February 14, 2020
The Honorable Mandy Cohen, MD
Secretary, N.C. Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-2001

Dear Secretary Cohen:
Thank you for the opportunity to make comments on NCDHHS white papers on the Behavioral Health I/DD Tailored Plan RFA Pre-Release. The NC Pediatric Society is a membership organization representing more than 2,300 child health professionals across the state. We represent both primary care and pediatric subspecialists. We applaud many elements of the Tailored Plan RFA Pre-Release

- Strong focus on dental care and vaccines
- Patient-centered approach, including choice in care manager
- Attempts at data alignment
- Higher PMPM than initially proposed in Tailored Care Management Provider Manual
- Medical Loss Ratio of 88%
- Solvency requirements
- Reimbursement rates of 100% even for out-of-network care during transitions and for behavioral health services.

We also have some concerns and suggestions:

Minimize regional variation: We recognize the current need to have seven Tailored Plan (TP) regions. However, if more regions need to be created, we urge using the Standard Plan (SP) regions to the maximum extent possible and aligning any “overlay” regions. (For example, footnote 25 in the draft Tailored Plan Management Provider Manual notes that the Healthy Opportunities Pilot Program may cross TP regions. Especially given that TPs are regional in nature, practices or other entities contracting with the LME in one area may not participate in an adjacent area.) Additionally, if the award process results in “empty” regions (page 3), we urge using that flexibility as an opportunity to more closely align TP and SP regions. The proposal notes that the Department “does not require plans... to hold a Standard Plan contract...in the same region as the Behavioral Health I/DD Tailored Plan (page 5).” This could create additional administrative burden and confusion.
**Protect access to pediatric subspecialists**: There must be a strong and explicit focus on access to appropriate pediatric subspecialists. Proposals that create barriers for subspecialists to participate – such as needing to manage a large number of contracts or reducing payment by 10% - are highly problematic. We applaud the requirement for access to out-of-network providers and no-cost second opinions (page 11). However, we are concerned about access to needed subspecialists for vulnerable populations. There are a limited number of pediatric subspecialists in North Carolina\(^1\) and they may be geographically concentrated around academic centers and major hospitals. It is not unusual for children who need TP services to also have other medically complex conditions that require the care of a pediatric subspecialist who may be outside a given TP region. We appreciate the expectation of strong access. However, we are concerned about the administrative burden of expecting a subspecialist to engage with seven TPs (plus PHPs, Medicaid Direct, ACOS, CIN, etc.) or only be paid 90% of Medicaid Direct (page 13). This is a barrier to needed care for children and a high level of administrative burden for subspecialists.

**Assure strong medical homes**: We understand and appreciate your glidepath to help promote AMH+. However, some practices may not seek to achieve this high standard, even with time and support. It is important to foster partnership and administrative ease even when the PCP is not striving towards AMH+ status.

**Reduce administrative burden**: Allowing the TP to *rely* on Standard Plan and other services outside the region for primary care (page 5) increases administrative burden further. It is important not to lose sight of how contracting and care would work for PCP and subspecialists outside of an AMH+ setting. Additionally, metrics should be kept minimized in number while maximized in impact.

**Include physicians and child health experts in “Entity Governance”**: The proposal requires that the Governing Board include “clinical experts” but not specifically physicians or anyone with child health expertise. Both perspectives are essential for success.

**Use a child-specific algorithm to adjust for risk for child populations**: As we have noted in previous input, we urge use of a pediatric specific risk-adjustment algorithm. In other white papers, the Department has suggested use of CDPS + Rx. The Washington Center for Excellence at Seattle Children’s Hospital used CDPS as the basis for developing a more child-specific methodology – the Pediatric Medical Complexity Algorithm (PMCA) - which has dramatically better sensitivity and specificity. In addition to being built off of CDPS, it is our understanding that PCMA is currently used with some NC Medicaid data sets as well. PCMA seems like a strong fit, but our main “ask” is that a child-specific risk adjustment be used for child populations.\(^2\)

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\(^1\) For example, 2017 data from the ABMS Board Certification Report shows 11 pediatric urologists, 11 pediatric rheumatologists, 34 pediatric gastroenterologists, 22 pediatric nephrologists, 66 pediatric cardiologists, 37 pediatric endocrinologists, etc. The overall range was 8 (pediatric dermatologists; next lowest was adolescent medicine with 9) to 136 neonatal perinatal medicine (next highest was pediatric critical care medicine with 75).

