# Advanced Medical Home (AMH) Technical Advisory Group (TAG)

***Meeting #:11***

- ***Transition of Care***
- ***Assignment Updates***

***February 23, 2021***

# Agenda

1. Welcome and Roll Call (5 minutes)
2. Transition of Care at Managed Care go Live (“Crossover”) (30 minutes)
3. Assignment Updates (20 minutes)
4. Wrap-up and Next Steps (5 minutes)

# AMH TAG Membership Introductions and Rollcall

| Name | Organization | Stakeholder |
|---|---|---|
| **C. Marston Crawford, MD, MBA** | Pediatrician<br>Coastal Children's Clinic – New Bern, Coastal Children's | Provider (Independent) |
| **David Rinehart, MD** | President-Elect of NC Family Physicians<br>North Carolina Academy of Family Physicians | Provider (Independent) |
| **Rick Bunio, MD** | Executive Clinical Director,<br>Cherokee Indian Hospital | Provider |
| **Gregory Adams, MD** | Member of CCPN Board of Managers<br>Community Care Physician Network (CCPN) | Provider (CIN) |
| **Ruth Krystopolski, MBA** | Senior Vice President of Population Health<br>Atrium Health | Provider (CIN) |
| **Amy Russell, MD** | Medical Director<br>Mission Health Partners | Provider (CIN) |
| **Kristen Dubay, MPP** | Director<br>Carolina Medical Home Network | Provider (CIN) |
| **Joy Key, MBA** | Director of Provider Services<br>Emtiro Health | Provider (CIN) |
| **Tara Kinard, RN, MSN, MBA, CCM, CENP** | Associate Chief Nursing Officer<br>Duke Population Health Management Office | Provider (CIN) |
| **George Cheely, MD, MBA** | Chief Medical Officer<br>AmeriHealth Caritas North Carolina, Inc. | Health Plan |
| **Michael Ogden, MD** | Chief Medical Officer<br>Blue Cross and Blue Shield of North Carolina | Health Plan |
| **Michelle Bucknor, MD, MBA** | Chief Medical Officer<br>UnitedHealthcare of North Carolina, Inc. | Health Plan |
| **Thomas Newton, MD** | Medical Director<br>WellCare of North Carolina, Inc. | Health Plan |
| **William Lawrence, MD** | Chief Medical Officer<br>Carolina Complete Health, Inc. | Health Plan |
| **Jason Foltz, DO** | Medical Director, ECU Physicians<br>MCAC Quality Committee Member | MCAC Quality Committee Member |

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# Transition of Care (ToC)

*As beneficiaries move between delivery systems, including between health plans, the Department of Health and Human Services (Department or DHHS) intends to* ***maintain continuity of care for each Member and minimize the burden on providers*** *during the transition.*

# The NC Transition of Care "Tridge"

**The NC Transition of Care processes were 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

"Tridge" in Midland, Michigan: https://www.kuriositas.com/2012/01/tridge-michigans-three-way-bridge.html

