Transcript for Medicaid Managed Care Webinar Series

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Presenters:

Dr. Shannon Dowler, NC Medicaid

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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)

Kelly Crosbie

Hugh Tilson

Well it's 530 in the music's over, so I guess it's time for us to get started. Good evening, everyone and thank you for participating in this evenings back porch chat for Medicaid providers. As a reminder, tonight's webinar is a part of a series of informational sessions put on by NC Medicaid and NC AHEC to support providers with Medicaid managed care implementation. They put on these back porch chats focus on hot and timely topics. And to give you the opportunity to ask questions of DHB and the PHPs. Sounds like a band that maybe did that music before turn it over to Dr. Dowler. I'll run through some logistics. We have a lot to cover tonight. So I'll be brief. You can adjust the proportions of the slides and the speaker by clicking on the gray bar just to the right of the slide and dragging it to either side to adjust the size of the slide. You can also adjust your video settings to hide the people who aren't speaking. There's a View button on the top of your screen if you click on that, and then select side by side colon speaker. That's the person that you will see. We'll put these instructions in the q&a for your convenience. We'll have time for questions at the end and everyone other than our presenters is muted. Two ways to ask questions. The easiest one is using the q&a feature on the black bar on the bottom of the screen. I see some of you all already doing that. If you're dialing in, you can't do that. So send an email to questionscovid19webinar@gmail.com. Please know that our goal is to respond to as many questions as possible during this webinar. We have a host of people set up to respond to those questions if they can. If your question is not answered, either live or in the q&a, please reach out to the PHP for an answer. And if they're unable to respond, please reach out to the provider ombudsman. There's a link to the slides on the q&a there on the AHEC website. We'll record this webinar and we'll add recording and a transcript of it to the slides tomorrow probably. So now let me turn it over to Dr. Dowler.

Dr. Shannon Dowler

All right, thank you. Sadly, I am not actually on my back porch right now but I'm sitting in a hotel in Raleigh, but I'm going to pretend like I'm on my back porch. The mountain view behind me anyway, thanks, everybody for joining us tonight. If you're like us, you're probably already in your 40th or 50th hour for the week and you're exhausted. So thank you for taking the time and the energy to join us and hear what we have to say. Our goal is always to try to respond to what we're hearing from the field and try to give you timely information to if we're not succeeding in that mission, then we need you to let us know. So there is an opportunity when you register for the webinars to put in questions or comments. We hope that you'll do that so that we can keep these webinars useful for you and your practices. Alright, we had a lot of content to cover today. So why don't we go on to the first slide. So our data team has been hard at work trying to understand the vaccination rate for our Medicaid population. And it's not as easy as you might think a lot of the things we measure in Medicaid is based on claims data. Well claims data on vaccinations was tough on a good day, but particularly with COVID vaccine, because there's high rates of turn a lot of our early mass vaccination events didn't actually submit claims. Some of our contractor entities didn't submit claims in the typical way. And on a good day you got claim flags, so it could be six or 12 weeks behind. So the department worked very hard with our data team to merge the data from the COVID vaccine management system with our Medicaid rosters so we can understand what percentage of our Medicaid population had been vaccinated for COVID. Very soon, NCIR is going to have a two way communication where you're going to be able to enter your vaccine data into NCIR. But I think as of this week, you should be able to see it, which is very exciting news. And we're getting lists out to the PHPs and also the practices of who you have in your practice that might not be vaccinated. The data is not perfect. I will be the first one to say it's not perfect. There are some things we can't get access to so we can't get access to Department of Defense or veterans, for instance, data because that went through a different federal vaccine supply. That also doesn't go through vaccinations that were delivered to military personnel and veterans to TRICARE. It doesn't include data if someone is vaccinated in another state. Long term care facilities are in here. For the most part. There are a few exceptions, but largely the long term care facilities aren't in here. And there's a little bit of a data lag between CVMS but it's at most a week. So it's actually better than our claims data in that way. So if you go on to the next slide, what you see sadface is that our Medicaid beneficiaries are vaccinated at a much lower rate than the rest of the state. So 30% of Medicaid beneficiaries that are 12 or older are fully vaccinated versus our state number which is much higher. The 33% are partially vaccinated. So we do a little bit better with a with a partially vaccinated but still wow, you know, half the rate of the state. So if you go onto the next slide.

What I did was I thought, are we like leading lagging How does North Carolina fair so I reached out to CMOS of a lot of different Medicaid states and got their feedback. You can see we are not the worst. There is a state worse than us, but we were amongst the worst as far as our vaccination rate overall, some of these states have expanded Medicaid. Some of these states are well established and managed care and have different levers to use for vaccination. But overall, you can see a lot of the states have similar low vaccination rates for Medicaid beneficiaries. So go on to the next slide. I'm going to break down the data for you so that you can see what we're looking at. So we broke down who had gotten a vaccine by whether they were the managed care population or if they were in the excluded population. So about 1.6 million went into managed care a little under a million were in the excluded population.

You see the rates much higher in the excluded population. And that's largely because of that. Each blind and disabled population long term care there's different folks that are in the excluded, which have a higher vaccination rate.

