

Presenters:

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

Hugh Tilson:

Well good evening everybody. It's 5:30pm on a Thursday, so you must be tuning into another COVID-19 webinar. It's put on by Medicaid, CCNC, and NC AHEC. Thank you very much for joining us. Tonight's session we'll provide an update on Medicaid policies.

Next slide, please. Provide some telehealth pearls in response to those policy changes, some best practices we've gleaned from talking to some of our colleagues, and we'll respond to your questions. We'll close with a list of resources and then Shannon's going to tell you something else we're going to close with. My name is Hugh Tilson and I'll be moderating tonight's forum. And tonight's forum will be Shannon Dowler, the Chief Medical Officer for North Carolina Medicaid, and Tom Wroth, the President of CCNC. Before I turn it over to Dr. Dowler, let me just stop and thank everybody for making the time in your busy schedules to participate in tonight's webinar. We know you have a lot that you could be doing and we really hope that the information that we provide tonight will help you in your important work, and will make navigating these trying times a little bit easier for you.

Next slide. After our presenters provide their updates, we'll turn to your questions. We have learned from past forums that the presenters will often address your questions during their presentation. We should have time to get to your questions, I encourage you to wait until the presenters are through, because we might just answer your questions. Please know that if we don't get around to answering the questions, though, we'll send those to Medicaid, so they can respond directly to you. To submit a question, if you're participating through the webinar, use the Q&A function on the black bar at the bottom of the screen. It's the Q&A function on the black -- bottom of the screen. Or, if you're on the phone you can send us a question at 'questionsCOVID19webinar@gmail.com.' That's 'questionsCOVID19webinar@gmail.com.' Lastly, we'll record this webinar and we'll make the recording, a written transcript of it, and these slides available to the public, hopefully tomorrow. Now Shannon, it's up to you and your Medicaid policy update.

Dr. Shannon Dowler:

Alright, thanks so much Hugh. I am excited to give you the updates this week. I'm always a little excited to share updates. For those of you that haven't paid much attention to Medicaid clinical policy in your lives, what you probably don't realize is how slow the train moves, usually. And I'm not throwing shade on my buddies at Medicaid. But, we don't necessarily do clinical policy changes rapidly, typically. And this team has just worked at remarkable speeds and pace over the last seven weeks. And so, seven weeks in a row, I've had a whole bunch of new policies to tell you about. I hope, frankly, that next week is the last week. That's why I've got this picture on the slide. I'm feeling kind of excited that we've gotten through the bulk of the work. And we can start working on some of the other things we haven't been doing for two months. But this week we are really focusing on our pregnant women and our policies around that. And I also want to update you on a few other items.

So, next slide please. So, I have learned a lot about pregnancy care and telehealth in the last couple of weeks. I am so grateful for OB champions, with CCNC, who are representatives around the state, who take care of pregnant women and lead their regions -- and the other providers that care for pregnant women. They have really leaned in and helped us formulate our policy, we've had some tough decisions to make, and they've helped us sort of lean -- in what direction we're going to lean around what we cover and don't cover. And so I just want to do a shout out. One of the champions pointed us to this program that is the sort of ad at the top of the slide, which is out in Washington state, where they've been doing teleOB for years. And they actually

have a lot of experience and data, and it was very reassuring to me to see that -- what felt like a sort of novel practice, because it's not something we have really seen done here, necessarily, in North Carolina. It's actually very well-established and safe, and has really good outcomes. So I was grateful to see some of that. So there is precedence around the country. If you look at AHEC guidelines, they had pretty vague guidelines around telehealth. But they are working on updating them right now, specifically around pregnancy care. We are going to look to our OB champions to help us with the clinical standards. So for most of us this is a new work, as we're caring for pregnant women. And so to understand which important milestones you want to have -- patient seen face-to-face versus not, how to coordinate it. Our OB champions are going to be giving us a lot of that guidance. So look to them for that help over the next few weeks. I will tell you that our current billing and coding solution is not ideal state -- we really wrestled with how to do this -- and it's because billing for pregnancy care is very complex and also extremely variable. There are a lot of different ways. There are some people that only do the prenatal care and somebody else does the deliveries. There are others that do the whole package. There's some that just do part of the pregnancy -- it's just a variety of ways people bill for it. So it became very difficult to figure out how to track telehealth visits without burdening everybody and the practices. And we really didn't want to change the way you're coding and billing and doing your work, any more than we had to. So our solution, is probably the best for the practices and not the best for me, who wants to have data. I want to study it and understand when we made this change, what happened. It's not going to be -- we're not there yet. So we are considering this interim guidance. We probably think in the future there is going to be a better way for us to track which prenatal visits are done with telehealth and which ones aren't. But for now, this solution is what we've got. And we really chose it because it was the least burden on the practices.

