State Network Adequacy Standards and the National Association of Insurance Commissioner’s Health Benefit Plan Network Access and Adequacy Model Act

Background

There has been an increased focus across the nation on the development of stronger national and state standards for network adequacy. Specifically, the National Association of Insurance Commissioners (NAIC), Centers for Medicare and Medicaid Services (CMS), Office of Personnel Management (OPM), as well as states have been considering the adoption of updated and stronger network adequacy standards for private insurance plans inside and outside of insurance Exchanges, in Medicaid, and in CHIP. In most instances, states will retain their responsibility for health plan oversight and will need to adopt or modify the relevant standards for the private and public plans in their markets.

Overview of NAIC model standards

On Nov. 22, 2015, the NAIC adopted new model network adequacy standards (“Model”) for private health insurance plans. On Feb. 29, 2016, CMS announced that it will delay issuance of discrete federal quantitative standards for qualified health plans (QHPs) in the federally facilitated Exchanges to allow states to adopt the NAIC Model. States must now decide whether to adopt the standards in the Model in part or in whole. If a state adopts the Model, the standards will apply to all private insurance plans with provider networks inside and outside of the Exchanges.

The Children’s Hospital Association and American Academy of Pediatrics actively participated in the NAIC stakeholder process, with the American Hospital Association, American Medical Association, American Heart Association, and other allied organizations. As a result of this united advocacy, the Model contains several new important provisions to improve children’s access to care. In particular, the NAIC Model includes:

- Specific references to “children and adults.” Previous standards referred to “covered persons” without specifically highlighting children.

- Specific protections to help guarantee that children and families have access to the services they need through in-network health care providers

- Provisions that address the needs of children and adults with “serious, complex or chronic conditions”

1 The NAIC has stated that adoption of the Model by a majority of states within three years is a priority for the organization.
• A requirement that plans indicate how their provider networks will include essential community providers (ECPs), when appropriate

• Provisions that recognize the regionalization of specialty care, which may require individuals to travel across state lines

• Protections for children in “active treatment” when their provider leaves the network

• A requirement that the type of hospital (e.g. children’s, cancer, rehab) be identified in provider directories and that directories include information about network tiers

• Some specific precautions and consumer protections related to tiered provider networks

**Needed improvements to the Model for children**

Though the Model made some important progress towards improving network adequacy standards for children, there is more work to be done. Children are not little adults and require in-network pediatric providers who have the specific clinical expertise, capacity and experience to appropriately diagnose and treat them. A network that lacks the full range of pediatric providers, particularly pediatric specialty care providers, places children and families at financial risk and threatens children’s long-term quality of life. Furthermore, availability of pediatric specialty care is often regional, meaning children may have to travel long distances and across state lines to receive necessary care from appropriate pediatric providers.

Therefore, the Model should be strengthened in the following areas to address the important differences between children’s and adults’ health care needs and their health care systems:

• All provider networks must be capable of providing in-network services for all levels of medical complexity, including for rare conditions, without administrative or cost barriers for consumers, even when the network is narrow, tiered or limited in some fashion

• Networks should include the full range of pediatric primary, specialty and subspecialty providers who typically care for children, including one or more ECP children’s hospitals, where available, that maintain comprehensive pediatric specialty services

• Plans must not be allowed to rely on out-of-network arrangements, exception processes and other mechanisms that delay or fragment care. Out-of-network arrangements should be allowed only for extremely rare services or when timely access to the type of provider a child needs cannot be assured.

• A child must not be penalized by the health plan through extra cost-sharing or administrative hurdles in the rare circumstance when that child must use an out-of-network provider

• Network adequacy standards must apply to the lowest cost-sharing tier in tiered provider networks to allow children to have access to a full range of providers for all covered services with no additional cost-sharing or administrative barriers

---

2 For a full set of principles for network adequacy and children’s access to specialty care see [Safeguarding Access to Medically Complex Care for Children by Requiring Health Plans and Exchanges to Develop Adequate Provider Networks](https://www.childrenshospital.org/files/For%20Act%20Members%20Only/Policy%20Statements/Network%20Adequacy%20for%20Children.pdf), Children’s Hospital Association, October 2014.
• States must use a broad set of objective, measurable standards to determine a plan’s network adequacy. The standards must reflect the unique needs of subpopulations and age groups, including children.

