



## North Carolina Pediatric Society

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December 7, 2017

**RFI NO.** 30-DHB-110217-18-A2

NC Department of Health and Human Services  
Office of Procurement, Contracts, and Grants  
Attn: Ken Dahlin  
Hoey Building, Dorothea Dix Campus  
801 Ruggles Drive  
Raleigh, NC 27603

Dear Mr. Dahlin:

Please accept these comments to the Request for Information (30-DHB-110217-18-A2 – Managed Care Program Actuarial) on behalf of the North Carolina Pediatric Society (NCPeds). NCPeds is a 501 (c) 3 working to empower pediatricians and their partners to foster the physical, emotional and social well-being of infants, children, adolescents and young adults. We have about 2,000 members statewide, including pediatricians, medical students, residents and other health professionals. Please note that our organization is **not** a potential applicant for a "Pre-Paid Health Plan." While we do not have direct actuarial background and experience within our state organization, we still would like to make short general comments on the Actuarial Elements of Medicaid Managed Care.

- 1) We urge the use of Medicare rates as the rate floor for primary care if the state expects to maintain the same level of** primary care participation it has today. Regardless of what actions the state takes to minimize administrative burdens, moving from the current Medicaid system to a managed care system is going to bring additional administrative complications to frontline primary care practices. Nationally, during the two years the federal government mandated Medicare rates for Medicaid, access to care clearly increased. Since those rates went down in North Carolina, the number of primary care physicians accepting Medicaid has dropped. Numerous other states have chosen to maintain the Medicaid to Medicare parity rate increase, and they have seen positive results in ongoing improved access to care, which will be crucial in the managed care environment. A recent JAMA Internal Medicine article has confirmed this increased access. When the fees paid to health care providers by Medicaid go up, appointments with primary care doctors suddenly become more available to Medicaid beneficiaries – and the opposite happens when fees go down. Coupled with potential loss of the per member per month, already stretched providers would be paid *less* for doing *more* work.

- 2) **Since children represent 70% of the population affected by the waiver, we urge a more child specific rate-cell model such as the Pediatric Medical Complexity Algorithm.** We are concerned about the sole reliance on the Chronic Illness Disability plus Prescription (CDPS + Rx) model. While it is our understanding that this is a well-conceived model for adults, it is further our understanding that it does not work well for children. Indeed, that is why researchers through the Washington Center for Excellence at Seattle Children's Hospital used CDPS as the basis for developing a more child-specific methodology – the Pediatric Medical Complexity Algorithm (PMCA) which has dramatically better sensitivity and specificity.
- 3) **Prepaid Health Plans (PHPs) data requirements should include full ICD-10 code use on Day 1.** One finding from the PMCA study was that fee-for-service Medicaid data was far more complete than the data coming from the managed care Medicaid groups, in part because of a lack of state requirements for full ICD data from the beginning. North Carolina should assure that data from the PHP is complete and useful from the very beginning. We would further suggest that specific data requirements be determined and approved by the group that will be doing data analytics for the DMA and included in the RFP. North Carolina successful quality improvement work stands on the shoulders of the complete data that the state has access to in the current system. It is important that we don't lose that in the transition to the waiver.
- 4) **We urge continued focus on administrative ease.** We appreciate the Preferred Drug List with a single formulary. We encourage specificity around vaccine administration given that children covered by Health Choice do not currently receive Vaccines for Children (VFC). Strong mechanisms that inform practices when patients change plans will be important. We applaud mechanisms around data collection but encourage that they work with existing systems and not add another layer of work at the practice level. We are very concerned that various provision could result in substantial increases in costs to practices through need to modify their EHRs.
- 5) **We urge child-specific and other important considerations for risk-adjustment.** We are pleased the state is undertaking actuarially sound risk adjustment for Medicaid beneficiaries. Quite simply, rate setting needs to be different for different categories of Medicaid patients, from well children to children with special healthcare needs, to older adults with multiple chronic diseases. We are concerned about how the cost of certain populations, such newborns and foster children, will be taken into cost calculations. (Both of these populations are likely to need care quickly, possibly needing care before assignment to a PHP is finalized.) We are concerned that trauma exposure (or Adverse Childhood Experience score) is not one of the variables considered in the rate cell methodology. We encourage trend or other adjustments in rate setting to take into account factors such as natural disasters, disease outbreaks and other emergencies. We urge that primary care and long-term child health be prioritized in risk adjustments towards budget neutrality. We encourage assessment of network adequacy as part of risk adjustment. We are concerned about the anticipated increase cost to practice from loss of CCNC care management. We urge that attention be paid to how Child Medical Evaluations for children when abuse or neglect is suspected are reimbursed, to continue to support the recent legislative increase in the reimbursement rate. We urge consideration of child-specific tools such as PMCA.

