

Navigating COVID-19- Topic changes weekly

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6:00 pm- 7:00 pm

Presenters:

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Hugh Tilson:

Its 6 o'clock so let's get started. Good evening, everybody. Thank you for participating in today's webinar on navigating COVID-19. This evening we are focusing on the health plans and approach in supporting practices during the pandemic. Tonight's webinar is cosponsored by CCNC, North Carolina Pediatric Society, North Carolina Psychiatric Association and North Carolina Academy of Family Physicians and North Carolina AHEC. It's the fifth of the continuing series of informational sessions designed to respond to needs you have identified as you navigate COVID-19. It's also Cinco de Mayo for our fifth one. How cool is that?

I'd like to start by recognizing Tom, Elizabeth, Robin and Greg for their leadership in identifying those needs and for their great partnership in putting on these webinars to respond to them. I want to thank everybody who has participated in this for the work you're doing for your patients to support your staff and communities every day. We hope the information that tonight will make navigating in these trying times easier. Next slide.

My name is Hugh Tilson and Tom Roth and I will be moderating today. We have a great panel for you tonight. Shawn Parker and Allen Dobson are back to help with financial updates. So, thank you for coming back. We have Doctor Larry Wu the medical director for Blue Cross Blue Shield North Carolina. Also, Leslie McKinney, also medical director for Blue Cross Blue Shield. Doctor Chris Broga, medical director of clinical solutions for Aetna. Doctor Lucinda Demarco chief medical officer for United Healthcare South Carolina. Thank you all so much for making the time to be with us this evening. We can only imagine how busy your days are and really appreciate you making time to be with us. Next slide.

After the panelist have provide their updates, we will take your questions. You can submit questions either by using the Q&A feature at the black bar on the bottom and if you are on the phone, you can't do that so send your questions by email to questionsCOVID-19webinar@gmail.com. That's questionsCOVID-19webinar@Gmail.com. Lastly, there's a lot of information in these slides I will make sure they are available as quickly as possible. Probably this evening. We are recording the webinar and transcript will be available on the

joint see CNC a website. Now let me turn it over to Shawn. Thank you, Shawn.

Shawn Parker:

Doctor Dobson is with us as well, I will take just a couple of minutes here to give a brief update on two of the progress we had been speaking to in the last few webinars. There's not a tremendous significant update however we would like to give more emphasis on the targeted funding out of the provider relief fund and give you recently IRS publication ruling on how you can use the PPP as far as deductible expenses. Looking at summaries, we spoke before that there was \$100 billion in the provider relief fund an extra \$75 billion appropriated in the last congressional act. From the fund there's general funds for really any healthcare services. The desire should be making up a percentage of your annual gross receipts, sales and program services and if you recall the IRS or the CNS said that you don't have to be specific to treating COVID-19. They were broadly interpreting your services for any patient as possible case of COVID-19. The first tranche came out in April 10th which was \$30 billion, it was either directly deposited or mailed based on your [indiscernible] and it came to about 6.2% of your 2019 Medicare fee for servicing not counting Medicare advantage. Required actions on your part were submit 30 days receipt [indiscernible] portal agreement of the terms and conditions providing documentation to demonstrate that you either have revenue shortage or increased healthcare costs beyond this pandemic. If you'll go to the next slide.

Shortly after there was a second tranche of funding which covered 20 billion dollars in the general fund and this now was either automatic to you or if it did not come automatically, you can go to that HHS portal and request such a payment. The key I would like to explain is that the funds through this tranche are not first come first serve. So, the funding is available to you if you meet the need and they distribute weekly. They will accept the application, so the funding is there. The required action on your part would be to sign a second attestation and there is a few new terms and conditions you need to be mindful of and in this case have sufficient documentation. We'll go to the next slide.

When they announced the second tranche, they were a bit strict are word a were liberal construing of what services constitute health care services and what the funds can be used for and we want to emphasis that there will be auditing afterwards so if you don't have lost revenues or increased expenses during this period of time then you don't want to receive these funds and you should return the funds that you have. We'll go to the next slide.

That is the general portion of this provider relief fund. The second portion was targeted. For targeted, there's much more specific on how you can use these funds. We did not speak to the uninsured portal for the last time because one of the conditions is it cannot be reimbursed elsewhere and at the time there was a possibility that our state was going to cover this population through Medicaid. Since that was not part of the house, senate and governors compromise over the weekend, it's worth bringing back up and speaking to a targeted fund to reimburse providers that are providing COVID treatment to the uninsured. It's very specific that this is for uninsured patients and

you have to attest they have taken steps to ensure that they are not covered by other payers and no funding is available to cover the services and then you must be sure that you are providing very specific services. If you'll go to the next slide.

