

Transcript for Medicaid Managed Care Fireside Chat

March 4, 2021

5:30 - 6:30 p.m.

Presenters:

Dr. Shannon Dowler

Melanie Bush

Kelly Crosbie

Dr. Julia Lerche

Dr. Janelle White

Carolyn McClanahan

Hugh Tilson:

All right. It's 530. Let's get started and see Shannon do a little bit more dancing. Uh, good evening everybody. And thank you for participating in this evening's webinar for Medicaid providers. As a reminder, our webinar tonight is part of a series of informational sessions put on by Medicaid and North Carolina AHEC to support providers during the transition to Medicaid managed care.

We'll put on these fireside chat webinars on the first Thursdays of the month. We're going to focus on hot and timely topics for you. I'll turn it over to Dr. Dowler and just a second, but let me run through some logistics first. You can adjust the proportions of the slides, uh, and the speaker by clicking on that gray bar, just to the right of the slide. And then dragging it either side to adjust the size of the slide. And then you can click on that view button on the top, uh, and, and click side-by-side speaker. So that the only person you see is the speaker when they're speaking. And that may minimize some distractions. Um, we'll put these in the Q and A for your convenience. I want to let you know, we'll do some polling tonight. So look forward to getting your feedback on a few questions. So keep your eyes open for those polls and please respond quickly so that we can move on. Uh, we'll have questions at the end. So as a reminder, everybody is muted. You can submit questions two ways. One is using the Q and a feature in the black bar on the bottom of the screen. If you're dialing in, you can't do that. So send us an email to questionscovid19webinar@gmail.com. What we've learned in the past, the presenters will often address your questions during their presentation. Uh, specifically it's about something that's on the agenda. I encourage you to wait until after they've presented, uh, to submit your question, um, we'll do our best to get back to you on those questions. Um, and, uh, anything we don't get to, uh, Medicaid will work on as a response, uh, either directly or as content for the upcoming webinars, uh, we've posted these slides on the AHEC website. There's a link in the Q and a record this webinar and put a recording and a transcript of it on the NC AHEC website as soon as possible, probably tomorrow and Shannon, all yours.

Dr. Dowler:

All right, thank you. How about that music? It always gets me kinda energized before we get into our end of the day, um, fireside chat and it occurs to me that a fireside chat seemed like a great idea in the fall, but it's starting to get warm. So we might have to change our name and we have a full agenda for you. Lots of our subject matter experts from the Medicaid team are with me tonight to help tell the story of the work that we're doing around Medicaid transformation, and also to give you some other clinical updates around Medicaid policy that we thought would be nice to hear. And. Teaser, we're going to tell you about a special payment that we have developed to help drive health equity in North Carolina. So we've got a full agenda tonight. We are going to try really hard to leave 15 minutes at the end for questions and answers, um, so that we make sure we cover what you're most interested in. So with that, I'm going to turn it over to our queen of quality. None other than Kelly Crosbie.

Kelly Crosbie:

Hi everyone. This is Kelly Crosbie, and I'm the director of quality and population health here at North Carolina Medicaid. And I'm going to give you two quick updates on the advanced medical home program and also in the panel management, um, uh, that we've been working on here over the past couple of fireside chat sessions.

So if you could go to the next slide, please. Hopefully folks remember, we've talked about the advanced medical home glide path payment on a few of the fireside chat, but also on our AHEC sponsored AMH webinars as well. So the Glidepath payment is for advanced medical homes, tier threes, um, who have signed at least two contracts with prepaid health plans as a tier three. And have completed data testing and integration. If you've done that you are eligible to receive an \$8 and 51 cent PMPM for all the patients currently assigned to you in the three months up to launch. So the Glidepath portal is now open. You can see there's a hot link in this slide. It takes you to the original article, explaining the glide path program in entirety. Uh, we'll be publishing an updated bulletin as well. That will remind you of all the guidance and the eligibility requirements. And it'll also tell you how to get to the NC TRACKS provider portal. This is a screenshot of the portal, so I'm going to walk you through it super quickly. So this is just a screenshot. You go to the NC TRACKS provider portal. You're going to go to that same tier three at a station tool attestation tool you use, if you're an advanced medical home, um, you do need to attest at each individual practice site. So you, all you do is put in your NPI for that practice site, the site you're attesting for you select that you're attesting for the Glidepath payment. That step two. On step three, you need to, um, uh, select the health plans that you've contracted with as a tier three and step four, you need to select that you have completed testing. You need to, uh, the pick, the plan that you have completed testing with the two plans. And then you just click the, I have attested a link at the bottom and then you're finished. So we tried to give it very easy. One page. It is live now. So please go ahead. If you've completed data and integration testing, and if you've signed up with two health plans for a tier three contract, please do sign up for your Glidepath payment. That link will also tell you deadlines for, for the Glidepath payment. Remember you have three opportunities. You have an opportunity for the payment in April, may and June, and the deadline for attesting for the April payment is March

30th. So you have lots of time, but the glide path out attestation tool is now open. So we want folks to go ahead and use it. Okay. Next slide.