- 6) **Care management should be retained in the transition.** We support the State's plan to phase-in more complicated populations, including waiting one year before adding foster children to Medicaid managed care. We also support a phased roll-out with the Standard Plans. We are concerned about the potential loss of care management for complicated populations if CCNC is eliminated and care management is only offered through Prepaid Health Plans (PHPs).
- 7) **We encourage special consideration for how enhanced payments for Advanced Medical Homes are calculated and how the payments are ultimately distributed.** Part of the reason so many primary care physicians accept Medicaid in North Carolina has to do with both the enhanced per-member, per-month payment they receive for acting as a medical home, and the on-the-ground care management support they receive. We are also concerned about how advanced medical homes are defined.
- 8) **Relevant to beneficiary choice, we have some questions and concerns about how often a recipient would be able to change plans.** In addition, we believe extra thought should be put into how a recipient may move from a Standard Plan to a Tailored Plan, or back. We are especially concerned to discourage potential "over-diagnosis" of children with conditions that may make it harder for them to get the education services, foster care placements or other supports they need and the potential need to switch providers when they switch plans. (We would anticipate that not all primary care providers would participate with a Tailored Plan.) We urge the consideration of special mechanisms to allow foster children to stay with their current PCP when feasible even if the PCP is only in another PHP.
- 9) **Reimbursement should be adequate to deal with additional requirements.** While we appreciate the need to use encounter data for risk adjustment, we are concerned that the burden of documenting and providing encounter data will be pushed down from the PHP to primary care physicians. This is one more reason why primary care rates should be increased and not simply left at today's current fee-for-service rates, particularly if each plan requires a different type or method of documentation.
- 10) We support ways to **mitigate risk including requiring plans to purchase Stop Loss Insurance.**
- 11) **We encourage the state to set a Medical Loss Ratio higher than the federal mandated requirement of 85 percent.** Every percent that goes to plan administration or profit is funding taken away from provision of actual care to patients. Our state has traditionally low administrative costs, meaning that there will be dollars taken away from care for Medicaid patients. Since children are 70% of the population to be served, they would likely be disproportionately affected by funding reductions.
- 12) **We support moving forward with the Carolina Cares Program** as soon as legislative approval is provided. We agree that covering additional childless adults and parents with low incomes who meet certain work requirements will benefit the state in numerous ways, including child health. Studies repeatedly demonstrate that children are healthier when their parents are healthier. Healthier adults often have healthier conceptions. Appropriate treatment of substance abuse is critical for successful reunification in child welfare placements.

- 13) **We encourage the state to direct Graduate Medical Education payments based on results.** The programs that produce physicians in the specialties of need, who practice in areas of need and take Medicaid patients, should be incentivized with additional funding. Hospitals that receive Medicaid GME should be also be appropriately incentivized.
- 14) **We are concerned about capacity.** We appreciate structures and processes such as Base Development Data, including data validation and summarization process. We urge such functions to be provided by NCDHHS for uniformity and integrity. We urge continued resource support adequate to meet the needs.

We appreciate the opportunity to respond to this RFI and look forward to remaining engaged throughout the Medicaid transformation process.

Sincerely,

A handwritten signature in black ink, appearing to read 'S. St. Clair', with a period at the end.

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

cc: The Honorable Mandy Cohen, MD, Secretary, NC DHHS  
Dave Richard, Deputy Secretary for Medical Assistance, NC DHHS  
Jay Ludlum, Assistant Secretary for Medicaid Transformation, NC DHHS  
Elizabeth Hudgins, MPP, Executive Director of the NC Pediatric Society