



North Carolina Pediatric Society

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December 7, 2017

RFI NO. 30-DHB-110217-18-O

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-O – Managed Care Program Operations) 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. Our membership includes approximately 2,000 members across North Carolina including pediatricians, medical students, residents and other health professionals. Our organization is **not** a potential applicant for a “Pre-Paid Health Plan” contract but chooses to offer information and insight to the questions outlined in Section III of this RFI.

Responses to Section III: Questions for Respondents

- A. Benefits:** We believe there will be undue administrative burden if each plan is allowed to develop various clinical coverage policies and therefore urge the Department to utilize current clinical coverage guidelines. In particular, the Department should mandate the continuation of all parts of Early and Periodic Screening, Diagnostic and Treatment (EPSTD) benefits in each plan without additional clinical coverage policies. We also believe preventive services should be based on *Bright Futures* guidelines. We urge the continued use of the Physicians Advisory Group (PAG) to ensure that clinical guidelines are based on evidence-based best practices. The PAG has been an important part of physician input into Medicaid and should remain in place for uniformity. We believe health plans can best innovate in non-clinical services that impact social determinants of health, such as housing, transportation and food scarcity. We urge that Child Medical Evaluations are paid at the higher rate recently funded by the General Assembly for all children when abuse or neglect is suspected, regardless of whether the case goes through DSS or DMA.
- B. Pharmacy:** We believe the Department should continue use of the Physician Advisory Group's (PAG) Pharmacy and Therapeutics Committee as part of a legislatively mandated single Preferred Drug List. Further, we urge that this list include both the specific medication and its formulation (for example, liquids). Furthermore, all Medicaid covered patients ought to have access to the same prescription covered by any of the PHPs.

- C. Enrollment into Pre-Paid Health Plans (PHPs):** We agree that clinical performance data and provider networks should be easily available to potential Medicaid recipients to engage in enrollment decisions in areas where patients may have a choice. We are very concerned about the potential complexity of enrollment for families seeking to find not only a provider, but also a plan that best meets their needs. It is particularly crucial that a plan's provider network be transparent and sufficient to meet the needs of recipients. As recipients are enrolled into a PHP, we believe first consideration should be their (or their sibling's) existing medical home/primary care physician. For foster children, we urge placement into practices already delivering trauma-informed care through the Fostering Health NC initiative. Care will need to be taken in enrolling certain segments of the Medicaid population.

Foster children: We appreciate the inclusion of the Fostering Health NC model into the program design of Medicaid reform. We appreciate that one PHP will focus on strong delivery of services to this vulnerable population. We are very concerned about the delivery of services, especially during the phase-in. In particular, we urge continued care management, preferably through CCNC. (We are concerned about the potential lack of care management if CCNC no longer exists and care management is provided through the PHP structure but the children are not yet attached to a PHP.) We appreciate that (per the Demonstration Waiver Application) children in foster care will not need to switch between Tailored Plans and Standard Plans to get the services they need. We urge that the designated foster care PHP utilize practices already delivering trauma-informed care through the Fostering Health NC initiative.

Newborns: Currently, it can take many months for a newborn to be enrolled in Medicaid and receive a card. We appreciate The Department's willingness to assure these infants receive fee-for-service care until such time as they are enrolled. Given that newborns are not currently part of the timeliness criteria, we are concerned this important population might be overlooked in some areas. The Department may want to consider a performance goal such as eligible newborns enrolled with a PHP within 6 to 12 months of birth.

CAP-C and other CYSHCN: This population is incredibly vulnerable to service disruption. We appreciate the graduated roll-in of services. As with foster children, we support continued care management through CCNC in the transition period. We urge the utmost care in designing and implementing benefits for this group with substantial stakeholder input, including parents.

- D. PHP Care Management and Advanced Medical Homes:** The percentage of primary care physicians who accept Medicaid patients in North Carolina is higher than almost any other state, allowing for strong access to care. If this is to be maintained, both financial and practice supports will be key. We believe it is crucial to build on the existing care management infrastructure, utilizing what has worked in North Carolina. Multiple care management programs from each of the PHPs would be costly and inefficient. We also believe it is important to maintain care coordination fees to practices and to emphasize additional practice-based support to smaller, independent practices.

