American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

North Carolina Chapter

North Carolina Pediatric Society

Chapter President
W. Scott St. Clair, MD, FAAP
Blue Ridge Pediatric & Adolescent Medicine
579 Greenway Road, #200
Boone, NC 28607
Phone: (828) 262-0100
wscottstclair@gmail.com

Chapter Vice President
Susan Mims, MD, MPH, FAAP
Mission Children's Hospital
Missions Hospital, 509 Biltmore Ave
Asheville, NC 28801
Phone: (828) 213-1747
Susan.Mims@msj.org

Past President
Deborah L. Ainsworth, MD, FAAP
Washington, NC

Secretary
Kenya McNeal-Trice, MD, FAAP
Chapel Hill, NC

Treasurer
Theresa M. Flynn, MD, FAAP
Raleigh, NC

Board of Directors
Richard Chung, MD
Christine Collins, MSW
Christoph Diasio, MD, FAAP
Katie Lowry, MD, FAAP
Larry Mann, MD, FAAP
Preeti Matkins, MD, FAAP
Michael Riddick, MBA, EA
Richard Sutherland, MD
David Tayloe, III, MD, FAAP

Executive Director
Elizabeth Hudgins, MPP
1100 Wake Forest Road
Suite 200
Raleigh, NC 27604
Phone: (919) 839-1156
Fax: (919) 839-1158
Elizabeth@ncpeds.org
www.ncpeds.org

September 1, 2017

The Honorable Mandy Cohen, MD
Secretary
NC Department of Health and Human Services
1950 Mail Service Center
Raleigh, NC 27699-1950

RE: Comments on NC Proposed Program Design for Medicaid Managed Care

Dear Secretary Cohen:

Thank you for providing an opportunity to comment on *North Carolina's Proposed Program Design for Medicaid Managed Care*. As you are aware, Medicaid covers mostly children (70% when combined with CHIP) and is of critical concern to pediatricians. Due to long-standing collaboration, quick payment and appreciation of the Department's continual efforts to further child health, most pediatricians in North Carolina accept Medicaid. We appreciate your careful and considered approach to redesign Medicaid with a strong focus on the impact to families and providers.

We are pleased to offer comments on the proposed *Program Design*. We will maintain our themes of the past three years focusing on factors that influence access to care for families and the ability of pediatricians to provide quality care.

Promoting administrative ease: This proposal makes steps towards administrative ease. However, given the design inherent in the model – more payers, more barriers for patient who now must choose a plan and a doctor, multiple networks to navigate to find children needed specialty care and more – administrative burden will increase. One way the proposal ***increases*** barriers is by reducing the time to submit a claim from 365 days to 90 days. Another concern is each payer potentially requiring different billing codes and/or modifiers. We urge you to work closely with all types of providers, including representatives from pediatrics and independent practices, as you work to ease administrative burden. We also urge that payment is sufficient to cover the increased administrative burden.

Assuring adequate payment rates: NCPeds has consistently called for a Medicaid rate floor equal to Medicare. We remain deeply concerned about what administrative burden, loss of infrastructure, the structure of quality payment and the potential loss of critical protections, such as Chapter 58, will do to the ability of practices to provide quality care. Practices are being asked to do significantly more administrative work for ever-eroding payments. NC pediatricians responding to a survey about reductions in rates in 2015 reported limiting Medicaid patients (26%) or freeze staffing levels (32%) to cope with those cuts. With additional administrative burdens, current Medicaid rates – or in some cases 90% of that rate – are simply insufficient. Bundled payments must take the enhanced needs of children, especially very young children, into account. Primary care is foundational and a higher rate floor would help reestablish the strong primary care infrastructure our state has enjoyed.

