ALABAMA CARE NETWORK MID-STATE MEDICAL MANAGEMENT MEETING

AUGUST 11, 2021; AUGUST 25, 2021; SEPTEMBER 8, 2021

AGENDA

- Introductions
- Medicaid Updates
- First Look Program
- Quality Improvement Projects
- Neonatal Opioid Withdrawal Syndrome – Dr. Pamela Payne-Foster

WELCOME AND INTRODUCTIONS

Presenters

- Kristin Mizerany, MD – Medical Director
  - Pediatrician, Mayfair Medical Group
- Susie Bonner, RN, BSN – Quality Care Manager
- Michael Battle – ACHN Executive Director
- Pamela Payne-Foster, MD, MPH – Alabama Perinatal Quality Collaborative

MEDICAID UPDATES – COVID-19*

- COVID-19 Emergency extended to August 31, 2021
- Agency waiver of certain requirements through August 31or conclusion of emergency
  - No co-pays for Medicaid covered services or medicine
  - No referrals needed for EPSDT, PCPs, or DHCPs
  - No cancellation of services unless move out of state or requested by recipient
  - Encourage use of telemedicine
  - ACHN Care Coordination Continues Telephonically
- Provider Alerts**
  - Webinar attendance at Medical Management Meetings
  - Referral requirements lifted
  - Telemedicine

*https://medicaid.alabama.gov/documents/11.0_Recipients/11.3_Recipient_News/11.3_AL_COVID-19_one_pager_4_7_20.pdf

**https://medicaid.alabama.gov/news_detail.aspx?ID=13729

COVID-19 EMERGENCY EXPIRATION DATE

HTTPS://MEDICAID.ALABAMA.GOV/ALERT_DETAIL.ASPX?ID=15521

ALABAMA MEDICAID AGENCY

A L E R T

July 16, 2021

TO: **All Providers**

RE: **COVID-19 Emergency Expiration Date Extended to August 31, 2021**

All previously published expiration dates related to the COVID-19 emergency are once again extended by the Alabama Medicaid Agency (Medicaid). **The new expiration date is the earlier of August 31, 2021, the conclusion of the COVID-19 national emergency, or any expiration date noticed by the Alabama Medicaid Agency through a subsequent ALERT.**

A listing of previous Provider ALERTs and notices related to the health emergency is available by selecting the Agency's COVID-19 page in the bottom section: https://medicaid.alabama.gov/news_detail.aspx?ID=13729.

During the COVID-19 emergency, it is important to file claims as quickly as possible to ensure payment from Medicaid is made to Medicaid providers close to the date of service. The Centers for Medicare and Medicaid Services has increased the federal matching percentage for the emergency time frame, but states can only receive the increased match on claims that are paid during the emergency. Providers should include appropriate COVID-19 diagnosis code(s) on claims submitted to help with tracking of COVID-19.

PATIENT CENTERED MEDICAL HOME REMINDER

- PCMH Certified PCP groups eligible for PCMH incentive
- Five percent (5%) of total incentive pool designated for PCMH
- Eligible providers must submit PCMH Attestation Form to Medicaid to receive incentive
- Deadline for Attestation submission is 10/1/21 and must be completed annually
- Form located on Medicaid website
  - https://medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.19_ACHN_PCP_Forms/9.4.1.9_PCMH_Recognition_Attestation_Revised_12-28-20.pdf

Q4 FY 2021 PROVIDER PROFILERS

- Updated Provider Profilers Available on Medicaid Secure Provider Portal
  - https://www.medicaid.alabamaservices.org/alportal/Account/Logoff%20Session%20Expire/tabId/54/Default.aspx?sessionExpired=true
- Quality and Cost Effectiveness Payouts Released on 2nd July Check Write

BMI REQUIREMENT

- BMI Requirement reinstated effective August 1, 2021
- PCPs, Nurse Practitioners/Physician Assistants (collaborating with a PCP), PCP groups/ individual PCPs participating with an Alabama Coordinated Health Network (ACHN), Federally Qualified Health Centers, Rural Health Centers, Public Health Departments, Teaching Facilities, and OB/GYNs that bill procedure codes 99201-99205, 99211-99215, and 99241-99245
- BMI must be documented on at least one claim per calendar year
- EPSDT procedure codes 99382-99385 and 99392-99395 must also include a BMI diagnosis on the claim annually
- Provider Alert: https://medicaid.alabama.gov/alert_detail.aspx?ID=15517

