Transcript for Healthcare Professionals Webinar Series
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Presenters:
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Hugh Tilson

It's 530. Let's get started. Good evening everyone, and thank you for participating in this evening's COVID-19 webinar for Medicaid providers. This webinar is part of a series of informational sessions put on by NC Medicaid, CCNC, and NC AHEC. Next slide. As you can see we've got a ton of great timely information tonight, including an update on Medicaid payment and policies, a discussion about telehealth and Care alerts data trends and an overview of an action plan for improving well child visits and immunization rates. We will then respond to your questions and close with a list of resources for you.

My name is Hugh Tilson, I'll be moderating tonight's forum. Our presenters are Dr Shannon Dowler, Chief Medical Officer for NC Medicaid. Kelly Crosbie, Director, Quality and Population health within the Division of Health enefits. Beth Daniel, Associate Director for medical and behavioral health but also within the Division of Health Benefits. Dr. Tom Roth President and CEO of CCNC and Anna Boone, Director of Quality Management, also with CCNC. Before I turn it over to Shannon. Let me start by thanking everybody for making time in your busy schedules to participate in this evenings webinar. We hope the information provided tonight will help you in your important work to make navigating these trying times a little easier. Next slide. Oh this slide. Sorry. After our presenters provide their updates we'll turn your questions. We've learned in past forums at the present presenters will often address your questions during their presentations. We should have time to get to your questions. I encourage you to wait until the presenters are through their presentations before submitting a question, please no we'll send any questions we don't get to Medicaid, so they can either respond to you directly or use your question to inform guidance and help inform future webinar topics. If you're participating through the webinar, please submit your question using the q&a function on the black bar at the bottom of the screen. That q&a function on the black bar at the bottom of the screen. If you're on the phone, you can't do that and you're muted. So the only way you can submit a question is by emailing us at questionsCOVID19webinar@gmail.com, questionsCOVID19webinar@gmail.com I record this webinar and make the recording the transcript and these slides available as soon as possible probably tomorrow morning. Now, I'll be turned over Shannon. Thank you, Shannon.

Dr. Shannon Dowler

All right, thank you. It's good to be back. I missed everybody. It's, it's been challenging trying to decide how often we want to meet and give you updates we want to respect your time, but at the same time

when we don't have regular meetings it's harder for people to remember to jump on and join us so we're going to come up with a calendar soon and hopefully make it a little more predictable and easier to track when we're having these updates. So next slide.

This is just a reminder that the last five months have been a very strange trip for all of us, it was not, I was talking about this the other day that if I looked at a year ago and predicted when I decided to take the job at Medicaid which was about this time last year. I could not have imagined that anytime I went outside my house I'd be wearing a face mask, like you couldn't have convinced me that that would be my new reality and so it has been an incredible journey over these last five months and from what we're seeing with our rates and the numbers where it doesn't look like the journey is gonna end anytime soon. And thank goodness for all of you out there who are steady and present and there for our Medicaid beneficiaries. Next slide.

So, last month, I gave you guys, an overview into the circuit breaker process, which was the process we use to look at the 360 some odd flexibilities that we made in the Medicaid program in response to COVID. Rapid changes you felt all of them, as we tried to keep you up to date and trying to modify things quickly. And as we made those changes, the teams the subject matter experts and others brought to leadership, the recommendations for what to keep, and what to keep with changes, meaning that we learned in the COVID pandemic that these actually made us a better program made us stronger, made Medicaid a better insurance plan for beneficiaries but also made it a better, a better plan for providers to work with. So, we are keeping a lot of changes that never would have happened or maybe they would have happened but it sure would have taken a lot longer. And so we're in the process of sorting through all of those right now. Next slide.

Of all the provisions. So about a quarter, we've said these really did strengthen us and we want to keep them. But when you break it down to the clinical provisions. And so that's all the provisions about a quarter we said to keep. Almost half of the clinical provisions we made felt like something that strengthened the program and not in a pandemic world would be something that we would want to continue. And so, I think that's pretty significant about, we made 130 clinical provisions over 500 codes were impacted billing codes, which is significant. So that does mean that half of the things or a little over half we're recommending not to keep that we felt like they were appropriate in a pandemic but not for long term. And I will tell you, Kelly's going to talk to you in a little bit about our telehealth utilization data. Some of it, we're going to continue to study some things we're going to keep on and then decide if we after we study the data and look at the outcomes and other things if it's a long term good thing or maybe not as much. Next slide.

So the biggest thing the number one thing is modifying the overall our overarching telehealth clinical policy, we refer to it as 1H in the department, and that is that is the policy that many people suggested needed modernizing. And so one of the things that I had started working on back in December with my colleague Ben Money, and the department around how we could modernize telehealth in North

Carolina and specifically for Medicaid. So we started working on it then. But we knew we have an uphill battle and getting things approved and getting finance and legislative support and we figured it'd be 12, 18 months before we made any progress. So one of the positives that came out of COVID. Is it really pushed us into high gear and it really modernized us from a telehealth standpoint, and I know a lot of you are grateful for that. And some of you are still trying to sort out how you feel about telehealth and that's okay too. But essentially we're making some permanent changes that I've talked about in other webinars that will improve the program and strengthen the program, and right now that's available for public comment. So if you go out to our website you can make comments on what we've decided to keep as part of our permanent telehealth policy it's gone to the physician advisory group to our PAG. They've approved it. They had lots of great comments and suggestions as well. So next slide.

So the process in Medicaid is a fairly predictable process, although we're moving through things in a little faster way than maybe we used to but in June. The 1H new policy, went to PAG, and now it's out for public comment July. It'll be up for 45 days and public comment. And then we'll take the feedback if there's significant public comment, like lots and lots of things, then we will take it back, look at it again and then rerelease it for public comment for another 15 days. If we feel like we need to generally the public comment is all two thumbs up. It was better than cats, you know, if it's all good stuff, then we'll just go on and make it real policy sooner. One of the things right now we can't give you an exact date is because we're waiting on HRSA, to let us know if the federal public health emergency is being extended or not we've, we've seen Secretary Azar and others say things like I can't imagine it not being extended, but it is an election year and sometimes things happen that don't make sense to all of us. And so, we can't give you firm dates without that. If it's not extended. We'll stick with what we've said before, which is September 30. And if it's if it's extended, then we're going to extend our current provision longer. So I'm sorry I can't give you an exact date. We're waiting on the feds, which will help us with that. And the little blue box at the bottom of the screen you can see a link to the that's actually how you can get to the public comment space. If you want to comment on that one 1H policy.

So the next thing that's happening is right now all of our Beth's teams are furiously working to change all the clinical policies that we're recommending have changes, and that will go to the PAG. In July, they'll get to read all those recommendations and make comments and give feedback on them and then in August, it'll be out for public comment. And then in October, we'll release, you know, the final decisions on that so again on the non broad 1H policy things the specific clinical policy changes that we're recommending for different areas for diabetes educators or for LEA's or things like that, that will be out for public comment in August and September, and we hope to hear from you during that time.   I would say because we're all drowning in work i would i would hold anything until public comment period and then go through the formal process for public comment, it's much less likely to accidentally get missed or dropped than one off emails or phone calls, so please use our process and go through the public comment period. Next slide.