So, next slide. Essentially what we are covering, is any pregnancy-related care -- prenatal and postpartum care -- that you want to do through telehealth aside from, obviously, the delivery part. It's going to be okay. And we are not putting limits. We struggled with, do we say 'these X percent of visits should be face-to-face and X percent can be telehealth' -- a total number of visits. And we decided with the help of the OB champions, that putting those, sort of, walls and boundaries around that would make it too cumbersome for folks. And frankly we are in this COVID space now, and we're going to be back in it probably a couple times, until we have a treatment for it or we have a vaccination for it. We're going to have ebbs and flows of this. And so we wanted to stand up something that everyone can lean into now and keep doing for a period of time, as needed. So we are not putting any specific guidelines around how many of the visits should be face-to-face, which visits should be face-to-face. We're leaving that to your clinical judgement. We are asking that if you are doing any part of the pregnancy care, if it's in a bundle or one of these other different coding aspects, that you do use the GT and CR modifiers, so we can at least know which pregnancies were all face-to-face, versus had some component of telehealth care. I think this should be the least confusing of the policy changes we make, but it seems so easy that you might think it's the hardest. Because it's just -- we are saying, do it, if you feel like it's the right thing to do clinically. And just let us know at some point, in your billing process if any of them were telehealth essentially, depending on how you bill. Because there are all these different ways that different practices bill. So that's the same, I should note that FQHCs and look-alikes and RHCs who do prenatal services -- and if they are being rendered by core service providers -- they continue to do that -- they can do telemedicine as well with that. They just want to use that GT modifier when they're doing telemedicine. The Pregnancy Medical Home incentive codes, I talked about these last week -- we are okay with you doing those in a variety of ways. The most important thing is that we're getting this information. We've seen that our prenatal risk assessment volume have gone way-way-way down in the last month. Not a surprise -- people have been really distracted. We'd like to see those go back up again, we think that's really important information to gather. So we encourage you to get back on using those antepartum and postpartum codes and taking care of the women that way. And again that can be a variety of ways. There's not a lot of guidelines on that -- that could be telephonic even, and not telehealth if you would like it to be. So we are not asking you to put the GT or CR modifiers on these two S codes. Just kind of trying to keep it simple where we can.

Okay, next slide. So I am going to turn it over briefly to my buddy, Carrie Brown, who is the CMO over in the Department of Mental Health, to talk about some of the behavioral health changes that are happening this week. Carrie?

Dr. Carrie Brown:

Thanks Shannon. Can you all hear me. Good evening everyone. You know, since I am a psychiatrist, I do have to remind everyone to make sure that they've been doing some self-care. It's really important as this drags on to find little moments each day to do just a little bit of self-care. Because this is definitely a marathon and not a sprint. And I feel privileged to have such amazing colleagues to work with and appreciate Shannon's leadership. So, I think -- remember we said in the beginning, we initially rolled out flexibilities related to enhanced behavioral health services, in terms of allowing the telehealth piece. Particularly for our SPMI population, and for community-based services that would need to utilize telehealth. And then we said we needed the next phase -- we had to wait until we got CMS approval because the way -- fortunately or unfortunately, our service definitions on the behavioral health side in Medicaid policy are extremely detailed. Which is great because we want to enforce a high standard of care. But it also means if you want to change things, it's a lot harder to do it quickly.

So we did get that permission for CMS to changes, you know, for the duration of the COVID-19 pandemic, while there's a declared state of emergency. And CMS clarified for us that we could make the changes in our service definitions, and then let them know what we did, sort of after the fact. So that has been this tremendous amount of work that the team has been working on. And hopefully the bulletin going through this in detail will be released tomorrow -- and these are really important flexibilities. So, these are going to -- this is in addition to everything that's been announced in previous bulletins. They will be all retroactive back to March 10. When the state of emergency ends, then all prior service requirements will automatically resume. And so the special bulletin that should be released tomorrow will go in detail, by particular service types. So it goes through assertive community treatment. It goes through the different child residential levels. It goes through facility-based crisis, et cetera. And each one it, sort of, goes through what's waived and what's not waived, based on current Medicaid policy.

The general categories of things that we've waived to try to maximize flexibility are things like prior authorization. The one note here is that only holds for Medicaid. So on the state-side, -- so if you're billing with single-stream dollars, then prior authorization, you'll have to contact your LME MCO to see whether -- how or whether the prior authorization is waived or not. And that has to do with the fact that state funds are limited, there's a cap on them. There's a hard stop. But prior authorization is being waived on the Medicaid side. Also if -- training requirements. The way we are handling training requirements is if -- recognizing that there'll be some initial training requirements. We're talking about initial training requirements right now. There'll be some initial training requirements that you can't really obtain virtually. And you can obtain them in person with appropriate physical distancing. Although there are a lot of trainings that you can do virtually, that are available online or have been converted to electronic means -- or virtual means. And there are some very creative ways that you can do things, even -- like parts of restrictive intervention training, et cetera, that can be done while maintaining six-feet apart. But, all of that being said, if there are initial training requirements that cannot be obtained because of -- they aren't available virtually, and it cannot safely be done maintaining six-feet of physical distance, then they'll be waived during this portion.

Another big category that's waived is -- a lot of our service definitions require that a staff member be dedicated to that specific team. Like an example would be a community support team. Saying that the psychiatrist has to be dedicated to that particular team. That actually -- actually I might be wrong on that specific example, but you get the idea. And we're waiving that so that people can group together and try to share resources. Because we want the work to continue, because it's really important that we continue to provide behavioral health care for all of our citizens. And we want, also, the providers to still be there at the other end of this. Where we have very strict staff-to-beneficiary ratios, that's going to be waived. Also things in the substance use disorder world, waiving the urine drug screen requirements, where that's written into a service definition. Because obviously that's an incredibly difficult thing to obtain over -- you know, virtually -- virtually impossible. And then also allowing all the staff supervision -- while supervision is crucial and important, and we want to continue -- it can continue via telehealth and telephonic means. It doesn't have to be physically in person. It's an incredibly complex document that we sort of summarized into brief details

here. But I'm really proud of the team trying everything that they've done to try to give everyone these flexibilities to keep operating safely. Thank you Shannon, I'll turn it back to you.

Dr. Shannon Dowler:

Awesome thanks so much. And thanks for all the work you've done with your team to stay on top of these behavioral health policy changes. Every week we do more behavioral health changes as we realize things that still need to get done. A ton of work.

