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

Meeting #:11  
• Transition of Care  
• Assignment Updates  

February 23, 2021
Welcome and Roll Call (5 minutes)
Transition of Care at Managed Care go Live (“Crossover”) (30 minutes)
Assignment Updates (20 minutes)
Wrap-up and Next Steps (5 minutes)
## AMH TAG Membership Introductions and Rollcall

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<thead>
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<th>Organization</th>
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AMH TAG TAG TAG
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)
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

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

**Assignment Files**
- Claims Files (FFS+ LME MCO)
- Prior Auth and Rx Lock In

**Behavioral Health Prior Auth Files**

**Transition Summaries/ Care Plans**

**Care Plans (for those in active CM)**

**Personal Care Service Assessments**

**DHHS “High Need Member List”**
(reflects high need subset of transitioning members) – see next slide

**Health Plan**
- Assignment files
- Claims files
- Pharmacy Lock In
- Patient Risk List

**Tier 3 AMH/CIN**
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” Members are a subset 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 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

- 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?
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.

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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 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
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?