The following guide provides important information for child health advocates regarding the specific provisions of the Model that should be supported and/or revised to ensure children have access to in-network pediatric providers with the training and expertise to meet their unique health care needs.

Overview of the structure and format of the NAIC Health Benefit Plan Network Access and Adequacy Model Act

How are NAIC models utilized by the states?

The NAIC develops model legislation and rules for use by states to promote uniformity. Each state decides what, if any, parts of a model should be adopted. This creates an opportunity for stakeholders to advocate for changes during each state’s legislative or rulemaking process.

Would the standards in the Network Access and Adequacy Model (Model) apply to Exchange plans?

Yes. State insurance regulators have authority over network standards for all commercial plans, inside and outside of the Exchanges, except for those that are self-insured. The federal government has delayed indefinitely the development of alternative standards for plans in the federally facilitated Exchanges so state rules will govern those plans as well.

On the other hand, in most states, the Model would not apply to Medicaid managed care plans because those plans are not usually regulated by state insurance commissioner. New federal rules for Medicaid managed care plans are expected in late spring 2016.

Can the language of the Model be changed?

Yes, states can, and often will, modify the language of NAIC models to meet certain policy or political goals. Some states may have the authority to adopt the standards in this Model through administrative rulemaking, while others may need to have it enacted by their legislature.

What should we look for when reviewing the Model?

The Model is formatted in a series of sections all of which may or may not be incorporated in each state’s laws or rules. If the state does not adopt the entire Model, it will be necessary to refer to the state’s existing statutory and regulatory language to assure harmony with new provisions. For example, a state may choose to retain an existing definition, rather than adopting the Model definition, potentially resulting in a significant difference in meaning.

Why should we carefully review the “drafting notes?”

Drafting notes provide guidance or suggestions to states about things to consider during the adoption and implementation process. The drafting notes for this Model were added as compromises when there was
no consensus on including a provision in the actual statutory language. However, drafting notes are often overlooked during implementation by state officials and their usefulness will fade over time.

Therefore, all of the drafting notes should be reviewed carefully. In some cases, advocacy should focus on the incorporation of the drafting note into the actual proposed legislation or rule. In other instances, drafting notes may provide insight into positions that are not necessarily aligned with child health advocates’ positions.

**What do the brackets in the text of the model mean?**

Some of the sections contain bracketed language which may, or may not, ultimately be included in a state’s proposed legislation or rule. The bracketed language reflects language for which there is a lack of agreement. The language should be analyzed to determine whether it is important for children’s health care access in the state.

---

**Section-by-Section Advocacy Guide – Table of Contents**

**Definitions – Section 3 (pages 5-7 of this Guide)**

- Covered person
- Emergency medical condition and Emergency services
- Essential community provider (ECP)
- Health care services
- Primary care / Primary care professional / Specialist / Specialty care
- Tiered network

**Network Adequacy – Section 5 (pages 7-11 of this Guide)**

- Overall network adequacy provisions
- 24-hr. emergency care
- Plan marketing
- Network adequacy evaluation criteria
- Regionalization of specialty care
- Access to out-of-network services
- Access to participating providers with requisite expertise
- Access plan
- Content of access plan

**Requirements for health carriers and participating providers – Section 6 (pages 11-13 of this Guide)**

- Provider selection/tiering criteria
- Review and transparency of selection criteria
Section-by-Section Advocacy Guide

Definitions – Section 3

Section 3 of the Model is very important as simple changes to, or failure to adopt, a definition can have a significant impact on the interpretation and application the Model.

The following are definitions of interest to children’s advocates.

❖ “Covered person” – Section 3.E (pg. 2)³ – Indicates the types of individuals covered under the health benefit plan.

**Significance for children:** The definition is very broad and does not differentiate between adults and children.

**Action for advocates:**
- Whenever possible the phrase “children and adults” should be used throughout the legislation or regulation to draw attention to children to emphasize the importance of considering the network’s ability to serve the unique needs of children.
- Advocates should also seek the following change to the definition, indicated by brackets: “Covered person” [means a child or adult] policyholder, subscriber, enrollee or other participating in a health benefit plan.”

❖ “Emergency medical condition” and “Emergency services” – Section 3. F and G (pgs. 2-3) – “Emergency medical condition” clarifies the types of conditions, including mental and behavioral health conditions, that would be considered emergencies and warrant these protections. The definition of “emergency services” describes the related services.

