Transcript for Advanced Medical Homes Webinar: Transition of Care at Managed Care Launch (Crossover)

March 11, 2021
5:30 - 6:30

Presenters:
Krystal Hilton
Trish Farnham
Vorinda Guillory
Garrick Prokos
Gwendolyn Sherrod

Hugh Tilson:

All right. It's 530. So let's go ahead and get started. Good evening everyone. And thank you for participating in this evening's webinar for Medicaid providers. Tonight's webinar is part of the advanced medical home AMH series of informational sessions. Put on by North of Medicaid and North Carolina AHEC to support providers during the transition to Medicaid managed care. As a reminder, we also put on the fireside chat webinars on the first and third Thursdays of the month that discuss topics, hot topics related to managed care. Tonight, we'll discuss transition of care at Medicaid managed care launch. I'm Hugh Tilson I'll moderate tonight. I'll turn it over to Krystal Hilton in just a second, but I want to first run through some logistics. If you need technical assistance with anything, please email us at technicalassistancecovid19@ gmail.com. You can adjust the proportion of speaker in slides by dragging the double grade lines between the slides and the speakers. You can also adjust the video settings to hide people who aren't speaking to do. So click on the up arrow for the pull-down menu to the right of the stop video button on the black bar on the bottom of the screen. It's like video settings and scroll down towards the bottom of the page and click the hide non-video participants box. Uh, there also, you can click on the view button at the top and click the, um,uh, panelists button. Uh, those instructions are in the Q and a for your convenience. We'll have time for questions at the end, everyone, other than the presenters is muted and the chat function is turned off. You can ask questions two ways. Uh, one is using the Q and a feature on the black bar on the bottom of the screen. Or if you're dialing in, you can send an email to questionscovid19webinar@gmail.com. We've learned past webinars at the presenters will often address your questions during their presentations. I encourage you to wait until the presenters are through their presentation before submitting a question, especially if it's something on the agenda, please know that we'll send any questions we don't get to, to Medicaid so they can respond directly to you or incorporate the questions into the FAQ or other documents or into future presentations.

The slides are available on the NC AHEC website. There's a link to them in the Q and A, or record this webinar. And we'll add that recording and a written transcript of it with these slides

on the NC AHEC website, as soon as possible, probably tomorrow morning. Now let me turn it over to Krystal.

Krystal Hilton:

Thank you. Good evening, everyone. As he said, I am Krystal Hilton, the associate director of population health for quality and population health at North Carolina, Medicaid. We are delighted that you've taken the time to join us this evening for the fourth session in our AMH webinar series, hosted by North Carolina Medicaid and AHEC tonight, we will be talking about transition of care at a pivotal moment in our managed care world, which is managed care launch. We also refer to that as crossover. Next slide. Tonight, I'll be joined by a host of colleagues who are quite skilled and adept at sharing this very, very pivotal information and our wealth of knowledge that we hope we'll be able to, um, to help prepare you, help you with any questions and help calm any fears that may have been going around transition to care in relations to managed care launch. I would ask that as I call the names, if the speakers would please just turn their cameras on for a moment so that people would be able to identify them, um, throughout the presentation, the first speaker tonight is Trish Farnham. She is the senior health policy analyst with North Carolina Medicaid, and she is one of our lead transition of care champions. So she'll be sharing a lot of tonight's information. Thank you, Trish. She's also joined tonight in the presentation by Garrick Prokos was a project manager with population health for Accenture. Additionally, we have Gwendolyn Sherrod who is a program manager with population health. Yeah. And we also have Vorinda Guillory, a program manager with population health. And usual fashion. We usually have our Medicaid sponsor, Kelly Crosbie, who is the director of population health within North Carolina, Medicaid and Dr. Shannon Dowler, who is our chief medical officer supporting us, um, on these webinars and other educational experiences. We may have a drop in. Where they were visiting us for the evening, but as of now, they're not scheduled to attend, but if you have some specific questions for them, please feel free to drop those in the email box that you shared as well.

Next slide today, specifically, we will have a discussion. Regarding the overview of transitioning care, where the presenters will walk you through the fundamentals of transitional care, provide some essential definitions and some clarity to some questions that we've already gotten, um, in relations to transitional care, the general overview. Additionally, we want to really focus on what advanced medical home practices can expect during that pivotal period. Managed care launch, right at launch, which we call crossover in regards to next slide, without further ado, I'm going to turn it over to Trish Farnham who will start us off to nice presentation with our transition of care overview.

