Advanced Medical Home (AMH) Webinar Series

“Ongoing” Transitions of Care

April 8, 2021 5:30-6:30 PM

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AMH Webinar Series presented in partnership by:

Quality and Population Health
Division of Health Benefits (DHB) – NC Medicaid

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 COVID-19 Forum

Question during the live webinar

Technical assistance

technicalassistanceCOVID19@gmail.com

Welcome to the AMH Webinar Series – Session #5

Today's Speakers:

- Kelly Crosbie, MSW, LCSW
  Director, Quality and Population Health
- Krystal Hilton, MPH
  Associate Director, Population Health
  NC Medicaid
- Trish Farnham
  Senior Health Policy Analyst
  NC Medicaid

Other Team Members in Attendance

- Vorinda Guillory, MHA
  Program Manager, Population Health
  NC Medicaid
- 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

PRIMARY CARE/AMH UPDATES

Panel Management—New Functionality in NCTracks

Office Administrators will get a monthly message in NC Tracks Provider Message Center with a link to a report with their Medicaid Direct (FFS) and Health Plan panels.

REPORT: PM02429-R0010 NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES PROCESS DATE: MM/DD/YYYY
PAYER: XXXXX NCTRACKS PROCESS TIME: HH:MM:SS
PAGE: XXX,XXX

AMH MEDICAID DIRECT/MANAGED CARE PCP ENROLLEE REPORT
AS OF MM/DD/YYYY

NPI/ATYPICAL ID: XXXXXXXXXX
PROVIDER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS LINE 1: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS LINE 2: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY, STATE ZIP: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

- DHB has gotten feedback on how to improve this report!
- DHB will be a publishing a 'How to Read/Use Your Enrollee Report" in an upcoming Medicaid Bulletin.

MID	RECIPIENT NAME	DOB	ACTIVE	ASSIGNMENT PROGRAM	EFF DATE	END DATE	LAST OFFICE VISIT	TOTAL VISITS
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/YYYY	Y	MED-DIR	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	XXX
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/YYYY	N	MED-MGD	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	BLANK
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/YYYY	N	MED-MGD	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	BLANK
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/YYYY	N	MED-DIR	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	BLANK

PCP Reassignment

- DHB has completed primary care reassignment for ***some*** beneficiaries

- Beneficiaries being reassigned must fall under one of this criteria :
  - Moving into managed care
  - Enrolled for 6 months in Medicaid
  - Do not have any primary care claims with their assigned PCP from 01/01/19 through 02/28/21
  - Have primary care claims with another PCP practice

- **~150,000 beneficiaries meet these criteria**

- **Beneficiary is assigned to the PCP practice with best fit (recent visit + most visits + geography)**

- Medicaid will distribute new Medicaid ID cards to affected members in April 2021

- Please visit the webpage to learn more about beneficiaries changing PCPs.

Healthy Opportunities Screening, Assessment and Referral Payment (HOSAR)

- Effective January 1, 2021, NC Medicaid and NC Health Choice is temporarily covering **Healthy Opportunities screenings** to encourage providers to gain capacity for screening Medicaid beneficiaries for unmet health-related resource needs and referring them to appropriate community-based resources, prior to the launch of Medicaid managed care.

- **Current Carolina Access (CAII) providers** are eligible to bill code **G9919** for positive healthy opportunities screenings conducted using the Department's standardized screening questions or equivalent questions. Coverage of this code will continue through June 30, 2021; continued coverage after managed care launch will be at the discretion of the Health Plans.

HOSAR Payment Issue has been identified. NCTracks issue was fixed on 3/31.

Please visit the DHHS website for more information about HOSAR

Bulletin update coming!

AMH Glidepath Attestation Is LIVE: AMH 3s can Receive $8.51 PMPM for 3 Months After Contracting with 2 health plans and Completing Data Integration Testing

Attest by April 25 for the May Payment. Providers only need to Attest once (by site).