**Significance for children:** These definitions have important financial and access implications for children because the Affordable Care Act (ACA) prohibits higher cost-sharing or prior approval for out-of-network emergency medical services. In addition, the inclusion of references to mental and behavioral health conditions and services expand access to services for children in crisis.

**Action for advocates:**

³ The section and page numbers throughout this section of the guide refer to the sections and pages of the Model.
• Request that the state review and update its definitions if they are not at least as robust as the Model’s
• Assure that references to “mental and behavioral health” are included in the definitions
• Be sure that any proposed changes that deviate from the NAIC model do not result in limits on appropriate treatment for children. For example, a definition that limits treatment to the nearest hospital emergency department may result in a child receiving care in a setting without pediatric clinical expertise or capacity.

❖ “Essential community provider” (ECP) – Section 3.H (pg. 3) – This definition mirrors the definition found in the ACA, which requires Qualified Health Plans (QHPs) to include ECPs in their networks.

Significance for children: Children’s hospitals are generally considered to be ECPs because they serve low-income and vulnerable children. Therefore, any provisions that reference ECPs and their inclusion in networks may impact the appropriateness of provider networks for children’s access to care.

States are generally permitted to have more stringent requirements than the requirements under the ACA. For example, non-QHP networks are not required to include ECPs, but some states have established ECP minimum standards for both QHPs and non-QHPs that go beyond the current federal standards.

Action for advocates:
Advocates should seek:
• An expansion of the definition to specify ECP types, such as children’s hospitals.
• Specific reference to children in the definition, indicated in brackets below, to highlight their unique health care needs and the unique capabilities of children’s hospitals to care for them. “ECP means a provider that serves predominantly low-income, medically underserved [children and/or adults], including a health care provider…”

❖ “Health care services” – Section 3.M (pg. 4) – A foundational definition that also clarifies that the treatment of mental health and substance use disorders are a type of health care service.

Significance for children: Many states have definitions of “health care services” that are either silent, or specifically exclude mental and behavioral health conditions. A specific reference to mental and behavioral health services will help assure that networks will provide sufficient access to these types of services.

Action for advocates: Urge legislators/regulators to adopt the expanded definition of health care services to assure that mental health and substance use disorder benefits are included.

❖ “Primary care” / “Primary care professional” / “Specialist” / “Specialty care” – Sections 3.V-Y (pg. 5) – These sections define categories of health services by level of care.

Significance for children: These are important definitions that support and clarify several sections throughout the Model. They also address the need for subspecialists who are trained to care for conditions that affect subpopulations or certain ages. These references help highlight the importance of having specialty care providers in-network with the training and expertise to provide age-appropriate care, such as pediatric specialty hospitals.

Action for advocates: Encourage legislators/regulators to adopt these definitions as written to retain the references to specific subpopulations and ages.

❖ “Tiered network” – Section 3.AA (pg. 6) – Defines networks that place providers and facilities into specific groups/tiers with different patient cost-sharing amounts or administrative hurdles, such as prior
Tiered networks are utilized by carriers as a means to control cost, utilization, quality or to otherwise incentivize enrollee or provider behavior.

**Significance for children:** Tiered networks may place specialty providers, such as children’s hospitals, in tiers with higher cost-sharing or strict prior authorization requirements, which results in a financial burden on families and may impede timely access to care.

**Action for advocates:** Urge legislators/regulators to include a definition of “tiered network” in the standards to ensure that network adequacy standards address the growing use of these types of networks and that all network adequacy protections apply to the lowest cost-sharing tier.

---

**Network Adequacy – Section 5**

Section 5 is the most substantial section of the Model as it sets forth the requirements/measures that determine whether a network is adequate and provides sufficient access to in-network providers. It also sets standards for how a carrier is to provide access if there are an insufficient number and/or type of providers in the network.

- **Overall network adequacy provisions – Section 5.A (1) (pg. 7)** – This provision establishes the framework for measurable network adequacy criteria which requires carriers to maintain networks that:
  - Contain a sufficient number of appropriate types of providers
  - Include providers that serve predominantly low-income, medically underserved individuals, including children and adults
  - Assure access without unreasonable travel or delay

**Significance for children:** This section is extremely important for children because it includes three key concepts:
- Networks must be sufficient to assure that all covered services are available from in-network providers
- Networks must include “appropriate types of providers,” which implies that providers with the requisite pediatric expertise and training should be in-network to care for children
- The specific reference to “children” reinforces the need to assure that networks have sufficient providers for all age groups and subgroups

**Action for advocates:**
- Seek the inclusion of this section in state law or regulation as it establishes the framework and context for the rest of the standards
- Ensure that the reference to children is retained. State legislators/regulators may need education about the unique needs of the pediatric population. It is important to emphasize that “children are not little adults” and their unique health care needs must be met by the appropriate primary and specialty care providers and facilities.