Trish Farnham:

Hi, everyone. Let me do a quick tech check. Can somebody give me a thumbs up? They can hear me. Thank you. Awesome. Thanks. And then you can take it to the next slide. Um, thank you all for joining tonight. Um, as many people on this call and on this panel, uh, also, um, uh, feel this is a personal and a professional, uh, priority and a commitment, um, of mine. To

support folks who are particularly vulnerable through the, uh, really important and pivotal, uh, experience of transitioning between health plans. Um, and particularly as we do this, broad-scale transition on July 1st, um, as a 1.6 million Medicaid beneficiaries transition into the standard plan option.

Um, we have been working, uh, over the last several years to take the initial transition of care requirements, uh, that were first established, uh, both in, uh, federal regulation, um, and then supplemented and, uh, shaped in our, um, Standard plan RFP. And we've worked over the last several years to further refine it and advance, uh, the various goals of transition of care activity that we will talk about tonight. Um, just to level set a few things, uh, before we kind of dive into the details. Uh, the term transition of care actually has, uh, kind of multiple applications depending on the context. And so we just want to make sure folks are really clear on what we're talking about today. Um, when we say transition of care, we are following the federal, uh, the federal regulatory, uh, description, which is really the process in which beneficiaries transition between healthcare coverages and service delivery systems. So if you have experience in transitional support, the way I do, uh, we often think of transitions as supporting people between facilities or from hospital to home. And in this, in this context, those those concepts are really kind of under the definition of care transitions, which is while it's part of our, uh, overarching transition work. Um, it is not the focus of tonight's discussion. So again, our focus tonight is on, uh, the transition experience that beneficiaries will have as they transition, uh, between service delivery systems. And you can go to the next slide Nevin.

And our priority within that dynamic, um, as Krystal said, uh, is what the timeframe that we refer to as crossover. So again, uh, we all recognize that all of us will be going through a, uh, a significant transition on July 1st. And we recognize that there are safeguards and practices, uh, that really need to be, uh, time-specific to this really, really critical transitional time. And so tonight our focus will be within the transition of care. Uh, domain will be on those practices, safeguards, and the architecture, uh, that we've established to support, uh, beneficiaries and providers. But, um, the purpose of this discussion will largely be related to beneficiaries, um, through the, through the transition to the standard plan option. Next slide.

Okay. What I value, um, a lot about this entire effort and this entire endeavor is that we are really, uh, guided by a, what I would call a North star in our transition of care, uh, design and architecture. And it's a design or it's a vision that was really established at the departmental level. And it's that as beneficiaries has moved between, uh, delivery systems, including between health plans. The department wishes and intends to maintain continuity of care for each member and to minimize the burden on providers during the transition. So this serves as our consistent North star, as we design the transition of care practices that we'll start outlining tonight. In case you haven't already seen it. We do want to, uh, make a note here that, uh, the department has released its transition of care policy. Uh, we have, uh, worked, uh, from its draft form last year, uh, and have refined it and hopefully improved it, uh, to really address, uh, the transition of care dynamics that, uh, we certainly can appreciate. And that, uh, our are very informed stakeholder network have also advised on. So we appreciate, uh, all, all of the folks

who contributed to, uh, this, this first edition of our transitional care policy and it is available on our transition of care website. Next slide.

So in North Carolina and I'm sure this group is very well informed of this fact. Uh, we have, uh, a particularly, uh, I would say North Carolina specific, uh, dynamic, uh, that occurs when it comes to transition of care. And we have various legislatively, uh, mandated fault lines, um, in our transition dynamics that we have to be very, very mindful of as we build again, the architecture that supports all transition of care processes. So, um, and this, this, uh, illustration or this picture actually exists. It's a bridge in Midland, Michigan called the Tridge. Um, and to me it visually represents. Uh, the work, um, and the flows that exist, uh, for members in the North Carolina Medicaid program. So in addition to thinking through transitions, that will occur between health plans and certainly at launch, um, from Medicaid direct into the health plan, the standard plant model. We also have to be mindful that there are other service delivery options, uh, that either exist for our members or that our members, uh, because of a change in eligibility will be, um, automatically experiencing. Uh, uh, throughout that throughout, uh, throughout transitions after, after July 1st. So for example, we know that, uh, some of, um, there are legislatively, uh, carved out categories of populations such as dually eligible beneficiaries or, uh, children who are enrolled in the foster care system. And it's important that as we think through, um, a comprehensive transition of care strategy that we recognize the particular dynamics and potential vulnerabilities that these particular disenrolling populations. So, uh, in addition to thinking through, uh, the transitions that will occur, um, uh, on July 1st and after July 1st between health plans, we also have to be mindful of the dynamics that will occur as members disenroll from the standard plan option. Next slide.

