



**TASK FORCE ON THE MENTAL HEALTH, SOCIAL, AND EMOTIONAL NEEDS
OF YOUNG CHILDREN AND THEIR FAMILIES**

Thursday, March 8, 2012

North Carolina Institute of Medicine, Morrisville

10:00 am – 3:00 pm

Meeting Summary

Attendees

Members: Beth Melcher (co-chair), Rosie Allen, Patti Beardsley, Karen Appleyard Carmody, Deborah Cassidy, John Ellis, Catharine Goldsmith, Michelle Hughes, Toby McCoy, Judy McKay, Laura Muse, William Purcell, Kevin Ryan, Terrie Shelton, Jean Smith, William Smith

Steering Committee and NCIOM Staff: Kimberly Alexander-Bratcher, Melissa Johnson, Marcia Mandel, Susan Robinson, Pam Silberman, Adele Spitz-Roth, Anne Williams, Berkeley Yorkery

Other Interested people: Kelly Crosbie, Katrina McDaniel, Shade Shakur, Donna White, Tamika Williams, Anna Yon

WELCOME AND INTRODUCTIONS

Beth Melcher, PhD

*Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services
Development*

North Carolina Department of Health and Human Services

Co-chair

WHAT ARE MCOs AND WHAT DO THEY MEAN FOR YOUNG CHILDREN'S MENTAL HEALTH CARE

Kelly Crosbie

Chief, Behavioral Health Section

Clinical Policy & Programs

Division of Medical Assistance

Ms. Crosbie gave the task force an overview of the 1915 b/c Medicaid Waivers and the role of local management entities-managed care organizations (LME-MCOs). The waiver allows DMA to contract with a managed care vendor (LME-MCO) for mental health, substance abuse, and developmental disability services in their counties. The waiver also allows DMA to offer habilitation services. LME-MCOs receive fixed administrative and per capita payments to manage the mental health care of enrolled patients. As LME-MCOs accrue savings, extra services can be offered, such as respite, peer support services, and community guides. A challenge presented by the waiver is that children ages 0-2 are excluded. Pediatric accountable service organizations (ASO) are being considered for future care management of children ages 0-5. LME-MCOs are also required to conduct gap analyses for the community and fill any identified gaps.

A copy of Ms. Crosbie's presentation is available here: [Medicaid Waivers](#).

Selected questions and comments:

- Q: Are Health Choice kids covered? A: Not yet. Anticipate that Health Choice kids will be care managed by LME-MCOs by July 2013.
- Q: Are the barriers to practices being able to enroll in multiple LME-MCOs being looked at? A: That is not currently changing. If a practice covers two areas, it must enroll in both LME-MCOs. Solutions to allow practices to apply to multiple LME-MCOs at once are being considered.
- Q: LME-MCOs are able to tweak the provider network to fit the needs of the community; can they also tweak the services offered? A: No. Currently, LME-MCOs must use the Medicaid service descriptions.
- Q: Have you looked at whether costs are being shifted elsewhere? A: Cost shifting is being looked at within Medicaid, and local partners are in close communication to try to prevent cost shifting outside of Medicaid.
- Q: One of the historical complaints about capitation payment arrangements is that it is difficult to get data without the billing to show what services have been provided. What level of data are LME-MCOs collecting and reporting on? A: Data is collected annually for anything you would see in a Medicaid claim—who, what, when—in order to look at utilization. Data is starting to be collected more routinely.
- Q: Patients are categorized in one of four quadrants on a grid that designates a patient as either high or low need for physical or behavioral health. For example, a patient may be high-low and have high mental health needs and low physical health needs. What happens when it is high-high or low-low.? A: High-high and low-low patients receive join care management.

PANEL DISCUSSION ON MCOs AND WHAT DO THEY MEAN FOR YOUNG CHILDREN'S MENTAL HEALTH CARE

Kelly Crosbie

Beth Melcher

Susan E. Robinson

Mental Health Program Manager/Planner

Prevention and Early Intervention, Community Policy Management

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

North Carolina Department of Health and Human Services

Anna Yon

Director

PBH Community Operations Center

Ms. Yon introduced herself and gave the task force a brief overview of PBH (Piedmont Behavioral Health). PBH was originally a pilot and has now expanded and merged with other LME-MCOs. The reorganization included the creation of a local community presence to handle provider, family, and patient concerns. The community operation

centers are responsible for coordination, quality management, provider network representation, capacity and needs evaluations, and gap analyses.