So one of the things that team has really been digging into and studying and understanding is what's happening with our claims, specifically with telehealth and virtual care, and probably something if we're

honest we should have been doing all along but sometimes when you get put into a crisis you recognize things that you could be doing better and, and you respond so I think this is one of the areas that we've gotten stronger and created some more transparency around is looking at the overall claims process and what's going on with it. So when we looked at the last 30 days of processing specifically telehealth and virtual claims, almost 92% were successfully processed, which is pretty darn good actually. 8% were denied, so unless you if you're someone who had a lot of denied claims that does not feel good to you, because it's it's no good. The top interestingly the top five claims we had that were paid were the same exact things as the top five denied. I think that's just fun they were in different orders. But that's where most of our claims are coming from and just interesting, interesting to see. So if you go to the next slide.

What the team did was they looked at why the claims are being denied, and wanted to share some of the reasons the top reasons they were being denied and what you can do, and your practices to keep claims from denying. And so the number one thing is that valid place of service, and we recognize that it has been very complex, I think we just came out with our special bulletin number 107 yesterday. So a ton of information coming to you from all places. And so I'm sure your billing offices and back office folks are feeling that, too. But this is if there's anywhere you want to point them to really look at and understand, is to go to that telehealth virtual patient communications billing guide, that's out there to go over the really specific point of service recommendations. So I just point you in your teams to that place so that that's not a reason for denying claims. The other two reasons are kind of regular business as usual reasons so you have to make sure that your service location is in on file and the address is valid. And then you have to make sure that you have an active and valid taxonomy on the claim, that's just that's anything whether it's virtual health or not, but the one on place of service is a place where we feel like practices can have a lot more success with getting their claims through the first time which of course makes everybody happy ourselves included. Next slide.

Oh, before I get to that. Let's see I got a question on retroactive, Elizabeth Hudgens emailed me today and asked about retroactive rate adjustments, the 5%, that was legislated to happen for those that hadn't gotten rate adjustments already. And just to let you know that that is in process with our vendor. This is actually a huge reprocessing effort. There are 32 plus programs, thousands of claims actually millions of claim lines in this report. And that also requires system changes. And so it's a big lift on that technology vendor to do that. They had given us September as their date but we are pushing them very very hard. And I think there was some pushing that happened today and we're now looking more we're hoping for late July early August, we recognize your, your practices need that money to come in. And so we're working hard to get that to you. Yes, yes.

Dr. Tom Wroth

This Tom, good question in the chat box about the policy changes, assuming they are approved and go through the process, will they be the kind of translated into Medicaid managed care so will the PHPs, will those be the same policies that go into, and go live?

Dr. Shannon Dowler

Yes. So, um, so it is great to be a superstar and all of you are superstars and they, Richard challenged me tonight to do a limerick. He of course challenged me to do that about 18 minutes ago, so this is not the best limerick I've ever written. It's not like my STD limericks which are far more interesting, but this one is for all of you out there, North Carolina is a fabulous state, our Medicaid providers top rate. You've weathered the storm and true to good form you continue to be totally great. So, we are so grateful to have such amazing partners across the state to take care of the 2.2 million rapidly rising beneficiary population that is Medicaid in North Carolina. So thank you all of you for sticking with it, and pushing through these really tough months. Next slide. And so, good news on provider rates. Some of you may have seen the special bulletin. For those of you that don't know that Dave Richard that's my boss. He's the man in charge of Medicaid. We have decided at Medicaid to continue the payment increases that originally were set to end June 30. We recognize that there continues to be a need to help support our practices and all of our Medicaid providers, financially as much as possible. And so we are moving those changes into the new fiscal year which started July 1 for us. I cannot tell you when they're going to end yet, but I'll just tell you that they're not going to end on June 30 So, any any extra time is great time and good news that there's enhanced rates and reimbursement and payments will continue for the foreseeable future. That does include that per member per month, increase that we put in place. So, good stuff, and just wanted to share that that that has been made official yesterday. Next slide.

Um, so, I saw it, it's funny that I put this slide in here because it's not Medicaid specific, but one of the questions I saw early on was about tell us about CHAMP so I'm glad I threw the slide in here. Although I told Kelly I've only talked for 12 minutes and now it's been 15, but I'll spend one more minute, talking about CHAMP because it's near and dear to my heart. I've been working with the historically marginalized population work stream over the last few months at DHHS. And this is one of the outputs is task order focused at community testing and high priority and marginalized populations around the state. On this slide you see in the background is the rates of COVID infection and then the foreground the yellow are the zip codes we selected, and without going into great detail, I will tell you that it was a very thoughtful, very data informed process we went through in the month of June, looking at, specifically African American populations Latinx populations and American Indian populations in the state, and focused on where their percentage of the population was the greatest, and then had other filters we applied to it. So in the African American population we had a filter for age and chronic disease that narrowed down the zip codes we wanted to focus on in this first round of CHAMP. In the Latinx population we looked at where the construction and farm workers were in the state, and we put that filter in place to help us narrow down the zip codes to go to first. And so, the one thing we did do is we looked at our map of where all the testing sites were. And we took those out. And so these zip codes are the ones where they're testing sites at least at the time when we did this data crunch which was a couple of weeks ago and so I know it's different today. But where there was a highest population of marginalized populations with those additional filters, and no testing sites. That's how we came up with this list.

And so I know it's given much angst and reflux to my friends in the West. Many of you know I am in the West myself. But the fact is we have a lot less diversity in the West relative to other parts of our state.

And so the percentage of the total population that's historically marginalized populations is less in the West, than it is in the east and so we're starting here this is not the end of it. This is CHAMP one dot O. We're going to have CHAMPS two dot O and three dot O and we're going to keep this work going on but we have vendors who applied for this through our RFQ process that was released back in June. That RFQ process rolls over every month so new people can apply to be vendors, and to create these task orders these bodies of work that we say we're going to help pay for and support this work. If you will go stand up testing in these places. Because we know that it's really putting a strain on your teams to do this yourselves and that you need help. So, the only challenge with that you know we have procurement rules we have to follow in state government. We can't just say, Hey, we like you. We know you're doing a great job we want the money to go to you, we have to go through a very defined process of procurement. And so if you would like to be one of those vendors that does this work, go out to the website, apply to be a qualified vendor we would love to have you on the list and we have a new round being announced, maybe at the end of this week it was going to be July 19 but I think they're doing it faster. So anyway, you'll continue to learn more about that, feel free to reach out to me if you have specific questions. And the two vendors that are were awarded for the zip codes that have been awarded so far, which is about 100 of the 174 zip codes is Vidant in the eastern part and then Origin, which is an out of state lab vendor, who's coming in partnering with local partners to do testing and a lot of the East areas, these vendors are required to do some really unique things, so they have to provide culturally and linguistically appropriate services, and we've actually stood up a secret shopper program we're going to send people out to the testing sites to verify that that is happening. They have to link to the primary care provider with the test results. And so there are a lot of aspects of this that we think will really help move health inequities for. So, that's it

Hugh Tilson

Before you turn it over to Kelly we got a couple quick questions, sorry Kelly. Before figured we'd grab these now. Somebody wants to be, who do we contact to be a testing center, how do they do that?

