Transcript for NC Medicaid Managed Care Hot Topics Webinar Series: Managed Care Transition Highs and Lows with extended Q/A time

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5:30 – 6:30 p.m.

Presenters:

Dr. Shannon Dowler, NC Medicaid

Dr. George Cheely, AmeriHealth Caritas (AMHC)

Dr. Eugenie Komives, WellCare (WCHP)

Dr. Michael Ogden, Healthy Blue (BCBS)

Dr. Michelle Bucknor, United Health Care (UNHC)

Dr. William Lawrence Jr., Carolina Complete Health (CCHE)

Hugh Tilson

Well it's 530 So let's get started. The music's over so let's get started. Good evening everybody and thanks for joining us tonight for our version of Medicaid managed care back porch chat, as this is our first back porch chat since go live and we have a lot to cover tonight so I will be brief and as you can see we've got some great panelists, provide some timely information for us. A quick reminder, tonight's webinar is put on by North Carolina Medicaid and NC AHEC to support providers during the transition to Medicaid managed care and I'm Hugh Tilson and I'll moderate tonight. I'll turn it over to Dr Dowler in just a quick second, but let me run through some logistics briefly. If you need technical assistance with anything you can email us at technicalassistanceCovid19@gmail.com. You can adjust the proportion of the speaker in slides by dragging the double gray lines between the slides and the speakers. You can also adjust your video settings to hide people 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 in the bottom of the video settings. Scroll down toward the bottom of the page and click the hide non video participants box. Don't worry, I know I ran through that quickly, those instructions are in the q&a. So you have those. We will have plenty of time for questions at the end of our webinar. As a matter of fact, we're planning to keep going until seven o'clock if needed, so that we can respond to all the questions that we get to submit your questions you got to remember that everybody has in our presenters is muted the chat function is turned off so you can submit questions, either using the q&a feature on the black bar on the bottom of the webinar, or if you're dialing in. Send an email to questionscovid19webinar@gmail.com Dr Dowler will describe a new approach to asking questions tonight. We're gonna do our best to get to them all, but just know that if for any reason we don't all the questions go to Medicaid so they can either respond directly to you or incorporate those into upcoming webinars or other ways providing information to you. There's great slides and they're available on the NC AHEC website, there's a link to them in the q&a, and

we'll record this webinar and we'll add the recording and a written transcript of this to the slides on the website. Probably tomorrow morning. Now let me turn it over to Dr Dowler.

Dr. Shannon Dowler

All right, Thanks Hugh. Thanks Nevin from a heck of you guys do such a great job of pulling us together for these webinars, we are doing something different. So for about a year now we've been telling you to hold your questions till the end. And that never works. So we're going to do something different. We're going to meet you where you are when you put your question in, even if it's right away. We want you to specify whether it's a question that applies to all the plans or if it's plan specific if it's plant specific just put that in parentheses or put that in the question and then ask if you are staying in there if you want your response to be public or private. Our folks in the background that can answer questions can send you your response privately if you'd like, or maybe you have a question that you think everybody wants the answer to, and then put public. That'll also help Hugh at the end when we go into the all the questions and answers to see which ones we should ask out loud versus not asked out loud. So whether it's for all plans, or if it's a specific plan, let us know. And if you want the question to be a public question or a private question let us know. So some examples, you might want a public question to go to a plan X saying Why don't you cover alien abduction scans for maybe you have a question, a private question for plan why because you can't get anyone to call you on a contract, or maybe you have a public question for everyone where you just want to thank all of us for being amazing human beings, and that's alright too. So just take a look at the new guidelines when you submit your questions we think it will make it easier to make sure we answer as many of them as we can, we had 200 questions last month in our webinar, so many questions and we want to answer them all. Alright, next slide.

We've got a full agenda per usual, but we have made it so that we are going to hopefully get through the content pretty quickly and then turn it over to questions and answers, maybe we won't have any and we'll all go home early. But if not, we've got the time to make sure that your questions are being addressed tonight. So if you go on to the next slide. We are bringing back the audience response questions tonight we did have a handful of things we really want to hear from you about. So Nevin would you fire away on the first audience response question yeah so this is asking what what it says provider type, but it's what attendee type best describes you. Are you a primary care physician or advanced practitioner, specialty, hospital administrator, aim to three administrator by those that could be billing or coding staff. Also we tried to clump we only got a certain number of choices here so we tried to kind of clump them together to get a sense of who is joining us on these calls so which provider type best describes you. If you will click on that, Nevin will show us the results here in just a few seconds and that'll give us a sense of who we're talking to today so let's see. So great. All right, a lot of primary care physicians and advanced practitioners, but shortly behind that as a behavioral health, non physician advanced practitioner so awesome. Okay, let's go on to the next thing.

So I'm seeing in that poll still does that mean do I have to close it. That's me. Sounds like a personal problem. Alright, so one of the things we wanted to update you on is we have some new and updated

fact sheets out there around submitting claims and prior authorizations and the quick reference guides but plans have updated, there is a bulletin going out today or first thing tomorrow around a common billing error we have identified that is happening on the provider side when they're submitting claims, and what is happening is that oftentimes the claims being submitted don't include taxonomy codes. We're not sure exactly why that's happening because that's always been something that's required on the claims it's not new. It doesn't have anything to do with transformation. But we think that maybe what happened was, you had those of you that work with claims clearing houses or other things, had them actually append the billing provider taxonomy codes and they don't have those instructions for the plans, that's just one of our guesses, but make sure that you're putting that in the, in your claims and there is a bulletin that just went out today on that to give you more details. All right, next slide.

One of the other things we did last week we were starting to hear way too many stories about Medicaid beneficiaries not getting services because staff or schedulers were worried that the plan wasn't in network. So the plans came together to say what can we do about this and decided that between them, they would spend the first 60 days, where everyone is treated in network for prior authorization purposes, and your prior authorization process doesn't actually have to happen before the service is rendered, they're going to be accepting some retro prior authorizations, we really don't want to see services being cancelled. And that's what's been happening we're hearing stories of practices not willing to schedule. Physical therapy or speech therapy for people they've been taking care of or refusing to schedule imaging studies for beneficiaries because of the type of plan they have so we want people to continue to get services. In this first 60 days while the entities are working out contracting, we don't want that to hurt our beneficiary. So please, please, please, don't turn away beneficiaries based on the type of plan they have don't cancel their appointments or services, and please do not make them slef paying with cash, we're also hearing about this across the state and various places where they are saying I don't know if we accept you or not, but we'll accept cash today. Please do not do that it's in the, in the, the guidelines for Medicaid and things you signed, was that if you accepted cash from a Medicaid beneficiary, you would not bill to their services. So that, that's a big no no. So we really just want people taking care of in this transition so thanks for the plans that flexibility and helping everybody get across the finish line. One exception to this is concurrent reviews for hospitalizations the plans really need to know about that in real time so that they can play and care management and transitions of care at hospital discharge, that's not something they want to find out about accurate happen.

All right, next slide, I just wanted to give you a heads up for those of you that prescribe any medications for substance use disorders, you might get a prior authorization request for something that you've already approved prior to the July 1 launch. The reason for that is a federal code is 42 CFR Part Two, and it's a regulation that protects the records of people with substance use disorder. And so because of that we weren't able to send all of your prior authorizations over the fans like we did for their blood pressure medicine or their diabetes medicines or all the other things we sent to them so you wouldn't have to do it again. So it's a very small number of beneficiaries that are affected a very even smaller number of providers that are affected, but we just wanted you to know it's not the plans behaving badly, it is just a federal rule that we have to follow. And we are asking our vendor G vet to be doing outreach to providers if you have to submit a prior authorization to the plan directly so you'll know and get a heads

up about it. We don't want there to be a lapse in services course. So it is a little bit of a headache and an inconvenience and we're sorry but it's one of those federal rules. Alright, next slide.

