American Academy of Pediatrics
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North Carolina Chapter

North Carolina Pediatric Society

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

Dear Dr. Cohen:

Thank you for the chance to respond to the proposed concept paper on Prepaid Health Plan Network Adequacy and Accessibility Standards. The North Carolina Pediatric Society (NCPeds) represents more than 2,000 pediatricians and other child health professionals across North Carolina. We remain deeply concerned about the potential impact of the proposed 1115 waiver on children, who represent 70% of the population to be served under the proposed waiver. We will continue to focus our remarks on our five major areas of concern in assuring the 1115 waiver works well for children. We will also restate our Network Adequacy specific concerns from our December 2017 waiver remarks.

Access

All ages starting at birth for pediatrics: The Prepaid Health Plan Network Adequacy and Accessibility Standards do not seem to include a methodology for assessing access by age. NCPeds had suggested using taxonomy codes. It is our understanding DMA does not find that to be a feasible solution. We urge finding and using a methodology that assures when subspecialists in a network are considered to provide services to a "child" they mean all ages for children, not just teens. We urge that the Table 4 include age as one of the access standards for subspecialty care.

Clarify sub-specialty care: In addition to being clear that there are sufficient sub-specialists in the network to provide care to ***all*** ages of children, there also needs to be clarity around urgent care. Urgent care should offer adequate and timely access to subspecialists, such as through direct access to an ER or with mandated confirmed direct follow-up in a specialty office (such as in the EMTALA rules for a hospital ER).

Directories should include more helpful information: We applaud the regular updating of directories. We urge that the directories indicate if new patients are being accepted and under what circumstances (Newborns? Siblings? Referrals? Emergency? All?). Further, directories should be in a format that can be manipulated and searched (such as Excel), not merely machine readable (such as an unsearchable PDF).

Strong data tracking at baseline and over-time: DHHS should establish a baseline and track over time the number and percent of practices/providers accepting virtually all new patients. Accessibility and availability should not rely on self-reports of the PHPs. A third party method, such as a "secret shopper" will yield more reliable results.

Use "practices" not "providers": Many standards in Table 1 are linked to equal/more than two providers for certain types of care, including pediatric. If there is one practice with two providers and they are not a good fit for the patient, then the patient effectively has no provider.

Clarify responsible parties: To what degree is the PHP expected to be the gatekeeper for specialty care? Do specialists need a referral?

Monitoring and enforcement are the key: Monitoring and enforcement of access should be the responsibility of DHHS and not rely on self-reports of the PHPs. There should be multiple enforcement strategies that can be quickly implemented depending on the severity and frequency of the problem.

Benefits

Include EPSDT: It should be crystal clear that each child has access to the full-range of EPSDT services, including delineating it in visit types.

Include screenings: Screenings should be included as part of the definition of preventive care.

All children should have access to top quality care: We are concerned that network adequacy standards "will vary by geographic region." While the travel time may need to be different, overall access to services and benefits should be strong throughout the state.

Pharmacies should be able to compound: In looking at pharmacy adequacy, at least one pharmacy should be able to compound needed medications.

Include dental benefits for appropriate measures: We realize that dental in general is carved out of the waiver. However, some dental care (such as in emergency room) will still be needed. We continue to urge streamlined coordination of dental with other parts of the system, such as the operating room and anesthesiologist costs when children need that level of care.

Monitoring and enforcement are the key: Monitoring and enforcement to assure that appropriate benefits are provided should be the responsibility of DHHS and not rely on self-reports of the PHPs. There should be multiple enforcement strategies that can be quickly implemented depending on the severity and frequency of the problem.

Administrative Ease

Monitor provider complaints: We applaud that you monitor beneficiary complaints. We urge you do the same for providers, especially around issues relating to administrative ease and prompt and accurate payment.

Monitor panels: Patient panels should be appropriate to the provider. (For example, pediatric patients should not be 50 years old and live 50 miles away.) When a mistake occurs, it should be quick and easy to rectify. Panel alignment should be one of the measures of the PHPs to assure that patients truly have access to appropriate providers.