# NC DHHS Transition of Care (ToC) Policy: 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

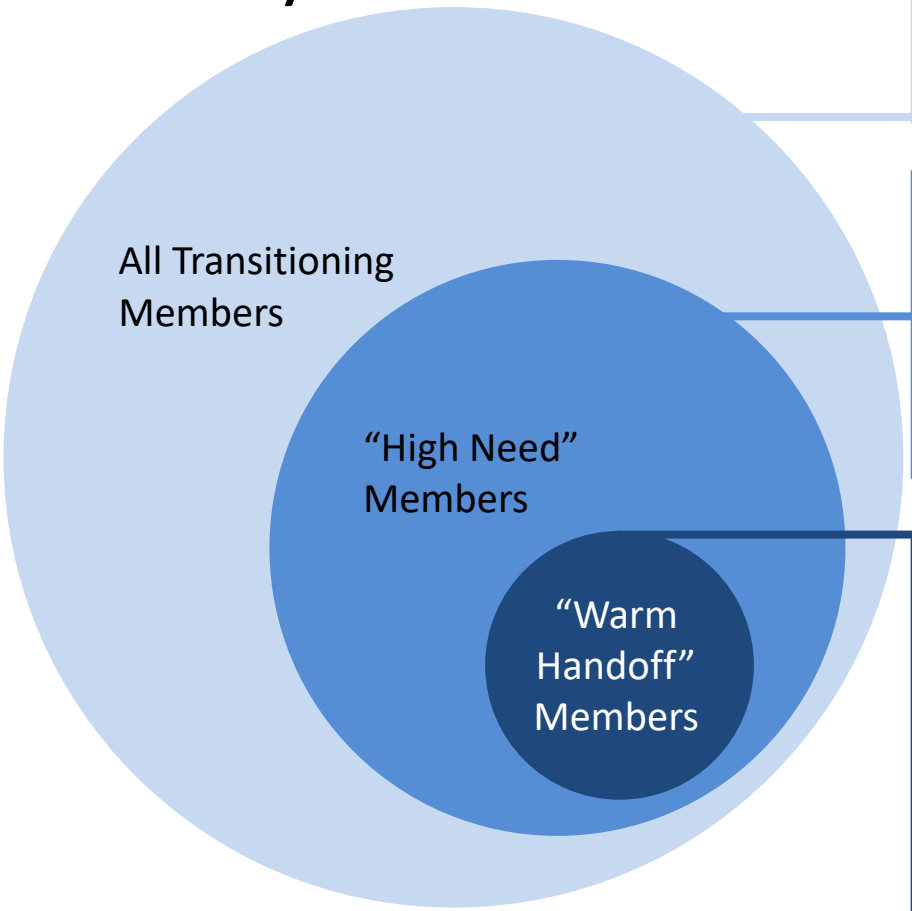
# What does ToC Mean for AMH Practices at Managed Care Launch?

**The period immediately before and after Managed Care Launch is called "Crossover."**

- **Today we will give a preview of Crossover, including what AMHs should expect, before we message the Policies to AMHs more broadly.**
- **Health Plans must start sharing information on assigned Members with AMH Tier 3 practices/CINs by 7 days after Managed Care Launch and may share information 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

