Transcript for COVID-19 Webinar for Medicaid Providers
June 11, 2020
5:30pm – 6:30pm

Presenters:
Shannon Dowler, MD, Chief Medical Officer, NC Medicaid
Tom Wroth, MD, MPH, President, Community Care of North Carolina
Hugh Tilson, JD, MPH, Director of North Carolina AHEC

Hugh Tilson

It's 530 Let's get started. Good evening, everybody. Thank you for participating in this evening's COVID-19 webinar. This webinar is part of a series of informational sessions put on by NC Medicaid CCNC and NC AHEC. Next slide, please. As you can see, we've got a lot of great timely information tonight, including an update on Medicaid policies, a discussion about telehealth and care alerts data trends. Then we'll talk about best practices for reopening practices, we will then respond to your questions and close with a list of resources. My name is Hugh Tilson. I'll be moderating today's forum. Our presenters today are Dr. Shannon Dowler, Chief Medical Officer of NC Medicaid, Dr. Tom Wroth, President of CCNC and Anna Boone, Director of quality management at CCNC. Before I turn it over to Dr. Dowler, let me just stop and thank everybody for making time in your busy schedules to participate in today's webinar. We hope the information provided today will help you in your important work and make navigating these trying times a little easier. Next slide please.

After you hear from Shannon, Tom and Anna, we'll take your questions. We've learned in past forums that the presenters will often address your questions during their presentations. We should have time to get to all your questions. I encourage you to wait until the presenters are through their presentations before submitting a question. If you're participating in the webinar, you can submit a question using the q&a function, the black bar on the bottom of the screen. It's a q&a function. If you are not participating in the webinar, you're on your phone and you're muted. So the only way you can submit a question is by sending something to questionsCOVID-19webinar@gmail.com. Let me repeat that questionsCOVID-19webinar@gmail.com. We will record the webinar will make the recording a transcript of it and these slides available to the public probably tomorrow morning. Now let me turn it over to Shannon. Thank you Shannon.

Dr. Shannon Dowler

All right. Thank you and thanks always for Nevin. He is the he's the silent force behind all of this, who makes sure we show up on time and that our mics work and that we follow all the rules, according to Nevin, so thank you for joining tonight. Can you believe that three months ago almost to the day very close three months ago, we had our first webinar talking about what was happening with COVID. We I was sitting around a room and actual room with a table in it and chairs with other humans, which I have now not done in three months, that shows. What we my amazing Medicaid team was sitting around the room with me and we were anxious. We were scared. We didn't know what was happening in the world.

I'm not sure that we know much more now than we did three months ago. But we do know that we can turn around some clinical policy really darn fast if we have to.

And so I did want to start off today with a little bit of gratitude in a couple of places. One is for that Medicaid team who has worked, you just can't even believe the number of hours that they have worked over the last three months to stand up all these policies and get everything so that it works in the system. And you know, in state government, the pay is not great. And you don't get like big bonuses when you work extra hard. And so they just have to rest on the fact that their hard work takes care of people that they care for in the state. And so I'm really grateful for them. But But, but also the thousands of you out there who have taken the time to listen in on webinars to follow the latest and greatest to put up with the fact that, you know, we don't all follow the same rules in healthcare and how difficult it can be to figure out who's doing what and when. It has been a crazy, crazy time and knowing that you're all there and available for our 2.3 million beneficiaries and rapidly growing number. It's huge. It's important and it's actually one of North Carolina's greatest successes is that we have such a comprehensive networkwork of providers in the state physicians, advanced practitioners, behavioral health, specialized therapies, I can go down the list and as long as I'm who take care of our Medicaid patients, so thank you. Next slide.

So things that are on my mind tonight, we're going to kick off of the things on my mind. And then we are going to jump over to Tom, who's going to tell us all about how to open our practices, and then hopefully hit some question and answer. I went kind of rogue tonight, and I didn't bring on my whole billing team and everybody else to back me up, because they're tired, and I didn't want to bother them for another hour. So I'll do the best I can with those. The first thing I want to talk about is clinical policy changes and some of the work we've done around the public health emergency, then we're going to look at some of our utilization trends with data around the state, which I just think is interesting. Then we're going to get sad because we're going to look at all the care gaps and how our patients have fallen behind on preventive care. And then we're going to get happy again because we're going to talk about timelines. So next slide.

So this is just not that you're supposed to actually learn anything from this slide. But this was my visual that I started putting together in late April as I realized that we would have to take all of the work from the prior eight weeks, and identify which provisions actually made us better made a stronger Medicaid program that we would want to keep on which things we would turn off as temporary modifications and the things we wanted to keep on could we keep them on literally, is there an authority issue with state legislature or with the federal government with CMS? is do we have the money to do it? Or do we have the budget for it? And so for every single provision that we did, we put it through this filter. And so the team has worked incredibly hard the last month going through that filter. And it is not, you know, I thought things were complicated when I worked for a health system, and you had to jump through all the compliance hoops to change things. I mean, that's nothing like a Medicaid program. So it's been a very complicated process. We hope and we think we've landed on what's gonna make people largely very happy. Next slide.