- **24-hr. emergency care – Section 5.A (2) (pg. 7)** – Requires plans to ensure that enrollees have 24-hour access to emergency services.

**Significance for children:** The provision in the Model does not specify that networks include emergency services equipped to care for children.
Action for advocates: Seek a modification to this provision to clarify that pediatric emergency services must be available for children enrolled in the plan. Suggested language is in brackets below: “Covered persons shall have access to emergency services twenty-four (24) hours per day, seven (7) days per week [and children will have access to a pediatric emergency department, when available].”

Plan marketing – Section 5.A Drafting Note (pg. 7) – The drafting note contains important information about tiered networks and other potentially discriminatory network designs.
- It warns legislators/regulators to be aware of how tiered networks are marketed
- It cautions legislators and regulators to review tiered and other network designs to assure that they are not discriminating against children and adults with serious, chronic or complex medical conditions by denying proper access to in-network providers

Significance for children: An increasing number of tiered plans are excluding children’s hospitals and other pediatric specialty providers from the lowest cost-sharing tier, or from the network altogether. This creates financial and administrative barriers to access for children with serious, chronic or complex medical conditions, which could be considered discriminatory, as referenced in the Drafting Note. The ACA specifically prohibits discrimination based on health status.

Action for advocates: Seek the incorporation of the drafting note provisions into legislative or regulatory language. Specifically, carriers should be required to disclose all information regarding the design of the tiered network, including cost-sharing and prior authorization requirements of each tier.

Advocates should emphasize to legislators/regulators that:
- Carriers that seem to be using tiered network designs to “avoid risk” may be discriminating based on health status
- Tiered networks that do not include all levels of pediatric care providers (primary, specialty, and tertiary) in the lowest cost-sharing tier discriminate against children with serious, chronic or complex medical conditions based on their health status
- Pediatric specialty services must be provided with the same level of pre-authorization or utilization review processes as similar conditions for adults

Network adequacy evaluation criteria – Section 5.B (pg. 7) – Delineates nine suggested criteria that the state may use to evaluate a plan’s network sufficiency.

Significance for children: The network criteria in this section are suggestions for state legislators/regulators to consider when developing their own standards. To adequately measure the sufficiency of a network for children, it is important that the state adopt a broad set of metrics and not rely on just one of the suggested metrics in this section, given the regionalization of pediatric health care, and shortages of some pediatric subspecialists. In particular, the sole use of distance standards is not an appropriate metric for children’s access to the specialty care provided at a children’s hospital.

Criteria #7 is particularly significant for children. It requires networks to meet the needs of “children and adults with serious, chronic or complex medical conditions….”, which can help assure that networks are assessed for their inclusion of pediatric specialty providers and are not designed in a manner that discriminates based on their health status.

Action for advocates: Urge legislators/regulators to:
- Adopt a set of metrics from the suggested list to adequately and appropriately measure network adequacy, particularly for children’s access to pediatric specialty care
• Incorporate criteria #7 into any state standards so networks are specifically required to include pediatric primary and specialty care providers and facilities that meet children’s unique physical, mental and behavioral health needs.

• Seek the following refinements of the criteria, indicated in strikethroughs and brackets below:
  o Provider-covered person [child and adult] ratios by [pediatric and adult] specialty [and subspecialty]
  o Geographic accessibility of [pediatric and adult] providers
  o Geographic variation and [pediatric and adult] population dispersion
  o Waiting times for an appointment with participating [pediatric and adult] providers[, including specialists and subspecialists]
  o The volume of technological and specialty care services available to serve the needs of covered persons [children and adults] requiring…

❖ Regionalization of specialty care – Section 5.B Drafting Note # 1 (pg. 8) – This drafting note provides guidance on additional network adequacy criteria, including the regionalization of specialty care, that could be incorporated into state standards. The drafting note specifically addresses the potential need for “some children and adults to cross state lines for care.”

Significance for children: This drafting note highlights the regionalization of pediatric specialty care. It is not unusual for children with serious, chronic or complex medical conditions to travel long distances and/or to another state for care.