If you go on to the next slide, you'll see that we're looking at it and measuring it by plan. And that's something that's just been tracking along pretty consistently. Our plans have different attributions too, so we know that some plans have a higher number of complex numbers than other plans. So we're just looking at it. It's right now. We're just measuring to see where we are. Do go on to the next slide. We're also looking at my age group, so 65 plus, you know, we're doing better. That's great, 18 to 64 comes in next and our 12 to 17 is really lagging and so we continue to see opportunity there. Do you go on to the next slide. One of the things we were interested in is does tier matter does they Hmh tear matter and it turns out it does the higher the tear of a medical home you're in that higher chance you are being vaccinated. Next slide. We also looked at this by race. So if you focus on the graph on the left, this is a proportion so as its relative to the number of beneficiaries of the population, and you will see that black is black African American is actually higher than our white population for vaccination rate. You see the Asian is far higher than the rest. If you go to the next slide, we do the same thing by ethnicity. And you see that actually our Hispanic population has a really strong vaccination rate relative to our Hispanic population. So that's different than a lot of the things a lot of the health inequities we have seen in Medicaid and our other quality indicators that vaccines seem to be going really well. There's more geographic variation than racial or ethnic at this point. If you go into the next slide.

This is the map that shows vaccination rates by county so find your county in there and see how you're doing green is great. As you can see, there's only one county there that green, a lot of comments we can make but we're not going to so a lot of opportunity in the state to do better on that. If you go onto the next slide. We do have a lot of things we're doing at Medicaid to try to get these vaccination rates out. We're trying to support you in your practices and getting folks vaccinated. And so I wanted to tell you about a few of these do go on to the next slide. You might have seen yesterday I believe we had a bulletin go out to the field telling you about a new code that you can use to go along with a 99401. You might remember a 99401 is our COVID vaccine counseling code that practices can use to do really comprehensive COVID vaccine counseling. It has a limit of one time per day but it can be billed by multiple different providers or even the same provider and more than one occasion. It can also be billed to a parent if you've seen your Medicaid child and the parents uninsured but you're counseling that parent, you can build that as well. We wanted to create a code that would allow your teams to get paid for doing some outreach work on those unvaccinated members that doesn't take a physician nurse practitioner or a PA to do the work. And so we've created this outreach code. So using the foundation of the 99401 now as a practice uses the KM modifier that notates outreach efforts that are made to unvaccinated members. Ideally, this is used in a practice that would then offer an appointment for vaccination or an appointment for more discussion with a provider if they need if they're hesitant and want more education on it. If a practice does not offer the vaccine, but they want to use this COVID vaccine outreach, then it's really important that you help coordinate a vaccine slot at another location for that person. So the idea is we're really connecting people to vaccines, if at all possible. They don't have to get the vaccine in order for you to bill for this code. You do have to make contact so you don't

get the bill for the no answers and the messages on the answering machine. But we think this will be helpful for practices as you begin to do more outreach and try to get folks connected and maybe it will set a precedence. This is not something that in the population health world we have necessarily paid for as a specific item. We'll see how this goes and then determine if this has other roles in the population health journey. If you go on to the next slide, and this talks about COVID vaccine administration, right.

So CMS came out a couple months ago and said if you want to pay people more than $40 for the vaccine, you would consider it apply for an exemption and we'll let you know if you can do it. Well, for the month or so no one got any exceptions. No one heard anything of it. Last month, they came back out again and said no, really, we seriously would consider it. So we've put together an application to CMS that we submitted yesterday, I believe, to ask them if they would allow us to pay more for the COVID vaccine administration rate for our practice. And we listed out all the reasons why and the context of a practice that you have to pay overtime for staff retention, bonuses, all the things that the practices are feeling in the crunch of not having enough staff the exam room space it takes so if we had approved and our goal would be for them to let us know in the next couple of weeks which might be too ambitious then we would as soon as we got approved for raise that vaccine, right? We have asked for $65 We'll see what CMS says TBD. So hopefully by the next backwards chat we'll have been using if you go on to the next slide.

We also have our vaccine communication team the Medicaid team really working on communication to members. We did a big town hall we have hold messages. We're doing postcard mailings, automated phone outreach, text messaging campaigns. We're along with the broader DHHS team. We're specifically doing average to Medicaid. If you go on to the next slide. We are also trying to raise our rate of vaccination with financial incentives for Medicaid beneficiaries. So the PHPs have partnered with the department and we have committed 5 million each so up to $10 million in developing and providing vaccine incentives to members to encourage them to get vaccinated, not to worry or Medicaid direct beneficiaries are going to have something as well. We're working with CCNC and the Eastern Band of Cherokee Indians to have a parallel incentive program for Medicaid direct beneficiaries. But now what I'd like to do is have each of the plans tell you about their member benefit. And this is going to be important this is gonna be good news for you. To be able to tell folks that you're trying to get the vaccine or giving the vaccine to to make sure they know about this. So I think Eugenie, Dr. Komives is first with WellCare.

Dr. Eugenie Komives

Thanks, Shannon. So yeah, we're really excited to offer a financial incentive for all members that obtain a COVID vaccine and the way that we're going to do this is using an attestation model. So members will have access to a website where they can enter some information about the vaccine that they obtained. And then we will authenticate that information and we'll mail them out a Walmart gift card in the amount of 50 bucks. And we're actually going to be able to provide this to any member that received

their full vaccination as of September o1 and we expect to extend this all the way through June 30 of 2022. At which point we'll evaluate the program. So very exciting things. Next.

Dr. Michael Ogden

Great I think I'm next here with Healthy Blue. It's Michael Ogden by the way, CMO for healthy blue. And we're really excited about the COVID vaccination member incentive program. For members that are able to get a vaccination documented. We are offering an incentive. We are strategy in offering this incentive is really to create some momentum and a sense of urgency among our membership. Our message to our members, is we want you to be comfortable with the vaccination. We want you to talk to who you trust with your health care decisions. To get the right advice, but we want you to have those conversations. Now. We want you to have those in the very short term and go ahead and get vaccinated. If you can do that the reward ends up being higher. Our requirement is proof of vaccination through submission of a photo of a CDC vaccination card right now going forward into November, December on perhaps even beyond our strategy will be to incorporate the NCIR data we'll have access to as well. One of the areas that we want to ensure that we're making constant revisions on is both the amount and the duration of the incentive. So we've we've programmed in some strategy around being responsive to our vaccination rates, so extension of the program, or even increasing the incentive or decreasing incentive. is a possibility. In our current strategy internally, our communication plan what we're planning to do to to maximize the benefit and get the message out is the focused outreach. The social media campaigns where we're already engaged with in fact, have already had 200 plus folks take us up on this offer. And also the member portal account. We'll we'll flash up the incentive information. We have outbound calls that are live we have an IBR messaging campaign as well. And we're doing direct outreach and community based events which have been very successful. already. We plan to leverage those to improve our vaccination rates. Next.

