the pediatric population in need of rheumatology services. The non-children’s hospital simply cannot adequately care for children who need specialty care.

- **QHPs must be required to contract with a sufficient number of ECPs in each category, rather than simply demonstrate that they have offered contracts in “good faith” to at least one ECP in each category.** An offer without a contract does nothing to ensure that the QHP network has the appropriate mix of providers even when it meets the minimum ECP participation standard. A network should contain a sufficient number of contracted ECPs to provide a choice. In addition, the safe harbor of just one ECP hospital per county as set forth in the “2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM)” may not provide sufficient capacity and access to services, particularly in a county with a large population.

If the “good faith offer” standard is retained, it must be strengthened to require a competitive offer of reimbursement rates that is comparable to other commercial product rates and is for all covered services. Furthermore, the contract must not allow issuer practices that can impede children’s access to needed specialty care, such as complicated and stringent prior approval requirements.

In some states, issuers have offered ECPs extremely low reimbursement rates; in other states, ECPs are being tiered into less attractive and more expensive plans for consumers or are being offered contracts for a limited set of services rather than the full complement of services otherwise covered by the plan. In addition, in some instances, plans are adopting stringent prior authorization and other procedures that prevent children’s access to timely care and cause undue stress for families and administrative burdens for providers. Taken together, these practices will undermine the ability of ECPs to continue to serve the millions of patients who depend on them for quality care.

- **Consumers and providers must be able to easily access the information they need about the QHP provider networks on the Marketplace websites.** All QHPs should be required to release a list of the ECPs with which they have contracted during each plan year. Those lists should be easily available on the Marketplace websites. We continue to hear from ECPs that do not know if they are in the networks of some QHPs and who are beginning to see patients who were

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2 Limited to pediatric services reported in the American Hospital Association database 2011: general pediatric medical/surgical care, PICU care, pediatric cardiology service, pediatric diagnostic catheterization service, pediatric interventional cardiac catheterization, pediatric cardiac surgery, pediatric cardiac electrophysiology, children’s wellness program, pediatric emergency department, child/adolescent psychiatric services, teen outreach services.
not aware that the network does not include that provider until they sought care. A public list combined with an improved website design will improve the consumer experience during the enrollment process and will enable them to make the most appropriate choices when a health issue arises.

The exclusion of children’s hospitals from networks is already having an impact on children’s access to care. In Seattle, this exclusion leaves children enrolled in these plans without access to many specialty services, such as level IV neonatal intensive care and heart, liver and intestinal transplantation, for which this hospital is the only regional provider. The hospital has added four new staff positions in order to submit more than 870 requests, to date, to insurance carriers for “benefit level exceptions” to receive in-network benefits because the hospital is out-of-network. Securing care and coverage for these families has imposed not only an administrative and financial burden on the hospital but an unnecessary emotional burden on families that face delays in care for their children.

On the other hand, we are pleased that some states, including Connecticut and Minnesota, have recognized the important role that ECPs play in meeting the health care needs of low-income and very sick children. Connecticut has adopted a high threshold for inclusion of ECPs in QHP networks that all but guarantees full access to needed services. Minnesota has taken a unique and promising approach through the enactment of legislation that requires pediatric hospitals and their affiliated clinics to be designated as ECPs. The legislation is intended to ensure pediatric hospitals the ability to participate in all product offerings on Minnesota’s marketplace so all families can access primary and specialty pediatric care. These types of stronger ECP contracting standards are critical if the health care needs of these children and others who require specialized care will be met under the ACA.

We know from extensive academic literature that improved outcomes are linked to the volume of care provided. We also know that delays in accessing timely and appropriate care can be expensive and lead to poor quality outcomes for any patients; for children delayed and/or inappropriate care can be catastrophic for their development and long-term health. Children who do not have timely access to a children’s hospital and its cadre of specialty providers will see less qualified or experienced providers in less appropriate settings. As a result, they are at risk of adverse outcomes, which not only threaten their very health and well-being in the short and long-term, but result in higher costs for the family, provider and payor.