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NC DEPARTMENT OF HEALTH & HUMAN SERVICES

Medicaid Children and Families Specialty Plan Proposal

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North Carolina Department of Health and Human Services
Division of Health Benefits
101 Blair Drive
Raleigh, NC 27603

VIA Email: Medicaid.ncengagement@dhhs.nc.gov

RE: Medicaid Children and Families Specialty Plan Proposal

To whom it may concern:

Thank you for the opportunity to engage in this public comment process regarding the proposed Medicaid Children and Families Specialty Plan ("the Plan") design. We applaud the Department's outreach and engagement in developing this proposed plan as part of NC's Medicaid Transformation.

Our comments on the proposed design are based on our years working in North Carolina with providers, care management organizations, human services organizations, and prepaid health plans, as well as our work in states such as Washington and Illinois, which have implemented specialty Medicaid managed care programs for children in foster care.

We respectfully submit these recommendations and questions to contribute to developing a high-quality, accountable, reliable system of care for a highly vulnerable population.

Sincerely,

Michealle Gady, JD
President & CEO
Atrómitos, LLC

Generally, we support NC DHHS' goal of establishing a single, statewide Medicaid managed care plan to administer Medicaid benefits for children, youth, and families served by North Carolina's child welfare system. We agree that a single, statewide specialty plan may effectively ensure seamless, integrated, and coordinated coverage and service delivery in a way that the current regional system cannot do. Additionally, integrating physical health, behavioral health, and LTSS benefits should facilitate appropriate access to care.

We acknowledge that NC DHHS has intended to launch the Children and Families Specialty Plan for many years and that, during this time, significant planning and stakeholder engagement has been conducted. We note the Department's goal of launching this plan by December 1, 2024, subject to plan readiness and legislative approval. We caution NC DHHS not to rush implementation. Based on NC DHHS' delay on the Tailored Plans, we know that the Department will put the best interest of patients first rather than achieve an artificial, self-imposed deadline. We ask that the Department continue this commitment, especially for this highly vulnerable population.

Lastly, NC DHHS must conduct a diligent monitoring process once implemented. Even the best-laid plans can go awry without careful attention. In the following sections, we identify issues that require careful attention in the design process, later during contracting, and then in ongoing monitoring.

Network Adequacy and Billing Recommendations

A primary concern that every state contends with during the design and implementation of Medicaid services for children enrolled in foster care is the challenge of consistency in services and network adequacy. Children in foster care are often placed in a county different from their intake county, leading to gaps in coverage and a failure to coordinate benefits across different regions. For this reason, we support the Department's plan to proceed with a single contract. We believe this is necessary to ensure consistent and comprehensive healthcare services, minimizing unnecessary transitions and administrative barriers for members and caregivers.

While a single, statewide plan may reduce administrative "churn" and barriers, with just one plan option, it is vital that the plan maintain a robust network of physical health, behavioral health, I/DD, and LTSS providers across the State to meet the needs of all members statewide. Given the needs of this population, it will be critical that the Department continue to invest in a robust and iterative system for monitoring provider participation and access.

Our experience following a recent transition of the foster care population to managed care in Illinois illustrates the importance of close scrutiny of network

adequacy data. Public reporting of Managed Care Organizations reflected a significant expansion of frontline providers available to foster children since the initiation of YouthCare, growing from 8,600 in 2019 to nearly 42,000 today. However, a recent audit by the state's auditors concluded that less than half of the providers listed were actually participating or accepting YouthCare patients. These findings underscore the importance of diligent oversight, particularly when dealing with a vulnerable, high-need population.

To ensure network adequacy, particularly in Behavioral Health services, NC DHHS and the CFSP must continue to pay close attention to **recognizing and removing barriers to provider participation** in the Medicaid program. As illustrated by the experience of many providers during the transition to Medicaid managed care in NC over the last few years, claims processing and billing present an administrative challenge for many providers. When procuring CFSP services, we recommend that the Department require applicants to explain, with specificity, the support that will be available to providers to address billing questions and receive training and support. We also recommend that the Department hold monthly meetings between the CFSP, provider groups, and the NC DHHS staff during the transition. This approach enhances transparency and provides a real-time platform to address concerns. In our own experience, this strategy of monthly meetings to highlight and troubleshoot issues was instrumental in addressing historic and current billing challenges in Illinois. Under this initiative, facilitated by regular meetings and leadership from the Illinois Department of Healthcare and Family Services (HFS), hundreds of billing issues have been proactively addressed. Since its institution in 2019, over a million claims have been reprocessed, reflecting adjustments arising from various scenarios, such as updates to plan IT systems, improved guidance from HFS, and providers resubmitting rosters or registering differently in the IMPACT system used by Illinois.

It is crucial to recognize that the sheer number of claims adjustments and billing issues does not fully encapsulate the commendable efforts and good faith demonstrated by HFS, MCOs, and providers at the table. Equally significant are the strengthened relationships fostered between providers and MCOs, a testament to the purpose of these Medicaid billing meetings. This collaborative approach not only rectifies immediate issues but also lays the groundwork for a more robust and sustainable healthcare ecosystem, ultimately benefiting the vulnerable populations the Medicaid program serves.

While NC DHHS utilizes the Ombudsman for problem resolution, our experience in North Carolina does not lead us to believe that it will be an adequate venue for problem resolution of the abovementioned magnitude.

Workforce Development Recommendations

We commend the department for undertaking good faith initiatives to ensure provider representation from historically marginalized populations. Moreover, we appreciate the department's commitment to training network providers on trauma-informed care and Adverse Childhood Events (ACEs). This training is crucial in enhancing their understanding of the unique needs of the population served by the CFSP.