This is just a quick update. We've talked at the last fireside chat around panel management and the policy around, uh, per, uh, uh, panel assignment, both in, in fee for service and current Medicaid, but also in the future. At that time, we told you that we had met with stakeholders and we were working on doing a batch reassignment process at the state. So trying to correct auto assignment to better match, um, patients with who they were actually seeing versus who they might actually be assigned to. So we've spent some time, uh, analyzing data and working with volunteer practices. So we got volunteer practices, uh, pediatric practices, internal med family med, FQHCs, uh, when we worked with pretty large practices who had multiple sites. And so we looked at their data. And we looked at again, that group of patients who are assigned to a PCP, but they're seeing another PCP. And when I say PCP, I mean a practice site, they're assigned to one site, but they're actually seeing a totally different site. We're looking back at 24 months of claims. So we're looking at two years of their claims history just to make certain, they've never seen that PCP on their assignment in the past two years to be clear, a assignment is at the site level, but also if you're a tier three practice and you have multiple sites and a patient's assigned to site a, but they're actually seeing site C that's okay. We still consider that the same PCP. We consider that the same PCP. So we're literally talking about a totally different provider with a totally different NPI. We're trying to look at last seen provider, most seen provider and geographic proximity. So we're looking at, um, is the, the member in your County or in a nearby County when we do reassignment, um, we're trying to complete this in March.

So members get cards in April at the very latest and members will get new Medicaid cards. So again, we're working on reassignment with those very specific parameters. We're testing now with practices to see if our algorithm actually works. And the goal is very simple to look at two years of data and do a better match between who patients are really seeing versus who they're assigned to.

Another thing that we'll be able to update you on in the next fireside chat or a future fireside chat is the work that we're doing with health plans to produce some fact sheets for, if you have panel management issues after lunch, how you can take care of them. And we're also looking at ways for alignment across health plans, um, to make sure that panel management isn't so challenging, uh, especially in that time period, right after launch ongoing. Okay, next slide. I think we have a, we have a poll question now.

Dr. Dowler:

All right. We haven't done poll questions in a little while, but we decided to bring them back tonight. So here we go. We hope everyone will fill out the poll question. So what panel issues concern you the most? Um, so pick the one that concerns you the most, being able to provide care for members who aren't assigned to you, removing patients from your panel, who aren't engaged in care, helping members change their assignment to you, having five different

processes to manage your panel, um, or lack of access to quality data on your panel, which of those panel issues is, is keeping you up at night right now? And we'll give it a few seconds and then we'll close the poll and see what people had to say.

All right. All right. So, uh, the, the one thing we can't fix, um, is the five different processes, but this is really helpful because one thing we can do is we're thinking about how we can streamline it and make it as easy as possible so that you're not doing five different processes if that's at all possible. So that's really helpful feedback. Okay. Um, next slide and Nevin. Okay.

Carolyn McClanahan

I think we turned it over to Carolyn McClanahan. Yes, good evening. And for some reason, I think my camera is not coming on again. Um, I'm Carolyn McClanahan. I'm the associate director at, uh, NC Medicaid for eligibility services. And we're going to talk about soft launch and open enrollment. Uh, next slide. Uh, you will see that the first date is March 1st and we have already passed it. So we are actually live in, um, soft launch right now. So mailings have started going out to beneficiaries to let them know about managed care and what they need to do. And our enrollment broker call centers opened early on Monday morning, just as a bit of an update, we already have mailed over 377,000 of the enrollment packets. There are packets going out every day, uh, through early next week. And we already had as of this morning, about 2200 enrollments individuals had actually access the enrollment broker website or called or gone through the mobile app and enrolled in a plan, uh, open enrollment extends until May 14th. April 15th in the middle of this period, we're going to send reminder postcards to those individuals who have to choose the plan. If they have not already, and let them know that, you know, open enrollment ends in about a month and we'd really like them to select the plan. And auto enrollment closes on May 14th. Uh, open enrollment closes on May 14th, and then we have our auto enrollment starting May 15th for individuals who did not select a plan during the open enrollment period. The plans coverage starts July 1st and the individuals have 90 days through the end of September to change their plan if they wish to do so.

Next slide. Wanted to spend just a little time here who is impacted by managed care. As far as our Medicaid beneficiaries, we have three major sort of groupings. There are those who are mandatory. These are the ones who must enroll in the health plan, or we will auto enroll them. So mostly family and children's Medicaid beneficiaries health choice, pregnant women and non-Medicare age of blind and disabled. So that's the main, uh, Individuals in our mandatory group because that's population have a choice. They may enroll in the health plan if they choose or they can stay in Medicaid Direct. The biggest group of these individuals is most likely will, are federally recognized tribal members and IHS eligible. They don't have to be, uh, Eastern band of Cherokee, but any federally recognized tribal member who lives in North Carolina and is a Medicaid beneficiary. And then those others who are exempt are the ones who are identified as being eligible for tailored plans. If they were available now, so they had that choice. And then we have our excluded populations. These are ones who cannot enroll into a health plan. At this time, they will stay in Medicaid, direct. Um, many of this group are individuals and family planning or our MQB only group because they get very limited benefits. We also have

individuals for whom we pay their health insurance premium through Medicaid, and they will stay, um, in Medicaid direct now and our Pace individuals, those who are enrolled in the program of all-inclusive care for the elderly, because they are already in a managed care program. Refugee Medicaid is very specific to a program that is not actually the same as our Medicaid. There it is funded through refugee funds and they get Medicaid medical assistance based on that. So they will not be included in managed care. This is distinct from refugees who are eligible for regular managed care and where you get a Medicaid. They will be in managed care depending on their status. So three major groups mandatory who must enroll, exempt who can choose a plan or stay in Medicaid direct, and the excluded the population that will stay in that direct next slide.