So we had we enacted 375 provisions, we included about 500 codes that we changed and added resources or change resources with in our Medicaid response. A lot of those were not clinical. So a lot of those were financial rate setting, eligibility, tons of provisions we put in place. Some of them are things you see in a hurricane. So if you live in a part of the state that gets hit by hurricanes, you're familiar with this process. Some of them were totally new for everybody. Actually, a lot of them were. But when we went through this process, and all the teams look through the 375, temporary provisions, we pulled out just over a quarter of them that we said we really should keep, we probably should keep with some changes, or we should think about keeping if we get the money to do it, which is pretty impressive. And then when you look at the Clinical provisions, it's actually almost half of them. The team went through and said, You know what, these really make us stronger. They make us a better Medicaid program. And so we really want to keep them. We really want to keep them maybe with some tweaks here and there. But but a significant number of clinical provisions that we have asked to keep on permanently outside of this public health emergency. Next slide.

So, over the last month, we've been going through all these temporary policy changes to put them in that category. We've had to look at the timing of what would be most appropriate based on where we are in a pandemic response. Knowing that any temporary changes to become permanent would require some of them estate plan amendments, so that means going to CMS and asking for permission. Knowing that anything we want to make permanent will have to go through our clinical coverage policy process, which is a very formal process that includes public comment period. The physician advisory group review, it's a process. And we also have said to you, we're going to give you at least 30 days notice before any changes go into effect. So we were kind of trying to line all that up together. Next Slide.

What we would like and you notice that I have desires italicize and underlined. So our team North County Medicaid would like to make some broad changes first to our telehealth policy. We had started a process I've talked about this before in our prior meetings Ben Money and I had started a process back in late fall early winter to do a telehealth modernization. The Secretary was very supportive and agreed that we needed to modernize our telehealth policies at the state. So then we did it in fast forward you know rapidly. From all that work and from the advice of the telehealth work stream that was developed as a response to COVID. There's been a DHHS wide workstream that's involved a lot of your specialty society leadership, a lot of providers from the field, a lot of different voices, they wade into this, we've been studying it our our data and evaluation team, Sam and Kelly at the Medicaid office have been studying this. And we've put together the list of things that we would like to make as broad changes to our telehealth policy. The first one is eliminating the restriction. So previously, you couldn't do video cellphone interaction, so tablets, cell phones were not allowed. We would like to make that a permanent change that you can use those. We would like this is a big one, to make changes around originating sites and distant sites specifically so that FQHC's and RHC's can continue to provide tele health services and originating sites can be in the patient's home. That's a huge change from before. We're eliminating requirements for referring providers expanding different eligible provider types depending on the service, eliminating the consulting language that's in there now. And then adding in addition to tele health some of the virtual patient communications that we turned on the very first

things we turned on, you may or may not remember was telephonic codes, and online digital E/M, EHR messaging codes, and then the interprofessional consultation codes, as well as some of our remote patient monitoring. So this is our perfect world. These are the broad sweeping changes we would like to make to the North Carolina Medicaid policy. Next slide.

So our team is going to continue to work and take that pr oposed policy to the PAG this month, and then it will go up for public comment. And then as that is in public comment, the team will start digging into a lot of the things we recommended keeping or keeping with changes, and it's a broad sweep of things. There are some changes that we made that we felt like were really important and will move us forward around prenatal care. You know, frankly, we have access issues. We have significant disparity issues. We have way too much maternal morbidity and mortality. So how can we change the way we provide obstetrical care in a way that's more patient centered and improves access? We think we can use telehealth to do that. Why not have childbirth education be allowed to happen through a zoom meeting. So there are a lot of things that we would like to continue. And some of these are things that you in the field have been asking for, for, you know, 10 years. So I think a lot of people are gonna be very excited. Next slide.

So really quickly, we would like to just go through some of the numbers. So our team back in March, 1 week in March, as all this stuff was happening, I sat down with Kelly Crosby and Sam and our, our data and evaluation team and said, We need to be paying attention to what happens and what the outcomes are of using all these telehealth modalities. So not only are we measuring their utilization, but some period down the road, we need to look at what happens do health outcomes improved as total cost of care change? We can't do it right now. It's too soon, but we don't want to turn everything off because then we can't really learn from this experience. And what we're learning is that a lot of folks are using telehealth and there's been a lot of uptake around the state. Next slide.

So Anna, do you want to kick us off and talk about this first slide?

Anna Boone

Sure. So this gray line at the top here is the total volume of claims. So that's all in person claims and you can see kind of that steady state prior to the pandemic emergency and then a really significant decline that I know all of you have felt in reality, starting in May or in mid March. And that has started to come back up just slightly you can see there in the dotted line and simultaneously, the telephonic and tele health claims have also increased as they were implemented back in the early March time period. As we go through these slides that the dotted line really accounts for the claims adjudication period, so it is not complete data, but we are counting the claims that have been processed. All right, next slide.

Dr. Shannon Dowler

So one of the things we have been studying a lot in the last I would say six months at Medicaid is looking at with a health equity lens and the work that we're doing. And so the data and quality team have been looking at a lot of our outcomes as a function of race and ethnicity. And we've been doing that with the telehealth claims as well. And what we have seen hasn't been terribly surprising. The one piece that sort of does seem to stand out is the Asian Pacific Islanders and the Native American. We seem to have much lower utilization than the black or white in the tele health claims.

Next slide.

