Transcript for AMH Webinar Series

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Presenters:

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Hugh Tilson

All right, my clock says 530 so let's go ahead and get started. Good evening everyone and thank you so much for participating in this evening's webinar for Medicaid providers. Next slide please. Tonight's webinar is part of the Advanced Medical Home Series Amh of informational sessions put on by North Carolina Medicaid and North Carolina AHEC to support providers during the transitions to Medicaid managed care, just as a reminder, there are also the back porch chat webinars on the first and third Thursdays of the month to discuss hot topics on Medicaid managed care generally. Tonight, we'll discuss ongoing transitions of care, I'm Hugh Tilson I'll moderate tonight and I'll turn it over to Kelly in just a couple seconds, but first let me run through some logistics. Next slide. If you need technical assistance and this an email it's technical assistancecovid19@gmail.com. You can adjust the proportion of the speakers in the slides by dragging the double gray lines between the slides and the speakers. So if you go to the left then the slides get smaller if you go to the right, then the slides get bigger. You can also adjust your video settings to hide people who aren't speaking. So click on the up arrow for the pulldown menu to the right of the stop video button in the black bar on the bottom of the screen, select Video Settings. Scroll down towards the bottom of that page and then you'll click Hide non video participants box. We'll put these instructions in the q&a for your convenience, but just so you'll know how to do all that.

We should have time for questions at the end. Just as a reminder again everybody, other than our presenters is muted, and the chat function is turned off so you can ask questions, two ways. One is by using the q&a feature on the black bar on the bottom of the screen. If you're dialing in. You can't do that so send an email to questionscovid19webinar@gmail.com. Just as a reminder, we've learned in the past that our presenters will often address your questions during their presentations. So I encourage you to wait until the presenter are through their presentation before submitting a question, please no, we'll do our best to get to all questions that are submitted any questions we don't we'll send out actual send all the questions to Medicaid, but any that we don't get to they can either respond directly or we'll incorporate the questions into FAQs or the documents or future webinar topics. The slides are available on the NC AHEC website there's a link to them in the q&a I've already seen somebody asked for a link. So, you should see that and if not we can post it again but you should be able to access the slides, we

will record this webinar, and we'll add the recording and a written transcript of it with the slides on the AHEC website probably tomorrow morning. Kelly, I'll turn it over to you now.

Kelly Crosbie

Thanks very much you Hello everyone, this is Kelly Crosbie and I'm the Director of Quality and population health at North Carolina Medicaid, thank you so much for joining us this evening. As usual, I'm joined by an awesome team here at Medicaid, Trish will be the primary speaker tonight Trish Farnham. And I'll be turning things over to her in just a moment. But as usual, Vorinda and Gwen will both be here to help with questions and Krystal Hilton will be joining us a bit later to also help with some questions tonight. Next slide please. So, before we turn things over to Trish who's going to do part two of our transition of care updates. I just wanted to review some really important primary care/Advanced Medical Home updates that we've presented in other forums. We've presented them here they've shown up in the Medicaid bulletins, we've presented them at the Advanced Medical Home tag, the technical advisory group. And they've also featured at the fireside chats, they were still called fireside chats, then, so I'm gonna call them fireside chats, though I know their back porch chats now, but I want to run through a couple of them because they're worth talking about. And they're very important ways that we've tried to support the primary care system. Before managed care launch. So if you go to the next slide please these should be reminders, you shouldn't be surprised as to anyone. The first is the new panel management functionality in nctracks. I'm going to get to the call out box in a moment, but office administrators now will get an email once a month in NC tracks, and they will be able to look at their Medicaid patient panel. For now, that's just Medicaid direct so all Medicaid fee for service, you'll see your patient panel, but in the future you'll also see your Medicaid direct patient panel as well as your panel across all of the health plans with which you are participating. We've met with some providers just to get some feedback on the report. We will be updating some of the functionality already we know based on some of those that feedback. And we also will be publishing a how to read this report guide, but remember this is just a way that we were trying to have one place where you could see all of your panels across Medicaid, but as a reminder, all advanced medical homes of all tiers will get patient panelists, every month from their health plan, but this is just one consolidated way you can get it NC tracks.

