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 29, 2018

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

RE: NC's Care Management Strategy Under Managed Care

Dear Dr. Cohen:

Thank you once again for the opportunity to provide comments on the Department's implementation proposals relevant to Medicaid Managed Care.

The Department clearly has put tremendous effort and thought into the tiering system for Advanced Medical Homes. We agree with your sentiment that practices should quickly move beyond Tier 1 as defined in the concept paper. We look forward to discussing Advanced Medical Homes, including quality measures, in more detail at our April meeting.

We appreciate the Department's thoughtfulness in this proposal, trying to balance the needs of providers with PHPs. We welcome your acknowledgement regarding the disruptive nature of the move to managed care. We remain highly concerned that the complexity of these changes and the resultant increase in administrative burden will lead to some physicians dropping out of Medicaid and/or practices closing altogether, which will reduce access to care for all children in a community (especially in rural areas.) As a result, most of our comments will center on ways we believe the Department can best minimize the complexity of changes and at the same time reward practices for providing high quality care to Medicaid recipients. We will continue to focus on our main areas of concern: administrative ease; benefits; vulnerable populations; payment adequacy and network adequacy/access.

Administrative Ease

Payment as offset to administrative burden: Our greatest concerns center around the increased administrative burden practices will face moving forward under the proposed changes. We recognize the Department is walking a fine line trying to balance the needs of beneficiaries, providers and PHPS. We appreciate the strong emphasis on primary care. Given those somewhat competing priorities, we strongly urge the Department to set rate floors for medical homes at Medicare rates (or Medicaid, whichever is higher) as well as monthly payments. This would offset some of the increased administrative burden of contracting with multiple health plans and moving toward value-based healthcare. Given the importance this plan places on the medical home, we believe upfront action is needed to encourage primary care physicians and independent practices to continue participating in the program.

Administrative Ease Con'd

Auto-assignment: We also have concerns about how patients are auto-assigned into plans. We appreciate the thoughtfulness of the Department in reducing burden on families. We also encourage reducing burdens on providers. For examples, current beneficiaries should be able to stay with the current PCP; newborns (if auto-assigned) should be placed in the same practice as siblings, providers should be informed in a timely manner as to assignments (and re-assignments). Finally, rather than being divided equally across plans, patients should be auto-assigned in ways that reward strong PHPs, such as some of the mechanisms you propose in the concept paper on *Provider Health Plan Quality Performance and Accountability*. Additionally, providers contracting with multiple PHPs should be able to identify a preferred plan so that patients who logically belong in that practice (such as a sibling of an existing patient) get auto-assigned to the practice's preferred plan, as a way to reward PHPs that work well with providers.

Data Transparency: The transparent and timely flow of data is crucial to the success of these changes. Without accurate, near real-time data, it will be impossible for primary care practices to achieve the goals outlined in this plan. This data should be presented in a uniform manner through one portal, namely NC HealthConnex, rather than requiring a different portal for each PHP. Practices are already required to connect to the NC Health Information Exchange Authority to continue to accept Medicaid, so it is logical that clinical and quality data flow back to the practice through that same mechanism. If data does not flow directly into the EHR, the burden of having to retrieve patient information from multiple portals for Medicaid patients will be enormous. Appropriate data collection needs to start on Day 1.

Data Ease: Access to accurate and timely data will be one of the keys to improve quality and lower costs. As a result, we offer several specific suggestions around data transparency outlined below:

1. Access to real-time or near real-time data is crucial. If emergency room or inpatient data does not flow quickly to the medical home, primary care physicians will not be able to take appropriate action or meet the follow up requirements for post-ER or post-inpatient care. How can practices be assured that they will receive the data they need in a timely manner?
2. Tier 2 practices will need the same access to data they currently have, or we will lose gains the state has made to date.
3. Multiple formats and sources of data are simply not acceptable. All data should flow through NC HealthConnex so that practices will not have to go to multiple sources for Medicaid patients. There should be a minimum set of data shared with practices regardless of the Health Plan, and this data should be integrated with EHR without additional costs to the practice.
4. "Timely enrollee-level claims and encounter data" needs to be clearly defined. This data should be provided to Tier 2 practices, as well as Tier 3 and 4 practices.
5. While we understand the need for plan flexibility, there needs to be some minimum standard across plans for who receives care management.
6. Currently, Community Care networks help practices retrieve and analyze data, particularly around what care management action may be needed. What happens without this extra assistance that practices receive today?