One of the biggest challenges we've seen in the first two weeks has been around non emergency transportation, and so having folks get rides getting picked up at the right time and get taken to the office. This is really important. A lot of these are dialysis patients or have really significant needs, but for you and your practices, you can't exactly tolerate a bunch of no shows on your schedule, particularly if somebody had a long appointment, so we are working with the plans, who are working with their transportation vendors to make sure that this is done really well, top notch, I had a meeting earlier today with the Medicaid directors, medical directors from all the states we get together once a month and I asked a question of them as What have you done in your states around non emergency transportation and managed care, and all of them said we struggle with this too. So we know this is one of the really hard things with taking care of Medicaid beneficiaries was critically important so we got to get rides for folks. If you are not able to resolve transportation issues for non emergency transportation with a PHP, We want you to go to them first. But if you're not able to resolve the issues or if you have patients missing appointments, missing services, please let the provider ombudsman know about this, because we really want to know about it. All right, next slide.

Can't talk about anything without talking about COVID So just a reminder, we've got this COVID vaccine counseling code out there that we turned on a few weeks ago all of the plans are reimbursing for this, there were so few little claims glitches early on. That's because they just found out about it a week before we went live with launch, but they've all worked it out, they're all paying for that. So really important. We know no matter what kind of provider you are out there asking a patient that they're vaccinated, means that it's important to you and that's going to help it be important to them, so please ask folks if they're vaccinated and if they're not help them find resources to get vaccinated or off of the vaccine in your clinic if that's appropriate. We're gonna have data soon in the next couple of weeks, that'll be able to tell us what percent of our beneficiaries are vaccinated, based on the plan there and based on the medical home they're in, and in a month and a half we hope to have actual lists of patients for you to do outreach to who are unvaccinated. So stay stay posted for that development. Okay, next slide. We wanted to do just as just a quick round robin with the CMOS to touch base on how you feel like it's gone with launch, I know that I have lost a lot of sleep and have had a lot of teeth grinding over the last few weeks trying to make this right and I know that the same is true for them. So Genie you want to kick us off and talk about how launch has been from your perspective.

Dr. Eugenie Komives

Sure. So, and I probably see for all of us CMOS on the call but I think all of us have been at this now for over three years of planning and is a really large and really complicated program. And so I think it would be probably unreasonable to expect it to be perfect. I personally am a perfectionist, it raises my blood pressure, every time I get, you know, potential patient harm email or text message from Shannon, about an issue, having to do with WellCare white in the greater scheme of things, the total number of issues

have been certainly not any bigger and probably fewer than what one could have imagined --. And for the most part members in here we've got claim some new authorizations or services. We've got members taking up prescriptions at pharmacies, and I think that was really all we could ask for. At this point, and Shannon just like you are losing a lot of sleep and dreaming a lot about all kinds of crazy things to do something broken. But you know we do the best we can.

Dr. Shannon Dowler

Alright, let us move over to Michelle.

Dr. Michelle Bucknor

Yeah hi everyone, Michelle Bucknor from United and I would agree that Genie, probably could speak for all of us, most of us, if not all of us are probably perfectionist so it has expected but not as well as-- theirs, person, or members of the provider community anyone such time that they're getting that maybe it's an opportunity for improvement, but I am really pleased with his partnership with the Department as a partnership with the other PHPs to identify issues that are flammable or --. As an example, we have about one member that has an issue, we just make an assumption that every member that needs dialysis issue and it helps us resolve the individual members level quickly but it's also respond in ways that we respond to others. So, again we -- because not, you know just happy to be taken care of members and supporting providers and we're going to continue to work hard to get this, keep it as smooth as.

Dr. Shannon Dowler

Awesome. Thank you and we'll before you go. Were you having a little trouble hearing Michelle or is it me on the side of the mountain, sometimes I don't know which it is. Yeah, we did have a little breaking up there. Okay, so Michelle your audio is a little Wackadoodle. Alright, William Lawrence.

Dr. William Lawrence Jr

Hey there, good evening everyone. I would say you know my colleagues have already hit the high points you know this has been an exciting time, I think, you know, for those of us who have been around. Caring for Medicaid patients or working with Medicaid for years and years, you know, obviously this has been a big transition that's been a scary transition but you know I think we're off to a really reasonable start and you know I'm excited about the opportunity that we have to truly do something different in our state, to take advantage of some of the flexibilities that CMS has granted us through the vision of, you know, the department, in terms of how we would implement this managed care transition. And as Michelle said earlier, in your the collaboration, you know I think between the state and about PHPs and really between the PHPs collectively has been outstanding. It's been something we've been excited to be a part of. And while we know things will not be perfect, you heard that all of us are perfectionist we all are really committed to serving our citizens in this state and we want to see this program work and work

well, so we are all putting in the midnight oil and busting our behinds, but with the hopes of really bringing good transition and good long term benefit to this program and North Carolina.

Dr. Shannon Dowler

Awesome, thank you and I think we might have an audience response question coming up now, is that right Nevin. Ah, look at that I remembered. Let's see what our question is. Ah, all right. So regarding supporting you and your team in the transition, which has been the most effective method of communication with the plans for issue resolution. Is it using the portal, email, fax, or phone. So what has been the most useful communication tool for you and your team in this transition, maybe you haven't done it but others in your practice or office have what's been most useful for you. And that's a pretty quick one for everybody to answer so I think we can close that one down pretty quickly navigate and see what people have to say. All right, email, nice. Um You heard a couple I think you heard Genie mentioned that we have this getting member harm texts and messages. We have a system set up that when things come through the provider ombudsman and there's any possibility of member harm. It goes right into action mode where it comes straight to me I get it out to the plan CMO it also goes to their appropriate team if it's a pharmacy issue or a -- issue or anything where we feel like it could impact the beneficiary right away, away we are all over it in real time and so that has definitely kept us up. Pretty long nights and trying to make sure we're resolving problems all through the weekends because we just want this transition to go well. Alright, I think we were going to go on before that I think we need to hear from Michael Ogden from healthy blue to talk about his thoughts about the transition.

Dr. Michael Ogden

Absolutely. Thank you Shannon. So, so, as you mentioned, you can probably see my hair on my, on my, my video here I've been needing a haircut for about three weeks, really haven't had had the time to even sit down, Take care of the basics on it I will echo some of the sentiments of my colleagues. You know I, although we spent two years planning, ensuring all the i's are dotted all the T's were crossed and expecting perfection or wanting perfection, um, you know, it has been a challenge for all involved, and especially our provider partners, and our own internal plan folks, one of the silver linings to that cloud though, really has been the, the, as you mentioned with the facts the phone, the email, I think I've gotten except for the fax machine pings on all of those different communicates communication methods. And what I've gotten it has been certainly issues that have been surface to the top. But what has ensued after that has honestly been a very collaborative conversation with providers with organizations with hospitals, and with the departments. And so, you know I'm both. I want things to go perfectly, but I'm also encouraged everyone has been so collaborative and wants to work to ensure that we are delivering the best care possible to the beneficiaries from North Carolina, North Carolina.

Dr. Shannon Dowler

Awesome. Thank you, Mike. Um, George.