It has a list of some of these targeted services. What you are looking for, I won't read through the list. The key here is at least \$2 billion available. This is on a reoccurring basis. They can use what is remaining that wasn't allocated to the general or other targeted fines. They will be specific on the work you do. Some will be done electronically. If you would like more information on this targeted one, or information on the general and instead of going through the FAQ this time please be sure to go to the community care COVID-19 triage plus where we're handling different questions coming through their 800 number 877 490 6642, or you can reach them on the website and address these specific to your need. With that said and unless Doctor Dobson has further information, we can move this onto the health plans and presentation this evening.

Allan Dobson:

Thanks, Shawn. We have seen a few questions still come. The issue of whether some of the additional funds will flow through Medicaid providers is still unresolved and we do have some indications from the state by questions they are asking us, that still may be forthcoming as a way to get to some of this money to Medicaid specific providers such as pediatricians and OB/GYN physicians. Hopefully by next week we will have an update on that as well if the state doesn't go ahead and announce something. We're and, we hopefully get that resolved shortly.

The second tranche as far as losing money, I can't imagine that there's not, at least in the primary care community it's not all providers can't show that there's a loss of revenue. It is important to keep track of that and the last piece is people being furloughed and being out of work, it's also really important if you are going to use funds to support care for those who are no longer covered by an insurance that you also have your office staff to keep track of that now versus having to scramble around later to prove that you have done so.

Shawn Parker:

Very good. With that we did have one quick update on the paycheck protection program. There's still funding and taking applications on that on the second appropriation. The IRS did, with a come out with ruling that was a little less favorable where they did indicate which had been their policy, we were hoping perhaps that they would shift it for this circumstance. It would be a typically qualifying expense deductible in your taxes, if you use paycheck protection program money to cover it. That will not be deductible. Probably not a big surprise to many people but it was the hope that they would overlook that this time. That is the end of our update on the paycheck protection program.

Doctor Wu and Doctor McKinney from Blue Cross Blue Shield take us into the health plans.

Larry Wu:

Thank you very much. Good evening all. Thank you for being here and the care you are providing for citizens of North Carolina. I am Larry Wu a family physician. I am 10 weeks out from seeing patients. I am honored to be joined by Lester McKinney and ER physician for senior medical director on our care redesign and value team. Next slide.

We're going to go over our response to COVID. What you will be seeing is the first two bullet points. Overall, we plan to our response to folks who are a member and supporting the health care system including providers, supporting employees and making sure that we stay solvent to support all the good care that's that they are doing. We will focus most of our remarks tonight on communicating the plans and committing to supporting the healthcare delivery system to all stakeholders. Next slide.

We will go over some members support measures. Next slide. So, the first case of COVID spotted in North Carolina on the third. Up to this point, we knew that there was sufficient person-to-person spread, social distancing or physical distancing would be a key part of strategy to mitigate. On the fourth the next day we made an announcement expanding the coverage of telehealth including parity as well as, early refills. And then over the course of the month, we had phased in our waivers of cost-sharing and prior authorization. Next slide.

So, we have a three-legged stool on how we are supporting and expand our coverage of telehealth, waving cost-sharing for screening and test and of course, part of that is required by law. Members would COVID diagnosis there's no prior authorization for diagnostic tests and or covered services medically necessary based on CDC guidelines. There're no prior authorizations for COVID testing, notification for only some type of requirements and assuring access to medication and speeding payments to providers. Next slide.

Blue Cross as you know, we oversee and administer several lines of business fully insured, self-insured plans which is a lot of small and large groups North Carolina state health plans and we have high deductible health care plan and federal employees plan and Medicare advantage plans. And then as you have experienced, Blue Cross patients from out of state within out-of-state Blue Cross plans we also provide them with each of our expansion that you can see when we turn on the switch for covering one service you want to make sure that all these lines of business are addressed. It is a busy slide don't worry about memorizing it. Next slide.

