February 23, 2021

The Honorable Mandy Cohen, MD
Secretary, NC Department of Health and Human Services
2001 Mail Service Center
Raleigh NC 27699-2001

Dear Secretary Cohen:

We submit these comments on the North Carolina’s Specialized Foster Care Plan on behalf of the NC Pediatric Society, representing more than 2,300 pediatricians and other child health professionals across North Carolina.

While we applaud many of the specific features of the Foster Care Plan, we are deeply concerned about its possibility for success for this vulnerable population. The FC Plan offers an opportunity to provide improved care for children and youth in foster care, their families, and emancipated foster youth. We are excited about the potential for one statewide FC Plan that can provide this vulnerable population with the full range of physical and mental health services that both SP and TP can offer. However, as currently proposed, we are concerned that the design is cumbersome and may actually limit access to care.

We commend many features of the Plan:

- Is offered statewide
- Includes robust services for both physical and mental health in a single plan
- Extends for 12 months after re-unification
- Extends to qualified emancipated foster youth up to their 26th birthday
- Focuses on continuity of care and providers
- Seeks to advance health equity for this diverse population
- Pays for collaborative visits, including with FFS
- Alludes to American Academy of Pediatrics Health Care Standards for children in foster care as part of PCP and FC Plan Care Management
- Lifts up Healthy Opportunities supports for families in process of reunification and young adults transitioning out of foster care
- Requires certain key personnel to reside in North Carolina
- Includes focus on impact of Adverse Childhood Experiences
- Aligns timely payment requirements with SP and TP
- Includes federally- and state-recognized tribes
We also have questions, concerns and suggestions.

**Overarching Concerns**

**Barriers to care and access:** Providing quality, trauma-informed care to children and youth in foster care is time-consuming and difficult. Adding another layer of administration with another Plan with whom to contract and another network of mental health and subspecialists with whom to engage/refer could reduce the care available to vulnerable children. We urge special care in the roll out to support providers and regular evaluation of access to assure that foster children have at least as much access to quality trauma-informed care after the FC Plan as currently. Even practices long-committed to caring for children and youth in foster care may be stymied by involved contract negotiations and additional reporting and other requirements as SP are in their early days and TP are being stood up. (For example, could the FC Plan contract with Medicaid Direct to access all those providers, without those providers having to go through an additional contracting step? Could the bidding FC Plan PHP/LME supplement their existing network but not require new contracts for those already participating with the PHP/LME? How can access to all pediatric subspecialists be guaranteed for this population who often have complex physical needs, especially for rare subspecialist? What kind of arrangements could help assure strong access for emancipated foster youth in case family physicians, internists, obstetricians, etc. may reluctant to contract with an additional Plan when only a handful of patients will likely be covered through the Plan?) Again, we strongly commend the concept of a statewide Plan with robust services but seek to understand how the implementation and roll-out work to achieve this important aim.

**Interaction with other NC systems:** It is critical that the FC Plan works well for children and youth in foster care, their families, and emancipated foster youth as well as the professionals who care for them. We are concerned that this plan does not adequately take into account the complexities of the child welfare system, foster care, primary care, mental and behavioral health services, subspecialty and other specialized care, Medicaid, commercial insurance, group homes, PRTFs, out-of-state care, community supports and other key players currently involved in helping children get physical and mental health care services. Layering on complexity without also addressing how these groups interact and could interact better to support families will hinder the success of the FC Plan.

**Interactions with federal requirements:** It is unclear how the FC Plan will interact with other federal requirements and programs on which NCDHHS is working. For example, how do the definitions blend with NC implementation of the Family First Prevention Services Act? How will changes of care management affect the approved plan NC has through Fostering Connections to Success?

**Timing:** It seems challenging to develop and bid an RFP, award a Plan, for a Plan to enter into meaningful negotiations and set up all the ancillary data and payment requirements for the type of services they do not currently offer and all of the other work associated with starting a new Plan in 16 months. This is not simply a matter of adding more behavioral or physical health services, although that work and contracting alone would be substantial. It is a complex set of providers and other stakeholders to identify and engage while bringing in the Division of Social Services and other key players in the child welfare system.

At the same time, pediatric practices are struggling to meet the demands of COVID and falling revenues while keeping up with the many requirements associated with the transition to managed care for Medicaid. Negotiating and meeting the requirements of another contract and data-sharing for a Plan set to go live in 16 months right as TP are coming on-board could serve as a barrier to robust participation by practices.
**Rates:** Rates will be paid at the rate floor. Is that the current floor published by the Department for SP or rates published as part of TP (and if so, which tier)? Lack of clarity and adequacy could serve as a deterrent to participation by those able to provide such services. Rates need to take into account the full array of services needed by children and youth in foster care, but also acknowledge that need may wax and wane.

**Applying lessons of Fostering Health NC:** For about the past seven years, the NC Pediatric Society has been privileged to work with the NC Division of Social Services, pediatricians and other providers, local Departments of Social Services, Community Care of NC, the NC Division of Public Health, emancipated foster youth and others to advance strong trauma-informed care for children and youth in foster care through the Fostering Health NC initiative. We have learned many applicable lessons about key components of care, identifying and engaging key stakeholders, determining and trouble-shooting barriers to care, and educating and engaging the provider community on ACES and other key concerns. We would welcome the opportunity to share those lessons with NCDHHS and, if appropriate, the awardee.

