



## 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  
828-213-1747  
Susan.Mims@msj.org

### Past President

Deborah L. Ainsworth, MD, FAAP  
Washington, NC

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Chapel Hill, NC

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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

December 19, 2017

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 opportunity to provide additional stakeholder input the revised waiver. The NC Pediatric Society (NCPeds) has long enjoyed a strong relationship with the NC Department of Health and Human Services (DHHS) towards our shared mission of healthier children. NCPeds represents almost 2,000 pediatricians and other child health professionals across NC.

As the NC Department of Health and Human Services (DHHS) noted in the listening session, children would comprise 70% of the waiver population but account for only 30% of the costs. For many practices, especially in rural areas, 40% or more patients may be insured by Medicaid or CHIP. Even relatively small changes in the administration or reimbursement can have a profound impact on these practices. Since these often rural, often independent, practices are the sole pediatric office in the community, if the practice can't keep their doors open, *all* the children served in that practice may lose access to health care. We understand the need for an ambitious timeline, we want to underscore the fact that it is critical that pediatric practices be supported and held harmless, including during the transition. We urge a strong focus on child health throughout the process.

In addition to robust networks of general pediatricians, it is critical that networks include as many pediatric subspecialists and other pediatric providers as possible with minimal burden to the provider who may need to contract with multiple regional Prepaid Health Plans (PHPs) as well as statewide PHPs to assure adequate access. This is essential in order to avoid exacerbating the existing shortage of pediatric subspecialists in North Carolina. It is not unusual for a pediatric subspecialist to be in a practice that otherwise serves mostly privately insured adults. If the billing becomes too complex for such a small fraction of their patients, the practice may decline Medicaid/PHP patients altogether.

Again, we appreciate the opportunity to provide comments to you at key points of the transition process and look forward to working with you on these important issues moving forward. The following comments constitute NCPeds' guidance on major themes and important aspects to protect and promote child health.

### **Benefits**

- Use Bright Futures as the standard of covered services for children
- Cover needed services - at a minimum, all services provided to children now 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
- Assure that 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
- Keep Into the Mouths of Babes at its current proven and successful structure
- Assure that legislatively mandated increased payment rate for Child Medical Evaluations is paid at legislatively mandated levels across plans (or by the State)
- 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 uninterrupted 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

### **Payment Adequacy and Promptness**

- Pay at Medicare-equivalent rates for primary care or 115% of Medicaid, whichever is greater. Analysis shows that paying enhanced rates increases Medicaid participation by providers. We are very concerned about implications in the waiver (see pages 5 and 30 for example) that many rates will be insufficient to cover costs. This is unacceptable
- Take the unique needs of children into account for payment measures, such as using the Pediatric Medical Complexity Algorithm rather than CDPS + Rx for risk adjustment of children
- Require prompt **and accurate** payments with daily interest of 1% after 30 days
- Pay providers directly from State at PHP negotiated rates if PHPs declare bankruptcy and/or fail to pay accurately after 90 days
- Fund required support services
- Assure data and methodology transparency and replicability
- Assure that pay-for-performance metrics involve stakeholder input, including from independent practices and have final approval from NCDHHS prior to implementation
- Pay under fee-for-services (FFS) during the period of presumptive eligibility generally and until newborns are enrolled specifically
- Continue the per-member-per-month (PMPM) or other mechanisms to encourage broad participation and promote adequate payment
- Reimburse services on a FFS basis in the transition window from Standard Plans to Tailored Plans (or vice versa)
- Use child-specific tools, such as the Pediatric Medical Complexity Algorithm for rate cell structure and other payment methodologies
- Assure that administration of the PHPs does not siphon off funding for health services

