

# North Carolina Chapter

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## North Carolina Pediatric Society

October 7, 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 revised comments on NCDHHS white papers on Value Based Care and Accountable Care Organizations. We appreciate the request for stakeholder feedback and input. 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 aspects of NC's Medicaid approach:

- Emphasizing health
- Using pediatric quality and outcomes as a gateway to savings
- Having a glidepath for participation
- Emphasizing primary care
- Including school-based care in ACOs and providing a mechanism for payment
- Taking into account diversity of providers
- Seeking to build on existing infrastructure
- Promoting Healthy Opportunities
- Recognizing explicitly some of the challenges in VBP as it applies to children

**We offer the following in response to requests for input around pediatric measures and other factors:**

**Clarify what "buying health" looks like:** Buying health is a motivating goal. Being able to help kids be healthy is why most pediatricians and other child health professionals spent years in training. Research on physician burn-out increasingly shows the importance of factors that increase job satisfaction, such as increasing patient care and decreasing administrative burdens. North Carolina's experience with Early Periodic Screening Diagnosis and Treatment (EPSDT) demonstrates that letting pediatricians provide needed care is an effective strategy for participation. In addition to the total cost of care calculations delineated in the white papers, other measures could include the following:

- Equity promotion: How do Transformation changes and strategies increase the likelihood that children in families of color will receive appropriate, high-quality care? What are key baseline measures or proxies? Some research suggests that race of provider can help promote better and more equitable outcomes so assuring diverse providers is another important step to promoting equity. Looking at the diversity of the PAGs or other PHP advisory bodies is another possible consideration along with the cultural competence of patient care environments.
- Crisis response: NCDHHS has done a stellar job supporting families and practices during the COVID crisis. What safety net provisions will remain in place to assure supports such as increased Per Member Per Month directly to the practice or unified communications and response during a hurricane or other emergency? (Needing to wade through communications from 7 or more insurers – 5 PHPs, Medicaid, 1 TP provider, with potential variation for Health Choice... - during a crisis would not promote an efficient or effective response from providers. Even worse would be needing to fill out and track on 7 or more emergency application forms.
- Access to care: Do as many (or more) practices accept children insured by Medicaid and CHIP on the same basis as privately insured children? Do children have strong access to subspecialty care? Are children attached to a medical home? Do children get the full array of services they need? Is there concerning variation (i.e., race, urban/rural, gender identity, etc.)? How friendly are those settings?
- Coverage for newborns and other vulnerable populations: Part of buying health is assuring that patients have timely access to care when they most need it. Now, in some counties, there can be substantial delays in newborns getting Medicaid cards. (Additionally, time to get newborns enrolled is not part of the “timeliness” calculation.) Most pediatricians will continue to provide care, knowing that that Medicaid will pay retroactively. New structures should enhance care, not increase barriers.
- Effective feedback loops: Share the good news. Ensure that pediatricians and others know when their patients are making progress towards health that might not show up quickly in the exam room. Provide information disaggregated by race when possible. Assuring the NCDHHS has timely access to strong data is key for this activity and more, as evidenced in the pivot of the Department in COVID.

***Keep the enhanced per member per month flowing directly to practices:*** This support has been critical during the COVID pandemic. It has allowed practices to minimize or avoid staff lay-offs, which makes it easier to ramp back up for vaccines and other care. Furthermore, having this direct flow from NCDHHS to the practices has promoted administrative ease. It is our understanding from colleagues in other states that their state Medicaid agencies struggled to get out relief. Also, by maintaining NC Medicaid/practice connection, there is an important backstop if PHPs struggle to pay for some reason (computer shut down, natural disaster, bankruptcy, etc.). To quote a pediatrician from our October 6<sup>th</sup> membership Solution Share call “what is saving us all (financially) is the action of Medicaid to increase the PMPM and rates.”