Now, when you look at this one, this probably isn't surprising to any of us. You see that in the Latinx population, that telehealth utilization is significantly lower. And that makes a lot of sense I've heard from from beneficiaries who have said, well, I get the instructions for my telehealth visit in English, but I don't speak English. So they can't open up the app or work through the process because it's not in the language that they speak or read. So we've got to do a lot of work doing a better job of language services and making sure we're providing things in Spanish. We've got a testing update on Monday night, I hope you guys will join us for and we're going to talk a lot about this, because there's a huge disparity we're seeing with COVID cases and the rates that are just skyrocketing around North Carolina now in the Latinx population. And so I hope you'll join us Monday night as we talk more about that. Next slide.

So gender, Anna, anything exciting here. So you

Anna Boone

Um I think that it just shows that men and women are seeking tele service care at pretty much the same rate, if you include OB care, which is the black line, it does lower the rate for female patients. But, you know, I think that there are reasons for that around in person OB care that was necessary. Yeah, there are also a lot of tele oh go ahead.

Dr. Shannon Dowler

Yeah, I would just say one of the things I've observed anecdotally over time, and I think this bears out in the data is that women tend to seek health care more consistently than men do. And it's interesting to me that it seems like men are maybe it'll be interesting at the end of it to see if they're more comfortable getting healthcare this way. I don't know.

Maybe not. Right. Next slide.

Tom, you want to talk about the foster?

Dr. Tom Wroth

Yeah, sure. Jen. Yeah. I think the story here is is actually good news. So about 24,000 children and different types of foster care and seeing that the foster care population is seeking care through telehealth at slightly higher rate. There it looks like they're the lines cross later on. But I think overall this is this is good news.

Dr. Shannon Dowler

Yeah, really important that the population which is a particularly vulnerable population is accessing through telehealth and telephonic services. All right. Take it to the next slide, Nevin. Okay, so this one is interesting. So it is kind of two different things on the same slide. One, you see that Peds and Family Medicine are kind of neck and neck. You will note that early on the Peds were leading like they just jumped on the bandwagon and we're go go go, you you see family medicines following closely behind is feeling sort of like a race right now, but I'm excited that primary care has leaned in so much. What is interesting to me is the RHC utilization. So the Rural Health Centers continues to be just significantly lower. Some of that is probably because they weren't allowed to be distant sites originally or distant sites back before these provisions. So like FWHCs, they had really limited telehealth ability. But but the FQHCs overcame that much more quickly than the RHC's have. And so I've been talking with Maggie and the Office of Rural Health and others to discuss like, what do we need to do for Rural Health Centers differently? To make sure that they're getting the resources they need? Is it investment in in is it the broadband issue? You know, what is the issue that's making them be so slow to adapt, because that's been an important strategy for a lot of our practices, not only for our patients, but for the practices survival themselves. So that's an area we're going to pay some attention to. Right next slide.

Yeah, so age groups, you see, you'll notice that the older adults are lower. That's not because they're actually using telehealth lower. So much as that in our Medicaid data, those are the Medicare beneficiary. So our number is much lower in that group. So it's a much smaller and Medicare would utilization suggests that it's being used quite well. I think I got excited seeing that my generation in then the green was like doing better than those millennials and the tech savvy younger people until I realized that's because we're just old and breaking that we're not actually doing better at using technology. So we're good uptake across the board. All right, next slide.

All right. This slide really gave me a lot of hope that the ABD population is doing using telehealth resources at a higher rate. That's what I would hope for they're going to be more vulnerable, it's gonna be more important to provide care to them without bringing them into the office. So I thought that was a great this was a great sign that there was that difference there. Next slide. Okay, so here's another slide looking at race based on the, it's based on the number of visits as the rate for 1000 beneficiaries. And so you, you see that whites and American Indians seek care they have a higher rate overall. And

then when you look at the tele health in person and telephonic claims on the other side of things, nothing really particularly jumps out to me on this except the I think it's interesting that the African American population is the same as the white population on telephonic but lagging on telehealth and lagging on in person. And so I wonder if there's an opportunity there around trust and trust building around using telehealth, access to resources, is it, are they more likely to live in areas that are broadband desserts. You know, some of those things. So we're still collecting that data and looking at it, Tom or Anna, any other observations on that that you wanted to make?

Dr. Tom Wroth

No, I think you captured it. Yeah.

Dr. Shannon Dowler

Right. Next slide.

So this is a map of our lovely state by county. And the bottom line is there is a very small statistically significant, though, difference on whether or not people have access to if they live in a rural area if they're less likely to use telehealth. And then the bottom right is around broadband access. And the same thing if you don't have broadband, you're not gonna use telehealth as much. So these are intuitive, but what I think we're going to do next week is break it out by telehealth versus telephonic, and then see where we see the utilization and trends because this has been a real ongoing debate over the course of the pandemic around how do we pay for telephonic codes versus telehealth codes and where that access is creating issues. It also creates great opportunity for us to go to our partners, downtown Raleigh and say, we've got to get the broadband issue fixed. We've got to get some of these super rural areas access to high speed internet so that they can we can get over some of these health inequities. Okay, next slide.

All right. So that was interesting. Looking at tele health utilization, I always find that it's just been a very interesting journey. I can't wait for Sam and Kelly to bring us the next swath as a really evaluate and look at outcomes and total cost of care and those sort of things as we get more data under our belts. But now we're going to talk about Debbie Downer, care gaps. So this is where we're going to see how the pandemic has affected our patient's ability to access preventive care or needed appropriate care. So next slide. This is sort of a broader overview and Anna, do want to kind of do the broad overview of what the slide tells us.

