

# North Carolina Chapter

INCORPORATED IN NORTH CAROLINA

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



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## North Carolina Pediatric Society

December 19, 2022

Secretary Kody Kinsley  
NC Department of Health and Human Services  
2001 Mail Service Center  
Raleigh, NC 27699-2000

Dear Secretary Kinsley:

Thank you for the opportunity to comment on *Medicaid Delivery Reform and Value Based Payment Update*. The NC Pediatric Society represents 2,300 primary care pediatricians, subspecialists and other members across NC. Our members serve on many Medicaid-related groups. This letter represents our 40<sup>th</sup> set of written comments on Medicaid reform related issues. Since more than 40% of children in NC are covered by Medicaid, a strong program is important for child health.

We will go through your specific questions below, but first we wanted to highlight a few key concerns and on-going themes.

**Seamless care management:** Pediatric experience with care management is highly variable. One NCPeds internal Medicaid Reform Task Force member noted that they could not find who the care manager was for the practice or patient and was advised to call the number on the member card to see if they could connect that way. A few members reported easy CM connection through their EMR that facilitates timely information sharing and follow up. Most were in-between those two extremes. Strategies to address care management will need to acknowledge the wide range of current approaches.

**Communication:** When our Task Force discussed the lessons learned from COVID, members repeatedly mentioned strong and trustworthy communication. They also noted appreciation for NCDHHS seeking timely feedback on proposals and how changes were working/when adjustments were needed.

**Equity:** We applaud the inclusion of equity as a top concern. We note that even pre-COVID, while about 40% of children generally in NC were covered by Medicaid, for Black children that percentage increased to about 60%. When extra barriers are created to strong care with Medicaid, children of color are more likely to feel the impact. This is a particular concern in access to subspecialty care.

**Children and Youth in Foster Care:** We are strongly supportive of one statewide plan for children and youth in foster care. We applaud Department proposals for coverage that reaches a broad swath of the families in foster care as well. Until that Specialized Plan is implemented, all elements of Medicaid need to ask the potential impact on children and youth in foster care and how information gets shared with key players. We would also urge strong communication with feedback loops as to what is working well and what could be improved.

**Prior Authorizations:** PAs continue to be difficult to navigate with multiple plans, changing rules, and challenges to obtaining, especially for highly specialized treatments and services. Often, PAs are submitted and navigated by primary care physicians or others who receive no payment for the referral or treatment.

**Accurate Data:** Continual pain points include inconsistent access to care management information, inaccurate panels, errors in other primary insurance information, delayed information from PHPS about care gaps that cannot be closed.

**Supports for local DSS:** This has been a strong theme across NCPeds committees, work groups and task forces for many months. Local DSS has always had a hard job that has only been exacerbated by COVID and staff turn-over and is about to get Unwinding layered on top. Strong resources here are critical to the success of Medicaid reform. A top level question when designing policies needs to be how the interplay of local DSS (including Medicaid/eligibility and child welfare/foster care), NCDHHS, Plans, practices, and other key partners will work.

To address the specific questions and concerns raised by NCDHHS, we note the following.

First, we applaud many of the proposed elements of design:

- Equity
- Administrative ease
- Focus on panels and attribution
- Accurate data

Now, to address the specific questions and concerns lifted up by the Department.

#### AREA OF FOCUS

Should Specified Key Strategies be the focus? We applaud many of the areas of focus and also offer the following.

- **Children and youth in foster care:** we recognize the intent is to move to a specialized plan for children and youth in foster care and others. Until that happens, there must be strong pathways for care for children and youth in foster care, especially during especially vulnerable moments, such as entering care or transitioning placements. The question “how does the current or proposed program work for children and youth in foster care” should be raised for every single design element with specificity. (How does a Plan (SP or TP) know that the 5120 has been started before it is finalized? How is local DSS, especially child welfare, supported in assuring that child is assigned to a PCP so practice can utilize the enhanced PMPM or other proposed policy levers? What safeguards are in place for medication, such as if a child needs duplicate medications – inhaler, seizure meds, etc – when they are removed from their home?)