As I said, a minute ago, their enrollment broker call center is live. They have enrollment specialists who are waiting to take calls and are taking quite a number of calls already. That will certainly increase as we get more and more of the notices out the enrollment broker has extended hours during open enrollment. And you can see that on the left, they are open 7:00 AM to 8:00 PM, seven days a week during open enrollment, once we're past open enrollment, they will go back to our regular schedule of Monday through Saturday from seven to five, they provide choice counseling, help individuals look for PCPs. They discovered they discussed the health plan services that are available through the various health plans. They will, disenroll members or enrolled members as needed. Um, and they of course process need complaints and grievances that come to them. They provide the support for the website and the mobile app, which, uh, the mobile app is also available now through Google and, um, the app store and they will aid with deaf and non-English speaking beneficiaries by providing the assistance that's needed for those next slide.

It's a poll question, Dr. Dowler, right.

Dr. Dowler:

It's time for a poll question. And, uh, I noticed someone put in the Q and A, a suggestion instead of a fireside chat. We should change to poolside chat. And I think that's a very good idea. Um, okay. So what role do practices have in open enrollment? And this is just a way to think about how do you think your practice might be able to engage with beneficiaries and the open enrollment time? Um, so are you going to ask patients if they're enrolled, uh, have posters and signs in your office, helping them understand how to enroll, uh, send portal messages to patients explaining how to enroll, let patients know which PHP that the practice has contracted with, um, verify your practice information and the provider directory, or all of the above. So these are I'm, I'm curious to think. What, what are the things that your practice is planning on doing to help, um, participate in the open enrollment time for the beneficiaries? Okay.

All right. And let's see. Good. Excellent. So it looks like a ton of engagement out there, um, which is wonderful. And we're going to be providing you with some extra tools that you can use to make this easier for you to help beneficiaries get into a plan. All right. Uh, next slide. I think it Melanie Bush is up next and she is going to talk to us about the provider, um, lookup tool. And

before that though, I believe we have another poll question we do. So for this poll question, this one's an easy one. Have you looked yourself up in the provider directory? Yes. No. Or what is the provider directory? Um, answer honestly. Yes, no. Or what is the provider directory?

All right, Nevin. Excellent. So a lot of people have looked it up, a few people, um, need Melanie's guidance further. So Melanie, turn it over to you.

Melanie Bush:

Thank you, Shannon. My name is Melanie Bush and I am the chief administration officer here at North Carolina Medicaid. Um, I will warn you that my cat has decided to be incredibly needy right at this moment. Um, so I apologize if I feel, um, I am otherwise distracted. So, um, I was on the last fireside, um, with, um, Dr. Tom Wroth, answering questions about the provider directory and what you should do, um, to, um, update your information. And we, we got some other questions. Um, so we wanted to give this a little bit more time. Um, and the first question is where the information in the provider directory comes from, um, NC tracks your NC tracks record, but it's also supplemented, like we mentioned, with the health plan contract data from the PHP network file. And there was questions about providers, multiple locations and affiliations. And so the locations that are, that are listed on the directory are sourced from NC tracks service locations that are associated with that NPI. Um, so if you are affiliated, um, and you want those to show, then you need to add those affiliated, um, locations as -- and NC tracks. Um, one other thing that is important to know is goes into the secure portal when they're actually making a health plan, change a selection, not change when they're going into the secure portal to make a health plan selection, um, they can do a provider search. And if they are affiliated, um, then that record will be returned for the beneficiary, but on the general provider directory, if you want that information to, um, display, then you need to have that added as a service location.

Um, the other question is, um, how the information is displayed in the provider tool. Um, information is displayed by, um, provider by plan or by organization. So if an, uh, provider is a practicing in multiple locations and has listed those as service locations, when you searched by health plan, you will find a list of all the providers contracted with that health plan and all of their service locations. Um, if it's through that geographic location, one thing I do want to note that is, um, important is that the provider, um, look up tool is limited by geographic location. Otherwise you would return thousands and thousands of providers. And so we, one of the required search fields is, um, geographic location. So that's either County or zip code. And so, um, I want to make that clear. Um, if you search by provider, then all the locations associated with that provider within that geographic location will display. And then if you search my organization, only the providers associated with that organization's location will display.

Um, the next question is can beneficiaries look up a group practice instead of an individual provider? Absolutely. Beneficiaries are able to look up by health plan, by organization and by individual provider. And then what beneficiaries pick a specific practice for provider in multiple locations? Yes. So a beneficiary first has to choose a health plan and then they will search by

provider and then they will need to pick a practice that is within the geographic location that they have searched for. Um, um, this question aren't professional designations. Do you have DO, MD, PNP included in the system? So the information that is displayed in the tool is actually derived from NC tracks and recognizes the provider's text reflects your professional credentials or designations. So if this designation is incorrect, a provider should submit an NCR to modify their taxonomy. Um, this will cause it to go through the credentialing process, which takes a little longer. So we. We again, encourage everyone to look yourself up and make sure that your information is correct. -- health plan or a PCP then the beneficiary will be auto-enrolled, um, to a health plan. And then the health plan will assign the client to an AMH PCP, and that'll be based on the beneficiaries fee for service claims history for the last 18 months. If that claims history does not include a PCP visit, then the beneficiary will be assigned on a round robin basis based on geographic location and PCP availability within that plan.