Unknown Speaker

Yeah, so you can't be a vendor, unless you've gone through the RFP process. But the vendors can subcontract that, so they can say, FQHC A, we don't have a staff for this part of the state but we've had to do testing here. Can we partner with you to pay you to do some of this testing. So you I would say if you're one of those people that would like to be a subcontractor or have a vendor, reach out to that to vendor or.

Hugh Tilson

Gotcha. And then, where can they get a list of testing sites where they're going to be.

Dr. Shannon Dowler

They're going to be put on the website at the find my testing site. We already have a pop up site listing on the DHHS website so they will be there, and they will also be as there, we just awarded it on Monday and the first site was yesterday. So they're moving pretty fast for us, which is what was that was part of the task order, but we're going to be getting the sites a little more in advance and be able to promote them, so definitely we'll have them up on the website

Hugh Tilson

Does Medicaid reimburse for being a collection site?

Dr. Shannon Dowler

So I'm not sure how to answer that question right now Medicaid is paying for lab tests. So, so we reimburse for our beneficiaries who are having the PCR tests. But Medicaid itself is not paying for CHAMP I should make that clear this is a Department of Health and Human Services effort, I just happen to be, you know, helping lead it.

Hugh Tilson

And then question about turnaround time are these going be better than the other labs?

Dr. Shannon Dowler

Yeah, I will say one of the cool things about both the vendors that were selected, is that they both add totally new additional capacity to labs, none of them are going through existing commercial vendors so they're not gonna lengthen your turnaround time we're seeing really big delays right now. And that's largely because health systems have run out of reagent, and then they have to use commercial labs for what they were doing themselves. And then that pushes the community testing out longer, so no this is all on top of added capacity.

Hugh Tilson

Right, Kelly now? Kelly, take it away.

Kelly Crosbie

All right. Hi everyone's thanks very much. This is Kelly Crosbie, and so I think some of the data that I'm going to present tonight I think you've seen this week over week. So tonight I'm going to share with you just some of the telehealth and telephonic uptake data that we've been tracking at the state as Hannah mentioned, we're evaluating a lot of things about telehealth during the pandemic. But this is something

that we've consistently been doing week over week just to understand the trends in telehealth and telephonic utilization. So, next slide please. So I'm going to use this first slide just to orient you guys a little bit to the slides that come after it and again I think folks are used to seeing these slides. I don't think I'm going to share anything that's going to startle anyone on these slides, tonight, but it does have new data. So we're able to turn the data, longer. Some of our slide goes through the first week in June and some of the data goes through the third week in June. But let me use this first slide to kind of orient folks to what we'll be seeing.

So the first thing is just a note on the data sources across the bottom you'll see that we tried to attribute to the analytic group who pulled the data for us. So we have an internal analytics group that pulls a lot of data for my team and the CCNC team is also pulling a lot of data. The data is all coming from the same place so just let me be clear about that it is Medicaid claims data, but typically the Medicaid analytics team will pull one to two general data and they'll pull telephonic and telehealth claims for all telephonic and telehealth services. Typically the CCNC claims are not as longitudinal. They focus, often on primary care op behavioral health services, and we're able to use that data to really drill down to the patient and to the provider level so they're just same claim wet data, so I just want to be clear about that.

So you'll see data presented in two ways. So one of the things that we saw is just general claims of volume like this first slide is a really good example, this gray line that you see going up and down is just good longitudinal data on volume of professional claims, that's what the gray line is, you're going to see slides about volume of professional claims you'll also see five on the volume of telehealth and telephonic claims. The other slides, you'll see talk about percentages. So this is where we take the amount of, we look at the amount of telephonic and telehealth claims as a percentage of the total professional claims. It's a better way to look at things because the volume overall is pretty small. So we tried to look at the percentage of the professional claims that are actually telehealth and telephonic On some slides, you'll see telehealth and telephonic services broken out. That's because we might look at a specific provider type for example, we might look at pediatricians and we'll say how much telehealth billing is how much of it is telephonic. But when we look at things like claims across the beneficiary types and so when we look at claims broken down by age groups. We tend to lump all the telehealth services together so telephonic and telehealth so you'll see that is different. One of the things I want to stress in this slide shows that well is that the percentage that I was talking about really is the factor of all professional claims and all telephonic claims. So you're going to see really interesting wave. When we look at the paint you're gonna see a wave of claims. But remember, that doesn't necessarily mean telehealth services are going down. It's a virtue of the fact that in person services to all professional services they're changing as well. And one of the things that we've been seeing if you look on this slide right here. Put it in red, is general visits, so all professional visits are rebounding in April, so you see a little upswing in April. So you're going to see a curve when you look at the telehealth billing plans that I show you, you're going to see a wave similar wave on on all the slides, but part of that is not necessarily reduction in telehealth services. It is a factor of the fact that in person claims are rising as well. Starting in April.

Let's see anything else I want to say oh the dotted line I think the dotted line is really important so remember the dotted line, are we're not ready to make it a solid line yet. That's really why it's dotted. We have to allow for claims to run out of time. And until we have at least a good month, solid claims run out time we're not going to make that line solid so you can see lots of dotted line. Please know that we're watching the trends over time. And when we feel like we have the vast majority of the claims adjuticated and in the systems then we will make that a solid line. Okay. So this slide again, it just shows you longitudinal volume of claims, this gray line is is all professional claims and down at the bottom you see yellow health, the yellow line is telehealth claims so that pure volume of claims across all provider types. And then the blue line is the telephonic claims, this is all provider types, longitudinal volume of claims and Next slide please.

So this is our ratio of telehealth visits to general visits again, this is all visits and if you look at the yellow line which is telehealth right now about 6% of where we've pressed it but it is still a dotted line there. 6% of all professionals claims who are telehealth claims. The blue is the telephonic. The 6% is going to be really low compared to some of the size, I'm going to show you in a bit. But this is all claims. There's great variation in the amount of telephone services provided by different providers types. Okay. So next slide please. These are slides the next set of slides, I'm going to show you where we're going to break down on utilization by provider type and also by beneficiary type. So we're looking at data across providers, and across different member groups. This data does run out to the third week in June, so this is great and thank you to the CCNC team for providing a lot of data for the analysis. So this is another slide that shows you claims volume. This is primarily primary care, and OB claims. So, again, the gray line is total volume we start to see that uptick again in April. And then you see a fairly steady wave for both telehealth and telephonic services across all of this time period. Next slide.

