**[AAP New Mexico | Pediatric Specialty Task Force](https://www.nmaap.org/pediatric-specialty-care-task-force)**

1. **Addressing pediatric specialty care/network adequacy/coordination across system**

In recent years private insurance plans, such as qualified health plans (QHPs) and employer sponsored plans, have been offering more and more “narrow networks” which can create barriers to care for patients and families. As states are largely charged with regulating insurance plans, there is much that can be done either legislatively or regulatorily in regard to setting network adequacy standards and enforcement to ensure continued access to pediatric specialists and subspecialists. With recent changes to federal rules regarding how network adequacy is determined for QHPs, states will have even more flexibility in creating and enforcing these standards.

The AAP has a comprehensive resource, [Network Adequacy | Advocacy Action Guide for AAP Chapters](https://www.aap.org/en-us/advocacy-and-policy/state-advocacy/Documents/NetworkAdequacyGuidance.pdf), regarding network adequacy that includes guidance and recommendations specific to the inclusion of pediatric specialists and subspecialists in insurance networks to ensure all children receive the appropriate care they need. Specific provisions that should be looked at in terms of access to specialists and subspecialists include:

* 1. **A pediatric focus**: network adequacy standards for children must document access to *pediatric* primary care as well as *pediatric* medical subspecialty and surgical specialty care. There are studies that show the positive outcomes and quality impact of care provided by pediatric medical subspecialists and surgical specialists, versus adult specialists and subspecialists for the pediatric population. (see attached annotated bibliography)
  2. **Use of objective measures to document network adequacy**: these should document the ability of the network to meet the needs of all covered persons, including children with special health care needs; should ensure provider availability and admitting privileges; and should ensure the availability of technological services required for children with special needs.
  3. **Telehealth care**: in creating legislation or regulation around network adequacy, telehealth care may be taken into account in establishing a network. However, telehealth care should augment, not substitute, a robust in-person network of pediatric providers.
  4. **Children’s hospitals**: children’s hospitals must be included in network – including those in geographic areas beyond an existing plan network area where one is not readily available. In some instances, this may require the inclusion of a hospital in a nearby/bordering state.

The National Association of Insurance Commissioners (NAIC) has developed a [model act](http://www.naic.org/store/free/MDL-74.pdf) on network adequacy. The AAP was part of a long process to develop this model act, and while some of our recommendations were included in the model, others were not, so when states begin discussing this issue, bringing up the importance of access to pediatric specialists and subspecialists is paramount. The advocacy action guide was created for the purpose of aiding AAP chapters and others in their advocacy work around this issue.

We hope this is helpful. Please let us know if you need any additional information or if we can be of any further assistance.