Dr. William Lawrence Jr

Good evening, William Lawrence from Carolina Complete Health. We are also excited you know about the partnership that the plans and the department have in terms of trying to improve access and utilization of the COVID vaccine. Our incentive program will initially target you know, those who are 12 and up, but we'll expand when we get approval for the 5 to 11 population, our incentive will be a $75 incentive for one vaccine, regardless of whether it's first second or a booster for those who are eligible and will go as long as the program funding is available. We will similarly use claims or a manual attestation process to identify those who are eligible and to process a payment. And we will use a similar array of marketing techniques that Dr. Ogden mentioned, for our populations. Well, we do plan to particularly identify those counties in our regions that have some of the highest disparities or lowest vaccination rates and make sure we do a little bit more targeted marketing and see community partnerships and outreach in those particular areas. But again, the overall hope is that we lift the tide of vaccination across the state with these collective efforts. Next thing

Dr. George Cheely

Hi it's George Cheely I'm the CMO for AmeriHealth. I'll echo the sentiments of my colleagues really excited about the program. excited about the opportunity to add a tool in the tool belt. You'll notice some similarities and some differences from those who presented before our Senate incentive is focused on members who are 12 years and older who have not been fully vaccinated by November first. We're really focused on primary vaccination initially, given the low rates and standard plans that that Dr. Dowler described. And we tried to build on lessons from the Division of Public Health and also feedback from providers that $50 didn't seem to be quite enough. And that the $100 available in certain counties just during the month of August really seem to have an impact. And so we're focused on a series of time limited campaigns. The first runs from November 1 to January 31. Really to try to motivate people to get vaccinated sooner rather than later. And we're paying $60 for the first of two shots and $100 for that full vaccination second shot if you're Pfizer or Maderna recipient and we're paying $100 for a one time Johnson and Johnson shot and I think we've thought about this using the WHOs framework focused on understanding hesitancy as a function of complacency, convenience and confidence. And in our view, the incentive really helps to tie some substantial dollars to help overcome complacency and also recognize that people who are taking time out of their day and are going to feel a little crummy may need some some dollars to offset the inconvenience on the confidence aspect. Look, the trust you all have worked hard to develop with patience is most critical. So our hope is that this will be just another tool in the tool belt if you're having tough conversations with patients. As some of my colleagues had mentioned, we have a few different ways we're going to communicate to members web phone calls, text message campaigns. Letters, we'll also have materials on our website that providers can access to provide to patients. And we're also I think similar to others eager to adapt our program based on what works so if you have ideas you have feedback about what's working well we are all ears where we're taking a QI sort of approach and expect to launch another campaign during 2022. That's going to be informed by our initial experience. And next slide.

Dr. Michelle Bucknor

Oh, good evening, everyone. Michelle Bucknor from United Healthcare. And I'm bringing up the pack. I'll say I will try not to repeat, but you're probably seeing some consistency across the PHPs and our strategy to include increase COVID vaccination rates by the use of a member incentive program. One thing and George mentioned another tool in your tool belt. I think for us, we've been committed since the beginning of the COVID 19 pandemic across our other lines of business to combating the pandemic and employing strategic efforts across the state. And so we continue on those efforts focusing on advocacy, vaccine hesitancy and support and outreach and so we're just picking up on that and this member incentive program allows us to bring more to the field like others we're going to focus also with grassroots community outreach and initiatives, not just in a historically marginalized community, but we know there's a lot of geographic changes and discrepancies in the vaccine rate so we'll have some geographic outreaches to but of course, the purpose of this has been to improve our outcomes and to align with the department and with other PHPs so we can sort of band together and include some vaccination rates. We also will use incentive cards that'll be a Walmart gift card in the amount of $50 our effort will run from the November first through January 31. Like others will they'll get an invitation to participate either via email or direct mail. Also have an online forum. So if you're vaccinating a member, you know having participated in some of these incentives I would encourage providers to to coach their patients and so not just count on PHP outreach, but this is something you can do when you're using

some of those outreach and counseling efforts that you can be reimbursed for why not let the members know that also, their patients can receive incentive for getting the vaccine that's more likely to bring them in. So it is an attestation model. They just have to go in mind and tell us when, where and what type of vaccine they receive. And so the other thing is we're going to make sure, as I mentioned, we focus on disparities and whatever those disparities are, if there's a way we can target and support practices, we want to do that also. Next slide please.

So this is the big news. I think we need a drumroll for this but I'm really excited to share with the field that we have created in collaboration, a standardized PCP change form. So this change form is live. The links are in this deck with every PHP so I think I can hear the applause on the field. I will say a couple of things about the form. First of all, calling member services for all the plans is going to be the quickest and the best way to ensure that members change their PCP and that does have to when they want to. That does have to be the member calling. These change forms are only for naught for cause reasons which they're allowed a couple of times a year. So it's really important that if the member has which PCPs twice that they have a for cause reason they're going to need to call in and some of that is just so we can understand what the concerns are at the member and support providers if they need support with addressing those concerns. The other thing I'll share is this is for not for cause but also only to move members into your practice. So it does require the signature of the member and the signature of a member of the office staff. So it's not to be used to move folks out of your practice. I think all of us would not understand the reason behind that. We don't want people shifting folks into your practice without your knowledge. So again, this is available. It is the facts form. And I think if you have any questions about it, feel free to reach out to your PHP contact, and we're happy to support you with this next slide.