Anna Boone

Sure, so this is a count of care alerts. And when we say care alerts, we mean you're out of compliance with whatever the measure is whether it's immunizations or well child visits, or A1C tests. And if you

look across the kind of timeline the x axis there you can see that across the board they are increasing meaning more patients are out of compliance with the necessary preventive care. All right, next slide.

Dr. Shannon Dowler

There we go. So look at that hemoglobin A1C is I don't know that's where my eye goes to immediately when I see that that the number of gaps and people that are due for hemoglobin A1Cs is really significant and climbing rapidly and one of the ways that I know some practices have gotten around this is doing drive thru labs. I just had my labs done earlier this week and they scheduled an appointment for me and I pulled up. I called and told the lab person when I was there. And I went in through the back door, not the regular door where other patients come through and went directly to the chair had my lab drawn and left immediately. So no paperwork, no front desk, no check in, um, that was a I felt very protected in that a way of getting labs done. And so being creative continuing to be creative in the way that we get folks, lab services, even if we're doing telehealth visits, making sure that they're getting their needed labs is going to be super important. Next slide.

And this again, so this looks at the Latinx population and some of these health disparities that we've been talking about. We're seeing that the overdue preventive care this is particularly for well child visits here to to that the Latin x population is has a growing care gaps more significantly than non Hispanic populations. Next slide. This one that was interesting, so this is well child visits three to six, and it breaks it out by race. And that actually, the Asian Pacific Islanders have the most significant gaps in care up 30% since January, which is huge. I mean three times that of the Native American population, and and so just a significant difference in care gaps there. Next slide.

So when we look at the overall who's due, who's overdue for well child visits, unfortunately, it's the zero to two range, which makes sense if we weren't bringing people into the offices or if we were doing tele health. It was that was one of our later telehealth codes to be released. And so we are really, really behind in that zero to two which means we're really, really behind on their immunizations and some of the other care. So getting those rates back down. It's going to be a ton of work for all of us over the next few months. Next slide. This is a slide that my team at Medicaid put together showing all of the different ways that the quality team is partnering with others to make sure that our Medicaid beneficiaries are getting the most access to services. So the partnerships are with AHEC with CCNC with the CC4C, with all the different partners that help drive our care management and outcomes. And so we're doing driver diagrams, and we've got action plans, and there's just a ton of work happening to try to overcome and compensate for some of the losses we've experienced over the last few months. So don't be surprised if you hear from folks and part of what we're going to do today,Tom's going to tell you about how you can open your practices back up and the safest way possible. Next slide.

All right. Alright, so this slide you want to you can click it twice, Nevin. So here is a visual of the timeline. So, originally we had said on July 25, we plan on turning off all of the temporary provisions, and then

announcing what provisions we would continue. I have gone back to the team and gotten permission and talked through it with the Secretary today. That assuming all things go well, and I use that caveat, that's a real significant caveat for our Medicaid program. based on what we know today in the world we live in today. I would like to extend the provisions as we know them through the end of September. And then in August, what we will do go ahead and click at one time for me and so end of July is the end of the public health emergency. We still don't know if the feds are going to extend that. I it's hard to imagine they wouldn't but there are a lot of things that happen in our world that are hard to imagine. So we can't count on that. So by pushing it back to the end of September, that keeps us from having to make the change now, because if it's extended, we will extend a lot of the provisions longer. So assuming that it's not extended and the public health emergency ends at the end of July, we will keep our policies on but have the new telehealth 1H policy will go through PAG this month and will be open for public comment essentially for the month of July. And then in August, we'll be able to finalize that 1H policy and that point, the recommend keep category of policy changes. We'll go through a public comment period, and the ones that are do not keep the things that we're not going to the temporary provisions. We will then announce to the field in August because they will turn off at the end of September based on the current end of the public health emergency. And so that is the promise we have made to you to give you a month's notice if we're going to make changes we are going to stick to this as much as possible, there are a lot of things and that could change to affect this. So some of its authority. I've mentioned authority before, not only our legislature, but also CMS, a lot of the things we do in Medicaid, we have to have permission from CMS to change. So if CMS says no, we don't like you doing mail order delivery of prescriptions, then we can't do mail order delivery of prescriptions, and we have to pull that back.

And so there's a lot of ifs in this. Everything is subject of budget, so anything that could potentially cost us money, we have to have the budget to pay for it. So if if our budget discussions are ongoing right now, if there was a change made to our budget that was significant, we just simply wouldn't be able to do these things. And so we are fingers crossed, going to get to do all these things in the timeline that we're sharing them with you. It means that the things that we decide not to keep you will hear about probably mid to late August and then that will also at the same time let you know that the things that we're recommending keep because there'll be a public comment period for those. So you will be kept in the loop as soon as we're able to finalize those things.