With everything that we have done to advance the North star that I mentioned earlier, uh, we try very hard to, uh, to make sure that we are aligned with our, our design priorities, our transition of care design priorities, which are outlined here on the left side of the screen and those design priorities, uh, while many of them are interrelated, um, are most succinctly summarized as facilitating uninterrupted service coverage. Supporting continuity of care through data transfer, clear and organized communication between entities and ensuring those clear and organized communication pathways are well-established and we'll use. The value and the priority of establishing additional safeguards for high-need members. And finally recognizing that oftentimes members and providers, uh, empowered members and providers are the best, uh, link to success of any transition. Uh, we certainly want to advance those educational goals so that people feel empowered and have the resources and tools they need, uh, to, to assist in navigating, uh, this transition.

Next slide. So we're going to pivot and talk about how this, the crossover, the transition of care crossover dynamic really is going to effectuate or be implemented, um, between the health plans, uh, and our AMH partners. So the next several slides, we're starting to get into the technical weeds of our transition of care practices. You well, Uh, so as just to, just to kind of recap that, that last statement in case I dropped prematurely, um, the next several slides are going to be addressing, uh, the, kind of the technical dimensions of how these transition of care concepts, um, will essentially be implemented, um, through our partners, uh, within the AMH

network. And so we're about to pivot into the much more technical dimensions of this process. And as it relates to our AMHs, so. Um, we can go to the next slide.

So it's important to know that a lot of our discussion tonight will be about the data transfer priorities and some of the engagement for the high need number groups. And we just wanted to, first of all, acknowledge that there will be, uh, uh, I think, uh, robust data transfer as this group probably already well-knows. Um, for all your AMH tiers and this, uh, simply summarize those, the, the data that will become available, uh, through the transition dynamics that we're going to go through in more detail. Next slide.

Importantly we recognize that there is a lot of very, uh, variance in the experience of the 1.6 million Medicaid beneficiaries that will transition, uh, on July 1st. And in order to really, uh, calibrate, uh, the involvement in the engagement. And hopefully, be surgical in our focus on those members that are the most vulnerable, uh, we have created, um, what really kind of emerges as a concentric circle model for, um, prioritizing and identifying those members who will transition and creating the supports, uh, related to their particular, um, transition. So it's important to know that all transitioning members for all transitioning members, there will be key data feeds, uh, that, uh, come over from the Medicaid direct program, NC tracks our vendors. Um, and then the, the PHPs will then synthesize that detail and, uh, Much of that data will then flow down to our AMH partners in particularly our tier three partners. And so we'll go into some of the details of that here in a minute. Not if you can go back to the next slide. Thank you. But we also recognize that data transfer may not be alone sufficient, uh, for some of our higher, our higher need folks, while a lot of our more vulnerable populations are actually carved out of the standard plan option. It is important to know that there will be, uh, members who, uh, experienced long-term care who have experienced crisis services, who may be discharging from an acute care setting at the time of transition. Um, and we wanted to make sure we created a set of, uh, safeguards and recording detail that really supported, uh, immediate response or rapid response, uh, to those members and rapid follow-up to those members. And then finally the final subset is the dark blue box. Um, recognizing that even within, um, the transition population, uh, there is likely going to be, in addition to the data that is transferred. We recognize that as well, quality care management, sometimes verbal communication and doing knowledge transfers is really important for certain, uh, for, uh, for a much more, much smaller subset of, uh, transitioning members.

So as, uh, our, uh, partners in the Medicaid direct program, our CCNC partners and our LME MCO partners identify members who are transitioning into the standard plan option and are at particular risk, uh, because perhaps of, uh, social determinant dynamics, perhaps a loss of housing, perhaps a family dynamic, perhaps they're in the middle of a crisis of some sort. Um, we wanted to make sure that there was a vehicle for, uh, doing, um, what is now be kind of known as a clinical handoff or a clinical, uh, shift change conversation on these particular members, uh, again, to augment, um, and to hopefully reinforce the data that will also be transitioning with them. So at this point, I'm going to hand the mic, uh, and apparently the video over to, uh, my wonderful transition of care, uh, uh, technical and spiritual advisor, Garrick Prokos to take us through the data flows, GP.