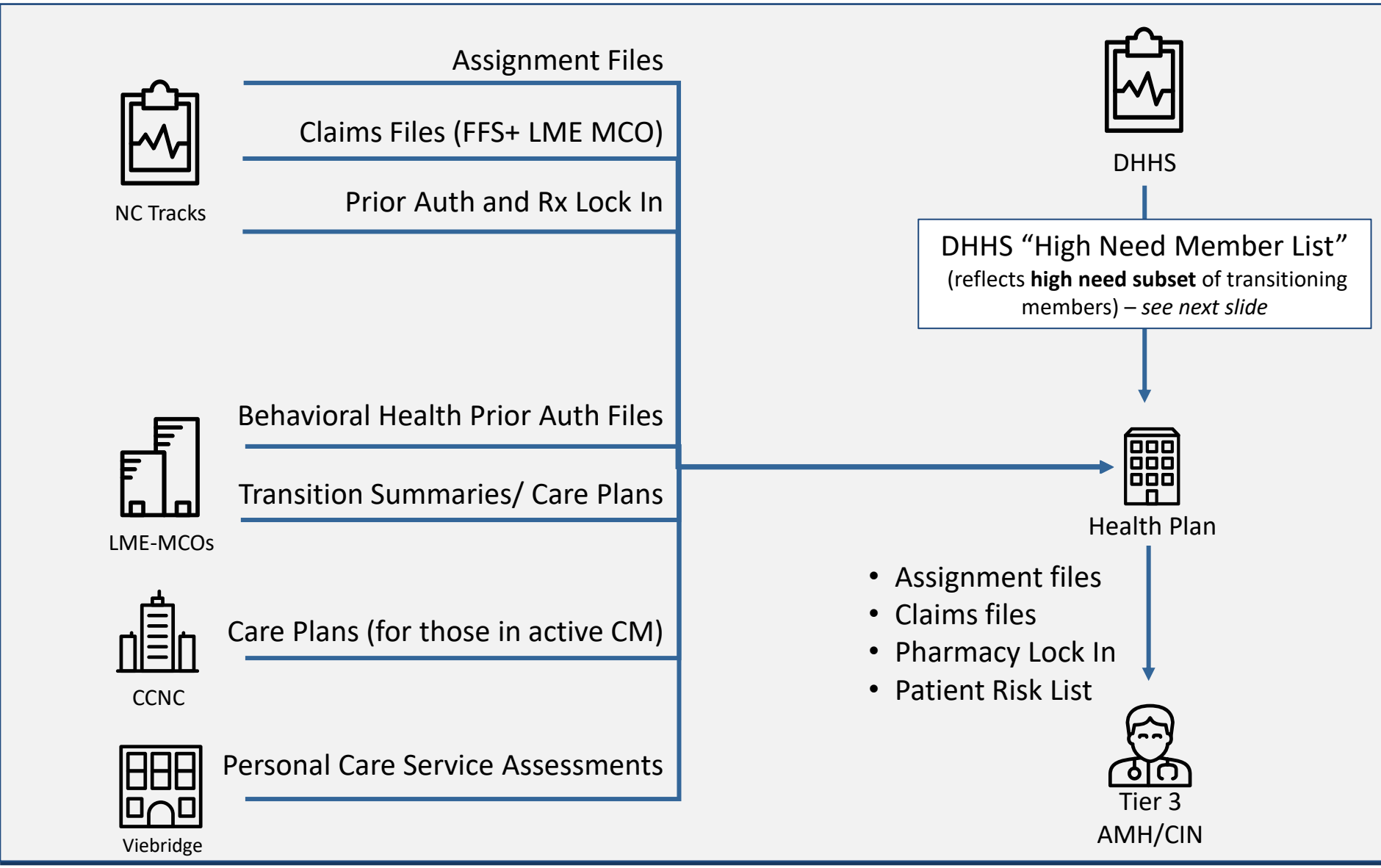
## "High Need" Members:

- 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:

- 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.

# Protections for All Members: Data Flows at Crossover



# Additional Safeguards for High Need Transitioning Members

- **"High Need Transitioning Members" are beneficiaries requiring time-sensitive, Member-specific follow up by Health Plans during Crossover.**
- **DHHS will send Health Plans a list of these High Need Beneficiaries twice in June.**