Okay Nevin, next slide please. So from a durable medical equipment standpoint -- a couple weeks ago we made it so blood pressure monitors are available for patients to get through DME, which has been met with a lot of positive energy. There's a link down there at the bottom of the slide -- it's also on our website, that's going to be on a bulletin that's going to be out tomorrow -- to help you try to put together which DME providers are approved by Medicaid in the state to make it a little easier for you guys to find that, if you're not a practice that's been ordering DME. This week -- we'll actually have it turned on next week. So I'm telling you about it this week, but it'll be turned on next week. You are going to be able to order scales for your patients to weigh themselves. And we're thinking that's going to be something used a lot with our congestive heart failure and our pregnancy. Portable pulse oximetry. In the past, you could order it but it was a rental from a hospital -- it was just sort of a strange thing -- we're actually approving the devices that can be purchased for your patients, so they get to keep them. And we think this is really significant for some of our patients who we need to be able to track that -- especially when we're doing more telehealth; folks that you're going to be worried about. Also patients that get COVID -- that you want to track their oxygen sats through the infection -- knowing that you don't want them to come in if they don't have to. But if they start to decompensate, you sure want to know it because it seems like it happens quickly. So those are two new things that are going to be available through DME. I will tell you that a lot of the things we're providing are not going to be forever. These are unbudgeted -- everything we've done in the COVID response has been unbudgeted. And so we are going to study it and see how things are used and decide whether we can continue -- what things we can continue. But I would just say, as someone who's been in the field for a lot of years, I would have been very excited to order this for a handful of my patient. Now is the time to do it. So I would go on and take advantage of this DME offering.

Hugh Tilson:

Shannon, before you move on we've got a couple questions about DME, that I thought I'd just ask while you're talking about it.

Dr. Shannon Dowler:

Sure, yeah

Hugh Tilson:

**One question is, that they need more guidance on remote blood pressure monitoring. Will it be covered if the provider provides the device is outside of DME providers? Medicare allows that, so I think you answered that.**

Dr. Shannon Dowler:

Yeah, so the blood pressure monitoring code -- so if you're billing the code to say I've reviewed my patient's the blood pressure and I'm modifying their plan, that is fine, whatever device they want to use. It doesn't have to be one that they ordered or purchased through the Medicaid program. It could be something they already have, or something a friend gave them, or something they bought by themselves. So the device is not specific for measuring patients' self-monitored blood pressure. That was the remote patient monitoring code that we turned on last week.

Hugh Tilson:

**And then we've got a couple questions about infant scales and then even neonatal weight checks.**

Dr. Shannon Dowler:

I'll have to check with John. I don't think we got into infant scales. I think that would have been very cost-prohibitive for us. I think we went with the run-of-the-mill stand-on scales. But I will check with our DME folks. I don't recall seeing anything around infant scales.

Hugh Tilson:  
Thank you.

Dr. Shannon Dowler:

Yeah. So as just a reminder to everybody, you have to use a Medicaid-approved DME company and it has to be medically necessary. So we got some questions today around that from a DME company -- like what is medical necessity for pregnant women? And what my response is, you the provider, if you believe that it is medically necessary for your pregnant patient who is going to have telehealth visits to monitor her blood pressure from home, then that's okay with me. So it's your assessment of what is medically necessary. We did not intentionally put a lot of guardrails on these codes because we didn't want there to be barrier to accessing them in this time. Again, we are kind of being more generous than is typical. Because we hope that there'll be some funding to help -- like the federal match will really help us with this and we'll be able to cover the costs that weren't planning on. But we think these are really important when we're doing more remote care. So if you believe it's medically necessary, we are not going to come back and argue. Now if we discover a provider who is literally ordering one for every single person in their practice, you know hundreds and hundreds, it might raise a red flag to somebody. But I think within reason -- you just need to be able to defend that it is medically necessary.

Okay, next slide. Alright, so with the remote physiologic monitoring codes -- we're turning on a series of these codes this week. A lot of you are not going to be using these. But for those of you that are doing remote physiologic monitoring -- for your heart failure patients, for your diabetics -- you are doing it already for privately insured or Medicare patients. You might be really eager and excited about using this on your Medicaid patients. It takes a little bit more set up and work to get ready for it. Procuring the devices and understanding how to use it. So this is not like the code we turned on last week, which was around self-measured blood pressure monitoring, which doesn't actually count, by definition, as remote physiologic monitoring. The RPM has to be something that's transmitted automatically into the practice from the device. And it needs to be monitored in a real-time or near real-time way. So it's not -- this is the sort of, what we're using more for heart failure patients, COPDers, sometimes diabetics. So if you're not doing this at all in your practice, my guess if you're not going to want to pick this up use it. But if you are doing it and you would like to expand it to Medicaid patients, we think this is a great opportunity for you. So take a look at that bulletin when it comes out tomorrow. It also has an accompanied FAQ with it, because we felt like this one needed a little bit more explanation. There is a little more nuance to the coding requirements on this.

Okay, next slide. Pharmacy. So last week we added the 90-day supply for MAT and stimulants if providers feel like they're clinically appropriate. We got approval this week, financial approval, to put in and edit -- we'll also have to put it in our disaster spa to get authority from the federal government, to allow for pharmacy delivery for Medicaid patients. I think this is exciting. This is something I have wanted for a long time. So they can either have their meds mailed to them or delivered if there's a pharmacy -- a community pharmacy. There's a little bit of a delivery fee that goes along with it to the pharmacies, so a little bump in their reimbursement. Even though some pharmacies who it for free, for everybody. It wasn't covered by Medicaid before, so they just weren't allowed to do it for Medicaid. So we are making that -- not only are we making it possible, we're adding a little bit of a reimbursement bump for those pharmacies. So I think this is really exciting. I can't tell you exactly when it's going to be live but I suspect it will be in a one week or so. I'm sure the pharmacists will cover this closely and keep track of it. But we hope to push this one through pretty quickly.