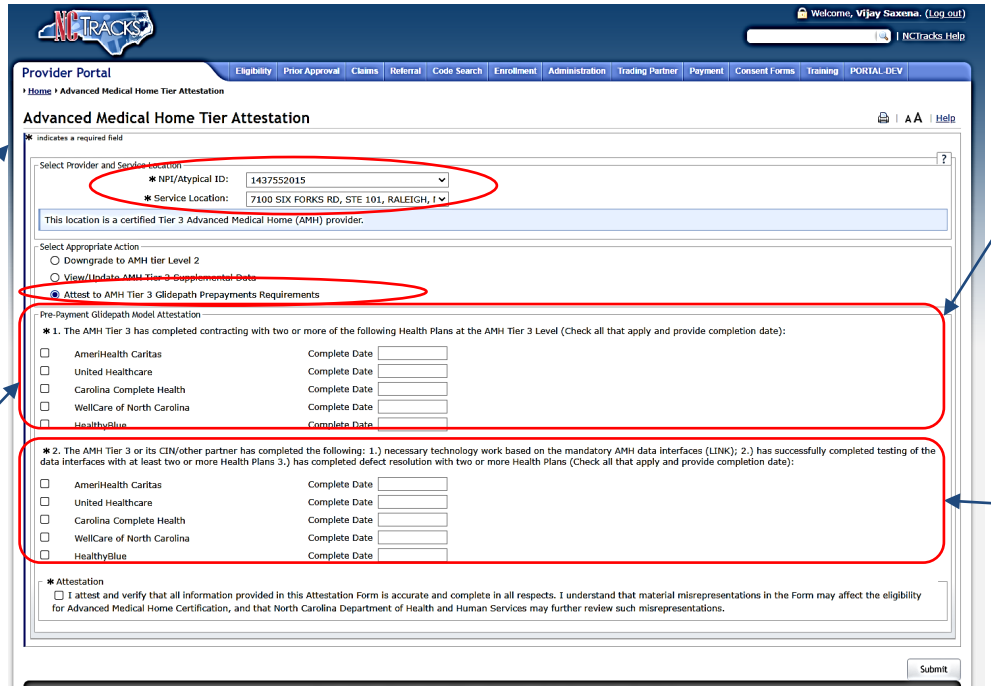
~1153 AMHs Paid for April (70% of Tier 3/members)

To Attest:

The AMH Tier 3 Glidepath Attestation is part of an updated set of AMH functionalities within the provider portal in NCTRACKS.

1. Input NPI and location for the practice attesting to glidepath requirements

2. Select "Attest to AMH Tier 3 Glidepath Payments Requirements"



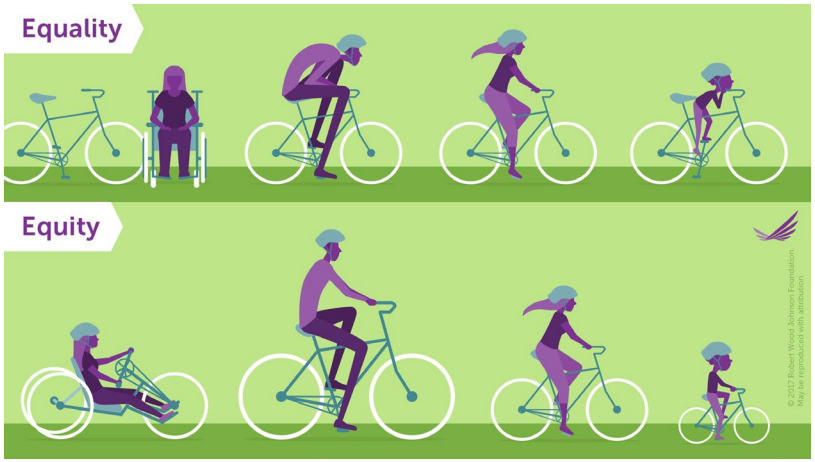
3. Practices should select the health plans they are contracted with at the Tier 3 Level and date contracts were completed

4. Practices should select the health plans they have tested with and testing completion date

Providers denied payment will get notice about reconsideration process. Reconsideration process will be published in Medicaid Bulletin.