Next slide please. As a reminder, working with a providers, both for consultation, but also for testing of a methodology. We have done some primary care re assignment prior to launch. We've only done it for some beneficiaries. So just to be really clear we didn't mass re assign everyone to a new primary care provider. So, beneficiaries who were reassigned to a different primary care practice fell under this criteria, it was a member who was actually going into managed care. They had been enrolled in Medicaid for at least six months, they did have a current assigned primary care practice not individual provider but practice, but they didn't have any claims for two solid years with that primary care practice, but they did have claims with another primary care practice so that means you may have people assigned to you that you never saw but they didn't see anyone else either. So they're not moving. So these were only people that were assigned to practices had not seen them for two solid years, but we're actually getting care at a another primary care practice so that was the criteria for reassignment.

We moved about 150,000 beneficiaries, again this was after testing our methodology with pediatric practices, FQHC's primary care practices that were both independent and associated with facilities. We reassigned beneficiaries to the best fit, based on the algorithm we put together, and the algorithm was based on recent visits versus most visits. I'm sorry not versus recent visit plus most visit plus geographic proximity. That's how we did read assignments, and the, the members that were affected, have gotten or will beginning their new Medicaid cards with that new assignment in April. We have the link there, the slides will be up on the website, you can go to the webpage to learn all about this, but the usual rules apply, if something did happen if a member is not happy with their reassignment, they can certainly talk to their DSS caseworker but also just escalate it to the Medicaid call center, who will help them go back to their PCP they want to be assigned to or move to another PCP, but this was, again, our effort to try to help correct some, some maybe some misalignment in primary care reassignment prior to launch.

Next slide please. The Healthy opportunities screening assessment and referral payments so remember this was a new code that primary care providers are able to bill from January through June of this year for screening for food, housing, interpersonal safety and transportation issues using the DHHS healthy opportunity screening questions or another validated tool like prepare. Um, most of you know I'm giving this update because this was a primary care enhancement we do want to get folks, screening, but also getting reimbursement for screening and associated referral activities that's why it is for a positive screening. And we've had some billing issues which I think people are well aware of. We have fixed those billing issues as of the 31st you will see next week, a bulletin that will tell you how to please rebuild your claims, and it will have a special note for FQHCs that you will need to build this on a separate claim or separate transaction. So for FQs the claim was denying if it was billed with the T 1015 code, but for other providers there was just an error that we have now corrected in the system so look for that bulletin. We're very excited about this opportunity very excited to collect the data and really analyze and work with our health plans in the future. If this is, this is definitely a billing code worth keeping maybe with modifications but thanks for your patience while we corrected this this issue in the payment system.

Next slide please. Our glide paths payments went live. We actually are paying the first payments out here in April. As a reminder, the attestation that she meant criteria for glide path payments was March, 30, and you had to contract with at least two health plans as a tier three and complete integration testing that was explained in seminars as explained in the bulletin about what that actually means. We had magnificent return. About 1205 providers a tested, about 1153 of those actually met criteria about 1153 of the tier threes represented, 70% of attested tier threes in the system, and that also represents about 70% of members so about 1.1 million members are enrolled in Tier threes who have completed contracting and testing and that's very exciting for us to see. You'll see a note at the bottom practices that were denied payment will be getting a notice through to NC track saying you were denied for this. And here's the reconsideration process. So if you think that you were denied an error. This is the information we need from you to be able to reconsider your request, there's a deadline for other providers to attest by April 25 for the main payment. Remember, if you're part of the 1153, you had did

a test and were paid in April, you'll get paid in May and June, you do not need to retest again you absolutely do not. But if you are one of the remaining 450 ish providers who are still finalizing your contract or your testing and integration you have until April 25 to attest to get your May and June payments. We'll be publishing an updated bulletin, just to remind folks that the April deadline we have moved that up a little bit, and we'll remind you of the May deadline, and we also will tell you about the reconsideration process again for providers who were denied. But we've also got notices from providers who forgot to attest to on time, things like that. So we will have a published reconsideration process for a MH tier threes.