Adequate practice protections for timely and accurate payment and fair treatment: We applaud the inclusion of beneficiary protections. Additionally, current protections for patients and providers should be maintained. The law (SL2015-245) is very clear that Chapter 58 protections -- long-standing statutory provider and patient protections applicable to commercial health insurance products -- should be applicable to all PHPs by law. Yet, those protections seem absent from the *Proposed Program Design for Medicaid Managed Care*. These protections - and more - are essential. For providers, timing and mechanisms of appeals must be crystal clear and not allow PHPs to threaten practices through underpayment. While we appreciate the provision of 18% interest for missed payments, payments must be *accurate* as well. (For example, paying a $1 "placeholder" on services could count as timely yet undermine the intent of supporting practices in providing care to Medicaid patients.) Underpayments could quickly put a practice, especially an independent practice, in dire financial straits; mere weeks or months of such treatment could result in bankruptcy. A long appeals process that goes through DHHS and provides no redress for the practice with the PHP provides inadequate protections for practices. Prompt payments during appeals are essential. The non-exclusionary measures that require PHPs to accept all willing providers is a positive step. It should be further clarified that practices may choose one product (such as the Medicaid PHP) without being required to accept all products (such as the private insurance offering, or vice-versa). We look forward to working with the Department as you develop the capacity to monitor and enforce these types of contracts.

Keep what works/CCNC: NC has established a strong infrastructure with Community Care of NC. In particular, coordinated care needs to be coordinated and community-based; having multiple care managers with differing priorities serving the same practice would likely result in fragmentation and lower quality care. Care management shared between the PHP and the advanced medical home could result in multiple care managers and fragmentation. Care management from outside the community (such as management provided remotely through 800-numbers) would undermine effective infrastructure. NC pediatricians have a high level of trust with CCNC and contributed to the creation of its sound infrastructure.

Assuring network adequacy: We remain deeply concerned about network adequacy. There appears to be room in the *Program Design* to allow for pediatric specialists to serve in all PHPs, which is positive. For some services, there may be only one or two pediatric providers in the state. Network adequacy standards must include availability of appropriate specialists for children of all ages. (For example, a cardiologist who treats patients 16 and older should not count towards network availability of a pediatric cardiologist. A pediatric vision network cannot just include general optometrists who provide lenses for teens and adult ophthalmologists but also must include neuro-ophthalmologists and other needed pediatric vision experts.) Telehealth should include payments not only for the consulting physician, but also for the primary care practice site linking in the consult and providing local site and implementation support. We urge explicit consequences for PHPs who fail to meet adequacy standards. Network adequacy standards should be available for public comment and review 60 – 90 days prior to review and release of the RFP. Pediatricians, including specialists, should be on the team helping to determine the standards of adequacy. Special attention must be paid to assure strong access in rural communities. Network adequacy, along with quality metrics and social determinants of health, especially needs strong, meaningful "in the weeds" collaboration with stakeholders, including consumer representatives.

Primary care is the foundation of healthier communities: Primary care must be the foundation of reform. If this plan does not work for family physicians and pediatricians, it likely will not work for anyone involved: patients, providers or the state. Quality primary care is essential for good health. We appreciate the focus on mechanisms to promote and support primary care providers, especially in rural communities and the inclusion of primary care measures in the quality metrics. Recent results in Rhode Island have further confirmed that as primary care spending as a portion of overall healthcare spending has increased, quality has increased and costs have plateaued.

Protecting children with special health care needs: We appreciate the thoughtful approach to rolling-in medically fragile children. We appreciate that certain special populations may switch plans at any time. Our concern is that children with higher needs who require specialists could be potentially negatively impacted by inadequate networks. EPSDT services must be protected.

Closing the coverage gap: Thank you for addressing the coverage gap in your proposal. Healthier adults conceive healthier babies. Parents who get needed health care, including mental health care, tend to be better able to parent well. As you repeatedly note, coverage can help link parents (and others) to substance abuse treatment.