Dr. Shannon Dowler

All right, that's great. You got to do the fun part. Thanks for Michelle. And all the CMOS who work together to really push that this came from them and was driven by them. They're the ones that put the form together and did all the lift on that. So I think that was really something we heard from the field and folks responded to quickly. I'm going to talk for a few minutes around the request and move forum the request to move process really from into Medicaid direct. So this is when we have someone who is in a standard plan and you have identified as their provider where they've come to you and said no, I need to be back with Medicaid direct because my needs aren't being met. So we continue to see member and provider ombudsman help desk tickets where a beneficiary is not moved back to Medicaid direct, either in the expected timeline or they just are unable to complete the process. So the team really dug into this and did a root cause analysis and we found several opportunities and ways that we might be able to optimize the process. But one of the key opportunities seems to be for providers and really understanding what this process is. And so we're going to take you through some scenarios. But as with all things, I'm a super visual learner. And so the first thing I did was I put together what is the flow? How do we actually do it? As we go to the next slide. Nevin.

One of the things that's important is the service authorization request. So this is in the behavioral health world now in the LME MCO world. For services. There's a service authorization request form or a treatment authorization request form. Once we go over tailored plans, it's gonna be the same form for everybody. Right now. Each LME MCO has a different form. It is my hope that we can go to a unified form sooner than launched in the tailored plans. But for now we want to do to at least have the link for the service authorization request. And if you don't know what that is, you're gonna learn about them in the next slide. So the next slide, this is my visual process. So you have to get my brain of what happens if you think somebody that beneficiary requires specific payment plan behavioral health services, where they meet the tailor same criteria. If not, and they stay in standard plans, everybody's happy. But if they do, and we want to make sure you understand the flows that folks move as quickly as you need them to move, if that's the case of time is of the essence, but also that the process is completed and we don't leave anybody out there hanging. I also put in there in the corner of the tailored plan criteria. It's hard to keep up with all this. There's a lot of learning going on, but essentially it's folks with severe mental illnesses, severe emotional disturbance, severe substance use disorder. An intellectual or developmental disability survived with dramatic brain injury. There's this sort of list of criteria that we have in our Tailored plan world. And those folks we feel like have services that are gonna be provided through the LME MCOs in a way that is unique and needs to happen that way. So until tailored plans launch right now they just moved from the standard plan to Medicaid direct. Seems easy. It's really not that complicated. There are really only like three choices on this algorithm. So the first question you asked is, is this a substance abuse intensive outpatient service? Or is the beneficiary at a state facility? If the answer is yes, then the provider completes that request to move for him and just checks the box that's at the top of the forum and you check that box. It's processed immediately. You don't need the service authorization. Request, and that beneficiaries move within one business day.

Let's say it's not for substance abuse intensive outpatient service, or it's not a state facility. Then the question is, is the service needed urgently? Or is a tailored plan service provider currently providing that tailor can service what we've seen is as a lot of the times, providers are providing the service, but they're not doing an urgent request for it. And so then it creates this difficulty and delay and billing. We don't want that to happen. So if it's needed urgently, or if you're already providing the service, then you go over to the algorithm and the provider completes the service authorization or fast there's the links I showed you on the other side, in the request route form simultaneously. That request and move form has a signature for beneficiaries. And this is important beneficiaries like all things Medicaid beneficiaries have choice choice is really important. And so they need to complete that form. So the easiest thing to do is when you have them in your office and you're providing a service to get that signature, right, you happen. Those are processed in one business day and then move is retroactive to the request date. Let's say it's not urgent, you just identify that there's a need you think they need the service but this is not an urgent need. Maybe you can't even get the appointment for a little while. Then there's just the request to move forward. So you don't need that service authorization request. You're just saying, Hey, I'd like to move the beneficiary can do this themselves, or provider can do this.

Dr. Shannon Dowler

It takes a little longer for that process. And the piece here I think a lot of people have gotten hung up is it takes five business days as a provider submits it for the request to be reviewed and approved and then

once it's reviewed and approved, it's the following month, the first day of the following month that goes into effect. So if that forms done on August 28, and it's not reviewed until September 3, then the person moves October 1. And so that process can actually be sort of a lengthy process depending on the timing of the month of when these things come through. That's why it's really important to be thinking about is the service needed urgently. Are you already providing that to a can service or not?

