

CHAPTER 4

Provider Networks and Access: Issues for Children's Coverage

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Key Points

- The adequacy of exchange plan networks for children has been a key feature of discussions concerning children who may move from separate CHIP programs to exchange plans if CHIP funds are exhausted during fiscal year 2016. At issue is whether such networks will be sufficient for the needs of these children. However, there is little research to determine whether network differences among Medicaid, CHIP, and exchange plans would significantly affect children's timely access to appropriate care.
- Network adequacy standards are one of many tools used to help ensure access to care. The design of provider networks must take into account the medical needs of children in different stages of development as well as the supply and distribution of providers who care for them. The needs of children with special health care needs, who comprise almost one quarter of CHIP enrollment, are also important to consider.
- Monitoring network adequacy is an important component of program oversight, particularly because plans across all payer types increasingly rely on narrow networks to control costs. Federal network adequacy requirements are similar for CHIP, Medicaid, and exchange plans, but specific monitoring activities vary.
- While plans and consumers look for adequate provider networks at a reasonable cost, plans face constraints in building their networks. For example, providers that are the only facility of their type in a region may demand higher rates than a plan is willing or able to pay. In addition, plans contracting with specialists who care for high-risk patients may attract a greater share of children with such needs, placing the plan at a financial disadvantage relative to plans with fewer such enrollees.
- Consumers need accurate information about networks to help them evaluate which networks are most likely to meet their needs and to inform them about the mechanisms for securing specialty care services when medically necessary.
- Ensuring network adequacy is an essential component, but not the sole component, in a strategy for making care accessible. Payers and issuers need other tools to ensure accessible care and for monitoring both process as well as outcome measures. More work needs to be done in order to develop appropriate access metrics and monitoring plans.
- MACPAC will continue to monitor network adequacy issues with a particular emphasis on children's access, measures of network adequacy, network transparency, and ways in which plans and payers can balance access, quality, and cost.

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Network adequacy and access to care affect the quality of health care received by all children, whether they are enrolled in Medicaid, the State Children's Health Insurance Program (CHIP), or exchange plans. If CHIP funding is exhausted in 2016, a projected 3.7 million children will lose their separate CHIP coverage. Of these, an estimated 1.4 million, or 36.5 percent, are likely to enroll in subsidized exchange coverage, as described in Chapter 1. Commission discussions on the future of CHIP have raised concerns about whether the provider networks used by exchange plans are adequate to address the health care needs of children enrolled in separate CHIP. Although we have little definitive evidence regarding network differences among exchange plans, Medicaid, and CHIP, we have identified a number of issues that must be weighed when considering the adequacy of provider networks for children in general and for children in exchange plans in particular.¹

Oversight of network adequacy is essential for ensuring access to care for an insured population. MACPAC began reporting findings about our research into network adequacy for children in its June 2014 *Report to the Congress on Medicaid and CHIP* (MACPAC 2014). We have extended this work by further analyzing children's health care needs, evaluating federal regulations on network adequacy, and convening a roundtable with experts in pediatric care and network adequacy. We have found a general lack of research on the adequacy of provider networks for children and a specific lack of information to answer the question of whether CHIP networks or exchange plan networks are better suited for children. MACPAC's work to date raises several key policy issues: how market conditions

affect issuers' ability to create networks, how to ensure appropriate access to specialty care, how to measure network adequacy, how to ensure network transparency, and how plans and payers can balance access, quality, and cost in network design.

Ensuring the adequacy of networks is a complex task and is one of the many tools that payers use to ensure appropriate access to care. In recent years, plans across all payer types have increasingly relied on narrow networks to control costs (Corlette et al. 2014a). Exchange plans are still relatively new, and not enough time has passed to examine network and access issues for children in these plans. At present, research is insufficient to definitively conclude whether differences among Medicaid, CHIP, and exchange plan networks are significant enough to affect children's access to care. To help fill this information gap, MACPAC convened an expert roundtable in late 2014 to identify the following: (1) the effects of provider network design and regulation on children transitioning between exchange plans, CHIP, and Medicaid; (2) strategies to ensure that provider networks are adequate to meet the needs of children; and (3) the appropriate balance between regulatory oversight and plan flexibility with regard to designing networks that balance access, quality, and cost of premiums. The roundtable discussion raised a number of issues, some of which we explore in this chapter; it also highlighted the need to collect additional information before making specific policy recommendations.

