October 9, 2019

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

Dear Secretary Cohen:

Thank you for the opportunity to make comments on North Carolina’s Data Strategy for Tailored Care Management. The NC Pediatric Society is a membership organization representing more than 2,300 child health professionals across the state. In addition, for more than five years we have been working on Fostering Health NC which seeks to ensure children and youth in foster care are linked to medical homes and other appropriate health care.

By way of some background: it is our understanding that the Department is still in process towards determining the populations encompassed by Tailored Plans (TPs). Our understanding is that this group of patients will have different care managers from patients in Standard Plans. It is also our understanding that Tailored Plan services will be provided through the current mental health MCO structures. For adults, this is expected to be mostly mental health and addiction management. Our further understanding is that anyone who receives intensive in-home services (including Child-First), psychiatric hospitalization or two or more emergency visits with a psychiatric primary diagnosis are automatically placed in TP unless the family opts out.

We are concerned that children with complex needs will be automatically placed into Tailored Plans. This includes anyone with a disease that can cause developmental and intellectual delay such as a metabolic disorder, autism, Down syndrome, etc. Most of these children do not need intensive mental health management. They need developmental support that should be within the expertise of their pediatric medical home, including medical homes that may not meet AMH+ (or CMA) criteria.

AMH+ medical homes are specific facilities that co-locate mental health services with primary care. We understand that the goal is for TPs to spur the creation of more facilities. It is unlikely that the average pediatric practice could meet the criteria for the small number of patients that may qualify for Tailored Plan services, especially in rural areas.
We applaud some elements in the *Data Strategy*:

- Requiring single designated care manager for each beneficiary
- Allowing but not requiring CMAs and AMH+ to contract with CINs and other partners to assist with requirements of TP model
- Minimizing provider administrative and operation burden for providers working in both Standard and Tailored plans
- Focusing on whole-person care
- Designating staff to support care transitions
- Considering using the HIEA as a way to share and bridge data

However, we also have a number of concerns, often relating to the likely impact on children and youth in foster care. We think two strategies could help address many of the concerns.

**Single statewide plan for children and youth in foster care:** Children and youth in foster care have inherently faced trauma and tend to have complicated lives. Having a single statewide plan would help minimize disruption if children moved between regions or between SP and TP. A single statewide plan could help ensure that these children and youth have access to appropriate services across the state and throughout their treatment.

**A dedicated plan for emancipated foster youth aged 18 to 26:** Currently children who are in foster care on their 18th birthday are eligible for Medicaid until they are age 26. It is our understanding that sometimes they inadvertently drop off Medicaid or are placed in Family Planning Medicaid. This is also an age range when many people start having children. Making sure this population has access to appropriate, robust services with minimal disruption could result in health benefits for emancipated foster youth and their children. There may also be unique opportunities for serving a population less subject to changes in eligibility.

We also urge consideration of the following:

**Standardize data and access:** The *Data Strategy* calls for continued development of standardized data sharing formats and protocols by Tailored Plans (TP) with AMH+, Care Management Agencies (CMAs), and the Department building on Standard Plan (SP) and Advanced Medical Home (AMH) standards (page 11). We urge that this standardization be a requirement. We are very concerned about the potential lack of standardization in transmission methods for care management assessment data among AMH+, CMAs, care team members and TPs (page 12). We encourage the Department to specify required methods for uniformity with shared formats and protocols (including for transmission across all SP, TP, practices and other entities) to result in better coordinated care for beneficiaries. This will help Primary Care Providers (PCP) quickly and easily access important data for children served through either Plan type and is especially important for PCP who may not obtain AMH+ status. Furthermore, a patient experiencing a crisis causing a move to a TP should not face any barriers to appropriate care because of lack of data-sharing. We also request special attention to data delimitation issues, such as the number of characters in a last name or how hyphenated names are handled so these issue do not inadvertently negatively influence care.
Address regionalization: One of the current challenges of mental and behavioral health services delivered through regional entities is assuring health services remain strong when children move outside their original catchment area. This is especially problematic for children and youth who may be placed in foster care outside their current LME/MCO region or move among regions. Addressing regionalization should be a key element of all Tailored Plan proposals and strategies, including data.

- **Data sharing among TPs:** Data sharing requirements need to address data sharing among Tailored Plans as foster children and others move between regions.

- **Foster children:** Special data protocols may need to be considered for children and youth in foster care given the particular time-sensitivity of out-of-home placements. It is critically important for foster home placements to receive accurate and timely medical information whether the placement is a facility or a private home.

- **Single case agreements:** Currently, obtaining a single case agreement with an LME/MCO can be extremely time-consuming and administratively burdensome. To improve care for foster children and others, every element of Tailored Plans should move toward streamlining care for children who move between regions, including data flows and administrative ease for single case agreements.

- **Medically fragile children:** Many medically fragile children are likely to fall into the TP parameters. They are also the most likely to need a pediatric subspecialist who may only practice in a given region. How will appropriate care be ensured? Are data feeds a consideration for this population?