- **Supporting county DSS:** County DSS plays many key roles in the success of Medicaid Reform. They too are grappling with staff shortages, increased workload, and soon possibly the unwinding of the public health emergency. They need strong education and supports for many pieces of proposed policies to move forward. This is especially a problem for newborns, and children and youth in foster care. There should be special attention on the impact of proposed policies on local DSS with appropriate engagement, input, education and resources.
- **Network adequacy:** We applaud the focus on primary care. However, to fully provide whole-person care, sub-specialty care is also needed. A study recently reported in JAMA noted that adults of color covered by Medicaid were less likely to get needed specialty care.<sup>1</sup> For many pediatric subspecialists, there are limited number of across all the state.<sup>2</sup> Assuring that children, including TP eligible children, have access to the subspecialist they need is critical to providing equitable and strong care. When looking at factors such as how care management information is shared, it is important that sub-specialty access is considered for equitable and whole-person care.
- **Smooth transition:** We recognize that smoothing transition is one part of the third bullet, but transition points are pain points. They deserve their own set of focus and attention, especially for child and youth transitioning into foster care. Other examples of transition include being born, transitioning between Plan types (such as SP to Medicaid Direct or Tailored Plans), changing Plans, changing PCPs, aging out of a care category, moving off a waiver waiting list and moving counties. The unwinding of the Public Health Emergency is another example of anticipated transition. All of these transition points will take a great deal of attention to work well, separate from financial flexibility and resources.
- **Contracting ease:** Currently, one practice could easily have contracts with Medicaid Direct, 4 or 5 PHPS, 1-3 Tailored Plans - each with a different contract, a different set of billing and coding requirements, different banking procedures, different points of contact to resolve conflicts, different PA requirements etc. They may also be expected to participate with multiple CMAs as TPs develop more fully. Especially if we expect practices to enroll in another contract for Specialized Plan, where they may only have 5 to 10 qualifying patients, paying particular attention to contracting ease will be critical.

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<sup>1</sup> Christopher Cai, Adam Gaffney, Alesia McGregor, et. al. Racial and Ethnic Disparities in Outpatient Visit Rates across 29 Specialties. JAMA, July 19, 2021  
[https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2782019?guestAccessKey=1daf3e28-cf5d-47f6-918c-4829f296e931&utm\\_source=For The Media&utm\\_medium=referral&utm\\_campaign=ftm\\_links&utm\\_content=tfi&utm\\_term=071921](https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2782019?guestAccessKey=1daf3e28-cf5d-47f6-918c-4829f296e931&utm_source=For%20The%20Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfi&utm_term=071921)

<sup>2</sup> For example, 2022 data from the American Board of Pediatrics reports fewer than 50 pediatric subspecialists in gastroenterology, endocrinology, infectious diseases and pulmonology; fewer than 30 in nephrology and developmental/behavioral pediatrics, fewer than 20 in child abuse, sleep medicine and rheumatology and only 4 in transplant hepatology. <https://www.abp.org/dashboards/pediatric-subspecialty-us-state-and-county-maps>

- **Timeliness:** If data is being used to drive decisions and behavior, it needs to be timely. Currently practices may not receive information on care gaps for a two-year-old child until after the child turns age 3, for example. That makes it impossible to meet the Combo 10 by age 2 measure. While primary insurance data information tends to be correct for patients covered by Medicaid Direct, it is often out-of-date for patients with PHP, which can lead to multiple filings of the same claim and multiple attempts to correct information on the same patient.
- **Accountability/tracking:** NCPeds sometimes hears concerns from some members that there may be confusion around implementation of Department policies. We realize that sometime these concerns may represent a misunderstanding, may be unique to the provider and/or may have been resolved by now. We applaud and appreciate the Provider Ombudsman as a tool for helping to dig in and resolve problems, as we also appreciate the PHP CMOS who often personally intervene before it reaches the Provider Ombudsman level. We think that some broader accountability tracking also bears exploration. This could help build trust and participation. (Examples could include building off the NEMT 2% sample regular reporting, reporting out on the top 5 or 10 issues raised to the Provider Ombudsman, or rotating review of a specific type of claims (such as pharmacy, or newborns in first 90 days or timely concerns, flu administration payment in early flu season, mental health screening, payments being received etc.) .