Garrick Prokos:

All right. Thank you, Trish. And, uh, for the next few slides, as Trish mentioned, we're going to go into a little more detail on the data transfers that are involved in the three categories of beneficiaries that Trish just reviewed and to start with for all transitioning members. We wanted to highlight all of the data that we'll be moving from the state systems and our partners to the health plans that might be used to support the advanced medical home functions. And so. The intention here is to ensure that the health plans and AMHs have everything they need from a data standpoint, to maintain continuity of care. When a member moves from Medicaid direct to the standard plan option. So if we start on the left side of this screen here, we have a set of core transition of care data. That's going to move from the NC tracks system over to the health plans. And this includes 834 eligibility file that will tell health plans, information such as historical PCP assignment. Along with other eligibility information. Also 24 months of claims history, that's medical pharmacy, and behavioral health claims will be moving from NC tracks over to the health plans and also all approved prior authorizations with remaining time or units at the time the beneficiaries are moving to the standard plan. Option will also be sent over to the health plans. And then in the middle, you'll see that we have data at moving from the LME MCOs over to the health plans as well. And that includes behavioral health prior authorizations. Those that have, that are approved with remaining time and units and also some transition summaries and care plans for applicable beneficiaries.

Uh, and then we have vibrage and CCNC, uh, who will also be sending care plans, uh, like personal care service assessments. Over to the health plans for applicable beneficiaries. Um, and then, uh, in addition, you'll see at the top of the screen, and Trish had mentioned this in one of the previous slides. Uh, the department's also going to be generating a list of high need beneficiaries to serve as a data booster for the health plans to really identify who, who needs to be engaged at this crossover on that July 1st date. And then toward the bottom here, we're calling out directly, uh, how some of this data is going to get passed down to the advanced medical homes and for tiers one and two, the AMHs there'll be able to access assignment information, but for the tier threes in the CINs, there's a lot more moving where you have the beneficiary assignment file. Those claims history files, pharmacy lock-in, and also the patient risk list as well. And in addition care plans will be made available to providers as applicable. Go to the next slide.

So this slide goes into a little more detail on the files that the advanced medical homes will receive from the health plans. The key item is that the health plans must share with AMH tier threes, a beneficiary assignment file claims history files. Pharmacy lock-in files and the patient risk list, according to the department's defined format. And they must do this seven days at least seven days after the managed care effective date. And the expectation is that that's shared much earlier than that. And we're going to finalize that as we get closer to launch. And as mentioned before, they made two tiers, one and two, we'll also access assignment information via list or a portal with their health plan. And we go to the next slide.

So now we're going to focus on the patient risk list and what the advanced medical home to tier threes and CINs should expect in the first month of launch. And as a reminder, the patient restless is going to include beneficiary information along with a risk level designation. And it will also have additional information that's going to be passed down from your health, from the health plan to the AMH tier three. The key item that we wanted to highlight is that the risk list that the health plans send down around launch is going to include beneficiaries who are identified by the department as high need members. It could also include beneficiaries who are identified by CCNC or the LME MCOs as high need members or any other members that the health plan themselves might have identified during stratification. And we want to provide a little more information of, okay. So what are the actions that the tier threes or CINs need to take as a result of receiving this risk list? Well, one you're expected to ingest the risk list into your care management system. And two, there's an expectation that if the health plan has delegated outreach down to you all, then the tier three or CIN should be reaching out to the beneficiaries, identified as transitioning and high need beneficiaries. Okay. The expectation is also that for the eight, the first eight weeks of launch that the tier threes or CINs should be reporting engagements back to the health plans on a weekly basis during this critical time of crossover and go on to the next slide.

And so finally we moved down to the subset of high need beneficiaries who have complex treatment circumstances or multiple service interventions that require a warm handoff between a transitioning entity. So if you think about CCNC or the LME MCOs, uh, and the health plans, uh, and some of these beneficiaries that, that need a warm handoff could be identified by CCNC or LME MCO, or even a health plan during their stratification and the LME MCO and CCNC, we'll actually be sending a list to the health plans to indicate who should be a part of that member specific meeting in knowledge transfer sessions that Trish had mentioned in previous slides. And as a part of these sessions, the transitioning entity will also create a two page warm handoff summary sheet. That can be used during those activities. And so you'll see on the slide here also that we're expecting the LME MCOs to identify about 1500 beneficiaries that will need this warm handoff activity. And CCNC, we're expecting to identify around 250 of those beneficiaries. So that gives you a full, the view of all the data that's, that's moving with all beneficiaries and also the subset of beneficiaries that Trish had reviewed right before I jumped on. All right. I believe I'm handing it back to Trish for the next slide.

Trish Farnham:

So as Garrick and I have both kind of addressed at a high level, uh, we really want to make sure to underscore the importance of, uh, the risk list as it particularly relates to these high need members as Garrick noticed or noted, uh, this is essentially a kind of a data booster of some of the most, uh, potentially vulnerable folks that you all will be supporting. And so we wanted to make sure everybody's clear on this particular group of, of, of transitioning beneficiaries and what the requirements are related to, uh, supporting them. So it's important to know that our transition of care policy and the supporting contract actually, uh, set the expectation that health plans will make direct contact with, uh, these identified members and, or the authorized representative, um, at launch to confirm continuity of services. To provide the health plan,

contact information directly to a member, uh, just to make sure that they are aware of which plan they're in and kind of making sure they know who to call if there are issues. And then finally, to address any crossover related issues the member may be experiencing. So if you think about a member who is receiving personal care services or a member who has urgent EMT needs, Wanting to make sure that all of those really critical services, uh, that are essential to the members, uh, wellbeing and, uh, in order to preserve continuity of care have, have remained uninterrupted because of the transition.