Next slide. I think that's my last slide. Oh no, the last thing, really important. We did create a temporary health equity payment for primary care practices. This was for Carolina Access one and two providers serving beneficiaries from high need areas. And that description of what a high need area is and how these payments were calculated isn't a Medicaid bulletin, I won't explain it here, please read the bulletin, and that was shared at fireside chats and there was also a, a Medicaid office hour where we had q&a on these. Practices will see the increased payment reflected in this month's remittance advice so please look at the bulletin and other resources, there's actually Medicaid factsheet on these health equity payments as well. But providers are getting those payments this month. I do you think that's my last slide now. And I will turn this over to Trish.

Hugh Tilson

Kelly before you do that, I know you have to leave, there's some questions there specific to this as we bring these up. Absolutely, yeah. Okay. So, one says thank you for setting up panel management in nctracks it's more efficient to get our lists, so yay shout out. Good job. Thank you. When will we know which plans are attributed to our patients.

Kelly Crosbie

I'm going to give you a good probably a follow up written answer to this one. Patients will get members will get assigned to plans, and then they'll get assigned to PCPs. But you really won't necessarily find out who your attributed patients are to plans until about 30 days. That's probably less than 30 days prior to launch if you're an advanced medical home, but let us do justice to that with a good answer where we show you a good timeline, auto enrollment happens in mid May is for plans and then PCP assignment happens and then then then you'll get notified as the AMH but, but please don't, don't quote me on any of those four dates we'll lay it out a little more nicely for you.

Hugh Tilson

Thanks have helped been stated If they plan to cover HOSAR payments, if so, which ones.

Kelly Crosbie

You know, we've had a lot of interest in that from the health plans, wanting to know what the utilization has been like, what the utilization patterns and which providers are using them and any kind of data we're getting on the Z codes that tell us. So we've had a lot of interest in understanding what that's looking like from the health plans, but that doesn't mean there's some health plans who've already decided they're not going to do it, I just don't know that yet.

Hugh Tilson

Thanks, is HOSAR for all screenings now or just positive screenings.

Kelly Crosbie

It's still just for positive, and I would say that's probably the number one bit of feedback we've got please make them for all screenings because all screenings take time and it is a strange workflow to only pay for positives. So we've gotten that feedback, and not that we're changing and I'm just saying that that's been, that's been very helpful feedback we've gotten.

Hugh Tilson

Can Medicaid provide a list of data integrators who can help us so that we can qualify for a major glide path payments, we're not in CIN.

Kelly Crosbie

It's very hard for Medicaid to sort of offer up a CIN and one of the things you might want to do is talk to, you know, we have the practice coaching programs to talk to the AHEC coaches they can't necessarily endorse someone but perhaps they could show you where you can find some of the CINs in North Carolina, we have a decent amount of of them. But I think that's probably your best route to go because Medicaid can't really endorse a particular CIN.

Hugh Tilson

When do people get paid for the glide path and Health Equity pay health equity.

Kelly Crosbie

So if you attested. If you successfully if you're one of those 1153 for the glide path payment that successfully attested. Any day now. Any minute now, you'll get your monthly pmpm. So if your medical home your T 50 And your five, $8.51 will be added to that, so you'll get them with your monthly

payment in April. If you missed the March deadline or you didn't qualify the same follows you'll get it with your, but you do qualify for April, you'll get it in your may check right for the health equity payments. If you are a provider who's getting a health equity payment. You will also get that as part of your monthly PMPM payment and so those, you should be getting those any day now, actually.

Hugh Tilson

So we got a question when will we know if we qualify for the health equity payment.

Kelly Crosbie

So one of two things will happen when you get your payment you'll either have the payment, or the health equity payment, the only way you'll know is if you get if you get a payment, if you get a bump in your pmpm.

Hugh Tilson

Last question I don't know whether you can answer this quickly is I signed in late what has to be attested for payment.