**Specific Concerns**

**Continuity of care:** Under Vision for State’s Specialized Foster Care Plan, it is noted that close partnership with County Child Welfare Workers will be needed to assure timely services, medications, supplies and continuity of physical and behavioral health services. Through our Fostering Health NC work, we are keenly aware of how complicated this can be and urge as much specificity as possible, including on how data sharing will work. (In the discussions around transition to Medicaid Direct, it is currently foreseen that new plan coverage will start on the first day of the month of removal from the home (as of 2/22/21). How is information shared across CCNC, CIN, ACO, County Child Welfare Workers and others the day that children are removed from the home? Is it sufficient to assure that foster parents (or other caregivers) have and know how to use insulin, asthma inhalers, medications and other essentials the first night? Is it sufficient so the pediatrician or other expert doing early exams has needed information? Etc.)

**Robust data reporting:** Under Vision of State’s Specialized Foster Plan, it is noted that the Plan must track and report on a number of factors. We support robust reporting and urge that the QMAF be re-instated with comparison to national HEDIS (where available) and general NC Medicaid population for the age group. We also lift up this dashboard proposal from the Georgetown to allow the FC Plan to be compared to at least SP and preferably TP as well: [https://ccf.georgetown.edu/2021/02/04/improving-medicaid-managed-care-for-children-what-a-dashboard-could-do/](https://ccf.georgetown.edu/2021/02/04/improving-medicaid-managed-care-for-children-what-a-dashboard-could-do/)

**Equity:** We applaud the inclusion of promoting health equity for racial and ethnic minorities. Another very vulnerable population, especially in foster care, is youth who identify as LGBTQ. We urge that special attention be paid to LGBTQ. This population is overrepresented within the foster care system – often with the intersections of race and disability. (see [https://www.childrensrights.org/wp-content/uploads/2019/04/2019.02.12 ](https://www.childrensrights.org/wp-content/uploads/2019/04/2019.02.12)) The entity managing the FC Plan should account for how they will ensure the needs of this population are considered/met. [https://www.childrensrights.org/wp-content/uploads/2019/04/2019.02.12-LGBTQ-Youth-in-Unstable-Housing-and-Foster-Care.pdf](https://www.childrensrights.org/wp-content/uploads/2019/04/2019.02.12-LGBTQ-Youth-in-Unstable-Housing-and-Foster-Care.pdf)

**Clarify kinship care:** Under Eligibility and Enrollment, there is a list of who is eligible for the FC Plan. Our understanding is that children in DSS custody placed in a kinship care placement are included in this population covered. This should be explicitly stated for clarity.
**Opting:** Under Eligibility and Enrollment, the process is delineated for opting out of the FC Plan. We applaud that the default option is opting in. Families and qualified children should also be able to switch back into the FC Plan if they determine that the other plan does not meet their needs. Furthermore, the situations that lead to a child being removed from their home often have lingering health consequences. We recommend that once a child qualifies for the FC Plan they can stay there until age 26, assuming eligible for Medicaid.

**Use AAP and Division of Social Services Benefit recommendations:** Under Benefits, we recommend adopting the recommendations of AAP and specifying the importance of care being accessed early and often. Following the enhanced schedule of well visits for this population is important for assessment and screening of a population AAP considers “Children and Youth with Special Health Care Needs.” It is important to note that the Division of Social Services has not adopted the full AAP recommended schedule in policy. We understand the need to start by complying with current State policy and urge moving towards the full slate of AAP recommendation.

**Healthy Opportunities and NCCARE360:** Under Benefits, we applaud the inclusion of robust mental and physical health services. This section would be strengthened further to include Healthy Opportunities for families on the path to re-unification and young adults on the path towards emancipation as priority populations. NCCARE360 could offer supports for families and emancipated foster youth when Healthy Opportunities is not a viable option. We realize this is specified on page 12 but it should be lifted up under Benefits as well.

**Clarify time frames:** Under FC Plan Care Management Model, the requirement is that the FC Plan will assign each member to a care manager within 24 hours. Within 24 hours of what? Placement into Foster Care? Placement in the FC Plan? Other standards? We urge clarity.