Benefits

Care management: Care management offers a tremendous opportunity to improve care and administrative ease. We appreciate the Department's recognition of this important service and the need to streamline care management when possible. We think this narrow tightrope raises some logistical questions and concerns:

1. Clarifying details are needed regarding how care management responsibilities will be delivered, especially across plans and across tiers. For example, in Tier 3 and 4, how does it work if the Plan is providing care management oversight and payment, but the practice is selecting how the care management is provided? What if a practice likes a service they receive but the plan does not and cancels that care management service?
2. Care management needs to remain as consistent as possible across plans. A practice simply cannot juggle five different care managers and five different quality improvement teams simultaneously. Could the Department pay for use of centralized QI staff for all plans in order to increase efficiencies?
3. If initial care management screening occurs as far out as 90 days after enrollment, how will a plan hold practices accountable to quality standards across that significant lag time?
4. Care management should absolutely remain at the local level. The concept paper indicates that care management should be delivered at the local level "when possible." Based on the Carolina Access Program, we know it is possible. Telephonic care management will not be adequate. On-the-ground nursing level care management is needed, particularly for the most complex patients.
5. Complex care management will be very difficult for independent practices. As a result, we appreciate the emphasis on having practices involved with Clinically Integrated Networks.
6. Will the Department or someone else define or certify "Designated Care Management Entities?"
7. While Health Departments are specifically mentioned, the local CCNC Networks are not. Will they be able to compete for this designation? We encourage the Department to consider allowing practices to maintain their contracting arrangements with these networks given the past success of the Carolina Access program.

Vulnerable Populations

CC4C: Care Coordination for Children provides many essential services for children. It has a growing role with child welfare since July, given their support for families when a local DSS is notified of possible maternal substance use. We urge that CC4C remains strong and its responsibilities and relationships with key stakeholders are clear.

Newborns: We appreciate the standards for follow-up after hospital care. However, the two day standard may not be appropriate for newborns since newborns often need a next day follow up post discharge home.

Pediatric representation: Primary care, particularly family medicine and pediatrics, must have a strong voice on the Technical Advisory Committee(s). Given many details are still in development, we believe pediatricians must remain involved in this process individually and through their professional organizations to assure policies that work well for children, especially vulnerable populations such as newborns.

Vulnerable Populations Con'd

PMCA: We understand that CPC+ is a strong model for adults. For children, we recommend looking at the Pediatric Medical Complexity Algorithm (PMCA) which has dramatically better sensitivity and specificity for children. It was developed by researchers through the Washington Center for Excellence at Seattle Children's Hospital using CDPS as the basis for developing a more child-specific methodology. Here is a link to more information: http://www.seattlechildrens.org/research/child-health-behavior-and-development/mangione-smith-lab/measurement-tools/ Here is a recent paper from AAP: http://hosppeds.aappublications.org/content/7/7/373

Foster Children: We look forward to learning more in a future white paper about how plans, benefits and care management will work for children in the foster care system.

Medically fragile and complex children: We appreciate the increased phase-in time for this exceptionally vulnerable population.

Payment Adequacy

Payment as offset to administrative burden: Our greatest concerns center around the increased administrative burden that practices will face moving forward under proposed changes. As a result, we would strongly urge the Department to set rate floors for medical homes at Medicare rates (or Medicaid, whichever is higher). We also urge consideration of stabilizing monthly payments, such as the current per member per month which currently represents close to 10% of income for some pediatric practices. These strategies would offset some of the increased administrative burden of contracting with multiple health plans and moving toward value-based healthcare. Given the importance this plan places on the medical home, we believe upfront action is needed to support and encourage primary care physicians and independent practices.

Timely payment and other Chapter 58 protections: All plans, including Tailored Plans, should have requirements in place similar to the Chapter 58 protections currently required of private insurance plans.

Access to Care/Network Adequacy

Robust network: In order for care management to work well, primary care and subspecialists need to work together to provide care for a patient. That means every PHP, even regional plans, need to have robust networks with adequate access to subspecialists and other needed services.

Other

An ombudsman program for both providers and recipients is needed. Pediatricians will need a mechanism for appeal to the state if satisfactory resolution of an issue or complaint cannot be reached with one of the health plans.

Stepwise enforcement of PHP standards is needed. We appreciate the range of "carrots" explained in the *Provider Health Plan Quality Performance and Accountability* concept paper. It is equally important to have a range of "sticks," short of denying a PHP the ability to have a plan in NC.

We appreciate inclusion of social determinants of health and acknowledgement of need to address "zip code" level problems. However, we remain concerned about the implementation details.

Health Departments play a crucial role in Medicaid, and we are glad that their role is acknowledged. We do have a few questions and concerns, including what happens to the role of Health Departments after the initial two years of managed care implementation? How will care management coordination work going forward, especially pertaining to CC4C?

Ongoing clinical leadership is crucial. We are concerned that the local clinical leadership in place today will be lost as we move to Medicaid Managed Care. The concept paper discusses clinical leadership with Care Management for High Risk Pregnancy and At-Risk Children, but not in other areas. Currently, local leadership assists with clinical pathways, quality improvement strategies and more. We would make the following requests: 1) The current Physicians Advisory Group (NC PAG) should continue to play an important role as Managed Care moves forward; and 2) Medicaid's Preferred Drug List Committee must remain in place, since the managed care legislation requires one preferred drug plan.

Overall, we believe the model presented in this white paper is conceptually strong. It also highlights the tension of reconfiguring a complex and inter-related system where care management has the potential to knit critical services together or to increase complication and burden. Given the centrality of primary care to the overall success of improving population health and the strain upcoming changes will put on primary care providers, especially smaller and/or rural practices, we urge the Department to use payment adequacy as a remedy to the increased administrative burden. We applaud and encourage the continued inclusion of multiple stakeholders in the development of strategies going forward.

Thank you.

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