Carolina Access Temporary Health Equity Payments

NC Medicaid's Focus on Health Equity



Source: Robert Wood Johnson Foundation:
https://www.rwjf.org/en/library/infographics/visualizing-health-equity.html#/download

Payments

- Eligible providers: Carolina Access I and II providers serving beneficiaries from high needs areas- NCTracks informing eligible providers.
- Practices will see this increased payment reflected on this month's remittance advice.
- $17M expected to be released in April's check write.

Session #5:

Ongoing Transitions of Care

Today's webinar will:

1. Define "ongoing" Transition of Care
2. Discuss what AMH practices should expect around Ongoing Transitions of Care

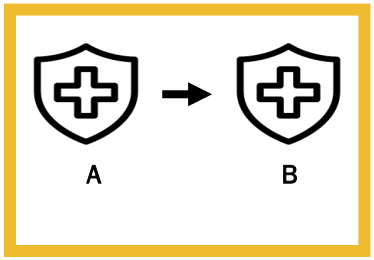
What is “Ongoing” Transition of Care?

A Reminder on Terminology

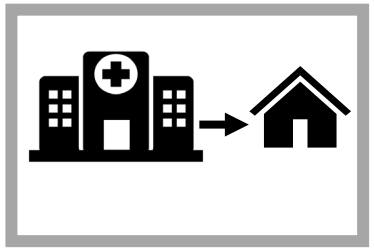
"Transition of Care," "Care Transitions" and "Transitional Care Management" all have distinct meanings.

Today's focus

"Transition of Care" refers to the process in which a beneficiary's healthcare coverage moves between service delivery systems, including between health plans. The Department has outlined Transition of Care requirements in its Transition of Care Policy.



"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

Focus of March 11 webinar: Please see NC AHEC AMH Page at: https://www.ncahec.net/practice-support/advanced-medical-home/

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)

Today's focus

Ongoing Transition of Care

Beneficiaries moving between Health Plans, or between Health Plans and Medicaid Direct.

Common Ongoing Transition of Care Scenarios: AMH Perspective

"Ongoing" transitions of care are transitions after Managed Care Launch.

1. Patient moves into or out of your AMH practice when they transition from one Medicaid Health Plan to another
2. Patient transitions from one Medicaid Health Plan to another, but stays at your AMH practice
3. Patient moves into or out of your AMH practice, with no change in Medicaid Health Plan

Key Requirements when a Member moves from one Health Plan to another, or to or from Medicaid Direct

The [Transferring] Health Plan must transfer **information necessary to ensure continuity of care**, including appropriate Transition of Care data files and member-specific socio-clinical information, to the [Receiving] Health Plan.

- The [transferring] Health Plan shall facilitate transfer of Member's claims/encounter history, and Prior Authorization data
- Member-specific socio-clinical information is also referred to as the Member's **transition file**,* which (at minimum) will include:
  - Member's most recent care needs screening (CNS)
  - Member's most recent care plan
  - List of open adverse benefit determination notices for which the appeal timeframe has not yet expired, and status of open appeals
  - A transition of Care Summary Page for Members identified for a Warm Handoff

These requirements apply at the Plan level.

*See second bullet on next slide

For more information, see pages 2-4 of the Transition of Care Policy

Requirement for Health Plans to share information with AMH Tier 3 Practices upon Transition

- Upon receipt of the relevant information, the Member's new Health Plan shall ensure that all data as defined by the Department, once received, are transferred to the Member's Advanced Medical Home Tier 3 or CIN up to 30 calendar days prior the effective date and no later than 7 business days of the effective date of the PHP's assignment of the Member.