Dr. George Cheely

Yeah, not a lot to add to my colleagues, other than echoing the strings of stress and loss sleep, and maybe building on Dr. Ogden comments as well you know I don't know that fielding the issues that come in related to the inevitable bump would have been maybe a potential source of positive energy but honestly it's allowed me to interact with providers across the state and to understand how committed people are to doing the right thing for their patients and being able to help that happen and using the insights that we get from those discussions to make additional changes to try to avoid those circumstances down the road I mean that's, that's why we're here and a big part of why we are so focused and committed to getting this right.

Dr. Shannon Dowler

I think that's true, George I felt like a real doctor for a few times in the last two weeks dealing or some of the clinical issues and Nevin I'm gonna ask you to go back one slide I threw everybody off by doing an audience response question in the middle of that. So Will do you want to talk about the Administrative Simplification workgroup that's been meeting and talk about some of the wins from that.

Dr. William Lawrence Jr

Yes man, so Good evening again. One of the examples of, you know, a great collaboration is the word we'll talk about real briefly here. No, I think all recognize, you know, as we entered the process of sentence plans. They're going from one source of truth, to dealing with bad entities, definitely increases more, there's no way to describe the fact that that's not an administrative change for folks, but recognizing that the CEOs of all five health plans made a commitment and committed time and you know significant resources from the organizations to really put the dots together to work collaboratively to try to identify areas where we could reduce some of that administrative burden for our provided community. And, you know, we started out by just meeting and brainstorming and saying, what are some of the things that we could do that may help. It may make a difference. The first thing that came to mind that we worked on was looking at creating the quick reference guides which all plans tend to use in one way or another, but say let's be uniform and what information we believe is most useful to those who are providing care, how do we make that easy to find, put it in the same location, put it in the same place, we can brand it differently, the less make it flow the same, so it's very easy to identify and use that information. So our uniform Quick Reference Guide format was developed out of those thoughts. Another thing that we looked at was by contract we were all expected to use the same prior authorization form that the state use. So we actually looked at it together, we had our own thoughts about it we talked with the state about it and realize there were elements on that form that took time to build out, but did not necessarily lead to a change in what needed to be done in providing that care, or getting that authorization so we slimmed that down, we were able to revamp that form and reduce some of those elements that may have been, you know, somewhat superfluous for the actual purpose at that time, another effort that we worked on was looking at our provider orientation materials from all five plans, you know, when we really looked at it, a significant amount of that content was the same, it might have been spoken a little bit we each had different slides that describe it in a different way or

made it fancy, but when you really to the core content. We were able to come together and say let's identify those things that we're all aligned on and create one orientation that, that includes those elements, and then allow just those things that are specific to each of our plans to exist from the other side, and that ultimately resulted in reducing a collective 138 slides down to about a 27 slide deck that we thought was a good outcome. And then one other issue, you know contractually we all had a responsibility to host quality forums in each of the regions in which we worked. We thought about, you know, the burden of trying to reach all of our different providers out there with these multiple meetings we work with the state and with AHEC so this was really a seven party, you know, collaborative, to come up with a plan that the department is accepted, where we will have three quality forums per year, with joint participation by all the health plans, where you'll be able to get Centralized Information and still have the opportunity to do breakout sessions with individual PHPs. So these are just some of the examples of things that we have worked on and are proud to have collaborated on, we continue to meet now and going forward even into our implementation and are continuing to look at additional opportunities to bring some benefit to the community.

Dr. Shannon Dowler

Awesome, thank you. So let's go on and hear about what we're hearing from you in the field and what the plans have to say about it, which will hopefully get to some of the questions and the answers out there. If you go on to the next slide. So this is our, we keep records and Medicaid side of our Help Center calls in the first two weeks and so the majority of our calls had been from beneficiaries or members that make sense there's more of them. But there were also quite a few provider calls as well. And so when we look at what the members are calling about. If you go to the next slide, you'll see that we can see on this table, how many calls we've handled from specific to the plans and whether it's from our enrollment broker at the contact center or --, how many of the percent of the calls are answered in 30 seconds which is pretty impressive and the abandonment rate which is very low. But what people are calling about so a lot around changing enrollments and have questions about their health plan, or they want to change their PCP or have benefits questions, those are the big things. If you go to the next slide we can see that our providers are calling about different plans with questions as well. They're answered pretty quickly and have a relatively low abandonment rate as well, mostly they're calling about enrollments and network status and authorization status on things. But when we go to the plans we want to hear what they have to say so George why don't you talk about what your call centers are hearing.

Dr. George Cheely

Yeah, I'm glad to do it I wanted to first address an issue that I know Dr. Dowler mentioned at the outset that was has been and continues to be one of the biggest sources of change for her providers. And I just wanted to paint for you all kind of a picture of what happened on July 1 When we received multiple calls from providers who were concerned about new prior authorization requirements, and were in a position of needing to decide whether they needed to cancel cases that had been scheduled for three or four months and we made the decision that day, you know, we need to put out there for providers that we're going to accept prior authorizations out to 60 days after managed care launch, we'll accept them retroactively because people need time to learn the system so that happened quickly mobilized quickly

really in close coordination with the department and my other colleagues who may speak to their stories as well but, but I wanted to kind of get the picture of how quickly we were able to act on that one of them. The next one we got a call from a provider who was not in network. And with that, wanted to draw routine labs for a member for a patient who is with them in clinic and receive the guidance that the provider would need prior authorization and that information was incorrect. uh, we were grateful to get the response in the call from the provider because it helped us look at our call center scripts for the call center that took the initial call until we were able to actually change the script, and the tool that that our staff member was using to provide the right information on the Transition of Care flexibilities that are existing currently, so hopefully we can avoid that if future providers make the calls, the next one, durable medical equipment. We learned that member was having trouble getting a spacer for an inhaler. And that's an item that's traditionally listed as CME in the Medicaid program and that was how we had configured our system to pay for it and I think quickly realize there's not just spacers but a number of items that fall on that CME list, that, that we're able to pay for through the pharmacy and we're in many parts of the state the pharmacy is far and away the fastest way to get those items so that list of items is growing but, you know, again, a good example of how I think one instance has helped us think through some additional considerations to really try to make it easier for providers to help their patients get what they need. The last one was probably the single biggest source of consternation and anxiety for me. We learned, courtesy of the Pediatric Society that several practices have been frankly incorrect guidance about collecting co pays from their patients, and that became a priority urgent issue for us we learned about it. Late in the afternoon, addressed it in the morning, I wasn't sure what IT systems might need to be addressed to really correct that guidance, but we deployed a team identified the issue, and made the coding change that day so you know I'm sharing those things, and in the timeframes for change, to emphasize how important it is, I think up to all of us on the session today to get the feedback in timely we want to make changes and correct the inevitable bumps that we know are going to come because many people are out there trying to do the right thing for the people they serve and we want to enable that as best we can. And then you can go to the next slide