\(^2\) Here is a link to more information on PCMA: [http://www.seattlechildrens.org/research/child-health-behavior-and-development/mangione-smith-lab/measurement-tools/](http://www.seattlechildrens.org/research/child-health-behavior-and-development/mangione-smith-lab/measurement-tools/)

Here is a paper from AAP: [http://hosppeds.aappublications.org/content/7/7/373](http://hosppeds.aappublications.org/content/7/7/373)
**Align VBP to the population:** A report prepared for New York Medicaid – *Value-Based Payment Models for Medicaid Child Health Services*[^3] - looked specifically at how “payment changes should apply to... Medicaid enrollees who are children and adolescents.” This analysis from Bailit Health recommends four strategies for VBP for children with medical complexity

- Assure a sufficiently large population
- Share risk, but avoid full risk due to the impact of high-cost outliers
- Base earned savings on quality performance
- Assure quality metrics are relevant to the health status of the population.

**Pay attention to transitions in and out of TPs:** We appreciate the detail on how children transfer into Tailored Plans. We are concerned about children, especially teens, who may need the higher level services that TPs have to offer, but only for a time limited period. Is it envisioned that once a patient moves into a TP, they stay there as long as they are covered by Medicaid or CHIP? And if someone loses eligibility, do they come back in at the TP or SP level?

Given the additional layers of complexity with multiple PHPs (and possibly ACOs and CINs) we urge special attention to transitioning populations who likely will be particularly vulnerable.

**Clearly define how attribution will work:** We know that attribution can be challenging. It can be even more so for children transitioning between Tailored Plans and Standard Plans plus more entities involved in their care. If a fully immunized patient moves from an SP to a TP, and the TP contracts with a different SP than the child had previously, where is the success of the quality metric captured? Who is responsible for which metric? Is the pediatric subspecialist accountable for the combo 10? Is the PCP accountable for the metabolic monitoring of drugs they didn’t prescribe? Is the behavioral health specialist accountable for UTI admissions? How do the withholds work for children who transition between SP and TP during the year?

Furthermore, payments to practices should not be at risk if a patient switches Plan types or PHPs. Practices should be able to control their panels. There should also be a way to note that patients received multiple notices for an appointment, counseling for vaccines, etc. but still declined. (This is also related to the panel control issues we have raised previously.) There should also be allowances for children with medical exemptions for vaccines. There should be special consideration for appropriate risk corridors.

**Pay quarterly on quality metrics:** Quarterly payments will ensure more timely and accurate data flows, allow for needed adjustments to improve, and assure appropriate coordination occurs.

**Align with Families First:** While focusing on the In-Reach and Transition Requirements for Children and Youth Members in Behavioral Health Settings (page 16), we urge consultation and alignment with on-going efforts in the Department towards meeting the federal goals of Families First.

[^3]: [https://uhfnyc.org/media/filer_public/02/4f/024fdd3f-4fd8-426b-86b8-128ef485f465/bailit-vbp-final_20160713.pdf](https://uhfnyc.org/media/filer_public/02/4f/024fdd3f-4fd8-426b-86b8-128ef485f465/bailit-vbp-final_20160713.pdf)
Report on QMAF at state and regional level: These Quality Metrics provide a strong range of data that includes routine early childhood developmental screenings, mental health screenings for new mothers and adolescents, and metabolic monitoring when needed due to medications. Rather than seeking appropriate (but inherently complex) attribution, we recommend that Plans (TP and SP) report on these measures quarterly for all of their child populations and that NCDHHS provide a statewide average. This will allow comparison across time and by region/TP and provide timely guidance if care for children slips or if improvements warrant “bright spot” analysis or celebration.

Ensure data is iterative and easy: Practices need to understand their data to make improvements. With multiple data flows, including from SPs contracted with TPs, there is a risk that data could become challenging to manage and understand. Data disputes need to be minimal to emphasize using the data to promote health.

Thank you again for this opportunity to provide feedback. If you need any follow up information, please reach out to me, or our Executive Director, Elizabeth Hudgins.

Sincerely,

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