## High Need Members Include:

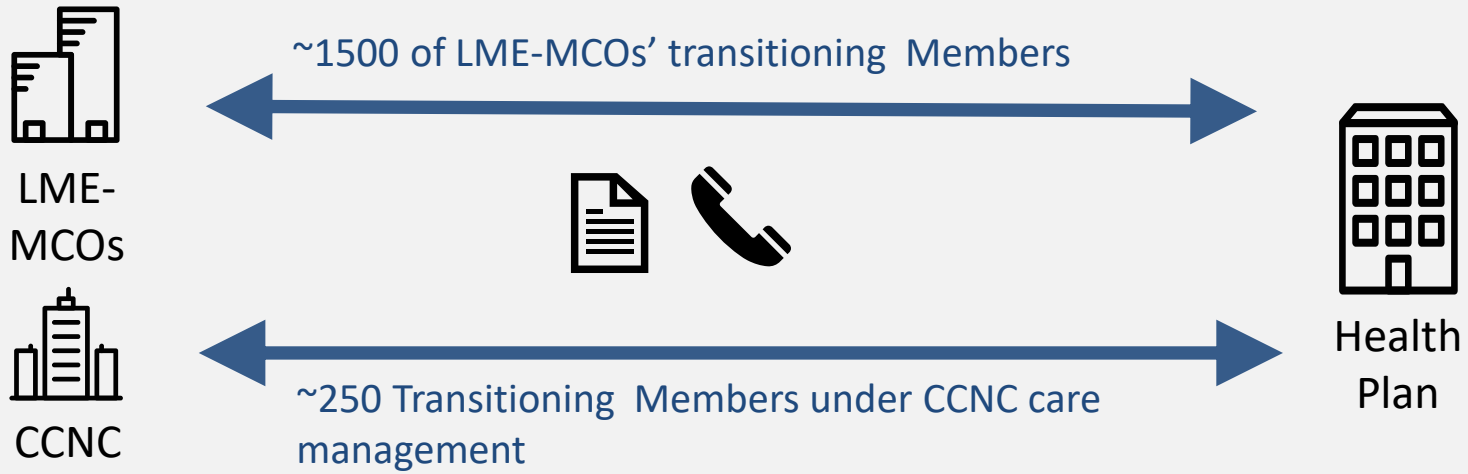
- Members receiving in-home LTSS;
- Members receiving crisis behavioral health services within 6 months of Managed Care Launch;
- Members with Inborn Errors of Metabolism;
- Members identified by CCNC, an LME-MCO, or the Department who have complex treatment circumstances or multiple service interventions and require a Warm Handoff;
- Members who are experiencing a care transition from a High Level Clinical Setting;
- Identified Standard Plan exempt members who elected to enroll in Standard Plan;
- Members authorized for transplantation;
- Members authorized for out of state services;
- Other high need Members or group of Members identified by the Department or the Health Plan.

## Required Follow Up

- 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.
- Health Plans must prioritize follow up activity with High Need Members based on urgency of need but should strive to conduct follow up with all identified High Need Members **no later than three weeks following Managed Care Launch.**

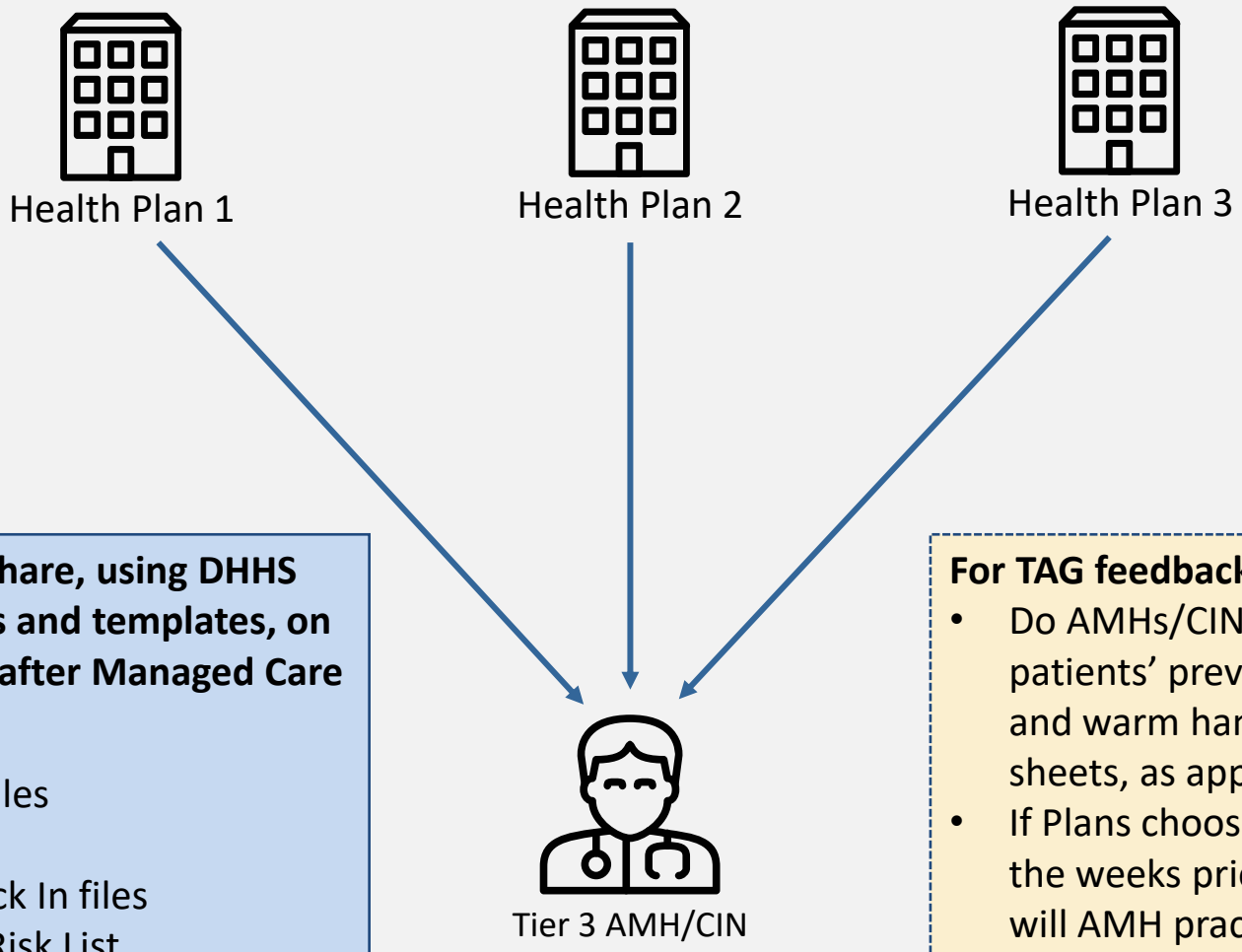
# "Warm Handoffs"