This chapter focuses on children who may move from CHIP to exchange plans if CHIP funding ends under current law.² The chapter presents MACPAC's analysis of network adequacy to date, informed by research into children's health needs and the regulation of networks as well as findings from the roundtable meeting. We begin by summarizing the health needs of children and how these relate to network design, and then provide information on the supply and distribution of providers for children. We then examine specific issues in designing and regulating provider networks in Medicaid, CHIP, and exchange plans.

Network adequacy and its effects on access are an important part of the discussion of the future of CHIP. Other entities, including the U.S. Government Accountability Office, the National Association of Insurance Commissioners, and the Office of Inspector General of the U.S. Department of Health and Human Services are currently engaged in the study of network adequacy and access to services. The Commission looks forward to the results of these efforts as well as others that can shed light on this important issue.

Network Composition Depends on Provider Supply and Needs of the Insured

Network design must balance two key factors: which providers are needed to ensure access for the insured population, and which providers are available and willing to contract with the health plan. These factors affect a health plan's ability to create a network at a cost that is acceptable to the plan, providers, and those paying premiums. Children's medical needs vary as they grow, and even relatively healthy children occasionally need access to pediatric subspecialists. Therefore, the medical needs of children, as well as the supply and distribution of providers who care for them, are relevant to the creation of adequate networks.

Children's health care needs

The unique characteristics of children's health care needs have been divided into four categories: (1) developmental change, (2) differential epidemiology, (3) demography, and (4) dependency (Forrest et al. 1997). There is also a need for a particular focus on children with special health care needs, who comprise almost a quarter of CHIP-enrolled children. Each category of characteristics has important implications for the adequacy of provider networks for children.

Developmental change. Childhood is a period of rapid growth and development, and therefore health services for children focus both on enhancing this development and on detecting and ameliorating conditions that can impede it and result in lifelong morbidity (Stille et al. 2010). In addition to treatment of illness and injury, access to primary care for children provides a venue for promoting normal development and to prevent and detect developmental delays. Children with identified or suspected developmental delays often need access to pediatric subspecialists who can assist in the diagnosis and treatment of conditions that contribute to these delays. In addition, children in different stages of development, from infants born prematurely to adolescents, have physiologic developmental differences that affect their need for subspecialty care. All these children can benefit from access to other health care providers—speech, occupational, and physical therapists, audiologists, and mental health providers.

Differential epidemiology. The epidemiology of disease in children differs significantly from that of adults, particularly for chronic conditions. Although roughly one-quarter of children have special health care needs, these needs represent many relatively rare conditions, such as neurological impairments or genetic disorders, spread throughout the population, with relatively fewer concentrations of specific conditions as compared to adults (Stille et al. 2010). But like adults, a small proportion of children accounts for the majority of child health costs in public insurance programs: 10 percent of children account for over 70 percent of the costs (Kenney et al. 2009). As a result, a given population of children can require access to a wide variety of pediatric medical and surgical specialists, and the need for different types of specialists is likely to vary over time.

Demography. In 2012, 22 percent of children under age 18 lived in poverty, compared with 14 percent of adults age 18 to 64 and 9 percent of adults age 65 and older (DeNavas-Walt et al. 2013). Children in low- and moderate-income families—those expected to churn between Medicaid, CHIP, and

exchange plans—are disproportionately from racial and ethnic minority groups (Harrington et al. 2014, Kids Count Data Center 2014a). Among children who had been enrolled in a CHIP program for at least 12 consecutive months, almost three-quarters were from racial or ethnic minority groups, compared to 47 percent of all children (Harrington et al. 2014, Kids Count Data Center 2014b).