Um, is the ability to search by DBA and option now. Um, yes, that functionality was deployed into production in mid February. So if you have not checked your information, um, since mid February, please review it. An organization search displays the results based on keyword. So if --

Dr. Dowler:

It seems like Melanie might've frozen up on us. Yeah. I was going to say I was, I wasn't sure if it was my mountain signal that it was having a little trouble hearing her or if she had frozen up. She does look frozen now. I've definitely seen people frozen and worse with worse facial expressions. Why don't we go ahead. Let's skip ahead. And then we'll have Melanie, uh, answer those questions, uh, when we get to the end, um, we did want to take a little bit of time today, um, as a team to talk about some of the things that are real wins that are coming out of managed care. I think it's easy for us to get bogged down and sort of overwhelmed by the changes that are coming to us and the impact that it may have, um, on our practices and the way we're doing business, knowing that we've done it for a long way, a long time this way. Um, and we've already had a lot of change in the last year with COVID.

So, um, we're going to go through some of the things that we've been thinking about as the positives that are going to come out of the managed care transition, and we thought it might be helpful for you to hear them as well. So I think Kelly's going to kick us off.

Kelly Crosbie:

Yes. Um, in managed care, we've really tried to design a system that has an emphasis on and an accountability for quality, with healthy competition between the PHPs. And we really hope to close gaps in care for members and to provide more robust incentives for providers to do so. The overall goal of managed care and the whole design of the program is to improve the health of North Carolinians. All right. Next slide.

Dr. Dowler:

I think everyone is having technical challenges today. Um, all right. I'll jump in here. So partnering with the community-based organizations for outreach and education at the local level. So the goal is to reach at our beneficiaries at home and Carolyn, you want to take the next one? I'll jump in again, providing information to members to increase their engagement. That's an important piece to this next slide, please.

Kelly Crosbie:

All right. Can you hear me? Can you hear me this time? I'm sorry. It's okay. We're on the provider support slide. If you want to hit that. Terrific. I hope you wrapped up my presentation very nicely. Shannon. Thank you. I left it for you to finish later. Um, so, um, what we're doing to support providers in managed care, um, we are soliciting provider feedback, um, to identify unmet needs. Um, We are, um, adapting our provider incentives to promote specific interventions, which I'm sure you've heard of. And we'll talk more about also later, we're utilizing advanced analytics to continuously monitor and improve quality and patient safety. Um, Julia, you want to take these last two?

Dr. Julia Lerche:

Sure. Uh, we're also promoting within our contracts with our health plans value-based payment arrangements to help provide financial stability for practices. And we have an effort to limit administrative burden and maintain integrity of the medical home.

Dr. Janelle White:

And for a member of support, what we're doing here is just. Being a bit more holistic in our approach to addressing those social determinants of health and our health disparities in our quality programs and community outreach also value added benefits. So providing our members with additional wellness, benefits and incentives, not otherwise available through Medicaid direct. So for example, um, flexible non-emergency medical transportation options, um, cell phone, nutrition, coaching and support, um, GED study programs, other, um, incentives that we see here on the slide, and then also ability to choose a health plan that meets their needs. Um, so this isn't a one size fits all type of model. Um, you know, you can change your health plan if not satisfied, a choice that they have not had before.

Dr. Dowler:

I think one of the other big things that we're doing with managed care is we're really trying to integrate physical and behavioral health. So it doesn't end up being separated out into two different systems of care in North Carolina. And it's going to take us a little while to get all the way through and to get through the tailored plans being, uh, active. But I think even in the standard plans, we're going to see significant differences for our beneficiaries. Um, also the attention to the care management and wraparound care coordination is far different than any

other state has done with managed care. So really this focus on the medical home and making sure that patients are being cared for in their communities is a top priority, um, as part of transformation. All right, next slide. This is something very exciting. And I'm going to turn it over now to Julia Lerche to tell you about.

Dr. Julia Lerche:

Hi, good evening everyone. Uh, this is my first fireside chat, so I wanted to introduce myself. I'm Julia alert. I'm the chief strategy officer and chief actuary for the North Carolina Medicaid program. And it's a pleasure to be with you all today and present on this initiative. And, um, we just went through some of the managed care items, but I wanted to add that we're also making a concerted effort to embed health equity within our managed care contracts as well. But this is a, um, a short term program, temporary program that we're proposing to, um, to implement over the next three months. And, um, just generally, if you haven't already noticed, um, the department and Medicaid have really, um, been focused on, um, explicitly building health equity into all of our initiatives and programs. Um, and we've been hard at work in Medicaid, identifying ways that we can leverage our available resources and the levers that we have available through managed care and other things, um, to really support equity within our program. And, um, so as part of those efforts, we're sharing with you this, this proposed, uh, temporary health equity payment program, um, the graphic here, which you may be familiar with demonstrates how one size fits all a one size fits all approach is not necessarily equitable. And so to promote equity, what we want is to right, right size our resources to the needs of our beneficiaries and communities.

So what we're proposing is a temporary payment enhanced payment for Carolina access providers. That payments would be available from April through June of this year. So it's a three month program. And it would be an increased per member per month payment. That's added on to the monthly PMPM that Carolina access practices get today. That would be based on a practices mix of beneficiaries. And we would be measuring what we refer to you as a poverty score based on those beneficiaries. And if we could go to the next slide, we can demonstrate this.

