

Advanced Medical Home (AMH) Webinar Series



Transition of Care at Managed Care Launch (Crossover)

March 11, 2021 5:30-6:30pm

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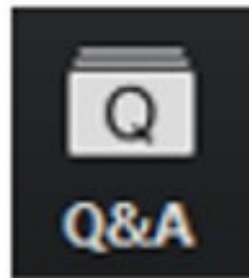
North Carolina Area Health Education Centers (NC AHEC)

**Medicaid Sponsor:
Kelly Crosbie, MSW, LCSW
Director of Quality and Population Health, NC Medicaid**

**Series Facilitator:
Hugh Tilson, JD, MPH
Director of NC AHEC**

Logistics for today's webinar

- **Chat and audio are disabled**
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Technical assistance

technicalassistanceCOVID19@gmail.com

Session #4:

Transition of Care at Managed Care Launch (Crossover)

Welcome to the AMH Webinar Series – Session #4

Today's Speakers:

Trish Farnham
Senior Health Policy Analyst
NC Medicaid

Krystal Hilton, MPH
Associate Director, Population Health
NC Medicaid

Vorinda Guillory, MHA
Program Manager, Population Health
NC Medicaid

Garrick Prokos, MPP
Project Manager, Population Health
Accenture

Gwendolyn Sherrod, M.B.A., M.H.A.
Program Manager – Population Health
NC Medicaid

**Dr. Shannon Dowler,
MD, FAAFP, CPE
Chief Medical Officer,
Division of Health
Benefits**

Today's webinar will:

- 1 Provide an overview of Transition of Care**
- 2 Discuss what AMH practices can expect during the Transition of Care “Crossover” period at Medicaid Managed Care Launch**

Transition of Care Overview

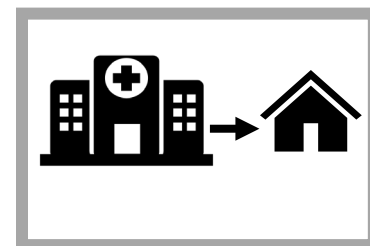
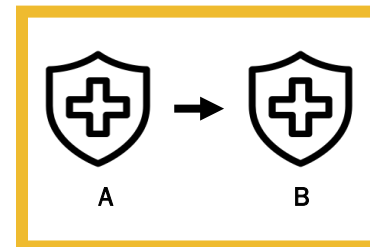
A Note on Terminology

“Transition of Care,” “Care Transitions” and “Transitional Care Management” all have distinct meanings.

- “**Transition of Care**” refers to the process in which beneficiaries’ healthcare coverage moves between delivery systems (e.g. FFS to managed care) or between health plans.



- “**Care transitions**” refers to changes in beneficiaries’ care settings (e.g. inpatient to community-based setting). Expectations for AMHs surrounding **transitional care management (care management during care transitions)** have already been defined in the AMH Tier 3 requirements and are also reflected in the ToC Policy document.



See AMH [Provider Manual 2.0](#) . See also the [AMH Training Page](#) for more information on Transitional Care Management in AMH Tier 3.

Transition of Care: Two Distinct Phases



Today's Focus

Crossover to MCL
Transition of Care

One time crossover of beneficiaries eligible for NC Medicaid Managed Care on “Managed Care Implementation” date (July 1, 2021)

Ongoing Transition
of Care

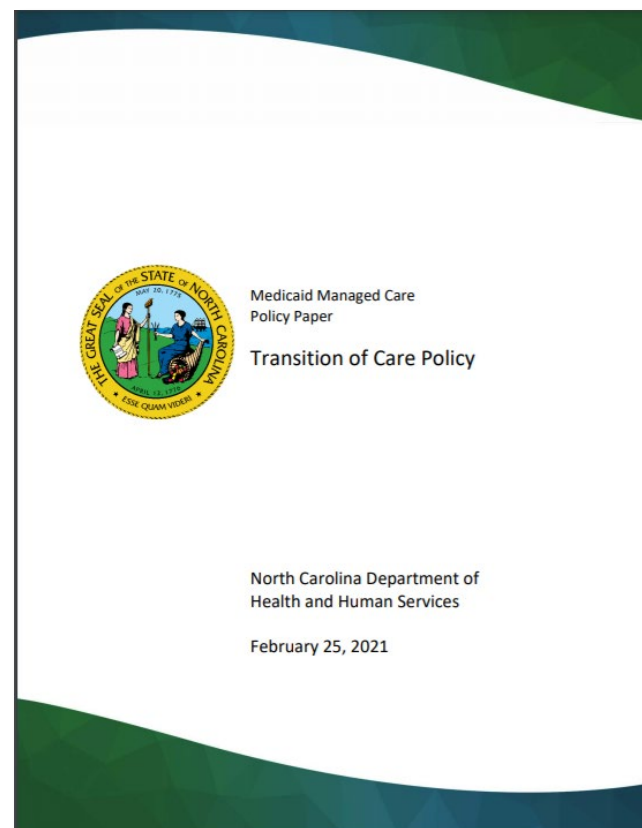
Ongoing transition of care for beneficiaries moving between PHPs, between PHPs and Medicaid Direct.