So, next slide. So one of the things we heard over and over again from folks around the state is 'I am ready to do telehealth but my patients aren't.' And so we have been thinking really hard about how we can help you; help your patients get the care that they need. And so we have done a few things. This week a letter went out to all Medicaid beneficiary households. It went out in English and in Spanish. Talking about

COVID-19 and several things about how you can stay safe, how you can prevent infection, the COVID triage plus line, as mentioned on here of how to get questions answered. And there is a whole section about telehealth and how using telehealth might help people stay healthy and safe. So making you aware that's gone out. You might see an increase in calls to your practice asking if you offer that. The other thing we've done is we have put together a flyer on telehealth, specifically, that's on the website and on the app, that folks are looking at. And the last thing is an educational video on telehealth. So I put out a call to folks last week saying 'send me clips of you doing telehealth.' And a bunch of people did that, which was awesome. And so my Easter-weekend project was making a sort of infomercial. So it's -- as all my videos, those of you that don't know, I rap about STDs a lot. This does not have any rap; no rhyming at all in fact. But it uses a lot of my family members. Which is true of all my videos. Because especially now, we're in the stay-at-home order; I couldn't leave my house to make this video. So a bunch of people emailed me little video clips. And it was great. I think it's a really -- it came together really nicely and highlights providers around the state, which is pretty cool. And it was shown today at the governor's press briefing. So they actually showed it at the beginning in the press room and at the end of his briefing. And so it's out on social media now. We are going to try to show it at the end of our time together today and then I hope you guys will go out and get it, and link to it -- share it on your practice websites or your social media sites. Because the idea is really to get people comfortable with medical care happening in a different way. I think we are going to be in this for a while, and it's going to be on-again-off-again. But our complex patients and our high risk patients, are going to really need figure out how to embrace this technology, probably for their own health and wellness. So anyway, hopefully we'll have time to get to that.

Next slide. So, this is the big reveal. So there are a couple of things that I have been working on really hard, that I wanted to tell you about them tonight. And then we're going to go into our cases. One thing I just learned about in the last hour, was there's now an online form that you can use to request PPE for your practice. And that is going out on the website tonight. So Hugh and Tom and I will email you the link, it's hot off the press. So folks will be able to apply for PPE resources in their practice. I don't know that you'll get it, but you can apply for it. And so that's exciting, that there's just -- a one place that you can do that now, I think that'll be a relief for a lot of people. Our team at Medicaid has been thinking really hard about how we can support the infrastructure, particularly our primary care infrastructure, as folks are responding to COVID. And knowing that primary care is foundational for our ability to provide excellent medical care to our Medicaid recipients. We're also very aware that we are getting ready to have a bunch of new Medicaid patients. So a lot of people are going to qualify for Medicaid that have not in the past because they've lost jobs and their finances have changed. And we're also not turning anyone away from Medicaid that's on it. So we're not terminating benefits for anybody right now. So even if your pregnancy Medicaid runs out, we're actually keeping things turned on right now. So that means there are going to be a lot more Medicaid patients out there that are going to need homes to take care of them. So because of that, for the next few months, we are going to be doubling the per-member-per-month payment that our medical homes get for taking care of our Medicaid patients. It's just sort of our way of acknowledging how important you are and the infrastructure that's so important for our patients. We will have more guidance on that soon, but it'll happen automatically. You don't have to ask for it or apply for it, it'll just happen in your payments. The other thing I was able to get approval on after working on it for a couple weeks is -- our team heard your feedback, that folks felt like the telephonic reimbursement rate was not adequate. We felt pretty strongly and we've held to the tenant that we don't think telephonic is as good as telehealth. But we think it's important, and we also recognize that a lot of people aren't able to access telehealth. And so we're making a rate adjustment, that I've gotten approved, where we'll do our telephonic codes. We'll reimburse for about 80% of the regular parity for the face-to-face visits. So that's for the fee-for-service world. We'll be doing an 80% increase -- to 80% of the current E&M codes for those telephonic calls. So that's another -- it's not a huge amount of money, but it is an increase for sure. It's a significant increase from where we are right now. And I just want you to know that we're listening and we're hearing and we're aware that some of the things weren't working for you, so we have made those changes. Last thing I'll say before you go to the next section is we are studying this, we've a whole team of my quality and data side at Medicaid who are really looking at how are we using telehealth, how are we used in telephonic care. Where are the gaps? What are we seeing with different genders and races and geographies of where it's happening and being utilized? And

I hope to share some of that data with you over the next few weeks as more claims come in and we understand it a little better.

Okay, next slide. This is out -- just to let you know we have three really robust Q&A documents on the website to help you understand all these policy changes that we've been talking about for the last month and a half.

Next slide. We have a team, at Medicaid, who has been looking at all of the federal funding that's available to providers. That's also going to be linked to on our website. But I put it in this slide deck as well, so you could see it. I have two slides here, there's actually a third slide that'll be out on the website. This one is for all providers and the next one, go onto the next slide --

So these are more specific provider types. There are a lot of dollars out there right now for telehealth capacity and for building telehealth capacity. And they're grant dollars -- you don't have to pay them back. And so if you are not looking at those things, now is a great time to do it. There is a strange amount of money being put out there for -- in telehealth grants.

Okay, next slide. Alright, so Tom, I'm going to hand it off to you. And we're going to do some round robin and talk about some of the things we've learned from folks around the state.

Dr. Tom Wroth:

Great, thanks Shannon. This is Tom Wroth from CCNC. This is the part of the presentation where we really talk about how people are putting these policy changes into action in real life. So remember last week we talked a fair amount about some of the barriers that are out there, on the patient side and provider side. So the CCNC and AHEC teams reached out to probably about 20-25 practices. And we're astounded at the responses we got back and we want share some of those with you today. These are real practices doing real things.