Moving towards stronger medical homes/value-based payments: We appreciate the focus on medical homes and the phase-in of payment strategies recognizing current capacity. We also appreciate the single accrediting body. We encourage "grandfathering" practices that meet one of the standards without relying on a sole pre-existing credential as practices move towards more meaningful QI work. It is difficult for practices to truly transform when they are being paid using entirely different models, and this is especially important for independent practices. It is crucial to keep the opportunity of independent practice intact in North Carolina, but competing payment models make administration of independent practice more burdensome. We believe primary care physicians are ready to engage in value-based payment models and some can even undertake risk, but are only willing to undertake risk they can control. (Please also see "all claims data" comments under **Quality metrics**.)

Improving Social Determinants of Health: We support the strong focus on social determinants of health, especially hunger which is a strong proxy of need. We foresee this as an element where on-going stakeholder input and strong collaboration will be valuable. Resources must be adequate and available for pediatricians to be consistently willing to screen and refer. This area, along with quality metrics and network adequacy, especially needs strong, meaningful "in the weeds" collaboration with stakeholders, including consumer representatives.

Fostering Health NC: This program is effective on a variety of measures. We applaud efforts to assure that children in the foster care system are linked to medical homes and other supports, including during their transition to adulthood. Additionally, we urge you pay special attention to foster children in the excluded populations. Currently, foster graduates are sometimes mistakenly placed into family planning plans instead of more comprehensive packages. While we appreciate the phase-in period for foster children, we urge immediate easing of the administrative burdens of providing care to foster children placed outside their LME/MCO catchment area.

We would also like to share two new substantial issues:

Mental health: We applaud the inclusion of whole-person care. This is especially important for both vulnerable populations, such as foster children and children with less severe behavioral health conditions. Receiving treatment through the primary care home can be highly effective and less stigmatizing. We urge careful consideration of the ease of systems working together; currently credentialing and other aspects of working with LME-MCOs are often a significant barrier to providing quality care. In particular, we urge the Department to ease the challenge of working across county lines, often essential for children in foster care or children who have families who live throughout the state (ie, spend significant time with divorced parents in different counties or spend summers with grandparents in a different county). (Please see our July 19, 2017 comments on the Behavior Health/IDD plan for more detail.)

Quality metrics: We applaud DHHS' attempt to set measures that use collection methods in place and build on existing standards. However, these measures were determined without the input of any representatives from independent pediatric practice. Some measures, such as HPV, are already outdated. Others, such as depression, will be exceedingly burdensome to collect, as the data point is for all patients, not just those seen for check-ups. Most concerning, pediatrics has repeated and recent negative experience with state data systems -- most notably, NCTracks. We appreciate the Department's focus on testing and assuring accuracy. However, more than the payment system needs testing. State data systems are not consistently and accurately tied to Electronic Health Records (EHR). The HIEA is off to a slower-than-anticipated start. When children move out of a practice and the practice does not inform NCIR, the immunization rate looks lower than it is as the denominator is artificially high. Under the new plan, payment will be tied to the inaccurate and lower rate. Additionally, the vaccine measure could punish practices that chose to work with vaccine-refusing families. Payment should not be tied to measures that are inaccurate or skewed. Finally, data should be transparent, iterative and easy to use, especially when the data is directly linked to payment. This includes consideration of use of existing EHR systems to minimize duplicative work and access to all claims data to patients assigned to a primary care home to monitor utilization. Along with network adequacy and social determinants of health, the area of quality metrics needs strong, meaningful, on-going "in the weeds" collaboration with stakeholders.

Our main concerns are around access as reflected in administrative ease, payment adequacy, network adequacy and fair payment and appeals. Other detail concerns include the following.

Statewide PLEs: SL2015-245 says that while only PLEs can bid on a regional contract, any PHP may bid on a statewide contract. The *Proposed Program Design* says that PLEs are regional. PLEs should allowed to bid on statewide contracts.

Review time: There are still many important details to be resolved, such as PHP capitation rate setting, risk adjustment/mitigation approaches and more. We strongly urge the Department to provide these important details for stakeholder input before releasing them as part of the RFP. Network adequacy standards should be available for review prior to the overall PHP RFP.

Staggered roll-out: We support the staggered roll-out proposal for some populations. We would also urge a roll-out by region after thorough testing and piloting. Ideally, the test region would include a Provider-Led-Entity and a commercial plan to allow for comparison of the approaches and strategies to improve both.