- The State intends to operationalize the practice of transferring a transitioning member's care plan and transition file between AMH Tier 3s. Sharing care plans of transitioning members helps ensure the receiving care management entity is informed on the goals, priorities and history of transitioning care managed member. Based on feedback received from the AMH TAG and Health Plans, the State is examining the timeline for implementing the systematic transfer requirement.

What does DHHS require the Health Plan to transmit when a new member is assigned to my practice?

DHHS requires Health Plans to share the following information up to 30 calendar days prior to the transition date and no later than 7 business days after the transition effective date.

Files/Information	Receiving practice is AMH Tier 3	Receiving practice is AMH Tier 1 or 2
Most recent Care Needs Screening	X	X
Transition File (includes Care Plan, warm hand off summary)*	X	
Claims and encounter history	X	
Pharmacy Lock In (if applicable)	X	
Beneficiary Assignment File	X	
Patient Risk List (if applicable)	X	
New patient included in Beneficiary Assignment Information/Panel Detail (Available through patient's Health Plan)		X

See the AMH Manual 2.0 and the AMH data specification webpage to review information about these files

*See second bullet in previous slide

What will I need to share with the Medicaid Health Plan when a patient is transitioning from that Plan to another Plan?

- **Tier 3:** When a patient assigned to your practice transitions to a new Health Plan or back to Medicaid Direct, the original Health Plan may ask you or your CIN to share the patient's care plan, even if the patient will stay with your practice.
    - *The rationale for the requirement that your practice shares the care plan is that it is an important piece of information for the new Health Plan to have, even though your practice remains responsible for care management of the patient.*
- **AMH Tier 1 and 2 practices:** You will not usually be required to share any information with the original Health Plan.

Direct Information sharing between providers

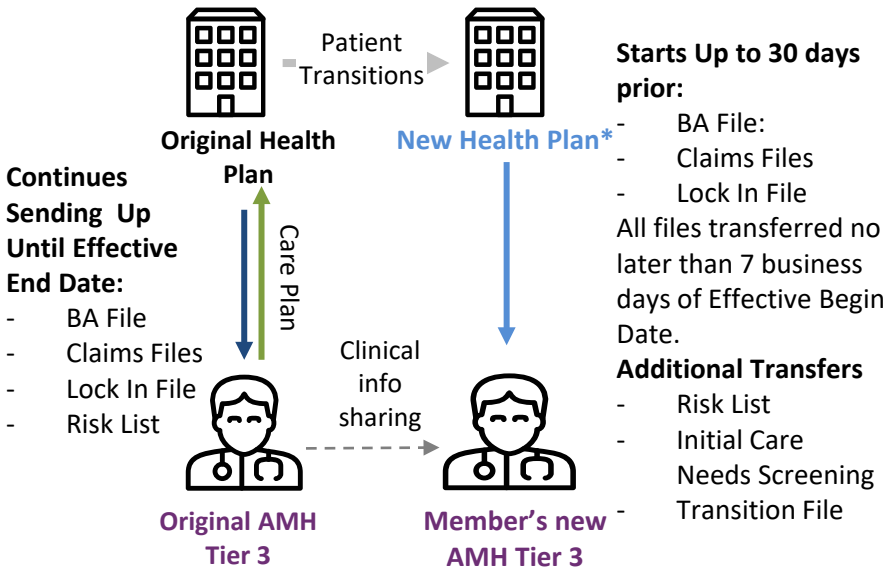
- The Transition of Care Policy is meant to enhance, rather than replace, typical clinical information sharing that occurs between providers (with patients' consent)
- If a patient switches from one AMH practice to another, the patient's old and new practices are still expected to connect to discuss the patient's needs and ensure continuity of care

Scenario 1: Patient moves into or out of your AMH practice when they transition from one Medicaid Health Plan to another

Tier 3 Scenario:

Patient moves from Health Plan 1 to Health Plan 2, and in doing so, switches from their original AMH Tier 3 to your AMH Tier 3 practice.