Importantly, like we've said, uh, the expectation is that there is a followup with these high-need members based on the urgency of need. And, uh, we are setting the target that these members are followed up with, uh, within no later than three weeks following, uh, July 1st. And again, just to reiterate the, the phrase, uh, Garrick used in his, in his, uh, presentation, um, this serves as a bit of a booster seat, or excuse me, a data booster for, uh, those, those folks who are transitioning, um, as, as, uh, AMH tier threes and as the plans, uh, work to identify their highest need members, uh, to, in order to conduct screening and to engage in care management. As I noted before, um, uh, the AMH tier threes or as Garrick noted before the AMH tier threes, uh, may be, uh, In supporting the PHPs, our responsibility under this particular, uh, this practice. And, uh, these members will be identified on the risk list, uh, that we've alluded to before. And that also is specified in the data requirements that is on the AMH website. If you haven't already seen them, it's a maybe useful reading. Um, and these members will be identified as being in the transitioning priority population. And a high risk, um, under the risk scoring category. So, uh, these members will be, uh, flagged, uh, and, uh, in, in that particular manner, uh, when these risk lists, uh, start, uh, coming down to our AMH partners, If you have questions about how your particular, um, PHP partner is going to be implementing this particular expectation, uh, we do encourage you to talk directly to that partner, uh, to make sure, uh, that, that it's, it's, it's clear to the AMH, uh, how, how the particular plan will be implementing this particular expectation.

So I know that, uh, this group is obviously very grounded in clinical care and commitment to, uh, individual people. Um, that certainly my personal background. And I know it's the background of most folks on this call. Um, and so at the end of the day, uh, transition of care dynamics really, uh, have to, uh, work to meet the goals of our vision and really, uh, work to support a member, uh, through what can be a pretty, uh, unsettling or daunting, uh, time as we transition, uh, on July 1st. Just wanted to conclude, uh, before we kind of, uh, give you a preview of some things coming up, um, with a person specific example. And so, uh, we just, uh, wanted to paint the picture of the beneficiary here, Joe and Joe is a 45 year old Medicaid beneficiary who has been determined to have a disability, but does not yet qualify for Medicare. So she's Medicaid only, which means she will be transitioning into the standard plan option. Joe has been auto assigned to a health plan, but hasn't opened her mail in weeks. Joe receives over 80 hours of personal care services a month, depending and depending on age and depends on aid, excuse me, to assist with many of her ADL's. Joe has also been recently hospitalized for COVID though. She is back home now. And CCNC currently provides care management to Joe and has been closely engaged in her care. After discharge she's considered clinically stable. So, this is the, this is how all of the slides that we've just walked through, uh, will really play out in the, in the member specific dynamic. So prior to launch, because of Joe's specific LTSS service use, the

department will be identifying her as a high need member and we'll send her name and detail to her health plan as a high need, but on a high need beneficiary risk list, whereas a high-need beneficiary. Excuse me. Because Joe is clinically stable CCNC has not identified her for a warm handoff though for health plan wanted to, the health plan could request one with CCNC. Admin managed care launch Joe's health plan noble Joe's health plan will expect, uh, Joe's tier three practice to do high need follow-up at crossover. Again, this may be variant may vary depending on the health plan, but in this scenario, the health plan has delegated this particular follow-up responsibility to their AMH partner. And Joe Joe's AMH tier three practice receives the risk list from the health plan, which indicates that Joe is like I mentioned before in the transitioning population category and is considered a high risk for the risk score category. The AMH contacts Joe, to ensure that her personal care services and other key services. For example, like I mentioned before in EMT, other dynamics have remained in place upon the transition to managed care and then do any troubleshooting as necessary. Joe's AMH would then report that contact. Um, once it was achieved on its first, uh, care management report, that would go back up to the health plan. So this hopefully, uh, puts a little bit more of a personal, uh, dimension, uh, to how, uh, these data transfers can actually very much advance the goals of our transition of care model, um, and hopefully, uh, advance, uh, the, the personal commitment that we've all made, uh, to these Medicaid benefits. Next slide.

