

# North Carolina Chapter

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American Academy of Pediatrics

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**North Carolina Pediatric Society**  
1100 Wake Forest Rd, Ste. 200  
Raleigh, NC 27604  
Ph: 919/839-1156

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### Executive Director

Elizabeth Hudgins, MPP  
1100 Wake Forest Rd, Ste. 200  
Raleigh, NC 27604  
Phone: (919) 839-1156  
Fax: (919) 839-1158  
Elizabeth@ncpeds.org  
www.ncpeds.org

North Carolina Pediatric Society  
www.ncpeds.org

## North Carolina Pediatric Society

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To: [Medicaid.NCEngagement@dhhs.nc.gov](mailto:Medicaid.NCEngagement@dhhs.nc.gov)

RE: MCP Feedback

These comments are in response to the request of the NC Department of Health and Human Services for input to Making Care Primary. The NC Pediatric Society (NCPeds) represents 2,300 pediatric professionals, including pediatricians and practice managers, across North Carolina. We have submitted more than 50 sets of [comments](#) on design aspects of Medicaid Reform. About half of children in North Carolina are covered by Medicaid so changes to the program have a tremendous impact on pediatric Care.

We have three main overarching comments about the proposed Making Care Primary model.

- 1) There needs to be more resources for the medical home.** Medical inflation and staff costs over the past five to ten years have been substantial, while workload due to Medicaid Reform and other factors has increased exponentially. Ratcheting up administrative burden further drains resources away from patient care. To be a benefit, prospective payment needs to provide more total resources to practices.
- 2) Panels must be correct.** The top recommendation in our August 2018 [letter](#) on AMH was "provide single source for panel information." Panels have consistently been a major pain point since the implementation of Medicaid Reform. Adults remain on pediatric panels and may not be moved even when identified until an appropriate adult physician with an open panel is found. Practices face great challenges to remove other patients from their panels as well. The burden should be on the Plan, not the PCP, to find a care provider for the patient inappropriately on the PCP panel. Prospective payments that are linked to incorrect panels are highly problematic.
- 3) Measure alignment is critical.** Measures and definitions need to be consistent across all the different Plans. Clarity (understanding the math) is essential. What does the prospective payment include? Is it based on panels or attribution? If yes, what is being done to monitor and enforce data correctness? Will recoupments or other take-backs of prospective payments be allowed? How are commercial duals handled in the calculations? Will that be consistent across Plans? Will all Plans use the same measures (i.e., vaccines) defined the same way (i.e., Combo 10) across the same population (i.e., dually commercially insured patients)? Etc.

**DHHS Question:** What initial reactions do you have to NC Medicaid’s approach to MCP alignment (starting with an aligned AMH incentives approach, with the potential of a future prospective payment model)?

- Primary care providers: would your practice be interested in participating in this aligned performance incentive model, or would you prefer to maintain the existing approach with a variety of performance incentive program designs across plans? Does your answer remain the same for more advanced VBP arrangements, such as prospective payment?
- Health plans and primary care providers: What challenges do you foresee with the implementation of a standardized performance incentive model across all Medicaid Standard and Tailored Plans? How would you recommend NC Medicaid address these challenges?

**NCPeds Response:** NCPeds has long advocated for aligned performance measures and remains strongly supportive of such an approach. Some practices may be interested in a prospective value based model, if there is a no/low-risk glidepath of 3 to 5 years, adequate and assured payment (no take backs), correct and transparent panels and payments, and low administrative burden. The smaller the proportion of Medicaid patients seen by the practice, the less likely they seem to want to take on an additional model and set of metrics. Timing and bandwidth is also a factor. When discussing this concept, pediatricians used words like “exhausted” and “frustrated.” The need for panel correctness as a prerequisite for participation was repeatedly highlighted.