- **If you are the patient's "original" AMH Tier 3*:**
  - If requested by the Health Plan, you will send the patient's care plan to the patient's original Health Plan, so that it can be transferred to the new Health Plan.
  - The patient will continue to appear in the BA file, Claims, Lock In and Risk List files from the Patient's original Health Plan until the effective end date.
- **If you are the patient's "new" AMH Tier 3:**
  - You will receive the BA file, Claims, Lock-in detail for the beneficiary from the new Health Plan up to 30 calendar days prior to the start of coverage under the new Health Plan ("new effective date") and no later than within 7 business days of the effective date.
  - You will also receive patient's detail on risk list and the patient's initial CNS and transition file.
  - If the patient is identified for a Warm Handoff, you are encouraged, but not required, to join the Warm Handoff meeting.



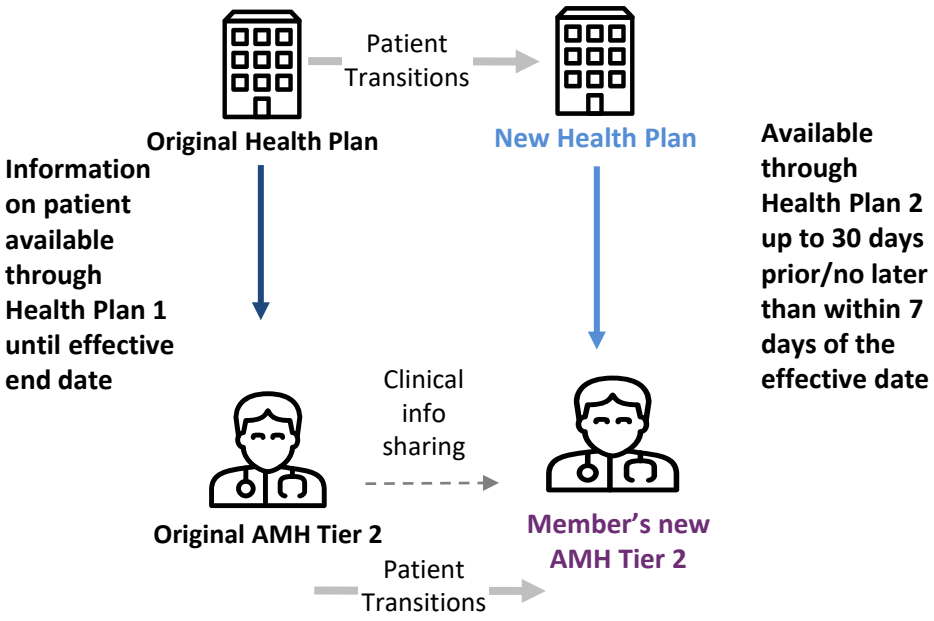
* If this patient were transitioning back to Medicaid Direct instead of another Health Plan, the expectations of the **original** AMH Tier 3 practice would be the same as depicted. The patient's data sharing with the **new** practice would now be governed by the CAII data sharing process.

See pages 6-7 of ToC Policy

Tier 1 or 2 Scenario

Patient moves from Health Plan 1 to Health Plan 2, and in doing so, switches from their original AMH to your AMH Tier 1 /Tier 2 practice.

- **If you are the patient's "original" AMH*:**
  - The patient will appear in the panel detail from the original Health Plan, and the patient's initial CNS will be available through the original Health Plan until the effective end date of the patient's enrollment with that Health Plan.
- **If you are the patient's "new" AMH:**
  - Information about the new patient will be available on the new Health Plan's panel detail up to 30 days prior to, and no later than 7 days after, the effective date.