Telehealth, next slide, we knew that promoting and helping and physical distancing was a key part. We had members who were reluctant and to go out of their doors and my sense, they are still very reluctant to go out of doors even to a provider's office. We have providers who are crippled with the lack of personal protective equipment and are not able to see a lot of patients and it has dropped. And we feel telehealth was a key force for social distancing to help flatten the curve. Next slide. So, we have taken several measures. Number one paying parity for telehealth is a face-to-face visit. We tried to keep it simple by asking all the providers and we are talking about all specialties including some rehab specialists like speech therapy occupational therapy, neurosurgeons, even

radiation oncologist, follow-up. Whatever you build face-to-face use the same procedural code and bill it with the modifier will be paid as though it was done face-to-face. Again, our goal is to expand access for members who get the COVID related care as well as non- COVID related care. Next slide.

We also waived some cost share for certain groups who have subscribed to tell a dock, this is based on the benefit contract where they have a way a new way cause and wave cost share for the vendor telehealth services, I am a big fan of boots on the ground primary care or physician so we felt it was even more important to what we as we said on previous slides to enable all providers to be paid at parity on telehealth especially during this crisis. Next slide.

So, we felt that the next strategy was to encourage testing and the testing, testing, testing is a key part of overall public health strategy. We did not want health cost of care out-of-pocket to stand in the way so we waved member quote cost share for COVID test the includes the antibody test and I know there's a lot of uncertainty with the inaccuracies and nevertheless we will waive cost share for the antibody test and that has been cleared and provided by the FDA. We also waived the cost share for COVID related treatment that are medically necessary inconsistent with CDC guidelines guidance if diagnosed with COVID or had suspected a diagnosis or the cost waiver also applies to hospital ICU, skilled nursing facility and can be related to COVID. Next slide.

We are also temporarily waving some prior authorizations. We are trying to turn on the program quote to coincide with the anticipated search and to envision the worst-case scenario where the staff had all hands-on deck but unable to take care of their patients. Our goal is to support the provider and enable hospitals to provide care for patients and not worried about prior authorization. During this period, through May 31, done a number of things, number one, we waive the prior approval for the test. Anybody who has a COVID diagnosis. We are also waving prior authorization for any type of emergent patient admission we had to rule out heart attack, chest pain or appendicitis. We're asking for notification only. And the goal is to enable hospitals and health systems to provide and to spend less time and administrative work. Next slide.

We understand the medications are also a key part of the strategy. We waive early medication refill limits so they can get up to a 90 days early prescription that keeps them from having to make unnecessary trips to a pharmacy. On the other side we are protecting supplies of medications by insuring their proper use. All of you remember that we had a guidance about the hydroxychloroquine when and protecting those supplies and monitoring those on the front and if they don't have a COVID diagnosis. Next slide.

In seeing patients, we realize that a lot of practices are seemed to drop off in revenue and we are sensitive to that we're trying to do our best in enhancing the claims payment. With the 90% will be paid in the week and certainly by two weeks and expediting credentialing and ask exploring to provide assistance to providers across the street. One of the questions that came up, what do we want to keep that may persist within the future and certainly we're going to be looking at

value and what additional quality has been created by some of these programs. And also, the member experience. Leslie, do you have anything to add? To these comments before we turn it over to the next speaker. Okay. We will be glad to entertain questions at the end. Thank you so much. I will turn it over to the next speaker. Thank you.

Hugh Tilson:
Lucinda, are you there?

Lucinda Demarco:
I'm here. Thank you. Thanks, everyone, for all that you are doing right now for our patients. I am Lucinda Demarco. I am the chief medical officer for United Healthcare for North Carolina and South Carolina. I am a practicing pediatric hospitalist. I certainly can commiserate with all you are going through during this time. Next slide please.

Basically, in short, I think you probably know what our agenda is. These are some of the things that I am going to try to address tonight. Some of the things that I will say to begin with is just a kind reiterate some of the things that Doctor Wu said to make a long story short, at United, we are doing a lot of the same things that I think probably all insurers are doing across the country and trying to make this the best experience that we can. Next slide.

For United, because we have to worry about all our different plans across the country, we started, we have UHCprovider.com which is a place you can go and really get a lot of information about everything United. As COVID came about and things started to ramp up and seemed to change about every two minutes in the beginning, and it's still really changing daily, we want we went ahead and created a site in the UHCprovider.com. The biggest thing I want to say about this is it's really the source of truth for us at United. As you can see, it has all the credentialing updates. The information about prior authorization, it's got information about telehealth and reimbursement and it has information about testing treatment coding and reimbursement. As you can see here at the top, it says that we're going to cover cost share for antibody testing for our members and there's more details. Unfortunately, yes, there's a lot of information here on this site. It's really the best place to go for any information that you need in regard to COVID and United Healthcare. Next slide please. Next.