Please go to the next slide. The first part, here is around how practices are engaging patients with telehealth.

So if you'll go to the next slide. This is a real practice, Island Family Medicine in Hampstead, North Carolina. And I love this one. This is really how you meet the patient where they are. They have a staff member call the patient to schedule them and really explain what telemedicine is. This is really new to all of us, so important that we are all in it together. And I love this that they give the patient some flexibility around their preferred mode of telehealth. Whether they want to do Skype, or face-time, or just the phone. And this really encourages patients to use the telehealth options and supports their choices. So a great way to meet the patient where they are.

Next slide. Here we've got a few examples. I love the language here. Again, just really engaging the patient well. Saying this is new to all of us and we'll figure this out together. Really engaging them in this new process of how you get healthcare. At UNC maternal-fetal medicine, some of the language they use is really around telehealth as a way to protect pregnant women and their families from COVID. And also ensuring them of the high quality of care and comprehensive care they can receive in telehealth. Over at Piedmont Health Services, they're reminding patients of the availability of telehealth, when they call about any issues. So if they're calling in about medications or other things, they're reminding them about the use of telehealth.

Next slide. So this is over in Asheville at MAHEC Family Medicine. I really like this. They're using their 'patient advisory committee to give us feedback on virtual health platform and usability.' So this is all new to us, we just put this up over the last two or three weeks. But now are starting to get survey data and patient feedback about how it's going and how we can improve the process. So a great QI piece here.

Next slide. And here are a few other examples. West Primary Care, over in Pembroke, having their outgoing voicemail mentioning telehealth and the changes due to COVID. Folks over in Boiling Springs Lake Family Medicine really trying to increase their chronic care management services and using that to engage patients

around telehealth. And then over at Piedmont Health Services, again, utilizing their social media and website to inform the patients of the availability of the new telehealth services. Next slide. Over to you.

Dr. Shannon Dowler:

Alright, and another place where we're looking at is our risk patients and how they're addressing high-risk patients with telehealth.

So go on to the next slide. So A Plus Family Care in Raleigh; so working on using patient reports from the HER and the Medicaid ONE LOGIN website from the CCNC Practice Perfect Dashboard to make sure they have future appointments. I think this is really important right now. You know we would do this in practice before when we'd hit slow seasons -- when we were episodically just down on volumes. That would be a time where we really dig in and think about, alright who are we missing that have care gaps? But now it's really about who are your active people? Who are you normally seeing and you're not seeing right now and going after them? That makes a lot of sense.

Next slide. So how are practices reaching out? Duke Outpatient Clinic in Durham; they're identify their highest risk patients and calling them if they don't have follow up. So they're looking specifically at the chronic disease and advanced age, and going out and calling to schedule proactively. Roanoke Chowan Community Health Center in Ahoskie, they pulled a panel of patients who are uninsured and below the 200% poverty line, and reaching out to this vulnerable population to make sure they have care. And that's really impressive. And hopefully a lot of those people are going to get Medicaid. You know, I don't know that our chance of getting expansion in this is great, but I think we're as close as we've ever been to getting more care for that under-200% of poverty level. So that's great work. Jacksonville Children's revamped their workflows and are being really proactive in outreach to patients. They are actually partnered with Aledade and so they are using that high-risk patient list with them, working that high-risk list.

Next slide. Wakefield Pediatrics and Adolescent Medicine, in Wake Forest, has found that with their asthma patients, they no longer have to wonder what the patients are actually taking, because the patient's at home. And so they can show them their meds on the screen and they know that they are taking the right ones and that they aren't expired. I thought that was a great -- that is really one of the benefits, not only being able to see the patient in their home environment, but to say 'show me that pill bottle' and 'when did you have that filled' and 'how many pills are left in there?' It's a good opportunity.

Next slide. So we've got Salisbury Pediatrics, is identifying asthma patients -- so that same thing -- they are kind of working on a patient list. UNC Maternal-Fetal is making sure that their pregnancy patients are getting the appropriately-sized blood pressure monitor and instructed on use. So they're just proactively saying if you're pregnant, we want you measuring your blood pressure and we want you to know how to do it. They are also working on their diabetes management, so they're using their patient portal to manage blood sugars and track them -- with poor control, and that's something we pay for now. So before we weren't paying for portal communication, so that's now a reimbursable code.

Okay, next slide. So Roanoke, again, is doing outreach behavioral health in substance use patients who have been in the ED or had an inpatient -- so they are doing some care management on those complex patients. Also Wake Forest Urgent & Primary Care is doing that same thing. They're really focusing on chronic care management during this time, which is a great idea. Dale Fell Center up in Asheville, is actually using their peer support folks in clinic to make sure they are doing outreach to their MAT patients and to check them in, and then guide them toward virtual recovery and getting them into resources that way. Next slide. Alright Hugh, what are the patients saying?

Hugh Tilson:

Well the patients are saying, they like this.

Next slide, please. So we heard from Vidant Family Medicine, Roanoke Rapids, 'thank you so much for doing this and not having me come to the clinic. I don't want to leave my house until it's safe out there.' So



patients are actually recognizing that not coming to the practice isn't necessarily a bad thing and having telehealth is a great way to get care.

Next slide. So you can read these, but not only do they like the idea of getting the care, and it's safer, we heard from Southern Regional AHEC that the patient actually enjoyed showing the doctor around her home. So it helped to enhance that relationship beyond just the patient care. And as you can see people may not want to go out in public, especially going to a doctor's office. So this is a way of getting that care that they need. And doing that safely and the patients are recognizing that.

