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North Carolina Chapter

North Carolina Pediatric Society

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May 16, 2017

Secretary Mandy Cohen, MD
NC Department of Health and Human Services
2001 Mail Service Center
Raleigh NC 27699

RE: 1115 Waiver Comments

Dear Secretary Cohen –

Thank you for the opportunity to make additional comments on the 1115 proposed waiver. Pediatrics represents many of the challenges and opportunities inherent in reforming Medicaid.

Access is critical and affected by many factors including administrative burden and rates. Currently, 70% of North Carolina Medicaid patients are children. It is not unusual for pediatric practices, especially rural and/or independent practices to have a client base that is 40% - 60% Medicaid.

- *Administrative Burden:* If administrative burdens are too high or reimbursement rates are too low, these practices may reduce services available for everyone or go out of business altogether. There is great risk in increasing administrative burden with 15 different billing entities throughout the state. Mechanisms such as uniform credentialing with the state to be deemed eligible by all PHPs, uniform drug lists, one portal for claims submissions that works at all PHPS, automatic enrollment of newborns into "straight" Medicaid until their PHP is determined, and consistent payment with coding for the same service/procedure will help lessen potential administrative burden. Practices ought to be able to submit the same electronic claim to each of the entities and have it process the exact same way (i.e., Payor A should not require a modifier while Payor B rejects the claim if the modifier is submitted). Practices should be able to seek prompt financial relief from state regulators if PHPs do not pay claims or pay them slowly or inaccurately. A structure such as an ombudsman office could help trouble-shoot problems for practices and patients.

- *Payment Rate:* Medicaid payment rates should have a floor equal to 100% of current year Medicare to better cover the increased administrative cost to participate in Medicaid. NC Medicaid codes without a corresponding Medicare rate should be increased from their baseline. Recent (since 2014) cuts to primary care providers total about 30%; concurrently, utilization of services of primary care has declined about 10% according to the (2016) Access Monitoring Review Plan between 2014 and 2015, during the loss of the ACA bump.

Provider-Led Entities should include adequate representation of pediatricians, including both primary care and specialists. Since children are 70% of the Medicaid population, Provider-Led Entities should be able to demonstrate substantial involvement and control by pediatricians towards key-decisions including implementation, quality metrics payment rates and other factors.

Coordination is an important element of care coordination. Pediatricians highly value their Community Care of North Carolina Care Managers. The services provided increase quality of care and allow pediatricians to focus on providing the right care at the right time in the right way. One concern of having multiple PHPs is the possibility of having multiple care "coordinators," each of whom could focus on different priorities using different support strategies while advancing different quality metrics. Having care that is actually **coordinated** and supportive is critical. Fragmenting care strategies with multiple efforts would lessen the quality of care for children. Goals and measures should be aligned across companies. The most efficient approach would be to maintain and require utilization of the existing care management infrastructure of CCNC. Large practices should be able to continue to have up to one care coordinator per 5,000 patients.

Think long-term horizon for value: Many treatments for children – vaccines, addiction avoidance, healthy diet and exercise, appropriate early screening and treatment, parenting education, Reach Out and Read– can result in tremendous health improvements for individuals and communities. However, the cost savings of these health-promoting behaviors may not be recognized for decades. Payment for value needs to take best-practice and long-term trajectories into account. Measures for quality of care **must** include appropriate and sufficient child specific measures, even when such indicators are not the cost drivers. To truly bend the cost-curve, measures need to go-beyond immediate cost-effectiveness to reflect the importance of long-term health. All data and indicators used should be transparent between the provider, the Prepaid Health Plan companies and the Division of Health Benefits.

Protect EPSDT: North Carolina currently enjoys the highest screening rate of any state in the nation. Assuring that children are screened, diagnosed and treated is critical for the best outcomes for our children. Many discussions at the federal level have talked about loosening these current requirements. Assuring that Early Periodic Screening Diagnosis and Treatment is written into the RFP and other blueprints is important for promoting and protecting child health.

Primary care is the foundation of healthier communities: Quality primary care is essential for good health. The RFP should focus on mechanisms to promote and support primary care providers, especially in rural communities. Quality metrics should include primary care measures, such as appropriate immunizations, well-child care, appropriate screenings, and best-practice management of conditions such as Type 2 Diabetes.