Dependency. Because children depend on their families to navigate the health care system, the needs of low-income and minority families are important considerations in the creation of adequate networks for children. These considerations include the location of medical facilities near public transportation as well as cultural and language competency.

Children with special health care needs. Children with special health care needs require more medical care, often need more specialized care, and have higher expenditures than children without special needs. In the National Survey of Children's Health, determination of special health care needs is based on five questions that ask about children's ongoing use of medications, whether they use more medical, educational, or mental health care than other children their age, whether they receive ongoing therapy, and whether they have ongoing emotional, behavioral, or mental health problems.³ According to MACPAC's analysis of this survey, almost one-quarter of children likely to be covered by CHIP (probable CHIP-enrolled children) and one-quarter of children likely to be covered by Medicaid (probable Medicaid-enrolled children) reported special health care needs compared to 19 percent for privately insured children.⁴ The types of care that these children may require is an important consideration for network design.

Supply and distribution of health care providers for children

The design of provider networks for children must also consider the supply and distribution

of providers. The overall supply of primary care pediatricians per child more than doubled from 32 pediatricians per 100,000 children in 1975 to 78 pediatricians per 100,000 children in 2005, presumably offsetting any potential adverse effects on children's access to primary care resulting from a drop in the number of family physicians providing care to children (Freed and Stockman 2009). However, there is substantial geographic variation in the supply of primary care providers for children. The variation in the supply of primary care pediatricians and family physicians can be greater than 600 percent across local primary care markets, and an estimated 1 million children live in areas in which there are no local pediatricians or family physicians (Shipman et al. 2011). The geographic distribution of children's hospitals, where many children access pediatric specialists, is similarly varied.

Historically, the majority of outpatient specialty care services for children have been delivered by nonpediatric specialists; however, by the end of 2006, the percentage of office visits to pediatric subspecialists was nearly equal to the percentage of office visits for nonpediatric specialists (Freed et al. 2010a). It is likely that this trend has been driven by a combination of factors, including the increased availability of treatments and survival rates among children with complex and rare conditions that require training in pediatrics (Cohen 2011).

Most pediatric subspecialties are characterized by both extremely low numbers of practitioners and extreme geographic concentration. Many pediatric subspecialties include fewer than 1,000 physicians nationwide, and nearly all of these physicians practice in urban tertiary care centers (Mayer 2006). Similarly, inpatient care for children with chronic conditions is increasingly concentrated in children's hospitals (as opposed to community hospitals) (Berry et al. 2013). Even care for children with common conditions appears to be increasingly more concentrated in larger hospitals (Hasegawa et al. 2013, Lopez et al. 2013). This

trend toward consolidation may further exacerbate geographic disparities.

Despite the potential of nurse practitioners and physician assistants to augment the primary and specialty care workforce for children, research suggests that there is an insufficient supply of these providers caring for children to have a widespread effect on access to care (Freed et al. 2011, Freed et al. 2010b).⁵ At this time, reliable data about the supply and distribution of other providers who care for children, such as physical, occupational, and speech therapists, is not readily available.

The availability of dentists is also important to children's healthy development. Many children see general dentists, who can perform most of the care they require. However, children with complicated dental problems or special health care needs require access to pediatric dentists. Some states have explored teledentistry for areas with an insufficient supply of dentists. When a state allows teledentistry, dental hygienists are able to offer an expanded array of on-site services with off-site support from dentists, who are able to bill for their services.⁶ Other states allow dental therapists and dental hygienists to provide some services to Medicaid and CHIP enrollees (GAO 2010).⁷

Federal and State Regulation of Provider Networks in Medicaid, CHIP, and Exchange Plans

As discussed in MACPAC's June 2014 *Report to the Congress on Medicaid and CHIP*, federal network adequacy regulations are similar among Medicaid, CHIP, and exchange plans. Federal law makes CHIP managed care subject to the same federal regulations that establish standards for Medicaid managed care (§2103(f)(3) of the Social Security Act) (MACPAC 2014). Federal rules also govern minimum network adequacy standards

for exchange plans. These federal requirements are broad standards, however, and in many cases states establish substantially more detailed requirements for network adequacy. In addition, states running a state-based exchange can issue their own regulations that comply with federal network adequacy requirements. Similarly, states running a plan management partnership exchange can recommend exchange plan certification to the U.S. Department of Health and Human Services (CMS 2013b).