We're about to pivot to questions, but before we do so we wanted to highlight, uh, some, uh, hot off the press dynamics and hot off the press information, uh, that has been posted and Krystal feel free to jump in here as well. But like I mentioned earlier, uh, the department published its transition of care policy, uh, late last month. And the link is available here. And really importantly, um, and really good reading. Uh, the department also released, uh, the AMH provider manual 2.0 with, and the link is provided here. Uh, just a few days ago, the department published updated guidance on the AMH tier three Glidepath payments and those, and that link is also provided. Importantly, and I will certainly defer to Krystal if she'd like to add anything. Uh, the Glidepath attestation is now available on NC tracks. I think we've got one more slide before we open it up to questions and turn it over to Hugh.

Okay. So like we've, uh, acknowledged at the beginning of this presentation, a transition of care has a number of dimensions and a number of phases within the concept. And so we wanted to prioritize again, the crossover dimensions of transition of care tonight, but we recognize that there is additional, uh, there's additional information to be shared, uh, for what we call ongoing transition of care. And our ongoing transition of care practices. And specifically as they relate to the AMH is, uh, will be presented at the AMH tag, uh, in a couple of weeks on March 23rd, and then provided again on this webinar series as part of this webinar series on April 8th. So, um, I'm sorry to tell you, you will be seeing a lot of us over the next couple of weeks, um, and we very much appreciate your, your, um, engagement in this important topic. So I think. Can Hugh, I'm handing it back over to you.

Hugh Tilson:

Great. Thank you guys. Lots of really good information. Um, I've been watching you guys respond to all the questions that have been asked and answered. So we have a couple of them that are left. Um, as a reminder, for those of you who are on the phone, if you want to, uh, submit a question, send an email to questionscovid19webinar@gmail.com. Uh, let me just ask these questions. Um, what is the date range of the data being transferred from NC tracks to the PHPs? And as a reminder, if y'all can turn your cameras on.

Garret Prokos:

Yeah. So essentially tracks will be sending 24 months of a claims history over to the PHPs. And in addition, if you're talking about prior authorizations, there'll be sending all open and approved prior authorizations with service end dates after the managed care effective date.

Hugh Tilson:

Thank you. How soon do you anticipate this data exchange to be completed? I so that it's all in one place and available to AMHs in advance of July one.

Garrick Prokos:

Yes. So the departments is still finalizing the exact dates when all of the data will move from the state systems over to the PHPs, but the PHPs are required to share that data with the advanced medical homes no later than seven business days after the managed care effective date. And the expectation is that the data will be shared much earlier than that. As early as 30 days prior to the managed care effective date

Hugh Tilson:

Will support be available during the holiday weekend.

Trish Farnham:

Okay. That one Hugh, because I think that's a very important question. And I think it's a broad question. We are certainly, uh, in our own planning, mindful of, uh, the fact that Monday, uh, is July 5th, uh, after, after launch happens the Thursday prior, um, what I would like to do is actually hunt and gather all of the different supports that will remain available and how they will remain available on that holiday and post that. I think that's a really important question to answer comprehensively.

Hugh Tilson:

Thank you for that. Yeah. Uh, how many standard plan members are expected to be identified as high need? And did you say they needed care management outreach within three weeks after MCL banks?

Trish Farnham:

Absolutely. So we are, uh, obviously we won't know the precise number until, uh, the transition actually happens and we'll have a much more informed sense of the projection after auto assignment. At this time, we anticipate the overall population to be hovering around, uh, 5,000, um, that would then obviously be distributed and divvied up among our five health plan options. Um, and then the second part of the question, I'm so sorry. Can you repeat it? I can't see it.

Hugh Tilson:

Well, I took it away because answer that's okay. Uh, did they say they needed care management outreach within three weeks after go live?

Trish Farnham:

The expectation is that there is, uh, what we have defined as a follow-up, um, recognizing that many of these members, because of their high need nature will likely be a prior fall into a priority population category for care management. So, uh, that high need, uh follow-up will, uh, be the, the. The launch point for many of these members, um, in, in conducting the care needs screening, and doing other care management engagement. So it may not be, it may not be necessary that all end up requiring care management, but again, to use the phrase that we've been using a couple of times, this is a data booster, uh, to advance that care manager engagement.

Hugh Tilson:

Thank you. Um, how about this one? We have three locations, but bill under one tin, the only location we're able to attest to level three is the main office where we bill from, how would we get help with this?

Trish Farnham:

Krystal unless you'd like to take that or Garrick, I'm going to propose. We take that back to give them a crispy answer. Yes, Trish. We can take that back. Right.