So this is a little bit challenging to wrap your brain around. Um, it's very technical, uh, but, and also I'll start by telling you what it's, what it's not. So the eligibility for these enhanced payments will not be based on the location of a practice and they will not be based on the income of the beneficiaries you serve. So just so you know, that's what, that's not what, what this is. This is based on the mix of beneficiaries that are assigned to each practice. And we measure this based on NPI and location. So the combination of NPI and location, that's where we measure this poverty score. And it's based on the poverty rate for where your assigned beneficiaries live. So we have an example here on the right of how the poverty score is measured. So if we assume there's four census tracks and the state and poverty rate means the percent of the population in that census track that is living below the poverty level. So here in this illustrative example, uh, census track a has a poverty rate of 10%, B has a poverty rate of 15% census track C has a poverty rate of 20% and census track D has a rate poverty rate of 25%. And

there's three examples of practices here with different blends of beneficiaries by the census tracks. So if we look at the weighted average of PCP one, they have a poverty score, 15% PCP two 19%, and PCP three is 22.5%. On average, across our beneficiaries that are with Carolina access providers. Uh, the poverty score is about 19.4%. So the way we've structured this program and the thresholds here are still, um, a little bit in flux. So some of the parameters here may change somewhat as well as the enhanced payment amounts.

But, um, for illustration, we would be looking at for those that are kind of in the range of our average, that they would get a \$9 PMPM bump for the three months, April through June. And for those that are above well above our average, uh, poverty rate for our beneficiaries, they would get an \$18 per member per month bump. So what we're trying to do is we're trying to get enhanced payments to practices that are really serving a disproportionate number of beneficiaries from really socio-economically distressed communities. That's how we've, um, developed this, this payment program. Um, I am going to now pass the microphone to Dr.

White.

Dr. Janelle White:

Thank you, Julia. Um, again, you know, we're, we're very excited about this. And the team, as Julia mentioned, has been working very hard, you know, on how we may see support providers in and give them the capability to, um, support health equity efforts. First, um, this slide here just gives some suggested uses of the payment. So again, these are not required, just some suggestions on how the payments may be used to address our health equity. Um, so telehealth, you know, that that may be, uh, one way that we may be able to use our payments enhancements to our telehealth access, um, health improvements and what that would potentially look like as additional patient engagement in key health areas, such as prevention of chronic disease, I'm supporting behavioral health needs and also paying attention to our maternal and, um, early child health, um, staffing. Um, so, you know, with a lot of the wraparound services, we certainly need, um, support of our ancillary staff and, and, um, other support staff. So, you know, training for them, um, also data analysis that allows us to sort of chart our course and let us know how we're doing. If we're meeting target, do we need to pivot? And then also recruitment of key staff, you know, um, to help us work with the efforts to reduce our health inequity. So, you know, maybe, um, community health workers, um, also through the COVID-19 pandemic on response to, um, close care gaps that resulted from different services or vaccine outreach, and also our social drivers of health. Again, just sort of taking more initiative to address those. So improving, um, the capacity to address those on non-medical drivers of health.

Um, I would also like to add, uh, just sort of moving forward, because I'm sure there will be questions about this, that our Carolina access providers will be receiving a notification via NC tracks, um, about your specific enhanced payment. Um, since the amount will vary by the patient serve. So there will be some communication. Um, fourth coming. North Carolina, Medicaid will also have additional webinars, written material and outreach to providers

receiving these payments over the next month. So again, tonight, we're just introducing the concept, but please know that there will be more communication around this. Um, in the near future, also over the summer providers, you know, will receive a survey on how these payments were used to better understand. It'll just help us our team better understand how to address health and equity going forward. So again, that survey will be provided, um, uh, over the summer, but we actually on our next slide, we have a zoom poll here and, and, you know, with this poll, we just want to get an idea of, um, how you all plan to use this money. Um, and you can either let us know in the Q and a or the poll question, um, or offline, if there are other ways that you recommend, um, that we encourage providers to make the investments for health equity.

Dr. Dowler:

Thanks Janelle and Julia, this has really been phenomenal work of the team. Um, a lot of folks, our finance team, our strategy team, everyone's really leaned in to, to come up with this health equity payment. And it's, it's one of these rare things where I'm just doing what you do, um, is so important to us that we want to provide this extra payment to help support you in doing what you do, particularly when you are serving a large population of historically marginalized populations that are socioeconomically depressed. Um, and we know that that is often the case in our Medicaid beneficiary world. Um, so Nevin, is there a poll question here? Yeah. So if your practice gets payments, I'm just curious that you've just heard about this, right? So no commitment here, but if you, if you get a payment, what do you think you'll use it for? Um, telehealth, health improvements, staffing, care gap closures, social drivers of health, sort of what's your gut. And this is just information for us. We're just curious, um, as you think about a little extra money coming in, how would you spend it, um, to help enhance health equity? And let's see what folks said, Nevin.

Staffing. Excellent. Um, so getting people out there to take care of those beneficiaries, we, we recognize that it often takes more of the team, um, to get the care done and delivered. So awesome. I'm super excited about this. I mean, again, kudos to the team for working so hard in the middle of a pandemic to come up with such an innovative payment. Um, okay. Next right. So, um, I'm going to give you a few quick updates on some Medicaid coverage that we, we highlighted these a few months ago, but in my conversations with docs around the state, it has occurred to me that a lot of people missed the memo. And so I want to make sure you know about them and I'll go through them really fast. Cause I'm looking at our questions and answers and there are fabulous questions in there that I want to make sure we answered it tonight. So next slide. Um, so that's me and my rap video about STDs and the older population. That's not really a headline, but it's headline news. This is a really big deal. Um, you can go to the next slide. Nevin. Um, the team worked really hard last year to make a change to our breast cancer and cervical cancer prevention program that allows women who are eligible to receive BCCCP to actually be able to get enrolled in it. Even after a diagnosis, might've happened with another provider before they were enrolled. If you don't take care of BCCCP women, this probably doesn't mean much to you, and you're not excited. If you do take care of BCCCP women, this is amazing news. Um, so it's not a huge number of beneficiaries. This will impact with those that it

does. It will mean a lot to them in their lives. Um, so I would just wanted to make sure that you were aware of this. If you make a diagnosis of breast or cervical cancer for a woman who's uninsured and they're not in the BCCCP program, it's not too late. You can refer them and see if they qualify. All right, next slide.

