



North Carolina Chapter

North Carolina Pediatric Society

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September 23, 2016

Secretary Rick Brajer
Department of Health and Human Services
101 Blair Drive
Raleigh, NC 27603

RE: Access Monitoring Review Plan

Dear Secretary Brajer:

Thank you for the opportunity to comment on the proposed *Access Monitoring Review Plan*. As always, we appreciate that the NC Department of Health and Human Services solicits and considers the input of pediatricians and other stakeholders when making key decisions about Medicaid. As noted by NCDHHS, children are the majority of Medicaid beneficiaries and therefore a critical constituency in formulating measures and assuring access.

We have five main points, detailed below.

1) Primary care utilization declined when reimbursements declined.

Throughout the *Plan*, DHHS notes that utilization of services for primary care declined more than 10% statewide between 2014 and 2015. (Please see, for example, Figure 14 on page 16 and conclusion on page 61.) This is the exact time frame of the loss of the ACA bump compounded by a legislatively mandated rate reduction, resulting in an approximately 25% decrease in key reimbursement rates. We encourage NCDHHS to examine the impact of these reductions on access to primary care. We also urge CMS to see if this reduction in access is a trend among the other states who declined to maintain parity rates for primary care.

2) Pediatric specialist utilization should be a separate measure.

According to the *Plan*, children are 60% of those covered. Additionally, CMS requires separate break-outs for key population, including children. (Please see slide 8 of CMS AMRP Development Slide Show, which note a requirement for service and payment variations for pediatric populations, for example.) We appreciate the inclusion of measures such as access to urologists, behavioral health services, dental health, general surgeons, home health providers and others. It is critical to include a measure that assesses whether or not children have access to providers who specialize in such services for children.

3) Additional primary care measures would provide more useful information while serving as a better baseline to assess the impact of future rate adjustments and policy initiatives, including NC's proposed 1115 waiver. We recommend addition of the following measures:

- a) Percentage of Medicaid beneficiaries assigned to a medical home, as evidenced by payment of per member per month (urban/rural; adult/child)
- b) Relative acceptance rate as defined by Berman and Tang (<https://www.researchgate.net/publication/11220469> Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients) of
 - i. primary care physicians for patients insured by Medicaid (urban/rural; adult/child)
 - ii. primary care physicians for patients insured by Health Choice (urban/rural)
 - iii. primary care physicians for new patients insured by Medicaid (urban/rural; adult/child)
 - iv. primary care physicians for new patients insured by Health Choice (urban/rural)

4) Top CPT codes should represent top procedures for the primary care population.

Figure 26 is designed to maximize comparison to Medicare. This is not always appropriate for more general primary care, and certainly not for pediatric care. For example, a well-child visit is not included in the current Figure 26. We urge use of the top 10 pediatric and other primary care codes. We urge comparing the current rate to 2014 rates (expressed in inflation adjusted dollars). It would allow inclusion of more appropriate measures while also demonstrating the impact of eroding payments.

5) Payment rates should reflect typical or weighted average payment, not lowest possible.

The current charts reflect non-modified payments, which may not be an accurate representation of actual reimbursement rates. For example, in Figure 26, the reimbursement rate of 90471 is given as \$13.30. Most pediatricians use a modifier code and are reimbursed at \$20.45. An effective "cut" to \$18 would look like an increase under this methodology and not offer a true perspective on rates paid or impact of cuts. Also, calculations of statewide averages should be weighted to reflect the population served.

Thank you for your consideration of these changes before submitting the *Access Monitoring Review Plan* to CMS.

If you have any questions or concerns, please feel free to contact our Executive Director, Elizabeth Hudgins.

Sincerely,



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North Carolina Pediatric Society (NCPeds)