Hugh Tilson:

Last question. And just as a reminder, you can submit questions using the Q and a, or send an email to questionscovid19webinar@gmail.com as pretending to the example, client Joe, the scenario suggests that the AMH will engage Joe to ensure transition has been made successfully. Wouldn't this be CCNC who would follow up with her and not the advanced medical home, seeing issues care managed by CCNC.

Trish Farnham:

So this question may, uh, involve a little bit of refinement or require a little bit refinement to answer it precisely because CCNC obviously plays various roles depending on the managed care status of the member and the timing. So I can't answer that question fully. I will say though. That the expectation is that on the PHP is that this member, uh, have a follow-up, um, encounter. Um, and if, if the PHP is going to delegate that down to Joe's AMH, tier three, uh, that AMH tier three would assume that responsibility.

Hugh Tilson:

Well, our queue is empty, so. Um, typically if I keep talking, we'll get another question or two that come in. Um, so why don't I just say thank you all so very much for this great presentation, lots of really good information. Um, and, um, uh, appreciate the work that goes into preparing for this and tonight's presentation. Now, see, here comes some actions, um, do the practices have to do care management before we go live on 7/1 or will CCNC continue until 7/1.

Trish Farnham:

I can take that one when we hold on trying to follow instructions and put my video. Okay. So, um, yes. And again, when we talk about CCNC in this context, I'm going to assume that we're talking about CCNC in the Medicaid direct, uh, context. And at this time, yes, uh, CCNC would assume, uh, and continue its care management responsibilities for these transitioning members up to June 30th or up through, excuse me, June 30th, 2021.

Hugh Tilson:

Trying to do multiple things. So let me get back to the question. So if somebody asks, if the slides are going to be available and I will post those in the Q and A, um, do the practices have to wait, just ask that one. What is tier three versus tier one or tier two? Is that, so we want to refer to the website for?

Krystal Hilton:

Krystal, do you wanna, do you want to take, take that one, happy to jump in and helpful, but that's a little outside the scope of transition of care. I don't know if crystal can hear, um, I'm

happy to start. Let me, let me kick the question off and then certainly welcome support from our, my colleagues who are, who are more in the AMH space than I am. So, uh, the AMH tier model is really, uh, working to advance the goals that have been established or advanced the accomplishments that have been established, uh, through our primary care care management network, uh, prior to launch and, uh, tier one, within the tiers. There are, uh, kind of various grades of responsibility, um, for, uh, engagement, um, and, uh, practices can be identified as either an AMH, one tier tier one, or tier two, or tier three, if an AMH assumes tier three functions and is established as a tier three provider, they must assume additional, uh, care management related functions and, uh, the ability to do risk stratification. Um, and so the capacity of, of those practices must much be much broader than those AMH tier one and tier two practices. So if anyone else wants to supplement what I've said, I'm kind of just doing that off the cuff.

Hugh Tilson:

Well, it looks like we're going to give the answer in writing as well. Okay. Um, uh, if a practice, attests for tier three and then cannot complete the requirements, provide care management by 7/1. If they received glide path funding, will they need to return those funds? How close to go live? Do we need to determine if we are really ready for go live?

Trish Farnham:

I need to defer that one to our AMH partners. So Krystal, feel free to jump in, um, or we can take it back if that's better. We'll take that back. Okay.

Krystal Hilton:

Um, uh, I have to apologize. I'm having technical difficulty, but we will take that one back. That's a more convoluted answer.

Hugh Tilson:

When will the remaining patients be transferred to practices or do they all come over at the same time?

Trish Farnham:

So again, that may be a question that requires a little bit more clarity. Um, I mean the questionnaire can ask a follow-up clarification just to make sure we don't. Yeah, it's a little vague about this one.

Hugh Tilson:

If you are an AMH tier three, how can you predict the additional auto assign lives, which will be in panel to your practice and ensure care management coverage?

Trish Farnham:

That's a, that's a, that's a really good question. And I'm sure, uh, people smarter than I do have a good answer for that. I know I cannot answer that, but that's a really good question to see what kind of forecasting can be done, uh, in order to appreciate the, the members that will be coming over.

Krystal Hilton:

There have been some models of forecasting that have been produced. So we will take this question back and be able to, to share that, um, that information that has been produced. All right.

Hugh Tilson:

All right. Once again, the queue is empty up here. Come one. Uh, what number of patients is the glide path funding determined on?

Krystal Hilton:

The glad path payments are based on the current patient panel for providers.

Hugh Tilson:

Great. Any other questions going once going twice? I'll look at that. Two more, defined patient panel attributed patients. How do you define how are you defining your patient panel for those purposes?

Trish Farnham:

Krystal, I would defer to you on the, on the specific definition patient panel has typically meant those enrolled those patients enrolled in your practice.