#### POLICY OR PAYMENT INTERVENTION TO ADVANCE DEPARTMENT STRATEGIES

##### **Timely access to high quality care especially for historically underserved populations:**

- **Reinstate the Access Monitoring Review Plan** to monitor how many practices and in what areas take Medicaid patients. Include information on practices taking new patients and what limitations are in place with historical information to determine gains/losses over time both generally and in underserved communities specifically.
- **Pay attention to network adequacy.** Members who do not choose a Plan should not be assigned to a Plan which does not have needed hospitals, subspecialty care, etc. as part of the network. Children should be assigned to Plans with hospital access and known-needed subspecialty care.
- **Pay attention to payment, capitation and paperwork.** Long-standing analysis has found these factors are key for influencing primary care participation with Medicaid.<sup>3</sup>

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<sup>3</sup> Steve Berman, Judith Dolins et. al. Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients, September 2002, [PEDIATRICS](https://www.researchgate.net/publication/11220469_Factors_That_Influence_the_Willingness_of_Private_Primary_Care_Pediatricians_to_Accept_More_Medicaid_Patients) 110(2 Pt 1):239-48  
[https://www.researchgate.net/publication/11220469\\_Factors\\_That\\_Influence\\_the\\_Willingness\\_of\\_Private\\_Primary\\_Care\\_Pediatricians\\_to\\_Accept\\_More\\_Medicaid\\_Patients](https://www.researchgate.net/publication/11220469_Factors_That_Influence_the_Willingness_of_Private_Primary_Care_Pediatricians_to_Accept_More_Medicaid_Patients)

- **Conduct outreach and focus groups** with practices that have stopped participating or newly limited Medicaid to see if there are certain changes that would cause them to re-engage. Pay particular attention to practices with POC doctors or high POC patient populations.
- **Reduce contracting burden.** We applaud the simplification work of the PHPs. However, five different SP with multiple TP plus Medicaid Direct plus an upcoming Specialized Plan is a significant burden to manage in terms of contracts, billing/coding to modify, payments, etc. More uniformity increases simplification and reduces burden.
- **Strong, easy and culturally aware care management:** Please see specific care management thoughts below. In general, connecting with the care manager should be seamless and panel management should include the ability to manage the panel (remove adults, people who have moved out of the region, etc.). Practices (all key providers/staff in the practice) should be able to see specifically who the care manager is (the specific person in addition to the overarching provider/LME/CMA etc.) We applaud NCDHHS requirements around care management being locally provided. We further urge a keen focus on cultural awareness.
- **Mystery shoppers:** NCDHHS could utilize “mystery shoppers” to determine access, oversampling in communities with higher proportions of historically underserved populations. Data should be reported overall and by Plan. Plans could be given two scores or recognition for having strong access overall and with historically underserved populations. The measurement should be static (as opposed to relative) so that only PHPs who meet a certain threshold are acknowledged as meeting the standard.

### **Financial flexibility and incentives**

**Provide resources:** The issue is less about incentives than resources to get the job done. Currently, members are reporting that the system is becoming increasingly complex without funding to keep up with the complexity. Unless and until basic billing and coding can be handled smoothly on a reliable basis, it will be hard for practices to find resources, including bandwidth, to add new services. Furthermore, funding is inadequate to bring on additional staff people to expand service array. Additionally, the erratic structure of ABP that pay annually or quarterly do not currently provide the income predictability for additional hiring.