So, here's where we start to break it down a little bit, race, ethnicity and some other groups. So again this is primary care and OB claims. The lines that you typically want to focus on only because it is our largest member groups are the blue line that's our African American beneficiaries. And our yellow line, which is Caucasian beneficiaries. The other lines are very important lines, don't get me wrong, but they're actually very small volume of claims for our Asian Pacific Islander members and for Native American members, those are pretty small. So typically you want to look at the yellow and blue line, and you see a pretty typical wave, no major, major differences in the volume of primary care to OB claims across these particular groups. Next slide please.

Okay. So, this is looking at ethnicity, so we're looking at Hispanic and non Hispanic, you see that same wave again, remember explain the wave that you see. You can see the wave on every slide. This is where we actually see a little bit of the difference so this is worth drilling down into. So we see almost a 5% difference that that major crest between Hispanic, and non Hispanic members, using this is combined telehealth and telephone. Next slide please. This is by gender, because the lines you actually want to focus from this one are the green and the yellow line, the black line is all female claims. But once we take out the OB claims which, for those of you that are maternal health providers or know a lot about OB claims, those huge latency and we have the bundled billing so they're not the most contingent claim

type to look at. So, once we take out the OB claims if you look at the yellow and the green line, that's our male and female, you see that same wave we're seeing on all the other slides, but the claim percentage of claims that are telehealth is about the same for both groups.

Next slide please. We also pull out foster children. So we're looking at children who are in foster care and children who are not in foster care. The green line is children who are in foster care we see a slightly elevated rate, but not necessarily a statistically significant difference but again also worth drilling down into. Next slide please. This is by age group so interestingly that top, top line is our 45 to 64 age group that has our highest, has our highest wave about 30% that's one of the highest percentages you'll see on all of these slides and and you could say, you could do some analysis and say that's a good thing, that is a high risk group that we probably want to be using more telephonic services or telehealth services, excuse me. So that was our largest group, other groups pretty much that whole block between birth through 45, a true blue and yellow line, they're consistently about the same, the black line is a bit shaky the 65 an older slide is pretty shaky. And it's a smaller volume, we've got some -- things in there so it's not, you know, that one looks really low, but take that with a grain of salt because there's some other things going on with that data that need to be normalized. Okay, next slide please. Alright, so here's where we looked at particular provider types. And this is where we're going to break out telehealth and telephonic. So just going to go through a couple different provider types. This is pediatric clearly we're hitting about a 20%. And we'll see how this wave continues or even thought about 20% of the building right now is telehealth much or yea telehealth a much smaller volume is telephonic. Next slide please.

Family physicians again that only crested about 16%. And you see almost as much telephonic as you see telehealth. Next slide. And this is the wonky slide I think the slide has been consistently wonky when it's been shown in these presentations. And we actually have a session with some FQHC, to talk with them about their billing, because we see the big spike in telephonic. But we've, we've started to see the pickup in telehealth billing we actually think they're just some different billing trends happening here. But we want to understand billing a little bit.

Dr. Shannon Dowler

And Kelly, I can also jump in on that one and what we saw was early on a lot of the FQHC's well none of them had been allowed to use telehealth with Medicare and Medicaid so they didn't have the infrastructure to start doing telehealth right away. And so they jumped right on telephonic because that was something that they could immediately access and do they were used to calling patients but setting up the systems for telehealth and investing in that took a little bit longer. So I think that's true for a lot of the telehealth lag, and the other piece is that the FQHCs have shared that a lot of their patients are don't have access to Wi Fi or don't have cell, you know, smartphones or internet or computers and and so that they found that telephonic has been a more reliable way for a lot of their patients. And so that I think is part of why it's you know telephonic was gangbusters right away. And then we see this telehealth is more and more FQHCs is get the infrastructure to do telehealth long term.

Kelly Crosbie

Yeah, that's helpful. Another group, the next slide you'll see I think the last slide we finish out with behavioral health. So this was another great example of kind of similar to what Shannon was just explaining it took a while for the behavioral health system, the LME/MCO billing systems and then the provider billing systems to get up and running on telehealth but once they have, you see a dramatic difference in billing and actually for the last two weeks, we've definitely seen the greatest spike in telehealth and telephonic utilization in our Behavioral Health Group. So again, if you look on the left hand side that's total volume of claims we see that same Green Line dipping like we see with everything else. Again with that uptake in the middle of April, and you see a kind of a slower start to telehealth than telephonic billing. But if you look at the ratio of the ratios side on the right hand side, the ratios are quite high. They're, they're consistently higher than any other provider type or beneficiary group. So the last slide is the last one that I have is the behavioral health slide as well so this is just to illustrate that we also are looking at the breakdown of behavioral health claims both by race and age just just just like we're looking at all telehealth billing. So again, this is, this is by race so you see Hispanic and non Hispanic, and you see. I'm sorry, this is African American and Caucasian excuse me. And, and you see, it's interesting, it this is dotted right so take it for what it's worth, you see the lines are fairly close, and we're not sure how they're gonna once those dotted lines become solid we're not sure if we're going to see a break there between African American and Caucasian claims but but that spike is tremendous look at 70% of claims via telehealth and telephonic. So, I just want to reiterate again. You know we're working on greater analysis, and we're pulling in a lot of other information to experience with care provider surveys so thank you all for participating in so many of the surveys. And I think it will produce a pretty rich analysis and I think in about three, four weeks, we'll actually start sharing some early results from that broader telehealth analysis.

Dr. Shannon Dowler

And then let me just jump in too and say, Kelly and her team did an amazing job of pulling this together, just like all of us everything was short notice, no one planned on the pandemic. But, but, immediately we're like we're doing all these changes we need to study it, we need to understand it and her and Sam and others on the team really jumped in. And I think it's really helpful to have the data like this so so thanks to your team for doing such a great job on that.

Kelly Crosbie

Definitely a team effort. And really, kudos to the unsung heroes they're all the, the data for pulling data, it's extraordinary amount of data that they're pulling in really quick time so we wouldn't be able to analyze if we didn't have the data so thanks to them.

Hugh Tilson

So Kelly, can I ask you a couple quick questions about this so does the lag in some lines for types of providers correspond with when the changes occurred for each type of provider, the Medicaid covid bulletin releases for example. That's that question makes sense.

Dr. Shannon Dowler

Yeah. Yes, there is a timing related to that when we release new things. When you start seeing it increase in the use and some of them more so than others.

Hugh Tilson

And then, have you been able to analyze by geography.

Kelly Crosbie

Absolutely. And one of the slides that I think we have an interesting looks at telehealth equalization by geography. It looks. It also compares it to the data thats publicly available data that we have on broadband access. We also correlate it to urban and rural. And we actually saw a high correlation between utilization and I'm going to say that wrong guys in the in the in the medical claims in the non behavioral health claim, you saw a positive correlation between access to broadband, and use of teleservices there wasn't a one to one, it wasn't consistent across all counties. But we did see a positive relation we saw the exact opposite of behavioral health, which just totally surprised all of us. So we had a slide in here I think if you look at an old deck you'll see a slide. But we're digging into that a little bit more but we absolutely are looking at differences, based on geography.