Kelly Crosbie

The short answer please read the bulletin but the shorter answer is you have to contract as a tier three with at least two health plans, and you also need to complete the data integration testing with those two health plans, but the files that count for the data integration testing and the defect resolution that's all explained in Medicaid bulletin.

Hugh Tilson

Fantastic. That's it, thank you for sticking around to answer those.

Kelly Crosbie

Absolutely. Thank you for having me and Trish you ready to go.

Trish Farnham

I think I am one second, let me see if I can get my video sharing great right. Hi everyone, nice to say hello to this group. Again my name is Trish Farnham, and I work on Kelly's team, and serve as one of the points of contact and kind of lead coordinators of our work around the concept of transition of care.

Really glad to come back to this group to provide what is a part two of an earlier discussion we had, you may remember our last session was focused on the concept of crossover and the concept of what's going to happen when members transition on July 1 into the Standard Plan option and some of the mechanics and the processes that are related to our AMH partners. So this is a part two that of that transition of care conversation and tonight we're going to talk about those dynamics related to members who are transitioning between health plans, and to a lesser extent between AMHs after launch, after we all move into the Standard Plan option. And what's going to happen more on a day to day basis. So, again, really appreciate your time and attention and looking forward to the conversation.

Couple of outlines of what we're hoping to accomplish tonight. So just to do a little bit of a refresh about what we're talking about when we say transition to care and like I alluded to was ongoing transition to care and you go to the next slide. One of the first recognize and this slide is busy but you all have seen it before, and wanted to kind of give a little bit more narrative on the details of this slide, we have received feedback that the concept of transition of care, obviously has multiple connotations, which we know those of us who have done transition planning in the past certainly can appreciate that, how that term is being applied in multiple scenarios. And we just wanted to give a little bit of context about how the transition of care concept is being defined for this purpose. So first of all we lean on the federal managed care regulatory concept of transition of care and really what we're talking about members transitioning between service delivery models, or between health plans. And so when we're talking about transition of care in this context we're talking about that migration of responsibility and the migration of data but not necessarily the number of going anywhere. And we just wanted to make sure to be clear that this is distinct from the concepts of transitional care or care transitions, which really are more about members just enrolling from an acute care setting or long term care setting or transitioning between settings physically transitioning. So, just wanted to make sure everybody had a little bit of a level on the distinctions of those terms.

Trish Farnham

All right, and just to really reemphasize the point, we have divided our transition of care work and discussions into two buckets and like I said a couple times now we talked about crossover. The concept of crossover on the march 11 webinar and tonight is focusing on those ongoing transitions, where members are changing health plans on on a, on a regular basis or certainly can change after launch. On the timelines that are allowed. Next slide. So just wanted to acknowledge a couple of things before we dive into some of the specific scenarios. The first is, and Kelly is really good at reminding you know I focus very much on the transition dynamics, but the reality is that even though members will transition, you know, as part of the managed care landscape. It's important to know that this, this won't necessarily happen often within a specific member situation. So it's important to know that a member will not be bouncing around, perhaps as frequently as some of these slides might suggest that they will, and that these are somewhat of exceptional circumstances when a member is transitioning between health plans. The other thing to, to remember as we get into some of the specifics of these slides, and some of the specifics are really busy some of these slides getting really busy because we've tried to provide information that's helpful and kind of gives you a full insight into how this process will work, but a lot of the detail on the slides are related to data transfer, and those data transfers are going to be largely

automated, so it's important to know that even though there's a lot of stuff going on on the slide and a lot of moving parts and arrows. A lot of these processes have been automated and will be operational at launch. So even though there is a lot of there are a lot of moving parts that are underway, the day to day impact of those moving parts, hopefully will be fairly minimal.