Network adequacy oversight and monitoring

Regulators can help ensure access by overseeing and monitoring network adequacy regulations. Methods of oversight and monitoring vary in CHIP, Medicaid, and exchange plans. The Centers for Medicare & Medicaid Services (CMS) recently issued new guidance for exchange plan issuers.

Medicaid and CHIP. Enforcement and monitoring mechanisms for Medicaid and CHIP network adequacy vary by state and include the state contracting process, requirements for managed care organization reporting, and federally required external quality reviews of network adequacy that must take place at least once every three years. However, plan reporting requirements vary widely, and several states do not validate plan data but instead allow for plan self-attestation (OIG 2014). The Office of Inspector General (2014) notes that typical review methods used by external quality review organizations include examining plans' policies and procedures and interviewing plan personnel. The Office of Inspector General has expressed concern that the low number of violations of access standards identified by states suggests that the access-verification strategies of states and external quality review organizations may be inadequate (OIG 2014).

Exchange plans. In final guidance for exchange plan issuers in the federally facilitated

marketplaces for the 2016 plan year, CMS stated that it will continue to use the “reasonable access” standard to identify networks that do not provide access without unreasonable delay as required by regulation (45 CFR 156.230(a)(2)). Each issuer will be required to submit detailed provider network data as part of the exchange plan certification application, including information on providers, facilities, and pharmacies. The letter also reminds plans that they must meet network adequacy standards continually throughout the year, not just at certification.⁸ CMS intends to monitor network adequacy throughout the year and mentions complaint tracking as one method for doing so. CMS also stated that it will use information about networks that it learns in the certification process to help develop future network adequacy standards (CMS 2015a).

Essential community providers (ECPs) are providers that primarily serve low-income and medically underserved individuals. Plan requirements for ECPs in 2016 will be similar to the ones in force in 2015: (1) plans must contract with 30 percent of available ECPs in their service area; (2) good faith contracts must be offered to all available Indian health providers in the service area; and (3) contracts must be offered to at least one ECP in each ECP category in each county in the service area, if an ECP in each category is available and provides services that the plan covers. If a plan cannot meet this standard, it must submit a narrative justification (CMS 2015a).

Because children's hospitals are just one of several ECP providers in the hospitals category, issuers are not required to contract with a children's hospital to meet these standards. Under the alternate standard, plans that use employed physicians or a single contracted medical group can meet the standard if 30 percent of their employed or contracted providers are in areas where 30 percent or more of the population is below 200 percent of the federal poverty level (FPL), or if they submit a narrative justification (CMS 2015a). The requirement to offer contracts in good faith

to available Indian health providers and at least one ECP per ECP category does not apply to these issuers (CMS 2015a).

CMS requires stand-alone dental plans to meet the same network adequacy standards that apply to exchange plans, except that stand-alone dental plans do not have to offer a contract to at least one provider in each ECP category in each county in the service area, because not all providers in all ECP categories offer dental services (CMS 2015a).

CMS published a final rule that also addresses several aspects of network adequacy in February (CMS 2015b). In this rule, CMS noted that it will wait until the National Association of Insurance Commissioners completes work on its Managed Care Plan Network Adequacy Model Act before proposing any significant change to network adequacy regulations for exchange plans. In the meantime, CMS will continue to use the reasonable access standard and urges state-based exchanges to do the same. The rule amended 45 CFR 156.230 to clarify that a provider network consists only of contracted in-network providers, meaning that available out-of-network providers cannot be counted towards satisfaction of network adequacy requirements (CMS 2015b). In the preamble to the rule, CMS also encouraged exchange plans that rely on a provider network to offer new enrollees the option of staying with their current providers for a transitional period of at least 30 days. CMS is considering whether regulations are needed for transitional periods (CMS 2015b).