We see a number of potential concerns. Ways to address them would include:

- Increase overall resources
- Align key indicators across all Medicaid Plans
- Reduce administrative burden, including reducing and aligning prior authorization requirements
- Assure panel correctness – If VBP is based on panel information, whether the number of patients seen by a practice or outcomes relating to a subset of patients, then the practice should agree that their assignments and panel are correct. If commercial duals are 17% of the overall beneficiary population and excluded from calculations, practices may do significant work that will not be counted in calculations or payment – while representing high administrative burden.
- Prohibit take-backs, including claw-backs or recoupments (except in cases of fraud or abuse)
- Adjust risk in pediatric specific way. [Millbank](#) (2020) indicates that pediatric-specific risk adjustment is critical consideration for prospective payments. In addition to health considerations, it is also important to look at barriers to access to care, especially for marginalized or underserved populations.
- Show your math. Practices should be able to easily understand which patients are on their panel, which ones are in the numerator and denominator, and all aspects of the math equation. Also, understanding the Source of Truth is important.
- Require commercial duals to be included in prospective payments. Excluding 17% of beneficiaries does not adequately capture patient health or practice effort.
- Provide transition resources and support as PCPS move to MCP or VBP.
- Develop a strategy to allow practices with a small number of Medicaid patients to keep seeing those patients without additional paperwork of a new model.

- Delink prospective payments from burdensome utilization management and prior authorization requirements. Milbank Memorial Fund 2020 [report](#) Prospective Payment for Primary Care: Lessons for Future Models notes these factors led to backlash among patients and physicians in the 1990s. They further note that strong pediatric risk adjustment, good attribution methodology, sufficient transition/phase-in support and infrastructure are key. Be clear and uniform in how commercial duals are counted. Regularly report on the percentage of Medicaid beneficiaries by age that fall into this category. If commercial duals are excluded, from data, who determines if a patient has other primary coverage? (Currently, we hear frequent concerns from members that this data seems to be incorrect.) What if dual coverage was present for a portion of the measurement period?

**DHHS Question:** What should NC Medicaid be considering as it designs an aligned AMH incentive model?

**NCPeds Response:** Please see above and previous AMH comments, such as [https://cdn.ymaws.com/www.ncpeds.org/resource/resmgr/advocacy/medicaid\\_reform/amh\\_data\\_strategy\\_august\\_201.pdf](https://cdn.ymaws.com/www.ncpeds.org/resource/resmgr/advocacy/medicaid_reform/amh_data_strategy_august_201.pdf)

Key concepts include

- Utilize a single source for panel information
- Assure data uniformity
- Minimize care management complexity
- Reduce complexity for determining complex patients/pediatric specific risk adjustment
- Preserve independent practices
- Assure incentives reach providers so they can make additional investments in care

We also continue to strongly urge aligned indicators and clear and consistent treatment of commercial duals.

**DHHS Question:** What operational or administrative investments by the Department are needed to support this approach?

**NCPeds Response:**

- **Increase overall payments.** Care provided in the medical home represents a small overall cost but tremendous health value. A Commonwealth Fund [report](#) in March 2024 concluded “Greater financial support for primary care, including physicians and their care teams, would give providers greater resources to expand access through telehealth, home visits, and after-hours appointments, and make care more comprehensive by addressing behavioral health and social needs.”
- **Align indicators:** Indicators and definitions/measurement should be aligned across Plans to assure that all oars are pulling in the same direction.