**Rely on AAP framework:** The American Academy of Pediatrics has spent years developing and honing a framework for care of children and youth in foster care that the State has spent at least 7 years refining and implementing for North Carolina through Fostering Health NC. We urge use of this model. (Here is a link to key AAP elements: [https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/About-Us.aspx](https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/About-Us.aspx) Also, here is a link to NC implementation resources through Fostering Health NC: [https://www.ncpeds.org/page/FHNCLibrary](https://www.ncpeds.org/page/FHNCLibrary) [https://cdn.ymaws.com/www.ncpeds.org/resource/collection/EB7D51D4-C7C0-41EE-8498-3592FD0AA4F2/Healthy_Foster_Care_America_adapted.pdf](https://cdn.ymaws.com/www.ncpeds.org/resource/collection/EB7D51D4-C7C0-41EE-8498-3592FD0AA4F2/Healthy_Foster_Care_America_adapted.pdf)

**Gather and consolidate medical records:** Historically, gathering and consolidating of medical records for children and youth in foster care has been a challenge. Due to the nature of movement from primary care providers within and among counties, as well as fragmented care that often occurs with children who have entered foster care, it is important to have a good system developed to access records quickly. The claims data system used by Community Care of North Carolina and accessible to county DSS agencies has been a helpful component of the work. It will be important that the FC Plan consider how to collaborate on documents and components of care that are mandated by state DSS for counties to complete. Providers play and integral role.
**Scope of FC Plan reach:** Under Continuity of Care and Coordination during Transition, the document notes the FC Plan will be required to ensure continuity of care for an active course of treatment when a child moves from one health plan to another health plan. Elsewhere in the section it talks about transferring from FC to another plan. How engaged is the FC Plan expected to be, if it is involved in transition among PHPs (not into or out of FC Plan)?

**Outreach to ensure on-going coverage:** Under Support for Members Transition to Adulthood, we loudly applaud inclusion of services up to age 21 or 26 as allowed. We also recommend that the FC Plan have an outreach function to assure young adults are aware of the benefit.

**Focus on appropriate medications:** We applaud a strong focus on appropriate medication utilization under Comprehensive Medication Management Services and recognition of the “Best Practices for Medication Management for Children and Adolescents in Foster Care” document developed through the work of Fostering Health NC. We encourage utilization of the AAP guidance as well as the American Academy of Child and Adolescent Psychiatrists (AACAP) Practice Parameters and guidance. It will be important to align work with the NC Division of Social Services to make a cohesive plan for this important monitoring. Collaborative work is a necessity in ensuring the appropriate oversight and monitoring needed, including metabolic monitoring, for those prescribed certain psychotropic medications. We also urge attention to other vital medications such as insulin.

**Health Passport:** We understand the potential merit of offering an electronic or digital form for health information. However, due to common circumstances – 40% of children in foster care are under age 5; children and teens may transition without possessions; children coming from homes where meth is produced may be stripped of their clothing, much less any other possessions - a file or packet of papers or even a jump drive may not be helpful. We urge considering a portal accessible via phone or device.

**AMH:** To limit administrative burden and maximize participation in the FC Plan, AMH requirements should be very carefully crafted. Consideration of “pre-approval” should be given to practices that have a history of strong work with the foster care population and are currently following the AAP enhanced schedule and components of FHNC or who meet AMH+ or who already offer integrated mental health services. Pre-approval standards should also be considered for practices providing care for patients 18 to 26, based on consultation with such practices or their representatives. We are deeply concerned that further increasing burden will result in less access for this population.

**Clarify FFS payment:** We applaud inclusion of FFS payment for participating in care team meetings in PCPS and FC Plan Care Management. We urge clarifying that this payment extends to out-of-network providers. Regarding care team meetings, would these meetings be combined with, or counted as, the Child and Family Team (CFT) meetings or Permanency Planning Review (PPR) meetings that are mandated for county DSS to complete for children and youth in foster care? A concern is burdening all involved with more meetings that likely cover the same or similar content. Careful attention should also be paid as children cycle between FC, TP and SP as they move in and out of foster care so that there is continuity of care management services. (We applaud that children can stay in the FC Plan 12 months post re-unification.) Also, we urge paying attention to the burden on the child and family of having new and different care managers and teams if they switch between FC and other plans.
**Administrative Burden:** Under Accountability for Quality, we urge that in seeking to promote quality with Performance Improvement Plans and other strategies, that practices are not overburdened with additional paperwork hurdles around a relative handful of patients. We are deeply concerned that creating too many barriers to participation will result in reduced access to appropriate care for this vulnerable population.

**Networks:** Under Provider Network and Payment, the bidder is required to meet network adequacy standards. Current SP standards do not seem to assure broad-based access to the limited pediatric subspecialists in our state; meanwhile, children and youth in foster care often have multiple conditions that may require specialty care. We urge that children and youth in foster care be allowed to access any pediatric subspecialist enrolled with Medicaid Direct. This will better assure access to the most appropriate subspecialist and allow the subspecialist to be paid at 100% of Medicaid rates. We also urge that FC Plan allow treatment by out-of-state specialists on the same basis as Medicaid currently.

**Oral health:** As of Quarter 4 2019 (when QMAF data stopped being reported as a step in the transition to Medicaid reform), Fostering Health NC found very strong utilization of dental services by children and youth in foster care. 78.4% with an annual dental visit for those accounted for in foster care (compared to 61.6% of all children measured). We urge an arrangement (such as tracking or paying current FFS or contracting with Medicaid Direct) to assure that children and youth in foster care have robust access to oral health services.

Thank you for accepting these comments. Our Executive Director, Elizabeth Hudgins would be pleased to provide additional insights or to connect with you or your staff with content experts to help further inform and refine the FC Plan.

Sincerely,

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President,
North Carolina Pediatric Society

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