Dear Secretary Kinsley:

On behalf of the NC Pediatric Society, thank you for the opportunity to comment on Update on NC’s Children and Families Specialty Plan. We applaud the focus on continuity of care, strong care management and family engagement and Plan participation. However, we have deep concerns about access to care, especially given the complexity of the contracting process and the relatively small number of Plan participants. We are concerned that provisions like a 90% Medicaid ceiling for “one off” providers and exclusion of PCPs from the medication management plan may impede access to the high-quality, trauma-informed care needed for children and youth in foster care, adoption services and in-home services, those who have aged out of foster care up to age 26 and their families. Through our work with Fostering Health NC, we well-know how complicated on the ground implementation of strategies that cut across child welfare and health can be and urge clarity to help avoid confusion and move towards improved care.

We applaud many aspects of the Plan:

- **Statewide**: One on-going challenge in providing strong care for children and youth in foster care is the regional nature of mental health services and how children being placed with families outside the region access care. Having one statewide Plan is a strong step forward if the Plan has strong broad participation of physical and mental health clinicians.
- **Including the family in the Plan**: The inclusion of parents, sibling and children will strengthen the implementation of the Plan, ease navigation for families and improve care.
- **Care management for all in the Plan**: Currently, only a small percentage of children and youth in foster care receive care management. Assuring this essential support for all children and youth in foster care who have experienced adversity and trauma is a strong step forward. Excellent care management, including attaching to resources to address Social Determinants of Health, is especially important for this population.
- **12 months of transition care**: Allowing patients to stay enrolled 12 months following the transition from foster care will help improve continuity of care for a particularly vulnerable population.
We also have recommendations for improvement:

**Acknowledge the challenges of negotiating and setting up contracts:** One of the lessons of Standard Plan roll-outs is that contracting is hard and time-consuming and that not all practices or systems can be assumed to be willing to contract. Initial payment and roll-out requires time, attention to detail and troubleshooting to identify and resolve problems. Panels are complicated. Also, COVID has contributed to staffing shortages, burn-out and fatigue, while ramping up the expectations on primary care in regards to COVID testing and vaccinating. Single case agreements for providers to care for children in foster care currently are burdensome and unwieldy even when the pay is at current rates. Children in foster care often have complex physical health in addition to having experienced trauma and may need not just a subspecialist, but a particular “super” subspecialist. The complexity of the Plan, the rate ceiling of 90% of Medicaid for “one off” care and the relatively few beneficiaries, especially in a given county, may deter strong participation by overstretched providers still trying to figure out their panels and get paid appropriately on their Standard Plan contracts. Reducing the complexity and time demands while streamlining and paying better for the new version of “single case agreement” will improve access. It is critical to have strong primary care and subspecialty health services for the specialized Plan to succeed and the targeted population to thrive.

**Improve administrative ease for providers to assure access and network adequacy for beneficiaries:** While much of the design focuses on children in facilities, a great deal of care happens in the medical home in the community much of the time. What are the access safeguards for strong participation by pediatricians, family physicians, ob/gyn, community psychiatrists and others who will provide the “routine” trauma-informed care for these 31,000 people up to age 26, especially in more rural counties? What are the access safeguards for the rare subspecialist – perhaps the only subspecialist who can provide certain care – to provide needed care to a foster child who is medically fragile? Mechanisms such as subcontracting with Medicaid Direct, limiting extra administrative requirements (PIPs, etc.), delaying the Plan until TPs are up and running and providers are getting paid timely and accurately, allowing limited case agreements to care for a small number of beneficiaries paid at more than 90% of Medicaid and providing more practice supports are examples of ways to ease administrative burden. We are concerned that the time and distance standards as operationalized for Standard Plans will not be sufficient for children and youth in foster care. We urge more requirements around “one off” contracts to assure on-going care when needed. We applaud the focus on trauma-informed care (page 16) but are concerned that additional supports – like help navigating consent requirements – are also needed. A ceiling of 90% of NC Medicaid Direct could prove a substantial barrier to care for providers, such as “super” subspecialists or rural primary care, who may only see a handful of Plan eligible patients.