So as far as telehealth, and this really have blossomed I think since the beginning of COVID. We, at United, had telehealth services at zero-dollar co-pay for all our fully insured commercial members. Some of our ASO commercial members and all our Medicare members. That was for both acute visits as well as behavioral health. So were actually starting to work on expanding the so that telehealth could be provided by the primary care provider and COVID hit and then so that all got accelerated. The other piece of this was also the virtual check ins and the fact that also it was able to be done through the EMR and we felt those should be reimbursed as well. The only limitation which was dictated by CMS was the fact that you couldn't have had a medical visit within the last seven days and the fact that you couldn't have had a medical visit within 24 hours of the first available from that.

Quote virtual check in or e-visit". As time is changing, if things change, they will be updated on that website as I told you initially. Next slide please.

So, our changes and you can read this as well as I can biggest thing was that we felt that we were following the CMS guidance as to what could be done from our telehealth standpoint. The biggest thing was the originating site restriction that were there. So, we initially had lifted those. Just like the recommendations, we have moved on towards being able to reimburse telehealth visit in your office that you are doing with parity and with payment. We also will reimburse audio only Tele visits. We also just like to Blue Cross Blue Shield, physical therapy occupational therapy and speech therapy can be reimbursed but those need to be audiovisual through telehealth visit. And one of the other big things was the fact that the HIPAA technology had been released and the fact that we could use FaceTime or Skype or WebEx, or all types of things with all the HIPAA compliance. And things that are available through EMR's. Next slide please.

And so, the only thing that in releasing these compliance situations where we just wanted to make sure that providers realized that things like Facebook live and TicTok could not be used for this type of thing. I think FaceTime is a great thing and I think the other areas that such as WebEx or Go to meetings have been utilized by the primary care network. Next slide.

Just a little bit on billing and reimbursement. As much as you have already heard, we have waived cost-sharing across the board and right now that is through May 31. The last I looked at the site, things have changed over the weekend. I did not update the slide. The big thing is members can get COVID testing, they can get antibody testing, they can get care all at zero-dollar co-pay and no cost share. I will say that if we have members that are seeing the provider for things other than COVID related illnesses, or what have you, that there could be a cost share associated with those. And then our self-funded customers were given options to opt in or opt out as to whether they wanted to do zero-dollar co-pay so not. One of the big things is checking eligibility and that can be done through our link tool and that is also a place that there's a lot of information in regard to billing. You can go there and check those types of things besides eligibility. There also is information videos that can be watched and sometime in the very near future we will be given CME credit on that website as well for some of the videos that are educational for providers. Next slide.

The big thing with the billing as far as this is concerned just like what Dr. Wu said, you really use the same ENM, cold that you would normally use, Telehealth service code and modifier. And that's what we're asking. I will say that early on the way I think a little bit of confusion and CMS kind of set things straight and we followed suit. I think that what I went over is probably the easiest method. Next slide.

As far as post COVID, we at United, I think we try to do a lot of things to help the members as well is the providers. I really think that telehealth is going to be here to stay, but I think that we really and truly all have to work together to use in air quotes petition CMS to be able to look at the liberalizing a little bit some

of their initial ways of blocking us in doing telehealth. I think that telehealth is going to be able to give us the ability to see some of our chronic patients without bringing them into the office. I also think that it is it may be a way to be able to actually do some screening on phone calls or after our visits that really may not require an after our visit or be able to direct the patient more to an urgent care or see the next morning in the office, those kinds of things. United also has a platform that we have purchased a company name Vivify. They have a platform that has allowed us to do education and provide monitoring of patients in the home. So, we will be working with various systems and providers in expanding this and being able to move forward education and monitoring the patient. I think that as we move forward with all of this, my hope is that we will be able to see this grow and expand and it will be another piece of ammunition in our toolbox and our arsenal that we will be able to leverage and use as we move forward. With that, I will conclude and looking forward to any questions that you have. Thank you. Next slide.

There's a whole bunch of additional resources that I put here. You can just quickly flip through all of those and get to the next presenter. Thank you.