**"Warm Handoff" Members are a <u>subset</u> of the High Need Member Group who have complex treatment circumstances or multiple service interventions and thus require a verbal briefing between "transition entity" and the Health Plan.**




- A Warm Handoff is a Member-specific meeting/knowledge transfer session. The transitioning entity creates a two-page "warm handoff summary sheet."
- Members requiring a Warm Handoff at Crossover may be identified by either the transferring entity or the Health Plan (if the Health Plan has identified Members through stratification).

# What AMH Tier 3 Practices Should Expect at Crossover




**Each Plan must share, using DHHS standard formats and templates, on or before 7 days after Managed Care Effective Date:**

- Assignment files
- Claims files
- Pharmacy Lock In files
- First Patient Risk List

**For TAG feedback:**

- Do AMHs/CINs want to receive patients' previous Care Plans and warm handoff summary sheets, as applicable?
- If Plans choose to share data in the weeks prior to launch, what will AMH practices do with the data?

# What AMH Tier 3 Practices Should Expect from the First monthly Patient Risk List

**The Patient Risk Lists shared by the PHPs with AMH Tier 3s at Crossover will reflect the ToC data shared with the PHPs by DHHS, CCNC, LME-MCOs and Viebridge.**

## Patient Risk List will contain Members to be care managed by the AMH Tier 3, including:

- DHHS-identified High Need Members
- Warm handoff Members (from CCNC and LME-MCOs)
- Any of the Plan's own stratification performed prior to Launch

**Patient Risk List must follow DHHS Data Specification Guidance for Risk Lists. These members will be flagged as "Transitioning + High Risk" on the Risk List.**

## AMH Tier 3 Actions:

- Ingest Risk List into care management system
- **Reach out to flagged High Need "Transitioning + High Risk" Members within 3 weeks, if PHP delegates initial outreach to AMH**
- Complete first Risk List report (due back to Health Plans weekly, for first 8 weeks after 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 his 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