- **Reduce administrative burden associated with commercial duals.** Currently, commercial duals are 17% of the overall beneficiary population. Denials of claims for other commercial insurance represents substantial administrative burden to practices. Data in the Plan portals for other insurance is often incorrect, resulting in more administrative burden. The Department could more rigorously monitor and enforce current Pay and Chase policies to assure that practices were not placed in a position of verifying and chasing payment from commercial insurance. The Department could maintain one single data base for other coverage and require all Plans to use the Department data. The Department could set, monitor and enforce Plan requirements on how commercial duals are counted for quality metrics.
- **Assure data transparency:** Assuring that practices understand and trust the underlying data elements and calculations will be important for buy-in.
- **Monitor and enforce Plan requirements and Plan provider friendliness:** The Department needs a line of sight beyond the Provider Ombudsman tickets on if panels and payments for VBP services are correct. Practices need to have trust that the elements going into the MCP/VBP payments are correct. Currently, there are deep concerns about panels, commercial duals, inappropriate or long-reach back on recoupments, nonpayment on required benefits (such as no wrong door on newborns) and other elements. Visible monitoring and enforcement could help improve data quality while reducing administrative burden and building trust.
- **Disallow recoupments going back more than one year.** Currently, there are number of recoupment projects underway by the Plans, some going back several years. This undermines budget predictability and stability for practices.
- **Pay attention to unique pediatric needs and opportunity in VBP design:** For example, analysis by the [Center for Health Care Strategies](#) (2021) notes “Of particular concern, cost-saving incentives built into many VBP programs may drive care delivery reforms for adults with complex health and social needs and not adequately incentivize health systems to focus on pediatric populations that tend to be healthier and have lower health care costs. Additionally, VBP strategies that focus on short-term health system costs may not be effective for pediatric patients, as the return on investment for children’s health is often realized long term and may accrue in sectors outside the health system.”
- **Support for practices less experienced with Medicare models:** Risk adjustment in primary care is still evolving. New structures will need to account for the needed change, evaluation and bandwidth. Of note, while some of the mechanisms have long existed for Medicare, this will be a relatively new approach for many pediatric practices. Children represent about half of NC Medicaid beneficiaries.

**NCDHHS Question:** What changes would most effectively reduce the burden on primary care providers relative to value-based contracting with Standard and Tailored Plans?

**NCPeds Response:**

- Easy panel management including shared forms, such as “Change My PCP” and placing burden on Plan (rather than PCP) to find a medical home for patients not part of a PCP panel. Further, Plans should allow electronic submission (not require snail mail) of forms, including panel-related forms. Value Based Care is challenging to measure at the practice level until issues around panels and attribution are better resolved.
- Reduced and aligned prior authorizations. Prior authorizations are a significant pain point and administrative burden for practices.
- Aligned measures
- Clear and explicit handling of commercial duals, both in the panel and as a tool of reducing administrative burden. PHP should allow practices to use one single Source of Truth (such as NCTracks) in determining other insurance. NCPeds is hearing growing concerns about denials of claims for other insurance, even when such insurance is documented to no longer provide coverage and even when the service provided is an EPSDT service.
- Adequate care management, especially by Tailored Plan. Also, it is important for the PCP to be able to communicate easily with the care manager without playing telephone tag. One example is communication via the portal.
- Robust networks including subspecialists so that families can access the services they need. When appropriate care is not available in the network, the onus should be on the Plan (not the PCP or family) to timely navigate any needed prior authorizations, contracting etc.
- Strong Departmental monitoring and enforcement, including of pay and chase and no wrong door for newborn policies.
- Sufficient sustained investment is essential. Currently, Plans can take back payments years after determining the service was appropriate for payment. Practices concerned about retroactive take-backs of prospective payments may determine it is fiscally imprudent to invest those funds in services.

**DHHS Question:** How should NC Medicaid approach attribution for the purpose of measuring quality in an aligned incentive model?

**NCPeds Response:**

- NCPeds recommends a joint work group convened by NCDHHS with the Department, each of the Plans and practice manager and physician members from the NC Pediatric Society, NC Academy of Family Physicians, NC Medical Society, FQHCs and other key partners to help resolve current panel problems.
- Accuracy tests should run the practice EMR panel against Plan assignments.
- If a patient currently with a PCP switches to another Plan taken by the PCP, the patient should remain with the existing PCP (even if the PCP has a closed panel) rather than getting re-assigned.
- There should be a single Source of Truth on other primary insurance, especially if commercial duals are omitted from calculations (as referenced in a summer 2024 TAG meeting).
- Change PCP form should allow for electronic signatures and be uniform across SPs and TPs.
- Plans should allow for electronic submission of all forms relating to panels.
- Significant changes should be beta-tested with a handful of practices before being turned on state or region-wide. One test could include how well the attribution process matches to the practice current EMR.
- Adults should be immediately removed from panels of pediatric practices upon request of the practice.

Please let us know if you have any questions or would like to discuss further.

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