We believe it is important to maintain the use of predictive modeling to determine what patients are most in need of various care management services. We believe care manager case loads should remain at current levels and that larger practices should continue to have co-located managers to facilitate warm hand-offs when needed.

Relevant to data, it is important that data be uniform, clear, transparent and actionable. Data should be centralized for a practice versus separate data management systems for each PHP. To do otherwise would be extremely inefficient and costly to practices. Other provider supports should be seamlessly integrated across payers to avoid inefficiencies and ultimately higher costs.

Appropriate understanding of the Electronic Health Record (EHR) is also critical. While EPIC is often used by large systems, independent practices use a myriad of different EHRs. It is important to assure structures that support a variety of EHR without practices being forced to assume additional programming costs.

Finally, we believe the state should consider enhanced payment for practices that serve as advanced medical homes, particularly when the practice adds additional key services such as behavioral health care, etc. Payments must be indicative of the population served, particularly considering special needs populations. We further recommend that practices already PCMH recognized should be allowed to keep that recognition without reapplication to NCQA.

- E. Access to Providers in Rural Areas:** Network adequacy for recipients will be crucial, especially in rural areas of the state, and we cannot support a two-tiered system of care where urban residents have greater access and quality. As a result, the state needs to mandate enhanced payment or other incentives to practices willing to fully participate in rural and underserved areas of our state.
- F. Workforce, Provider Supports and Telehealth:** As stated above, it is important that provider supports have some level of consistency and uniformity, without multiple practice support specialists or care managers entering already overburdened primary care practices. As a result, we encourage coordination of practice supports and uniformity of data analytics. We also believe enhanced payments should be a key mechanism for practices to transform into the Medicaid Managed Care environment. Even in the best of situations, moving from one Medicaid payment system (the State) to dealing with multiple Medicaid managed care plans will lead to increased administrative burden and workload for practices. This is particularly true for smaller practices and practices in rural and underserved areas. As a result, it is critical that payment to primary care increase and payment methods evolve. We believe in and of itself, this is a key “practice support.”

Relevant to workforce development, we believe Medicaid reform offers a great opportunity to look at Graduate Medical Education in our state. We believe residency programs should be awarded for producing the physicians our state needs, in the specialties our state needs, who ultimately practice in areas of most need.

Finally, we believe telehealth can be a positive for our state's Medicaid programs, but only if it is utilized to supplement existing services, not to supplant services and not when a pre-existing relationship with the practice is absent. An actual physical exam cannot be replicated electronically. As a result, we urge caution in the use of telemedicine for primary care services. We do believe that telehealth can work for certain illnesses or follow up visits when a patient has an existing, long-term relationship with a medical home. We also believe telehealth can be effectively used for consults from specialists and to enhance patient care when a recipient is already in a primary care office. For example, a patient may be able to see a specialist remotely while visiting their medical home. In these cases, it is crucial that both the primary care physician and the consulting physician receive adequate pay. Also, it should be noted that such a "visit" is not a traditional consultation. Attention should be paid to telehealth consults by specialists or others, including for regional PHPs seeking to expand care options. In addition, our state must continue to work to provide broadband access to all areas of our state. In some instances, broadband does not exist, or is insufficient.