- NC Tracks sends Jo's claims history and open/recently closed PAs to her Health Plan.
- Viebridge sends Jo's most recent PCS Assessment to her PHP.
- *If Jo had any Behavioral Health Authorizations, LME-MCO would send. She doesn't, so N/A.*
- CCNC sends Jo's current care plan to PHP.
- Because of Jo's specific LTSS service use, DHHS identifies her as "High Need" and send her name/information to her PHP 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 is delegating Care Management to Jo's AMH Tier 3 and is expecting the AMH Tier 3s to do High-Need follow ups at Crossover.
- Health Plan synthesizes all of the information it has received on Jo and conducts additional risk stratification.
- Jo is reflected as "Transitioning + High Risk" on the first Patient Risk List sent to the AMH Tier 3.
- 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 weekly Risk List Report.

# Discussion Questions for Practice/CIN-based AMH TAG members

- How is your practice/CIN preparing for Crossover?
- Is your practice/CIN expecting to perform claims/encounter analysis prior to 7/1?

# For Discussion at a forthcoming TAG: Ongoing ToCs after Launch

**The Updated NC DHHS Transition of Care Policy will be published in the next few weeks.**

- Transition of Care Policy will include requirements related to:
  - Data and transition information transfer;
  - Member protections;
  - Additional safeguards for care managed members and members transitioning back to Medicaid Direct.

1. 42 C.F.R. § 438.62(b)(1), 42 C.F.R. § 438.208(b)(2)(ii)

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**Recent Practice-Facing DHHS Guidance:**

# Managing your Primary Care Patient Panel: **Prior to Managed Care Launch**

- POLICY: Carolina Access II practices agree to have Medicaid members assigned to their practice
- POLICY: Members can choose at PCP at DSS during Medicaid enrollment OR they are auto assigned to a practice.
  - Please get a copy of your current Medicaid assigned patient panel from CCNC
  - In March 2021, NCTracks Provider Portal will send make practice panel list available to each office administrator (OA)
- Members can call DSS to ask for a change in primary care. This would apply if:
  - They are seeing you but assigned to another PCP
  - They are assigned to you but seeing another PCP
  - The member wants to change for any reason
- October 27, 2020 bulletin: https://medicaid.ncdhhs.gov/blog/2020/10/27/managing-your-primary-care-assignments%C2%A0

# DHB Exploring Ways to Improve Current Assignment **Prior to Managed Care Launch**

- DHB is looking at members who are:
  - Transitioning to managed care on July 1, 2021
  - Have not seen their assigned PCP practice but ARE seeing another PCP practice
- DHB is testing ability to switch assignment prior to launch
  - Look-back at 24 months of claims
  - Likely will re-assign children and adults to the MOST recently seen PCP practice (if not their currently assigned PCP practice).
  - Members will be assigned to Carolina Access II practices as they are today
  - Timeline:  March/April 2021
  - Members will get new Medicaid cards

**Recent Practice-Facing DHHS Guidance:**

# Managing your Primary Care Patient Panel
# **AFTER Managed Care Launch**

- POLICY: Advanced Medical Homes (formerly Carolina Access II) practices agree to have Medicaid members assigned to their practice
- POLICY: Members can choose at PCP managed care open enrollment OR they are auto assigned to a primary care practice by the Standard Plan.
  - Health Plans will provide each practice with a panel list every month (AMH Tier 1, 2, 3)
  - After launch, NCTracks Provider Portal will continue send make practice panel list available to each office administrator (OA)—it will have a panel list from Medicaid Direct (FFS) AND each Health Plan
- Members can call the Health Plan to ask for a change in primary care assignment.
- This should be easy for members.
- Member can change without cause twice per year or with cause (no limit).

# Discussion Questions for Practice/CIN-based AMH TAG members

- DHHS is looking at Health Plans' policies for PCP changes and considering whether it is possible to create a "cheat sheet" for practices.
- What are the specific panel management scenarios that would be helpful to cover on 'cheat sheet' and in trainings?