**Include FHNC expertise in the design and implementation:** Over our past seven plus years of contracting with NCDHHS to run the Fostering Health NC initiative, NCPeds has garnered some potentially helpful insights into how health care for children and youth in foster care works “on the ground.” We urge incorporating more feedback from FHNC into ongoing program design. For example, prior to Medicaid reform, FHNC, in collaboration with CCNC, had developed a legal pathway for information sharing through agreements contract between county DSS/health and human services and CCNC to assure access to medical history via paid Medicaid claims in a HIPAA compliant way. This work could help inform the proposed centralized platform for secure, bi-directional sharing of data between the Plan and local DSS (page 12). Our staff has done considerable work to gather information and understanding of consent policies and practices at the county level and how they interact with State DSS (page 11). Our specific, on-the-ground knowledge could aid in identifying, understanding and resolving...
potential implementation problems if we were included in design-phase conversations. The inclusion of an FHNC representative in the CMS Affinity Group related to child welfare is a positive step forward.

**Be crystal clear on definitions and expectations:** Through our Fostering Health NC work, we hear on a weekly basis confusion or different interpretations regarding who is a “guardian”, “legal guardian” or “custodian.” The State currently provides guidance to counties but then directs them to consult with their attorneys on what steps to take regarding issues such as consent. The definitions, as well as the rights and responsibilities of foster parents, kinship placements for children in foster care, and children in the care of kin but not child welfare-involved can be a source of confusion. Private child welfare agencies may require additional forms based on requirements of their accrediting body and/or Administrative Code. State guidance allows attachment of a visit summary to state forms if that summary includes all necessary information. However, that is not always considered acceptable by NC DSS consultants completing case audits. Adding another entity to the mix could increase the number of possible interpretations of what is allowable or preferred so greater clarity is needed. It also needs to be clear who has the responsibility and authority to make the final determinations when there is ambiguity.

**Align CHIP and Medicaid:** This Plan seeks to streamline care for families, a goal we applaud. However, the different requirements for CHIP and Medicaid, such as copayments and nonemergency transportation, could be confusing for families and providers. Also, as currently proposed, there are approximately seven different Plans a single family eligible for a Specialized Plan could participate in, approximately six with a CHIP and Medicaid variation. This adds complexity for the family and the local DSS. Also, a great deal of extra work is being put on local DSS in this proposal. Aligning CHIP and Medicaid would help streamline decision-making for the specialized Plan while perhaps reducing overall work volume for the county office, especially during the unwinding of the Public Health Emergency.

**Include PCP in med management:** Currently, medication management frequently happens in the medical home for foster children. A pediatrician often prescribes medication for treatment of lower intensity mental health needs (i.e. stimulants for ADHD). Also, the PCP may see a patient who has been prescribed medication by a provider who is no longer accessible to the child due to distance or appointment availability. The PCP may be reluctant to take a child off a medication prescribed by a psychiatrist, but also reluctant to continue a medication without that provider involved. The Specialized Plan strategy for comprehensive medication management (page 14) requires care managers to work with psychiatrists and pharmacists for metabolic monitoring and more. At times, a child is referred to the PCP for the monitoring needed when psychotropic medications are prescribed. PCPs must be included in this coordination.

**Establish baseline data:** Prior to the transition to Medicaid Managed Care, CCNC reported quarterly data through their Quality Measurement and Feedback (QMAF) program, looking at key benchmarks, including HEDIS indicators. They were able to provide a comparison of children in foster care to other children in the state covered by Medicaid. This report was discontinued several years ago. Baseline data should be collected and publicly reported starting prior to launch to assess a baseline now and how well the Plan is improving outcomes for children and youth in foster care going forward. We commend the inclusion of a measure focused on practices taking new referrals for children and youth in the Plan. We also urge a similar measure for others in the Plan, such as adults up to age 26 who have aged out of foster care.
Specify the full enhanced schedule for services is covered: AAP guidelines recommend an enhanced visit schedule for children and youth in foster care. We realize this could be covered under EPSDT. However, we urge that it be expressly noted and lifted up in Appendix A as a covered service.