**Reduce complexity around billing and payment.** Some positive steps forward would be:

- A designated contact person for each PHP for each practice or region than can be found easily on the PHP website
- Faster and easier credentialing. Currently, credentialing take several months, which is a particular concern in this time of workforce crisis. We have not dug deep here, but reported problems include
  - Flow of information from NCMB to NCDHHS (this seems to be getting better)
  - Flow of information from NCDHHS to PHPS (one practice has been told by two different Plans that they (PHPs) don't download the files and the practice needs to let the PHP know that they've added new providers and again when NCDHHS is done credentialing and then the PHP will take steps that add further time and delay to allow new doctors to care for patients)
  - OPR issues for academic programs
- Accurate primary insurance information on the PHP portals (and/or assuring the PHP is responsible for actively seeking, identifying and securing third party payment)
- No take-backs/recoupments when portal reports no other insurer to bill on day of visit and then retroactively notes there was other insurance<sup>4</sup> Again, this is consistent with assuring that the PHP is responsible for seeking, identifying and recovering third party payments.
- Assuring that all services, including those tied to ABP (such as vaccination), are counted regardless of entity billed
- Accurate and timely information on care gaps from PHPs
- Fewer portals rather than more

**Credit the practice for work done:** Practices should be eligible for ABP even when a child switches Plans or the service is paid by a different payer (such as other primary insurance). This also affects income predictability for hiring staff.

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<sup>4</sup> Please also see *Primary insurance data should be accurate and timely* under Support and Incentivize Actionable Data.

### **Engage and support providers and reduce administrative burden**

***Allow for care management within EMR:*** One key for success with all Plans, especially TPs and a possible Specialized Plan, will be communication with a Care Coordinator through the EMR. This is especially true for children with special needs where activities likely include:

1. Writing numerous prescriptions for federally regulated medications
2. Making and tracking referrals
3. Coordinating care

Requiring a practice to leave the EMR, have the doctor play telephone tag with the coordinator or manager, re-enter data, etc. will slow and possibly fragment care. The primary care workforce is already overstretched.

***Include name and provider of care manager in NCTracks for more access levels:*** Currently, it can be challenging for key staff in a practice to see who the specific care manager is (both the overarching provider/LME/CMA and the specific person and contact information). It seems to perhaps vary by access level in NCTracks. It is also unclear how this works for child welfare workers in local DSSs.

***Reduce and streamline prior authorizations:*** Examples could include gold cards for providers, uniform requirements and forms. PHPS could be limited to adding new prior authorizations only once a month and post a list each month of the 10 highest volume services requiring PAs monthly the previous month. (We understand from PHPs this list changes frequently.)

***Require PHPs to provide contact information to help resolve issues:*** NCPeds frequently hears from members that they cannot find a point of contact to help them resolve issues, sometimes as basic as getting checks sent to the right address. For example, PHPs could post on their website key contact for a county/region/zip code who will respond or triage issues with initial response occurring within 72 hours (autoreply of “message received” insufficient).

***Require new services/products to pend rather than deny:*** For example, when the new flu vaccine is issued each year, it can take a while for the NDC to get loaded. Claims submitted prior to that time should pend rather than deny. (Denying requires the practice to submit the same claim multiple times for payment.)

***Hold regularly scheduled listening or “what if” sessions:*** Members reported these were helpful during the teeth of COVID. A regular time is preferable to a quickly called meeting that people may have difficulty attending. Examples could include a quarterly call the first Thursday of the month or the last 15 minutes of a Back Porch Chat being devoted to provider input.

***Look at ways to reduce administrative burden association with TPL and Pay and Chase:*** This is a frequent pain point noted on our Practice Manager Listserv. Please see ***Primary Insurance should be accurate and*** timely under [Support and Incentivize actionable data](#) for more detail.

***Streamline portals:*** Currently a practice needs to check multiple portals for each patient. This is administratively burdensome.

***Keep the Provider Ombudsman:*** We appreciate the work of the Provider Ombudsman team. It would be additionally helpful if results or top issues seen were reported out on a regular basis, such as quarterly.

### **Support and incentivize actionable data**

***Data should be accurate:*** Currently, practices report not getting information on two-year-olds who are not up-to-date on vaccines until after the child has turned three (thereby making it impossible to meet metrics like Combo 10 by 2<sup>nd</sup> birthday.) Practices report that patients seen for well-child visits do not count towards quality payment when there is primary insurance besides Medicaid. Practices frequently report that primary insurance information for Plans other than Medicaid Direct are inaccurate. (Please see ***Primary insurance*** data bullet below.)

