June 27, 2019

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

Dear Sec. Cohen

Thank you for the opportunity to provide comments on the Department's move to Medicaid Managed Care, including North Carolina’s Care Management Strategy for Behavioral Health and Intellectual/Developmental Disability Tailored Plans. The NC Pediatric Society is a membership organization of more than 2,200 health care professionals, mostly pediatricians. We are deeply concerned about the potential impact of Medicaid Reform on children, especially the most vulnerable children who may need Tailored Plans (TP).

We applaud many factors of this proposal:

- **Integrated care**: Integrated care is the best way to approach both physical and behavioral health needs.
- **Care Management**: Strong care management provided locally and the ability of patients to change managers when needed supports the need of patients. We also applaud the focus on face-to-face interaction.
- **AMH**: We appreciate the focus on tying care to existing medical homes through AMH+ or CMAs.
- **Social determinants of health**: Focusing on Adverse Childhood Experiences (ACES) and assuring families are connected with other supports, such as housing, promotes healthier environments for children. (Stable housing and addressing interpersonal violence can be particularly critical for patients with mental health needs.)
- **Enhanced match**: Seeking additional funds through a 90% match rate, especially in the critical early years, is a wise approach for building a strong system.

Our overarching concern is that Tailored Plans may result in the inappropriate carving out of mental health services for children. Some children may fit the TP criteria for a period of time but then be more appropriately served in Standard Plans (SP) and then may need to return to a Tailored Plan for “booster shot” service. This could disrupt the relationship with the medical home and the care continuity for the child. Additionally, a strong and appropriate medical home may not qualify as an AMH+. Overall, assignment of the patient will be based on whether their mental health need outweighs their physical needs, which inherently is an arbitrary calculation, and particularly problematic for children.
Specific recommendations include the following:

**Foster children should be served through a statewide plan:** Foster children inherently may move more often, often across regional lines. Having one statewide plan will provide better, more robust, less-fragmented care for this vulnerable population. It will also reduce administrative burden for providers who now must spend many hours on single or limited case contracts and other paperwork to serve children in foster care.

**Pay special attention to young children:** We understand the intent of TP is to assure that LME/MCOs contract with strong networks well able to provide for the physical health needs of all patients, including children. The early years – especially birth through age 1 – are particularly critical in the development of the child. CC4C through the Local Health Departments are well-established in this area. We are deeply concerned about moving care management away from CC4C after 2022.

**Keep responsibility for certifying CMAs and AMH+ with NCDHHS or otherwise centralized:** We appreciate that the Department will initially certify CMAs and AMH+. We are concerned that thereafter, TPs can decertify a CMA or AMH+. Currently, there is frequent substantial administrative burden to providers in coming on with an LME/MCO, especially for a handful of patients, such as children living in the LME/MCO “next door” while getting services outside the region. This is especially a problem for foster children, but also happens in rural areas near LME/MCO lines, where appropriate specialists are not readily available, or where children may move among relatives in different regions (joint custody arrangements, spending a summer with grandparents, etc.). We are also concerned about sufficient availability of CMAs and AMH+.

**Assure AMH+ can serve pediatric populations:** For children and adolescents, moving from their medical home and specialist network to an AMH+ could potentially disrupt care. While many pediatric practices will likely meet Tier 3 medical home criteria, to pursue the AMH+ criteria, some with limited numbers of children and adolescents with severe, persistent mental illness may not be feasible. Pediatricians have extensive experience in managing children and adolescents with IDD. Moving these children and adolescents to an AMH+ practice that does not have pediatric experience would not be best for their care.

**Protect physical health of children:** We understand that the goal is to provide robust mental and physical health services to children with BH and IDD needs. Often these children have complex physical health needs as well and need access to a range of specialists. Given that there is often just a handful of pediatric subspecialists in a given field, children must be assured access even if the pediatric subspecialist is outside the LME/MCO catchment area. We appreciate that AMH+ can help bring strong expertise to physical health needs, including vaccine schedules. We strongly urge that appropriate use of physical health services are promoted by Tailored Plans and monitored by the Department, given the newness of this type of service for LME/MCOS.

**Use the Pediatric Medical Complexity Algorithm in future rate setting:** We have concerns about the CDPS +Rx model as it pertains to children. While it is our understanding that this is a well-conceived model for adults, it is further our understanding that it does not work optimally for children. Researchers through the Washington Center for Excellence at Seattle Children’s Hospital used CDPS as the basis for developing a more child-specific methodology – the Pediatric Medical Complexity Algorithm (PMCA) which has dramatically better sensitivity and specificity. (For more information: [http://www.seattlechildrens.org/research/child-health-behavior-and-development/mangione-smith-lab/measurement-tools/](http://www.seattlechildrens.org/research/child-health-behavior-and-development/mangione-smith-lab/measurement-tools/) )
Allow use of CINs: We understand the Department anticipates allowing CINS to support CMAAs and AMH+. Allowing (but not requiring) CINs is a reasonable approach.

Allow providers to assess capacity building fund (if approved): We appreciate that the Department is seeking a capacity building fund for training and onboarding staff. This is a prudent approach. In general, providers mostly are expected to absorb the additional direct and indirect costs of contracting with multiple providers and setting up different systems. Providers should have access to capacity building funds. (page 10)

Use input of pediatricians and other health providers who have had contact with the child: We understand the need for independent assessment and review. However, great weight should be given to the recommendation of providers who have worked closely with the child and family, especially for Individual Family Support Plans. In addition, there should be a requirement for regular communication by the care manager with the medical home, especially since the provider is likely not going to be able to leave practice to attend such meetings.

Include more child specific measures and markers: For example, care transition requirements note provision of care management to avoid adverse outcomes. Removal from home or transitioning foster care placements should be considered an adverse outcome. Currently, Table 3 is strongly weighted towards adult measures. (page 13, page 19) Please consider—Quality Measures and Feedback that includes the NC EPSDT visit rates and visit component, with special note of maternal depression screening at infant well-visits (NQF 1401), the NC Assuring Better Child Health and Development metrics for developmental and autism screening, psychosocial screening for school-age children, screening for adolescent depression ages 12 through 21 (NQF 0418); Use of Multiple Concurrent Antipsychotics in Children and Adolescents from the CMS Child Core Set, and BMI percentile and counseling for nutrition and physical activity (NQF 0024). As always, strong alignment among measures promotes administrative ease.

We also think there are important questions left unanswered:

- How will children transition between the TP and SP?
- What about children who move between TP regions or travel (such as spending a summer with grandparents in another region)?
- In particular, how will this process work for children in the foster care system and former foster children who remain eligible for Medicaid after their 18th birthdays?
- How will this work for children 0-3 currently served through CDSAs?
- How does enrollment work – upon whose recommendation does a child become eligible for a TP?
- How will Plan of Safe Care operate, given that it is based on a referral to CC4C/CMARC. Will these newborns automatically go into Tailored Plans?
- How will providers access medical records for transitioning patients, either as children move from MCOs to FFS before TP “go live” or to TPs after “go live”?
- Will Enrollment Brokers ultimately determine which children go into TP vs SP?
- How will payment to providers work?
As always, we welcome the opportunity to work with the Department on strategizing policies to promote the health of children. Please let us know how we can help.

Sincerely,

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North Carolina Pediatric Society (NCPeds)

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