We made a ton of changes to our family planning policy. I think we've gone back to it three different times, um, in the last six months, tweaking it and making some big changes. So our beneficiaries that get family planning Medicaid are now going to be able to have some other services covered that hadn't been covered before. And most of you know why now I'm kind of an STD queen. Um, and so some of these are some of the new tests. So, um, there's a nucleic acid amplification test now for trichomonas vag analysis that wasn't covered, that we're going to cover for family planning, Medicaid. There's also a Nat test for mycoplasma genitalium, which we're going to cover. And, um, some other exciting things we wanted to make sure you are aware of them. Another thing is we can cover COVID testing. If a family planning Medicaid beneficiary doesn't have private health insurance during the public health emergency.

And that's a significant change. Um, I'm going to pause real fast and can everybody that's on the zoom webinar, mute your phones. I hear someone breathing in my ear. Okay. Next slide. Okay. Um, so how is North Carolina doing with HIV prevention? Are we killing it? Are we leading the country? Are we in the middle? Could we do better? Is Alabama doing better than us? Um, bad news guys. We're not killing it. Next slide. So, uh, what we see in North Carolina is we lead the country and rates of many STDs, chlamydia, gonorrhea, syphilis, um, and we're not doing great with HIV either. And this is a map that shows people in North Carolina, living with HIV, um, you know, over half the people, half of the people living with HIV or over 50 interesting fact. Um, but there are a lot of people spreading HIV and there are ways we can prevent that next slide. So there's a medicine that we can prescribe. It's called prep pre-exposure prophylaxis. That, um, is actually a great way to keep people who are at risk for getting HIV infection to prevent that from happening. Um, the problem is these tend to be, um, younger uninsured men. Um, and that means we don't necessarily prescribe it all the time because of the cost of the lab work and the doctor's visits and the medicine. So we have made a change in our family planning Medicaid program that will help us perform on this. And, um, the prep to need ratio is a metric that's used around the country to say how many we think you should be treating based on your population. So in 2018, our ratio should have been at 4.89. And look at that we're at less than half of that, which means we're providing prep less than half the time, the rate that we should be based on our population.

So next slide. Um, we are also not great at getting men enrolled in family planning Medicaid and family planning Medicaid is a wonderful benefit. Um, if someone qualifies, it covers for a physical exam, several office visits every year. It covers for labs, STD testing, and of course family planning related services. And so men can benefit for this as well as women, um, that it's really important to take care of everyone's health during this time where they might be starting a family. Next slide. So, um, in order to use the family planning benefit to prescribe prep, to use prep, um, we have added the metabolic panel into the, um, labs that are covered in the family planning program so that you can do the liver tests that are needed to prescribe prep. Um, it will

cover the cost of six visits a year, including a physical. So that's a significant income to come into your practice. If you're doing prep for, um, otherwise uninsured men. And it covers for all the STD tests. The only one that doesn't cover is hepatitis B, which is through the state lab. You can send hepatitis B to the state lab for people who meet the criteria. Um, so that allows you to actually get the test done without the patient having to pay for it out of pocket, get your practice paid for the office visit. So their return on investment to invest in a prep clinic is really there for you. So what you hold, we've got to get the young men enrolled in the family planning benefit. Um, the drug can be obtained through the HRSA. Um, drug benefit or the medication assistance programs, again, the state lab for the hepatitis B tests, and you have colleagues all around the state that are doing this, make sure that you spend some time learning from them. Next slide. Um, just a reminder that our test for chlamydia and gonorrhea at the state lab are really limited still because of the shortage due to the reagent that's the same as with the COVID test. So if you send someone to a public health department for STD testing, you might find that they're not getting all the tests they used to get it's because they literally don't have the test. Um, and sad news, the STD treatment guidelines, which were supposed to be at in 2020, and then we're supposed to be out in March of this year. I just found out today it's going to be May at the earliest. So I don't know if you've been losing sleep. I've definitely been losing sleep. Um, but there's a great webinar out there that gives you the updates that are coming and there's some big stuff coming. That's very different. Next slide.

Um, last thing I'm going to tell you about clinically is, um, just to remind you that in January we changed our medically necessary circumcision policy. Um, I know for the 20 years I've practiced medicine, North Carolina, Medicaid's kind of been on again off again about whether circumcisions covered. Um, we are covering it, um, as of January 1st, 2021. Um, it requires though the medical necessity for this test to be, or for this procedure to be done is that you're doing it to prevent infection. Um, so if you use the code Z29.8, which is the code for encounter of other specified prophylactic measures, um, in with the appropriate circumcision code, this will now be paid by North Carolina Medicaid, um, which I think is a pretty big win. Next slide.