The new rule also put in place new requirements for exchange plan provider directories, including a requirement to include provider details such as specialties, locations, and whether or not they are accepting new patients. Plans must update the directory regularly (the preamble suggests once a month) and make it accessible to the general public without requiring an account or insurance policy number. The rule also strengthens the ECP standard effective January 1, 2016 by specifying that entities described in Title X and 340B of the Public Health

Service Act are ECPs, whether or not they receive federal grants under that law (CMS 2015b).

Network design: Issues for plans and consumers

Health plans and consumers share the desire for contracted networks of conveniently located providers sufficient to meet patients' clinical needs at a reasonable cost. However, providers may not be located where needed, willing to contract at the offered rates, or accepting new patients.

Payers also have a strong interest in the networks. They would like to keep premiums low regardless of whether insurance is being purchased by an employer on behalf of its employees, by a state on behalf of Medicaid enrollees, or by an individual through the exchange. Many of the traditional mechanisms used by commercial health insurance issuers to lower premiums were limited or eliminated by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). These include denying policies to those with pre-existing conditions, increasing premiums based on health status, and excluding benefits such as maternity services or prescription drugs (Corlette et al. 2014b). This leaves provider payment and the design of provider networks among the few mechanisms left that issuers can use to lower premium costs, and this situation increases the tension between affordability and access. Specific challenges in network design and potential mitigations are summarized below.

Limited negotiating power. Plans may have less control over the number, type, and distribution of providers in a given network than network adequacy regulations may presume. For example, it may be difficult to contract with providers that are highly specialized or are the only facility of their type for a region, such as a children's hospital.⁹ These providers may have sufficient market power to be able to demand higher rates than Medicaid, CHIP, or exchange plans are willing or able to pay.¹⁰

In some cases, rules intended to promote access, such as the requirement that plans contract with ECPs, create their own challenges with respect to network design. Such providers are necessary for access in many low-income and medically underserved communities. However, some plans have characterized the ECP requirement as potentially harmful because it can distort market dynamics in communities with other available provider groups. As one plan representative at the roundtable said, "In my network, I have to contract with FQHCs because I wouldn't have a network otherwise."¹¹

To counterbalance areas in which they have limited negotiating power and still maintain a sufficient provider network that is affordable, insurers may seek to negotiate better payment rates where there is greater supply by contracting with a limited number of providers and negotiating lower fees in exchange for higher volume (Howard 2014). Narrow network designs also give issuers the opportunity to offer plans that include providers who meet specific access and quality benchmarks, although this does not currently seem to be a widespread practice (Corlette et al. 2014a, 2014b; Howard 2014). Insurers may also contract with alternate providers where possible, for example lower-cost community hospitals rather than academic medical centers, although these trade-offs may have consequences for patient satisfaction.

Provider unwillingness to contract. Even when sufficient specialists exist, some may not wish to contract with plans, regardless of payer, or will contract with an insurer but will not accept new patients. For example, Medicaid health plans have found that some providers do not want their names to appear in network directories because they do not want to attract large numbers of Medicaid patients. Others are willing to accept some Medicaid patients on a case-by-case basis but not as part of a network, but it is not yet clear whether this dynamic will also affect exchange plan network development. Provider unwillingness to contract has been a particular problem with dental

participation in Medicaid and CHIP, and access to these services is of particular concern for low- to moderate-income children. Dental participation rates in both Medicaid and CHIP remain low, although it is too early to measure dental provider participation in exchange plans (GAO 2010).

Providers consider comparative payment rates and administrative burdens when deciding whether to participate with a particular insurer. Health plans can improve provider willingness to contract by offering higher payments rates on a case-by-case basis or by implementing strategies to reduce the administrative burden on providers.

In addition, where insurers are unable to provide access to certain services or providers on a contracted basis, they must still have mechanisms to provide medically necessary covered services to enrollees. Health plans can develop single-case agreements with providers on an as-needed basis for specific patients as a necessary but imperfect method of ensuring beneficiaries' access to care. However, these agreements can be administratively difficult for plans and providers, and if the responsibility for requesting these arrangements falls to families, the arrangements can be burdensome to consumers as well.

