American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

North Carolina Chapter

North Carolina Pediatric Society

July 15, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Comments on the Proposed NC 1115 Medicaid Waiver Application

Dear Mr. Slavitt:

The North Carolina Pediatric Society (NCPeds) has deep concerns about the fundamental model set forth in the NC proposed 1115 Waiver. This complicated system to ensure competition will increase administrative barriers to participation and likely reduce access to care among both primary care providers and specialists. Any reductions in services or access particularly will affect children who are 71% of the estimated population affected by the proposed waiver.

In short, Medicaid reform will not work if it does not work for children and the medical professionals who provide their care. The proposed model does not adequately take child health into account and should not be implemented across North Carolina.

Furthermore, and most importantly, the proposed waiver does not meet the basic criteria for an 1115 waiver for the following reasons:

The waiver proposal does not expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible except for the parents of children in foster care. This is a very small subset of adults who could possibly be offered Medicaid eligibility through some other channel. If North Carolina had expanded Medicaid according to guidelines in the Affordable Care Act, most parents of foster children would be eligible for Medicaid.

The waiver proposal does not provide services not typically covered by Medicaid. Indeed, it specifically excludes from waiver services mental and dental health, which will be covered through other avenues than the proposed reform structure. Pre-paid Health Plans (PHPs) have the option to provide other services.

Innovative models may be achieved without an 1115 waiver. While the waiver notes some innovative strategies, many of these models do not need an 1115 waiver for implementation. For example, the Fostering Health model offered in the waiver is currently operated by us, the NC Pediatric Society, through a contract with the Office of Rural Health within the NC Department of Health and Human Services in about half of counties. While the waiver extends the services to all counties, we know firsthand that these services can happen without a waiver. We applaud the State for wanting to inculcate the services and assure statewide availability, but this model currently operates in the absence of a waiver. Also, NC moved early to the medical home model for primary health care and implemented Community Care of NC (CCNC) without an 1115 waiver.

Otherwise, by turning over the management of Medicaid to for-profit Prepaid Health Plans, the waiver proposal will most likely cause costs to rise, access to fall, and quality of care to dwindle. Requiring low income people to navigate a complicated health insurance system will not improve access. Requiring primary care providers to deal with multiple Prepaid Health Plans will increase the administrative hassles and costs of providers, resulting in decreases in access and quality. The current Community Care of North Carolina program is a model for optimal access to care, high quality of care, cost-effective care, and efficient integration of the professionals who must collaborate to improve patient outcomes. This waiver proposal will fragment this very successful CCNC Medicaid program, and set health care of low-income people back at least 25 years.

We also want to lift up some particular concerns.

Community Care of NC (CCNC) is a proven effective model at improving health outcomes while controlling costs. For example, separate studies from Population Health Management, Milliman Consulting, Kaiser Family Foundation, and NC State Auditor have found that CCNC is effective in saving money and controlling costs. Additionally, unlike many Managed Care Organizations (MCOs), CCNC has developed measures that are specific to child health. Keys to the success of CCNC identified by pediatricians include a single care manager coordinating efforts who is frequently co-located in the practice, helpful use of and access to key analytic measures, and concrete assistance to improve health outcomes. CCNC also makes additional investments in improving health throughout the state through grants and other outside sources of income that would likely be lost under the new reform model. We appreciate that the proposed 1115 waiver keeps the key functions of CCNC, but are concerned about the loss of the actual program and infrastructure. We are also concerned about the statutory language that calls for eliminating CCNC once the first contract is signed and the possibility one practice could have five different care managers and respond to five different sets of quality metrics.

Eighty-five percent of pediatricians responding to a July 2016 survey from NCPeds oppose eliminating CCNC. CCNC is home-grown and enjoys strong support. Once the waiver period is over, CCNC cannot be re-established with a quick flip of switch. Rather, its elimination will create a long-term deficit for child health in our state.

Fifteen different systems plus assignment needs will inherently increase complexity of the system. The proposed model calls for three statewide MCOs or PHPs plus regional PHPs in multiple regions. We appreciate NC DHHS' willingness to explore options to mitigate the impact of complexity, but there is only a limited amount they can do within the confines of North Carolina's law. A practice could be asked to participate with five different plans — more if they practice in an area close to a regional line. It is unclear if practices would need to additionally work with five (or so) care managers, respond to five (or so) sets of quality metrics, in addition to filling out paperwork to apply, credential, report and otherwise respond to five different plans. Additionally, patients must chose or be assigned a PHP. There are about 60,000 - 65,000 births each year in NC to mothers eligible for Medicaid. However, it is not unusual in NC for there to be delays of two to three months for these relatively "easy" newborns to get their Medicaid cards according to many practices active with NCPeds. Eligibility and assignment issues will be magnified by a factor of 15 under the new system.

A July 2016 survey of pediatricians found that less than half of those responding (44%) would likely accept all plans. There are concerns that the best plans for primary care may not include the specialists needed for some families. The complex array of multiple plans and likely multiple standards, care managers, quality metrics, payment requirements and other factors will create barriers to promoting positive health outcomes. We have specific concerns about community specialists such as ENT, urology and orthopedic surgeons not participating in any of these proposed plans.