Um, this is an update from the office of rural health. They asked that we share this with you. They have updated the tele-health resources guide for practices that are really trying to, um, lean in and put in permanent tele-health resources, even after the public health emergency. Just go out to that website. I wanted you to be aware of it. Next slide. Okay. This is our last poll question, and then we're gonna hit the questions and the answers and right on time. All right, Nevin. So this one is one where you get to actually pick, um, you can select up to five topics. We're asking you, what topics would you like to hear in the future fire slide/poolside chats? Um, so choices COVID. Do you wanna hear more about COVID um, care management for at-risk children or women pregnant women? Adequacy and contracts, behavioral health women's health provider directory, PCP assignment, and panel management member education quality. Or we've really missed the mark completely and there's just other stuff you'd like to hear about. Um, so what we would like to know, kind of pick five, if you would, what are the things that you'd most want to hear about? We want to make sure this time is helpful for you and we're getting you the information you need. All right. Nevin. Let's see what people.

All right. So a lots of interest in PCP assignment and panel management. That's great. Behavioral health is up there. Quality's up there. Oh, Kelly. You have to be so happy right now. Um, all right. Great. Well, let's, um, turn it. Let's get folks to turn on their cameras and then let's launch into the questions and we'll do speed round of questions and the answers take it away.

Hugh Tilson:

You. Happy to let me just always observe that, uh, questions can be submitted to Q and A. So we've got a bunch of them we'll try to run through. And if those of you who are answering questions, see something that jumps out at you as needing to be asked, please jump right on in, got a couple questions about timing. Um, can beneficiaries go in and change their PHPs or PCP selection multiple times up until May 14th? Or can it not be changed once they submit their choice?

Carolyn McClanahan:

I will take that they can change as many times as they want during open enrollment. They can change after, uh, auto enrollment and up until Jane, uh, till September 30th of 2021. So they have the whole entire enrollment period plus, uh, 90 days after the fans, the plans take effect.

Hugh Tilson:

Thank you. And while you're on, got a couple questions about where to find the tools and handouts and flyers. And can you respond to those.

Carolyn McClanahan:

We talked a little last time about the, um, provider page on the NC Medicaid website, or you have the provider playbook, you can get to beneficiary information from the provider playbook, and it will take you over to access those materials in the beneficiary or the County playbook area. So you can get there from either the County playbook or the provider playbook shows the flyers, the posters, and the other information.

Hugh Tilson:

And did you talk about the mobile app?

Carolyn McClanahan:

Okay. I did see a couple of questions about that. So you can search for NC Medicaid, managed care on Google or the app store to find our managed care app. I actually had it come up with just typing NC Medicaid for me. So, uh, but MC Medicaid or anything, Medicaid managed care.

Hugh Tilson:

Thank you got a couple questions about, um, uh, designations, everything on the website about the provider directory says primary care. This is a bit confusing to the other MDs and practitioners who need to be enrolled for network adequacy is the website and directory only for PCPs also, is there indication a licensure provider?

Melanie Bush:

So the provider directory does include all Medicaid providers. Um, it is not limited to PCPs. Um, however, the secure portal where a beneficiary will make a selection is limited to primary care providers and AMHs um, so we do encourage all providers to make sure their information is correct. And as I mentioned earlier, um, provider designations are, um, displayed in. The directory tool through the taxonomy of the provider. And so I would encourage you to make sure that those taxonomies are correct. You hear me? Yep.

Hugh Tilson:

Um, how can a practice indicate alternative locations that are not physical locations? We have one physical location, but serve patients in their natural environment in 12 counties.

Melanie Bush:

That's a good question. And I'll have to take that back.

Hugh Tilson:

Um, when you refer to integrated primary care and behavioral health care, do you generally mean both types of care provided by one practice or do you mean care that is coordinated, but might be provided by two different providers, example PCP and specialty behavioral health provider.

Kelly Crosbie:

I don't know. I don't know who brought that up, but we mean anything. So unless it was used in a specific context, I mean, there's a, you know, we support the entire array of integrated care, but there might've, I don't know if there was a specific point that someone made about provider directory enrollment around integrated care.

Julia Lerche:

I think it was on the slide about managed care, where we're talking about within a managed care plan. So our new prepaid health plans will cover both behavioral health and physical health services under one plan.

Hugh Tilson:

So maybe this is a follow-up. When I asked local LME about tailored plans, they said they were subcontracting with a standard plan. How was integration when it's still two different payers?

Julia Lerche:

So there is a requirement that the tailored plans contract sort of subcontract with, um, a standard plan or, um, a plan that holds a PHP license. I know that's very technical. Um, it doesn't the that's in statute and, um, there are not strict parameters around what those subcontracts look like. Although we do have parameters in our contract with the tailored plans around what integration looks like. So they cannot completely subcontract their physical health services separately from the behavioral health services. There are requirements around how those need to integrate between the entities.

Kelly Crosbie:

And the design is that when an individual goes into a plan, if they're go into a standard plan or a tailored plan, that the plan is responsible for having providers in their network to meet all of their needs and coordinating all of their care. So that's the goal, not that you, as a provider, you don't have to bill a standard plan for physical health services and a tailored plan for behavioral health services. You bill the same plan for all the services, and that plan is responsible to coordinate all of the care in having an adequate network to cover both physical and behavioral non-standard plan or a tailored plan. They both have to have both types of services and coordinate all care.

Hugh Tilson:

Thank you guys. Um, if I see a patient on Sunday of the weekend of July 4th, when our practice is open, uh, who has a plan I'm not signed up with, will the enrollment broker changed their PHP plan on Sunday? So I can get paid for that visit on Sunday, or does the claim get rejected? And the plan changes effective the next month.

Carolyn McClanahan:

I think I can start the answer to that. The plan, anytime a plan changes, it is effective the next month. Um, so during that month, the coverage would be an out of network claim and Kelly you may want to address that further, but it's effective the next month.