So if you go to the next slide, I'm gonna take you through a few scenarios, because I'm all about imagining this in real life. So let's say you have a patient you're taking care of a young woman who's got substance use disorder, and she's decided she's ready for treatment. But the provider taking care of her says, the only way we're going to get the treatment we need this is serious enough that we need an intensive outpatient service, in which case you use that form and we have a little screenshot of it below. So you can see where that little checkboxes and you submit that provider completes the request through form with that checked and it's processed immediately, very fast. Let's go to the next era. Let's say you've got to do monitoring and cure up and she developed postpartum psychosis. It's not a substance use service. It's postpartum psychosis. That's a tailored plan diagnosis. If she's admitted into a psychiatric institution, that that team may decide that she needs more intensive services, but because it's a psychotic disorder, that actually qualifies as a tailored plan service. But let's say you're an outpatient, maybe you're able to keep her an outpatient environment. She doesn't need to be admitted. That provider that's taking care of that postpartum psychosis would then say we need the service urgently. We need really more specific intensive services. And they would do that service authorization form in the request to move forms and this can be processed rapidly. Let's take another scenario. Let's say you've got a college student who has their first manic episode and they get a little tangled up with the law. And maybe in their court case, they say listen, you're not gonna have to do jail time. If you go into some sort of intensive outpatient. Maybe it's for substance use disorder, but maybe it's not. Maybe it's just a bipolar break in they got into some violent altercation or something like that. That would be a situation where the service would be needed pretty urgently, especially if it was an intensive outpatient program, in which case that provider would complete the SAR and the request and move simultaneously and that person gets the service they need. All right, let's hit another scenario. I'm gonna wear you out with scenarios but I really wanted to drive this point home for everybody. Let's say you've got a child who develops behaviors that require a residential facility, and maybe it's residential treatment. Maybe it's that the child really just the family needs respite, they meet the criteria for respite to keep them in their home. That would be something that would be a fairly urgent need most likely, and that would follow along where the provider would fill out the SAR, also the request to move and we get that service pretty quickly for that beneficiary go on to the next slide.

Let's say you have a child though, that you're just doing an evaluation for learning differences. They're maybe not succeeding in school in the way that you would hope or they're hitting some barriers in that diagnosis and evaluation. They have an IDD diagnosis, and you realize that not only does that meet tailored plan needs but there are some services that can be offered in a tailored plan that are in Medicaid direct that are unique for this child. Maybe you don't need it urgently though. So in that situation, the parent or the provider could fill out the request and move forward and it would happen in that other process. All right, if we go on to the next slide.

One of the things we've gotten over and over again from folks is around foster care placement and the timing for that. So you've got a family you take care of there's domestic violence and the child gets put into foster care. The child has moved to Medicaid direct with a date retroactive to the first of the month in which the child was moved. But that action is dependent on the child welfare worker submitting the appropriate form to the county Medicaid caseworker can enter them if they're new or change their status if they're already on Medicaid. It's not actually the Medicaid team that does that it happens to the county DSS office, and that is what triggers the move to North Carolina Medicaid direct from the standard plans. If you're running into situations where you feel like this process isn't happening in a timely fashion. We obviously want to share that feedback with our partners and make sure that this is happening the way you need it to. So I would encourage you to reach out let us know if you're finding that this process isn't as smooth as you would hope it would be for the families or taking care of. Alright, next slide.

We're gonna shift gears we're going to totally mix it up now. I hope that was helpful and understand that process if we have some questions at the end. Deb Goda on and she's the mastermind at much of this and she's going to keep you straight. Um, I do want to share with you that we are working really hard to have a public facing claims dashboard. We thought we had it ready the month before last and we thought we had it ready last month. We thought we had it ready this month. I promise you it's coming. I wanted to give you a preview of what it's going to look like. These dashboards are going to really provide transparency on claims data payments and denials. And really, I think one of the most important things is what are the top denial reasons that plans are saying we're going to be updating that dashboard monthly. We'll have a link to it. Surely by our next backwards chat, maybe sooner there'll be a pull put out a bulletin when it's available. So folks will see it. But we think this is really important for everyone to know that it's coming and to know that we're working together to understand what's happening with the claims that you're submitting. So if you go to the next slide, here's a sample view of what the claims dashboard will look like. This is looking at the top three claims denial reasons. And so the dashboard will have multiple tabs and you'll be able to select different things that you want to look into if you're interested in this. This is an example where it's looking at professional claims at the headers. We also have professional claims at the line level we have facility claims. We have pharmacy claims there's been a lot of information on this, and then it shows by the plan what's happening, then you should know this is the data coming from the plans back to the HP and so not every plan is submitting the data in the exact same way because they have their own systems. So it's not exactly an apples to apples comparison. But it's really helpful information. On this dashboard. You see in the box I have circled what are the top three reasons that they're having to deny claims. And you'll see for all of them. There's like one thing that's like the thing that's causing the claims denials and there's some difference between them but there are a lot of the same things happening over and over and the denial process so more information is coming. I want to pause for a second and see if any of the CMOS have want to weigh in or say anything about this process. George, do you want to take us on.

Dr. George Cheely

Since I'm at the top of the list, maybe I'll start and first offer some recognition that I'm leaning a little bit out over my skis here. So forgive anything that I may not get quite right. I know my colleagues may chime in and correct but that this first component is really important to us. We want to be able to pay claims. So when if you're receiving a denial from AmeriHealth that says the rendering or the billing providers not enrolled in Medicaid. What that means is our claim system can't recognize the provider on the claim. And there are two main reasons we're finding that that are are causing that to happen. The first is that the appropriate taxonomy code was not present on the claim that we received from the provider. The second is that the taxonomy code present on the claim doesn't match the taxonomy code that we have from NC tracks. And so what to do about that the first is going to seem pretty obvious based on my second statement, double check the taxonomy code on the claim matches the relevant code in NC tracks. If you've done that already, the second one, we have spent a lot of time will continue to spend a lot of time really working hard to address and it's probably a little bit more subtle than that first one, if your practice is using a clearinghouse for claims submission, please contact your clearinghouse to confirm that they are including the appropriate taxonomy codes, when they're submitting claims to change healthcare who's the vendor that we use to receive claims electronically? What we have found is that many provider EDI vendors have either needed to make a system change to avoid removing the taxonomy information or are looking for the taxonomy information in a field on their on their forums that's not necessarily intuitive for practices. And so we have interacted with a number of practices and vendors. We are finding that we're interacting with the same vendor multiple times, which to us means that the vendors may be making changes for individual providers making changes for individual practices rather than making changes for all practices to whom the change might apply. So I'll say again, please contact your your vendor to confirm where they need the taxonomy information and to confirm that that would be set to change healthcare. That's a lot of talking in a lot of detail. I'm going to paste a link to our claims and billing page on our website, which has some additional details. I'm also going to paste a link to our account executive contact information who will also be happy to work with your practice and to help talk them through the process and interaction with the EDI vendors. Michael, did you want to weigh in?