And then by the end of October, that means our telehealth modernization will have completed which is very exciting. So it's good to have goals. But, Nevin, but hit it one more time for me. Sometimes you can be running at the goalposts and you're making great progress. And it looks like there's no way you could possibly miss that goal. And you miss it. So there are all the things that could happen. And so this is my big caveat with you. I am trying very hard to push out the date. So it goes past the end of July. So it'll be the end of September, where everything kind of stays the same in the clinical policy land. So that you have more time to adapt and deal with the fact that we still have a lot of COVID cases like our numbers are higher every day for the last few days. So we don't really want to turn things off right now if we don't have to. But just know that there are a lot of things that could impact whether or not we're able to

follow our plan the way we'd like to. Okay, then I'm going to turn it over now I think, Oh, no, I got one more thing I have to tell you.

So, one of the things that was we tried to stress over and over again was with different billing guidelines and bulletins, of which there were 4 million. I know it's very hard to keep up with, but one of them is a really nice summary billing guide. What we have discovered is that there have been a significant number of instances where people have been billing for telehealth when they were doing telephonic care. And so that's not okay. Because the reimbursement rate is different. And so, and that's not a permanent, none of these are permanent policy changes. They're all temporary flexibilities in the pandemic environment. And so if we get audited by the feds or by the state or by ourselves, not only would you have to pay back money, but we would have to pay back money and that would be bad. So we just want to reiterate the importance of following the billing guidelines that are out there to the letter and just to know that there is an edit that's being put into the system now, so that when you're doing telehealth, you have to have the GT and the CR modifier. And that's how we're going to be able to justify this to any audits that happen, federal, state, or our own, that the changes were done based on the guidance that we gave you. So I'm just giving you a heads up. If you're getting denials, it may be that the way you're submitting the claims is not correct. Okay. Next slide. All right. Take it away, Tom.

Dr. Tom Wroth

All right. Great. So thanks, Shannon. So we've we've seen the data. We've seen the care gaps, move up. We also know that North Carolina is very cautiously trying to open and we've had some a difficult week in terms of the data, but our practices must start to make that transition and you all are and so what we want to do tonight is pull together a lot of the collective wisdom we've heard from you all over the last many couple of months. And also, there's some new guidance out from some of the specialty societies as well. And CDC, so want to make you and the state and want to make you aware of that. So let's go to the next slide.

[Indiscernible] and then go through some of the guidance and talk through some best practices, and then we'll get to questions at the end. So, so reopening principles, I think, this first one was brought out by Dr. Reinhardt at one of our other webinars, but it's really important that that patients feel safe. So they're, especially those that are high risk for COVID. They're not going to come back until they feel safe. So there's an importance to communication about what you're doing. We'll talk a little bit more about that. There's also new workflows Shannon talked about drive thru lab tests, the term I'm hearing a lot is the contact list check in process. So that's where as little contact as possible. So the the check in and payment setup and insurance verification is done by phone. Folks drive up there, the waiting room is actually the car and they get a text when it's time to go to their visit and they're escorted right to the exam room, have their visit and go right back out. So pretty contactless. So the other key principle is the need for flexibility. We talked about this quite a bit, especially as you're reaching out to those patients that have care gaps. So with folks with chronic disease, how can you do a telemedicine telehealth visit to do the majority of the visit but then have them come in for a lab only visit to get that that piece done. So

we talked before about hybrid visits as well. I think communication overall is a key. We've talked about how dynamic this situation has been. I think aligning your communication to what the what patients are hearing about in the news, the North Carolina News and national news and ensuring you're sort of addressing that some of the key things that are coming up, we'll also build confidence in coming back. The other key principle is when things come up and you're not sure a scenario comes up and you're not sure exactly how to handle it, you know, always sort of go to the top, there may be CDC guidance. There's great North Carolina DHHS guidance usually aligning with the CDC. And there's also a specialty society guidance out there. We'll go through some of that. I think reaching out to your local health department is a great place to start. If that doesn't work, you can reach out to AHEC or CCNC support and we will track down Dr. Dowler and her team and get you an answer. One of the other things suggestions that folks have mentioned is talking to your liability insurance carrier as well. And just ensuring that you're doing things like getting people back to work, etc. aligned with what the community standard is. That way so, next slide.

So I think one thing that's kind of exciting, you know, you always look for the good news in a, in a crisis is all those things we've been working on around population health is it's really real now. And it never has been as important. So using your your EMR to, for some registry functionality and finding all your COVID high risk COVID patients and reaching out and getting them back in for care. That's been so important. And just using some of those other tools, CCNC has tools, some of the other payers have tools, but using all those to reach out to patients. And then I think there's there's clear evidence we've just seen some of it, that patients are deferring care due to COVID. And really looking at some of those high risk populations, not just chronic disease care, but preventive care the children zero to two year olds, the other children that are missing immunizations, of course, reaching out to patients with chronic disease. On the Medicare side, the annual wellness visits. And then I think thinking about patients with behavioral health needs that those patients that are managed a lot in the behavioral health realm they have an ACC team or other supports is making sure that you're coordinating with those entities to get folks in for their chronic disease care as well. I think our group homes, mental health homes, adult care homes, ones that don't have clinical staff on on premise, really reaching out to those vulnerable living situations and those patients and setting up telephonic or telehealth visits preferably telehealth visits. They're really important. There's lots of other high risk groups to be thinking through. So great. Next slide.