I also want to acknowledge that my wonderful and trusted technical spiritual advisor on all things Transition of Care Garrett Prokos had a family commitment that couldn't be moved for tonight so I'm pinch hitting for both of us. And because of the very technical nature of this discussion, I will probably be very conservative any, any specific answers just so I don't lead folks astray, inadvertently. So over the next couple of slides we're going to go into these three that we're going to go through the specifics of these three scenarios. The first is we're going to start with when a member moves into or out of. You're going to go back. Thank you, goes into or out of your AMH practice when they are transitioning from one health plan to another so they have started with health plan, A they have made the choice to transition to help plan B. And in doing so, or at the same time they have also elected to change practices. So that's going to be the first scenario we've worked through the second scenario we work through is when a member transitions from one health plan to another but stays in your Amh practice we anticipate this to happen with with with regularity and we want to make sure that we've conveyed kind of the department's process for this particular scenario as well. And then finally, we know that it is also possible that a patient moves into or out of your ama practice with no change to the health plan. And so we want to again acknowledge the reality of this potential potential scenario and provide some detail on it. Next slide.

It's important to know when we think about transitions of care. Our primary focus is on the member dynamic as it relates to members transitioning between health plans. And so, if you reviewed our transition of care requirements, or attended any of our transition of care, educational sessions you'll appreciate that most of the information is provided at the health plan level, that is really where our larger focus is because of the various dynamics that members experience in where they're care is care managed, and because of the different dynamics between health plans so we want to make sure to really re emphasize that we are starting with the expectations about when a member moves from one health plan to another. And it's important to know that we expect health plans to share information about the members who are transitioning between them. And so we expect health plans transfer the information necessary to ensure continuity of care, including appropriate data files and member specific socio or clinical information. So, the health plans are once again operationalizing the process for facilitating transfer of member claims and encounter detail and prior authorization history. Additionally we have supplemented those data, data transfer requirements with a more member specific detail related to the members care plan, the members care needs screening, and additional information that may be applicable and timely at the time of transition, we call that collectively the transition file. So these are expectations that we have established at the health plan level for how health plans share information between each other when a member transition. Next slide.

It's important to know that as we drill down into a members transition and how that impacts the AMH network, we want to make sure folks are kind of clear on how those how that data, and how that information will be eventually migrated down in synthesized form to our amh tier three partners. And so we want to re emphasize that the expectation that the plans are under is that upon receipt of relevant information. The members new health plan shall ensure that all data as defined by the department once received are transferred to the members ama tier three or CIN up to 30 calendar days prior to the effective date to the members effective date, and no later than seven business days of the effective day. We also want to note and this is a, this is an important note to acknowledge that we are still wanting to make sure that as we finalize the data transfer requirements and as we finalize the knowledge transfer expectation we that we are considered that we consider and that we are mindful of feedback that we've received to date. So I wanted to note that our expectation as a state, is that care plan information is transferred and is shared between different entities that will be supporting this member. We want to acknowledge though, that we want to we want to take feedback that we've received from our amh tag, and from the health plan. We're examining exactly the timing for expecting this particular care plan requirement to be implemented. So we do expect that over time, amhs will contribute to that care plan transfer that if an AMH tier three is managing that care plan. We want to make sure that the receiving health plan receives that care plan, but we also want to recognize that there's going to be a lot going on on July 1. We want to make sure that the data transfer migration works effectively, and we will we will we will be examining the implementation of this particular care plan sharing requirements, the timelines related to this care plan sharing requirements. So just wanted to acknowledge that. So even though we talk about care plan transport we want to we want to put that qualifier on. So this table provides a summary of the files that will be transferred to the AMH tier three, and in some respects to AMH tier twos to ones or twos. When a new member enters on the health plan. And so all of these are reflected, not only on the table but in the amh manual. We really, really encourage people to look at the AMH provider manual, the 2.0 version, which is I believe going to be hyperlinked in the deck that will be posted, and all of the details related to the intent of these files, and the content of these files are more fully, more fully reflected in the manual. Next slide.

So this is re emphasizing an earlier point that we just want to make that for Amh partners. And the question is what will I need to share with the medical Medicaid health plan when a patient is transitioning from one plan to another. And it's important, like I keep saying that we are going to eventually be setting the expectation that as a systematic expectation that care plans are transferred when a member transitions between health plans, and again I think people can appreciate the rationale for this requirement, and that we want people to have we want the receiving entities to have the benefit of the care plan content, and frankly for the for the any new care management that care management teams that are involved, to have the benefit of that history so that they can, and that the member can have continuity and folks understanding the members goals and and and care plan strategies. So it's at some point that care plan transfer is expected to be operationalized. But again, we're examining the timeline at that particular requirement. With Amh tier one and tier twos, there will not typically be information sharing requirement when a member transitions between health plans.

