Transcript for NC Medicaid, CCNC, and NC AHEC Webinar Series for Providers
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Presenters:
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Hugh Tilson:
Good evening everyone.

Thank you for participating in this evening's webinar. This forum is put on by North Carolina Medicaid, CCNC, and North Carolina AHEC to discuss recent updates of the state's COVID-19 policy and its real-world application. My name is Hugh Tilson, I will be moderating tonight's forum. Before I introduce our panelists I'd like to take a brief moment to recognize the challenging times everyone is facing and thank all of you for your hard work and commitment to our employees, communities, friends, patients, and everybody else in our state. Thank you for making time in your busy schedules to participate in tonight's webinar. We hope it will help you in that important work.

Our panelists this evening are Dr. Betsey Tilson, our state's Health Director and Chief Medical Officer, Dr. Shannon Dowler, Medicaid's Chief Medical Officer, and Dr. Tom Wroth, President of CCNC.

Next slide please. Here's what we have tonight. We will go through some brief logistics; and Shannon will talk about recent Medicaid DHS -- excuse me -- Betsy will talk about DHS provider updates. And Shannon will work through some Medicaid clinical policy changes, and coding and billing summary. Tom and I will work through resources and support, and then Shannon will go through what's next with phase three. We are going to try something a little different this evening. Instead of focusing on questions, we'd like for you to think about what's missing. We'd like for you to think about as we moved to this next phase of Medicaid policy, phase 3, what else should the state be thinking about? That's what we have planned for tonight.

Next slide please. How will you tell us about how to give us that information? Go to the slide at the bottom and you will see the Q&A function on the black bar. That is how you will submit your suggestions. Those of you who are on the phone can't do that. We apologize for that, only those of you who are on the webinar can use the Q&A function to submit your suggestions. Lastly before I turn it over to Dr. Tilson, we wanted to let you know that we'll record this webinar and we'll make that recording, a written transcript of it, and these slides available to the public as soon as possible on both the Medicaid website and on a joint website maintained by CCNC and North Carolina AHEC. Next slide. Dr. Tilson.

Dr. Betsey Tilson:
Great, thank you. I appreciate everybody joining. I will be relatively brief because I know that Shannon has a lot of really meaty detail to cover with you. But, I'll give a pretty brief update on the status of where we are with COVID-19 across the state. Also to make sure you know where you can get the most up-to-date guidance and numbers and status, so you have that at the ready. And then just a little bit of a high-level summary of some of the new provider guidance we pushed out on Sunday and Monday, a little bit earlier this week. So, that's what I'll have for you.

Please advance to the next slide. Great. Just a little of a current status of where we are with at least lab confirmed COVID-19 cases in the state. As of this morning we were up to 1,857 lab confirmed cases -- and I'll tell you why I stress the lab confirmed cases -- 16 deaths. You can see the number of tests that have been done statewide. More and more labs are coming online and we have our state lab with no backlog now and we'll talk little bit about some of the priority populations in the state lab, but there's also several commercial labs as well as university and health system labs coming online as well, to make testing more available. You

will see the number of currently hospitalized and the number of counties. We have lab confirmed cases in 83 counties, but I say that because we have been acting and have classified North Carolina as widespread community transmission. So even in those counties that don't have a lab confirmed case, they most likely have community transmission. So I think the lab confirmed cases are kind of the tip of the iceberg. So we are assuming we have statewide community spread.

On the top of this slide you will see the direct link on our website to the case counts as well as -- we are putting up more and more granular data up looking at age, looking at gender, I think we have put up or will be putting up race/ethnicity. We also have numbers down at the county level. We have numbers looking at outbreaks in long-term care facilities. We have numbers looking at how many -- what are bed capacity is, what our ICU capacity is, what our ventilator capacity is. So we're trying to put as much up on that part of the website so you can understand where we are and trying to be as fully transparent as possible with our data. So please check out that part of the webpage and see that granularity of data that we are trying to push out.

Next slide please. The other part of our website that I want to make sure you are aware of, on the very top is our overall COVID-19 website. So it's the NCDHHS.gov/coronavirus. That's what it looks like when you go there. And on the right-hand side you will see where it says COVID-19 guidance. I think especially for healthcare providers that is one of the easiest ways to navigate into guidance that is specifically for you. So, if you click on that link.