Dr. William Lawrence Jr

So for us, I think we've already heard a little bit when Shannon talked about the substance abuse related, you know, care and drugs and those prior authorizations not being in one of the early things that we learned first couple of days was that we had some prior authorizations for medications that we will consider to be continuity of care that we weren't actually getting covered initially so we had to quickly learn how to fill that gap, that was a little early lesson learned, but one I think we've gotten under control. Another pharmacy related issue we had is, you know when you have these big eligibility files and transferring between different systems, sometimes you do have minor errors in the data that cause members to drop out, but what happens with that is if you have someone who follows off of an eligibility file that should be on there, and they go to a vendor that's managing a service for you. They appear ineligible and we had some situations where members some should be eligible and covered by Carolina complete health. We're appearing that to be eligible, affecting their ability to get care again something we were able to learn and identify, create a workaround for that it issue. And, you know, have been able to put some things in place to fix that. Similarly, you know, if you think about the two biggest things that our Doc's and our, you know colleagues thought about when managed care transition was coming in, will we get paid right. Will we have our patients, and that you know get our

patient panels mixed up. Well you may have heard it with Carolina complete help initially, we had an IT error that caused us to send out ID cards that had wrong PCPs. But fortunately, we identified that we're able to make a very, you know, quick adjustment to it, but a lot of work to make sure that we got all of those reassigned in the right way, but we were able to re issue early implementation ID cards that will correct and have all of our members so that at this point we think that is totally under control, and we're happy to be able to make a quick response to something that was important. And then in terms of prior authorization similar to, you know what we've heard from a colleague already, And what we talked about earlier with the changes that the department has, you know, made in collaboration with us, to ease that burden over the first 60 days, but we do encourage you know the reason that we have that break is to allow us to work with you all to help you all learn our prioritization processes and how to make those work, so that when we get past that delay things are able to work smoothly and Tara's able to do so fast the next slide.

Dr. Michael Ogden

Great, thanks. Well, um, so, so from healthy blues perspective. We have had some of the same issues that my colleagues have already mentioned. Oh, and that Shannon mentioned at the outset of the call. It strikes me how similar these, these issues have been and what we have focused on is ensuring that we're being as responsive as quickly as possible. The first issue that's come up, related to what Shannon had mentioned at the outset of the call is rejected claims. Many of these rejected claims were related to submission errors. But, you know, and, and some of them related to taxonomy, some of them are related to other issues. And thanks to the feedback we've received from our provider partners, and thanks to the help of some, some really smart folks inside our health plan and working with the department. We've been able to reach out, do some do some training, working with our availability platform to ensuring that that providers are using clearing houses, like you know waystar EMD teams clearing house, have the right instructions they can they can give their, their clearing houses it. Another issue that we want to ensure that our provider partners have been taking advantage of relates to, you know, getting claims in and getting paid as quickly as possible. So we've also been providing some education around, you know, how our website works, how our platform works and how to get enrolled into EFTS, which makes things a whole lot easier on providers, gets them paid a lot faster, and ensures that there's a loop that's closed, and that they get what they need as quickly as they need it. Um, one of the other issues that we've experienced and are continuing to work through with our provider partners, has to do with with what's been mentioned by by my colleagues and that's the prior authorizations, helping folks understand, you know when you need to submit on what platform you need to submit, and how, how the process ultimately will work on one example that has come up, just recently, is a great example of how we're being responsive to how we're trying to respond. While while being good partners with the folks that are taking care of patients in North Carolina has to do with the physician minister drug program. In this case it's, it's a relatively small number of pediatricians myself being a pediatrician I've done this as well before, who are submitting vaccines without, you know, during a well check which is normal and natural, but also submitting them without the, the required Z 23 code, the ICD 10 code this required to identify that as a vaccine.

Dr. Michael Ogden

We are working through a process now, by which will end up doing a manual override and end up paying that during the first 60 days after managed care launch, but also reaching out and ensuring that our folks that are giving vaccines understand that appending this ICD 10 will improve that turnaround time that you're looking forward to ensure that you're getting that reimbursement, as quickly as possible, so that I'm, I'll pass it over to my colleague.

Dr. Shannon Dowler

And I think we've got a couple audience response questions before the next person goes so we for those that never. And by the way in the background over 87 questions have been answered so the teams are working hard on answering your questions in the background. So we have found the online prior authorization lookup tools to be a helpful addition, true or false. So have you found the online prior authorization lookup tools to be helpful, true or false. All right. What do we got Nevin. All right, so most people, not I said true a few say false actually 58/42 What about the next question. Nevin, you got one coming. There we go. I found the Quick Reference Guide from the health plans to be useful. So the quick reference guides that each plan has, which we've linked to and all of our backwards tasks and they're on our website, it's sort of, it has all the everybody you can call and how to get to them. True or false are they helpful. All right, and then what sort of people said, Alright good. So those are that's got a much better, thumbs up. Alright, let's go on to the next slide. Michelle, you're up.

Dr. Michelle Bucknor

Okay, Shannon, can you hear me, yes better. Okay, we're gonna try to turn up the volume so I hope I'm not too loud for anyone. So, much like many of our, my colleagues, we have seen the same sort of calls coming in. I will say although these are the call types that we have needed to take time to address most of our calls have been related to the benefits, eligibility, and then prior authors you would suspect that most of the prior art costs coming in really are just for submission, but for our top three calls that I think having an understanding is useful for this audience is around us paying out of network providers, and as chairman stated earlier, you know, for the first 60 days, the requirements of the same for out of network providers, and we do pay 100% and specialty providers as well and then of course there's no referrals needed so, I think, you know, we've been able to address that and when you think about, you know, comparing Medicaid managed care I think a lot of folks have thought it would operate the same as a commercial or another type of health plan and I think what folks are seeing is that nicely the Medicaid rules are different and we all align around what the department requires and so we've been able to reassure folks that if they are out of network or if they are referring a patient to be seen, but out of network provider that we will cover those services for the first 60 days and I think that's what's important to the department, important to us that united and to all of the PHPs that no member goes that without services that have either been pre scheduled before the launch, or certainly now that we are live. The other area that we get a lot of questions around is the prior off submission process and tracking process, and I was able during some of the Q and A's to peek at the chats and I see a lot of questions still coming in around the power off process and more importantly the tracking process I did see one question saying, you know, how do we know that it was accepted and how do we know where it is in the process so united, we have a system that we call pan, so it's the prior authorization process and

you know in that system you can actually track where the request is in the process, submit it and then track it. And what's really exciting about using that online portal is sometimes you can actually get real time authorization approvals. And so for me, you know, when I was a practicing provider that would have been key, you know, and that's the beauty of automation and being digital now that you can know if you do an authorization well requests while the members in the office, sometimes you know immediately, or can at least know, you know, after they leave whenever the staff member submits information so we've been able to educate our providers on that and people that participate with other lines of business are probably very familiar with that process. What I will say is that, you know we are updating and advancing the process to meet the needs of the provider community and so if you haven't been in there lately I would really encourage you to try it out. The other thing like my colleagues the proper billing and claims processing has been a concern that folks have called them and I know that that, you know, we all want to take care of members but we need resources to be able to do that so, being able to receive timely payment is an important goal to send to our provider community and so we actually are very proactive and reviewing our claims submissions. Looking for errors looking at what might be denied and so with that process we were also able to identify that taxonomy issue and have identified providers that seem to be submitting those claims without the taxonomy and are proactive with the outreach so people may or may not see denials actually come because we stop pended those claims, and are doing the education on the provider community so we, I would encourage you and thankfully our provider service folks on this call, I hope you know the column because every call gives us an opportunity to identify ways in which we can help support the provider community support our members and address issues real time so I personally want to thank you for taking care of our members and I'll go to the next slide and pass it off to my colleague.