BMI REQUIREMENT

- Telemedicine Guidance: "BMI will be required for all visits including the telemedicine visits. To be eligible for reimbursement for the telemedicine visits during the current PHE, the provider must file the claim with place of service '02' (telemedicine) and a modifier of 'CR' for catastrophic/disaster to assist with claims tracking. Providers should use subjective data to calculate the BMI which can include providers asking the recipient for his or her height and weight during the telemedicine visit. The BMI should be calculated, based on the information provided by the recipient, and appended to the claim for reimbursement. The BMI should also be documented in the recipient's medical record."

PCP REFERRALS

- Effective August 1, 2021, Specialists no longer require PCP referral for reimbursement from Medicaid
- EPSDT referral requirement will remain intact; meaning services that require an EPSDT referral will continue to do so effective August 1, 2021
- Alert: https://medicaid.alabama.gov/alert_detail.aspx?ID=15537

ONLINE VIEWING CODE

81621

SOCIAL DETERMINANTS OF HEALTH

https://health.gov/healthypeople/objectives-and-data/social-determinants-health

CODING FOR SOCIAL DETERMINANTS OF HEALTH

- **MARA risk score/Cost Effectiveness**
  - Milliman Advanced Risk Adjusters (MARA) software
  - Risk adjustment software to calculate individual risk of each ACHN eligible patient
  - Evaluates what someone should cost given clinical and social issues
  - Top 40 diagnosis codes on each claim for an individual are in the input file in MARA software
  - "Can't know what it's not told"
  - Scores could be impacted by optimizing appropriate coding, maximizing preventative care and utilizing ACHN care coordination resources
    - Concurrent Risk Scores – provide a singular, standardized, expected risk score given the past year's claim experience and are used for **Provider's Cost Effectiveness Calculations**
    - Prospective Risk Scores –predict future risk given the past year's claims experience and are used by an ACHN for Care Coordination

HTTPS://MEDICAID.ALABAMA.GOV/DOCUMENTS/5.0_MANAGED_CARE/5.1_ACHN/5.1.3_ACHN_PROVIDERS/5.1.3_ACHN_PROVIDER_CE_BONUS_EXPLANATION_AND_FAQS_5-7-21.PDF

CODING FOR SOCIAL DETERMINANTS OF HEALTH

- Ensures payers know the "whole story"
  - document how the identified SDOH may impact the diagnosis or treatment, but to also code for it using the many ICD-10 codes available
  - Utilize secondary ICD-10 Z codes to explain the increased complexity
- When to Code SDOH
  - EPSDT screens
  - ADHD evaluations
  - Include with Mental Health Evaluations and Follow-Up
  - Relevant to current chief complaint/primary diagnosis

HTTPS://DOWNLOADS.AAP.ORG/AAP/PDF/SDOH.PDF

EXAMPLES: ICD-10 Z CODES FOR SDOH

- Z62.810 Personal history of physical and sexual abuse in childhood
- Z59.5 Extreme poverty
- Z59.6 Low income
- Z55.0 Illiteracy and low-level literacy
- Z55.3 Underachievement in school
- Z63.4 Disappearance and death of family member
- Z63.5 Disruption of family by separation and divorce
- Z62.21 Child in welfare custody
- Z62.29 Other upbringing away from parents
- Z62.22 Institutional upbringing
- Z59.4 Lack of adequate food
- 59.0 Lack of housing (homeless)
- Z59.1 Inadequate housing
- Z59.8 Other problems related to housing and economic circumstances
- Z63.72 Alcoholism and drug addiction in family
- Z71.42 Counseling for family member of alcoholic
- Z71.51 Drug abuse counseling and surveillance of drug abuser
- Z71.52 Counseling for family member of drug abuser

USING Z CODES:

The **Social Determinants of Health (SDOH)** Data Journey to Better Outcomes

What are Z codes

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

SDOH are the conditions in the environments where people are born, live, learn, work, play, and age.

Step 1 Collect SDOH Data

Any member of a person's care team can collect SDOH data during any encounter.