Krystal Hilton:

I'm sorry, I'm still having some technical difficulties, but yes, it is the patients that are enrolled in the practice we have, we will, I'm trying to find a webinar link, a link for the guide path payment bulletin. So you'll be able to get additional details and I'll try to put the link in the, in the Q and a format tonight, if not, it will be a part of the Q and a, and when you you'll be able to go in and get additional details that you have, that will apply specifically for you.

Hugh Tilson:

Thank you so much this, uh, um, will there be any upcoming web? Oh, I guess Chris just answered that. Um, so information will move from NC tracks to PHPs and back to CINs for care, transition activities. Is that the way the informational flow?

Trish Farnham:

GPM may tag team this one a bit. I think it's important. First of all, to recognize that there are going to be multiple data sources and while many of the data sources will originate with NC tracks, they're going to come from multiple sources. And the whole purpose of the data transfer is to help ensure member continuity of care and to inform the process of risk stratification. So it's really important to know that these data sources, um, are, are, are coming to the PHPs, uh, really to provide, uh, the best picture of the members, experiencing members, current current care, uh, to ensure continuity of care. And again, to inform that care management prioritization. So the data will flow from multiple sources. And again, we may want to go back to that slide that outlines the diagram. It will go to the health plans. It will then, uh, in, in, in, in often a synthesized form will come down to, uh, the CINs if applicable. Um, and, and then, uh, and then we'll come back, uh, uh, up through the upstream channel, uh, back to the PHPs and then back up to. Uh, the department and GMP, that was just very much an overview. So feel free to add any technical clarification.

Garrick Prokos:

Yeah, I think that was excellent. Trisha and it's definitely important to point out that it is these data sources are coming from not only NC tracks, but other sources as well.

Hugh Tilson:

So, well, we get a data flow drawing at some point to help explain all the high level data flows. Um, it's in the deck. Uh, is there something else. You can think about.

Trish Farnham:

I want to give a shout out to the, um, the AMH. Can you go back one slide here or actually two slides? One more. Yeah. Um, the AMH provider manual 2.0 actually provides some really nice diagrams, um, that outline this, um, and provide additional detail. Another thing that may be helpful. Um, and I want to give my colleague Garrick and his team, a lot of credit for this. Uh, the, the technical specifications on the AMH website provide a lot of the nitty gritty detail about these data transfers and the format of the data that will come to the AMHs, um, it is, it is I think, a really, really helpful, uh, desk reference and can help conceptualize what we're talking about.

Hugh Tilson:

Thank you. We'll all. Enrollees assigned to the plans, be transferred to AMH here through practices at the same time. It's like we answered that.

Trish Farnham:

Um, I think, I think the, the the, the status of that member will be live on July 1st. So I think it's in that regard, I think the answer is yes, in case I'm misunderstanding the question and GP feel free to jump in.

Hugh Tilson:

Uh, do AMH three, have to share care plans with the health plans.

Trish Farnham:

Um, so AMH threes need to share with the health plans. It's important to know. And I will say this in GP, Garrick, feel free to jump in here as well. If there is a care plan that is developed, the, the much of the content may be uploaded through the data, the data processes that we've talked about, and that we continue to we'll continue to talk about the care plans specifically may be requested by the PHP for a number of reasons, including if a member is transitioning to another AMH or to another health plan. To be included in the transition file detail. Garrick, do you want to add or correct me on anything? Nope, that's correct. Trish.

Hugh Tilson:

All right. We're back to an empty queue. So going once going up. Will Medicaid members, well Medicaid members who do not choose a health plan, be assigned to exclusively tier threes. Would the only patients who have tier one or tier two provider offices only be assigned. If they actively choose those offices.

Trish Farnham:

I'm going to need to defer to my AMH colleagues on the attribution logic, um, and the prioritizing groups or the way the groups are prioritized.

Hugh Tilson:

Any response to that? Do you want to take that one back, take that one back and be able to share more details with you. Okay. All right. Queue is empty again? We'll see how long it lasts. You give everybody 10 minutes back in their day. All right. So why don't we do this? Why don't we wind her up and, um, Krystal, thank you guys. Your team has done a great job of pulling all this information together, answering these questions. Really appreciate all that y'all do. Um, let

me turn it back over to you. Um, after I thank the participants tonight for joining us and you can provide some final comments. If you're technical capacities continue to exist. Otherwise I'll just say thank you for you.

Krystal Hilton:

I think I may have it for a few more moments. Thank you all again. Um, thank you, Hugh. Thank you, Trisha and Garrick for Sharon, she has wonderful and insightful information. Thank you all for joining us. And we look forward to being able to share more information and address questions with you at another time, they can have a good night.

Thank you. You take care. Bye everyone. Bye.