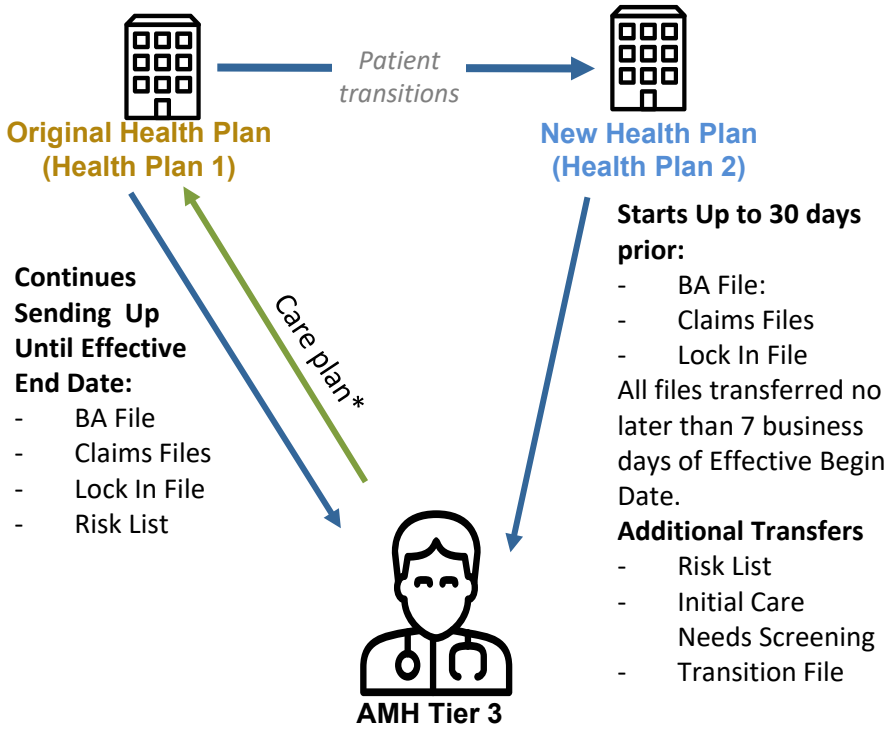
* If this patient were transitioning back to Medicaid Direct instead of another Health Plan, the expectations of the **original** AMH Tier 2 practice would be the same as depicted. The patient's data sharing with the **new** practice would now be governed by the CAII data sharing process.

Scenario 2: Patient transitions from one Medicaid Health Plan to another, but stays at your AMH practice

Tier 3 Scenario

Patient moves from Health Plan 1 to Health Plan 2, and stays with your AMH Tier 3 practice.

- Your practice will share the care plan with the patient's original Health Plan if requested.
- **Your practice will receive the same standardized information about this patient as before the transition, but now from Health Plan 2.**
- If the patient was identified for a Warm Handoff, you are encouraged, but not required, to participate in the meeting.



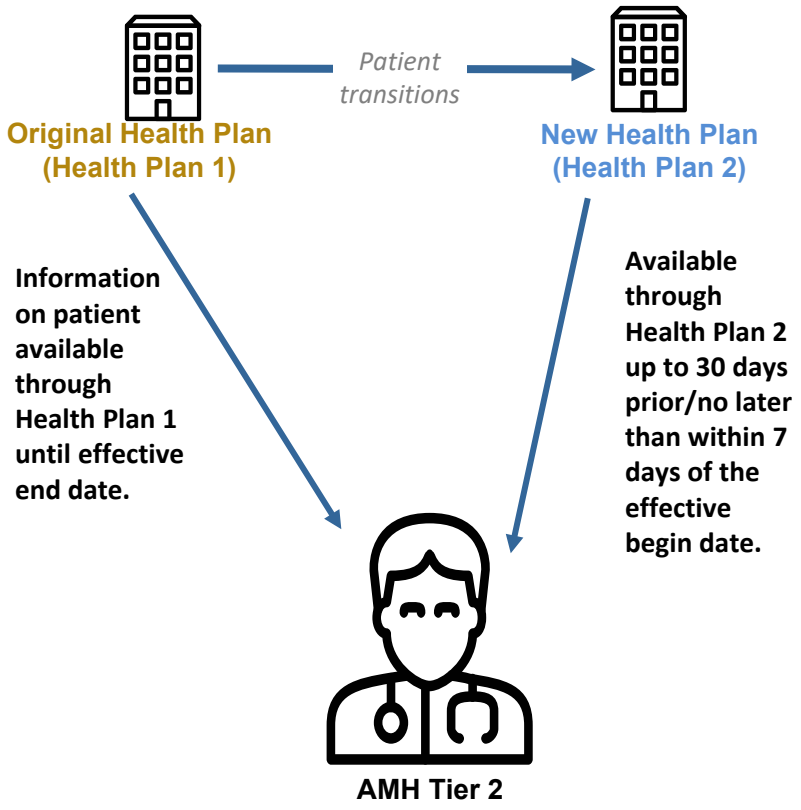
**Because care plans are an important component of the transition file that the original Health Plan will share with the new Health Plan, you should still share the care plan if requested, even if the patient will remain with your practice*