What is Transition of Care (ToC)?

As beneficiaries move between delivery systems, including between health plans, the Department intends to maintain continuity of care for each Member and minimize the burden on providers during the transition.

On February 25th, the Department published its finalized **Transition of Care Policy**, which includes:

- Data that health plans must share when a Member transitions into or out of a health plan
- Timelines for sharing required data
- Additional requirement for the transition of care-managed Members, or members transitioning to NC Medicaid Direct or Tribal Option
- Requirements for transitions that entail a change of providers (e.g. provider is no longer part of health plan network)



The Policy is available at <https://files.nc.gov/ncdma/documents/Transformation/caremanagement/NCDHHS-Transition-of-Care-Policy-20210225.pdf>

The NC Transition of Care “Tridge”

The NC Transition of Care Policy has been established to guide transitions between Plans and Service Delivery Systems.

Health Plan 1



Health Plan 2

**Medicaid
Direct/Tribal/LME-
MCO**

- Enrolling
- Disenrolling
- Tailored Plan eligible

Transition of Care Design

Driving Design Priorities



Facilitating Uninterrupted Service Coverage



Supporting Continuity of Care through Data Transfer



Clear and Organized Communication Between Entities



Establishing Additional Safeguards for High Need Members



Member and Provider Education



Resulting In

Continuity of care protections related to service authorizations and provider continuity.

Automated data transfer of prior authorizations, claims/encounter data and pharmacy lock-in data.

Communication protocols between health plans and with LME/MCOs, CCNC and other entities engaged with the transition.

Rapid follow up at Launch, warm handoffs between entities and transfer of additional Member information.

Transition of care-specific educational materials, webinars and call center scripting.

**What Should AMH Practices Expect
at “Crossover”?**

What does ToC Mean for AMH Practices at Managed Care Launch?

The period immediately before and after Managed Care Launch is called “Crossover.”

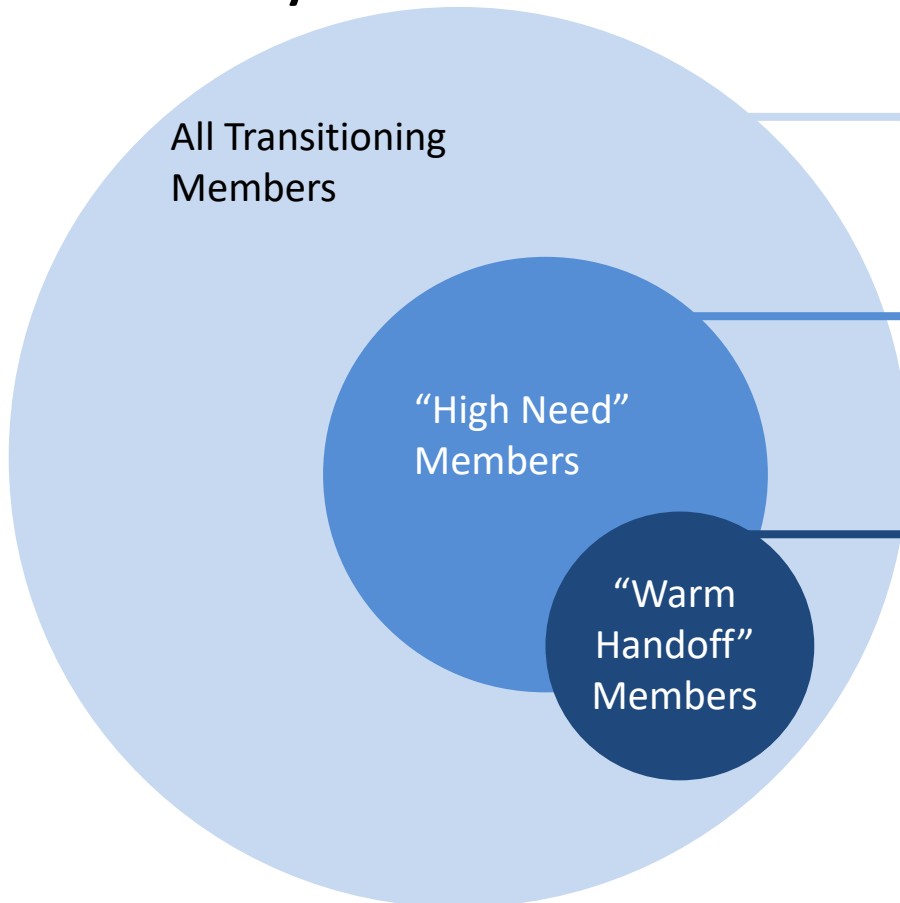
Tier 1 and 2 Practices: AMH Tiers 1 and 2 will gain access to beneficiary assignment from each Health Plan via list or provider portal.