Hugh Tilson:

This is Hugh, just to remind everybody you can go to the CCNC NC AHEC website, it's been posted there and searched through the webinar and you can download these slides. Thank you, Paul.

Thank you.

Chris, are you there?

Chris Broga:

I'm here. Thank you for joining us. I want to join my colleagues working for United and Blue Cross and in thank you all and everything you're doing. I will make a deal with you if I can get a few minutes of your attention at 6:36 PM. After a busy workday I promise to be very brief. But the other payers, we at Aetna made the decision to fully embrace telehealth and tried to make it as simple as possible. To sum up in a real quick bullet point, a few bullet points, you have heard what you have already heard this evening for my colleagues working in other organizations is that yes, financial obligations on the part of a member and co-pays had been waived. There's a caveat. Those are waived for in network providers and those are waived for a fully insured member. For self-insured members, that is something that they had the option to wave that or not. After that it gets much more simple. The issue of co-pay yes, that depends on thin network versus out-of-network. It gets simpler after that. We're reimbursing those without regard to the platform that's being used. Maybe our Teledoc platform may be a platform favored by the practice, maybe some other platform, maybe audiovisual maybe telephone only, maybe it's real-time, or telephone then we are reimbursing without regard to that particular platform. I hope that makes it easy. In addition, we are reimbursing for those office visits without regard to diagnosis. Like I've heard from others on the call tonight, we're simply saying you get your point of service modifier with the GTO 95 modifier for example 213 will pay at the same rate that it would pay for in person face-to-face office visit regardless of diagnosis. We're being

careful to remind folks that if you use the telemedicine codes that the standard codes, those will continue to reimburse at telemedicine rates so we are encouraging folks to go to the website and make sure that they are up to speed on which codes we are recommending so you can get reimbursed at the full rate for a face-to-face visit. These slides I provided are not meant to be, I did not send them in the intention of speaking to them with you. I said all I wanted to say in terms of the introduction of how Aetna is handling telemedicine and I hope that's helpful and it doesn't sound like it's dramatically different from the other payers. I want to be sure to leave time for questions. I hope I can answer most of the questions if I can't answer them tonight, I can certainly will make every effort to answer them by tomorrow. What you will find on the slides will be, I reviewed the myself and they strike a nice balance between being comprehensive to answer questions, but not being some of the things that you find with payers and Aetna is often guilty with this with the policy 20 or 30 pages and our folks have done an excellent job soon putting the stool together in a way that you can get a quick answer to your questions. If you can't, the individuals at CCNC are nice enough to arrange these tonight and I am more than happy to have them share my email and my cell phone and happy to take her cell calls and to correspond and talk and help in any way I can. So given the time, I will end my comments there and let my colleagues, be happy to take any questions you have.

Hugh Tilson:

Thank you. Thanks everybody for the work that you have put into preparing for this. We got a ton of questions. I want to start with the bigger picture thing. You basically said you recognize telehealth has been used successfully to reduce exposure for patients and healthcare providers. You have also implied that you could access increase access to patients, especially professionals that work for shortages psychiatrists and others the underlying question for all relates to extension of telehealth. You all kind of have touched on it. But from the provider perspective, not having a time certain is problematic in terms of setting up appointments and managing patients. So how can you provide more certainty to providers about it's okay to set these patients up because they will continue for long enough time you can schedule them and get your patient managed.

Larry Wu:

This is Larry Wu, we will continue to expand coverage through May 31st and we are hoping to give advance notice of any extension and if there are any extensions, we will try to get it out 14 days in advance of May 31st that would be May 17th. We understand of the challenge you will have.

Lucinda Demarco:

This is Lucinda from United. I think the biggest thing is I wish we could predict what CMS is going to do. I think that is probably a piece that all of us need to do which is to encourage CMS to more or less leave things as they are. Except maybe go back to the HIPAA compliance thing. But I think until CMS rules, I don't know that any of us can predict and say go ahead, this will continue exactly as it is. And so, I wish we could, but I think but I don't think we can at this point.

Hugh Tilson:

Are you giving any thought to working together to have common timelines from the provider perspective? You have to figure out which is the end date for each of you in a fair way to coordinate that, that would be helpful. Have you thought about that?

Larry Wu:

This is Larry Wu again. I should I am sure we would make it easier for providers.

Hugh Tilson:

We are asking if you could give a thought for that, I think that's a purpose of the question.