Recognizing historically marginalized populations have been underserved, we advocate for allocating dedicated funding to support comprehensive training, service enhancement, and workforce development efforts. These resources will be instrumental in fortifying the ongoing initiatives, ensuring that the CFSP's provider network is well-equipped to meet the diverse and often complex needs of the communities it serves.

We agree that NC DHHS' implementation of a robust monitoring program to ensure adherence to these expectations is necessary. When designing a monitoring program, we recommend that the department consider how to evaluate *outcome*s associated with program requirements (such as training in trauma-informed care and Adverse Childhood Events) in addition to process adherence.

Transparency and Quality Recommendations

Access to relevant, timely, understandable data dashboards evaluating the quality, accessibility, and equity of care delivery is critical for program transparency and accountability.

We support the Department's plan to establish a standard set of quality measures to ensure the CFSP meets quality care expectations. We agree that the measures should align with NC DHHS' quality strategy and prioritize the needs and experiences of the CFSP population.

Identifying and implementing the right quality metrics is necessary to accomplish this. A multi-state analysis (including Arizona, Florida, Georgia, Tennessee, Texas, and Washington) conducted in 2018 illustrates the challenges frequently encountered in quality data collection and reporting. The analysis assessed the availability of data on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) performance and quality measures for foster care plans in these states. The analysis revealed no available data for EPSDT and only found quality measures for three of the six operational programs that year. Furthermore, the examined quality measures lacked disaggregation by race or ethnicity, impeding meaningful performance

comparisons among MCO/FCs or between MCO/FCs and more broadly focused child enrollment MCOs. Finally, some states lack transparency regarding the performance of the single, statewide plan for children in foster care, as the data reported by the EQRO is aggregated across the MCO's entire Medicaid population. This makes it impossible to assess the performance of the specialty plan.

Creating and maintaining a publicly available child health dashboard that clearly presents how the CFSP is performing for the enrolled population would facilitate public access to critical information, enabling researchers, advocates, policymakers, and other stakeholders to monitor the ongoing transition and hold state agencies and the CFSP accountable for the results.

Continuity of Care Recommendations

We commend the Department's plan to mandate CFSP onboarding providers into its network or safely transitioning members to existing in-network providers if their historical provider is not part of the network. However, it is crucial to address the transitional period when beneficiaries move to the Plan from FFS and between the Plan and other prepaid health plans (PHPs) or types of coverage (ex., QHPs), which may occur in the future.

Drawing on our experience, to address these challenges, we advocate for implementing a minimum one-year timeframe for providers as the Plan builds up its network adequacy and actively recruits providers into the network. Additionally, we strongly recommend establishing continuity of care agreements specifically designed for beneficiaries transitioning from FFS to the Plan and between the Plan and other PHPs or MCOs. When fee schedules and network adequacy differ between plans, this transition can disrupt care and life for an already vulnerable community.

In the context of medication management, we propose a grandfathering provision for foster children. This ensures that if a child receives medication on FFS, they can continue that same treatment at the Plan. We also recommend that they be grandfathered should they move to another PHP or MCO. This approach acknowledges the sensitivity of this population and the potential adverse impact of abrupt medication changes. We recognize that children in foster care are more likely to be prescribed psychotropic medications than their peers not in foster care. This overmedication of children can be mitigated with a comprehensive medication reconciliation and management program. However, requirements like step therapy may interfere with medications that are working well for the child (ex., ADHD medications). Given the frequent transitions and changes children in foster care experience, it may not be easy to provide the documentation needed to

demonstrate that these steps have already been taken. Therefore, we recommend that NC DHHS err on caution and prevent medication disruptions for this population.

Prioritizing continuity of care and maintaining stability in medication management are essential components of safeguarding the well-being of this vulnerable population.

Prior Authorization Recommendations
While acknowledging the significance of prior authorization, we understand that foster families may face unique challenges, including limited access to networks, patient files, understanding of trauma, and healthcare providers. In instances where obtaining prior authorization is impossible or not feasible, especially when rapid treatment is essential, we recommend that the state consider these challenges.

In some states, a common denial for hospital services is "no authorization," emphasizing the critical need for prior authorization for specific services and inpatient days. This poses a significant challenge, given the unpredictable nature of the foster care population.

To address these situations effectively, we advocate for robust training and guidance to ensure a mutual understanding between providers, CFSP, and foster families. Oversight mechanisms should be in place to monitor and confirm that these trainings occur promptly. This approach will enhance flexibility while maintaining the integrity of the prior authorization process, ultimately ensuring that foster care children receive timely and necessary healthcare services, even in challenging circumstances.

Closing Questions:

We offer these final closing questions for the Department to consider as it continues to refine the CFSP design and its administration.

1. We understand that the CFSP will also implement a robust monitoring program to ensure that providers meet members' needs and adhere to program requirements. What are the specifics associated with the monitoring program? Is there additional oversight from the State?
2. What reporting mechanisms exist for parents or guardians to address concerns regarding the CFSP's failure to identify and classify risk levels, conduct comprehensive Health Risk Assessments, or document Individualized Care Plans? Does the Department have any feedback or data on the adequacy or accessibility of these mechanisms?

3. How does the state anticipate ensuring transparency in holding the CFSP accountable for its performance, and how will these activities and outcomes be communicated to the public?
4. Could the state outline the steps taken to address instances when the CFSP consistently fails to meet the standards for timely identification, classification, and documentation of health risks for children?

Conclusion

Atrómitos expresses gratitude for the considerable efforts North Carolina is undertaking to facilitate a seamless transition for this vulnerable population. We value the opportunity to provide input on the transition plan.

In conclusion, this discussion emphasizes the importance of careful consideration and attention to detail in the transition of North Carolina's healthcare system for children in foster care. The well-being of this vulnerable population necessitates a healthcare system that prioritizes their health and ensures a secure future.