Action for advocates: Use this drafting note to:
• Educate state legislators/regulators about the importance of assessing issuers’ inclusion of out-of-service area providers in their network to assure children in-network access to the full range of covered services
• Advocate for a requirement that carriers set up arrangements with appropriate pediatric specialty providers, including hospitals, to assure children’s access to all covered services. These arrangements should be established in advance so that the agreements are fully in place before they are needed.
• Emphasize that single-case agreements executed at the time of admission delays care and puts the patient and hospital at risk for unanticipated expenses

❖ Access to out-of-network services – Section 5.C (pg. 8) – Requires carriers to have a process in place to assure enrollees have access to out-of-network providers when there are no appropriate in-network providers. The specific circumstances that warrant such a process are described, but the process itself is left up to the carrier, within certain parameters that require:
  • Notice regarding the process
  • An in-network level of cost-sharing for the enrollee who must go out-of-network
  • Assurances of timely access to out-of-network providers
  • Documentation of all out-of-network requests
  • The out-of-network referral process cannot be a substitute for a sufficient provider network

Significance for children: Section 5.C offers some protections for children who may need to go out-of-network for certain specialty providers, particularly if their condition is rare or unusual. These include:
• In-network cost-sharing levels
• Timely access to out-of-network providers
• An assertion that an “out-of-network process” is not a substitute for a sufficient network as measured through the criteria established by the state. Therefore, when a state’s standards are sufficiently robust and reflect the uniqueness of pediatric health care, there may be little or no need to use an out-of-network process.
Though Section 5.C requires an in-network level of cost-sharing it does not hold patients harmless from balance ("surprise") billing.4

**Action for advocates:** These consumer protections should be included in any state legislation or rule. Advocates should:

- Remind legislators/regulators that networks must include the full range of in-network pediatric providers, from primary through the most specialized. If a network is sufficient, an out-of-network request will be necessary only in extremely rare circumstances.
- Consider seeking additional language to protect enrollees from potential balance billing in addition to the section’s cost-sharing protections. Suggested language is in brackets below:

  “(3) The health carrier shall treat the health care services the covered person receives from a non-participating provider pursuant to Paragraph (2) as if the services were provided by a participating provider, [at no greater overall cost to the covered person than if the than if the benefit were obtained from an in-network provider].”

**Access to participating providers with requisite expertise – Section 5.D (pg. 9)**— Requires carriers to establish and maintain reasonable access to participating providers. Assessment of carrier compliance with this requirement will take into account the relative availability of providers with the “requisite expertise and training” to provide services.

**Significance for children:** The clarification that consideration should be given to the reasonable availability of health care providers “with the requisite expertise and training” may help assure that networks specifically include pediatric providers. Pediatric specialists and subspecialists will have the unique training and expertise to care for children.

Carriers are also required to monitor their networks on an ongoing basis to assure ongoing adequacy, which may offer further protections for enrollees.

**Action for advocates:**

- Encourage states to adopt these provisions, even if they have similar language in existing standards, as it is unlikely that the older standards includes the Model’s language regarding access to providers with the “requisite expertise and training”
- Educate legislators/regulators about the regionalization of pediatric specialty care
- Seek clarification that these provisions will not prevent carriers from including distant facilities and providers, including those that are out-of-state, from their networks
- Remind legislators/regulators that “relative availability” of providers should not be measured solely through traditional time and distance standards, which are not an accurate measure of children’s access to children’s hospitals.

**Access plan – Section 5. E(1) and Drafting Note (pg. 10)**— Requires carriers to file an “access plan” with the state. The access plan is an important regulatory tool that provides a detailed description of how the network assures access to in-network and out-of-network providers. The drafting note with this section describes the states’ enforcement options for the access plan – “review” or “prior approval.”

---

4 Failure to establish an adequate network of “in-network participating” providers may result in families’ receipt of “surprise” balance bills. States may choose to address surprise balance billing in their network adequacy standards or in separate legislation/regulation. Advocates will want to ensure that children and their families are held harmless for surprise bills and that out-of-network providers are paid appropriately.
Significance for children: The access plan requirements in the Model include important protections for children. However, the Model’s flexibility regarding the enforcement (i.e., states may choose “review” or “approve”) of the plan weakens its utility as a tool to ensure that networks meet children’s unique health care needs.

