American Academy of Pediatrics
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North Carolina Chapter

North Carolina Pediatric Society

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Secretary Mandy Cohen, MD
NC Department of Health and Human Services
101 Blair Drive
Raleigh NC 27603

Dear Secretary Cohen

Thank you for the opportunity to comment on the best way to serve patients with a behavioral health (BH) or intellectual development and disability (IDD) need, especially as NC moves towards more of an MCO structure. As always, issues for the pediatric population may present different opportunities and challenges than treating the adult population.

Treat as many conditions as possible in the primary care medical home: The medical home model is proven effective. Mild to moderate BH and IDD needs can often be addressed in the medical home. This is easier for families who have fewer providers and visits plus (unfortunately) can be less stigmatizing than visiting a stand-alone BH service. It assures that one provider is familiar with the interacting factors affecting child health. Anecdotally, these populations sometimes miss out on routine vaccinations and other services as all attention is focused on their BH or IDD need. That is less likely to happen in a primary care medical home.

Support practices in integration, including for unique needs of children: Especially for children, the best treatment is often in the primary care medical home. Adult-based systems risk separating children from the care they need. For children, integration means the medical home and care should be team-based, including mental health professionals. Care of the whole child/adolescent must be in the context of family, school, and community—no longer "separating the head from the body." Furthermore, there are unique aspects to mental health integration in pediatrics:

- Mental health competencies include health promotion, primary and secondary prevention, management, and co-management.
- The spectrum of mental health and behavioral problems presenting in primary care extends from parents and youth with concerns, to functional issues but no diagnosable disorder, to functional issues with a diagnosable disorder.
- Severity of problems for which integrated primary care is most appropriate ranges from mild to moderate, but practices still have to be prepared to recognize, engage, monitor, and sometimes treat or collaborate in the treatment of children with higher levels of severity (including linking them back to care if/when they fall out of care) .
- The focus is on maximizing functioning of the child, reducing distress in the child and family, and prevention of adult morbidity.

Promote administrative ease: Administrative ease is a strong theme of importance for pediatric practices, many of whom have large Medicaid populations. Adding additional potential payers, more measures, more contracts, etc. at a time of transition to multiple MCOs for the 1115 waiver will pose administrative challenges. Additionally, practices already face barriers when trying to work together with LME/MCOs. Establishing structures that promote administrative ease and prompt and appropriate payment will be essential. Administrative barriers -- such as those currently erected by LME/MCOs, multiple credentialing, etc. -- should not be allowed. If a physician meets the quality standards to participate with Medicaid, the physician should be automatically credentialed to participate with the LME/MCO.

Reward integration of behavioral and physical health: We applaud NCDHHS for moving towards better integrated care. Payment and administrative structures should reward this kind of care with a PMPM or another type of premium. Payment for care should not depend on rigid diagnostic classification, particularly for very young children. Services such as consultation, non-face-to-face care, navigation, family support etc. should be financially supported. This issue ties closely to administrative ease. Administrative burden penalizes integration.

Ease transitions: It is our understanding that there may have been discussion about having certain high-need populations served in a separate plan geared more towards their BH or IDD needs. While these plans may make sense for adults with SPMI, it could be challenging for moderate-need children, children with new diagnoses, or children who can mostly be managed in the primary care home but may need occasional treatment in a residential facility. Children should not have to change plans (and thus maybe providers) on a regular basis to get the most appropriate treatment.

Keep needs of children in the foster care system front of mind: Children and youth in the foster care system by definition have experienced trauma and likely will need mental health services. About 40% are ages 0 to 5, an age range generally outside the expertise for LME/MCOs. Additionally, children are often placed outside their home county, often in a different LME/MCO catchment area. When practices try to offer integrated services now, they must register with LME/MCOs across the state which is administratively burdensome and sometime impossible. It is not usual for an LME/MCO to refuse to pay for services unless the child returns to the home county for each appointment, which puts an enormous strain on families already facing many challenges. The complexity of the current system does not well serve children, families, physicians or other providers.

Assure appropriate access to specialists: For some specialties, there are only a few pediatric specialists in the state. Children should have appropriate access to specialists, regardless of the specific plan or region of the state in which they live. Importantly, all network adequacy and access measures need to include specific analysis around access to pediatric specialists.

Pay special attention to needs of children served in the CAP-C program: These families have already endured a number of transitions recently. Any changes should work as seamlessly as possible with the careful array of supports that families have already developed.

Track both screening and referral: Currently NC enjoys very high screening rates for the child population, as tracked through billing codes. However, measures are not in place to track referrals. Adding a billing code or other mechanism to track referral and treatment will be important for documenting success or areas for improvement.

Assure appropriate dental care: Anecdotally, we hear that dental needs are often unmet for MH and IDD populations. We recognize there are many moving parts, especially for dental care. However, assuring that dental needs are met, especially for children, is an important factor for consideration.

Permit promising innovation: Right now programs exist that may be outside a standard model (for example, using integration to focus more on higher-need youth, providing services in schools). Any new system should continue to make room for appropriate structures that integrate mental and physical health in effective ways.

Also, as you move forwards towards integration, we urge you to keep in place mechanisms that work well. Examples include

- **Continue to promote screening:** NC has the best screening rate for children in the nation. Those efforts, currently promoted by CCNC, should be maintained. The program could be further strengthened by also tracking referrals. There is currently no code for pediatricians to use to demonstrate they referred a child with a screened-in condition to appropriate services. One way to address this issue would be to establish a code to track the referral.

- **Treat appropriate needs in the medical home without contracting with an LME/MCO:** NC already allows pediatricians to treat some BH issues, such as ADHD. The current system of fee for service (currently through Medicaid) without a separate LME/MCO contract works well.

- **Allow children who need residential treatment to keep their primary care physician**: Currently, if a child needs to be referred to residential treatment, they stay in the same plan (Medicaid), have access to the same providers, and can return to the same primary care provider following discharge without switching among plans. This kind of continuity needs to be maintained.

Thank you again for this opportunity to provide input. If you need anything further or have questions about potential pediatric impacts as you move forward with details, please let us know.

Sincerely,

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North Carolina Pediatric Society (NCPeds)