Next slide. They also recognize that it's convenient for them. So Cone Family Medicine Center in Greensboro said -- or heard from one of their patients that, they 'have transportation issues and prefer this to taking multiple buses and waiting,' And as we look at social determinants and unmet social needs, using telehealth is a way to ensure people have access to care.

Next slide. So we heard from Shore Fun Pediatrics that their patients didn't miss making that 20-minute drive, especially with the kids. And if you look at UNC Maternal and Fetal Medicine, down at the bottom. You know, leaving the house with a newborn isn't always easy and being able to leverage telehealth to get that care is really important. And as you can see with Piedmont Health, it also helps to work around busy work schedules for folks that are actually still going to work.

Dr. Tom Wroth:

Next slide. Great, so this is the really fun part, looking at how practices are overcoming barriers. A lot around internet access.

So let's jump in there with the next slide. So Roanoke Chowan again, I thought this was awesome. They set up Wi-Fi hotspots in their parking lot and had patients come to the parking lot and use the Wi-Fi hotspot and do a telehealth visit right there. You may have to boost your Wi-Fi signal if you do this.

Next slide. So some other great examples. Similar MedNorth Community Health Center over in Wilmington, they've set up an exam room with a video station. So they actually have the patient safely come into the clinic. But they do a no-touch visit with a video right there in the exam room. Language barriers, UNC Maternal and Fetal Medicine has a bilingual provider or interpreter helping the patient to set up and sign into the MyChart, by phone. And Albemarle Pediatrics over in Albemarle, North Carolina, when you have those technical barriers and the patient's having trouble getting the mic to work, they sometimes call over on the phone and use the video at the same time on the laptop.

Next slide. So Advance Community Health Center, again this is a really nice example of how to overcome some of the barriers of folks having access to Wi-Fi and internet. So 'we are offering curbside telemedicine as an option. The current workflow is that the patients get scheduled and they do all the pre-work up front with the clerical staff and then the patient actually drives up into the parking lot and utilizes the -- gets an iPad and utilizes the Wi-Fi that, I guess, comes out from the building. That's a really cool way of providing telehealth. Next slide. Alright Shannon, back to you.

Dr. Shannon Dowler:

Yeah, so we just wanted to highlight a few things that we identified that we felt like were best practices to wrap this section up.

So, next slide. Blue Ridge Health, hey that's my old stomping grounds in Hendersonville, says 'we found it helpful for the clinical staff to call the patient to set up the visit prior to sending the link. This helps with setting up the chart, some of the screening, as well as med recs. And if they're late, we can let them know. I've actually heard that from a lot of people, that patients really appreciate it, because if you're running late, then they're at home and they can cook something, or knit, or take care of their kid. They're not sitting in an office and so they're tolerating us being -- us running behind a little bit better.

Next slide. Let's see here; A Plus Family Care in Raleigh, is making separate appointment types in their HER. So they're differentiating telehealth from regular appointments, so it's actually an appointment type. I think that's a great idea. Lincoln Community Health Center in Durham, is doing combined telehealth visits with a prescriber and the mental health providers sitting together, talking to the patient, which is an awesome idea of doing, sort of, team care. Mountain View Pediatrics in Morganton, North Carolina, is converting pharmacy and patient refill requests into telehealth visits. And so they are using that opportunity to check in with patients.

Okay, next slide. Mountain View Pediatrics is contacting patients from the daily reports after hours. So they get their after-hours triage support, and they're turning those into phone visits the next day if appropriate. Burlington Pediatrics is -- had already doubled their Internet speed. And they felt like having super users really seemed to help push telehealth for them. Cone Medical Center, in Greensboro, is working on developing a system so the front office can schedule the virtual visits or in-person visits without the provider's input, or a list of complaints. And that's a great idea.

Okay, next slide. UNC Maternal and Fetal Medicine gave us a ton of feedback. This is their schedule of needed face-to-face visits for pregnancy care. You can definitely look for more of this; this will be available to you to look at after -- this will be posted. So you can see what they're doing around OB care and telehealth. And then the OB champions will be putting out guidance on that too.

Next slide. So 'with the system and a team of skilled nurses, most of the provider's care can be delivered via telehealth. Virtual care is not all about the provider visit. So don't overlook the importance of nursing education. And make the most of every in-person visit, take the opportunity when the patient's in -- take care of everything you can while they're there. Getting the bloodwork, ultrasounds, injections, vital signs, and anything you need to do; take advantage of it while they're in your office.

Okay, next slide. Hugh do you want to do some Q&A?

Hugh Tilson:

**Yeah, we got lots of questions about well-child checks. Can you give us an update on that?**

Dr. Shannon Dowler:

Yeah, so we have been working really hard on the well-child check front. That's our I think probably, not our last frontier, but one of our last frontiers. And we are working with several docs around the state to help us with this guidance. We are actually leaning really heavily on Tennessee's guidance that came out last week. They stole some of our early work and so we're stealing some of their work. And we'll have the formal guidance out next week. But we're still sorting through some of the logistics of it. If you want to get sort of an idea on what we're going to be doing, you can look at Tennessee's guidance, and that will give you an idea. We're kind of following along with the pediatric recommendations too, right now. But I can't tell you much more than that, because we haven't finalized anything yet.

Hugh Tilson:

**I've got some questions about telephonic rate increases. One about codes only going to 30 minutes and if there's -- possible for a longer session? And then one question about whether there's a retroactive? And then one question about do they apply to FQHCs?**

Dr. Shannon Dowler:

Okay, so the telephonic rate increases, we are going to have them go back retroactively to March 10. FQHCs have a separate telephonic code, they have a G code they use. We are doing a rate increase on their code, as well. So for theirs, I don't know all the numbers off the top of my head, but it's more than double the current telephonic code, so it's a bump. What else, what did I miss?

