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

North Carolina Chapter

North Carolina Pediatric Society

April 13, 2016

Secretary Rick Brajer
NC Department of Health and Human Services
Adams Building, 101 Blair Drive
Raleigh NC 27699

Dear Secretary Brajer:

The NC Pediatric Society applauds the NC Department of Health and Human Services for its consideration of stakeholder input, express focus on children and desire to improve outcomes. In particular, we appreciate the following:

1) Foster care provisions, including recognition of the Fostering Health Model to improve the connection of children in the foster care system to medical homes; proposed expansion of Medicaid coverage to biological parents whose children have been temporarily removed from the home, and one single statewide PHP for children in foster care for simplicity's sake
2) Strong focus on patient-center medical homes and primary care
3) Attention to the importance of strong, timely, transparent, multi-directional data, including the bi-directional immunization registry across all care entities
4) Use of intervention to impact social determinants of health
5) Emphasis on rural health
6) Desire to improve physical, mental and behavior health integration
7) Focus on the quadruple aim, including quality outcomes for patients
8) Acknowledgement of the importance of telemedicine
9) Strategies to grow the workforce, especially for primary care
10) Attention to the staffing needs of DHHS to assure adequate transitional systems for providers

However, we remain deeply concerned that the fundamental model will reduce access of children to health by increasing administrative barriers and exacerbating payment concerns for pediatric providers. We are also concerned about how the number of outstanding issues will be resolved, including details on how administrative ease will be assured, payment levels, structure and payment of telehealth, network adequacy, Chapter 58 protections and other factors.
How these "details" are resolved will have a substantial impact on the ability of pediatricians to keep practicing and to continue to serve publicly insured children. Since the vast majority of people with health insurance through Medicaid and Health Choice are under age 21, ***Medicaid reform won't work if it doesn't work for children and the professionals who care for them.***
The consequences are substantial for children who are mostly healthy. The potential impact is even more significant for children and youth with special health care needs, those who have experienced trauma, those with mental and behavioral health needs and teens transitioning into adult care.

North Carolina has traditionally enjoyed strong participation by pediatricians in the Medicaid and Health Choice programs. Fully 40% of all NC children are publicly insured. It is not unusual for practices in both rural and non-rural areas to have 40% or more of their patient caseload insured through Medicaid.

If public insurance becomes untenable because of too many PHPs with too many competing rules, these practices could close their doors, affecting access for all children in the community. Inadequate payments could also reduce access. A March 2015 survey of pediatricians across NC found that with the recent loss of federal funds for enhanced primary care payments and 3% state rate cuts, one quarter of pediatricians reported limiting Medicaid patients and one third reported laying off staff or not filling positions. Respondents noted that more cuts would likely lead to more limits on accepting Medicaid patients (46%), more staff lay-offs (31%), and some practice closures (8%). Concerningly, one in six pediatricians reported they would retire earlier than otherwise planned. These changes would substantially impact access for all children, especially those in rural communities, regardless of insurance provider.

It is therefore very important to look at provisions in the waiver that will increase administrative difficulties or lower payments. We are also concerned about vagueness in provisions that could result in unintended consequences or unenforceable policies.

Fifteen different PHPS are likely to increase administrative burden and reduce access to care; more details are needed in the waiver on how administrative ease will be enhanced. The basic model proposed seeks five PHPs to operate in each region (seven in Alamance). Practices will need to go from mastering one set of complex rules, coding guidelines, outcomes measures, key contacts, etc. to learning five completely new ones. Practices in border counties will likely serve patients from other regions and/or refer outside their region, further increasing complexity. We appreciate that DHHS seeks to diminish these burdens with "contracts that are designed to lower provider burden, such as uniform credentialing and requirements for prompt payments from PHPs". However, the waiver, as written, lacks the specifics to assure this will happen. Throughout the state, there will be an anticipated 15 PHPs, five that a practice could join in each region (2 regional + 3 statewide groups). This, by definition, is going to increase complexity exponentially. Assignment of patients who do not choose a PHP will further exacerbate problems. Furthermore, since Chapter 58 protections only apply to solvency, it will be very challenging for an independent practice to timely resolve complaints with PHPs without risking substantial revenue loss (delayed payment, legal costs, etc.), on top of additional financial stressors that are already placing independent practices in fragile financial positions. In short, without specifics on what provisions (beyond the drug list) will be uniform, how many points of contact each provider must negotiate, ways to assure compliance and other critical information, it seems likely that the new model will increase complexity rather than reduce administrative burden. This could lead to some practices no longer taking Medicaid patients or folding up shop altogether. Certain measures could help promote administrative and enforcement ease, given the inherent complexity of the model:

DHHS as clearinghouse for claims: Rather than requiring practices to keep five (or more) sets of forms, learn five (or more) sets of rules, etc., DHHS should serve as the single clearinghouse for claims. DHHS has already developed the infrastructure and must maintain the capacity due to the legislative requirement on dual eligibles and other groups. This simplifies filing for the provider and assures stronger and more real-time data for the state.

Uniformity: We applaud the legislation for providing for uniform credentialing as part of the reform. We would further urge that DHHS credential clinicians who provide Medicaid services and have the PHPs use the list maintained by DHHS. This eases administrative burden by assuring that a provider only needs to credential once, not submit duplicative paperwork, etc. DHHS also would then continue to have the information about which clinicians are participating in Medicaid without having to ask for data from 15 entities. DHHS could also use CAQH (Council for Affordable Quality Healthcare) to simplify the credentialing process. Further, the State needs to assure uniform claims, reporting and disclosure requirements, and payment under locum tenens arrangements. Mechanisms such as a list of providers in good standing of not over-referring patients could help ease difficulties with prior authorizations.

Chapter 58 Protections: Chapter 58 has a number of important provider and patient protections. Those need to be maintained. Examples include uniform claims, reporting and disclosure requirements, payment under locum tenens arrangements, provider directories and member identification cards. Strong enforcement is also needed. We appreciate the inclusion of provisions such as 18% interest for clean claims not paid within 30 days, but without adequate enforcement, such provisions may be of limited use.

Creation of an ombudsman: A state ombudsman would provide a neutral, state structure for resolving problems between providers and PHPs. We are deeply concerned that PHPs may inappropriately delay payments for claims. The ombudsman needs to have the ability to act quickly. An ombudsman would provide remedy and venue to resolve conflicts short of going to court.

Rate floors should be set at parity with Medicare for primary care and the $100 million currently going to support direct primary care should remain in support of primary care practices: The waiver proposal is lacking on specifics regarding payment beyond "redesign(ing) payment to reward value and outcomes." The legislation requires DHHS to set rate floors for primary care. Almost one-third of states, including South Carolina, currently pay primary care for Medicaid on par with Medicare. The March 1, 2016 *Legislative Report Transformation and Reorganization of NC's Medicaid and NC Health Choice Programs Final Report* notes that DHHS intends to limit the use of rate floors to provide greater flexibility to PHPs and tie payment to ***Medicaid*** rates rather than ***Medicare.*** This strategy could well result in even lower payments for primary care. It could thus undermine the ability of pediatricians to continue to treat Medicaid patients. We urge DHHS to set rate floors at parity for Medicare payments for primary care in the waiver.

Primary care providers have recently seen a rate cut of about 30% due to loss of the ACA bump at the federal level plus 3% state rates cuts, with another impending 1% cut at the state level. Pediatricians responded to these cuts enacted in 2015 by not taking new Medicaid patients, cutting back on staff or other services and closing locations. A survey of NC pediatricians from March of 2015 found that additional cuts would lead to almost half of responding pediatricians not taking new Medicaid patients, 8% closing their practices, and 17% retiring earlier than planned. This would have a profound impact on access.

With the legislatively imposed changes, pediatricians are now looking at loss of their per member per month and loss of the essential care management and data analytic supports of CCNC, which total about $100 million going to primary care practices. Those funds should stay dedicated to primary care and not be rolled into the capitated payment to PHPs.

Furthermore, the rate floors should be set at the greater of current year Medicare or NC Medicaid as of 9/3/2015 (the current posted fee schedule) so that access is preserved rather than reduced. For example, NC Medicaid currently pays for some codes that Medicare does not, especially 99051, add-on code for regularly scheduled night/weekend/holiday clinic. Payment for these codes supports provision of after-hours (nights, weekends, holidays, etc) care. Without this ability to pay staff at these times, practices likely will not remain open at these times, potentially driving up visits to Emergency Departments during non-traditional office hours and further increasing costs.