Dr. Eugenie Komives

So, I've had the benefit I guess of bringing up the rear here to listen to my colleagues and I was thinking that there's probably some layers of response that all of us have had on the issues that have come up. So I think everybody is saying, we're going to fix the issue for the member first right. If there's a member that needs a service, and for whatever reason, whatever issue. That service is has not been able to be obtained because of a PA or some other issue that I think we're all number one taking care of the member first. Number two is certainly taking every opportunity to educate, writers, pharmacies, if there's a workaround on some kind of a technical issue that can be done in the short term, while we fix a long term issue right. The third is making sure that our staff are well educated, and you know it's again, it's a big and complex program and no matter how well you train your staff, they're going to get a question they don't really answer to and they're usually going to give the wrong answer and I personally really appreciate when I've been getting outreach from providers and associations that, you know, if we haven't given correct information or if something is uncovered our website, it's not where it should be, so that we realize it's there and can go out and try to get it fixed as quickly as possible and then finally, using the system issues in some issues are credibly fixable and other issues, take a little bit more time but we're doing everything we can do in the meanwhile to mitigate those impacts so sitting down and more specific for us because we've waived a lot of outpatient authorization servers 90 days after go live, we're seeing where she's on the policy side where authorizations are not waived and we've seen some issues around our COVID vaccine going. And in particular we were getting any valid perscriber ID and rejection there. And we've contacted the pharmacies that are having that problem, and also put out a

text blast all the premises about using Dr. Tilson's MPI using the vaccine protocol for the vaccines that seems to solve that problem. We have had some NDCs at the pharmacy that were not correctly loaded and we're able to uncover those for monitoring the pharmacy clinician, really carefully on a day to day basis, and also getting feedback from providers and department about how things should have paid that did not appear to pay at the pharmacy, we've been able to fix that. And again, EMT has been a challenge for all of us. And we had some trips that were correctly booked with a driver and then driver cancelled, and we didn't have a quick enough feedback loop to get those rescheduled resulting into missed -- for members which is something that none of us want to have happen. So we've been working with our EMT vendor, make sure that they put some dope checks in their process whenever there's a canceled trip to prioritize that and really try to work it immediately so that any can get rescheduled. And then we also had some longer than desirable wait times on our a&t Call line. We've worked really hard with them to bring in some additional staff, and we're seeing improvement in at this point in time. And then finally, we've had some policy issues. But we staff education around how to handle pharmacy requests that are not on the preferred checklist, particularly for EPSDT. And then also, we found out through some of those escalations that we also didn't have some of the information out available both are provided for us to our staff so that they could take from CPA requests over the phone person. And so again, thanks to folks for escalating those issues to us so that we realize the issue and could fix.

Dr. Shannon Dowler

All right, let's jump to an audience response question. Thank you all for your very candid answers to what your call centers are hearing, I think it's helpful for folks to see that some of you have asked questions by the way in the background and you haven't got an answer yet. Hugh is going to be answer some of them we feel like it'd be really good questions for everyone to hear the answers to so some are going to be answered, live as we get through our last few slides. So Nevin what's our next audience response question. So when you think of your and your team's experience and patient's ability to access services since the transition. Have your patients had challenges accessing and I want you to check all those that you have observed and your experience, patients having difficulty accessing services. And I would say differently than prior to the transition. I think some services are hard to access all the time, but which ones are Have you noticed that since the transition are particularly more difficult for your patients to access, if any of them. And you can select all that apply. So there's not just one answer, it's all those where you've seen this. so it's a little bit of a longer one, we'll give you a few seconds to fill that out radiology procedures, pharmacy specialized therapies, verbal medical equipment, personal care services private duty nursing transportation. Any differences since the transition, and patients accessing services. Alright Nevin let's see what people had to say. So pharmacy seems to be the big one. Really, really closely tied with specialized therapies with transportation in third place this is really helpful for us to see and to take back to work on. So thank you. All right, next question.

Or it may be. And that was the slide. Okay, so we did do a survey, thanks to the 425 people that did respond to the survey, trying to figure out what to do next with our backwards chat series. If you go to the next slide, just really quickly, I'll let you know that overall, We ask people how many chats, have they been to since the beginning of March when the pandemic started and we started this webinar series. The most had been to just a handful of them. A few of you are compulsive people that have been to 20

plus I'm very impressed and. Next slide. For people that are longtime attendees and we asked if the chats had stayed steady, improving over time become less helpful or been erratic and it looks like most people feel like they've stayed steady or improved, which is great. We're glad to hear that. Next slide. After launch how often you want to have these updates so we were doing every other week for the last year and a half we were even weekly at one point in the pandemic. And the vast majority of you said once a month is plenty. So thank you for that feedback and what we're going to do is start with monthly will be the third Thursday of the month, starting with this month, and we'll be once a month on these chats until March of next year and then we're going to be fired up and get ready to launch our Tailored plans, so we'll go to twice monthly starting in March of next year to get ready for that Tailored plan launch. I think we have a ques tion that's a bunch of the people responding, go on Nevin and fire that question, I was saying that they wanted to move the webinar time that they didn't like this after hours time and they'd rather have it be during the work day. But we know that we have a lot of providers also on the call and so we just wanted to get a sense of what is better for you. So would you please select the time that you think is best for these webinars, we gave you a handful of time 730 In the morning, nine in the morning, noon, four in the afternoon or 530. So what time would you like best. That will help guide us on these. I think you'll probably my husband's hoping you pick one of the earlier ones but we're we'll do whatever you need us to do. All right, never would have people have to say about that. All right. Winner winner chicken dinner, so we're keeping the time. All right, next slide.

We also asked about the what was the most valuable things and the least webinars the chats and the number one thing was actually the slide deck just being able to get the recording and the slide deck afterwards. But question to answer came in in either the open question and answer, or the background questions and answers that are happening, came in second place. So we wanted to make sure that we gave some extra time for that tonight. So speaking of, let's get into some of the questions and answers that still remain out there in the slide deck just so you'll know we do have a lot of things in the appendix links and quick reference guides and just things to help make your lives easier, we try to include these in the appendix of our talks, and those slides are available online. So, whew, panelists, everybody ready to fire up their cameras and ready to answer some questions. In the background we have gotten 130 questions have been answered, which is pretty impressive.

Hugh Tilson

Yeah, we've got a lot that I've been trying to pick the public, all questions and a couple that have come in. Will the PHPs be using the same telehealth billing guidelines we used in the pandemic, like the GT and CR modifiers and place of service codes.

Dr. Eugenie Komives

Yeah, so, the expectation is that at a minimum, the PHPs will all follow the current state policy guidance around how to build for telehealth. And then I think there may be some PHPs that are accepting some additional telehealth billing codes as well. But if you follow the state's policy guidance I'm doing you should be okay and I think I would speak for my colleagues if you get any level of claiming directions,

please reach out, let us know so we can dig into our systems and figure out what's going on and make sure it gets fixed.

Hugh Tilson

Thank you. You know, as a quick follow up question this is during the pandemic. Do we have any idea how long we're going to be part of the pandemic or at least part of the executive order.

Dr. Shannon Dowler

That's a great question here and so if we've got a couple of things and Medicaid, we can make sudden changes like we did with all these telehealth policies and some of the other accommodations we made in the public health emergency. Some of them are made using federal authority, and some of them are used state authority. And so a lot of our modifications we actually have turned into permanent policy, we've done that over the last year and I've updated you at these back porch chats on what is permanent policy, moving forward because we felt like they really made us a stronger Medicaid program, but there are so a fair number of things that are temporary policy in place until the end of the emergency. The some of them are state based and so we're waiting now for the Secretary and the governor and others to decide when our state, state of emergency will end. And when that does some of the things are going to turn off, we are really committed to giving you 30 days notice on those things so no one's totally surprised. We'd like to give you more time than that. And then others will be with the federal public health emergency, we've heard rumors, it may even go into March of next year on the federal level but who knows. We, as you know from the last year plus, we kind of hear at the last minute when it gets extended, for the most part, but the state probably will end sooner, and we're just waiting to hear when that'll be. Alright what else you got here.