Hugh Tilson:

**I think you got them all. A couple questions about the PPE link, can you tell us more when that's going to be available and how we can access that?**

Dr. Shannon Dowler:

It's available now. It was just literally put up on the website tonight. And so it's on the DHHS website. Let's see if I can just pull it up in my email, fast. But what I can do is send it to you.

Hugh Tilson:

**And while you're doing that, is it for any practices, or just practices that accept Medicaid?**

Dr. Shannon Dowler:

No, this is anybody. But we hope all of you accept Medicaid. Oh wow, it's a really long link. But it's [DHHS.gov/divisions/public-health/covid19](https://www.dhhs.gov/divisions/public-health/covid19), so you go into that COVID-19 bucket. Healthcare providers, hospitals, and labs, is that subtopic and it's Requesting PPE. So we will get that out to you in a variety of ways. That's going to be a good tool.

Hugh Tilson:

Great, thank you for that. That's really, really helpful. One of the things we keep hearing is 'how do I get PPE?', so that's great. Can a patient request a medication refill through the portal? Can you bill the portal communication charge for medication refills?

Dr. Shannon Dowler:

I would think so; you have to look at the number of minutes that it requires. So there's a minute -- an amount of time you have to spend, and it has to be the provider spending that time. So I think it would depend on how much time you're having to spend on it. It makes sense to me that if a patient sends you a message through the portal saying they need five prescriptions refilled, and you had to look at their history and what they were due for, you would probably spend the right amount of time on it. If it's the automatic clink-click-click, you know because you've got a ton of refills that are coming in as a fax from the pharmacy, then I don't think that would count. That's not in our guidance, specifically. What is in the guidance is the amount of time, so I would look at that.

Hugh Tilson:

**So I'm going to ask a specific question about behavioral health, but the broader question applies to NC Health Choice. So, the specific question is, the changes we see in Medicaid for behavioral health enhanced services also apply the same services under NC Health Choice, including possible rate adjustments? And we got this question before, about the link between Medicaid and Health Choice. So specifically for behavioral health, but in general, do these changes also apply to Health Choice?**

Dr. Shannon Dowler:

Yeah, so I'm going to phone a friend. I believe the answer is yes, but I'm going to ask Beth Daniel if she's on the phone, to keep me straight.

Beth Daniel:

Yes.

Dr. Shannon Dowler:

Woohoo, I'm learning.

Hugh Tilson:

**Phoning a friend is great. Alright, some confusion about when these will end? Carrie said at the end of the state of emergency. Is it the North Carolina or US state of emergency, or have you guys even thought about that yet? Kind of when --**

Dr. Shannon Dowler:

I'll speak to the medical care, and you can speak to the behavioral. The language we're using in most of our policies is the end of the state of emergency, which would be the state, or until the policy is rescinded; and the earlier of those. So we keep it sort of vague. I mean, I think realistically a lot of things aren't going to be -- the state of emergency ends on Monday and suddenly everybody's back to business on Tuesday. There's going to have to be some sort of grace in there. But Carrie, are you using any kind of definition for behavioral health, or is it the same?

Dr. Carrie Brown:

Yeah, my conceptualization is the same. It's based on North Carolina's state of emergency. And I agree with you, we'll have to figure out some nuances as we go on.

Hugh Tilson:

We are getting a lot of comments, about how helpful this is. And also how much providers and patients would love for this to go on after the state of emergency. So I think you all know that, but this is just validating all of those things.

Dr. Shannon Dowler:

And some of it, I will say -- you know we were advocating ahead of -- before this even happened; we were working on trying to get FQHCs and RHCs to be allowed to be distant sites for telehealth. So we couldn't get the authority and we didn't have the budget to pay for it, essentially beforehand. But now that we've done it, you know like, we have turned this on, there are some things that I hope we are really going to be able to make a case to keep on. We're not going to, obviously, be able to keep all of it on. But we're going to try to, when we can.

Hugh Tilson:

**We've got a question on when will there be a webinar for mental health? Have you guys thought about that?**

Dr. Shannon Dowler:

Well they have them every week and I think there was -- wasn't there a provider meeting this afternoon.

Dr. Carrie Brown:

There was. It's hosted by Deputy Secretary Kinsley and Richard [Indiscernible].

Hugh Tilson:

**We can work to get word out on that a little bit better. Maybe that's something we can work on together. For the telephonic rate increase, do we need to refile or will it happen automatically?**

Dr. Shannon Dowler:

I'm going to phone a friend on that. Beth do you know how to answer that question?

Beth Daniel:

The best way to handle it would be to refile it, you'll get your money faster. There is so much involved for is in trying to identify and reprocess them, ourselves.

Dr. Shannon Dowler:

Yeah, so the rates aren't in the system yet. I think they are in process right now. Beth, do you remember which day -- are they Monday or Tuesday next week that we think the new rates will be available?

Beth Daniel:

I think they said Tuesday.

Dr. Shannon Dowler:

I feel like it is too. So every time we make a change, any single little change, there's this whole huge process that has to happen with our vendor who does the claims, adjudication, and payments. And it's remarkably complex. So it takes -- from the time we ask for it until the time it gets done, even though they're working really fast, It's still not an overnight thing.

Hugh Tilson:

**We've got a question about will telephonic context count towards the OB package billing, or just in-person and telehealth visits?**

Dr. Shannon Dowler:

Yeah, so just telehealth. The only thing that's telephonic is those S codes. So the intrapartum risk screening, you can do by telephone. So the S codes can be telephonic, but everything else OB needs to be face-to-face or telehealth.