Monitoring and enforcement are the key: Monitoring and enforcement factors relating to administrative ease as it relates to network adequacy should be the responsibility of DHHS and not rely on self-reports of the PHPs. There should be multiple enforcement strategies that can be quickly implemented depending on the severity and frequency of the problem.

Payment Adequacy

Payment adequacy is linked to network adequacy: We realize the focus on this white paper is not on payment adequacy. However, given that rates are an important component of contract negotiation, assuring an adequate rate floor (such as Medicare or Medicaid, whichever is higher for the particular service) is critical to assuring network adequacy. Monitoring that payments are timely and adequate will be a critical piece of enforcement.

Monitoring and enforcement are the key: Monitoring and enforcement of payment adequacy as it relates to network adequacy should be the responsibility of DHHS and not rely on self-reports of the PHPs. There should be multiple enforcement strategies that can be quickly implemented depending on the severity and frequency of the problem.

Vulnerable Populations

We are especially concerned about the potential impact of the network adequacy standards on newborns and children in the foster care system.

Newborns: We urge compliance with Bright Future guidance on newborn visits. Appointments within 30 days for new patients does not work for this population. Typically, a newborn has multiple visits with a pediatrician (or other physician) within the first 30 days of life.

Foster children: This is another population for whom an appointment within 30 days is far outside best practice standards. AAP recommends a visit within hours of removal from home and the counties participating in Fostering Health NC have a goal of seven days. Additional appointments may well be needed before the 30-day mark. Additionally, the PHPs bidding on Fostering Care NC should demonstrate that their provider network is adequate to meet the standards of Fostering Health NC and includes the maximum feasible number of providers already participating with Fostering Health NC. Services should be statewide, not regional, as this population tends to move regions.

Monitoring and enforcement are the key: Monitoring and enforcement should be the responsibility of DHHS and not rely on self-reports of the PHPs, especially for these particularly vulnerable populations. There should be multiple enforcement strategies that can be quickly implemented depending on the severity and frequency of the problem. Vulnerable populations in particular should have “quick out” to a better-suited plan when there are problems.

Here are our comments from December 2017 regarding network adequacy. We thank for your inclusion of #6 and encourage consideration the other recommendations as well.

Network Adequacy

1. Assure that the definition of "child" covers all ages of children, including for access to subspecialty care
2. Require plans to document network adequacy of all pediatric medical care.
3. Assure network adequacy measures include access to pediatric primary care, pediatric medical subspecialty and pediatric surgical specialty care
4. Require PHPs to accept all willing pediatric subspecialists in every network (including regional networks when the subspecialty is in short supply) with determination of specialty based on certain taxonomy codes
5. Provide access to full network through any door (not just the Emergency Department)
6. Use a measure of travel time to calculate network adequacy (rather than "as the crow flies" distance)
7. Provide out-of-network coverage of pediatric specialty and subspecialty care at appropriate payment rates in rare instances when such necessary pediatric care is not available in-network. Monitor instances of out-of-network care as a marker for inadequate networks and provide mechanisms for addressing inadequate networks.
8. Assure reasonable access and travel when service exists locally; extensive travel should not be required when a more proximate and fully appropriate pediatrician or pediatric subspecialist can provide a quality service in the needed time frame
9. Keep access to non-emergency medical transportation strong
10. Assure access to rural providers, including through enhanced payments or other incentives
11. Promote access to primary care. We are very concerned about the lack of emphasis on the need to promote primary care or the inclusion of primary care as a provider shortage concern
12. Require network directories to be in clear language and updated very frequently, with clear practice characteristics (practice contact information, specialty certifications, facility affiliations/admitting privileges, etc.) and indicate whether physicians are accepting new Medicaid enrolled patients and if so under what conditions (for example, only newborns or siblings).

Thank you again for the opportunity make comments. Please do not hesitate to contact us if you have any questions.

Sincerely,

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

Cc: Dave Richard, Dept. Sec for Medical Assistance, NCDHHS
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