Examples of Concerns about Regional Care for Children and Youth in Foster Care – May 2022

**Issues with children getting care**

Children and youth in foster care often have many placements. Pre-COVID, about a third of children and youth in foster care had three or more placements.\(^1\)

Guidelines from the American Academy of Pediatrics and NC policy note that foster children often need more frequent physician visits to monitor well-being, screen for developmental progress, and treat trauma-related and other conditions. This is called an enhanced visit schedule.

Since 2014, the NC Pediatric Society has regularly convened experts and constituents at the state and county level to help assure children and youth in foster care get strong medical care through appropriate medical homes. Struggles with helping children and youth in foster care get psychiatric care when they are placed outside their home district are a frequent part of discussion.

In April of 2022, a Wake County pediatrician was asked to prescribe strong medications including antipsychotics\(^2\) previously prescribed by a psychiatrist for a foster child. The child had moved across regions and was unable to continue to see their previous psychiatrist and unable to timely establish with a new psychiatrist in the new region. The primary care provider was on a statewide contract (Medicaid Direct) and thus could continue to prescribe. However, the psychiatrist who had more knowledge and expertise in these particular medications and was vastly more familiar with the ongoing needs of the patient was on a regional contract and could not.

In 2022, a pediatric practice in Craven County could not refer a boy in foster care originally from Mecklenberg County to a local and good-fit psychiatrist because the LME/MCO from Mecklenberg was not contracted with the Craven County psychiatrist.

In March of 2022, a pediatric practice with offices in Hoke and Cumberland Counties reported that a foster parent was unable to change the primary care provider of the child in foster care and was unable to reach their child welfare professional to help make the change.


\(^2\) Lamotrigine, Risperidone, Desmopressin Acetate and Hydroxyzine)
A child in foster care who was in a statewide Plan moved LME regions and was still able to receive medical care. This shows the promise of statewide coverage. However, when the child then needed intensive in-home services only available through LMEs, the psychiatrist could no longer get paid for treatment of the child, even though her practice is contracted with the local LME for Moore County, and was credentialed by Medicaid and the NC Medical Board. The “home” LME made it overly burdensome to apply for approval with the LME and get paid by the LME because the child was from outside Moore County. This shows the limitation of regional coverage.

In 2022, a pediatric practice in Moore County with two child psychiatrists on staff analyzed their patient distribution with different LMEs in preparation for the transition to Tailored Plans. In order to serve their patients, they have an agreement with their local LME (Sandhills) that covers more than 850 children. Three of the other arrangements – which are each administratively burdensome to complete - cover six or fewer children. This practice has already met all the requirements of both their local LME/MCO and Medicaid Direct. Additionally, all the providers in the practice are enrolled with Medicaid, multiple Standard Plans, and are credentialed by the NC Medical Board.

**Sample Arrangement Issues**

A contract allows a practice to fully participate with the LME. A Single Case Agreement allows a practice to care for one child covered by the LME. Single case agreements take a minimum of one month to complete, often with requests for additional documentation, each time for each patient. The child may not be able to access care in the interim while the agreements are being worked out.

The practice attempted to contract with “LME A” in 2015. “LME A” stated that they were not accepting any new providers and that the practice had to execute an out-of-network, single case agreement for any patient from the “A” areas.

The practice had six patients under a single case agreement with “LME C” and were told they had exceeded the allowed amount of single case agreements. After spending considerable time attempting to contract and jump through hoops not required by any other LME, the practice elected to no longer pursue the contract.

The administrative burden relating to meeting the financial information requests from one LME became so great that the practice terminated their contract since it only helped them provide care to a few children from outside their area.

The administrative burden for on-boarding, finances and auditing can be steep, serving as a deterrent to a practice being able and willing to spend the many hours of administrative time to serve a relative handful of patients to contract or enter into single case agreements with multiple LME/MCOS.

---

3 All examples from one practice with integrated mental health, on-site psychiatrists, and multiple providers licensed by the NC Medical Board, participating with multiple commercial insurance and PHP as well as Medicaid Direct. They are regularly audited, file tax returns and meet other financial requirements. They are inspected every year by their local LME.