Additionally, many practices are facing loss of time-limited federal incentive payments relating to meaningful use. Given that children are mostly healthy and that pediatricians have been squeezing savings out the system for years, there are not many more short-term savings to be achieved. Any payment for performance measures should be based on considerations such as best practice (for example, vaccination rates) and not rely on shared savings factors used in many Medicare models to measure success of treatment of older, sicker patients, such as averted hospitalization. Incentive payments must recognize the importance of prevention. Structures should also recognize the importance of the per member per month for innovation and best practice, such as phone care management, after-hours care, and other measures that appropriately limit visits while still promoting child health. When the starting point of payment is adequate, it allows more room for innovation and promotion of best practice.

More specifics and more time needed on how quality and prevention will be assured. NCPeds commends DHHS for submitting a draft waiver for public comment on such a quick turn-around. A legislative extension should be sought to allow time for stakeholder input as to the RFP. With so many important issues to be resolved through the RFP, one month for review is insufficient. Here are some examples of details that need to be resolved in advance with public input. These "details" are critical to successful implementation and child health and deserve time and consideration.

Ninety days to comment on RFP: The proposed timeframe has one month from consultation with JLOC on terms and conditions of the RFP (February 2018) to letting of the RFP (March 2018). What is in the contract will determine whether or not children have access to basic health services, specialty services and more.

Adequate networks that assure children have access to primary care, pediatric subspecialty and surgical specialty care: Lessons from other states teach us that the details here really matter. Time, distance and seeing patients under age 21 alone are not adequate measures. Pediatric primary care, pediatric subspecialty and surgical specialty care must be included, as should adequate interpreter services (sign-language as well as spoken languages) to assure true access and quality. The range of types of providers should continue to be responsive to the needs of the population. Currently, school-based health clinics provide important care in some communities and this option should be preserved moving forward.

Referrals are frequent in the pediatric world, and subspecialists and surgical specialists must be available to provide care to children birth to 21. Lessons from Tennessee suggests that a specialist may "check the box" on treating patients under age 21 – but only treat patients who are at least 16. This does not constitute true network adequacy for children. Tennessee also considers a network adequate if transportation is provided. So a child with spina bifida who needs routine Pediatric Urology appointments may be placed in an ambulance and driven past multiple Pediatric Urologists in Memphis to go to Nashville for routine appointments with an "in-network" urologist.

One nationwide study found that less than 15% of doctors listed in official directories could see patients within a month - and fully half weren't taking Medicaid patients at all.
Consumers should be protected against "surprise balance billing" where an out-of-network doctor provides services in-network (for example, an out-of-network anesthesiologist at an in-network hospital) and a family receives a large bill for the services. These details matter for child health and deserve careful review and understanding. Extending the time allowed for public review of the RFP will help assure that adequacy is defined appropriately in the contracts.

Timely patient assignment that protects medical home and access to timely, quality care: We appreciate the care and detail DHHS provides in describing how patients will be helped to choose a PHP, and then, absent a decision, assigned to one based on factors including current primary care provider for patient or family members. We also appreciate that a patient may change PHP within 90 days of assignment. We are particularly concerned that, given the experience of states such as Illinois, patients who are assigned based on PHP may be forced to change practice - or worse, left with no provider at all - if the PHP drops the patient's practice. The PHP should not receive a capitated payment for a patient who does not have access to services. Also, the primary care home should be paid for services it delivers in the transition.

Direct fee for service payment for patients not yet assigned to a PHP: Currently, it can take several months for Medicaid patients, especially newborns and refugees, to receive their Medicaid cards. If practices provide services in good faith waiting for those cards to be issued or while a patient is transitioning from one PHP to another, the practice should be able to direct bill to DHHS for services pending assignment to a PHP, just as would happen for dual eligible or other patients or services paid on a fee for service basis by DHHS.

Direct fee for service payments for dental services: The legislation carves dental out of services to be provided by the PHPs. Currently primary care offices who provide services such as dental varnish bill Medicaid directly for the procedures. This method of payment should continue, just as direct billing to Medicaid will continue for other services. There should not be a separate "dental care organization/local management entity" for dental care. This would create additional layers of bureaucracy to a service that is currently delivered efficiently and effectively.