Well, this isn't great, this next slide. So this was really one of the most striking examples that's come out in the last couple of weeks around evidence for patients deferring care. So this comes out of Northern California, Kaiser Permanente. And they really simply just looked at the rate of hospital utilization with a diagnosis of MI and looked at the trends over 2019 and then match that to 2020. And showed saw a 48% decrease in hospitalization for MI and you can see the blue line where COVID-19 starts to go up. And clearly it would be there's no logic behind less people having a heart attack and the scary thing here is that folks or patients are having heart attacks or Ischemia at home and not not getting needed care. So super disturbing and interesting at the same time. Next slide.

So this is a great survey that just came out from NCMGMA, the medical society. They surveyed 272 people broad geography, many different specialties. So there's not just primary care and but many of these are independently owned practices. And this is just showing what at that point in time two weeks ago, what folks are doing. So interestingly, you know, 61% are doing having patients wait in the car until call for the appointment, so that contactless, check in. Some of these next couple things are hopefully these rates will be coming up. So that percentage of staff that are using masks and patients that are using masks, the temperature checks, cleaning rooms, those all in terms of the guidelines that are coming out are going to be really important. It's good on the bottom there 91% or clearly communicating these new office and patient protocols. So that's so key to get our patients more comfortable coming back in, and then having enough PPE for more than 20 days only 40%. We know that's improving week after week, but still an issue in North Carolina and nationally. So great. Let's go to the next slide.

So this is sort of the money slide, we can leave you with anything, there's really great guidance out there now. AFP last week updated their reopening practice guidance, and I'll go through some of us kind of adding in some other information as well, the AMA a couple weeks ago had similar practice and health care setting reopened guidance. And then around workplaces that's a good place to go and, and then the American College of the ACP American College of Physicians put out a kind of a overall policy statement but discusses reopening there as well. So, those are really good references and let's just go through some of the highlights on the next slide. So the first piece is this is the pre planning phase and we're probably coming out of this but the first piece is really making a plan. This is where kind of mapping out your overall strategy for switching over to more and more face to face visits from doing telehealth and looking at your supplies as you see more patients face to face, and your staffing plan we'll talk a little bit more about that and your claim protocol, how are you going to do that so creating a plan and a timeline is really going to be key here. And then the second piece around communications not just with patients but with staff and letting them know about a different process we're going to call you 24 hours before your appointment and talk and screen for COVID and talk through the new workflow, how are you going to be met in the parking lot and you're going to get your temperature, taken and have another questionnaire and talk through all that with patients and make them comfortable with the, with the process. Again using your website social media is so key and so many of you've done that, so well.

So let's go to the next slide, and then getting into logistics so these are just recommendations, but a lot of this makes makes good sense so that the gradual reopening process so none of us know exactly how all of this is gonna play out so I'm in a practice in a county that has now become a hotspot. And that's made us sort of be a little bit more cautious about reopening so a gradual reopening we're about 30% face to face 70% telephonic or telehealth right now. And our plan is after June 15 to try to get to 50/50. And then in July start to inch up even more to get to more and more face to face so creating that gradual reopening folks think is really key. Office staff safety so daily symptom screening. Temperature checks for staff. You're going to looking at your physical workplace Of course you need to create physical distance thing in your workplace and that's hard for a lot of small smaller practices and talking to the folks on the behavioral outside psychiatrists, oftentimes or therapists oftentimes a very small space, but

really look at how you can best do that. Practices that have break rooms really closing those for now so there's not a place for folks to congregate and be closer to that six feet together, dividing your staff into shifts the idea there is that if one of your someone on your staff were to get symptomatic and get COVID that you're not taking your entire workforce down. Potentially get folks tested on one team and but not wipe out the entire staff for the practice and and things like having your administrative staff if they don't need to be in the practice, having them continue to work remotely So next slide.

So getting into patient screening and flow, we've talked through quite a bit of this, the importance of [Indiscernible] So when you're reaching out to patients having protocols around which patients, you're going to recommend for telehealth versus face to face and really making some of those switches and switches in real time, when you need to. So, and there's some nice phone scripts from the CDC there that might be helpful, the workflow of many of these things that we've, we've talked about considering screening patients outside those sorts of things so let's go the next slide.

The PPE and office sanitation won't go through all of this, and the office sanitation side the CDC guidelines are there to help you figure out your strategy there. But some of the routine things to do are cleaning some of the high touch areas like doorknobs, light switches, all those things at least at least daily. All right, next slide so slightly different topic is we've had a lot of our practices, really get into these quandaries around care, school and work notes so what is the best guidance. Your job is to be the ally of the patient and you sometimes get in these difficult decisions with their daycare, work or school. So one thing that's really helpful is the state put out the guidance on how we're going to reopen schools and in there, there's very specific language around, return to school which I think can be translated to, to daycare and and workplaces as well. Many of you are aware of these scenarios so folks diagnosed with COVID. They can go back after 10 days of their onset of symptoms, three days without fever and three days since symptom improvement yes to all three of those. And there's other scenarios that come up of course there's folks that have been diagnosed with COVID, with a test but have never had any symptoms so they get to go back 10 days after their positive test. And there's other scenarios to go through in there, but I think the key thing here is, is DHHS is really trying to guide employer schools, day care that a physician note is not required that these questions can be asked and and folks can go back and that doesn't mean that physicians won't be doing those notes but that's the intention here. So, next slide.

Some other considerations, I think we covered the other two. Remember that the COVID triage line we have nurses, seven days a week covering this triage line so this is a way you can offload some of your telephone calls that you're getting and having that number available. And they're always trying to route folks back into primary care, as, as appropriate.

