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North Carolina Chapter

North Carolina Pediatric Society

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September 5, 2018

Kimberly Kilpatrick
Contract and Compliance Specialist
NC Department of Health and Human Services

RE: Request for Proposal #: 30-190029-DHB, Prepaid Health Plan Svcs

Dear Ms. Kilpatrick:

On behalf of the NC Pediatric Society, we submit the below questions relating to the RFP:

Thank you for your emphasis on EPSDT, including the PIP requirement if performance falls below 75%. Which specific 416 measure will be used please? (For example, we have particular concerns about the 416 screening ratio as it does not take into specific account whether or not children are receiving the appropriate screens.) (page 173 of Section V)

Will education and training materials around EPSDT need to include information on network adequacy and inclusion of specialists to address treatment needs? (page 92+ of Section V)

How will vaccine-hesitant families be accounted for in calculating performance measures for providers and PHPs? Will norms be available by region? How will new patients who came to the practice/Plan behind in appropriate vaccines be calculated in vaccine rates?

We applaud the inclusion of pediatric specific quality measures. We appreciate that these measures may be refined as the process moves forward. Could you please explain what that process will be and the extent to which stakeholders will be involved in honing these measures and analyzing the data? Two examples: 1) We have concerns that the inclusion of flu in #15 will detrimentally impact providers who are strong on vaccination rates overall but face flu specific barriers, such as not receiving their VFC supply promptly. While we applaud encouraging flu vaccination, we are concerned that including flu in the Combo child immunization metric may result in hiding practices with relatively poor immunization rates beyond just flu. It would be helpful to look at Combo 7 as well as Combo 10. 2) We are concerned that placing #38 as a priority measure emphasizes visits that are less critical than the well visits at the younger age when life-saving vaccines are delivered (Concerns reference Table 2 in Attachment E.)

How will stakeholders be identified and involved in the refinement of policy and roll-out of additional populations (such as foster children, youth and graduates) including into Tailored Plans?

What is the assurance that PCP will be informed when a patient enrolled changes PHP or PCP or experiences changes demographic information? How quickly will the attribution change?

Thank you.

Sincerely

Scott St. Clair, MD, FAAP, Chapter President
North Carolina Pediatric Society (NCPeds)