Hugh Tilson

How about this one. Oh, when will the other beneficiaries be added to managed care?

Dr. Shannon Dowler

Um, great question so 1.6 million people rolled over July 1 of those almost 77% are under 21. So, our youngest population have moved into the standard plans next year in the summer we will be moving into the tailored plans and so those are folks that have intellectual and developmental disabilities, and more significant behavioral health needs, and then a year after that, we are going to be moving into the foster care. So July of '23 is when we'll have our foster care program that will launch. So lots of change, lots of things are happening and then we'll start thinking about long term care and all the other things different states are doing, but we do have it being phased so what that means for all of us is that no one gets to live fourth off for a very long time.

Hugh Tilson

I'm sorry about that. We heard lots of kind of different iterations of this and I think it was Dr Komives who referenced this but we were under the impression that authorization processes that were in process with North Carolina Medicaid would also be the same with managed care plans. However, this does not seem to be the case, can you please address this.

Dr. Shannon Dowler

So I think a couple of parts of that question this is something we brought up over and over again in our chat, dating back last fall, because I felt like this was going to be one of the hardest parts of moving in the manosphere and the end is called Managed Care for a reason it's a feature, not a flaw, it's it's actually by design, that there is more management of the care and that, so that one of the ways that's done is with utilization management. So why we have said to the plans you have to follow the floor of our clinical policies and scope a mountain duration, and there are some, you have to follow to the letter we have those 13 special policies that they have to follow exactly to the letter, including the utilization management piece for everything else they can have different utilization management, ultimately, they have to be able to provide that service in the same scope amount and duration as our existing critical policies work, so they are going to have different prioritization, There, there are going to be different hoops to jump through they've worked really hard to try to align, they use a lot of the same guidelines, so it shouldn't be that much different, it should be very similar to your commercial world that you live in, when you take care of commercial folks but it is an that is a feature that is part of managed care.

Hugh Tilson

How about this one, we're in the process of applying to be an in network provider. Now, can we continue seeing patients while pending credentialing.

Dr. Michael Ogden

Shannon, happy to jump in on that one, if you'd like. So, so, here's how I'd answer that question. And really it's it's for the first 60 days after managed care launch, you know, if you're actively in a negotiation process with a, with a PHP, you know, you can still see patients. There are some pa rules rates might be a little different so it's important to check with with the PHP who's patient you're seeing if you're, if you're currently negotiating, or even if you're not in negotiations and don't plan to ultimately take that PHP, that's for the first 60 days. One of the things that we've been seeing is fairly rare but, but we are seeing it, is that if you're not enrolled in Medicaid, which is a different story than being in process of contracting with the PHP. If you're not enrolled in Medicaid, but have a contract with another line of business and other commercial plan another Medicare Advantage plan. Um, and, and you want to you know see a Medicaid patient. It's important to remember that you have to enroll in Medicaid and you have to be active in nctracks in order to, to see a Medicaid patient and build Medicaid in any way shape or form, whether it be PHP or Medicaid direct.

Hugh Tilson

Thank you very much. Um, lots of different versions of this one too, please expand on what ID is needed to submit on claims Medicaid ID or the Member ID.

Dr. Shannon Dowler

Yeah, so we actually went through and made a grid, and I was going to show it to all of y'all tonight. So you can sort out this very complicated thing and it turns out it's actually not that complicated. All of the plans for medical and pharmacy claims will take either the Member ID or the plan ID, healthy Blue has a different kind of payment where you can do something different, Michael, you want to explain that.

Dr. Michael Ogden

Certainly, so with with healthy blue I can speak to that, you know we do, we can accept both our healthy blue ID and the Medicaid ID. One of the exceptions to that though is if you're going into our portal which streamlines the process and helps, you know, expedite the claim. We do want you to use our healthy blue ID. When using the availability portal. Again that's going to streamline the process.

Dr. Shannon Dowler

Yep, so but otherwise everyone says Medicaid ID or the plan ID for pharmacy and medical claims.

Hugh Tilson

Thanks, I got a kind of follow up question that one will help plan IDs be in NC tracks.

Dr. Shannon Dowler

Um, we just had a meeting about this today. Um, I don't know, is there anyone on from my team that can answer that question. Think I think we're probably gonna have to take a pass on that it is not, I think, oh good Kelly turned her camera on.

Kelly Crosbie

Yeah I mean I think folks have raised it raised that question, because of the billing use case. There was probably an authorization use case as well so I think it's a good question and I think we're exploring why folks might need that and what the best solution is, and what what what we should do to help with the

situation so it's a, it's a bit of a long winded answer but noted as something that folks have requested but we're just trying to understand why the requests and what the right solution is.

Hugh Tilson

Somebody just wrote we're hearing that the plans are not accepting both we heard from healthy blue that you must have health plan ID for claims and PAs if that's helpful. So Shannon I've got a ton of questions in here, I've highlighted a couple but typically you have a couple that have just jumped out or others have a couple that you want to hit before I start just picking the ones I think are interesting, is there anything that's just jumping out of you that you want to respond to or anybody on the team.

Dr. Shannon Dowler

Yeah, I will confess that I've not been trolling them like I usually do because then when I do that I forget to do my part of the webinar so I've actually been not looking at that carefully but are others did anybody see something that they like so important to highlight. Yeah so Serena's telling our PCS providers, we saw there are a handful of questions about the team is actively working on those with the plans and in the next couple of days we're going to have a lot of clarity for you. So just know that if your question wasn't answered right away it's because it's in process and we're working on those answers.

Hugh Tilson

Thanks. There are a number of plan specific questions that still haven't been responded to. So, I know there are lots of people looking at these if you could kind of go back up to the top and work your way back down that might be helpful. I got there a number of different iterations of this one which is still concerned about network adequacy, while there's a window of time we're okay, concern that to large regional hospitals have only signed up for two health plans, as we will have to refer for specialty outpatient care elsewhere, or otherwise handle it, putting burden on PCP and potentially on the patient. Can you talk about network adequacy and how y'all are responding to that.

Dr. Shannon Dowler

Let me open this up, or just anyone from the plans when I speak to this contract is kind of two issues it's it's contracting and or being excluded from not contracting, and how are you going to make sure that beneficiaries are cared for. If you're not with a big system.

Dr. George Cheely

I would mention and I'm happy to jump in and would say that when I feel the questions related to network adequacy, you know, the contracting didn't stop when managed care started so we continue to really work towards contracting and would say to providers see maybe, maybe, fielding those concerns,

you know, let the, the local leadership at the hospitals in your area know I can speak for AmeriHealth Caritas North Carolina we continue to engage in contract discussions and negotiations, we're really committed to trying to get to agreements, and all of them PHPs are held to adequacy standards in terms of specific times and distances to an assortment of different services and we will all be working very actively to try to meet those standards first, and then be developing plans member the member for how we're going to help that member get the service they need. If there's a deficit and the first part of that again comes back to checking for available providers locally, and really emphasizing the outreach in the contracting process.