Address transition between Standard Plans and Tailored Plans: We appreciate the focus of the Data Strategy for Day 1 of go-live to TP. As the system progresses, some children will likely move from SP to TP and back to SP again. It will be important to implement processes for easy and complete data transition between Plans. For example, transition between Plan types could be added to list of data use on page 6.

**Notify PCP and key subspecialists when a patient transitions between SP and TP:** The Data Strategy proposes that data files will be generated by Plans as members migrate (page 8). The primary care provider as well as key subspecialists for medically fragile children should be notified of the change as well.

**Preserve the medical home to the maximum extent possible:** Not all practices will be at the AMH+ or CMA level. When a patient has an effective medical home, data and other policies (such as single case agreements inside or outside the catchment area) should be permitted. Quick data-sharing through standardized policies will help further preserve the medical home, especially if it is the same data format and feed for both SP and TP.

**Provide clarity on foster youth and emancipated foster youth:** Children who are in foster care on their 18th birthday are eligible for Medicaid until they are age 26. These children likely experienced trauma and at some point and may need services only offered through TP. During this time frame, they may also start families of their own and have other medical needs that fall squarely into the physical health side of the equation. As noted previously, we urge a specialized plan and strategy for this group that includes special attention to eligibility and medical information flow through data connection points. For children entering foster care for the first time, special consideration will be needed to obtain all appropriate
data. Finally, we have questions about how the TP Care Management Comprehensive Assessment (page 11) and Individual Support Plans/multi-disciplinary teams (page 12) will coordinate with DSS.

**Limit barriers to vaccines and other physical health services:** We are concerned that TPs may focus on mental and behavioral health to the inadvertent detriment of physical health. This can be particularly problematic for young children who need developmental and other screens timely or medically fragile children who may need access to subspecialists not available in the region.

- **Medical home:** Children who need Psychiatric Residential Treatment Facility (PRTF) services will need to move into a Tailored Plan. We feel it is important to share information with their medical home (if they have one) even if the existing medical home is not an AMH+ or CMA. There will also need to be a process when a patient lives in a community without an AMH+ or CMA in that community. When children need to transition into a TP, policies should promote continuity of care and established relationships.

- **Vaccines:** While TPs understandably will focus on mental and behavioral health care needs, it will be important for them to address physical health needs as well. A two-year look back on claims and encounter data may not reveal if a child is up-to-date on immunizations. Especially for foster children who frequently move, access to complete data can prevent duplicative immunizations. This is also important for any patient who may be placed in a congregate or institutional care setting and needs specialized TP services. Vaccine data should be included, through NCIR or HIEA, if not the actual health record (page 7 and 8). (We recognize that immunization histories are included on page 9. We are concerned that allowing for “up to” two years of history will not capture this needed element.) We applaud the inclusion of NC HealthConnex as a possible data source and urge consideration of others, such as NCIR and consideration of expanding the medical history review back more than a two years.

- **Access to subspecialists:** Medically fragile children often need access to subspecialists. There may be only a handful of such providers and they may be concentrated around major medical centers. We encourage processes that facilitate information sharing and communication between care managers and medical providers and that promote established relationships through continuity in specialized care.

**Limit barriers to dental care:** Anecdotally, we consistently hear that children and youth with special health care needs are among the least likely to get needed dental and other oral health care. CDT and other oral health data should be expressly included in historical claims and encounter data (page 7). If this data is excluded it could inadvertently suggest that dental care is not an important consideration for the health of the patient.

**Ensure strong historical data:** Currently, the proposal is that “up to” 24 months of look-back data be provided (page 7). Strong historical data is needed, especially in cases where abuse or neglect is suspected or determined. We suggest that data going back “at least” two years (or since birth) is provided.

**Other suggestions**

**Allow physicians and other providers to suggest an eligibility review:** Currently, beneficiaries will be assigned through review of encounter or claim data and individuals can also request a review (page 7). A provider familiar with the case should also be able to request a review.
Share Healthy Opportunities and NCCARE360 data as part of enrollment file: The data elements to be shared are listed on pages 7 and 8. They do not include linkages with Healthy Opportunities and/or NCCARE360. Social determinant of health information can be critical for addressing mental health concerns. Page 14 talks about the expectation that TPs will refer members to NCCARE360. This sort of information can be important for a provider, especially in times of transition.

Require TPs to have documentation systems in place: The Data Strategy notes the Department “expects” TPs to ensure contracted care managers have appropriate documentation. This should be a requirement. Data is fundamental to treatment and the ultimate success of Tailored Plans.

Design a process to troubleshoot problems: The Data Strategy envisions a provider appeals process to raise complaints (page 16). It would be preferable to a have a process to raise, address and resolve issues without needing to immediately elevate to an appeals process. One of the lessons from the rollout of the Enrollment Broker website is the need for checks and balances to ensuring accurate data is transmitted.

Thank you for the opportunity to make these comments. If you have any questions or concerns, please reach out to our Executive Director, Elizabeth Hudgins (elizabeth@ncpeds.org).

Sincerely,

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