### **Network Adequacy**

- Assure that the definition of “child” starts at birth, including for access to subspecialty care
- Require plans to document network adequacy of all pediatric medical care.
- Assure network adequacy measures include access to pediatric primary care, pediatric medical subspecialty and pediatric surgical specialty care
- 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
- Provide access to full network through any door (not just the Emergency Department)
- Use a measure of travel time to calculate network adequacy (rather than “as the crow flies” distance)
- 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.
- 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
- Keep access to non-emergency medical transportation strong
- Assure access to rural providers, including through enhanced payments or other incentives
- 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 (see page 32 for example)
- 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)

### **Administrative Ease**

- Assure uniform credentialing
- Use current clinical coverage policies to promote uniformity
- Require one standard PDL with all types of the drug (such as liquids) available on each. A PHP could offer more options, but not fewer
- Disallow substantial (perhaps 10% or more) re-assignments of existing patients to new PHPs outside the open enrollment period. When changes occur, providers should be informed promptly and held harmless if they provide services before notification of the PHP change.
- Require uniform and streamlined prior authorization to allow patients to receive services at the most appropriate hospital, with both service delivery options and geography as consideration, even when the hospital is out of network or region.
- Impose vendor requirements that include 80 hours of computer system and website uptime weekly between 7AM and 7PM, including weekends and holidays. Providers will be paid for services rendered during “down time” when checking for eligibility or other services was unavailable
- Assure adequate computer supports by vendor, including HIPAA compliant mechanism to get prior authorizations (PA) on-line without dialing in, functional with all Electronic Medical Records (EMRs)

- Provide for streamlined and timely appeals
- Use enforcement mechanisms that make sense and have worked in other states. Enforcement mechanisms need to be set up prior to the delivery of services through PHPs
- Grandfather in practices that have already met Patient Centered Medical Home standards and focus standards on quality improvements
- Require payment from the vendor to fully offset any additional EMR programming that is required, including practice staff time
- Centralize data collection
- Provide enhanced payments for advanced medical homes, especially when additional services such as behavioral health are provided. Consider practice support payments for mental health care that is not compensated by CPT codes
- Assure care management is uniform and in the community, as it is now with Community Care of NC (A practice should not need to support multiple care managers from multiple PHPs coming in with multiple different priorities throughout the week)
- Assure data is transparent, timely and replicable by the provider and NCDHHS
- Assure data systems (PHP, Health Information Exchange, NC Immunization Registry, etc.) work together seamlessly. Any reprogramming of a EMR that is required for PHP participation should be reimbursed by the PHP
- Assure administrative ease for families, including strong supports in PHP and PCP selection, serving children in the same practice and families in the same network, involving families in program design and more

#### **Social Determinants of Health**

- Assure that services are available to address social determinants of health before requiring screening
- Assure that EMRs support requirements (any required adjustment should be fully reimbursed by the PHP)
- Provide legal assistance and guidance for collecting and documenting SDOH in the health record, especially for children when the issue also affects the parent (domestic violence, substance use, etc.)
- Include proven supports, such as Reach Out and Read and evidence-informed home visiting programs

#### **Newborns**

- Reimburse fee-for-service directly from Medicaid to providers for services provided before a newborn is assigned to plan
- Take care when cost calculation include newborns, as under the current system it often takes many months for newborns to get their Medicaid card
- Provide 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
- Assure continued coverage of benefits such as maternal depression screening, lactation support, EPSDT service and other Bright Future guidance

### **Foster Children**

- Assure providers use trauma-informed care and Bright Futures guidelines
- Pay on the enhanced schedule
- Require that the PHP designated for Fostering Health seek inclusion of all practices operating within the Fostering Health NC model currently
- Encourage and incentivize the inclusion of current FHNC practices with foster health focused PHP
- Phase-in services for foster children
- Provide Care Management, ideally through CCNC, in the transition
- Allow foster children to be served in a Standard Plan without switching between Standard Plans and Tailored Plans
- Avoid policies that would encourage over-diagnosing children that could later limit placement or education options
- Assure that a neutral party convenes key stakeholders to determine and troubleshoot potential problems and share solutions
- Assure mechanisms allow for time-effective sharing of information and provision of services in all counties and regions of the state as foster children are highly mobile
- Assure that young adults transitioning out of Foster Care are covered with full Medicaid services (not just family planning) and that they can continue to get appropriate mental health services without needing to move into a Tailored Plan