***New data should mean new payments:*** The G9919 codes encouraged many practices to screen newly for factors relating to social determinants. These sorts of payments can help provide the practical support some may need to do new or additional work.

***Guidance should be clear:*** For example, when encouraging or requiring the use of a Z or V code in a child's medical record, be explicit this is a requirement and where it should be noted.

***Data should be timely and easy to use:*** When a practice has to access multiple portals to obtain basic information, such as care gaps, it slows care and disrupts workflow. . When care gap reports come after key deadlines for providing care, they are not useful. When care gap reports only come in the middle of flu season, they do not allow a smoothing of the workflow.

***Data should be believable:*** If all of the Plans are performing above the state average on HEDIS measures, for example, that would suggest that the measure is flawed. Panel issues could be a (denominator) factor in such a case. If patients who are fully vaccinated or have asthma well managed are not counted because of other primary insurance that would again suggest the measure is flawed. Lack of full information for services received could be a (numerator) factor in such as case.

***Primary insurance data should be accurate and timely:*** Currently, practices report that while NC Ttacks will make changes in about 3 business days after completing an HMS form to have primary insurance taken off. However, the prepaid health plans take months to get the information taken down from their website and pay the claim. Examples of administrative burden associated with trying to rectify the issue include creation of ticket stating the member has no other active health insurance, submission of screenshots and other efforts. One solution might be for PHPs to receive daily COB files from Medicaid since Medicaid is able to quickly make changes.

### **Panel assignment and management**

***Practices must have some control over their panels:*** Currently, pediatric practices have adults assigned to their panel but they can't remove them. When patients move, if the family doesn't proactively change the PCP, the practice has to figure out where they've moved, figure out how reach out to the new county DSS and try to get the patient assigned elsewhere and removed from their panel. This is even more complicated when a child used to be in foster care but is no longer. When a patient is abusive to staff, there is no easy way to remove the family from the panel. Practices must also be able to limit their number of patients, including capping high-need patients. One practice does not have endless capacity and should not be expected to accept more patients than they have staffing to accommodate. We recognize the need to guard against cherry picking; at the same time providers need to be able to have reasonable panels to provide good care.

***Panel assignment should take full needs of patient into account:*** If a patient needs a certain type of care (such as certain subspecialists or access to the major hospital in the area), then they should not be assigned to a Plan lacking that care.

***Panels should be transparent:*** Practice frequently report struggling to match their EMR panel to their multiple panel information from Plans. Furthermore, it should be easy for a practice to tell who is on their panel with a PHP and if they are being paid for all the patients on their panel.

***A certain level of contact should demonstrate good faith outreach:*** For example, if a practice documents two calls and a certified letter over the course of 4 weeks, that should represent a good faith effort to bring in a family for care.

***Panels could be spot-checked to increase reliability and trust:*** Plans or the Department could work with a few practices to assess who the practices has on their panel through their EMR compared to what the PHP info compared to NCDHHS data. This information could be used to refine technique and/or promote the strong match to build trust in panels.

***Twins should be assigned to the same Plan initially (unless parent elects otherwise):*** We have heard a few examples recently where twins have been assigned to different Plans. Practices have been able to work with the families to get both babies onto the same Plan but guardrails here could reduce administrative burden for practices and families.

**CARE MANAGEMENT:** How has this worked for supporting members? What changes are needed?

Pediatric providers report highly variable experiences with Care Management (CM). Here are some elements to facilitate CM.

**Easy access in the EMR:** Both PCP and subspecialists need to be able to see how referrals and follow ups are being addressed. This is especially true for children with special needs where activities likely include

- Writing numerous prescriptions for federally regulated medications
- Making and tracking referrals
- Coordinating care

Requiring a practice to leave the EMR, have the doctor play telephone tag with the coordinator or manager, re-enter data, etc. will slow and possibly fragment care.

**At a minimum, PCP should be know who the CM is:** One pediatrician reported being unable to find the care manager and being advised to call the number on the patient card. This strategy did not lead to any connection. Information on who the care manager is (name and contact and associated organization/LME/CMA, etc.) should be available/accessible for all key providers in NCTRACKS.

