March 15, 2021

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

Dear Secretary Cohen:

We submit these comments on the North Carolina’s Transition of Care Policy on behalf of the NC Pediatric Society, representing more than 2,300 pediatricians and other child health professionals across North Carolina.

We applaud many of the aspects of the Policy and also offer concerns, questions and suggestions.

We commend many features of the Plan:

- Warm hand-offs for high need members
- Continuity of prior authorizations for 90 days in transition
- Creation of a PHP PA resource page
- Paying claims for first 60 after launch (or end of episode of care) at in-provider rates to Medicaid eligible out of network providers
- Clarity on requirement that Standard Plans are to provide behavioral health or I/DD services subject to EPSDT that are typically offered only by Tailored Plans to children under age 21 who require a service

We also have questions, concerns and suggestions.

Reduce barriers for care of newborns: The current NCDHHS policy is that newborns are assigned to their mother’s Plan, regardless of whether the hospital or any pediatricians in the community take that Plan. We continue to urge changing the newborn policy to more of “no wrong door” approach similar to Tricare. Regardless, clarity is needed for how these transitions will happen (For example, how Plans pay and transition newborns is not covered in PHP Transition of Care Policy Content on page 4.)
Support the medical home: The transition steps seem to assume that a patient will transition from the medical home when transitioning Plans. Some transitions will be due to moving, etc. but there could well be scenarios where a patient is moving Plans but wants to keep their same medical home (for example, someone who needs a subspecialist not in PHP A). Also, if a provider is terminated from a PHP’s network but is still a licensed provider, then the patient should have the option of staying with the provider and changing Plans. This could be especially important for concerns about equity in terms of race, gender or other factors. The Transitional Care Managed section talks about sharing information between Plans when a patient moves clinical settings. Information should also be shared with providers, especially the medical home. Fostering the continued connection of patient and medical home should be threaded throughout the Policy. (Examples where this could be improved include page 4 - #8; page 6 #1, page 7, F etc.)

Consider moving as a reason people may change provider or Plan: The scenarios in Transition of Care Requirements with Change of Providers seems focus on developing a Plan for when care changes (such as discharge from a high level clinical setting). Some people may change provider because they move. Moving can be a time of vulnerability, especially for children. We urge that Plans offer supports to families in this circumstance, such as helping to link them with an appropriate provider for primary care when they change locations and assuring access to key prescription medications.

Include foster care as a risk factor: Factors for identifying members at-risk of poor outcomes is detailed on page 8 (#4). We urge inclusion of history of foster care as a risk factor.

Encourage aligning of policies across PHPs: From the practice perspective, the Transition of Care Policy will create new contractual obligations that were not part of the initial contracting process. We urge alignment of implementation specifics across PHPs to minimize administrative burden to practices. We also urge assuring written policies are in place prior to go-live.

Thank you for your consideration. If you need anything further from us, please let us know.

Sincerely,

Christoph R. Diasio, MD
President,
North Carolina Pediatric Society

Cc:
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