Selected Panel Questions and Discussion:

- The 0-5 population in LME-MCOs:
 - Q: What do you envision MCOs doing with children ages 0-3?
A: Policy could be written to allow children younger than 5 to sometimes qualify for enhanced services. Outpatient mental health services would be pretty easy to include.
 - Q: Currently, LME-MCOs have an incentive to focus on high cost individuals who require institutionalization. Data shows that earlier interventions save money later, but at that point the patient may no longer be on Medicaid. How can LME-MCOs be incentivized to focus on the 0-5 population within the capitation context?
A: The Medicaid program can include valued populations in their contracts with LME-MCOs.
- Provider Networks:
 - Q: PBH is in the biggest metropolitan area in NC, where it is not difficult to find therapists. Is there any effort being made to train enough psychiatrists and therapists to go into rural NC? Is it realistic to expect they will go?
A: Have been able to incentivize psychiatrists to move into rural counties. Telepsychiatry is also improving for areas where it is prohibitive for people to travel. There aren't incentives to go into psychiatry. There is a dearth of psychiatrists and particularly child psychiatrists across the state.
 - Q: There is not currently an ECMH provider credential in NC, but such credentials are being developed by other states. Does paying differential rates require a different credential, or could the provider demonstrate a specialty or capacity or complete training?
A: It is difficult to include/exclude providers based on subjective criteria in the absence of a credential.
- Community Stakeholders:
 - Q: What is the next step for people providing training?
A: The gap analysis is an annual process. Stakeholders in the community should be proactive and offer their data and input to the counties for the purpose of the gap analysis. Identify the gap and solution options and request to be involved.
- C: There are some disincentives for LME-MCOs to offer certain types of programs or interventions. Substance programs for pregnant women or mothers, for example, do not get reimbursed and often hurt the LME-MCO's reporting data because the target population tends to miss a lot of appointments.

DISCUSSION OF RECOMMENDATIONS AND OVERVIEW CHAPTER

The task force reviewed and discussed the group recommendations and the draft of the overview chapter.

Selected Discussion:

- Recommendations after Morning Discussion:
 - DMA should increase the reimbursement rate for outpatient mental health services provided in the natural environment with parental involvement by qualified licensed staff. Qualified will need to be defined.
 - Tie higher reimbursement rates tied to provider qualifications/competency.
 - Does a provider need certain competencies in order to be qualified to provide in-home services?
 - Is there a way to include provisionally licensed providers require a year of supervision?
 - DMA, DMHDDSAS, LME-MCO, CDSA, and children and family representatives should explore the possibility of bringing children ages 0-3 into the LME-MCO system for mental health services. They should also consider whether this includes children enrolled in Early Intervention.
 - What program should children be enrolled in? What services should the system provide?
 - Should mental health services for children ages 0-2 be covered through LME-MCOs?
 - Early Intervention is an educational program that addresses the functional issues of developmental delay in order to assuage later educational issues. Is there a better model to address social and emotional needs of young children?
 - Children's Developmental Service Agencies (CDSA) can't get the providers they need due to a lack of providers and because providers won't provide in-home services at current reimbursement rates.
 - Could have a specialized Medicaid policy for children ages 0-5. But this compartmentalizes children into age ranges 0-5 and 6-8, for example.
 - All LME-MCO's should have at least one staff member with specialty and responsibility to ensure that the needs of children ages 0-5 are being met.
 - DMA should require in MCO contracts that MCOs provide mental health promotion and prevention services for children ages 0-5.
 - Look at earlier interventions in foster care to allow families to be reunited before children experience toxic stress.
- Report Overview Chapter and Recommendations:
 - Ms. Yorkery gave the task force an overview of the planned chapters for the report.
 - Do we need a recommendation around improving care transitions?
 - Identify who should be looking at care transitions and add it to recommendation 1.
 - A lot of current Medicaid work involves care transitions for other populations. As the state moves forward with these populations, they should consider how it could be extended to young children as well.
- Additional Issues to Address:
 - Recommend building capacity for evidence-based practices (EBP) and discuss the existing family strengthening programs. Prioritize the sustainability and transferability of these programs.
 - Incorporate physical health in order to emphasize the comprehensive nature of young child development and discourage "silo-ing."

- Need to address the issue of mental health stigma. Education and outreach to raise awareness are needed to reduce stigma for young children who need mental health care.
- The workgroup suggested that the workforce chapter mention the specific needs of rural communities.

Selected questions and comments:

- C: The same provider cannot provide two outpatient mental health services the same day (i.e. individual and family sessions), but a provider team could manage this by having one provider see the child and another see the family.
- C: Washington state has done a phenomenal job of looking at cost shifting—it doesn't show up in Medicaid, but it shows up in the education, juvenile justice, and criminal justice systems.

The next meeting is Thursday, April 12th from 10:00 am – 3:00pm. The Task Force will be looking at the effect of health reform on early childhood mental health and reviewing additional report chapters.