**Pay special attention to pharmacy issues:** NCPeds greatly appreciates the work of NCDHHS to address numerous issues with pharmacy concerns. While fewer issues have been lifted up, we continue to hear that this is burdensome to practices and we remain concerned. This can be a particular issue for children being removed from their home into foster care (the first night and/or any time before the 5120 form is processed). Special attention by the CM to these issues may help assure children get the medications they need.

#### CURRENT PAYMENT MODEL

Are AMH providers able to use payment to better serve patients and provide whole-person care?

**Flexibility must be paired with adequacy:** The cost of providing care is going up. The money a travelling nurse can earn is well-publicized but inflation affects all staff and the ability of practices to hire professionals across the board. Because of staffing shortages, practices have to pay more overtime. More PPE and cleaning supplies are needed than when contracts were negotiated. Also, flu, RSV and COVID are putting huge strains on existing infrastructure. Also as noted previously, the cost of the increased complexity has not been offset by increased payments.

**Denominator issues:** NCPeds members frequently report multiple problems with their panels which may include adults, children they know have moved elsewhere, children they have no way to contact, families dismissed from the practice for being abusive to staff, etc. Children may have transferred into the practice at 750 days old making it all but impossible to meet 2 year benchmarks. As practices are expected to contract with more and more entities with smaller and smaller subsets of patients, especially when further narrowed by age or condition, missing one or two services (such as a vaccine) could mean non-payment of a VBP which effectively penalizes practices for participating in multiple contracts. Also, it is unclear if children who have been in the practice for 12 months but a Plan less than 12 months can count towards performance bonus. Also, it is unclear if the 12 month period is rolling or as of date certain (such as December 1) which makes identifying and closing care gaps challenging.

**Numerator issues:** We have heard concerns that EPSDT services, such as well child visits or vaccinations, are not counted when they are covered by a different primary insurance, leading to a potential undercount of quality performance. When service is provided and quality metric is met, such as combo 10, the fully vaccinated child should count towards VBP regardless of payer, especially when the child has been enrolled with Medicaid/CHIP for 12 months. Also, when other professionals, such as community health workers, help close care gaps, it is unclear if that activity can be counted towards quality metrics. Those activities should count and the policy should be clear, well-published and enforced by the Department. It is currently unclear if NCIR is used for vaccine information, if Plan is counting child/performance for the practice based on a specific 12 months, day data was pulled, 12 months from day data was pulled etc. This information should be clear. If data is particularly time sensitive, there should be flexibilities to account for tridemics, natural disasters or other factors that could unduly impact one or two months of care.

What changes are needed to support coordinated care?

**Care coordination should be through the EMR:** Requiring practices to get out of the EMR to report coordination concerns that then need to be entered back into the EMR disrupts care, adds to work load, and is not coordinated.

**Easier contracting:** It is hard to coordinate care when the specifics for access vary across five SP, six LMEs, and dozens of CMAs, often for a relative handful of patients. Figuring out a way to streamline the process will be essential for participation of both PCP and subspecialists.

**More streamlining:** We applaud the work of NCDHHS, PHPs and others in attempts to smooth the transition to managed care for Medicaid. However, many of the pieces, are still bumpy. Assuring the fundamental pieces – credentialing/onboarding new doctors and others, connecting with the care manager, understanding who is on the patient panel, getting paid timely, connecting with the PHP or other entity to resolve hiccups – are in place are key to supporting coordinated care.

DO APPROACHES BALANCE NEEDS OF THE FIELD?

Based on feedback of members of NCPeds, we offer the following

**Assure all the pieces work before layering more on top:** NCPeds consistently hears from members about issues with existing policies not being followed/enforced, network adequacy concerns; panel assignment concerns, functionality being unduly cumbersome (multiple portals, multiple billing paths, etc.) We urge attention to make existing strategies work well before layering on new requirements, additional portals, more measures, etc.

**Pay attention to the transition points:** Many of the concerns that NCPeds hears from members relate to transition points – when babies are born, when children and youth are placed in foster care, when a new medication is needed, when families move Plans/practices/counties, etc. These are times to provide families with extra help, not erect extra barriers. Program design should hone in on how policies work during transitions.