Dr. Eugenie Komives

Yeah, Shannon, this is Genie and I would echo everything that George said and then the other thing that, you know, right now, for the first 60 or 90 days depending on the plan of care can be covered at an out of network basis, at the same rate as in network but we definitely want to contract with everybody. If we run into a member issue where there's truly an access issue is a result of not having a provider in the network. And there's not another network provider available then the other thing is location agreement an option to make sure that the members thing. So I'm sure we're all working really hard to try to get all the providers into our networks

Dr. Shannon Dowler

And I think there are definitely some areas in the state where people have said they're just gonna move beneficiaries. They cannot move them the beneficiary has to select that themselves but they're going to encourage beneficiaries just to move to the plans or contracting with them. It's important to know that if somebody does change a plan which the first 90 days they can change, for any reason they don't need to have a core cause reason, but it will go into effect the first of the month following when they submit that and so the 60 day window that's a really important window of time where the plans are, there's just a lot of grace around accepting everybody as in network is going to end soon so we only have a couple more weeks where we can make sure that beneficiaries are really switching up their plans and getting into the plan you need them to be in, to stay with you or to stay with the specialists they need. But ideally, best case scenario is I've been talking about this for over a year. The best thing is if everybody contracts with everybody, then we don't have these, these issues, knowing that there are going to be situations where it just doesn't work out.

Hugh Tilson

So, thank you for that, I got this question that kind of relates to that. Just moved. But the bottom line from go. Sorry. The question was I had a bunch of patients assigned to me that aren't my patients and I have a bunch of patients that weren't assigned to me that should be my patients what should I do.

Dr. Shannon Dowler

Yeah, so we want people to get in the right medical home. This is important for a lot of reasons but Kelly do you want to give that guidance on that.

Kelly Crosbie

I mean, the first thing you should do is, of course, talk to the health plan right to try to understand. There will be plenty of situations where you might get patients assigned to you that were previously not your patient, that happens, we assign new patients every day to your practice and we want you to engage with them. In cases where you lost patients, please talk to the health plan because they can research it to find out why someone might have been legitimately reassigned maybe because of a family match or because they were seeing another provider, or it could be an error. So please, again, first check with the health plan to try to understand if you feel like you're not going to get resolution you can always reach out to the provider ombudsman and we can try to help as well but, but hopefully it's just a perfectly logical explanation for, for, for an error or why why your members company.

Hugh Tilson

Thanks. There's a specific question which is will the PHP address behavioral health needs, but there are a number of questions that have come up throughout this whole thing which is, does this apply to behavioral health does this apply to behavioral health. Can you talk a little bit about that.

Dr. Shannon Dowler

Yeah, I'll kick it off and then if Deb is on the phone, she is our resident guru on behavioral health things if you want to plug in any of the specific things or the plans can weigh in. Absolutely I mean part of the design of North Carolina managed care is integration full person care, and so that is a huge focus of this, so this standard plan is mild to moderate Behavioral Health Leads. If someone has severe, persistent mental illness or IDD, then there have the option to be in a tailored plan where they can get a different bundle of services, they'll stay in Medicaid direct until that time. But yes, mild to moderate stays and Standard plan, it's wrapped around it's everything. And there's a lot of positives to this, as far as accessing services. So does anybody else on the panel want to weigh in on behavioral health coverage or whew, Are there any specific questions that folks can answer.

Hugh Tilson

Panelists answer but no, that's just the question is is this behavioral health also and is this behavioral health also so..

Dr. Shannon Dowler

There I would say that we've done a couple of webinars specific to behavioral health, so if you go to AHEC's website where where all the backwards chats are listed. We do have a couple webinars that are totally focused on behavioral health services, and if that might help answer some of the questions that are still out there.

Hugh Tilson

Going back to the patients. This is a public all plans, when we view download or list of plan assign patients from the portal, can we differentiate between NC Health Choice and NC Medicaid patients.

Kelly Crosbie

Not yet. Um, if you read our information on the enrollee reports, it calls out that at the moment you can't differentiate between Medicaid and health choice you can differentiate between Medicaid direct or managed care in which particular plans. So, that is, that is something on the radar and it's a it's a potential future enhancement but not right yet.

Hugh Tilson

Thanks. Who can we contact regarding coding issues I codes that have been covered in the past but are suddenly being denied.

Dr. Shannon Dowler

So first thing we want you to do is work with the plan, because it could just be that, you know they have a little glitchy we're all human and in this transition, maybe there's some little glitchy things So work with the plan first to see if it's a plan specific thing that they can fix. If it's a systemic issue that you feel like you're hearing this from all plans we certainly want to hear about it, reach out to the provider ombudsman, so that we can get those things on the radar. I also know that the North planet medical societies are meeting all those specialty societies on a regular basis so that they're taking in all this feedback they're getting so we can fix things as quickly as possible. And so we really want to fix those things quickly, and you might recall that the plans are, have a lot of financial incentive to get you paid accurately and on time, because the penalties they have to pay for not doing that are not insignificant, and so they really want to get this right too. So go to the plan first, try to get it resolved, and if you can't get it resolved there then please go to the provider ombudsman.

Hugh Tilson

Somebody commented please note that we're going through a lot of challenges staff turnover due to COVID new OSHA requirements that are significant COVID-19 Vaccine administration, this is a lot on us and again I know we've talked about that in the past but just wanted to remind everybody that there's

that sentiment and that sentiment there's that reality out there is all these practices are dealing with all this.

Dr. Shannon Dowler

I think that's worth observing. Yeah, no, I appreciate that it is a lot. It is a lot a lot a lot, just know that I could not be more confident that the folks behind the curtain are working really hard to get this right. And so we're, we're constantly troubleshooting and problem solving. So hopefully you're feeling that

Hugh Tilson

Got a bunch of questions about, when will PMPMs be paid and is there a PMPM for those beneficiaries in the dual population.

Dr. Shannon Dowler

As I said, comment, Kelly you when to start it and then we'll

Kelly Crosbie

The PMPMs, the Medical Home fees. So did your medical home fee in Medicaid direct it's going to come out just like it always does in Medicaid direct the plans will also pay a once a month Medical Home fee, and for AMH threes. Also once a month care management fee, but maybe it'd be great if the plans can say if they pick it on the first check rate second check rate I'm not actually sure.

Dr. George Cheely

Shannon, I know for amerihealth, we had an issue where we didn't pay it right on the first but we paid it last week and at least for us, we'll pay monthly on or about the first of the month. That's when we're intending to make the payment.

Dr. Michael Ogden

I'll follow up with that. Ours were processed yesterday and check should ride start arriving this week. I didn't want to call it because it sounded like there the question involved duals which, you know, certainly ABD patients on aged blind disabled patients would would be included duals, I believe are not included in managed care. So

Dr. Shannon Dowler

Correct. Good flag. Yes. Thank you.

Dr. William Lawrence Jr

Hey, at Carolina complete health to go for our PMP exam payments will be around the 20th. Each month, the date of that first one, we're still working out some final kinks. So it'll be before the end of the month. If it is not directly on the 20th. We're going forward to be the 20th of each month. Anybody else?

Dr. Michelle Bucknor

Yeah, Shannon for United? It's the 15th of the month. For the money I just keep rolling in. Yes.

Dr. Eugenie Komives

Yeah, and our timeframe is fairly similar to Carolina complete Health.

Hugh Tilson

What if providers patient panel is increased beyond the practices capacity? Is there an option to limit with the plans? On the same lines? What is the process with the plans if a provider would like a patient removed from their attribution list? There are patients that have been dismissed in the past for legitimate reasons that were then re attributed? What is the providers responsibility to that patient at this point?

Dr. Shannon Dowler

Great question. Plans now want to take that one.