Next slide, please. Great. Then you will see all the different guidances. And then when you go to health you will see all of this healthcare guidance. And then the plus means that a little accordion opens into all sorts of granularity of guidance. So specifically, for this call the top one, all guidance for healthcare providers and local healthcare departments. If you click in there, then you'll be able to see any of the updated provider guidance including the one that I'll go through. But I just wanted to -- there's a lot of stuff on that website so I just wanted to make it as easy for you to understand how to navigate that website and how, if you're looking for the most updated provider guidance, how to get there most efficiently. I hope that's helpful, because we are putting up guidance almost hourly, so I just wanted to make sure you know how to navigate that more efficiently.

Okay Hugh, next slide please. One piece of the guidance is, as I said, we pushed out some slightly modified new provider guidance on March 29. You can see the direct link there that will get you to that guidance, but you also can get through via that provider's link that I showed you. There weren't as much major changes to the provider guidance as there was last week in terms of thinking through testing, but I did want to highlight a few pieces. One, still maintaining this idea of having as much telehealth, tele-video, tele-triage to not only assess patients initially, but also to reassess patients, especially those in high risk categories. So just continuing to stress that and all the work that Medicaid has done to facilitate that. We are really trying to help you execute on that bullet and I know Shannon will be talking to that, and I want to give Shannon and our Medicaid team a huge shout out for how quickly they pivoted on so many policies at lightning speed to allow you to be able to do this and care for your patients as safely as possible. So that first bullet wasn't a change, but I just wanted to be sure that we are continuing to stress that.

The next bullet is that we have some -- oh, no, go back. Okay good. So we do have updated criteria for specimens sent to the state lab and then a more streamlined process for submission of specimens to the state lab, which I'll go into. Another piece is we cleaned up that providers are no longer asked to fill out that full patient under -- person under investigation form for patients they are testing for COVID-19. We wanted to clarify that. They are still asking -- we're still asking to report those patients to the local health department, but it can just be as simple as the person and their date of birth and address -- so just some identifying information, but you don't have to fill out that full PUI form for patients that you're testing. And then, also just wanted to be sure that you are aware that -- I think back in February or January we did make the requirements, for reporting requirements for suspected of confirmed cases for COVID-19. And then we also did an emergency rule and that is going through our public health rules commission as well, to report for COVID-associated deaths, as well. So just wanted to make sure you knew that as well. There are some other

pieces on that new provider guidance. Goes into a little more on medications, therapeutic options, where we are understanding that. And some other little good nuggets in that provider guidance.

Next slide, Hugh. I did want to just highlight some of the changes specifically to the state lab. We had talked about this verbally, but just really wanted to codify the priority criteria at least for the state lab. And that is, hospitalized patients, healthcare workers and first responders, patients and people who have contact with patients who are in high risk settings. So a lot of congregant settings, not just congregant care settings like long-term care facilities, but also congregant living settings like homeless shelters, correction facilities, migrant farm care -- workers, domestic violence shelters. We wanted to just be sure we were being explicit about those high-risk settings. And then also people who are at higher risk for severe illness and for whom a clinician has determined that results would inform clinical management. We know that's a little bit big, but we want to give you that clinical judgment -- that space for clinical judgment there. So those are our criteria for the state lab. With that, now prior approvals -- having to call and get prior approval, you no longer have to do that. Instead we have this new COVID-19 submission form, which you can get on that provider guidance. You can just use that form, you check off which of the priority areas they are in and then you can submit that form, and you don't have to get prior approval. So we think that will streamline it for our provider community.