Next slide. I think the last one here is just a ton of other resources there's algorithms around a phone advice tool. Different guides on cleaning and disinfecting multiple kind of scripts and posters and other

things so we just put all these in there for you all to play with to be possible resources, as you go forward into this brave new world. So I think that's all I have. Let's see what's next. Right. All right.

Hugh Tilson

I'll open it up for questions before I do just want to make a couple quick observations. These slides will be available on the CCNC AHEC website. If not later this evening. tomorrow morning. So you don't have to worry about screenshotting all those links, you can get those directly on that website. There was also a request for a link to Monday's testing webinar, and that is on the NC AHEC website, maybe on others but I know it's on the AHEC website. And I actually put it in the answers. The q&a I responded to a request for that. So just a couple things before I turn to specific questions. A couple quick things. List of future telehealth services that the group is working on did not include a mention of optometry. Are optometry services going to be on the list to extend telehealth abilities.

Dr. Shannon Dowler

Yeah, so we haven't we in August we will be announcing what the final list is so we're still working through a lot of different services so anything that I showed on my slide deck were examples of possibles, with the exception of the specific telehealth modalities. But we that in August we will be releasing the things that we are going to turn off as temporary modifications,

Hugh Tilson

A couple questions about Medicaid transformation any the updates on that and then how will Medicaid managed care plans for the future be impacted by telehealth changes, will they be maintained.

Dr. Shannon Dowler

Good question. So, I get my Medicaid transformation updates from WRAL. I will tell you that uh i think i think the latest I've heard is like mid year next year is the goal but then there are others that would like to do in January and others that don't want to do whatever and so I don't really, I can't have no insider information I'm sad to tell you, I find out when you do when you turn on the news. But Tom, or Hugh you guys have insights that I don't have.

Dr. Tom Wroth

I know that the.

Yeah. Please go ahead.

We're probably, neither of us want to go into this that we know that there's a there's a bill going in the house and senate are really for the health plans really trying to lock down the, the timeline and the funding so. So we'll see that process go through during the session.

Dr. Shannon Dowler

Yeah. And so when I was how you though is they, the way it works is that when we go live our Medicaid clinical policies are the floor, so they can't be more restrictive. They can have utilization management, but they cannot be more restrictive than our clinical policy floor. And so, if we're covering it before we make this change, then they will be covering it as part of their services as well.

Hugh Tilson

I was gonna say what Tom said so thank you Tom. Is there a code to be reimbursed for PPE?

Dr. Shannon Dowler

Not that I'm aware of. There is I learned and you guys may all know this. I was looking I got asked a question at a medical school meeting a couple days ago around reimbursement for a collection code or outpatient hospital outpatient facilities. And I asked my team to see if there was a any kind of collection code for just ambulatory routine care practices and what CMS has recommended. And you guys may all be doing this already but to do a low level 99211 when you're doing a lab only that they have approved using that visit to go along with a lab visit, which would help you know pay for your staff time and supplies essentially. So that was kind of new information to me and so we talked about it on the team today and, you know, talked about, would we be okay with that and we sort of decided we were CMS is saying it's okay there's no reason, we wouldn't cover that. From a lab testing standpoint I can give you an update that historically we've only been paying for the PCR tests, starting next week we are going to cover antibody test but it has to meet medical necessity criteria. And so we're still working through the details of that it's not indicated for immunity status checks and so it's not appropriate to cover for that. But it will be an orderable test, starting next week and there will be a bulletin that comes out, that has the details on the medical necessity criteria.

Hugh Tilson

When will the increased PMPM stop?

Dr. Shannon Dowler

It's slated to stop at the end of June, whether we're able to continue any of those rate changes or not it's gonna really depend on what happens with our budget. And what happens in the legislature so right now I would say it's slated to end at the end of June.

Hugh Tilson

Will telemedicine payment parody continue in the modernization telemedicine policy if approved?

Dr. Shannon Dowler

Oh, you guys just ask the easy questions right. So, there are some less topically and fundamentally broadly, I would say that we are supportive of payments parody. We're, we're still working through how do you focus on medical homes, and making sure that you're, you're reimbursing for the right care for the patient. And so, the portal codes, the telephonic codes they have different rate structures than the regular E&M visits. So all of that will be in the policy that's going to be up for public comment, in July, and so I would encourage you when that's out for public comment to review it and give feedback,

Hugh Tilson

Follow up on the PMPM end of June, PMPM so we have received the last one already question?

Dr. Shannon Dowler

I don't know if we do it ahead or behind Tom you know that off the top of your head?

Dr. Tom Wroth

I don't know.

Dr. Shannon Dowler

Yeah, that's, that would be taking my brain to a place that it just doesn't go regularly, so I can't answer that question.

Hugh Tilson

All right, let's turn some clinical questions. How are we addressing those patients who do not have a car to wait in, may have had to walk use public transportation to get a ride from a friend, also concerned about hot weather and folks not having air conditioning. So, I assume that's the check in.

I'm not sure. Thanks.

Dr. Tom Wroth

Yeah, I think, uh, yeah, every practice is different if the, I think practices are still better able to maintain a waiting room, they're just keeping a waiting room with physical distancing in place and trying to minimize that. So I think that would be a place where you try to bring that patient in with the hot weather and those issues coming up this summer. Yeah, I don't i don't know that I've got a great.