Specific attention to integrated child mental health services: We appreciate initiatives such as Fostering Health and expanding Medicaid to parents of foster-system-involved youth with mental health issues. The system would be further strengthened by additional measures to improve general child mental and behavioral health. We recognize that mental health is carved out of the service package by legislative mandate, but as pilot programs are being considered, we urge measures to improve general child mental health as well. This includes Medicaid as the single payer for child mental health services.

Maintenance of care management, data analytics, set funding (PMPM) to allow innovation, quality initiatives and other current CCNC functions and dollars: CCNC is a critical support for patient health. The concrete supports they provide in terms of care management, data analytics, quality initiatives, and PMPM structure are critical to practice success. The waiver seems to advance the CCNC model. We commend the inclusion of the concept but would like for it to be far more explicit, especially in light of *the Final Legislative Report* calling for amending our current State Plan Amendment (SPA) to eliminate CCNC. In addition to care management and informatics, CCNC or its successor could also have a role as the foster care PHP, the Innovations Center, or provider of other functions. CCNC also brings substantial dollars into the state through grants and awards. The services and funding base are essential for continued measures to drive down cost while improving quality. While it is clear that it is envisioned that these important health-enhancing services of CCNC are maintained (pages 3, 13-14 for example), it is unclear who (and how many different entities) will be providing the service and who will be paying for it. Will it be the PHP? Provider? Patient? How will practice participation be supported in quality initiatives?

Single care manager for each practice: We recommend that the services continue to be provided by a central entity rather than multiple providers. Five different care managers (one from each potential PHP) using different analytics would be disruptive rather than constructive. Additionally, quality improvement needs focus across the patient population – not scattered metrics depending on the PHP.

Funding that allows flexibility: It is also critical that funding to practices allow flexibility as currently permitted in the PMPM for services such as phone nurse consults, Reach Out and Read, co-located services and other measures that protect child health and improve convenience for families but reduce the volume of patients seen as well as billable visits. Incentives should be aligned with desired outcome measures. One mechanism for this could be comprehensive primary care payments.

Payment structure sufficient to incentivize primary care and offset the increase in administrative burden and other concerns: Quality primary care, especially during the early years, is critical to ultimately bending the health care cost curve. However, the changes proposed in the 1115 waiver increase barriers to participation by primary care providers. Will payments be sufficient to cover the anticipated increased administrative burdens? Assuring payments with Medicare parity, maintaining the $100 million currently going to services for primary care (such as care management, data informatics and per member per month), increasing the uniformity of various provisions, supporting strong and swift enforcement of contract provisions, addressing social determinants of health and not increasing barriers to billing for dental services would be a step in the right direction.

Broad support of telehealth: Telehealth is an important and emerging strategy to treat patients timely, conveniently and with improved outcomes. Used poorly, telemedicine can be a way to circumvent the medical home, overprescribe antibiotics and other medications, and delay treatment of potentially debilitating conditions. For example, the waiver should be explicit in noting that the primary care physician and specialist should be paid for the visit when both are involved. Consults around “store and send” should be covered, as should services for Children and Youth with Special Health Care Needs and safety net services. Telehealth should be available throughout the state, paid appropriately, and build on – not substitute for - the doctor/patient relationship.

Support of all technologies that advance patient health in ways that continue to promote the medical home and provider/patient relationship: Phone, email and text consultations can be helpful to providing timely care to patients without requiring a patient to make an unneeded trip into the office. Such services should be permissible and appropriately reimbursed in a way that incentivizes care through the medical home.

Detailed information on impact on other funding streams, especially as they may affect social determinants of health: Understandably, the waiver proposes that virtually all Medicaid funding will go towards the 1115 demonstration. Medicaid dollars currently fund aspects of the work of the Division of Public Health and other state agencies. Will those funds now be directed to PHPs as part of their payment? What will be the impact on other services? Will they result in draining additional Title V dollars away from local health departments, for example? The waiver should detail the programs that will lose funding and the potential impact on services for North Carolina children and others.

In closing, the NC Pediatric Society appreciates the work of DHHS in drafting this waiver proposal. We applaud the inclusion of many strong provisions for children and families. However, we have many deep concerns about the potential impact on the financial viability of pediatric practices, and thus access and other critical elements of child health.

Sincerely,

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