See pages 3-4 of ToC Policy

Tier 1 or 2 Scenario

**Patient moves from Health Plan 1 to Health Plan 2,
and stays with your AMH Tier 1 or 2 practice upon enrollment in Health Plan 2**

- The transitioning patient's information will continue to be available via the "original" Health Plan until the effective end date of the patient's enrollment with that Health Plan.
- After the patient transitions, the patient will appear in panel detail from the new Health Plan, and the patient's CNS will be available typically through the new Health Plan.

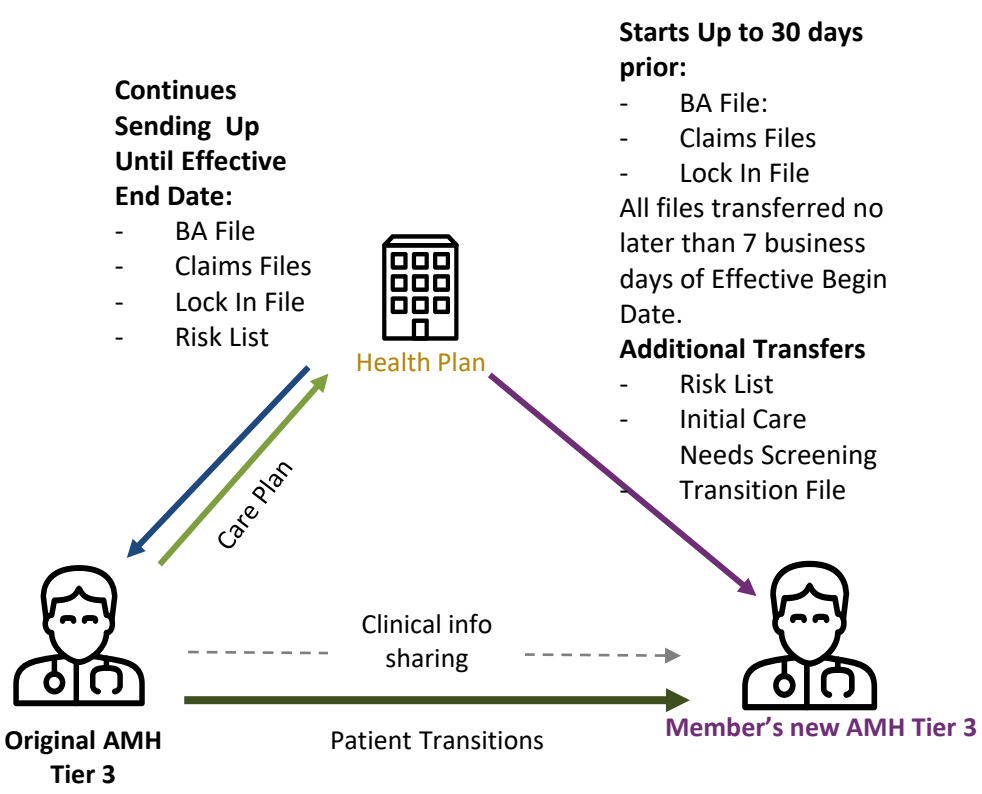


Scenario 3: Patient moves into or out of your AMH practice, with no change in Medicaid Health Plan