Hugh Tilson:

**Last week you mentioned you'd be covering optometry codes in this phase.**

Dr. Shannon Dowler:

We released those codes last week. And so there's a bulletin on the website with a ton of optometry clinical codes.

Hugh Tilson:

Okay, so go to the website to find those.

Dr. Shannon Dowler:

Yep, with our 5-million bulletins.

Hugh Tilson:

**Let me see. Yeah, so let's do this, I am trying to filter through a lot of these. Are medical students allowed to perform telehealth services, as long as the physician has a physical presence, or the resident or teaching physician?**

Dr. Shannon Dowler:

I would think you would do it just like you would in a -- I mean think of it as like your clinical experience. If you have a med student seeing a patient, you know, the attending goes in and sees them with them. I would think they could be part of a telehealth visit. They could be leading the conversation, certainly while the billing provider was with them. That seems reasonable to me. Beth, would you say anything different?

Beth Daniel:

I believe we even address this in one of our earlier bulletins, because we had received several questions, so I would --

Dr. Shannon Dowler:

It's in one of the Q&As. It's one of the millions of -- I know there was for residents, I don't remember medical students. But you might have answered all that.

Hugh Tilson:

**Just got time for a couple more. Will DHHS be suspending the MUEs during this temporary period? So will you be instructing LME MCOs to also suspend MUEs?**

Dr. Shannon Dowler:

I don't know what an MUE is? Carrie, do you know?

Dr. Carrie Brown:

No, unfortunately I don't either.

Dr. Christoph Diasio

This is Christoph, it's medically unlikely edits. So it was originally intended for things like you don't do a circumcision on a woman or you don't do ovarian surgery on a man, and that kind of thing. But was then, sort of, misapplied when a lot of insurance companies to basically come up with another way to block payments. And a lot of the MUEs come from, sort of, desires to -- you know it just kind of slows down payments and makes things more difficult. So I think it would help if the original questioner could give us a for-example, of an MUE that's the problem for them.

Beth Daniel:

This is Beth

Hugh Tilson:

Please, go ahead.

Beth Daniel:

The MUE is part of the national correct coding that all Medicaids are required to utilize. And in February, well back to February 1, there were some changes that we've now uploaded, to meet things that have been identified as being a problem during the COVID and how people were going to be doing services. We are not allowed to cut them off, we have to continue to use them. But CMS is going through and giving us an update since the crisis began, to the codes that we use in processing our claims. If there's a specific question I'll be glad to answer it.

Hugh Tilson:

That's helpful. So we want to leave time for the video. So Nevin, can you run through the resources quickly, and I'll just -- I will remind everybody that there is a list of resources that is attached to the end of this. When this is linked up to the website, please look at those. And there are lots of helpful resources for you. And I'll show the video.

[Video Audio]

Because I have diabetes.

Because my son has asthma.

Because my Mom has high blood pressure.

Can't sleep -- poison ivy -- depression.

I'm Ursula White, a family nurse practitioner.

My name is Nicole O'Nash. I'm a physician assistant.

My name's Steve North, and I'm a family physician.

My name's Crenicia. I am one of the social workers here at Carolina Outreach.

Hi, I'm Brett Peterson. I'm a psychiatrist with Mission Health.

I'm Shannon Dowler -- Chief Medical Officer of North Carolina Medicaid.

There are a lot of reasons why it's important to keep seeing your doctor or other healthcare provider, even when we're in a stay-at-home order. Luckily across North Carolina, all the insurance companies, including Medicaid and Medicare, are covering your healthcare visit through something called telehealth. It's a two-

way office visit from the comfort of your own home, using a computer, tablet, smartphone, or other approved technology.

Telehealth is so much more than just a virtual visit between you and your provider. especially during this COVID-19 crisis. Technology like telemedicine, can actually be used to help fight COVID-19.

There are lots of ways you can continue your healthcare using telehealth, with your doctor, physical therapist, counselor, optometrist, or even your dentist, if you have an emergency.

Because not everyone has access to Internet, computer devices, or even cell service at home, doctor's offices are trying lots of creatives ways to get in touch with you virtually.

Now tell me, how are you feeling?

I see you got the email from our practice.

Hi, this is Dr. Christoph Diasio from Sandhill Pediatrics. How can I help you?

Benefits of telemedicine include privacy assurance, convenience, less waiting time, and unnecessary exposures to viruses like COVID-19.

For the past few weeks I have noticed my acne is getting pretty bad.

Just sitting in a waiting room that's held sick patients increases our risk of getting infected.

If the care can happen at home, it's safer.

Ignoring chronic health problems during the pandemic puts you at a much higher risk if you are infected. Keeping excellent control of chronic health problems makes your chance of surviving a COVID infection better.

Sheltering in place is really important and we want to make sure that we're here for you. By keeping you safe at home, with a provider you already know and trust.

We are able to connect, either on the phone or hopefully video so we can see each other. But in some way, reach each other.

And I hope that can encourage some of you, that may be a little hesitant to try it. Hopefully it can be helpful as we go through this crisis all together.

So please, stay home, stay well and stay in touch with your health. Your provider's still available virtually to evaluate whether your care can happen on video, by telephone, or if it requires a visit to the office.

With telehealth you can stay-at-home and stay well.

Dr. Shannon Dowler:  
Alright, well that --

Hugh Tilson:  
Do you want to take us on home?

Dr. Shannon Dowler:

Yeah. So thanks everybody for joining us for one more weekly update. We'll see you next week, and we'll focus on well-child, and other things that are turned on during the week. Thanks for everything you're doing out there. Keep the questions coming, and we look forward to seeing you virtually next week.

[Event concluded]