Next slide. Just wanted to reemphasize, also, some of the control measures, because I think there was maybe a little bit of concern that we weren't thinking through control measures. So, one thing is that -- when you're testing someone, and also if they're positive then -- although you don't have to submit that PUI form to local health departments, giving that person under investigation form to the patient and having them understand that, is still -- we're still recommending that. And that means that patients are knowing they need to self-isolate and that also understanding the guidance for the household contact. And people should self-isolate if they are tested or even if you are triaging them by the phone, they have mild symptoms -- you are kind of maybe making that clinical diagnosis over the phone. This is the recommendation for patients for self-isolation whether or not they are lab confirmed, or that you are making kind of that clinical diagnosis over the phone. And we try to simplify some of the self-isolation criteria and when someone can be released from self-isolation. So talking to your patients and saying that they can release themself from isolation when they can say yes to all three questions and those three questions are: it's at least seven days since symptoms first appeared -- so everyone should be in self-isolation for a minimum of seven days. It could be longer because in addition to the minimum there has to be three days without fever, without any fever-reducing medicine and then at least three days of resolution -- after resolution of respiratory symptoms. That is the clinical diagnosis for release of isolation. And the other piece then to note is people then don't need a negative test to release from isolation, as long as they are meeting those clinical criteria. They can be released from isolation. Close contact, especially household contact, we are continuing to recommend 14-day home quarantine. I also wanted to be sure, it's not that local health departments are not doing identification contact tracing and control measures, they still are. For some of our counties, now we are having a lot of outbreak in congregate settings, they're going to need to be prioritizing to those congregate settings. But for some of our counties where they still have capacity, they still can be doing that individual contact identification and contact tracing. I just wanted to be sure we were pretty clear on the control measures. I think that is my next slide but if you can go to the next slide I'll make sure. So that is some of the highlights. Again, making sure you know the status across the state, had to get the updated status. We are assuming it's widespread, so even if you're practicing in a county that is not blue yet, assume you have it circulating in your community. How to access all of our guidance. And then again just a summary of some of the changes in that updated provider guide. And I will say ours is probably going to change often and we will proactively push it out but know you can always go to that website to find the most updated one. And with that I am done.

Dr. Shannon Dowler:
Thank you Betsey. Thanks for joining us on the call. Are you able to stay on for the whole call for questions at the end?

Dr. Betsey Tilson:
Yeah, I can. It's okay.

Dr. Shannon Dowler:
Awesome. Alright, well we are going to shift over and talk about some of the Medicaid policies that we're releasing this week, we have another wave coming through.

So Nevin, if you'll go to the next slide. This is just a reminder of telehealth modifications. We're on wave three this week. The first wave was medical, clinical pharmacy, and a large chunk of behavioral health. Last week we released the PT, OT, ST, audiology, dental, and some more behavioral health. This week we're doing, CDSA, LEA, registered dietitians, diabetes educators, lactation specialists, and autism spectrum disorder therapies -- are going live. So we're excited to tell you about those.

Next slide. I did not go put every code that we're covering in our slide deck tonight. And that's because it was literally 10 pages long. By the time you include the LEAs and CDSAs, and all the different codes -- a lot have already been covered essentially in the other telehealth parameters. But we're making it clear they are able to bill for these services. And so by Saturday -- I think probably tomorrow -- we're going to have our bulletin out. We are finalizing it, making the final little tweaks. It is a really long bulletin and we want to make sure we have it as close to perfect as we can for you, so that when you get it you can run with it. We have gotten confirmation from our team on the IT side that the claims will be able to be accepted on the seventh, possibly on the six, but just to be safe I would say on the seventh. Just in case they run into any glitches over the weekend. And then again, like all of our telehealth provisions and virtual health provisions, they are retroactive to the 10th. Those for of you who have been doing this work, just because you're not wanting to differentiating between payers for your patients, you will be able to go back and bill for services. So this wave is really focusing on those LEAs, local education agencies, the children's developmental service agencies. We added in diabetes education in there, registered dietitians, lactation services -- that was feedback from a recent webinar, someone said 'what about lactation?', and we hadn't included them, so we were able to add it on. And I just say that so you know your feedback really makes a difference. And then a series of codes for research-based behavioral health treatment for autism spectrum disorder, are going to be going live tomorrow. They will go live officially next week but you'll get the bulletin tomorrow, so you'll be able to see what the codes are. But again, retroactive to the 10th.

Next slide. I wanted to give you a heads up about some other things that we're working on that I think are pretty exciting. Next week we are going to have the ability for prescribers to provide 90 day supplies of stimulants -- buprenorphine for appropriately identified patients. That's not going to be the right quantity for everybody but you are going to be able to do more than a 30-day supply. This was some feedback we received, a lot of the pediatricians have asked for longer ranges of the stimulants just to keep kids out of the office. And so we are going to have that live next week. Medical Board and Board of Pharmacy and DEA are all in support of this change right now in the COVID environment.