- G. Social Determinants of Health:** This is the area where innovation and flexibility are most needed. This is also the area where the current fee-for-service system does not work, meaning managed care will provide a great opportunity for improving how our system deals with social determinants of health. For example, pre-paid health plans should be given the flexibility to provide unique services to address housing, food insecurity, transportation and even education. We know these areas can impact the health of individuals and communities greatly. We encourage flexibility and experimentation in this area while continuing to measure results. However, pediatricians will be loath to screen for conditions (such as food insecurity) when referrals or follow-up services are repeatedly inadequate or non-existent.
- H. PHP and Provider Contracting and Payment:** First and foremost, the Department should mandate adequate minimum payments to primary care, the first-line to success as we move into Medicaid managed care. In North Carolina, payment rates and innovative payment methodologies will be crucial. We believe the state should set primary care rates at a minimum of Medicare rates. Nationally, during the two years where the federal government mandated Medicare rates for Medicaid, access to care clearly increased. When the enhanced rates ended, access to care decreased, according to both DMA data and a survey by the NC Pediatric Society. Numerous other states have chosen to maintain the Medicaid to Medicare parity rate increase, and they have seen positive results in maintaining enhanced access to care, which will be crucial in the managed care environment. A recent JAMA Internal Medicine article has confirmed this increased access. As we move to value-based healthcare, access to primary care is going to be even more important, making proper payment to primary care practices crucial to the success of this Medicaid transition.

It is also critical that contracts not be exclusive to one PHP. There must be transparency and non-exclusivity in contracting. Provider protections must remain in place, including prompt payment requirements and a statewide ombudsman program to help practices with disputes with PHPs. In addition, value-based contracting should be encouraged.

- I. Medical Loss Ratio:** We encourage a Medical Loss Ratio at a higher rate than the federal requirement of 85%. A higher ratio will mean more funding to direct health care efforts as opposed to administrative overhead of the PHPs. We also encourage the state to take proper measures to ensure enforcement of contract provisions with PHPs.

- J. Information Technology and Data Exchange:** It is crucial that NC HealthConnex, the state's Health information Exchange, be fully operational as we move to Medicaid Managed Care. There must be real-time access to data, particularly emergency room usage, hospitalizations, imaging, etc. Real-time exchange of information will be critical to improving care and lowering costs, helping to avoid unnecessary testing and unnecessary ER utilization. This information must be easily integrated into Electronic Health Records at the medical home level. It is also critical that our state's Controlled Substances Reporting System and the NC Immunization Registry be fully integrated into NC HealthConnex and that each of those systems work with the practice EHR to assure adherence to NC's minor consent laws. HealthConnex should be searchable for usage data, including by specialists. Finally, we encourage the state to examine Medicaid recipients' access to technology and their ability to use technology effectively.
- K. PHP Licensure:** We believe it is crucial to maintain Chapter 58 consumer and provider protections for PHPs. There must be prompt payment, financial solvency and other requirements for PHP licensure. We also urge the use of an ombudsman to assist practices with disputes with PHPs. Providers should be able to opt-out without penalty when payments are not prompt or accurate.

General Concerns

Children: Children comprise 70% of the potential waiver population, but only a small fraction of the cost. The needs of children must not be overlooked when attention turns to cost drivers. Importantly, for many pediatric practices, especially rural practices, it is not uncommon for 40% or more of the patients to be insured by Medicaid or CHIP. Reimbursements that are too low or administrative burdens too high for these practice to participate will hurt access to care and child health.

Network Adequacy: We appreciate the thoughtfulness and wide range of factors considered for stakeholder input in the RFI. We are concerned about provisions relating to Network Adequacy having the same level of robust consideration. It is our understanding that in other states, networks have been considered adequate even if specialists served only limited child populations (such as children 16 and older) or required unacceptable levels of travel to specialists and even common services (such dialysis). Structures in NC must assure that children of all ages have adequate and timely access to services and specialists.

Non-exclusivity: SL2015-245 in Section 5, 6(d) prohibits exclusivity provisions. This will be critical to assure access to both primary care and specialty care for children.

PLEs are to be statewide: SL2015-245 specifies in Section 4 (6(a)) that statewide contracts are to go to PHPS (6a) and defines a PHP to include a PLE (2b). Yet the RFI says that commercial plans will be statewide and PLEs will be regional.

Chapter 58 Protections are required by law: SL2015-245 specifies in Section 4 (6a) that Chapter 58 protections shall apply for both consumers and providers.

Thank you for the opportunity to provide these comments. If you have any questions or concerns, please do not hesitate to contact us.

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, Executive Director for the NC Pediatric Society