Expand definition of transition: We applaud NCDHHS for the specific focus on points of transition (page 12). The focus seems to be transitions into and out of facilities. This is clearly a vulnerable and critical time. However, one of the lessons of Standard Plans is that transition into foster care is another critical and not universally well-understood transition point. This can result in delays in children receiving their initial screening visit within 7 days of entering foster care which is required by State child welfare policy. We also know that moves to different providers can currently result in delays in care. In addition, changing Plans is another important transition to monitor. Young adults transitioning out of foster care but still eligible for the Specialized Plan may need support. Families, biological and foster, local DSS and providers need education and support in all of these transitions.

Reduce complexity and confusion for families: Currently, the strategy seems to be to offer to some sets of beneficiaries the Specialized Plan first but allow them to alternatively opt in to about six other Plans while other sets of beneficiaries will start with participation in the approximately six other Plans with an opt-in provision for the Specialized Plan (page 7). While we understand the value placed on choice, this seems overly complex and confusing for families already in a time of crisis. If this level of complexity is deemed truly essential, we urge strong training and supports at the local DSS level, specialized staff with Beneficiary Ombudsman and others and creating strong lines of oversight and authority to identify and correct issues. Through our FHNC work at the local level, we are well positioned to see the confusion and variation across counties now in the transition in and out of Standard Plans and Medicaid Direct.

Require subcontractor staff dedicated to Specialized Plan eligible beneficiaries: This Plan is complex. The lives of families who need this Plan are complex. Local DSS is overstretched. We urge dedicated Specialized Plan experts at the Beneficiary Ombudsman level and with other subcontractors to help with transitions and other issues facing this population.

In addition, we have a number of questions about how the details of the Plan will work. One of the lessons of the roll out of Standard Plans is that early attention to the details can help avert problems.

How will local DSS be directed and instructed towards making key health decisions for children and youth in foster care, such as which type of Plan? Currently, there can be confusion over who has the ability to make health decisions for children and youth in foster care. For example, State DSS instructs county DSS to confer with their local attorney for provision of ACIP recommended vaccines. Counties exhibit substantial variation in how medical care for children is authorized and provided. Furthermore, there was a great deal of confusion at the county level with the transition to Medicaid Managed Care, including who should stay in Medicaid Direct.

Increasing the options to four plan types (Medicaid Direct, SP, TP and the Specialized Plan) with different Plans within types for TP and SP (with further variation across Medicaid and Health Choice) risks increasing complexity and confusion.

How will the authority of Plan decisions to be clearly delegated to the appropriate entity? How will education and on-going training be provided? How will county DSS turnover be addressed? Who has oversight and authority of county DSS for this purpose and what is the enforcement mechanism? What will be the likely impact of potentially unwinding the Public Health Emergency at the same time local
DSS will have the added responsibility of oversight of Plan selection? Will there be good cause reasons for switching Plan-types and who has the responsibility and authority to instigate that change? Will it include factors such as moving to another county and turning 18 or 21? Who will be the arbiter of good cause? Is there intent for extra county support during the transition in particular? Is there a way to provide greater supports to use this opportunity to identify eligible former foster youth to assure they are appropriately linked to Medicaid? How will local DSS, at the child welfare level, as well as the Medicaid/income maintenance level, assist youth in a SP or TP about to age out of foster care to assure they remain in the Specialized Plan to retain coverage to age 26? How will transitions be handled when a beneficiary who is Specialized Plan eligible but enrolled in a TP moves out of the region? Whom is responsible for changing the Plan, the card, the panels, etc. and on what time frame?

How will adherence to AAP guidelines and standards be maximized? AAP has guidelines for children and youth in foster care that are considered best practice. They are also part of NC DSS Child Welfare “guidance” which also includes a statement noting that recommendations of the provider should be followed. The AAP guidelines are important for overall health and well-being of children in foster care and providers who promote and adhere to it should receive appropriate reimbursement and promotion at all levels to provide care that is outlined in best practices. What safeguards will there be to assure compliance on the enhanced visit schedule and other recommended care? Who has oversight and authority? How will this work on the ground? What tools will the Plan have to enforce or incentivize compliance?

How will transitions between Plans and providers be handled? Currently, there is confusion and delay with the form DSS-5120 and other issues relating to transitioning a child from private insurance or a Standard Plan to Medicaid Direct when they enter foster care. Who will have care management responsibility to assure smooth transitions for children and adults in this Plan, and children transitioning to adult services? We realize the white paper proposes a strategy for transition between facility and non-facility care. What is the strategy when patients switch Plans or move LME region? In particular, we are concerned about the potential confusion when Plan eligible patients have chosen a TP and move to a different region of the state, which would likely be outside the purview of the care management of the Specialized Plan (since the beneficiary is enrolled in a TP).