Larry Wu:

We also have to respect and, there's laws put into in for reason and that something that we have to consult with the legal team.

Hugh Tilson:

Another question that came up, how are you promoting to your subscribers that they go to their medical homes so that number one if they use telehealth and number two they go to their medical homes rather than go to a tele-doc or other service that they don't have a comprehensive medical home model.

Lucinda Demarco:

At United, sorry Chris, but United we sent out mailings and we also specially on our Medicare side of the house, we have done phone calls. And our high-risk patients even on the commercial side of the house have gotten phone calls to remind them about going to see their primary care docs. Because we feel that is extremely important. The scope of things.

Chris Broga:

This is Chris from Aetna. That is one of the things that we struggle with about any sort of issue that we are trying to help our members. There are a few people look at the phone and go as my health insurance company calling, I'm so glad they called me let me pick up the phone. But what we tried to do is to through a combination of telephone outreach, targeted mailings, updating websites and continuing to encourage folks to use our app we're trying to reach out to people in any way we can and one of those messages that we try to bring home is the benefits of sticking with your PCP, finding a PCP, a tremendous amount of what we do and what we call a value-based side. We're trying to find better ways to reimburse physicians and, and simply fee-for-service and that's a different conversation. That's one of those things we try and bring home for reasons other than just COVID.

Hugh Tilson:

We have a series of questions about the financial struggles that a lot of practices are experiencing whether you have given a thought on the PMPM type of approach rather than relying on fee-for-service to help navigate these times.

Larry Wu:

This is Larry Wu from Blue Cross. This is a useful input, it's the first time I've been informed that there's a request by providers to

conserve PMPM approach certainly I will take it back to the team.
Thank you for that input.

Lucinda Demarco:

I will just say ditto for me for United. I know that we are working on a lot of things post-COVID but definitely we will make sure that it is on everybody's radar.

Hugh Tilson:

Great. Thank you. Are there limits on where in person visit can occur before or after our virtual visit for example if a plan won't pay for a visit if it occurs within three days of a telephone visit, are those limitations still in existence?

Larry Wu:

For Blue Cross, anything that you would do face-to-face with apply for telehealth. So, if you have a patient that is high-risk with a fever and you want to see that the next day, there are no limits in terms of sequential days. I know that was an old coverage criterion that we did have in our telehealth policy, but I think that has been struck.

Hugh Tilson:

Is that true for everybody else?

Chris Broga:

Yeah.

Lucinda Demarco:

Yes.

Hugh Tilson:

I will turn it over to Tom in a second. A couple times this came up, a search that we got to the mental health surge what are you doing to prepare for increased utilization behavioral health services the specific question refers to the collaborative model is that something you are looking into and supporting, and wondering generally thinking about how you support and pay for those types of integrated behavioral health services that patients are going to need in this post COVID environment.

Larry Wu:

This is Larry Wu for Blue Cross. I think that's going to be one of the recurring themes of the increased need for the behavioral health. We have a multi-pronged behavioral health strategy. Obviously, Reimbursement and helping to support behavioral health providers a key part of that strategy. In addition, the area of telehealth deserves to be looked at particularly for telehealth for rural areas where they don't have access. These are areas we are looking at. We have other strategies as well as quartet our hope is that with increasing the finances and improving the systems, that we would have a larger reach for many of our patients who struggle or who have behavioral issues.

Lucinda Demarco:

This is Lucinda from United. Our behavioral health is really run and administered through Optum. My hope is that because of the behavioral health issues around COVID have really brought to the forefront. A lot of people will perhaps would not have gone and gone after

behavioral health treatment will do that. So I think we have been really trying to ramp up the number of providers that can provide care for these patients as well as covering the telehealth and then there's also support on the Optum side that was supported as well that we are ramping all that up at this time.

Chris Broga:

This is Chris from Aetna. We extended that waving of the co-pay to include not just medical services, but also behavioral health services. We think there's more specific information on the codes that will allow behavioral health providers to get reimbursed at similar rates as the face-to-face in person visit detailed, quite a simple as what I described on the medical side, but it is there. The unfortunate reality is that all the things that make getting people to behavioral health services they need are still going to remain in place and it would be wonderful if this crisis becomes an opportunity for things to prove, but I am concerned that we're going to get a worsening problem without immediate avenues to make things better. In this particular area.

Hugh Tilson:

A resounding support for the collaborative care model, as you think about how you do that in the future. Tom, are you seeing anything that resonates with you in terms of the next questions?