AMH Tier 3 Practices/CINs/Other Partners:

- AMH Tier 3 practices will receive additional information to help them effectively manage care for their assigned beneficiaries (see next slides)
- Health Plans must start sharing applicable files with AMH Tier 3 practices by 7 days after Managed Care Launch and may share them up to 30 days earlier.

Safeguarding Beneficiary Services Through Crossover

Crossover Activities Customized Based on Service History, Vulnerability



All Transitioning Members:

Data Transfer:

- Claims
- Prior Authorization
- Pharmacy Lock In Data
- Care Plans or Assessments, if relevant

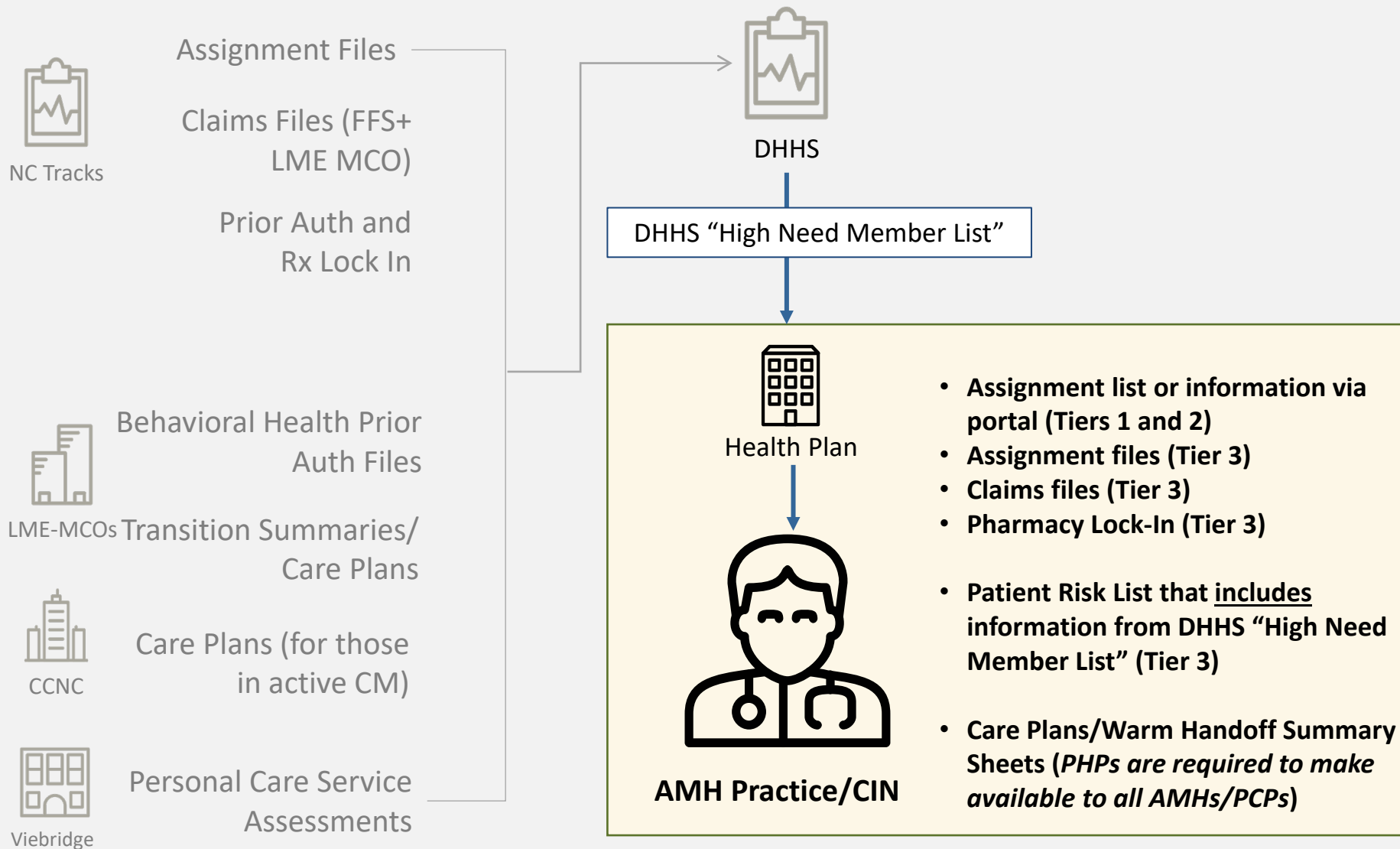
“High Need” Members:

- High Need Members are transitioning Members whose service history indicates vulnerability to service disruption
- **This group is identified on DHHS “High Need Member List”**

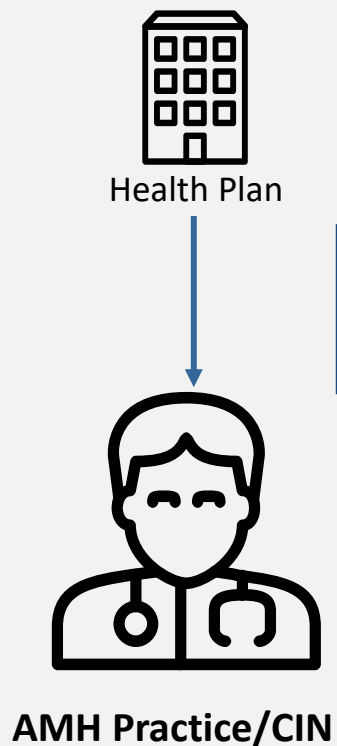
“Warm Handoff” Members (<2000 Members):

- High Need Members who have been identified by Medicaid Direct “transition entities” (CCNC/LME-MCOs) or by the Health Plan as warranting a verbal briefing between transition entity and Health Plan
- This group is identified on the DHHS “High Need Member List” and through a specific warm handoff/summary sheet process.

Data Flows to AMH Practices at Crossover: Summary



Assignment, Claims and Pharmacy Lock- in Files



No later than 7 business days after Managed Care Launch, Health Plans must share:

Tier 1 and 2:

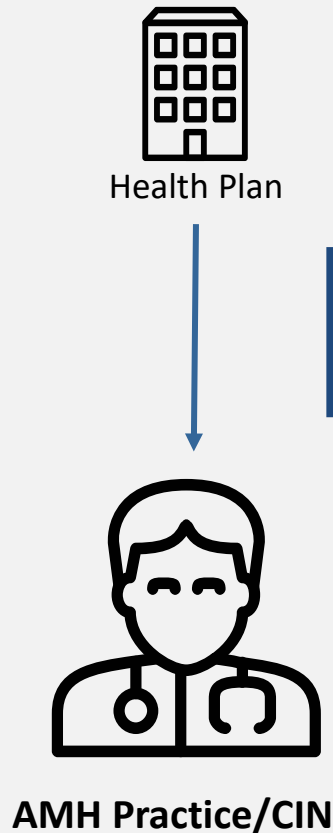
- Assignment information, via list or portal

Tier 3 and CINs:

- Assignment files in DHHS standard format
- Claims files in DHHS standard format
- Pharmacy lock-in in DHHS standard format

Please refer to the [AMH Data Specification Guidance website](#) for standard file formats.

Patient Risk List (Tier 3)



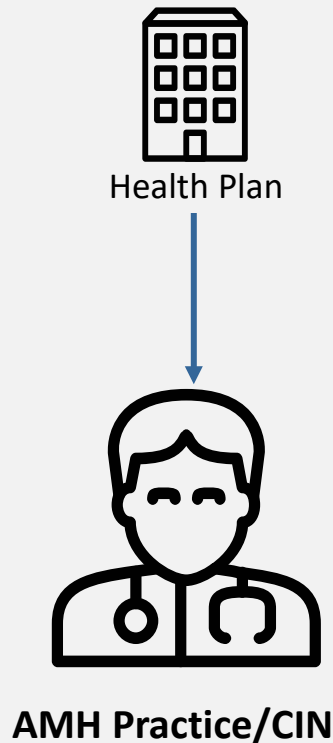
First Few Patient Risk Lists sent to AMH Tier 3s will include:

- Member names/IDs
- **DHHS-identified “High Need” Members (including “Warm Handoff” Members)**
- Any risk scoring/stratification performed by the Plan prior to launch

- Plans must share Risk Lists in accordance with DHHS’s Data Specification Guidance.
- Risk lists will be sent weekly for the first 8 weeks* after MCL and then will move to monthly.