Action for advocates: Seek a requirement that the commissioner must approve the access plan prior to a carrier selling the product. Suggested revisions are indicated in strikethroughs and brackets below: “…a health carrier shall file with the commissioner [for approval] prior to or at the time it files a newly offered network.”

❖ Content of access plan – Section 5(F) (pg. 11) – Delineates the minimum contents of the access plan.

Significance for children: The following provisions of the access plan have particular implications for children’s health care:

- How the carrier’s network may use telemedicine. As written, the provision may be interpreted to mean that telemedicine could be used in lieu of in-person visits, rather than to augment a network.
- The procedures used to make and authorize referrals within and outside of the network.
- The factors the carrier used to build its network, including tiers.
- How the carrier will address the needs of children and adults who face disability, cultural or health challenges, including if there are essential community providers in the network, if appropriate.
- How the carrier will assess the health care needs of its enrollees and their satisfaction with services.
- The carrier’s methods for informing enrollees of its coverage policies, including benefits, grievance and appeals procedures, referrals, updates to provider directories, etc.
- The carrier’s system for ensuring coordination and continuity of care when enrollees are referred to specialists, discharged, or lose their provider as a result of contractual changes.

Action for advocates: Encourage legislators/regulators to adopt all the provisions of the access plan in the Model with the following additions and refinements:

- There should be separate procedures and requirements documented in the plan for children’s access compared to adults’.
- The plan must reflect the uniqueness of the pediatric health care system.
- Carriers must demonstrate that they have included a children’s hospital essential community provider in their network.
- The legislation/regulation must clarify that telemedicine should be used to augment an adequate network.

Requirements for health carriers and participating providers – Section 6

Section 6 deals with how a carrier builds its network and selects its providers, and how care is transitioned if the provider or facility leaves a network.

❖ Provider selection/tiering criteria – Section 6.F (pg. 14) – Sections 6.F (1) and (2) require carriers to describe their standards for selecting/tiering providers and facilities. Section 6.F (3) prohibits the selection criteria from discriminating against high-risk populations by excluding or tiering providers that treat those individuals.
Significance for children: These provisions prevent carriers from avoiding risk by excluding specialty providers, such as children’s hospitals, in their networks or placing them in higher cost-sharing tiers.

Action for advocates: These provisions should be included in any proposed legislation or rule to prevent network designs that could be discriminatory because they impede children’s access to needed specialty care necessary to treat their chronic or complex medical conditions.

❖ Review and transparency of selection criteria – Section 6.G. (pg. 15) – Requires the carrier to make its standards for selection/tiering available for review by the commissioner, and a description in plain language available to the public.

Significance for children: The public availability of the selection standards is an important oversight resource for stakeholders, particularly when there is concern that the network is not sufficient or may be discriminatory.

Action for advocates: Use this provision to:
• Educate legislators/regulators about the implications of narrow, limited and tiered networks on children’s access to specialty care
• Encourage legislators/regulators to require a review of tiered network selection standards to assure that all covered services, including pediatric specialty care, are available in the lowest cost-sharing tier

❖ Notice of network change – Section 6.L(1) and Drafting Note (pg. 16) – Requires the carrier to notify patients, within 30 days, when their regular provider leaves the network, with or without cause. The drafting note following Section 6.L. (1)(a) sets forth some public policy issues a state may wish to consider when a provider leaves or is reassigned to a “higher cost-sharing tier” in a tiered network

Significance for children: Children with serious, chronic or complex conditions often establish a long-term reliance on their providers. It is extremely important that they have at least 30 days notice, along with a transition plan, if their provider leaves the network. (Section 6.L (2) establishes continuity of care requirements.)

Notice requirements are also extremely important when a provider is moved to a different tier with higher cost-sharing. A change in tiers could have significant financial implications for the family of a child with a serious, chronic or complex health condition and may necessitate a change in provider mid-plan year.

Action for advocates: Encourage the following changes to strengthen the notice requirements:
• A longer notice period to assure that adequate time is available to implement a transition plan, especially when an alternative facility or specialist may not be available to treat the patient
• Specific requirements that apply to changes to the network’s mental/behavioral health providers. Children develop a particularly strong reliance on these providers and could suffer severe consequences if sufficient notice is not given to identify a new appropriate provider.
• Specific notice standards for tiered network changes

❖ Continuity of care and transition requirements – Section 6(L)(2) (pgs. 16-18) – Establishes continuity of care protections for enrollees when their provider leaves the network. Under those protections, current treatment may continue to the earlier of:
• Termination of treatment
• 90 days, unless a longer period is deemed necessary by the carrier’s medical director
• Care is transitioned to a new provider
• The plan’s benefit limits are met
• Care is no longer medically necessary

The carrier’s medical director, in consultation with the treating provider, reviews and approves continuity of care requests following specific processes outlined in this section. The original provider must agree to accept the same payment form, and terms and conditions as provided in the original provider contract.