Beneficiary eligibility and enrollment process: The bottom line is simple: patients must be able to get the care they need in a timely matter. However, the new system is inherently more complex as patients must choose both plans and providers. We applaud the Department's effort to streamline the process for enrollment, particularly the concept of a one-stop enrollment, plan selection and primary care choice process. We also encourage special attention to resources including capacity building for this new type of work at the state and county level. We encourage you to work with appropriate experts including consumers in the design, roll-out and education of these services. It is also important that families can switch plans when health needs change or PHPs don't deliver as promised. Practices must be informed when families switch plans.

Newborns: Currently it can take months for newborns to be determined Medicaid eligible and receive a card. We have concerns about how the process will work as parents are also choosing plans. We appreciate that newborns will go into Medicaid until parents choose. We urge you pay special attention to newborns in designing the eligibility and enrollment process for beneficiaries.

Opioids: We applaud the focus on opioids. The number of substance-exposed newborns has sky-rocketed. Substance abuse is increasingly noted as a reason for removing children from families. Strong treatment options for adults is critical for child well-being. We urge that the needs of children are considered, including when adults are placed in residential treatment facilities that do not also provide family wrap-around services. Additionally, we urge appropriate treatment and support for children and their care providers to avoid misuse in the first place.

Vision: We are concerned about footnote 60 as it pertains to children. Sometimes children need specialized providers, even for eyeglasses and visual aid dispensing.

Oral health: Oral health is a critical component of physical health. Especially given the legislative carve-out, special attention should be given to oral health needs, payment ease for dental varnish and other strategies to promote oral health.

Rural health: Compared nationally, North Carolina has a high proportion of rural children covered by Medicaid and CHIP and a large gap between urban and rural coverage. Careful attention must be paid to assuring no loss of access in rural communities, including sufficient support to rural providers.

We would also like to lift up some elements we hope will continue throughout the process.

Uniformity: We appreciate the single electronic application, the uniformity in credentialing and quality assurance, and in particular the drug formulary including both the drug and the type (e.g., liquid). This is the sort of uniformity that assures needed medications are available for children and promotes administrative ease.

Social Determinants of Health: Given the importance of social determinants in setting health trajectories, we applaud this focus. We also recognize that it is hard to measure and reward. We encourage on-going stakeholder input on this area in particular.

DHHS as lead data aggregator: This reduces possible administrative burden and the need to deal with multiple different calculations for the same data point.

Medicaid as back up: We appreciate that a straight fee-for-service Medicaid program will continue both to assure the infrastructure and to help provide insurance coverage for patients, such as newborns, not-yet-enrolled in plans.

Continued stakeholder engagement: Health care is not a "one and done" effort. NCPeds has enjoyed a long and strong relationship with NCDHHS. We appreciate proposals to continue to engage with key stakeholders around Medicaid.

Workforce efforts: We appreciate strategies to support community-based residency and other strategies towards strong and adequate workforce, especially in shortage areas such as primary care and rural communities. We also agree with the need to increase community-based residency slots to attract physicians to rural and underserved areas.

Continuity of care: Thank you for including measures and protections for families to stay in their current medical homes and with their siblings, including during plan choice.

Responsive to status and need: We appreciate your recognition that not all practices are starting in the same place and may need extra supports to fully implement the elements of reform.

We value your thoughtful approach and look forward to hearing greater detail, especially as it relates to access for patients and protections for providers.

Please contact us at any time for additional information, linkages with pediatricians (general, specialist, independent practice, hospital and university-based, etc.), queries to pediatricians in other states about how certain strategies work, etc.

Thank you again for this opportunity to provide input into this important process that has profound consequences for child health. We truly appreciate DHHS' thoughtful and considered approach to reform.

Sincerely,

Scott St. Clair, MD, FAAP, Chapter President
North Carolina Pediatric Society (NCPeds)

CC: Dave Richard