Dr. Michelle Bucknor

I can start Shannon. So for us, you know, if a practice feels like they're at capacity, they can limit their panel size, just work through our provider call center, and we'll get you to the right place. I did see a question in the chat that I'll just that's related to that. If you do have a closed panel, but you're a pediatrician, you see the other family members, and you want to add the newborn, you can also call in and add the newborn, we wouldn't add them because you have a closed panel. But we want to keep the family unit together. Right. And so you can call and have them added to your panel. And I think there was a third part of that question, oh, removing patients. So we do have a process. If you have a reason that a member should be removed from your panel, I would apologize if anyone was reassigned. The plans did their best to keep historic PCPs. And so if they had a new PCP, they should have been assigned to them. I think the challenge comes when someone came into our plan, and historic PCP was not in network, and then we would reassign those members. So there is the potential that someone was

added to your panel. So I would recommend that you call our provider call center and we can work with you to have the members removed.

Hugh Tilson

Somebody wrote in is there a form that they can fill out?

What are you thinking about that somebody wrote in Dr. Dowler, please read some of the responses from the plans in this q&a replies, you're saying their IDs only and other conflicting information than what you are giving? This seems to be a recurring issue on so many levels? Say thinks one thing is happening because they said it. It should be what's happening, but it's not what's happening in reality.

Dr. Shannon Dowler

Well, my special powers are limited. Walking and chewing gum at the same time. It's not my strength. But what I will commit to you is that we will all of us. Look through we get a printout of all these questions and the answers we'll get from a hack tomorrow. And we will go through them and make sure that we correctly a consistencies and identify those, some, some of the things are responded to privately and others are responded to publicly where you can see them. And so it's right now 184 have been answered. And they're still 88 waiting. So that's a lot to go through and catch it. I'm sorry.

Hugh Tilson

But one of the question is are we going to post the q&a? And the answer is yes. We'll put on the NC AHEC website after it's been gone through and looked at, as you described, we want to make sure that whatever does get posted is accurate and consistent. So somebody commented that hospitals are already mailing out to patients to switch plans to the ones that are participating with we may end up having to reduce our plant participation to align with local hospital and employee specialists in response to our network adequacy discussion earlier. Yeah. Trying to figure out if there are other questions that are, are EOB sent to patients homes.

Dr. Shannon Dowler

Great question when you guys want to grab that one?

Unknown Speaker

I'll try. Because we reviewed that not that long ago. And I believe the answer to that is mostly No. For making it's not required, since there's no out of pocket. I think the answer is also no for health choice, because it's only the copay. And I think there was also Shannon and some of the questions that we

talked about in preparing for this. On the EOB question, there was also comment around sensitive diagnoses and adolescence. And in any situation where we would send an EOB to the member or the responsible party we would mask any of that protected information.

Hugh Tilson

Somebody responded, can you look at our responses variations, see how you can continue to try to standardize things. Otherwise, this isn't sustainable. As just as a comment to some of the variation and all this. If patient comes to the clinic with the wrong provider on their card, is there a form that we can utilize to have them sign and fax in to initiate the change, and it's a follow up from our prior conversation.

Unknown Speaker

So I don't know about a form. Like at the point of service, if the provider wants to, they can get the member on the phone with our member service agents, and they can change the PCP. There are rules around, there's one not for cause PCP change. And then after that, I think that's right. And then after that, it can change for cause as well throughout the year. And I think all the plans have really quick, average your answer on those calls. So that would be an option. I don't know whether or not we can follow up on that.

Dr. Michelle Bucknor

And Shannon, we're actually exploring the utilization of a form. We don't have a form currently. But we do realize that would reduce the administrative burden on the providers and create some efficiency for the practice. So I will say I'm advocating strongly for a form with tonight.

Dr. George Cheely

This is George, and processes, similar to what Dr. --'s described in terms of getting the member on the phone and calling Member Services. I also think at the start of the question, there was a question around the points of variation. And the need to focus on the Administrative Simplification. I think Dr. Lawrence has done a really nice job of continuing to convene the PHP is and I mean, I can speak for myself, I think I probably speak for all colleagues on the line that we're committed to continue to take issues and work through those that we can so appreciate the comments, appreciate the point towards the points of difference. And yeah, I think we are committed to continuing to work through those as they come.

Dr. Michael Ogden

Yeah, I think they're going to be points of differentiation that add value, they're certainly going to be points that don't, you know, like my, my colleague on Dr. Cheely. Oh, we're always looking for ways to eliminate those that don't add value to the patient experience.

Hugh Tilson

Thank you got this question. Is referral required from the patient's PCP or can the patient conduct a self referral?

Dr. Michelle Bucknor

So if you can start to answer that question, and I think I spoke to it a little on my slide that no referrals are required for office visits for United I do think that's true across all of our plans. What I will say is that if a member is seeing an out of network provider after the 60 day mark, they will need to have authorization for that service. But no referrals required at this time for any office visits.

Dr. Shannon Dowler

Same conditions exist for all the other PHPs. See, everyone is the same and something Yay.

Hugh Tilson

I did get a shout out that says thank you for trying to make the process easier. We know our clinic staff are too busy seeing patients to make those phone calls. So they're specifically responding to you Dr. Buckner but up all the ideas of standardization. So thank you all for that.

We've seen several pregnant women that have been required to pay co pays for specialty providers and pharmacies, pharmacies not able to override co payment requirements can you advise?

Dr. Eugenie Komives

So this Genie, we did uncover an issue with the pharmacy override. So if the member is in the line of business to Medicare for pregnant women, no co pays should show up at the pharmacy for the members who would otherwise have Okay, and they are pregnant, but they're like on standard Medicaid, we did have an issue where we hadn't programmed for the override, which I think we've either fixed it or rapidly in the process of fixing it. So any, if any of those well care, we apologize, and we are aware of it, and we'll go back and make sure the member gets reimbursed necessary.

Dr. Michael Ogden

Healthy blue has not experienced that if if a provider is experiencing that, we would love to hear from you. If I've got my email on this, I'm on the slide deck, please give me a shout.

Dr. Shannon Dowler

I think that's a really good point. And as we wrap it up, you know, that's one thing I will say is the more information you feed us or when things aren't going the way you think they should be going. Claims not being paid services not being rendered. If something feels glitchy, it's probably glitchy and we want to fix it and we can't fix it if everyone suffering silently and doesn't let us know. So please communication with the plant communicate with the plans directly. If you're not able to get your issue resolved or your beneficiaries issue resolved, use the provider ombudsman or the member ombudsman, because those go into a system that automatically involves and flags all of us to get involved. And so that's the only way we're going to know to fix a lot of these things. And we want to fix them. We want them to we want this to work for everybody.

Hugh Tilson

I think it's a great way to end since it's seven o'clock. So I'll thank you, Shannon, your whole team and all of our panelists for just all the work you're doing and wonderful presentation I without to get information. It looks like we responded to I can't see if I can pull this up. We responded to almost 200 questions and we still have 100 to go. But thank you so much for all you're doing. Let me turn it back to you for final words.

Dr. Shannon Dowler

Yes. All right. Thank you. Cameras up all the CMOS. Thank you. Thanks for all the folks in the background from our teams that have been helping answer all these questions. It takes a village and we're all working together to make this right and thank all of you out there who joined us on a Thursday evening for this webinar. Keep them the questions coming. We commit to going through the answers and making sure they were answered correctly and fixing anything that's not correct because we all want to get this right. So go enjoy your families tonight. If you're able or go for a walk or have a nice meal or do something to take care of yourselves. And thanks we know it's a lot. We appreciate you and everything you do have a great night