Care coordination and emerging care delivery models could also ameliorate the effects of provider shortages and improve quality of care overall. When specialist supply is limited or not geographically accessible, plans and specialists can assist primary care providers in keeping care local, when feasible, by coordinating care, incorporating telemedicine, and providing training and direct consultative support to primary care providers. Traditional measures of network adequacy involving time and distance would need modification in order to capture these services.

Adverse risk selection. Plans that are successful in contracting with certain pediatric provider groups or subspecialists who care for high-risk, high-cost patients may find themselves at a financial

disadvantage if they attract high proportions of children with chronic conditions or specialty care needs.¹² Improvements to risk adjustment may be necessary to prevent undue financial burden on plans contracting with relatively high proportions of specialists. Conversely, there is also a concern that exchange plans, which are generally not designed for children, could discourage enrollment of children with special needs by not contracting with appropriate providers.

Accurate provider information. Consumer advocates highlight the consumer's need for information about network design—both when choosing a plan and when choosing a provider. Both decisions may affect access. Plans with narrow networks may be less costly, but may exclude certain providers. And consumers can have difficulty predicting the types of providers their families will need in a given year or how much medical care they will consume. Some consumers balance the competing elements of cost and network design when choosing a health plan. Others are specifically interested in picking a plan based on whether its network meets their predicted health care needs.

Provider directories, whether printed or online, are currently the only source of information for consumers about available providers. Keeping such directories accurate can be challenging as providers enter or leave a network or close their practices to new patients at various points throughout the year. Providers may not update plans about their participation or availability to accept new patients, and not all plans publish updates as timely as consumers would prefer. Moreover, directories may not be sufficiently detailed, for example, they might not provide information on specialized expertise with certain conditions. Thus, directories are not a panacea; consumers are likely to need additional information and assistance from plans, states, and advocates to understand whether the provider network in a plan will meet their needs.

Network Adequacy Does Not Equal Access

While network adequacy is an essential component of access, it is not the only component—ensuring access requires other strategies as well. Networks that are deemed adequate based on the likely needs of the covered population may not actually ensure access to timely, integrated care for patients with special health care needs. Although narrow networks might impose limits on consumer choice and access, broader networks and their sometimes higher premiums do not guarantee access or quality of care. In order to determine whether network adequacy standards are effective, payers and issuers need other tools to ensure accessible care and must monitor both process and outcome measures. These tools might include the following:

- examining claims, Healthcare Effectiveness Data and Information Set (HEDIS), or Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores;
- monitoring the number of appeals and grievances filed and how they were resolved. This can also provide a measure of enrollees' ability to access care (including consumer complaints and complaints from advocacy organizations); or
- conducting secret shopper surveys, in which state or plan staff call practices to assess whether the practice is taking new patients, how long it takes to get a new appointment, and other measures of access.

More work needs to be done in order to develop appropriate access metrics and monitoring plans. The types of approaches described above have the potential to be effective in pinpointing access issues, but they can also be resource intensive and cost prohibitive for states or plans to conduct on a routine basis. In addition, when considering access for children, existing child-specific case-

mix adjustment methods must be strengthened to account for underlying differences in the health status of enrolled populations. Only then can outcome measures be reliably used to assess the adequacy of access to care for children. Thus, purchasers will need to ensure that effective and appropriate tools are developed, selected, and implemented. This may be challenging for Medicaid and exchange plans, which are governed by both state and federal rules.

Conclusion

Network design is a critical part of access. Consumers depend on states, plans, and the federal government to enforce minimum standards so they can understand the insurance products they purchase and inform themselves about the trade-offs between cost and broadness of networks. Because a significant portion of probable CHIP-enrolled children report special health care needs, access to pediatric subspecialists will likely be important for their care. Regional concentration of specialists can exacerbate access issues, so careful consideration of network adequacy requirements is needed to ensure that those who require pediatric subspecialists can access them in a timely and efficient manner.