Will the new Plan streamline or complicate current placement processes? Having a single Plan could create clarity and streamline processes. Alternatively, it could add another layer and more potential for confusion and delay. For example, there is still confusion over the transition of children from Standard Plans to Medicaid Direct and the role of DSS-5120 form. Currently, private child welfare agencies have required forms that can create duplicate work for practices. Inconsistencies in case reviews have resulted in some counties being penalized for having state required forms (specifically DSS-5208) with visit summaries attached, although instructions on said forms allow for this if all required information is covered in the summary. How will the Plan and staff from NC DSS who complete case reviews collaborate to ensure understanding? How will involvement of a new Plan make this process more streamlined rather than more complicated?

How are guardianship and custodian defined for purposes of the Plan? Who can take children to appointments and make decisions regarding their care? What about kinship care? Are statutory changes needed for clarification?
How will Plan variation in Medicaid and Health Choice be handled? If part of the vision is that families have a shared Plan to maximize understanding and benefit, the difference in benefit packages, copayment requirements and non-emergency transportation could be confusing. We urge the Department to seek statutory changes to align CHIP and Medicaid. If that does not happen, we urge strong guidance and testing to assure the Plan appropriately handles both types of claims with swift enforcement by NCDHHS if services are not covered appropriately.

How will Plan streamline coordination with County DSS work on the ground? Currently, one key method of communication with County DSS is the Dear Director Letters from the Division of Social Services. How will communications from the Plan be handled? How will county level staff turn-over be handled? Who has the responsibility and authority to monitor and enforce this coordination works well on the county level? (Page 9)

Are comprehensive assessment and multidisciplinary teams a new and additional feature?
Permanency Planning Review (PPR) meetings and Child and Family Team (CFTs) meetings are required, per NC Child Welfare Policy, at certain intervals when a child is in foster care. Will the care plan/ISP be an additional assessment? (Page 10) Will the multi-disciplinary team be an additional meeting? If yes, how will they complement rather than duplicate the work other assessments and team meetings? Since multi-disciplinary teams are required for each “member” how will that work for adults who have aged out of foster care? How will this work in InCK counties which already require more assessments and meetings?

How will this work for children in foster care placed through private child welfare agencies? Currently, private agencies follow guidelines through NC Administrative Code and may also be accredited through various accrediting agencies. These agencies often require separate forms, medical evaluations etc. How will the coordination between/among DSS, private agencies, and the Plan work?

How will transition age youth and young persons previously in foster care be identified and informed of their options? Is there an opportunity during the unwinding of the Public Health Emergency to shepherd these young adults to the right Plan? (Page 13)

How will the HealthCare Passport work? Who has access to the Passport information for a child under age 18? Will PCPs incur extra charges in their EMR to comply with Passport requirements? (Page 13)

What about Health Care Powers of Attorney? The Affordable Care Act (P.L. 111-148 Section 2955) requires States to include information about the importance of having a Health Care Power of Attorney as part of the transition plan. The proposed care management could be a strong opportunity to promote Health Care Powers of Attorney. Whose responsibility will it be to assure this information is provided in a meaningful way?

What is the communication strategy between the Plan, the Division of Medicaid and the Division of Social Services and local Department of Social Services? Each of these entities will hold key pieces to the well-being of children. How will they work together and how will problems be identified and solved? How does the Plan assure compliance with NC’s Child and Family Services Plan 2020 – 2024, specifically HOCP?
Thank you again for the opportunity to provide input and comment. Children and youth in foster care, in-home services and adoption services deserve the best medical care and care management. Please let us know how we can help inform strong development and implementation of the Specialized Plan.

Sincerely,

Christoph R. Diasio, MD, FAAP
President,
North Carolina Pediatric Society

Cc: Lisa Cauley
Shannon Dowler, MD
Debra Farrington
Susan Gale Perry
Chameka Jackson
Elizabeth Hudgins
Jay Ludlum
Heather McAllister
Susan Osborne
Dave Richard
Christy Street
Charlene Wong, MD