Please refer to the [AMH Data Specification Guidance website](#) for standard file formats. Weekly transfer cadence at Crossover will be reflected in revised Requirements document.

Care Plans and Warm Handoff Summary Sheets (All AMHs and PCPs)



Care Plans and Warm Handoff Summary Sheets:

- For Members in active care management with CCNC , Health Plans will receive the Care Plans.
 - For Members identified for a Warm Handoff by the LME/MCO, Health Plans will receive a “Warm Handoff Summary Sheet”
 - ~1500 statewide transitioning from LME MCOs
 - ~250 statewide transitioning from CCNC
- PHP Contract requirement: *“The PHP shall ensure that each Care Plan is documented and stored and made available to the Member and care team members, including the Member’s AMH/PCP.”*

[Standard Plan Contract](#), p. 178.

Following up with High-Need Members

The ToC Policy requires targeted follow up with High Need Members as defined by the Department and additional members as identified by the PHP.

The ToC Policy requires Health Plans to:

- Make direct contact with the identified Member/authorized representative to:
 - Confirm continuity of services;
 - Provide Health Plan contact information directly to Member/authorized representative;
 - Address any Crossover-related issues the Member may be experiencing.
- Prioritize follow up activity with High Need Members based on urgency of need; strive to conduct follow up with all identified High Need Members **no later than three weeks following Managed Care Launch.**

Role of AMH Tier 3s/CINs/Other Partners:

- Some Health Plans plan to delegate some or all outreach to the “Transitioning+ High Risk” group to AMH Tier 3s, for their assigned Member population.
- **DHHS Recommendation: For additional information on specific health plan strategy, please discuss division of responsibility with your contracted Health Plans prior to launch.**

Supporting High Need Members through Transition to Managed Care

Meet Jo



Jo is a 45 year-old Medicaid Beneficiary who has been determined to have a disability but does not yet qualify for Medicare. Jo has been auto assigned to Health Plan 1 but hasn't opened her mail in weeks. Jo receives over 80 hours of personal care services a month, depending on aides to assist with many ADLs.

Jo has also been recently hospitalized for COVID-19, though she is back home now. CCNC currently provides care management to Jo and has been closely engaged with her after the discharge. She is considered clinically stable.

Prior to MC Launch

- Because of Jo's specific LTSS service use, DHHS identifies her as "High Need" and sends her name/information to her health plan as "high need beneficiary" list.
- Because Jo is clinically stable, CCNC has **not** identified her for a "warm handoff" though her health plan could still request one.



At MC Launch

- Jo's Health Plan will expect Jo's Tier 3 practice to do High-Need follow ups at Crossover.
- Jo's AMH Tier 3 practice receives the risk list from the health plan, which indicates that Jo is "Transitioning + High Risk"
- The AMH contacts Jo to ensure Personal Care Services and key services have remained in place upon transition, troubleshooting as necessary.
- AMH reports contact achieved on its first Care Management Report.

Next Steps and Additional Information

On February 26th, the Department published the Transition of Care policy. Information on the TOC policy is available at:

<https://medicaid.ncdhhs.gov/blog/2021/02/26/transition-care-policy-prepaid-health-plans-under-standard-plan-option-released>

On February 26th, Department released the updated AMH Provider Manual 2.0. The Manual is available at:

<https://medicaid.ncdhhs.gov/blog/2021/02/26/advanced-medical-home-provider-manual-20-released>

On March 8, 2021, the Department published updated guidance on the AMH Tier 3 glidepath payments. Guidance is available at:

<https://medicaid.ncdhhs.gov/blog/2021/03/08/advanced-medical-home-tier-3-%E2%80%9Cglidepath%E2%80%9D-payments-update>

Glidepath attestation is now available on NC Tracks. Eligible practices that are interested in receiving glidepath payments starting in April should complete attestation by 5:00 PM ET on March 30, 2021.

AMH Upcoming Items

- Ongoing TOC – AMH TAG – March 23, 2021 – 2:00 -3:30 pm
 - <https://medicaid.ncdhhs.gov/transformation/advanced-medical-home/advanced-medical-home-technical-advisory-group>
- Ongoing TOC – AMH AHEC Webinar – April 8, 2021, 5:30 pm
 - Registration via AHEC website: <https://www.ncahec.net/practice-support/advanced-medical-home/>

Q & A

- Enter questions using the Q&A function within Zoom Webinar
- Send additional questions to:
Vorinda.Guillory@dhhs.nc.gov
- Upcoming: Any questions not addressed during the webinar will be added to the FAQs for publication on the [AMH Training Webpage](#)