**Significance for children:** Children are eligible for the continuity of care protections if they are:
• In an “active course of treatment,” or
• Have a “life threatening condition” or “serious acute condition,” or
• They are in an ongoing course of treatment and the discontinuation of treatment by their provider would worsen their condition or interfere with anticipated outcomes

As drafted the continuity of care process in the Model may not meet children’s unique needs. Specifically:
• The 90-day limit for a transition plan may not be sufficient to ensure that a new provider can be found and that the child will not experience health setbacks by a change in provider
• A child with a chronic condition who has developed a strong reliance on the provider may experience a health decline if the provider is changed too quickly
• It may not be possible to find an alternative in-network pediatric provider, given the regionalized nature of pediatric specialty care
• A child who is receiving mental health or behavioral health services faces more profound challenges transitioning to a new provider
• The reliance on carriers’ medical directors for the review and approval of requests could be problematic for children. They typically do not have pediatric health care expertise and may not have an understanding of their unique needs and the regionalization of pediatric specialty care.

**Action for advocates:** Seek to strengthen these provisions by allowing the child to stay with the current provider for up to 12 months, unless the treating physician determines that:
• The current course of treatment is no longer necessary or
• The patient has successfully transitioned to an in-network provider of the same specialty who is able to provide such care

---

**Provider directories – Section 9**

Section 9 outlines the content and format requirements for provider directories, which are a critically important consumer information tool.

❖ **Provider directories – posting and updates – Section 9.A(1-2) (pgs. 25-26)** – Requires carriers to electronically post a current, accurate provider directory for each plan, which must be accessible and updated at least monthly.

**Significance for children:** These provisions will help improve the accuracy of provider directories to ensure families have the most up-to-date and accessible information. Inaccurate directory information may cause families to unnecessarily choose out-of-network providers, resulting in significant financial burden, administrative obstacles for providers, and harmful delays in treatment for children.
Action for advocates: Advocates may want to seek more frequent directory updates to improve accuracy. Ideally, updates should be in real time.

Provider directories – general content – Section 9.A(4) (pg. 26) – Specifies that provider directories must include the following information “in plain language”:
- Criteria used to build the network
- Criteria used to tier providers and how tiers are designated
- Any prior authorization or referral requirements

Significance for children: This section provides critical transparency protections for families by allowing them to understand how a carrier has built their network. Information about narrow and tiered networks is particularly important because children’s hospitals are often placed in higher cost-sharing tiers or excluded from limited networks. Additionally, prior authorization and referral requirements can result in significant care delays; it is critical this information is disclosed to families.

Action for advocates: Encourage legislators/regulators to:
- Ensure that information on network design criteria, prior authorizations and referrals is required in provider directories
- Require directories to include information on coverage and costs of out-of-network care

Provider directories – information about hospitals – Sections 9.B and C (pgs. 26-28) – Specifies the provider information that must be included in the directories. There are specific information requirements regarding hospitals, including the following in a searchable format (info must also be available in print, upon request):
- Hospital name
- Hospital type (i.e., acute, rehabilitation, children’s, cancer)
- Participating hospital location
- Hospital accreditation status

Significance for children: The requirement that carriers disclose “hospital type” is new. It is important to maintain this requirement to alert families that a children’s hospital or other specialty hospital is available in-network for their child. This information allows families to make informed health coverage and care decisions to meet the needs of their children. This is especially important information when a child with a serious, chronic or complex health condition is in need of tertiary health care as it can help ensure that the most appropriate type of hospital with the requisite pediatric expertise is utilized.

Action for advocates: Work to ensure that the Model’s specific information requirements about hospitals are included in state legislation or regulation.

For more information to support state-level advocacy to strengthen pediatric network adequacy standards, contact:
Jan Kaplan, Children’s Hospital Association, 202-753-5384
Kelly Whitener and Sean Miskell, Georgetown University Center for Children and Families

Back to Table of Contents