Okay. We want to make sure there's a lot of obviously information in this deck and a lot of discussion about file transfer from members who are transitioning, we want to really underscore the point that nothing we're saying in this deck or in the expectations should be construed to in any way, reduce or minimize or supplant or replace the good quality clinical knowledge transfer and record transfer activities that you all do every day. So we just want to make sure to reiterate that that of everything we're talking about is either to reinforce that continuity of care knowledge transfer at the plan level, or frankly to provide the information that you all need as AMH tier three to really provide effective care management so we want to make sure that we're super clear that nothing I'm saying in any way, reduces or supplants that that, that good quality clinical practice that you will do on a day to day basis. Next one.

So like I mentioned at the beginning of the presentation we're going to run through three scenarios, and just want to let you know, visually, brace yourselves for the slides again, there's a lot of information on these slides, we will not be going into the granular detail of every single line on the slide, we just want to paint the picture for you for the scenario. But like I said, many of the files that are referenced on these slides are going to be automated. So, from a day to day practice perspective, we really don't anticipate this to anything we're presenting to be to be a new lift. The first scenario is when a patient moves into or out of your Amh practice when they transition from one Medicaid health plan to another. Next slide. And again, the key piece here is that the member has got has started with their original health plan, and has, for whatever reason selected a new health plan, and that selection of a new health during that selection of the new health plan that member also chooses to change or needs to change their amh tier three. And so we just want to again to paint the visual picture of how the data will flow, when this transition occurs. So it's important to know that if you are the original AMH. It is that it is possible that the health plan may request that care plan from you as part of their requirements for transferring the transition file in the care plan to a or the health plan to the new health plan. Again we are working to finalize the timelines related to operationalizing that expectation. But it's important to know that that, that is the eventual expectation.

And it's also important to know that if you're the original amh tier three, the patient will continue to appear in all of the file detail that you've received. Up until that member's effective end date. The data will continue to flow just as it always has. And at this time, the, the, the care plan may be requested as part of the transition preparation. When that member transitions or through that transition to the new health plan. If you are the patients, new amh tier three, you will start receiving all of the file detail that we've outlined here. Excuse me up to 30 calendar days prior to the start date of the coverage, and the new health plan and no later than seven business days with the effective date. So all of that data will begin flowing to you on those timelines that I've just outlined. It's important to know you will also be receiving additional information like the risk list, the care needs screening, and again. Eventually, the transition file that we keep alluding to. Just to reiterate, and this was discussed as consequence than discussed on earlier calls that we have an expectation that if the member is transitioning who is care managed, and either the original health plan or the new health plan really feels that a warm handoff or a plan to plan clinical knowledge transfer session would be beneficial. They will be conducting that. And to the extent that it is appropriate and feasible we encourage our amh partners to participate in those,

but it is not required. I don't know what is the scaler required connector is. Excuse me I have something I had a pop up on my screen I thought, I thought it was on your screen apologize. So our next scenario is with our tier one and tier two AMH's and again other members transferring between health plans, and that transfer involves the transition of amh tier threes. Having can you still hear me.

Hugh Tilson

Yes, we sure can.