Tom Roth:

Just a couple follow-ups and a few other questions. Lucinda around CMS in providing that guiding post for the peers, can you talk more about the importance of CMS setting policy and wide commercial payers it's harder to take away from what CMS is doing?

Lucinda Demarco:

I think some of it really has to do at least for us is around the Medicare side of the house and the Medicaid side of the house. So, in trying to keep with consistency across all lines of business, CMS really has been adopted by us and by other payers as sort of the truth. So, I sometimes think that yes, they want to be thoughtful and I think they want to be helpful, but I think now it's time that they move forward and become much more current some of the things that they are doing. I think I know us, a United, have asked them to consider loosening things a little bit, and continuing with current models, except for using HIPAA compliance. But there has not been anything that's been stated yet. I think if boots on the ground all of us practicing providers, go to CMS and say hey, we really think that this is a benefit and needs to continue as we move forward. Then perhaps we will stand our voice and show our voice and be able to move saying it that way.

Tom Roth:

Thank you that's helpful. One question about all of you about preventive care, one question around well child checks and for greater than 2 years old and then also for adults just for physical exam and preventive care visits, you all looking to allow billing for those visits under telehealth?

Larry Wu:

Yeah, for Blue Cross we do cover preventive under telehealth. We had some questions about the physical exam and obviously the physical exam problematic now. But certainly, if you decide that for standard care issues or better care to do a physical later and that's perfectly fine.

Lucinda Demarco:

I think for a pediatric standpoint, a lot of your visits can contain anticipatory guidance. That telehealth really means that you ready to do that. I cannot say at this point for 100% sure that United is going to continue to cover those because again is going to depend on what CMS decides.

But you can't get your shots that way [Laughter]

Larry Wu:

Yeah, and your bloodwork [Laughter]

Lucinda Demarco:

That's right.

Chris Broga:

This is Chris from Aetna. Can I address that. I am a pediatrician by training. This and comes under the category of reimbursing for telehealth visit with appropriate modifier just as if they were face-to-face without regard to underlying diagnosis.

Tom Roth:

That make sense. Thanks, Chris. Another question for everyone. Around the prior authorization and reducing some administrative burden during COVID, are there of other learnings from that around whether those policies can be redesigned for the future, is it possible that there may be some changes on prior authorization?

Larry Wu:

The answer is yeah, we want to look at that so in our strategy direction, we are looking at especially services that are emerging whether they are valid for prior authorizations, it's very early. I have a feeling we have a long way of time and I think some of these dynamics of COVID are not going over night. The definitely plan to look at it. We are acutely aware of the burden that prior health system puts on providers and health systems in hospitals.

Hugh Tilson:

Thanks, Larry. We got this question that's really cool, are your companies experiencing providers in the field increased access improve patient satisfaction and ability for some patients to get better care? That's what the providers are experiencing. Are you experience the same thing?

Lucinda Demarco:

That's what we're hearing at United. Yes.

Hugh Tilson:

Tom, I think I interrupted you. I'm sorry.

Tom Roth:

Yeah, no that really encouraging. It's 6:58. One of the things I wanted to address was, there was a couple of questions about the paycheck protection program. And I think some specific questions with people still having trouble with that program. So, I might offer those folks if you want to email CCPN and CCNC support or AHEC support that will be up on the website, we can try to connect you with Dr. Dobson and Shawn had been doing and Hugh why don't we wrap up?

Hugh Tilson:

Great. Thank you everybody for joining us tonight. We really appreciate you carving out some time in your busy lives to listen to the presentations, Doctor Wu, Doctor Broga and Doctor McKinney and Dr. Demarco thank you so much for the work that you did to prepare for this being here tonight and fielding the questions and really appreciate you making time for us. And it is Cinco de Mayo, I hope you can enjoy the right kinds of Corona this evening how about that is a closer [Laughter]

Allan Dobson:

Very nice.

Lucinda Demarco:

Thank you.

Hugh Tilson:

You have anything else you want to say before we shut down?

Lucinda Demarco:

Stay safe, everyone.

Larry Wu:

Yes, thank you again for your hard work.

Hugh Tilson:

All right. Tom, any last words?

Tom Roth:

No. Thank you all. It's been wonderful. We appreciate it.

Hugh Tilson:

Everybody, take care.

Bye-bye.

[event concluded]