Hugh Tilson

It's 530. Let's get started. Good evening everyone, and thank you for participating in this evening's COVID-19 webinar for Medicaid providers. This webinar is part of a series of informational sessions put on by NC Medicaid, CCNC, and NC AHEC. Next slide. As you can see we've got a ton of great timely information tonight, including an update on Medicaid payment and policies, a discussion about telehealth and Care alerts data trends and an overview of an action plan for improving well child visits and immunization rates. We will then respond to your questions and close with a list of resources for you.

My name is Hugh tilson I'll be moderating tonight's forum. Our presenters are Dr Shannon Dowler, Chief Medical Officer for NC Medicaid. Kelly Crosbie, Director, Quality and Population health within the Division of Health enefits. Beth Daniel, Associate Director for medical and behavioral health but also within the Division of Health Benefits. Dr. Tom Roth President and CEO of CCNC and Anna Boone, Director of Quality Management, also with CCNC. Before I turn it over to Shannon. Let me start by thanking everybody for making time in your busy schedules to participate in this evenings webinar. We hope the information provided tonight will help you in your important work to make navigating these

trying times a little easier. Next slide. Oh this slide. Sorry. After our presenters provide their updates we'll turn your questions. We've learned in past forums at the present presenters will often address your questions during their presentations. We should have time to get to your questions. I encourage you to wait until the presenters are through their presentations before submitting a question, please no we'll send any questions we don't get to Medicaid, so they can either respond to you directly or use your question to inform guidance and help inform future webinar topics. If you're participating through the webinar, please submit your question using the q&a function on the black bar at the bottom of the screen. That q&a function on the black bar at the bottom of the screen. If you're on the phone, you can't do that and you're muted. So the only way you can submit a question is by emailing us at questionsCOVID19webinar@gmail.com, questionsCOVID19webinar@gmail.com I record this webinar and make the recording the transcript and these slides available as soon as possible probably tomorrow morning. Now, I'll be turned over Shannon. Thank you, Shannon.

Dr. Shannon Dowler

All right, thank you. It's good to be back. I missed everybody. It's, it's been challenging trying to decide how often we want to meet and give you updates we want to respect your time, but at the same time when we don't have regular meetings it's harder for people to remember to jump on and join us so we're going to come up with a calendar soon and hopefully make it a little more predictable and easier to track when we're having these updates. So next slide.

This is just a reminder that the last five months have been a very strange trip for all of us, it was not, I was talking about this the other day that if I looked at a year ago and predicted when I decided to take the job at Medicaid which was about this time last year. I could not have imagined that anytime I went outside my house I'd be wearing a face mask, like you couldn't have convinced me that that would be my new reality and so it has been an incredible journey over these last five months and from what we're seeing with our rates and the numbers where it doesn't look like the journey is gonna end anytime soon. And thank goodness for all of you out there who are steady and present and there for our Medicaid beneficiaries. Next slide.

So, last month, I gave you guys, an overview into the circuit breaker process, which was the process we use to look at the 360 some odd flexibilities that we made in the Medicaid program in response to COVID. Rapid changes you felt all of them, as we tried to keep you up to date and trying to modify things quickly. And as we made those changes, the teams the subject matter experts and others brought to leadership, the recommendations for what to keep, and what to keep with changes, meaning that we learned in the COVID pandemic that these actually made us a better program made us stronger, made Medicaid a better insurance plan for beneficiaries but also made it a better, a better plan for providers to work with. So, we are keeping a lot of changes that never would have happened or maybe they would have happened but it sure would have taken a lot longer. And so we're in the process of sorting through all of those right now. Next slide.

Of all the provisions. So about a quarter, we've said these really did strengthen us and we want to keep them. But when you break it down to the clinical provisions. And so that's all the provisions about a quarter we said to keep. Almost half of the clinical provisions we made felt like something that strengthened the program and not in a pandemic world would be something that we would want to continue. And so, I think that's pretty significant about, we made 130 clinical provisions over 500 codes were impacted billing codes, which is significant. So that does mean that half of the things or a little over half we're recommending not to keep that we felt like they were appropriate in a pandemic but not for long term. And I will tell you, Kelly's going to talk to you in a little bit about our telehealth utilization data. Some of it, we're going to continue to study some things we're going to keep on and then decide if we after we study the data and look at the outcomes and other things if it's a long term good thing or maybe not as much. Next slide.

So the biggest thing the number one thing is modifying the overall our overarching telehealth clinical policy, we refer to it as 1H in the department, and that is that is the policy that many people suggested needed modernizing. And so one of the things that I had started working on back in December with my colleague Ben Money, and the department around how we could modernize telehealth in North Carolina and specifically for Medicaid. So we started working on it then. But we knew we have an uphill battle and getting things approved and getting finance and legislative support and we figured it'd be 12, 18 months before we made any progress. So one of the positives that came out of COVID. Is it really pushed us into high gear and it really modernized us from a telehealth standpoint, and I know a lot of you are grateful for that. And some of you are still trying to sort out how you feel about telehealth and that's okay too. But essentially we're making some permanent changes that I've talked about in other webinars that will improve the program and strengthen the program, and right now that's available for public comment. So if you go out to our website you can make comments on what we've decided to keep as part of our permanent telehealth policy it's gone to the physician advisory group to our PAG. They've approved it. They had lots of great comments and suggestions as well. So next slide.

So the process in Medicaid is a fairly predictable process, although we're moving through things in a little faster way than maybe we used to but in June. The 1H new policy, went to PAG, and now it's out for public comment July. It'll be up for 45 days and public comment. And then we'll take the feedback if there's significant public comment, like lots and lots of things, then we will take it back, look at it again and then rerelease it for public comment for another 15 days. If we feel like we need to generally the public comment is all two thumbs up. It was better than cats, you know, if it's all good stuff, then we'll just go on and make it real policy sooner. One of the things right now we can't give you an exact date is because we're waiting on HRSA, to let us know if the federal public health emergency is being extended or not we've, we've seen Secretary Azar and others say things like I can't imagine it not being extended, but it is an election year and sometimes things happen that don't make sense to all of us. And so, we can't give you firm dates without that. If it's not extended. We'll stick with what we've said before, which is September 30. And if it's if it's extended, then we're going to extend our current provision longer. So I'm sorry I can't give you an exact date. We're waiting on the feds, which will help us with that. And the little blue box at the bottom of the screen you can see a link to the that's actually how you can get to the public comment space. If you want to comment on that one 1H policy.

So the next thing that's happening is right now all of our Beth's teams are furiously working to change all the clinical policies that we're recommending have changes, and that will go to the PAG. In July, they'll get to read all those recommendations and make comments and give feedback on them and then in August, it'll be out for public comment. And then in October, we'll release, you know, the final decisions on that so again on the non broad 1H policy things the specific clinical policy changes that we're recommending for different areas for diabetes educators or for LEA's or things like that, that will be out for public comment in August and September, and we hope to hear from you during that time. I would say because we're all drowning in work i would i would hold anything until public comment period and then go through the formal process for public comment, it's much less likely to accidentally get missed or dropped than one off emails or phone calls, so please use our process and go through the public comment period. Next slide.