***Be mindful of bandwidth and simplify and slow down where possible:*** There is a pandemic. Concerns about patient and provider mental health are growing. Practices are struggling financially. Staff are balancing schooling their children while working. We realize there is a July 1 2021 legislative deadline, but to the extent possible, whenever possible slow down timeframes, lengthen glidepaths, provide materials in advance, avoid quick-turn around deadlines, etc. Also, keep requirements and data criteria

as streamlined as possible. Make materials, including supports to practices trying to help patients navigate the Enrollment Broker, as turn-key as possible. Specifically in terms of VBP, make sure criteria – including how they are measured and data source/entry – are clear and actionable.

**“Bake in” all the recent Medicaid improvements:** Examples in addition to the enhanced PMPM include the rate increase, coverage of telehealth, lactation improvements, emergency assistance for PPE, timely and unified communications and other supports.

**Cover trained medical interpretation/translation in the setting of limited spoken English proficiency and other language needs.** In addition to being supported by Title VI of the Civil Rights Act and National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS standards), interpreter use maintains confidentiality, reduces errors and cost, and increases access to and quality of health care delivery. This is critical for supporting quality. Interpretation services should include sign language or other appropriate communication modalities for patients/families who are deaf or hard of hearing. The PHPs should be required to have their own language service provider for their patients to use regardless of the medical setting.

**Clearly define how attribution will work:** We applaud using pediatric quality and outcomes as a gateway to savings. We know that attribution can be challenging. For example, 416 screening is number of billed EPSDT/number of expected billed EPSDTs and can be thrown off by one child receiving multiple screenings (such as a sports physical, a school exam, and an evaluation in a pediatrician’s office). The 416 participation ratio is the number of children with a check-up/ number of children insured through Medicaid. This undercounts services to young children, who need more than one check-up per year. Additionally, a child must be enrolled in Medicaid for 90 days to “count” for 416 measures. In contrast, it is our understanding that HEDIS requires that a child be enrolled in Medicaid and with a PHP for an entire year to count. How children are attributed to ACOs and PHPS needs further details. In particular, payments to practices should not be at risk if a patient switches PHPs or ACOs. The Department should consider strategies to control the denominator for length of time enrolled. 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.) This sort of strong, patient-center data will also be integral in assessing how policies, including those related to crises or equity, are working, including for people of color.

**Be transparent and include research-informed elements when reporting on PHPs:** A recent study from Georgetown Center for Children and Families provides insights for essential elements to include when evaluating and reporting publically the work and success of the PHPs. <sup>1</sup>

- The total number of children enrolled in each PHP
- The total number of children enrolled in each PHP broken down by age (e.g., 0-1, 1-5, etc.)
- The total number of children enrolled in each PHP broken down by race and ethnicity
- The total amount the state paid each PHP to manage the care of the children enrolled during the most recent contract year

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<sup>1</sup> <https://ccf.georgetown.edu/2020/09/02/medicaid-managed-care-for-children-in-iowa-not-so-transparent/>>

- The share of children in each MCO who received the general health screenings, referrals for corrective treatment, screening blood lead tests, and dental preventive and treatment to which they are entitled under the [Medicaid EPSDT child health benefit](#)

***Lengthen the glidepath for Advanced Medical Homes:*** Given the impact of the pandemic on practices, including staffing and other capacity, the glidepath towards AMH3 should be lengthened to help allow more practices to participate.

***Include cost-data in elements that PHPs are required to provide to providers:*** Providers cannot be expected to control costs if they do not have basic information about what costs their patients are incurring. This kind of data also allows assessment of determining if certain populations are getting more – or less – of certain benefit packages.