Trish Farnham

Okay, I just want to let you know that for some reason, I just lost connectivity. So I have my print out, I'm going to keep going but I just wanted to let you know that I'm not able to see this. Okay, I'm gonna keep going. You're on the tier one or tier two when a patient moves from health plan one two health plan two. And it's important to know that if you are the patient's original AMH, the patient will appear, continue to appear in the panel detail, and the patient's initial initial attorney screening will be available through the original health plan until the effective end date. And if you're the patient's new AMH, the information about the new patient will become available in the members, new health plans panel detail up to 30 days prior to and no later than seven days after the effective date. We're going to go to the next slide, and I'm at scenario two, and so we're now going to go to the patient transitions from one Medicaid health plan to another but stays at your Amh practice. And so again we recognize that members may choose to transfer between health plans or transition between health plans, but that may not actually result in a change in their Amh. And so we're going to go through those two scenarios, these, these scenarios one at the tier three level and then the second one at the tier one or tier two level again because we are expecting. Again, eventually, eventually the care plan transferred to be operationalized and to make sure that the health plan two does have the benefit of that information. There may be requests for that care plan to be submitted to the original health plan as part of the transition of care transition practice. And if you are, if, if you continue to use me you will continue to receive the standardized information that you have always received from the members original health plan, up into the effective date, and then after the effective date of transition, you will begin receiving the same information. In addition, beginning state receiving the same information from health plan two. And if this number hasn't been identified for a warm handoff I know that may seem a little bit redundant. In some cases if they're not changing AMHs, but just know that that because we are trying to promote knowledge transfer between our health plan partners. If the health plans do have a knowledge or knowledge transfer warm handoff session the AMH tier three partner is not expected to attend but certainly can, it would like to. I'm going to go to tier one and tier two or tier two scenarios.

Slide 26. So again, this is where the numbers, stay put with the Amh practice that is either a tier one or tier two but is transferring between health plans, and this is probably pretty common sense that you'd be able to see that numbers detail through the panel information of your health and one until the transition. And then after the transition, you will be able to see the panel detail from health plan to actually 30 days prior to the transition and up to seven days after. I'm going to go to scenario three and

now I'm on slide 27, that's what we're seeing. Alright, awesome. And so in this scenario the patients moving into or out of your AMH practice with no change in the health plan. So, this is a situation where a member may have selected a new PCP, but as otherwise stays input with the members original health plan. And so again, recognizing the importance of the knowledge transfer process, even if the member is not transition, transferring between health plans, obviously, the health plan will begin sharing data with the members new amh is tier three practice. So in this scenario and I'm now on slide 28 As you if you haven't already gotten there that if you're the patient's original amh tier three again once again, if you requested. You'll send the patient's care plan to the patient's health plan if requested. The care plan, importantly, and this is maybe an obvious point but the care plan can also be shared directly through the standard clinical information sharing that you all already do between practices, and the patient will continue to appear in the data files you receive from the health plan until the members. Effective Date effective end date, excuse me. If you are the numbers Amh or new Amh tier three, you'll start receiving the member detail on the data files listed here, up to 30 days, count 30 calendar days prior to the start of the coverage of health second health, excuse me, but the new amh, and no later than seven business days is the effective date. You'll also receive, again, additional information that's going to be provided through the patient risk list and patients, carrying screening, and again the transition file. Once that transition file requirement becomes populational.

The final scenario we're going to run through is on slide 29. And that is, again, probably going to be a fairly straightforward dynamic, but when a patient decides to change between practices and that practices is an Amh tier one or tier two, if you're the patient's original AMH, the patient will be in your panel detail with the health plan, and you'll be able to access that patient's care needs screen through the health plan until the effective end day until the members effective end date. And if you were the new patient, if you're the patient's new AMA, the patient will appear in your panel detail, and you'll be able to access the care need screen for the health plan, up to 30 days prior to the effective begin date, and no later than seven days after. And again this is another situation where we want to really underscore that this nothing nothing we're talking about tonight in any way, replaces or supplants the clinical knowledge transfer and clinical record transfer that you all again do on a daily basis. I think that's the last slide. We have time for a few questions.

Hugh Tilson

We have time for questions. As a reminder, you can submit questions two ways. One is using the q&a feature, the other is if you're on the phone, send an email to questionscovid19webinar@gmail.com. So, first question is PCP we are held accountable for transition of care for attributed patients if they have chosen us as their PCP, but if not come to our office for care, question mark.

Trish Farnham

I think that, let me take that question back because I want to make sure I'm understanding it, so maybe if there can be additional clarification provided, I'm happy to try to feild that question again.