**Be mindful of bandwidth and capacity:** We know that many significant practice changes will happen in 2023, such as full launch of Tailored Plans (April 2023), commercialization of COVID vaccines (possibly first quarter of 2023), alignment of CHIP and Medicaid (not later than July 2023), unwinding of public health emergency (TBA) and anticipated design and launch of Specialized Plan (no earlier than December 2023). We don't know what awaits in terms of COVID, RSV, flu, child mental health crisis, full hospital beds, staffing shortages, and shortages in formula, albuterol, antibiotics, ADHD meds, trach tubes, etc. Proposed changes should be considered in the context of capacity, especially for independently-owned, smaller, rural, HUP and other practices.

#### LESSONS LEARNED FROM THE COVID PANDEMIC

**Keep the equity focus:** North Carolina was an early leader in reporting data by race and ethnicity. Practices and systems had flexibility to be innovative and targeted, such as Dr. Rasheeda Monroe and her "sister circle" incredibly strong outreach and penetration for certain zip code areas for early COVID vaccination. Materials were available in multiple languages. Special attention was provided to practices in HMP areas. The Department worked with NCPeds and others to help recruit practices specifically in underserved areas to be early COVID vaccinators.

**Communicate often and well:** NCDHHS did a remarkable job in the early days of COVID explaining why changes were happening, the underlying reasons, and how to find help when needed. This was very helpful to practices caring for patients.

**Work with providers on what is helpful to them to be able to achieve the goal:** The Immunization Branch has met regularly with providers organizations, including NCPeds, to see what supports would be helpful as different COVID vaccines rolled-out. Our input helped inform CVMS and then the transition back to NCIR. Key concerns about operationalizing vaccination as identified by the professionals vaccinating children were taken into account before/during program design.

**Keep strong telehealth with payment at parity:** One of the pluses from COVID was a strong pivot to telehealth. While we learned some services are best provided in-person, we learned that a number of services can be well-provided by telehealth. However, we also learned that while the patients saved travel time and hassle, the time needed by practices to on-board the patient was the same or longer. Additionally, teleconnection issues can be an impeding factor which often can hit rural and historically underserved populations particularly hard, as their communities may also be underserved with Internet.

**Support infrastructure:** COVID shone a bright light on the need for solid infrastructure – fiscally solvent practices, strong Internet, vaccine storage capacity, etc. The Department took steps such as doubling the PMPM and helping link practices with PPE and other necessary supplies to assure that practices could keep caring for patients. Both the state and federal government allocated funds to help keep critical infrastructure of practices in place through fiscal relief.

**Look at the whole family:** NCDHHS recognized that when a parent needed to isolate or quarantine, the entire family was impacted and provided supports accordingly.

**Emphasize uniformity:** Many COVID interventions were uniform. For example, there is only one way to bill a COVID vaccine. This has made it easier for practices to offer COVID vaccines. In contrast, testing for COVID was not paid in a uniform way. Some PHPs would not cover in-office testing in the early days, leading some practices away from expensive investments in contracts and equipment for PCR testing. We are aware of one practice who still has not been paid for these tests by two PHPs. Uniformity helps create a baseline and predictability. When asking that practices make investments in staffing and infrastructure, knowing the payment level will be consistent and adequate to support the additional service is critical to success.

Thank you again for the opportunity to provide input and the on-going partnership to promote strategies to promote strong Medicaid for children and others. If you have any questions or need additional information, please reach out to our Executive Director, Elizabeth Hudgins ([Elizabeth@ncpeds.org](mailto:Elizabeth@ncpeds.org)) and she will be happy to help connect you.

Sincerely,

A handwritten signature in black ink that reads "Kenya McNeal-Trice". The signature is written in a cursive, flowing style.

Kenya McNeal-Trice, MD, FAAP  
President, NC Pediatric Society

Cc:

Dr. Shannon Dowler  
Elizabeth Hudgins  
Elizabeth Kasper  
Jay Ludlam  
Dave Richard  
Dr. Janelle White