### **Children and Youth with Special Health Care Needs**

- Adopt a longer phase-in this incredibly vulnerable population for services to ensure continued access to care
- Continue to provide care management, ideally through CCNC, in the transition
- Establish strong mechanisms for stakeholder input, with a focus on parents and families
- Assure smooth interaction with CAP-C and other programs
- Look at multiple-needs together since sometimes a combination of conditions may present additional complications or needs
- Assure that oral health care works well for this population. While dental is carved out, it is unclear how the ancillary services (such as those provided by an anesthesiologist) will be paid and at what rates (Current rates are too low to incentivize the services)
- Incorporate robust quality measurement and improvement strategies specific to CYSHCN into PHP contracts, consistent with October 2017 publication of the National Academy for State Health Policies

### **Rural Access**

- Require enhanced payment or other incentives to practices willing to fully participate in rural and underserved areas of our state
- Assure that broadband is sufficient to support telehealth in rural communities
- Assure payment for telehealth is provided to both the consulting specialist and the referring provider who is using office resources including space and provider time to facilitate the consultation
- Allow telemedicine for primary care only when there is an existing, long-term relationship with the medical home; provide adequate reimbursement for telehealth visits
- Use GME to improve rural access, including for primary care

### **Oral Health**

- We recognize that most dental services are carved out of the waiver by law
- We applaud the inclusion of Into the Mouths of Babies (IMB) as a service that can continue to be offered in the primary care setting. We urge that IMB maintain its successful structure (again, no bundling)
- We 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
- We urge adequate reimbursement throughout the system so that children get the full range of health services they need, including oral and dental care

### **Other**

- Provider Led Entities must have the option of providing state-wide coverage. The state law (SL2015-245) says that either a commercial plan or a PLE can offer statewide services
- One PHP should not be able to limit participation with other PHPs (no exclusivity provisions)
- Chapter 58 protections should be maintained for providers and consumers as provided in SL2015-245
- Evaluation should be strong and on-going and include child-specific measures and topics such as network adequacy, benefits, impact on children, impact on children in the foster care system, impact on medically fragile children, etc.
- Eye care for children, including fitting, should stay within fee-for-service Medicaid without bundling in an PHP
- As part of the strategy to address social determinants of health and mental health, especially for teens, school-based health centers should be able to participate on a fee-for-service basis when high-quality can be established
- Emergency Medical Services and other related services should be funded to serve very young children, including having appropriate equipment
- Necessary support services should be funded. To the extent that success of Transformation requires support of the NC Pediatric Society (or other organizations), the organization should receive appropriate funding to provide the service that would not be needed in the absence of transformation
- Families must have appropriate supports to navigate both providers and PHPs, including navigators, coordinated care managers, ombudsmen and reliance on their identified needs.
- Stakeholder input should be on-going and include representatives from independent practices, hospital systems, primary care, sub-specialty care, families and others
- Workforce and provider supports should be assured
- Grievances and appeals should be fair and timely
- Prepaid Health Plans (PHPs) data requirements should include full ICD-10 code use on Day 1
- We strongly support covering parents and other adults with health insurance through Carolina Cares. However, we oppose work requirements or limiting barriers to eligibility and coverage

Previous comments on waiver issues are available on our website; go to [www.ncpeds.org](http://www.ncpeds.org) then click on Advocacy, then click on Medicaid Reform. (Direct link: <http://www.ncpeds.org/?page=MedicaidReform> )

Thank you again for your work on crafting a revised Medicaid program that continues to work for children and the professionals providing their care. We remain deeply concerned about the potential impact on access for children.

Please let us know if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "S. St. Clair". The signature is fluid and cursive, with a prominent initial "S" and 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