Dr. Shannon Dowler

We were just all about that earlier today around a lot of the testing sites where you know we like to drive through testing sites because it creates that distancing and you use less PPE so less exposures. But not everybody has airconditioned cars. Not everybody has cars and so as our recommendation for testing sites as you have walk in access as well as drive in access. But yeah, these are ongoing you know struggles, we do have non emergency transportation for Medicaid beneficiaries. So, those can certainly be used. That seems to be less of an issue than it was, I think earlier on in the COVID scare folks were having more trouble with that I have not heard anything lately about that

Hugh Tilson

Kind of related is would our experts recommend parking lot, blood draws and vaccines for adults?

Dr. Shannon Dowler

I think it's a great idea. I'm not in a position at Medicaid to recommend something or not, I will just tell you that personally, I mean it was fine, walking in the back doors of practice earlier the week, when I had to have my labs, but if I just needed my flu shot or something like that I would love to just stick my arm out the window and not even have to get out of my car but you know I'm busy and over scheduled Tom, what do you think?

Dr. Tom Wroth

I agree. And I know some practices are, are doing it.

Dr. Shannon Dowler

I think it's, it makes a ton of sense.

Hugh Tilson

Is there still a need for providers out of state for telehealth who obtain emergency North Carolina license who do they speak to or get connected to be helpful?

Dr. Shannon Dowler

I am not sure when it's I know that was in an executive order. And so I would just point you to the DHHS website, if not the medical board I'm sure would be able to help point you to that process.

Hugh Tilson

Do we use modifiers GT and CR for telephone visits CPT 99441-99443 or GQ and CR?

Dr. Shannon Dowler

Ah, I don't like coding questions. CR is for telephonic GT and CR is for telehealth. And I would just point you to the billing guide. That's on our website. It was one of the bulletins that came one of the more recent bulletins and it's a super comprehensive table of every code we've approved and what you need to put in there to bill for it. That is what you should use, do not use my voice in the call to make that decision.

Hugh Tilson

Good advice, would you want to repeat that again just to make sure everybody understands that. No, yeah, go.

Dr. Shannon Dowler

Yea go to the bulletin, look at the bulletin.

Hugh Tilson

There's been a great many recent medical papers written about the Association of low vitamin D levels being associated with more severe COVID cases. Is anyone at state level looking into this the recommendations for, we assume some sun exposure which is minimally effective with black patients. Could that be part of the over representation of black COVID patients in the ICU.

Dr. Shannon Dowler

So, great question Graham and I got your email today and I'm sorry I hadn't written back I actually started a whole conversation with a bunch of the docs in DHHS and so we've had lots of back and forth on that question. And folks are doing different research and looking at it so I don't have an answer for you right now. You know the studies are the studies are conflicting. But anyway, I've got a team of our epi team and folks over in public health are looking at your questions on that.

Hugh Tilson

How much uptake has there been so far of the hybrid visit option with chronic conditions well child etc at home with staff.

Dr. Shannon Dowler

So that was one of our last ones to turn on and so the claims adjudication is usually a six to eight week lag. So we don't have a sense, yet of that well we probably in the next week or two, we'll know if people started using it I know it's been utilized but being able to I can't measure it yet.

Hugh Tilson

So it's 6:28, I'm going to close with a comment, not a question, which is a big thank you to all of you. God bless you.

So, I just want to make sure that you will hear that and it is heartfelt and we've said many times, Shannon and you and your team have done more in a limited amount of time then lots of us have seen done and our entire careers so we can ...

Dr. Shannon Dowler

We've learned to do back bends and things we didn't know we could do. And there's one question I want to bring up fast I saw someone making a comment that their telephonic visits weren't paid with CR. If you have any billing issues or questions please use the Medicaid that COVID-19@DHHS@nc.gov. Use that website to send all of your questions to because they're tracking all of the claims that are denied and they're doing a lot of analysis of it but they will resolve your issue, or at least do their best to reach out to you and try to resolve the issue. Most of the time we found that when the claims haven't been paid it's actually sorry to say this user error. And so, not a system glitch. So, so something about the way it was submitted wasn't quite right.

So I would encourage you to use that website so we can get it fixed and pay you.

Hugh Tilson

Before we close Nevin can you advance the slide. So, a couple quick resources that I just want to make sure. Next. You all know so if you want to telehealth vendor support. Go there next one. Next slide. So, we talked a number of times about practice support whether it's for telehealth or whether it's practice workflow redesign, either CCNC AHEC no wrong door we're happy to help you. Next slide. Tom I talked about this next slide. So this is the link that Shannon was talking about and that's what I wanted to get to. So, all kinds of great information here. You can go to the NCAHEC website to download this but that will give you the link to those particular links that Shannon was talking to and then lastly, you can also go to next slide, website to get all this information. So we'll leave that up for you, and that. Thank you everybody for making the time to join us tonight. Tom, Anna, Shannon thank you so much for great information and Shannon any final comments before we sign off.

Unknown Speaker

Um just thanks to everybody for listening in, and we will meet again probably in a few weeks or a month for our next meeting and we'll know much more about where we stand then.

Hugh Tilson

Thank you everybody and thank you Nevin for doing a great job behind the scenes. As always thanks, everyone.