Children need access to appropriate specialists regardless of their age or region: There are only a few pediatric specialists in North Carolina for some types of care. Parents of children with special health care needs may well choose plans based on access to specialists rather than primary care providers. Parents of children who develop cancer, scoliosis, or other conditions after selecting a PHP may have focused Prepaid Health Plan company choice based on primary care needs. Children regardless of when they are diagnosed or where they live should have access to the pediatric specialists they need. RFPs

should be written accordingly. In particular, access to the pediatric specialist needs to be a specialist who treats children of **all** ages. Regional PHPs may need to go outside their geographic boundaries to be able to assure such care. Research is clear that children with chronic illnesses in rural areas without access to specialists have poorer outcomes, increased hospital readmissions and higher healthcare costs overall.

Appropriate behavioral services should be available where and when they are needed: North Carolina should consider integrating behavioral and physical health services earlier than the four year time-frame of the legislation. While we appreciate the attempt to limit the moving parts, the current system does not always work well, especially for foster children. We appreciate that foster children are intended to be enrolled primarily in one Prepaid Health Plan. That Plan should certainly cover mental health services without requiring providers to credential with multiple LME/MCOs around the state or requiring the foster parent to drive hours every week to get to the "home" LME/MCO. The State should also consider enrolling foster children in "straight" Medicaid during evaluation or transition periods so that children not yet or newly in foster care (and the adults helping them) do not have to navigate the PHP system while in the midst of a crisis. Special attention should also be paid to teens. The more services that can be provided in the medical home, the better, assuming that providers are well credentialed to provide the needed level of care. Payment levels should take these additional services into account. Financial incentives should be provided for co-located behavioral health providers. At a bare minimum, providers that have mental health partners integrated into the practice should have payments protected and no undue administrative burden for providing integrated services.

Healthier communities grow healthier children: Children are healthier when their communities are healthier. Many factors play into these aspects of health.

- *Close the coverage gap*: Research repeatedly demonstrates that children are healthier when parents are covered by health insurance. Parents are both healthier themselves and more likely to assure their children are covered. In addition, when people of childbearing age are healthier (healthy weight, chronic conditions such as diabetes are well-managed, etc.), they conceive and women deliver healthier babies. This could also be a strategy to address treatment of substance addiction.

- *Address social determinants of health*: It seems that research emerges daily further documenting the substantial role played by social determinants of health. The American Academy of Pediatrics in their newly updated *Bright Future* guidelines includes screens and strategies for social determinant of health and health promotion activities. Wide-ranging and creative supports are needed here, from housing to advancing built environments that support healthy lifestyles to assuring access adequate healthy foods in all communities utilizing WIC, school nutrition, SNAP, policies to reducing food deserts, etc. to promoting appropriate tax credits and the claiming of such credits. Unified care management could help link people in communities to support networks advanced at the state level. Efforts should build on existing work, such as Carolina's Collaborative which is focused on social determinants of health and toxic stress.

- *Prevent addiction and if that is not possible, assure adequate treatment*: Assuring that children develop healthy lifestyles and receive appropriate supports for mental health issues and pain management early is an important first step to deterring addiction. Parental addiction interferes with parenting and child development. Linking children to medical homes, closing the coverage gap, providing adequate mental health care and other strategies already mentioned will help address addiction issues long-term. In the short-term, strategies such as minimizing the "hassle-factor" in checking the CSRS (delegate accounts, not needing to check for every recurrent prescription; making linking fast, easy and free, etc.) will also help.

Support the medical home: North Carolina should build on the considerable work of Community Care of North Carolina to continue to promote medical homes. The Department should require in the RFP that the Prepaid Health Plan companies support delivery of care coordination and care management services to advanced medical home practice, such as through an enhanced care management fee. Care coordination needs to be consistent across companies. (*Please see "coordination is an important element of care coordination.")* North Carolina pediatricians were among the first physicians in the nation to adopt the medical home model and are ready to move toward measured health outcomes rather than mere process measures.

Thank you again for this opportunity to comment. We are happy to convene groups of pediatric experts to discuss any areas of key concern in greater depth or provide other types of expertise or input as you move forward in this important endeavor.

Thank you.

Sincerely,

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