So one of the things that team has really been digging into and studying and understanding is what's happening with our claims, specifically with telehealth and virtual care, and probably something if we're honest we should have been doing all along but sometimes when you get put into a crisis you recognize things that you could be doing better and, and you respond so I think this is one of the areas that we've gotten stronger and created some more transparency around is looking at the overall claims process and what's going on with it. So when we looked at the last 30 days of processing specifically telehealth and virtual claims, almost 92% were successfully processed, which is pretty darn good actually. 8% were denied, so unless you if you're someone who had a lot of denied claims that does not feel good to you, because it's it's no good. The top interestingly the top five claims we had that were paid were the same exact things as the top five denied. I think that's just fun they were in different orders. But that's where most of our claims are coming from and just interesting, interesting to see. So if you go to the next slide.

What the team did was they looked at why the claims are being denied, and wanted to share some of the reasons the top reasons they were being denied and what you can do, and your practices to keep claims from denying. And so the number one thing is that valid place of service, and we recognize that it has been very complex, I think we just came out with our special bulletin number 107 yesterday. So a ton of information coming to you from all places. And so I'm sure your billing offices and back office folks are feeling that, too. But this is if there's anywhere you want to point them to really look at and understand, is to go to that telehealth virtual patient communications billing guide, that's out there to go over the really specific point of service recommendations. So I just point you in your teams to that place so that that's not a reason for denying claims. The other two reasons are kind of regular business as usual reasons so you have to make sure that your service location is in on file and the address is valid. And then you have to make sure that you have an active and valid taxonomy on the claim, that's just that's anything whether it's virtual health or not, but the one on place of service is a place where we feel like practices can have a lot more success with getting their claims through the first time which of course makes everybody happy ourselves included. Next slide.

Oh, before I get to that. Let's see I got a question on retroactive, Elizabeth Hudgens emailed me today and asked about retroactive rate adjustments, the 5%, that was legislated to happen for those that hadn't gotten rate adjustments already. And just to let you know that that is in process with our vendor. This is actually a huge reprocessing effort. There are 32 plus programs, thousands of claims actually millions of claim lines in this report. And that also requires system changes. And so it's a big lift on that technology vendor to do that. They had given us September as their date but we are pushing them very very hard. And I think there was some pushing that happened today and we're now looking more we're hoping for late July early August, we recognize your, your practices need that money to come in. And so we're working hard to get that to you. Yes, yes.

Dr. Tom Wroth

This Tom, good question in the chat box about the policy changes, assuming they are approved and go through the process, will they be the kind of translated into Medicaid managed care so will the PHPs, will those be the same policies that go into, and go live?

Dr. Shannon Dowler

Yes. So, um, so it is great to be a superstar and all of you are superstars and they, Richard challenged me tonight to do a limerick. He of course challenged me to do that about 18 minutes ago, so this is not the best limerick I've ever written. It's not like my STD limericks which are far more interesting, but this one is for all of you out there, North Carolina is a fabulous state, our Medicaid providers top rate. You've weathered the storm and true to good form you continue to be totally great. So, we are so grateful to have such amazing partners across the state to take care of the 2.2 million rapidly rising beneficiary population that is Medicaid in North Carolina. So thank you all of you for sticking with it, and pushing through these really tough months. Next slide. And so, good news on provider rates. Some of you may have seen the special bulletin. For those of you that don't know that Dave Richard that's my boss. He's the man in charge of Medicaid. We have decided at Medicaid to continue the payment increases that originally were set to end June 30. We recognize that there continues to be a need to help support our practices and all of our Medicaid providers, financially as much as possible. And so we are moving those changes into the new fiscal year which started July 1 for us. I cannot tell you when they're going to end yet, but I'll just tell you that they're not going to end on June 30 So, any any extra time is great time and good news that there's enhanced rates and reimbursement and payments will continue for the foreseeable future. That does include that per member per month, increase that we put in place. So, good stuff, and just wanted to share that that that has been made official yesterday. Next slide.

Um, so, I saw it, it's funny that I put this slide in here because it's not Medicaid specific, but one of the questions I saw early on was about tell us about CHAMP so I'm glad I threw the slide in here. Although I told Kelly I've only talked for 12 minutes and now it's been 15, but I'll spend one more minute, talking about CHAMP because it's near and dear to my heart. I've been working with the historically marginalized population work stream over the last few months at DHHS. And this is one of the outputs is task order focused at community testing and high priority and marginalized populations around the

state. On this slide you see in the background is the rates of COVID infection and then the foreground the yellow are the zip codes we selected, and without going into great detail, I will tell you that it was a very thoughtful, very data informed process we went through in the month of June, looking at, specifically African American populations Latinx populations and American Indian populations in the state, and focused on where their percentage of the population was the greatest, and then had other filters we applied to it. So in the African American population we had a filter for age and chronic disease that narrowed down the zip codes we wanted to focus on in this first round of CHAMP. In the Latinx population we looked at where the construction and farm workers were in the state, and we put that filter in place to help us narrow down the zip codes to go to first. And so, the one thing we did do is we looked at our map of where all the testing sites were. And we took those out. And so these zip codes are the ones where they're testing sites at least at the time when we did this data crunch which was a couple of weeks ago and so I know it's different today. But where there was a highest population of marginalized populations with those additional filters, and no testing sites. That's how we came up with this list.

And so I know it's given much angst and reflux to my friends in the West. Many of you know I am in the West myself. But the fact is we have a lot less diversity in the West relative to other parts of our state. And so the percentage of the total population that's historically marginalized populations is less in the West, than it is in the east and so we're starting here this is not the end of it. This is CHAMP one dot O. We're going to have CHAMPS two dot O and three dot O and we're going to keep this work going on but we have vendors who applied for this through our RFQ process that was released back in June. That RFQ process rolls over every month so new people can apply to be vendors, and to create these task orders these bodies of work that we say we're going to help pay for and support this work. If you will go stand up testing in these places. Because we know that it's really putting a strain on your teams to do this yourselves and that you need help. So, the only challenge with that you know we have procurement rules we have to follow in state government. We can't just say, Hey, we like you. We know you're doing a great job we want the money to go to you, we have to go through a very defined process of procurement. And so if you would like to be one of those vendors that does this work, go out to the website, apply to be a qualified vendor we would love to have you on the list and we have a new round being announced, maybe at the end of this week it was going to be July 19 but I think they're doing it faster. So anyway, you'll continue to learn more about that, feel free to reach out to me if you have specific questions. And the two vendors that are were awarded for the zip codes that have been awarded so far, which is about 100 of the 174 zip codes is Vidant in the eastern part and then Origin, which is an out of state lab vendor, who's coming in partnering with local partners to do testing and a lot of the East areas, these vendors are required to do some really unique things, so they have to provide culturally and linguistically appropriate services, and we've actually stood up a secret shopper program we're going to send people out to the testing sites to verify that that is happening. They have to link to the primary care provider with the test results. And so there are a lot of aspects of this that we think will really help move health inequities for. So, that's it

Hugh Tilson

Before you turn it over to Kelly we got a couple quick questions, sorry Kelly. Before figured we'd grab these now. Somebody wants to be, who do we contact to be a testing center, how do they do that?