***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. PMCA seems like a strong fit, but our main “ask” is that a child-specific risk adjustment be used for child populations.<sup>2</sup>

***Build on success on EPSDT, including as a foundation for addressing social determinants of health:*** Early Periodic Screening Diagnosis and Treatment (EPSDT) has decades of success in promoting health for children. In North Carolina, when EPSDT started, pediatric leaders with the NC Pediatric Society promoted it with their colleagues, noting that if pediatricians cared for patients insured with Medicaid the benefit package through EPSDT was robust and would allow for good care. Importantly, even if a service was not part of the standard benefit package, the child could still receive the service if it was medically necessary to be healthy. In other words, EPSDT offers a strong model for going outside the standard benefit package to promote better health by letting doctors be doctors<sup>3</sup> and linking patients with the full range of care they need. EPSDT is a critically important benefit for children that should undergird work on measures and value.

***Align CHIP and Medicaid to reduce administrative burden:*** The white papers do not clearly delineate differences in measures between CHIP and Medicaid. However, given that children insured through CHIP have a different benefit package, ACOs, PHPS, pediatricians and families face different standards for the two programs. In particular, how would Healthy Opportunities work for a family where one child is insured through Medicaid and another through CHIP? Aligning CHIP and Medicaid would be a concrete step towards administrative simplification as the Department is rolling out a complex plan.

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<sup>2</sup> Here is a link to more information on PCMA: <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>

<sup>3</sup> And nurses be nurses and PAs be PAs, etc.

**Avoid narrow networks/consider administrative burden of subspecialists:** There are a limited number of pediatric subspecialists in North Carolina.<sup>4</sup> If ACOs create smaller groups to provide care, it is important that each of these groups have appropriate pediatric subspecialists. At the same time, pediatric subspecialists should not be expected to need to manage contracts with Medicaid, CHIP, 5 PHPs and an unknown number of ACOs. While many pediatric subspecialists practice in hospital settings, some are in independent practice for whom this could be particularly burdensome.

**Continue to pay for care coordination and per member per month:** A report prepared for New York Medicaid – *Value-Based Payment Models for Medicaid Child Health Services*<sup>5</sup> - looked specifically at how “payment changes should apply to... Medicaid enrollees who are children and adolescents.” This analysis from Bailit Health recommends three strategies for VBP for children (except those with medical complexity):

- Capitate Primary Care Payment
- Care Coordination Payment
- Performance Incentive Bonus (looking at both excellence and improvement)

Again, the enhanced PMPM has been a critical support to practices during the pandemic is a way to continue to allow practices to stay strong and weather the vagrancies of adapting to new models of care, hiccups in payment schedules and more.

**Pay attention to transitions in and out of SPs:** We understand that these white papers pertain to Standard Plans. It is also our understanding that there will be a statewide specific plan for children in foster care. If these children need to transition between plans, it is important that ACOs understand the unique care management needs of this population, that risk and attribution are calculated appropriately, that children are not over-immunized as they switch between plans, etc. Similar concerns may apply if other child populations switch between Tailored Plans and Standard Plans. Especially for children in foster care it is important that they can continue to see a pediatrician with whom they are already connected and/or a practice participating in Fostering Health NC.

We are also concerned ACOs and PHPS understand the unique needs and likely high ACE scores for adults aged 18 to 26 who qualify for Medicaid because they were in foster care on their 18<sup>th</sup> birthday.

Given the additional layers of complexity with multiple PHPs and now ACOs, in possible addition to CINs, we urge special attention to transitioning populations who likely will be particularly vulnerable, including foster children and children in historically marginalized populations.

**Weigh early childhood measures more strongly than current proposals:** Most of the withhold and other “pay” measures for the PHPs focus on children ages 3 and older. Yet infancy is a particularly vulnerable time and one where pediatric practices often focus many resources. To buy health, appropriate attention must be paid to these early years.

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<sup>4</sup> 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).

<sup>5</sup> [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)

**Beware power imbalances:** We applaud the flexibility and the ability to negotiate. However, larger, better funded entities will inherently have larger, better funded legal departments. Current statutes mandate rate floors at current Medicaid levels. The Department needs to provide strong oversight and guardrails so that ACOs and VBP are not used a back channel to reduce resources to practices below these mandated levels. Extra care should be taken in areas with high HPSA scores or high percentages of historically marginalized populations. In times of emergency especially, response should be swift and not impose substantial administrative burden.

