

TALKING POINTS FOR MEDICAID WAIVER PUBLIC HEARINGS

Thank the Department of Health and Human Services (DHHS) for their hard work on the waiver and their acknowledgement of the importance of medical homes and the special health care needs of families involved in the foster care system.

Children are the majority of people receiving health care through Medicaid. ***If Medicaid reform doesn't work for children, Medicaid reform won't work.***

About 40% of children in NC are insured through Medicaid currently.

IMPORTANCE OF ACCESS

Medicaid should be easy to use for everyone involved. If the new system is too bureaucratically challenging or payments are too low, pediatricians will not be able to participate and access will be hindered for all children, regardless of which insurance plan they have.

Administrative ease: There will be 15 Prepaid Health Plans (PHPs) throughout the state – three statewide and two in each of six regions. Therefore, a single practice would likely work with five PHPs – five sets of rules, five sets of accountability standards, five sets of billing guidance, etc. (Alamance Co. will be in two regions and thus practices there could participate with seven PHPs. Counties on the border of regions may also deal with more than 5 PHPs.) It is critical that there is as much uniformity as possible to assure participation by pediatricians in the program. Careful attention needs to be paid to timely receipt of Medicaid cards. There are currently sometimes long delays and this could likely be worse with multiple PHPS. There needs to be one point of contact – not five – to resolve problems. We need specifics on how this will work in the waiver.

Adequate payment: Payments should be paid at parity with Medicare. (This is the amount paid during the “ACA bump” years. About 15 states already do this.) Furthermore, all the monies currently dedicated to primary practice support – about \$100 million – should stay in supports for primary care providers, not be rolled into the capitated rate paid to PHPs. This \$100 million covers services currently provided by Community Care of NC (CCNC) such as care management, data informatics and quality initiatives as well as the per member per month. Furthermore, some funding to practices must be flexible. This is how practices pay for services such as nurse triage lines, after hours care, Reach Out and Read and other services that are not directly reimbursed or reimbursed at a rate lower than actual cost. Many practices are already in a financially precarious situation with 20%+ loss of federal funds provided through the primary care ACA bump, 3% state rate cuts, impending loss of meaningful use incentive payments, inflation-diminished payments for services provided to publicly insured children and other factors. Since the work of pediatrics focuses on prevention and improvement of lifetime health trajectories, savings, while likely substantial, are likely to be years or even decades away.

Network Adequacy: Children need access not only to primary care, but also pediatric subspecialty and surgical specialty care. Referrals are frequent in the pediatric world and access is more than a matter of distance but also includes ages birth to 21, availability of appointments and a range of other factors. The waiver as currently drafted only has one month before issuing the draft Request for Proposals (RFP) which will define adequacy and the letting of the final RFP for bids by PHPS. More time is needed for stakeholder review and input into the RFP to assure network adequacy.

FOCUS ON QUALITY AND PREVENTION

We appreciate the “quadruple aim” that DHHS uses as a guiding principle for the waiver: better experience of care; better health in our community; improved provider engagement and support; and per capita cost containment. The elements that are critical to maintain and grow quality and assure prevention are multi-faceted.

Care management linked to strong analytics: Currently, these services are provided by Community Care of North Carolina. They are easy for practices to use and navigate. Both the services and the administrative ease must be continued to maintain strong, data-drive services for children and youth with special health care or other needs and to assure quality outcomes.

Quality Improvement Supports: Currently, these services are provided by CCNC and specific to the pediatric population. These services are critical to continuing to improve quality and use the best evidence-based practices. There should be one (not five) areas of focus for the publicly insured child population. Projects should be easy to implement and include specific strategies to improve the status of child health now and prevention of later diseases/conditions, such as measles or obesity. (Many existing strategies outside CCNC focus on adult health issues.) The services should be provided to the practices without the practices contracting separately for each consultation or service. Furthermore, there should be personnel and financial support for participation.

Strong, transparent, timely data: We appreciate the focus of the waiver on iterative data that is useful to both the provider community and those responsible for the management of public health programs. We further urge that the data be mutually available and as close to “real time” as practical.

Support for creative and appropriate use of emerging technologies, such as telehealth. The waiver focuses on using telehealth in rural communities. This is a positive step towards linking families with the care children need on a timely basis. However, children throughout the state – not just rural areas - should have access to the care. It should include “store and send” and payments to both professionals providing the service (such as the primary care pediatrician and the specialist). Similarly, clinicians should be paid for services, such as triage or diagnosis, provided by phone or otherwise outside an in-person visit.

Brief Waiver Background:

In 2015, the NC General Assembly passed a Medicaid Reform law. One key provision is that the State will pay a capitated rate to Prepaid Health Plans who will then contract with providers for health services. Payments to providers are not required to be capitated.

The law requires multiple Prepaid Health Plans (PHPs) – both commercial and provider-led, keeps CCNC only in the transition, preserves many CCNC functions after PHPS begin operation, allows statewide MCOs or provider-led entities, allows regional provider-led entities, allows 18 months for implementation once the waiver is approved and leaves many key decisions to DHHS.

It also requires DHHS to submit an 1115 waiver to the federal CMS (Center for Medicare and Medicaid Services). An 1115 waiver is a very “high bar” type of waiver and requires a state to show substantial system change. CMS is in the process of strengthening its network adequacy requirements and is placing a very strong emphasis on maintaining access to care.

A survey of NC pediatricians by NCPeds in 2015 found that recent cuts were causing practices to limit the number of Medicaid patients and additional cuts would likely lead to the following

- *Limiting the number of Medicaid patients served (46%),*
- *Laying off staff (31%),*
- *Closing practice (8%), and*
- *Reducing the number of practicing pediatricians (17% said they would retire earlier than planned).*

Eroding payments further will impact access for all children in North Carolina. Once the waiver is submitted to CMS, stakeholders will also have the opportunity to provide comments to CMS.

Medicaid reform website: <http://www.ncdhhs.gov/nc-medicaid-reform>