Kelly Crosbie

Yeah, realquickly. First of all, I want to echo what Dr. Cheely mentioned about taxonomy and working with your EDI vendor. That's that's been a pain point across the board, for providers and for PHPs. And it's healthy blue is not exempt from that one. For our common claims, rejections that we're experiencing a lot of them and this is this is a kind of a good thing definite duplicate claims. You know, folks are submitting more than one we're gonna we're gonna pay one related to that service that was delivered but that's uh, that I think is intuitive for most folks. The second one I went that did want to highlight because this is is tangential to what George mentioned with the taxonomy. For especially for certain types of PDP drug codes, we are seeing some missing information that's resulting as having to reject that claim. And the last one would just kind of a generic listing disallowed not under contract has sometimes to do with a mismatch in the taxonomy as listed in nctracks, but also also tangentially related to to incomplete information, or just a request for an uncovered service.

Dr. Shannon Dowler

Anybody else? Well, you get something.

Dr. William Lawrence Jr

Hey, I'll just jump in quickly because I know our data looks a little bit of an outlier, but it's really just a misnomer there. The system that we use doesn't necessarily capture denial reasons in the same way at the header level. So we really process it mostly at the line level. So our graph looks a little bit different because this is a different subset of providers where the header does lead to a denial reason, but rest assured that if you look in our line level detail, that the reasons for denial are very similar to our colleagues and the solutions are the same. So just wanted to clarify that. That's great.

Dr. Shannon Dowler

Thanks. Well, great clarification. And this really is evolving on these dashboards and getting the data that the best way possible to share with everybody so thanks. The next thing we're going to do is I believe I'm going to be bringing on DuPont to the next slide. I think we're going to talk about our clinical clinical dashboards and so I'm going to bring on our queen of quality. I'm Kelly Crosbie, who should be somewhere in the Zoom land. All right to talk about our clinical dashboard for a few minutes, and then we're gonna open it up for questions and answers. So the clinical section is our last I know that is something that a lot of folks feel really passionately about. So we're going to get you some clinical data now.

Kelly Crosbie

Thanks a lot Shannon. Hi everyone, Kelly Crosbie here. So this is a really wordy slide. But pretty much what I want to to get from this is we collect a lot of clinical and quality data at Medicaid. We collect at the state level, but as more and more managed care plans rollout will continue. We will stratify the data by plans. So you see it by standard plans then by tailored plans, you'll see it by each individual plan will still track Medicaid direct. We want you to know we're monitoring a lot of clinical and quality data. We also stratify the data by race, ethnicity, geography, even different eligibility groups within Medicaid because we want to understand how each of our groups are doing, make sure they're getting good access good outcomes, utilization looks about right. Some of our data is longitudinal. So we track it over time, some of its point in time, and it comes at all different times. So we get some data every month, some data quarter, some its annual, it really depends on the source of the data and the lag. Just want to know we're tracking a lot of things some of it's currently published. So if you look on the Quality Management website, you see the Annual Quality Report. It's got a lot of longitudinal data in there, it's stratified. The next iteration will have quality data, my plan membership. We also have other dashboards in the Medicaid website where you see things like plan enrollment and costs and I put some of those links in here.

So the next couple of slides I'm going to show you and I'm going to hit them quite quickly. is some data that we track internally. And overtime. We'll be releasing more of this publicly. So you see more clinical and quality dashboards on our website. And we'll try to do our very best to give you some explanation of what it is that we're sharing. So this is just really quickly some data that we track now. So this is enrollment of members in Tier threes. So but 80% of our members month over month fairly consistently, or enrolled in in a major tier three practice. On the next slide, you'll see that broken down by plan so again, but 80% of our members my plan are enrolled in tier three. And on the right hand side you will see contracting so we have many types of PCP uses, you know, tier threes, twos ones PCPs. But by and large, the vast majority of the contracts that health plans have are with our tier three PCPs, which is good, that's great. That's exactly what we want. On the next slide. We have some really cool management data. So care management data has started to come in and we'll be sharing that more publicly. But one of the first groups we looked at from a -- lens -- members that we did identify based on their services, of course utilization, they were pretty high risk. So we want to make sure they did okay during the transition to manage care. So we shared these members and their information with the health plans, the health plans will engage in outreach, and about 50% of those members, which for those of you that are that do care management, and this actually quite high, but 50% of these members did engage with the health plan care managers and they did to support them through the transition of managed care. We actually did exit surveys from a lot of those members just to talk about the experience what it was like and we have that data to share as well. Next slide.

We also track PCP assignments because we want it to remain pretty stable. So we know what PCP assignment was like month over month well before managed care launch right because we kept assignment at the state. It needs to be pretty stable because folks are obviously concerned about expectation, expectations of quality and cost. And so you need your assignment to be relatively stable. We see two big spikes. None of those are surprising. In April, you know that we assigned about 150,000 members. So that's the first spike you see on PCP reassignment. And the second you see in July of course, that's when plans reassigned members, we did have overall very high rates of reassignment to the to the primary care provider that the member was seeing in, in that case direct, but there was some allowable variation there. And as you can see, we'll continue to track that trend. And again, the goal is to have a stable PCP assignment with around 3% variation and the remark on the next slide. I'm going to show you there's about six slides now. And I want to show you just three key performance indicators that we track at Medicaid. I'm going to hit these really high level and they really are key performance indicators. So we have an adult child and maternal health dashboard at Medicaid. We track many indicators and we stratify the data many ways, all the data that we have no still Medicaid, direct data. In November, we'll start to see managed care data coming into our dashboards. But here's a couple of indicators and please remember their indicators, right? They tell us this is interesting. How does it combined with other data should we dig deeper? So the first is our primary care visits and you look at the trend, the trend is not surprising, lost about 10 points in adult primary care visits. We see differences across the state darker green is better and we see different rates of PCP engagement by age group. So just showing you a snapshot of some of the data we look at. The next slide I believe is the inpatient visits.