Hugh Tilson

Here's the question. The question is, if some if a patient is attributed to them but they don't come to their office, are they still accountable for the quality of care or transition of care, I'm sorry.

Trish Farnham

I think that I think there's going to be, obviously, there's going to be. The AMH that is assigned to that member is going to be responded AMH tier three is assigned to that member they're still going to be responsible for providing the information necessary. I think there's additional question about whether that member should be appropriately assigned to that practice. So, just wanted to acknowledge that and we can take additional information back or additional questions back.

Hugh Tilson

Gotcha. How will transitions of care work for a PCP when we participate in a health plan but the local hospital does not concern as we will be accountable for overall cost and quality of care. When the hospital isn't participating.

Trish Farnham

I think that's a question, more about care transitions, unless I'm misunderstanding the question then the transition and care of dynamics, we're talking about here, defer that question.

Hugh Tilson

Perfect. If a patient moves from one health plan to another health plan, anytime after July one and you have a prior off for services from the first health plan will a new health plan honor the PA from the original health plan. How long before you have to submit a PA under the new health plan.

Trish Farnham

So open authorizations are required to be transferred between health plans, and the receiving health plan is responsible for honoring the open authorization to the, to the expiration of the authorization.

Hugh Tilson

We have a policy of at least 30 days notice to send records of patients to another office. Is this okay if the patient chooses another PCP, we wouldn't provide the information unless the patient provides a written request.

Trish Farnham

Yeah, clinical, that you're all clinical standards at this point are supported and we can, I can provide additional additional guidance if necessary, but there's nothing, there's nothing in our transitional care requirements that should modify your current clinical practice.

Hugh Tilson

It maybe difficult for practice staff to be part of warm handoff meetings or patient panels are quite large and already overwhelmed.

Trish Farnham

Yeah, that's one of the reasons that again trying to promote good continuity of care and good effective clinical knowledge transfer. We wanted to make sure that the AMHs are aware of the health plan requirements related to warm handoffs, but we also acknowledge that that the expectation to participate is, is it's potentially not viable, which is why we've made it voluntary on your part.

Hugh Tilson

And last question we've got so far is how will we get all of the patient's information if our hospital and employed specialists hasn't participated in the patient's health plan but saw the patient out of network.

Trish Farnham

That's a good question. So, claims and encounter detail is going to be available to the AMH, through the claims to claims encounter detailed transfer that we talked about as far as how that claim would be reflected if it's an out of network claim I'm going to need to defer to my technical team who's not here.

Hugh Tilson

Trish, those are all the questions we've gotten so far. Usually when I say that, yep, another one pops up which just does follow up to our question about patients attributed to us there are lots of patients who end up not seeing their PCP or amh, urgent care centers are great for convenience but often don't coordinate with the Amh, this is a great concern the model may be difficult to implement.

Trish Farnham

So I know that. Certainly the model and the expectations, want to encourage engagement patient engagement in various forms, as far as the specifics of how the practice may be accountable for members who don't regularly attend their practice. I'm going to need to defer to Kelly and Krystal and our other amh experts. And I don't know if any of them are on the call to answer this. At this point.

Hugh Tilson

Kelly or Krystal. Okay, so I guess we left follow up. So those are all the questions that we have. Let me just throw this out to our participants, please submit a question using the q&a feature or send us an email to questionscovid19webinar@gmail.com. Hearing no other questions, Krystal and team, excuse me, Trish and team, thank you so much for all that you've presented tonight and all the work that you're doing and participants, thank you so much for joining us tonight for a very content rich presentation tonight so Trish, let me turn it back over to you for any final comments.

Trish Farnham

Well I, again, just thank you for the time and for your for your patience, both with my technical issue, and also the density of some of the technical discussions on the slides, we're really excited that our transition of care practices are going to advance the goals of continuity of care and we're very grateful for y'alls engagement in that, in, in achieving that goal, so. Hugh, I'm okay with that if there's no if there's anything else.

Hugh Tilson

Well you just got a thank you. Great job exclamation points I think it's a great time to call it.

Trish Farnham

I love it thank you I really appreciate it. Bye bye.