Our understanding of network adequacy will continue to evolve as more information about provider participation in exchange plans becomes available. MACPAC will continue to monitor network adequacy issues with a particular emphasis on children's ability to access specialty care, the development of meaningful and accurate measures of network adequacy, network transparency, and how plans and payers will balance access, quality, and cost.

Endnotes

¹ One small piece of evidence regarding network similarities is the extent to which issuers of separate CHIP programs using managed care also issue exchange plans. This varies by state. In Utah, all separate CHIP issuers also participate in the exchange. In 18 states, there is some overlap, and in six states, there is no overlap (Kanchinadam 2014, NASHP 2014). Even though benefits, cost sharing arrangements, and providers can differ among plans offered by the same issuer, the fact that the plans are administered by a common issuer may be beneficial for children transitioning between programs.

² The outcome of *King v. Burwell*, heard by the Supreme Court in March 2015, will also affect children's eligibility for coverage if CHIP ends under current law. At issue in this case is whether federal tax subsidies for coverage purchased through exchanges established by the federal government are permissible under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

³ MACPAC analysis of the National Survey of Children's Health 2011-2012.

⁴ In its analysis of the National Survey of Children's Health, MACPAC sought to identify children likely to be covered by CHIP by using separate CHIP income levels to distinguish among children at higher and lower family income levels in states with separate CHIP programs. This analysis divided children identified as having respondent-reported Medicaid or CHIP coverage into those whose family incomes were above the Medicaid threshold and those whose family incomes were below. This threshold differs by age group in most states, with older children needing to have a higher percentage of the federal poverty level than younger children. For example, in Alabama, children under age 6 with respondent-reported Medicaid or CHIP coverage who lived in families below 133 percent FPL were assigned to the probable Medicaid category; children under age 6 with respondent-reported Medicaid or CHIP living in families above 133 percent FPL were assigned to probable CHIP. Respondent children from Alabama age 6 or over in families below 100 percent FPL were assigned to probable Medicaid; children from Alabama age 6 or over living in families above 100 percent FPL were assigned to probable CHIP. This method allows for a crude comparison

of utilization and access between children likely to have Medicaid and those likely to be covered by their state's separate CHIP program. Children in states with no separate CHIP program who reported Medicaid or CHIP coverage were all assigned to the probable Medicaid group.

⁵ The Public Health Service Act, as amended by the ACA, stipulates that "a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law," but it does not require a health plan to contract with any willing provider and does not prohibit varying reimbursement rates (§2706(a) of the Public Health Service Act). A U.S. Department of Health and Human Services interpretation of this provision states that plans are not required to accept all types of providers in their networks (CMS 2013a). Insufficient data exist to clarify the effects of this provision on the participation of other medical professionals in qualified health plans at this time.

⁶ For example, see California Assembly Bill Number 1174, signed into law on September 27, 2014.

⁷ The ACA authorizes demonstration projects to train alternative dental health care providers for the purpose of increasing access to dental care in rural and underserved communities (§5304 of the ACA, codified at 42 U.S.C. 256g-1). These projects have not yet been funded.

⁸ While up-front assessment of network adequacy is important, these assessments are not necessarily valid throughout the plan year. Ongoing monitoring is important because providers enter and leave networks throughout the year.

⁹ One additional concern is that if a plan does not contract with a children's hospital, enrollees may not have access to the hospital's employed physicians.

¹⁰ The Supreme Court heard oral arguments in *Armstrong v. Exceptional Child Center* in January 2015. At issue in this case is whether Medicaid providers may sue a state to enforce federal Medicaid payment law (42 U.S.C. §1396a(a)(30)(A)) when Congress did not create an enforceable right under that statute.

¹¹ Federally Qualified Health Centers (FQHCs) are a type of ECP.

¹² Not enough is known about whether children treated by pediatric subspecialists have better outcomes. For example, studies suggest that children with asthma and those undergoing surgery have better outcomes when treated by pediatric subspecialists, but the evidence on quality outcomes with other medical subspecialists is inconclusive (Mayer et al. 2009).

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