Loss of infrastructure could have long-lasting, negative effects on child health: While there is room for improvement, NC's overall Medicaid structure is sound. A high percentage of pediatric and other providers participate with Medicaid. The Division of Medicaid Assistance has often demonstrated their concerns to improve both health and the provider experience. CCNC, as previously noted, offers a proven effective model to drive achievement. This 1115 waiver demonstration calls for substantial change for pediatric practice but few of the anticipated benefits will accrue directly to children.

Pediatricians are not supportive of the proposed changes and don't think it will improve child health. NC DHHS did an impressive job holding hearings and soliciting input. Pediatricians spoke at most hearings and dominated some. No pediatrician spoke in favor of the proposed changes. Consistent themes were concerns about administrative complexity, the value of CCNC, concerns about potential reduction in payment, the complexity of serving children who live in multiple regions, and the impact on child health. Administration is seldom the reason that people choose pediatrics as a profession and any changes that, in total, put more emphasis on administrative complexity than caring for children are more likely to drive pediatricians away from caring for children rather than drawing them into the profession.

The waiver proposal notes that 71% of those affected are estimated to be children, but the vast majority of the pediatricians providing their care do not believe it will improve child health. A survey of 1222 pediatricians in NC in July 2016 found that of 236 respondents, 85% or more opposed the proposed changes, opposed getting rid of CCNC, and thought the competition would not improve child health.

Access to care for ALL children will be negatively affected. The waiver calls for a panoply of changes, will likely reduce payment to pediatricians, and will likely result in host of outcomes that will reduce access to care. A July 2016 survey of NC pediatricians found that respondents anticipate limiting the number of new Medicaid patients they take (45%), limiting the total number of Medicaid patients they see (39%), or not taking new Medicaid/Health Choice patients (24%). Some even anticipate retiring earlier (21%), cutting staff (29%) or closing offices or clinics (14%). These changes will reduce access to ALL children in the area to quality care and further stress health systems that do not limit Medicaid patients and will not have to capacity to offer timely access to meet the health needs of children and keep children healthy.

It will become more difficult to focus public health priority initiatives. Thanks to strong participation with Medicaid and CCNC, it is possible to focus priorities — such as monitoring of certain outcomes for children prescribed antipsychotic medications, promoting vaccinations, or screening for maternal depression. With five different plans, each could have a different area of focus. Monday could become ADHD day, while Tuesday is HPV day and Wednesday is screening day, with no real concentration on any one strategy or set of outcomes.

Fully 40% of children in NC are insured by Medicaid and thus Medicaid changes can shape behavior for many practices and health for all children in the community. Substantial proportions of many practices' patients are publicly insured. A survey of NC pediatricians in March 2015 found that most (53%) of respondents reported that at least 50% of their patients had Medicaid. If substantial changes make it harder for practices to stay open, keep staff, or practice quality medicine, those changes will have a substantial impact for all children in the area. Pediatricians have expressed particular concern about the impact of potential reduction in payments through new plans. While NC DHHS has the ability to set rate floors, their focus seems to be on assuring flexibility for the plans rather than adequate payments for primary care providers.

Medicaid expansion would likely do more to improve child health than the proposed waiver. While children up to 200% of the poverty line are already covered with public insurance, research repeatedly demonstrates that expanding coverage improves child health in a variety of ways, including improving parent health and potentially improving birth outcomes as women and men are healthier prior to conception. NCPeds applauds the Fostering Health NC provisions of the waiver. However, much of the likely benefit of expanding health care coverage to biological parents who have had their child temporarily removed from the home to resolve mental and other health issues to promote family reunification could be achieved by making more parents eligible for public health insurance generally.

In short, the fundamental model is flawed and unlikely to achieve the desired results given the extreme complexity. Furthermore, it is being overlaid on what is widely viewed to be a model system and will eliminate our current infrastructure, including CCNC. Most importantly, it does not meet the basic criteria for an 1115 waiver, given the lack of expansion of services to substantial new populations, lack of provision of substantial new services, or necessity for implementation of new innovative models that would require an 1115 waiver.

In closing, I would like to emphasize on behalf of the NC Pediatric Society that, whether pediatricians like reforms or not, most of us will do whatever we can to assure that children, especially low-income children, have access to quality health care. But pediatricians across the state are already stretched thin with recent Medicaid payment reductions, moving to EMR, implementing meaningful use and other changes in this rapidly changing medical world. We are deeply concerned about our ability to continue to deliver effective medical care as supports like CCNC are removed, specialists are harder to access, and multiple administrative and payment barriers are erected. As it gets harder, more bureaucratic, and less rewarding to care for kids, practices will become more stretched and stressed and more pediatricians will likely retire or otherwise limit serving children.

We urge you to consult with NC pediatricians at every step in the process. The proposed changes will have a profound impact on our practices and the children we serve. I am happy to meet with you at any time or arrange for other deep experts to connect. We urge you to keep the potential impact on children in the forefront as you make any decision about this complex and flawed plan.

Sincerely,

Deborah Ainsworth, MD, FAAP
Chapter President
NC Pediatric Society, Inc