October 26, 2015

The Honorable Roger A Sevigny
Commissioner
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

The Honorable Mike Kreidler
Commissioner
Office of the Commissioner of Insurance
Insurance Building, Capitol Campus
Olympia, WA 98504

ATTN: Jolie Matthews, NAIC Sr Health and Life Policy Counsel

Dear Commissioners Sevigny and Kreidler:

The American Academy of Pediatrics (AAP) is a nonprofit professional organization of 64,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. The AAP appreciates the substantial work of the National Association of Insurance Commissioners (NAIC) Network Adequacy Model Review (B) Subgroup on revising its Managed Care Plan Network Adequacy Model Act (hereafter “Model Act”). We applaud the Subgroup on completion of this draft and thank the NAIC in its ongoing effort to address the critical issue of network adequacy for children and families.

While the AAP supports many aspects of the Model Act, we believe there are areas where it must be strengthened to appropriately protect children and families. In an October 23 letter, the AAP joined NAIC Consumer Representatives, the American Medical Association (AMA), Children’s Hospital Association (CHA), and others, to express remaining concerns with the model act. Specifically, we highlighted concerns that the Model Act does not require approval of network adequacy prior to going to market, does not ensure the use of quantitative measures in documenting network adequacy, and does not regulate tiered networks to prevent discriminatory network design. We strongly recommend further Model Act enhancements that are necessary to protect children and families.

The AAP’s goal is to ensure that all children, and in particular children with special health care needs (CSHCN), have access to medically necessary care without undue burden or delay. As such, we offer the following additional recommendations.

**Pediatric Medical Subspecialists and Surgical Subspecialists**

With respect to children, quantitative network adequacy measures must take into account access to in-network pediatric care, including that of a pediatrician-led medical home,
pediatric medical subspecialists, and surgical specialists. The Model Act does highlight children as having specific needs, but can be strengthened by making this requirement explicit.

Studies have demonstrated the positive outcomes and quality impacts of care provided by pediatric medical subspecialists and surgical specialists versus adult specialists and subspecialists for the pediatric population (see attached Annotated Bibliography: Benefits of Pediatric v. Adult Subspecialty Care). Access to adult providers should not substitute for that of pediatric providers in measuring network adequacy, except in extenuating circumstances.

In its June 1, 2015 proposed rule, the Center for Medicare and Medicaid Services (CMS) proposed that states establish quantitative measures for pediatric primary and specialty providers for Medicaid managed care plans, stating that network adequacy is often assessed without regard to practice age limitations, resulting in inadequate networks and an increased need for out-of-network authorizations. While the Model Act provides a process for patients to access needed out-of-network providers, the AAP believes this should be used a rarely as possible. For pediatric patients, the number and type of pediatric specialists and subspecialists should be taken into account when determining network adequacy.

**Balance Billing**

While we applaud efforts to address the issue of balance billing for emergency and planned care by nonparticipating physicians and other health care professionals at in-network facilities, we believe that this issue should be addressed separately in another forum. In states that have taken up the issue of balance billing for out-of-network care, it has taken significant time, consideration, and compromise to arrive at a solution that is workable for all parties. As the issue of network adequacy is also a substantial one that will serve to help consumers, joining these two issues could cause considerable delay of both matters.

If these provisions (Section 7) remain in the Model Act, we recommend that the benchmark for nonparticipating facility-based provider payments must be raised to an appropriate level. If payment benchmarks are set too low insurance carriers will have no incentive to contract with physicians at appropriate payment rates. Moreover the AAP believes the goal of any balance billing adjudication mechanism must be to hold families harmless for surprise bills. With genuinely adequate networks, balance billing should become a rarity.

The AAP appreciates the efforts of the Subgroup, particularly its Chair, JP Wieske, to move toward meaningful standards for adequate networks for children. Thank you for the opportunity to provide comments on the Model Act, as these standards will impact the ability of children to access needed care. If you have any questions, please contact Dan Walter, Senior Policy & Government Affairs Analyst at dwalter@aap.org or 847-434-4086 or Wendy Chill, State Government Affairs Analyst at wchill@aap.org or 847-434-7797.

Sincerely,

Sandra Hassink, MD, FAAP
President
American Academy of Pediatrics

SH/wc
Enclosure
Annotated Bibliography: Benefits of Pediatric v. Adult Subspecialty Care


*Pediatric neurosurgeons are more likely than general neurosurgeons to extensively remove malignant pediatric brain tumors. In these tumors, extent of removal has been demonstrated to influence survival.*


*Lower complication rates and shorter lengths of stay for children with significantly perforated appendicitis when treated by pediatric surgeons.*


*After adjusting for patient characteristics, injury severity, and hospital characteristics, splenectomy was more likely among children treated at general hospitals than among children treated at children’s hospitals. There are significantly lower rates of splenectomy at designated children’s hospitals.*


*High surgeon volume and specialization are associated with improved patient outcome, while high hospital volume is of limited benefit.*


*Pediatric emergency medicine physicians provided better care than family medicine physicians and those in the “other” category. The quality of care provided to children is associated with age, hospital setting, and physician training.*


*Pediatric surgeons treat younger children with more severe appendicitis. There are no specialty-dependent differences in clinical outcomes for simple or complicated appendicitis. Hospital charges are lower for simple appendicitis treated by pediatric surgeons.*
Annotated Bibliography: Benefits of Pediatric v. Adult Subspecialty Care


For all measures, pediatric surgeons demonstrated superior proficiency on exercises conducted in pediatric conditions. Pediatric surgeons possess unique skills compared with general surgeons that relate to the technical challenges they routinely face.


Compared with physicians with a pediatric background, rates of resource utilization were higher for EM-trained physicians who managed uncomplicated cases of croup. There was a reduced length of stay by 40 minutes when pediatric emergency medicine physicians treated croup. Also, pediatric emergency medicine physicians treating croup reduced direct costs by $90 when compared to the same treatment delivered by adult emergency medicine physicians.


Shorter time spent by young children treated for fever in the pediatric emergency department.


Younger children with appendicitis have reduced hospital days and charges when they are treated by pediatric surgeons v. general surgeons.

Nwomeh BC, Rothstein D. Evidence shows children treated by pediatric surgeons have better outcomes than those treated by adult specialists. *AAP News*. 2014;35.

The risk of bowel resection during operative intussusception reduction is 80% less when performed at hospitals employing full-time pediatric surgeons compared to hospitals providing pediatric care by non-pediatric surgeons.

Annotated Bibliography:
Benefits of Pediatric v. Adult Subspecialty Care

Surgeons caring preferentially for children as a proportion of their overall practice generally have improved mortality outcomes in general and cardiothoracic surgery. These data suggest a benefit associated with increased referral of children to pediatric practitioners.


Shorter length of stay for closed femoral shaft fractures when treated by a pediatric orthopedic surgeon; pediatric orthopedic surgeons achieved lower hospital charges than adult orthopedic surgeons for closed femoral shaft fractures.


Each study documented better pediatric patient surgical outcomes under the care of a pediatric subspecialty trained surgeon regardless of discipline. Those studies that studied costs showed more cost effective care was delivered by pediatric subspecialized surgeons.


Hospital charges were significantly less ($1095) for patients under the care of a pediatric urologist compared to general urologists. Complication rates were also lower.

Questions:

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