Unknown Speaker

Yeah, so you can't be a vendor, unless you've gone through the RFP process. But the vendors can subcontract that, so they can say, FQHC A, we don't have a staff for this part of the state but we've had to do testing here. Can we partner with you to pay you to do some of this testing. So you I would say if you're one of those people that would like to be a subcontractor or have a vendor, reach out to that to vendor or.

Hugh Tilson

Gotcha. And then, where can they get a list of testing sites where they're going to be.

Dr. Shannon Dowler

They're going to be put on the website at the find my testing site. We already have a pop up site listing on the DHHS website so they will be there, and they will also be as there, we just awarded it on Monday and the first site was yesterday. So they're moving pretty fast for us, which is what was that was part of the task order, but we're going to be getting the sites a little more in advance and be able to promote them, so definitely we'll have them up on the website

Hugh Tilson

Does Medicaid reimburse for being a collection site?

Dr. Shannon Dowler

So I'm not sure how to answer that question right now Medicaid is paying for lab tests. So, so we reimburse for our beneficiaries who are having the PCR tests. But Medicaid itself is not paying for CHAMP I should make that clear this is a Department of Health and Human Services effort, I just happen to be, you know, helping lead it.

Hugh Tilson

And then question about turnaround time are these going be better than the other labs?

Dr. Shannon Dowler

Yeah, I will say one of the cool things about both the vendors that were selected, is that they both add totally new additional capacity to labs, none of them are going through existing commercial vendors so they're not gonna lengthen your turnaround time we're seeing really big delays right now. And that's largely because health systems have run out of reagent, and then they have to use commercial labs for what they were doing themselves. And then that pushes the community testing out longer, so no this is all on top of added capacity.

Hugh Tilson

Right, Kelly now? Kelly, take it away.

Kelly Crosbie

All right. Hi everyone's thanks very much. This is Kelly Crosbie, and so I think some of the data that I'm going to present tonight I think you've seen this week over week. So tonight I'm going to share with you just some of the telehealth and telephonic uptake data that we've been tracking at the state as Hannah mentioned, we're evaluating a lot of things about telehealth during the pandemic. But this is something that we've consistently been doing week over week just to understand the trends in telehealth and telephonic utilization. So, next slide please. So I'm going to use this first slide just to orient you guys a little bit to the slides that come after it and again I think folks are used to seeing these slides. I don't think I'm going to share anything that's going to startle anyone on these slides, tonight, but it does have new data. So we're able to turn the data, longer. Some of our slide goes through the first week in June and some of the data goes through the third week in June. But let me use this first slide to kind of orient folks to what we'll be seeing.

So the first thing is just a note on the data sources across the bottom you'll see that we tried to attribute to the analytic group who pulled the data for us. So we have an internal analytics group that pulls a lot of data for my team and the CCNC team is also pulling a lot of data. The data is all coming from the same place so just let me be clear about that it is Medicaid claims data, but typically the Medicaid analytics team will pull one to two general data and they'll pull telephonic and telehealth claims for all telephonic and telehealth services. Typically the CCNC claims are not as longitudinal. They focus, often on primary care op behavioral health services, and we're able to use that data to really drill down to the patient and to the provider level so they're just same claim wet data, so I just want to be clear about that.

So you'll see data presented in two ways. So one of the things that we saw is just general claims of volume like this first slide is a really good example, this gray line that you see going up and down is just good longitudinal data on volume of professional claims, that's what the gray line is, you're going to see slides about volume of professional claims you'll also see five on the volume of telehealth and telephonic claims. The other slides, you'll see talk about percentages. So this is where we take the amount of, we look at the amount of telephonic and telehealth claims as a percentage of the total professional claims. It's a better way to look at things because the volume overall is pretty small. So we

tried to look at the percentage of the professional claims that are actually telehealth and telephonic On some slides, you'll see telehealth and telephonic services broken out. That's because we might look at a specific provider type for example, we might look at pediatricians and we'll say how much telehealth billing is how much of it is telephonic. But when we look at things like claims across the beneficiary types and so when we look at claims broken down by age groups. We tend to lump all the telehealth services together so telephonic and telehealth so you'll see that is different. One of the things I want to stress in this slide shows that well is that the percentage that I was talking about really is the factor of all professional claims and all telephonic claims. So you're going to see really interesting wave. When we look at the paint you're gonna see a wave of claims. But remember, that doesn't necessarily mean telehealth services are going down. It's a virtue of the fact that in person services to all professional services they're changing as well. And one of the things that we've been seeing if you look on this slide right here. Put it in red, is general visits, so all professional visits are rebounding in April, so you see a little upswing in April. So you're going to see a curve when you look at the telehealth billing plans that I show you, you're going to see a wave similar wave on on all the slides, but part of that is not necessarily reduction in telehealth services. It is a factor of the fact that in person claims are rising as well. Starting in April.

Let's see anything else I want to say oh the dotted line I think the dotted line is really important so remember the dotted line, are we're not ready to make it a solid line yet. That's really why it's dotted. We have to allow for claims to run out of time. And until we have at least a good month, solid claims run out   time we're not going to make that line solid so you can see lots of dotted line. Please know that we're watching the trends over time. And when we feel like we have the vast majority of the claims adjuticated and in the systems then we will make that a solid line. Okay. So this slide again, it just shows you longitudinal volume of claims, this gray line is is all professional claims and down at the bottom you see yellow health, the yellow line is telehealth claims so that pure volume of claims across all provider types. And then the blue line is the telephonic claims, this is all provider types, longitudinal volume of claims and Next slide please.

So this is our ratio of telehealth visits to general visits again, this is all visits and if you look at the yellow line which is telehealth right now about 6% of where we've pressed it but it is still a dotted line there. 6% of all professionals claims who are telehealth claims. The blue is the telephonic. The 6% is going to be really low compared to some of the size, I'm going to show you in a bit. But this is all claims. There's great variation in the amount of telephone services provided by different providers types. Okay. So next slide please. These are slides the next set of slides, I'm going to show you where we're going to break down on utilization by provider type and also by beneficiary type. So we're looking at data across providers, and across different member groups. This data does run out to the third week in June, so this is great and thank you to the CCNC team for providing a lot of data for the analysis. So this is another slide that shows you claims volume. This is primarily primary care, and OB claims. So, again, the gray line is total volume we start to see that uptick again in April. And then you see a fairly steady wave for both telehealth and telephonic services across all of this time period. Next slide.