And again, we see large variation across the state darker green is more inpatient visits. Here we just hear some stratification by race. So we see differential rates by race, as well as urban and rural is actually fairly close for inpatient utilization. We do see differences among age groups. Not a huge surprise. But again, we see that big dip right during the public health emergency. Our rate fell 15 points. That's our trend over the state. The next is Adult ED visits. Again, we're going to show you a map. So dark green means higher rates of of eating euicc pockets in the state where we have much higher rates of use. We've seen much higher rates of Ed utilization in rural areas, reduce the significant differences by race. If you look at the trend, the ED rates by race trend, and again, another area where Ed rates tick a tick a large hit during the public health emergency. Again, indicators, not necessarily good nor bad. It is just something to think about, and see how it adds to other data. Let's look at the same data for children really quickly. So this is primary care visits. Look at the trend, the trend we fell about nine ish points. But this is a great example of a place where I know folks we're working incredibly hard to make sure our kids we're still seeing our adults as well. So we did take ahead, but still not bad. PCP visit rights there's not a lot of variation across the state, but there's pockets in blue is where we do see lower utilization. We do see some differences. When we look at race, and we do see some differences. We just put a foster care because that's really important to make sure that our children in foster care getting PCP they actually outperforming by about seven or eight points as children who are not in foster care with rates of PCP is it. The next are impatient rates for children. Again, not tons of variation across the state darker green is higher inpatient rates. We do see a bit of variation by race in the left hand corner, and you see again, that the impatient rates for children took a hit during the public health emergency. And the last are Ed visits. So again, green, dark green or higher ed rates, these are for kids. We do see some differences by race. You'll get the slides later so you can really dig into it. And we saw ED rates cut in half for children over the past 16 months in the public health emergency. So again, just want to show you a snapshot of some of the data that we're sharing. We will start to cut this by health plan and share it again with explanations of what it is that you're actually looking at. These are KPIs and I'm going to turn this back over to Shannon.

Dr. Shannon Dowler

Great in the interest of time, I think we're going to go on to questions just so you know in the deck we did include some of our recent bulletins, so we can just flip through these Nevin and go on to the questions hold her slide. I want to make sure we get some questions and but just know that we are trying to keep you up to date on all the buttons so they are in the deck. Here. Do you want to hit us with some questions and I'll ask the speakers to turn on their cameras.

Hugh Tilson

Absolutely. Just as a reminder, this deck is available there's a link in the q&a so you can download that. We asked the PHP CMOS to have a question that they got that they wanted to be sure to be able to answer. So Dr. Komives let me start with you.

here so the question that we got is wellcare requiring prior authorization for behavioral healthcare because and we did discover that, as many of you know, we had a 90 day Transitional Care authorization waiver in place that ended at the end of September. Unfortunately, we discovered that when that authorization waiver ended we inadvertently turned on a prior authorization requirement for those behavioral healthcare because so we're aware of it. We're getting it turned back off again and we're going to go back and reprocess and pay any claims that were incorrectly denied for those codes. So if you've experienced that sit tight and you should be getting payment on this.

Thank you, Dr. Buckner, you're next.

Dr. Michelle Bucknor

Thank you. I actually grabbed the question from the chat. So someone asked the question about the PCP change form. And why are there five forms? Why can't we just have one form? With all the contact information on it now you have to print five forms, in fact, five different forms. And we did discuss that and we felt that it was really important that the practice staff actually identify and make sure that they had the right PHP form for that patient if we receive a form and I'm glad someone asked a question that is not for a member we have to destroy that form and he wouldn't get any feedback from us. So we thought that that would make it easier from a workflow standpoint for the practices. I will say this was a baby step, right. And so you know, we all love quality improvement. And so if there's feedback, if it looks like there's opportunities to improve the form, then we're happy to hear that. The other thing I heard from the chat is people asking about a Spanish version. So I hope the blue answered that they'll get one published and we'll work on that it united to I think thank you for bringing that to our attention. And I think we can all get to work on that.

Hugh Tilson

Thank you

Dr. Michael Ogden

Dr. Ogden. Absolutely, no, I I thought I think actually Dr. Cheely hit on the um, one of the answers for this one, but it's one I get fairly commonly since since our launch that healthy blue. You know, I've received a lot of feedback related to taxonomy related denials. And I wanted to do a little bit of explanation of what happened here and and how healthy blue and I'm sure my PHP colleagues across the board have worked through this. So we received a large number of submissions that were missing taxonomy either from the rendering or billing provider. One of the things we ended up doing was very quickly contacting providers, giving them building instructions, building guides, showing them exactly where and how these elements needed to be put into indoor building systems. Most in by most, I mean 99% of those that we've worked with directly we've been able to solve their problems, but we are continuing to run reports on a daily weekly basis to ensure that we're proactively identifying when these

issues occur. As Dr. Cheely mentioned, one of the one of the causes not not a universal cause, but one of the causes has been working with some of the EDI vendors, we've noticed that you know, sometimes the taxonomy will be scrubbed off, and that needs to be replaced or remediated. But I thought that that at least needed some attention here tonight. Really appreciate your attention.

Hugh Tilson

Thank you, Dr. Cheely.

