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North Carolina Chapter

North Carolina Pediatric Society

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The Honorable Mandy Cohen, MD
Secretary, N.C. Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-2001

RE: Social Determinants of Health in 1115 Waiver

Dear Secretary Cohen:

Thank you once again for the opportunity to provide comments on the Department's implementation proposals relevant to Medicaid Managed Care.

We appreciate the strong focus on social determinants of health. Research has long shown that a patient's zip code is a telling health factor. Furthermore, challenges are compounded during critical early years. For example, hunger is not good for anyone, but it can be particularly concerning for young children whose bodies and organ systems are still growing and forming. A recent study by AAP found that linking families with appropriate resources was a substantial cause of stress for early and mid- career pediatricians. Thank you for your thoughtful approach to this important issue and development of a strong screening tool.

We will continue to focus on our main areas of concern: access to care/network adequacy; benefits; administrative ease; vulnerable populations; and payment adequacy. We are happy to discuss any of these in more detail, but will focus on a few key concerns for each area.

Access to Care/Network Adequacy

Strong access to services is key: We applaud the strong and thoughtful array of service as well attention to the potential service gap. We are concerned that inadequate service availability, especially early on, will deter use and lead to frustrated expectations for families and providers.

Keeping CC4C strong and responsive: Care Coordination for Children serves a very vulnerable population and is a linchpin to the NC's approach to dealing with substance exposed infants. We urge that CC4C is maintained beyond the first few years of Medicaid reform throughout the state.

Benefits

Resource Platform: We urge that the Resource Platform include diverse supports beyond housing, food and violence protection. For example, Reach Out and Read demonstrates multiple positive outcomes for at-risk families.

Concerns about screening frequency: We appreciate that Plans, with the most current contact information, screen first and immediately work to link families with resources. We appreciate that practices are encouraged but not required to use the tool to promote administrative ease; rather the obligation to screen falls to the Plan, especially before the finalization of Advanced Medical Home determination. However, that means that families may only be screened once (instead of perhaps annually). Even if the Plan screens first, it may make sense to have the "core" screening fall to the PCP during the first or second visit and annually thereafter to assure that families are timely linked to needed resources, including as new challenges arise. If providers screen, we urge a dedicated CPT code for both evaluation and payment purposes.

Resiliency focus: The screening tool is deficit-focused. We understand why that might be needed to help address urgent needs. However, especially given that there may be follow-up or add-on information by the Plans, we urge the inclusion of resiliency factors at that time.

Administrative Ease

Potentially complicates care management: The Plans will be required to screen and serve the patient SDOH needs. If that is not working smoothly, how does the provider step in effectively to help and what is they expectation that this is done? Will this be part of care management or vary by Plan? What if addressing the SDOH is critical to a Tier 3 or 4 practice meeting quality metrics but the Plan is reluctant for the practice to be proactive in this area?

Technology: We applaud use of the current EHR. As always, we urge the State or Plans pay for reprogramming that will be required across all providers to comply with the waiver or the Plan. We also urge strong legal guidance for any screening done by the provider that is recorded in the EHR, especially for factors relating to the parent rather than the child/patient. We urge use of a dedicated CPT code for evaluation and payment purposes.

HIPAA Compliance: Given that actually linking families to the services is key for the success in addressing SDOH, guidance on HIPAA compliance would be appreciated.

Vulnerable Populations

Concerns about Long Screening Tools: We understand the desire to provide Plan flexibility but are concerned about the potential to develop a too-long screen that becomes burdensome to families, especially those facing multiple challenges. We urge you to limit the number of additional questions that can be asked by the Plans or require a second tool based on responses to the first screen. This issue is especially salient for families with limited literacy and multiple challenges.

Vulnerable Populations Con'd

Children who may be maltreated: We applaud the inclusion of interpersonal violence measures. We urge you to also clarify to parents, Plans and providers that this is not a screen for child welfare and does not replace a referral to DSS when appropriate. (Parents need to know that truthful answers will not result in their child being taken away. Plans and providers need to know that they still have a duty to report suspected abuse and neglect.)

Strong and complete resource platform: Plans will have information on special health care needs of patients. It is important that referred resources are appropriately accessible. We urge that the Resource Platform includes information such as wheelchair accessibility, food for special dietary needs, etc.

Immigrant families: Given proposed federal changes in immigration policy including public charge, we have concerns about the potential chilling effect of asking questions about immigration status.

Payment Adequacy

Payment as offset to administrative burden: While this change is potentially positive for families and providers if families are actually linked with needed resources, it is another example of increased administrative burden as providers must engage with multiple Plan strategies to screen, share information and care manage. As a result, we strongly urge the Department to set rate floors for medical homes at Medicare rates (or Medicaid, whichever is higher). We also urge consideration of stabilizing monthly payments, such as the current per member per month, which represents up to 10% of income for some pediatric practices currently. These strategies would offset some of the increased administrative burden and possible legal compliance issues associated with these proposed changes.

Sincerely,

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