So, here's where we start to break it down a little bit, race, ethnicity and some other groups. So again this is primary care and OB claims. The lines that you typically want to focus on only because it is our largest member groups are the blue line that's our African American beneficiaries. And our yellow line, which is Caucasian beneficiaries. The other lines are very important lines, don't get me wrong, but they're actually very small volume of claims for our Asian Pacific Islander members and for Native American members, those are pretty small. So typically you want to look at the yellow and blue line, and you see a pretty typical wave, no major, major differences in the volume of primary care to OB claims across these particular groups. Next slide please.

Okay. So, this is looking at ethnicity, so we're looking at Hispanic and non Hispanic, you see that same wave again, remember explain the wave that you see. You can see the wave on every slide. This is where we actually see a little bit of the difference so this is worth drilling down into. So we see almost a 5% difference that that major crest between Hispanic, and non Hispanic members, using this is combined telehealth and telephone. Next slide please. This is by gender, because the lines you actually want to focus from this one are the green and the yellow line, the black line is all female claims. But once we take out the OB claims which, for those of you that are maternal health providers or know a lot about OB claims, those huge latency and we have the bundled billing so they're not the most contingent claim type to look at. So, once we take out the OB claims if you look at the yellow and the green line, that's our male and female, you see that same wave we're seeing on all the other slides, but the claim percentage of claims that are telehealth is about the same for both groups.

Next slide please. We also pull out foster children. So we're looking at children who are in foster care and children who are not in foster care. The green line is children who are in foster care we see a slightly elevated rate, but not necessarily a statistically significant difference but again also worth drilling down into. Next slide please. This is by age group so interestingly that top, top line is our 45 to 64 age group that has our highest, has our highest wave about 30% that's one of the highest percentages you'll see on all of these slides and and you could say, you could do some analysis and say that's a good thing, that is a high risk group that we probably want to be using more telephonic services or telehealth services, excuse me. So that was our largest group, other groups pretty much that whole block between birth through 45, a true blue and yellow line, they're consistently about the same, the black line is a bit shaky the 65 an older slide is pretty shaky. And it's a smaller volume, we've got some -- things in there so it's not, you know, that one looks really low, but take that with a grain of salt because there's some other things going on with that data that need to be normalized. Okay, next slide please. Alright, so here's where we looked at particular provider types. And this is where we're going to break out telehealth and telephonic. So just going to go through a couple different provider types. This is pediatric clearly we're hitting about a 20%. And we'll see how this wave continues or even thought about 20% of the building right now is telehealth much or yea telehealth a much smaller volume is telephonic. Next slide please.

Family physicians again that only crested about 16%. And you see almost as much telephonic as you see telehealth. Next slide. And this is the wonky slide I think the slide has been consistently wonky when it's been shown in these presentations. And we actually have a session with some FQHC, to talk with them

about their billing, because we see the big spike in telephonic. But we've, we've started to see the pickup in telehealth billing we actually think they're just some different billing trends happening here. But we want to understand billing a little bit.

Dr. Shannon Dowler

And Kelly, I can also jump in on that one and what we saw was early on a lot of the FQHC's well none of them had been allowed to use telehealth with Medicare and Medicaid so they didn't have the infrastructure to start doing telehealth right away. And so they jumped right on telephonic because that was something that they could immediately access and do they were used to calling patients but setting up the systems for telehealth and investing in that took a little bit longer. So I think that's true for a lot of the telehealth lag, and the other piece is that the FQHCs have shared that a lot of their patients are don't have access to Wi Fi or don't have cell, you know, smartphones or internet or computers and and so that they found that telephonic has been a more reliable way for a lot of their patients. And so that I think is part of why it's you know telephonic was gangbusters right away. And then we see this telehealth is more and more FQHCs is get the infrastructure to do telehealth long term.

Kelly Crosbie

Yeah, that's helpful. Another group, the next slide you'll see I think the last slide we finish out with behavioral health. So this was another great example of kind of similar to what Shannon was just explaining it took a while for the behavioral health system, the LME/MCO billing systems and then the provider billing systems to get up and running on telehealth but once they have, you see a dramatic difference in billing and actually for the last two weeks, we've definitely seen the greatest spike in telehealth and telephonic utilization in our Behavioral Health Group. So again, if you look on the left hand side that's total volume of claims we see that same Green Line dipping like we see with everything else. Again with that uptake in the middle of April, and you see a kind of a slower start to telehealth than telephonic billing. But if you look at the ratio of the ratios side on the right hand side, the ratios are quite high. They're, they're consistently higher than any other provider type or beneficiary group. So the last slide is the last one that I have is the behavioral health slide as well so this is just to illustrate that we also are looking at the breakdown of behavioral health claims both by race and age just just just like we're looking at all telehealth billing. So again, this is, this is by race so you see Hispanic and non Hispanic, and you see. I'm sorry, this is African American and Caucasian excuse me. And, and you see, it's interesting, it this is dotted right so take it for what it's worth, you see the lines are fairly close, and we're not sure how they're gonna once those dotted lines become solid we're not sure if we're going to see a break there between African American and Caucasian claims but but that spike is tremendous look at 70% of claims via telehealth and telephonic. So, I just want to reiterate again. You know we're working on greater analysis, and we're pulling in a lot of other information to experience with care provider surveys so thank you all for participating in so many of the surveys. And I think it will produce a pretty rich analysis and I think in about three, four weeks, we'll actually start sharing some early results from that broader telehealth analysis.

Dr. Shannon Dowler

And then let me just jump in too and say, Kelly and her team did an amazing job of pulling this together, just like all of us everything was short notice, no one planned on the pandemic. But, but, immediately we're like we're doing all these changes we need to study it, we need to understand it and her and Sam and others on the team really jumped in. And I think it's really helpful to have the data like this so so thanks to your team for doing such a great job on that.

Kelly Crosbie

Definitely a team effort. And really, kudos to the unsung heroes they're all the, the data for pulling data, it's extraordinary amount of data that they're pulling in really quick time so we wouldn't be able to analyze if we didn't have the data so thanks to them.

Hugh Tilson

So Kelly, can I ask you a couple quick questions about this so does the lag in some lines for types of providers correspond with when the changes occurred for each type of provider, the Medicaid covid bulletin releases for example. That's that question makes sense.

Dr. Shannon Dowler

Yeah. Yes, there is a timing related to that when we release new things. When you start seeing it increase in the use and some of them more so than others.

Hugh Tilson

And then, have you been able to analyze by geography.

Kelly Crosbie

Absolutely. And one of the slides that I think we have an interesting looks at telehealth equalization by geography. It looks. It also compares it to the data thats publicly available data that we have on broadband access. We also correlate it to urban and rural. And we actually saw a high correlation between utilization and I'm going to say that wrong guys in the in the in the medical claims in the non behavioral health claim, you saw a positive correlation between access to broadband, and use of teleservices there wasn't a one to one, it wasn't consistent across all counties. But we did see a positive relation we saw the exact opposite of behavioral health, which just totally surprised all of us. So we had a slide in here I think if you look at an old deck you'll see a slide. But we're digging into that a little bit more but we absolutely are looking at differences, based on geography.