- Includes providers, social workers, community health workers, case managers, patient navigators, and nurses.
- Can be collected at intake through health risk assessments, screening tools, person-provider interaction, and individual self-reporting.

Step 2 Document SDOH Data

Data are recorded in a person's paper or electronic health record (EHR).

- SDOH data may be documented in the problem or diagnosis list, patient or client history, or provider notes.
- Care teams may collect more detailed SDOH data than current Z codes allow. These data should be retained.
- Efforts are ongoing to close Z code gaps and standardize SDOH data.

Step 3 Map SDOH Data to Z Codes

Assistance is available from the ICD-10-CM Official Guidelines for Coding and Reporting.[1]

- Coding, billing, and EHR systems help coders assign standardized codes (e.g., Z codes).
- Coders can assign SDOH Z codes based on self-reported data and/or information documented in an individual's health care record by any member of the care team.[2]

Step 4 Use SDOH Z Code Data

Data analysis can help improve quality, care coordination, and experience of care.

- **Identify individuals'** social risk factors and unmet needs.
- **Inform health care** and services, follow-up, and discharge planning.
- **Trigger referrals** to social services that meet individuals' needs.
- **Track referrals** between providers and social service organizations.

Step 5 Report SDOH Z Code Data Findings

SDOH data can be added to key reports for executive leadership and Boards of Directors to inform value-based care opportunities.

- Findings can be shared with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs.
- A Disparities Impact Statement can be used to identify opportunities for advancing health equity.

CMS

For Questions: Contact the **CMS Health Equity Technical Assistance Program**

[1] cms.gov/medicare/icd-10/2021-icd-10-cm
[2] aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

SCREENING TOOLS

SCREENING TOOLS FOR SOCIAL DETERMINANTS OF HEALTH

Three screening tools can aid physicians in addressing multiple social determinants of health in a primary care setting.

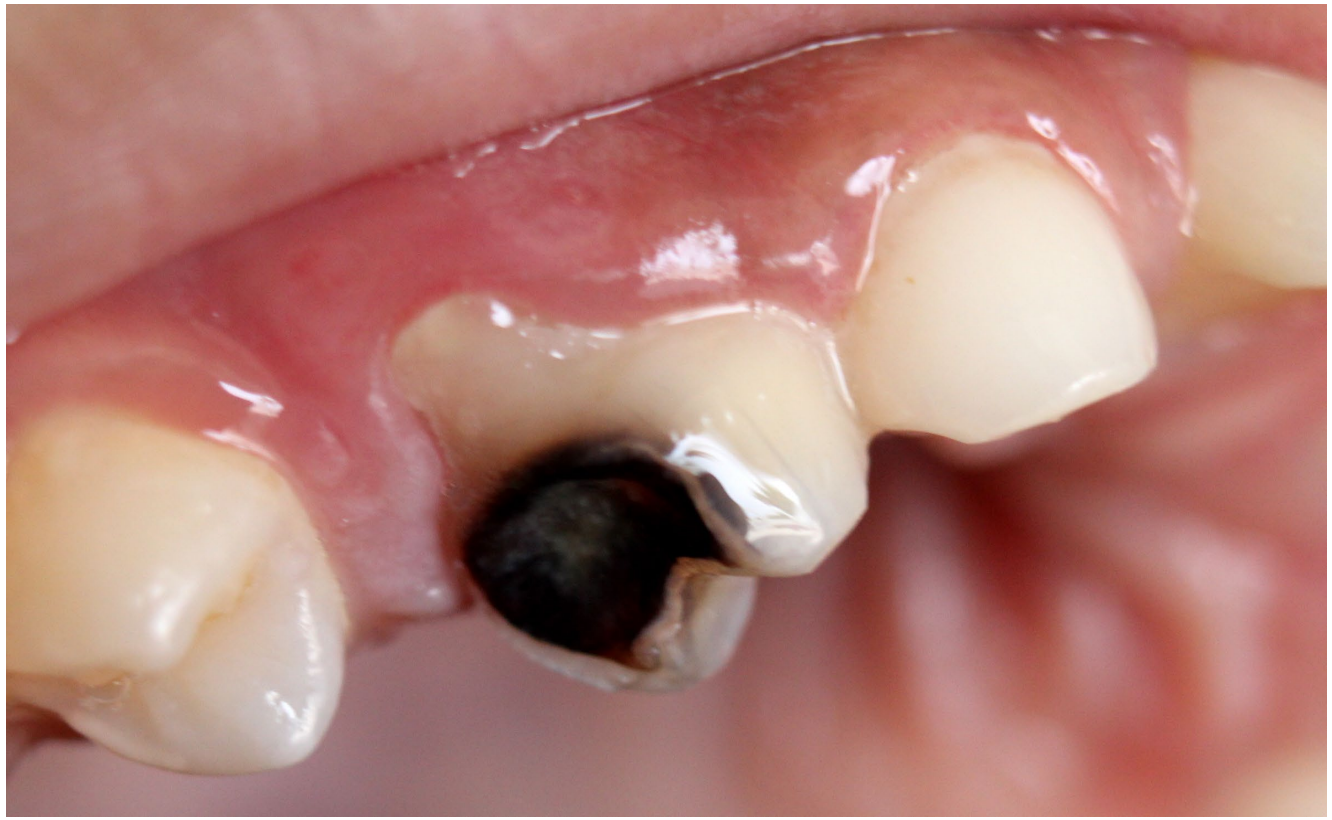
Screening tool	Number of questions	Source
The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)	15 core, 5 supplemental	http://www.nachc.org/research-and-data/prapare/toolkit/
The American Academy of Family Physicians Social Needs Screening Tool	11 (short form) 15 (long form)	Short: https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf Long: https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-long-print.pdf
The Accountable Health Communities Health-Related Social Needs (AHC-HRSN) Screening Tool	10 core, 13 supplemental	https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf

The AHC-HRSN tool draws on evidence from several need-specific assessments, below, which can provide valuable background.

HTTPS://WWW.AAFP.ORG/FPM/2018/0500/P7.HTML

1ST LOOK PROGRAM

BY CONTROLLING RISK FACTORS BEFORE DISEASE OCCURS, THE POSSIBILITY OF PREVENTING DISEASE, BOTH IN THE IMMEDIATE FUTURE AND THE LONG-TERM, IS IMPROVED." -AAP ORAL HEALTH POLICY STATEMENT, 2008



1ST LOOK ORAL HEALTH PROGRAM

- Mounting evidence to prove that the incidence of caries can be reduced by having children six months to 36 months of age assessed by their pediatric provider and a fluoride varnish applied during routine pediatric visits
- Best practices: oral health risk assessment and a referral to a dental home within 6 months on the eruption of the first tooth, and no later than 12 months of age

1ST LOOK PROGRAM

- Qualified providers perform an initial oral assessment and the application of fluoride varnish for high caries risk children
  - (oral exam<3 years old, counseling)- billed once under D0145
  - (topical fluoride application)- varnishing billed under D1206
  - Does not qualify if they have seen a dentist
- Documentation:
  - content of the anticipatory guidance & counseling given to parents/caregivers
  - results of the Caries Risk Assessment Tool
  - a referral has been made to the Care Coordinators for all high risk children
- Training- https://www.alaap.org/oral-health-risk-assessment-module

HTTPS://MEDICAID.ALABAMA.GOV/CONTENT/4.0_PROGRAMS/4.2_MEDICAL_SERVICES/4.2.2_DENTAL/4.2.2.4_1ST_LOOK.ASPX

QUALITY IMPROVEMENT PROJECT UPDATE

Quality Improvement Projects

Childhood Obesity

- Virtual six week nutrition & physical activity counseling program
- Provide tools to promote healthy eating and active living
- Partnered with Alabama Extension to expand the program to reach more

Infant Mortality

- Diabetes & Hypertension Education
- Provide Blood Pressure monitors to pregnant women and women age 18-44 not pregnant with hypertension

Substance Use Disorder

- Partnered with local agency to provide dedicated Peer Support Specialist
- Partnered with UAB Family Wellness to provide family education to assist with EI recovery.
- UAB will develop PCP education modules for SUD

PAMELA PAYNE-FOSTER, MD, MPH

- Alabama Perinatal Quality Collaborative (ALPQC)
- Preventive Medicine/Public Health Physician
- University of Alabama College of Community Health Sciences

Microsoft
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THANK YOU FOR PARTICIPATING

Questions?