Dear NC Section 1115 Waiver Renewal Team:

Thank you for the opportunity to submit responses to the NC Section 1115 Demonstration Waiver. The NC Pediatric Society (NCPeds) is the state chapter of the American Academy of Pediatrics incorporated in North Carolina. Representing 2,300 pediatricians and other child health professionals across NC, NCPeds has been deeply engaged in the Medicaid reform process. We offer the following comments.

We enthusiastically applaud the proposed eligibility changes for children. Allowing children younger than age 5 to have continuous Medicaid eligibility, older children to have 24 months of eligibility and youth aging out of foster care to remain eligible until age 26 without filing additional paperwork will reduce disruptions in care. Also, given the 40% “churn” rate, this proposal will reduce administrative burden for families, local DSS, practices and others.

We applaud the expansion of HOP and urge further expansion to children and youth at-risk of being removed from their homes. The Healthy Opportunities Pilot currently operates in regions of the state to help address social drivers of health while promoting non-medical interventions such as food insecurity, housing and transportation. Extending these services to children and youth at-risk of being removed from their home (as defined through the federal Family First Prevention Services Act) would provide important supports to families to help children stay in their current homes.

We applaud the focus on health equity. The Department has done a commendable job focusing on health equity. It is also a focus of various ancillary work groups. However, there is still great opportunity to close gaps.
We applaud efforts to increase the behavioral health workforce. We lift up increased rates as an additional strategy to help address the inability of some psychiatrists to participate.

We applaud the Justice Involved Reentry Initiative: NCPeds supports efforts to address the specific issues of justice-involved individuals, including justice-involved youth.

We continue to applaud one single statewide proposed plan for children and youth in foster care and transitioning out of foster care (Children and Families Specialty Plan). We also continue to have significant concerns about current services until that Plan begins. One single statewide plan will help resolve some of the many issues associated with foster children moving among LME regions. However, we continue to be deeply concerned about the current transition period, including how Tailored Care Management works in the interim for some of our most vulnerable children. Even before go-live of CFPF, much stronger communication with local child welfare experts is needed on TCM and Medicaid Direct for children and youth in foster care. We also urge strong attention to reducing the administrative burden in the CFSP, especially for contracting, given that most practices will only have a handful of children and youth in foster care or adults who have aged out of foster care. Assuring that practices can participate without navigating new contracts, value based payments based on very small panels and additional portals/panels/coordination of benefits procedures will be critical for Plan success of for these children, youth and young adults to get the care they need.

We urge a strong focus on administrative burden. The Sheps 2022 Medicaid Provider Experience Survey linked in the waiver request reports “notable administrative burden” for practices. An April 2022 survey in NC by the NC Pediatric Society and NC Academy of Family Physicians found two-thirds of primary care physicians reported an increase in administrative burden between 2021 and 2022, and further reported a 19% decline in ability of primary care physicians to help their patients get timely access to care.1 Further, the concern about administrative burden is bolstered by regular and on-going informal reports from NCPeds’ membership about challenges with panels, coordination of benefits, payments, contracting, challenges getting help from PHPs and other concerns. These problems continue to persist and could impact the success of Tailored Plans and a Specialty Plan as practices are not willing to take on substantial administrative burden for a relatively small handful of patients when other administrative implementation issues linger after months or years. Examples of ways to improve could include the following:

- Greater oversight of Managed Care plans specifically around denied and pended claims
- Definitive steps to correct beneficiary assignment areas, particularly when adults are assigned to pediatric practices, children are assigned to internal medicine practices, and patients are assigned away from their PCP with minimum burden to the PCP
- Strong monitoring and assurances of provisions of Tailored Care Management (not just care coordination) services for qualified individuals
- Contracting simplification requirements, especially for new contracts such as the single statewide plan for children and youth in foster care
- Specific efforts to reduce the number of prior authorizations required by the Pre-Paid Health Plans

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1 Survey of Primary Care on NC Medicaid Post Go-Live – April 2022, NC Pediatric Society and NC Academy of Family Physicians.
• Continued efforts to minimize the number of quality metrics, align quality metrics beyond the Medicaid market (commercial/Medicare) as possible, and to ensure that reporting and measurement requirements are consistent across plans
• Continued efforts by the Plans’ Chief Medical Officers to simplify administrative processes and procedures

We urge stronger evaluation criteria, including more robust and better comparison data including for network adequacy. Shortly before go-live, the State stopped producing quarterly QMAF (Quality Measurement and Feedback) data to assess how children (including in foster care) compared to overall HEDIS data. That report is no longer provided. It would be helpful to have an apples-to-apples comparison on basic HEDIS indicators before and after go-live.

In terms of network adequacy, the State should consider reinstating the NC Medicaid Access Monitoring Review Plan\(^2\) that included adult and child access to primary care, dental service, behavioral health services and other care with baseline and on-going data. This Plan reported on PCPS per 1000 enrollees. That report does not seem to have been issued since the beginning of the transition to Medicaid reform. Anecdotally, we hear some pediatric providers are dropping Medicaid patients, or not taking new patients, because of the administrative burden associated with PHP participation. We also hear anecdotally that practices, especially rural practices, struggle to find the other medical supports, such as specialized screenings/testing, therapies and subspecialty services, such as ophthalmological and optometric services. Part of this is due to workforce shortages but part seems anecdotally to be linked to lack of adequate networks both for PHPs and TCM, especially as some providers, such as therapy providers, may not have the infrastructure to contract with multiple Plans. Having strong data to assess network adequacy is critical to determining the success of Medicaid reform.

Restoring the Access Monitoring Review Plan with baseline and current data collected and reported in the same way would help provide an important line of sight into provider participation and network adequacy.

**We strongly urge apples-to-apples data going into baseline comparisons.** As the state chapter of the American Academy of Pediatrics, we hear numerous concerns on a weekly basis from pediatric practices about panel inaccuracy which suggests denominator information may not be representative. While we applaud the merging of CHIP and Medicaid, this did not happen until after go-live so tens of thousands of relatively healthy children have been added to the calculations and how that is being adjusted in any data comparisons is unclear.

Further, the State seems to be moving towards excluding commercial duals from rate calculation. While this is understandable given data complications, the State has not been able to provide us any data on the magnitude or overall health status of the commercial dual population. A handful of responding pediatric practices reported commercial duals represented 5% to 25% of their Medicaid patients. If the percentage is indeed substantial and children are commercial duals because of complex social dynamics, that would create barriers to getting well child visits and vaccines, removing these children from calculations could make comparisons seem unrealistically favorable. If children fall into commercial dual status because they have access to more resources and live in families better equipped to address social drivers of health, then removing them from the calculation could paint a different picture.

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Again, we need baseline data of the same data sets calculated in a consistent manner that allows for meaningful and accurate comparisons to determine if child health is better after managed care. Also, on-going data should continue to provide overall state information, in addition to specific information by PHP and Medicaid Direct.

Given churn and panel and attribution problems, looking at eligible patients of the population assigned to the practice for a year could result in concerning percentages of children being potentially dropped from the HEDIS calculations. For accurate comparisons, there should be reporting of the same data set with uniformity of the members calculated consistently before and after go-live.

If you would like to discuss any of these concerns further, please do not hesitate to reach out through our Executive Director, Elizabeth Hudgins.

Thank you.

Sincerely,

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President, NC Pediatric Society

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