Dr. George Cheely

Sure, I have one that we are still getting with some frequency and it's maybe a little less hard hitting than what my colleagues have have tackled. And that's really just how to find more information about value added benefits and value added services available to be able to counsel patients about what's available. And maybe because people are focused on the provider part of our website, I just wanted to also offer the member section of our website includes drop down menus with succinct descriptions of the value added benefits available in English and Spanish. So members can take a look and review providers can take a look and review we also just have the contact information for our Member Services team who are ready willing and eager to help connect members with those services. So if you're curious if your patients are asking questions, the member section of our website is the place to look.

Hugh Tilson

Great. Thank you, Dr. Lawrence. I don't know if anything came up that you wanted to respond to.

Dr. William Lawrence Jr

I'll just make one point you you know, I did see a question that asked about why can't you know we all just use one portal and you know, one claim system. You know, obviously one cannot deny that there is a difference for providers when we go from having one single Medicaid agency to working with, you know, five PHPs and Medicaid. But as I've tried to point out before the one good thing, if there's a good thing about those five is you now have a very dedicated provider relations teams that are interested in trying to do the best we can for all of our members. And more people more resources on the ground to try to help solve problems for providers. And hopefully you've seen through efforts like Dr. Bucknor presented with a PCP change form things like the changes and the prior authorization form that was unified earlier in the process. These are all things that have come out of Administrative Simplification efforts that all of the PHPs have really collaborated on and we remain committed to doing everything that we can to improve and create as little burden as we have to implement the Medicaid transformation that are just like your parents.

Hugh Tilson

Thank you. So Dr. Dowler it looks like you've flagged a couple that you wanted to respond to you want me to ask those or do you remember what they were now? Do we continue to receive the $5/$10 ppm for Medicaid direct?

Dr. Shannon Dowler

Yeah, so you know, we increased as part of the public health emergency that remember per month and we have kept those turned on. We are not sure yet when those turn off I think we had I'm not sure what the date is now that's out there but the team is talking about when does that end not knowing knowing that the state public health emergency will likely end before the federal and see how many of those dollars are available so we have not turned off those rates yet. They will go away. It was a it was a covered response. I just don't know exactly when yet but thank you for asking that.

Hugh Tilson

Then this one came in more PCPs downgraded from T three to T two with an ACO and CIN. Were told to keep their tier status at T three in nctracks. Is your slide completely accurate?

Dr. Shannon Dowler

Yes, that was when I quote Kelly might want to weigh in on.

Kelly Crosbie

Yeah, that's actually really important. So we have providers, we ask providers to make sure that your tier status is accurate in tracks. That is a two status we send to health plans. We have expectations that they attempt to contract really hard with Tier threes. Now plans also send a report back to us because some providers may decline so we do get a separate report that tells us providers that have declined but if you are in tier three, please change if you if you decide to downgrade you really need to go and change it in tracks. There's lots of bulletin information how to do it. And also you really need to make sure that you're contracted appropriately with the health plan. You do get extra payments if you're a tier three, there are expectations you get lots of data. And so if you're not really a tier three doing all those two things, you definitely need to update your contract with health plans and update tracks.

Hugh Tilson

Thank you. I can go through and identify other questions, but Dr. Dowler anybody anything you particularly want to respond to?

Dr. Shannon Dowler

I think those are the ones that I originally wanted to get to anybody else to something they will find. There are several. I mean, I've seen several examples of can you tell the plans to pay for this because they're not paying for that. If that's the kind of information it's helpful for us to get with examples, if there are things that we've historically paid for that we say we're going to pay for moving on. So this those examples because it may just be a glitchy thing in the system, and we just got to get the systems tweaked. You know, we're still only like in the fourth month of this, so don't just sit and suffer, please email us, let us know. So we can do something to make sure that everything's getting paid the way it's supposed to get paid.

Hugh Tilson

Anybody, I see you Dr. Buckner.

Dr. Michelle Bucknor

I just I'm gonna bring forward a concern from the field that I heard today and I share with Dr. Dowler I don't have an answer, but I do want the field to know that I've heard and I'm going to share with the other PHP CMOS that people seem to be really struggling with the codes around respiratory viral panels, and realizing that tis the season right and we want to make sure that you are being reimbursed appropriately for those panels code. So I'm going to take that to the COs and commit to trying to solve it. And the messages we hear your concerns and definitely want to work together and partner to resolve any issues that you're seeing in the field.

Hugh Tilson

I guess a great way to actually wind us up since it's 630. And, as a reminder, the questions we weren't able to get to there to a PHP please direct those to the PHP. There are some that are Medicaid related and Shannon I assume we'll get those to you and you can think about what comes next with those. Let me take a minute to thank our PHP CMOS, Shannon, you and all your great team for the great information tonight. And all that you guys do and we turn it over to you now for any final comments.

Dr. Shannon Dowler

Yeah, thanks so much. Thank you and everybody, we really appreciate this. We appreciate all the work that you're doing out there. We know this transition has been really challenging for everybody and we appreciate you tuning in and and letting us try to help make things better. If you don't tell us about it, we can't fix it. So please communicate with us use that provider ombudsman, you can email me directly or the CMOS directly if you're not getting what you need when you're communicating with the plans. But I promise you we all want this to go well so please stay in touch and let us know how we can make it better and then if there are things you want us to cover in future chats, please let us know that as well. So in the RSVP, there's a place where you can put in comments or questions. We would love to hear what you want us to share with you. We guess at it thinking that we're hitting the right things but we

might not be we want to we want to talk about what you want to hear. So thanks so much. Thanks for all your work taking care of Medicaid beneficiaries across the state. Stay happy and healthy, and we'll see you next month.