# American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

North Carolina Chapter

## North Carolina Pediatric Society


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December 17, 2015

To Whom It May Concern:

Comments pertaining to file code CMS-2328-FC:
*Earlier this year, the Supreme Court decided in Armstrong v. Exceptional Child Center, Inc., 135 S. Ct. 1378 (2015) that the Medicaid statute does not provide a private right of action to providers to enforce state compliance with section 1902(a)(30)(A) of the Act in federal court. Section 1902(a)(30)(A) of the Act says that State Medicaid plans must "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and services are available to the general population in the geographic area."*

In North Carolina, fully 40% of children are publicly insured. NC pediatricians – including those in independent practices - have long accepted Medicaid and CHIPRA. However, with the loss of the ACA bump, cuts to state rates and growing complexity of the system, providers are reporting greater reluctance to accept Medicaid patients. Further cuts would likely result in substantial loss of access, not merely for children who are insured through Medicaid but for all NC children. Having appropriate recourse to assure rates are sufficient is critical for children and the professionals who serve them. As the state chapter of the American Academy of Pediatrics, the NC Pediatric Society works actively with pediatricians and other health professionals every day towards improved health and health care structures for children, including a highly-functional Medicaid system that promotes preventive and primary care in a medical home.

Based on the new Rule and the attached comments/responses, we would offer the following comments:

**Rate reductions are already affecting access in North Carolina.** A survey of NC pediatricians soon after the bump ended (March 2015) found that about a quarter of respondents reported newly limiting the number of new Medicaid children they were taking. Additional cuts would result in 48% of respondents likely limiting Medicaid patients; 12% of respondents no longer serving current Medicaid patients; 17% taking earlier retirement; 31% laying off staff; and 8% closing their doors. Already, NC pediatricians report delaying equipment upgrades, closing clinics and not filling positions due to rate reductions. This loss of care affects health care access for *all* children in North Carolina.

**Providers have critical data that should inform CMS determinations regarding access of Medicaid-eligible patients to health services to the same extent as patients with private health insurance.** The current rule allows Medicaid administrators to submit data and reports to CMS to determine if rates are adequate. State Medicaid has many pressures and competing priorities to manage within legislated budgets. Providers know best if the rates paid cover the services and allow practices to remain strong and should be allowed to present evidence to CMS. Primary care doctors taking Medicaid already receive just two-thirds of the payment provided to similar doctors serving patients with Medicare with essentially the same service. Providers – not the state Medicaid agency - are in the best position to report the impact of inadequate rates.

**Medicaid should be paid on parity with Medicare.** CMS has established a thorough method for determining Medicare rates, yet uses a completely different methodology for Medicaid. Prevention and primary care has a strong evidence base that does not vary across state lines. Yet, this rule requires providers to convince their state Medicaid program to pay better. This requirement interjects greater disparity, unfairness and politics into rate setting while de-emphasizing evidence-base and cost-effectiveness of treatment. CMS should apply its strong existing and evidence-informed Medicare payment structure to Medicaid. This builds on existing infrastructure; fosters fairness across states, practice types and patient age groups; and – most importantly - promotes improved access and health, allowing for a strong focus on prevention and primary care

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**Measurement in Medicaid should focus on access to patient-centered medical homes.** This means that patients should have 24-7 access to a physician who can look at their medical records and who takes responsibility for making sure patients have access to comprehensive health services. Telemedicine and emergency departments have their place, but are by no means a substitute to access to medical homes for quality, consistent care. Research repeatedly demonstrates the benefit of medical homes for improving health and reducing costs. Assuring that children remain served through this model is critical to the long-term ACA goal of bending the cost curve.

Sincerely,

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Chapter President
NC Pediatric Society, Inc