**Pay quarterly on quality metrics:** Quarterly payments will ensure more timely and accurate data flows, allow for needed adjustments to improve, and generally help emphasize the need for improving health (compared to waiting for an annual payment).

**Ensure data is iterative and easy:** Practices need to understand their data to make improvements. What happens when a patient switches PHPS so HEDIS or 416 doesn't capture key metrics appropriately? When data is reported up through ACOs then PHPs then aggregated and reported back to the practice in a different format showing different results, the emphasis becomes on resolving differences in the data for appropriate payment rather than promoting timely improvement in the processes that lead to better health outcomes. Initially, internally report outcome data by race so pediatricians and other professionals can see their results and how they compare to others in the state.

**Consider additional incentives:** One of the lessons from EPSDT in NC is that uptake is strong when the incentive is providing tools to practice good medicine, even outside the usual benefit package. One of the lessons from Electronic Health Record is that processes that make physicians feel isolated from patient care can contribute to burnout. How can ACOs and VBP help ensure that pediatricians and other have more positive tools? Possibilities for consideration include

- Streamlining (or eliminating) the Prior Authorizations for low utilizers and key subspecialists
- Providing feedback on “buying health” (did the family get new carpet yet?)
- Ensuring that ACOs proactively inform the PCP when a patient is admitted to or discharged from the hospital
- Noting publicly key achievements (such as the current “breastfeeding friendly” designations for hospitals but consider areas of focus such as strong warm hand-offs among providers and culturally competent environments)

**Continue to protect patients and providers:** How do Chapter 58 or other protections apply to ensure that patients get care and practitioners get paid in a Value Based System where ACOs create another layer between providers and PHPs? How do these protections apply to historically marginalized populations in particular? How do these protections apply when the appeals process is outside of North Carolina?

**Ensure strong alignment with validated measures for ACOs:** The American Academic of Pediatrics examined key factors for ACOs that work well for children. While many elements are discussed, some key factors include incentives and payments that align to promote patient center medical homes and measures are clinically validated and developed by nationally recognized organizations.<sup>6</sup>

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<sup>6</sup> Accountable Care Organizations: Evaluation and Engagement, 2011 <https://www.aap.org/en-us/professional-resources/practice-transformation/getting-paid/Pages/Accountable-Care-Organizations-and-Pediatricians-Evaluation-and-Engagement.aspx>

In terms of the broader question of feedback on data, data exchange, system needs, opportunities and concerns when assessing practice participation in the ACO model:

- Ensure consistent, strong use of EPSDT
- Include access to care and to medical homes as key “meta” data points
- Keep full QMAF panel
- Use a pediatric specific algorithm for risk adjustment
- Provide iterative, timely, actionable data that is disaggregated by race and other factors
- Ensure that data that is easy to share and does not need to be entered multiple times
- Use standardized language and labeling, such as treating hyphenated names consistently
- Minimize EHR programming changes (for example, could EHRs be required to apply a “bulk rate” to changes across multiple practices? Could HIEA be used to promote efficiency? Etc.)
- Provide clarity on member attribution at the PHP, ACO and practice levels
- Align CHIP and Medicaid. If that is not possible, be clear on how different benefit packages, use of Vaccines for Children, etc. impact the ACO, PHP, practice and value-based payment, especially in counties with Healthy Opportunity pilots
- Ensure a multiple year “look back” for children when they are removed from the home. Since children are mostly healthy and may not be actively care managed prior to removal from the home, how is a sufficient level of multi-year medical record information quickly provided the pediatrician doing the evaluation required by the state within 7 days of being taken into DSS custody? Information is also needed on appropriate vaccination, especially for children being placed in group setting.

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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President, North Carolina Pediatric Society

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