1. **Number of pediatricians/specialists needed per 100k kids?**
   1. [American Board of Pediatrics](https://www.abp.org/content/workforce) | [Pediatric Physicians Workforce Data Book 2017-2018](https://www.abp.org/sites/abp/files/pdf/pediatricphysiciansworkforcedatabook2017-2018.pdf)
      1. New Mexico (*pediatricians ever certified under 70 years of age per 100,000 children*)
         1. Pediatricians (general and subspecialists) | 85.4
            1. Pediatricians (general and subspecialists currently certified) | 72.6
         2. Adolescent Medicine Subspecialists | 0.4
         3. Pediatric Cardiology Subspecialists | 1.8
         4. Child Abuse Pediatrics Subspecialists | 0.06
         5. Pediatric Critical Care Medicine Subspecialists | 2.2
         6. Developmental-Behavioral Pediatrics Subspecialists | 0.4
         7. Pediatric Emergency Medicine Subspecialists | 1.8
         8. Pediatric Endocrinology Subspecialists | 0.4
         9. Pediatric Gastroenterology Subspecialists | 1.2
         10. Pediatric Hematology-Oncology Subspecialists | 2.2
         11. Pediatric Infectious Diseases Subspecialists | 1.0
         12. Neonatal-Perinatal Medicine Subspecialists | 5.3
         13. Pediatric Nephrology Subspecialists | 0.8
         14. Pediatric Pulmonology Subspecialists | 1.0
         15. Pediatric Rheumatology Subspecialists | 0
   2. AAP Recommendations
      1. We do not recommend a specific ratio of pediatricians to children. Our technical report, [The Pediatrician Workforce: Current Status and Future Prospects](https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Pages/Committee-on-Pediatric-Workforce.aspx), notes that:
         1. “More difficult to measure, and usually ignored, are the rich and complex factors that relate the number of health services delivered per child to children's health and well-being, termed health outcome productivity (Fig 1, box 17). A short list of factors includes the technical excellence and appropriateness of the service and the division of labor across the many possible clinicians (Fig 1, box 11) or even across the nonmedical workforce—parents, teachers, coaches, clergy, and therapists (Fig 1, box 16). Relative health needs are also of central importance (Fig 1, box 17). All else held equal, we would also expect a greater production of health (ie, improvement in health status or well-being) when care is delivered to a less healthy child. The organizational and community milieu can also modify the efforts of the child health workforce (Fig 1, box 14). When these factors are considered together, it becomes apparent that successful health outcomes might occur with a widely differing number of pediatricians. Workforce forecasters have accounted for these factors through 5 different models.130,139,143,144 Each model requires particular theoretic assumptions and data, and none of these methods should be viewed as mutually exclusive of the others. The acceptance of a particular framework partly depends on the definition of “requirement” and the policy goal of the forecasting process. Another way of looking at the task of assessing requirements is that it is not a science in the traditional sense but is intertwined with the values expressed in the assumptions. Is the goal to optimize health or the perception of access to physicians or to maximize employment opportunities for physicians? Is reducing disparities in the access and use of medical services one goal? What level of public funding in education and payment of health services is assumed, and what is the rationale for public funding at all if it is thought that markets will drive the health care system to desirable outcomes? Although the values inherent in different requirement models may not be explicitly stated, the careful reader will find them implicit in the models' assumptions.
2. **Recruitment/retention (turnover) costs of pediatricians and pediatric sub specialists?**
   1. [What You Don’t Know Can Cost You: Building a Business Case for Recruitment and Retention Best Practices](http://www.aspr.org/?696)
      1. Average interview cost per vacancy for physicians | Around $30,000
      2. Hard costs of recruiting
         1. Up to around $88,116
         2. Agency recruiting fees | $0-30,000
         3. Sourcing/advertising | $0-10,000
         4. Interview-travel cost | $0-2,205
         5. Interview-entertainment | $0-911
         6. Signing bonus | $0-30,000
         7. Moving cost | $0-15,000
      3. Indirect costs
         1. Include cost of human resources to source, interview; start-up costs; and lost revenue while position is vacant.
   2. JAMA Internal Medicine | [The Business Care for Investing in Physician Well-being](https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2653912)
      1. While this article focuses on physician burnout, it includes information on the costs to hire/replace physicians
      2. Cost to replace a physician is 2-3 times more than the physician’s salary
   3. Rand Corporation | [Does It Cost More to Train Residents or to Replace Them?](https://www.rand.org/pubs/research_reports/RR324.html)
   4. [United States Bureau of Labor-Occupational Employment and Wages, May 2017 | Pediatricians, General](https://www.bls.gov/oes/current/oes291065.htm" \l "st)
      1. Mean annual wage | $187,540
   5. [AMGA’s Medical Group Compensation and Productivity Survey](https://www.cejkasearch.com/physician-compensation-report)
      1. List of average compensation for physicians, includes pediatric subspecialties
3. **Economic Impact of Physicians**
   1. American Medical Association/IQVIA | [The National Economic Impact of Physicians](https://www.ama-assn.org/sites/default/files/media-browser/public/2018-ama-economic-impact-study.pdf)
      1. New Mexico
         1. Total economic output (medical revenues generated in the course of patient care) (billions) | $8.0
         2. Total job created by physicians | 46,688
         3. Total wages and benefits of physicians and employees who are hired to support patient care (millions) | $3,877,800
         4. Total taxes that are paid by physicians and the positions they create (millions) | $316,400,000

**Resources**

* [AAP Committee on Pediatric Workforce](https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Pages/Committee-on-Pediatric-Workforce.aspx)
* AAP Policy Statement | [Pediatrician Workforce Policy Statement](http://pediatrics.aappublications.org/content/132/2/390)
* AAP Policy Statement | [Enhancing Pediatric Workforce Diversity and Providing Culturally Effective Pediatric Care: Implications for Practice, Education, and Policy Making](http://pediatrics.aappublications.org/content/132/4/e1105?sid=69c386fa-05dc-4db0-8ae1-c0c32e36ecf6)
* AAP Policy Statement | [Financing Graduate Medical Education to Meet the Needs of Children and the Future Pediatrician Workforce](http://pediatrics.aappublications.org/content/121/4/855)
* AAP Technical Report | [The Pediatrician Workforce: Current Status and Future Prospects](https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Pages/Committee-on-Pediatric-Workforce.aspx)
* *Pediatrics* Article | [Current Workforce of General Pediatricians in the United States](http://pediatrics.aappublications.org/content/137/4/e20154242)
* *Pediatrics* Article | [Current Workforce of Pediatric Subspecialists in the United States](http://pediatrics.aappublications.org/content/139/5/e20163604)
* *Pediatrics* Article | [Jobs and Career Plans of New Pediatric Subspecialists](http://pediatrics.aappublications.org/content/137/3/e20153298)
* *Pediatrics* Article | [The Pediatrician Workforce: Current Status and Future Prospects](http://pediatrics.aappublications.org/content/116/1/e156.full?sid=26875331-c50e-47c2-a8ca-c27fb443c1a8)
* AAP Press Release | [Shortage of Pediatric Specialists, Rising number of Chronically Ill Kids Prompts AAP Call to Revamp Training Funds](https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/Shortage-of-Pediatric-Specialists-Rising-number-of-Chronically-Ill-Kids-Prompts-AAP-Call-to-Revamp-Training-Funds.aspx)