Tier 3 Scenario

Patient decides to change assigned PCP to or from your AMH Tier 3 practice, but remains enrolled with the same Health Plan

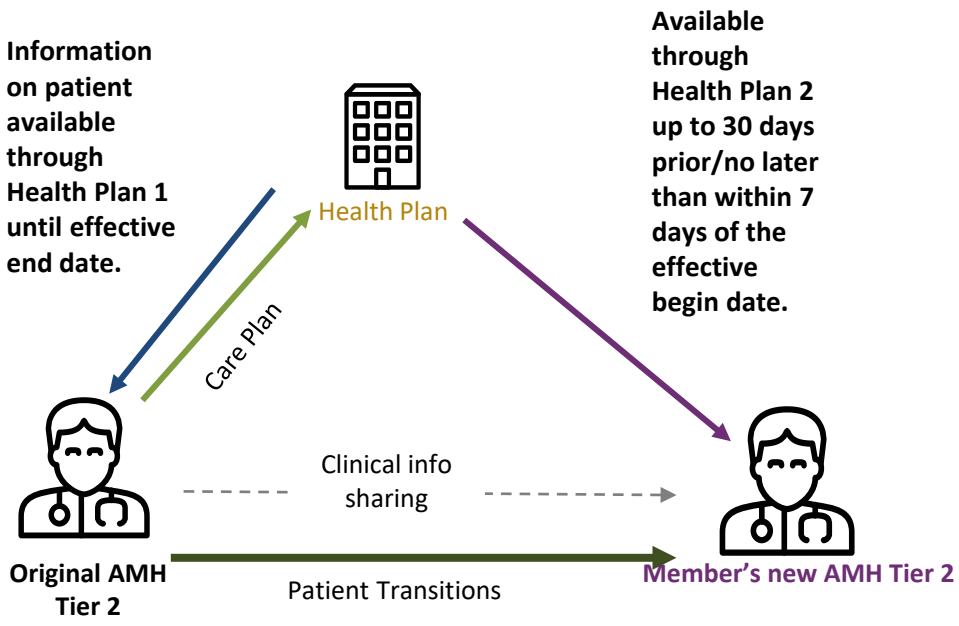
- **If you are the patient's "original" AMH Tier 3:**
  - If requested, you will send the patient's care plan to the patient's Health Plan if requested.
  - The care plan may also be shared directly through standard clinical information sharing between practices.
  - The patient will continue to appear in the BA file, Claims, Lock In and Risk List files from the patient's Health Plan until the effective end date.
- **If you are the patient's "new" AMH Tier 3:**
  - You will receive the BA file, Claims, Lock-in detail for the beneficiary from the new Health Plan up to 30 calendar days prior to the start of coverage under the new Health Plan ("new effective date") and no later than within 7 business days of the effective date.
  - You will also receive patient's detail on risk list and the patient's initial CNS and transition file.



Tier 1 or 2 Scenario

Patient decides to change assigned PCP to or from your AMH Tier 1/Tier 2 practice, but remains enrolled with the same Health Plan

- **If you are the patient's "original" AMH:**
  - The patient will be in your panel detail from the Health Plan and you will be able to access the patient's CNS through the Health Plan until the effective end date.
- **If you are the patient's "new" AMH:**
  - The patient will appear in your panel detail and you will be able to access the patient's CNS through the Health Plan up to 30 days prior to the effective begin date and no later than within 7 days of the effective date.



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**