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, FAAP
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

March 27, 2018

Secretary Mandy Cohen, MD
NC Department of Health and Human Services
Adams Building Reception
101 Blair Drive
Raleigh NC 27699-1950

RE: *Managed Care Benefits and Clinical Coverage Policies*

Dear Dr. Cohen:

Thank you for the opportunity to comment on *Managed Care Benefits and Clinical Coverage Policies*. The NC Pediatric Society (NCPeds) is a statewide organization representing more than 2,000 pediatricians and other child health professionals statewide. We are also the state chapter of the American Academy of Pediatrics (AAP), incorporated in NC. Since children represent 70% of the population covered by the proposed waiver, the changes will have a profound impact on children and those who provide their health care.

We appreciate that current services may continue to be covered. We urge more specificity across the board in what exactly those services will be going forward. Overall, we recommend consideration of more specificity for a benefits "floor," at least in the RFP, to assure children continue to receive critical health benefits. We understand the need to avoid granularity; certain parameters, such as using *Bright Futures* as the standard, could provide comprehensive guidance, responsiveness and flexibility.

We also recommend offsetting measures to address the increased administrative burden to providers to accommodate new PHP flexibility.

Additionally, we urge that both Standard Plans and Tailored Plans have robust packages for children with an adequate mechanism for determining network adequacy for children. Furthermore, children should not be required to move between Standard Plans and Tailored Plans to get the care they need. Children should only be placed in Tailored Plans if Standard Plans cannot meet their long-term needs. Young children including newborns, in particular, mostly belong in Standard Plans.

Once again, we will focus on our five major areas of concerns. Specific recommended changes to the *Policies* are bolded and italicized.

Benefits

- Use Bright Futures as the standard of covered services for children
- Use the American Academy of Pediatrics' *Scope of Health Benefits for Children* document as concrete guidance for RFP and plan development (http://pediatrics.aappublications.org/content/129/1/185)
- Cover needed services - at a minimum, all services currently provided to children should be covered in the new system, with a special-focus on the full range of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit and services for medically fragile children as consistent with 2016 CMS guidance. ***Each element of EPSDT should be delineated in the Policies and mandated to be provided by every Standard Plan and Tailored Plan and it should be explicit that EPSDT would override any soft limits that are established.***
- Assure carved out benefits will still interface with the other benefits at an adequate payment rate. For example, provide coverage of wrap-around services for oral health care for special needs children, such as needed hospital and anesthesiologist services associated with dental work at a rate sufficient to ensure hospitals and other providers are able to provide the necessary services
- Avoid bundling of benefits
- Keep Into the Mouths of Babes at its current proven and successful structure
- Assure legislatively mandated increased payment rate for Child Medical Evaluations is paid at legislatively mandated levels across plans (or by the State). ***Specifically, on Table 2, please strike "Case Conference for Sexually Abused Children" and insert "Physician Participation Case Conference."***
- Use current clinical coverage policies and continue use of the Physician Advisory Group (PAG) for review
- Promote warm hand-offs when appropriate
- Continue to allow special populations (such as medically fragile children, foster children, etc.) to have access to their existing provider network
- Continue services undisrupted during the transition, with a focus on services for the most medically needy children
- Assure other changes will not result in lowering the amount, duration, scope or quality of care and services available under the plan
- Cover trained medical interpretation/translation in the setting of limited English proficiency. In addition to being supported by Title VI of the Civil Rights Act and National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS standards), interpreter use maintains confidentiality, reduces errors and cost, and increases access to and quality of health care delivery
- Assure strong trauma-informed care
- A pediatric vision network cannot just include general optometrists who provide lenses for teens and adult ophthalmologists but also needs to include neuro-electro-ophthalmologists and other needed pediatric vision experts
- Develop step-wise enforcement to assure PHPs are providing and reimbursing all required benefits with strong Chapter 58 protections for all beneficiaries and providers.

Network Adequacy

Network adequacy and benefits are inherently linked. If there are not adequate services, including those offered by pediatric subspecialists, the benefits are effectively denied. Please see our March 2018 comments on network adequacy and December 2017 waiver comments for additional details. In terms of medical necessity, we urge you to reference the AAP's *Essential Contractual Language for Medical Necessity in Children* (http://pediatrics.aappublications.org/content/132/2/398).

Administrative Burden

There are elements of the *Managed Care Benefits and Clinical Coverage Policies* which will result in increased administrative burden to providers, namely PHP variation in PDL/PA clinic coverage policy (page 6), clinical, PA and utilization management policies (page 5), adding some but not all new clinical coverage policies to PHPs going forward (page 5) and in-lieu of service (page 3). Going forward, NCPeds would welcome the opportunity to work with the Department or PHPs to help develop ILOS, including around Social Determinants of Health.

Some particular concerns around PA include the following:

- 90 days is insufficient time for the initial transition in light of such a wholesale shift to managed care. We recommend 12 months.
- PA determinations must be made by pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, with appropriate pediatric clinical expertise in the child's condition.
- Enforcement should include periodic review of PA determinations to report on how the PA process is working.

Additionally, while we appreciate some of the carve outs, they will add another level of complexity to billing by providers. We appreciate the Department is seeking to promote uniformity in PA forms and appeals process, but this is not enough to offset the burden of these other changes. We urge requiring a standard decision support methodology and specificity on how the state will track benefit determinations in relation to those policies.

We urge the Department to identify additional ways to improve administrative ease and/or adjust payment to offset the increase resource demand of the increased burden. (Please see our December 2017 waiver comments for further recommendations.)

Payment Adequacy

We realize this document focuses on benefits, but payment adequacy is a critical component to assuring that benefits are robust and timely. Increased payment (and administrative capacity) is also a strategy to help offset increased administrative burden.

Vulnerable Populations

Foster Children: Foster children need a specific benefit package that includes trauma-informed care, initial visits within 7 days of removal from home, and appropriate access to medical records by their CPS caseworker (for example, to assure they have an inhaler when removed from the home). One of the strong successes of Fostering Health NC has been around improving oral health visits. The Benefits Policy should also provide details on how that will continue.

Newborns: We appreciate that newborns can be a challenging population, especially when they need care in the NICU. We support a strong benefit package in a Standard Plan for these children, at least until it is determined that they will need ***lifelong*** IDD or behavioral health services. We also continue to urge legal support and assistance for notification under new CARA provisions, including assuring HIPAA compliance and reporting on medical issues not relating to the (child) patient (such as parental substance use) or when there are not concerns for a child's safety and continued coverage of benefits such as maternal depression screening, lactation support, EPSDT service and other Bright Future guidance.

Thank you again for the opportunity to comment. If you have any questions or concerns, please let us know.

Sincerely,

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

Cc: Dave Richard, Dept. Sec for Medical Assistance, NCDHHS
Jay Ludlam, Asst. Sec. for Medicaid Transformation, NCDHHS
Matt Gross, Asst. Sec for Government Affairs, NCDHHS
Elizabeth Hudgins, Executive Director of the NC Pediatric Society