Hugh Tilson:

Excellent. Great. How about this one? Um, there are a lot of questions happening in the field about network adequacy. Given several large systems do not appear to have contracts with the PHPs. How will this effect go live?

Melanie Bush:

So I'll, I will say is that we are monitoring the network adequacy on a weekly basis and encouraging providers to sign contracts and working with several large associations to make sure that, um, we have eliminated all barriers to contracting. Um, and so we are, um, really keeping an eye on network adequacy, but our plan and our hope is that we're still in good enough shape that we are going live.

Hugh Tilson:

Um, will any of the Medicaid HMO's be coming to the various offices to quote, check us out and visit us.

Melanie Bush:

Um, I am not aware that there's a requirement that PHPs make visits. Um, but I do know that some are meeting with providers as they contract with them. Um, I will find out what our requirements are on that.

Hugh Tilson:

Are the services that have been added for prep under family planning benefit only for offices, or does it cover the hospital as well?

Dr. Dowler:

That's a really good question. It's whatever is covered in family planning now, which I'm not sure that any hospital services, other than a procedure, you know, that's in the family planning program would be covered. So I think like someone going to an emergency room to get prep prescribed, probably my guess is that would not be covered. Um, but I would refer to the full policy and if, actually what we can do is I'll get the for sure answer for you. And, um, we'll send it back to you afterwards.

Hugh Tilson:

So this may not be Medicaid transformation related, but uh, many clinical coverage policies have been updated to include telehealth when we'll clinical coverage, policy 10a and 10 B be updated to include telehealth, hopefully before the July transformation.

Dr. Dowler:

Um, I don't have the policies memorized by number and letter, but we will take that question back to the team that probably do have all the policies memorized by number and letter and get the answer to that. We have done. I will say we have done everything we're going to do for the most part. Um, right now we've got some speech, um, speech therapy and occupational

therapy. I think that are getting ready to come through the PAG. But I think otherwise we don't anticipate, I don't think there'll be any more tele-health changes between now and go live.

Hugh Tilson:

Thank you for AMH status who provides cultural competency training?

Kelly Crosbie:

That's a really good question. We do require a long set of competencies and training for advanced medical homes, but we don't specify where the training has to come from yesterday. Provided we do require all of the niches to have training plans. And to ensure that their, um, that their care managers and all of their staff, um, care management team staff and other staff are trained in cultural competency and a long list of other competencies. Hey, Hugh, can I, can I call out a question?

Absolutely. It's I don't want to hit one question, but there's, there's about three or four and they're all around transition. So I think that's a really important topic. It's too big to get into in this moment, but I'll make a plug for, um, a policy that was posted in a training that's coming out. So there's a couple of questions around foster children who might be transitioning from Medicaid direct to health plans or vice versa. We got questions about prior authorization. How do we hire up through stations more? Um, when we spanned July 1st, so there's are really great questions. Medicaid posted its final transition of care policy. I actually posted the link in one of the responses, but on March the 11th and I'll repost it, there's a training. Please come to the webinar where we explain the transition of care policy, because it is just full of all the answers to those kinds of questions. Like what's that first 90 day period look like what happens to my prior authorizations? What can members be assured of? How do I know I'm going to get paid in those first 90 days? So it's really critical policy things, um, that you don't want to. So please check out the policy and please, uh, sign up for the webinar.

Hugh Tilson:

So we're just about out of time. I don't know if there are other questions that y'all want to respond to, or do you want me to just pick a couple more or I...

Dr. Dowler:

There were a couple around family planning and, um, those changes are in effect now. So as far as covering the metabolic panel and there's other, that is, that is live now. Um, there's something else that's in, that's gone through PAG and it's open for public comment right now. And that is dispensing 12 months of oral contraceptives. Um, and not just oral, but, um, that we're going to be able to give a 12 month supply dispense at once for, um, our women, which is a big change, um, for Medicaid. And so that's open for public comment. Now, if you love it, go

on there and say that you love it. If you don't love it. Well, I guess you can still make that comment. Um, but, but I'm excited about this. Um, I think it's a major improvement.

Hugh Tilson:

Anybody else? Anything you want to respond to in there?

Carolyn McClanahan:

There were just a couple of questions that I can quickly answer about, um, individuals who are dumped of eligibility only they're excluded. So they fall into that group that are not going to be enrolling in plans. And there was another one about medically needy. The medically needy population mentioned there are the ones who have a spend down or deductible, and they are also excluded for now because they can go on and off Medicaid and to get some deductible status and then need it. I also did want to say there was one for contacts for the EDCI plan, so I can give you the telephone number for that. It is (800) 260-9992. And they are open from eight to 430 Monday through Friday.

Hugh Tilson:

So it's six 30 Dr. Dowler. Do you want to keep going? Or do you want to, uh, I guess I'm sorry I was answering your question in the, um, in the chat, but I think that we probably should honor people's the end time we tell people when we're going to end and we're going to end. So, um, we will answer any questions that didn't get answered, um, and send them out within usually about a week. Sometimes it takes us a little longer. Um, we're going to keep every couple of weeks having these hot topics updates, and we hope you'll join us. Um, because we always have some interesting things coming up, like our new equity payment and some of the other cool stuff. So thanks to the Medicaid team for being here, working on another night. I know everyone's working every night, these days. Um, and thanks Hugh as always. And Nevin. Thank you guys so much. All y'all do. Y'all are doing a great job. Really appreciate it. Thanks everybody. Have a great night. Thanks.