Another thing we got a lot of feedback on is there has been a loud request for telephonic care to be reimbursed at the same level as telehealth or face-to-face visits. And we really have struggled and wrestled with that. We recognize there are some places where folks don't have access to internet in the state. There are places in the state where you don't have access to cell phone either. And some patients are resistant to using virtual health or telehealth services. And so we want to honor that. At the same time, we feel really strongly the integrity of the medical visit is important, in that if you can lay eyes on the patient you are going to learn more from laying eyes on them than you are just with a phone call. I think that's true in a lot of the kids we care for, seeing their home environment, or maybe our other patients where -- I don't know how many of you have done home visits, I have done home visits for 20 years, I love doing home visits because you understand your patients. Telehealth allows you to do those home visits and you learn a lot from the environment. At the same time, we know not -- everybody can't do it. So rather than just saying no, what we're saying is we are going to create a COVID differential so we're going to reimburse telephonic care at a higher rate right now. So have got the finance team working on that. Coming up with a rate that's not the full EMM rate. It's going to be a little bit of a step down, but will be certainly significantly better than it is now. So just making you aware of that. Another thing, feedback we got, is that beneficiaries have been resistant or hesitant to engage in care this way. So we are actually sending out a letter to all the Medicaid beneficiary households, encouraging them to engage with their providers with telehealth, and using that resource during

the COVID time. And we are also writing some letters to the editor, we have got a -- NC Health News is going to do a story on it, we're trying to really get the message out and advocate for folks to feel comfortable using telehealth. I've heard so many stories now of older patients that have used it and been thrilled. And have said why in the world haven't we always done this? You know? Now I don't have to drag myself across town to the doctor's office and try to find a parking place. So I think once people do it, they actually like it a lot. But we know that you guys need some support in helping beneficiaries feel comfortable, so we're going to be doing that.

One of the things that came out of some of the federal work around was the F-mapping. That's the federal match we get for Medicaid patients. And to qualify for that, we are not allowed to collect co-pays for COVID-related care. So for medications it's easy because there's no specific COVID treatment right now that's FDA approved and clearly the treatment for COVID. So we wouldn't collect a copay for that. But we're asking practices to not collect co-pays for patients that have COVID-related care. And what we're going to do with the end of this timeframe, probably in six months, is we will do a true up. We'll see what practices would've gotten in co-pays based on symptoms and the codes that have been recommended by the CDC to be used for COVID related symptoms, and then we will true up and make those practices whole, for not collecting that copay. So I am just asking you now, we have said all along don't turn somebody away if they can't pay, but now we are asking you not to collect a copay if there's COVID-related care and we will make it right at the end of this. Another thing that is exciting news is we are not going to be terminating beneficiaries until the state of emergency ends, and so that's true for your patients that – it's just they're due to re-up and can't get their paperwork together, or for whatever reason they're having trouble getting in. No one is going to get terminated during the state of emergency. That includes your pregnant women. So if their postpartum Medicaid is going to end at 60 days, and that falls during this time, they are going to continue to have Medicaid services until the end of the state of emergency. So I think that's really exciting news and I wanted to share that with you all today.

Next slide. So now we are getting into the less exciting stuff.

Next slide. So I was having a pity party this morning as I was going through all the emails about claim problems and trying to understand all the billing things and put together this little -- I like to sketch normally but since I'm on the computer all the time now, I've gone to this. But we are hearing loud and clear everybody wants us to turn everything on really quickly. And we've said, guys we're working so fast, we are turning the Tanker around in a narrow canal and they're going to be waves and it's going to be messy. Give us some grace once these codes go live, because it's not going to be perfect. And sure enough it has not been perfect, as I predicted. The team has worked really hard; the noise level went up really high on Monday of claim problems, and stuff not going through well.

So Nevin, if you'll go to the next slide. We are well aware, we have been aggressively changing our policies and trying to get the processing system updated to reflect these. And one of the things that happened is people were getting paid but they were getting paid at a lower rate, and so we had to figure why that was happening. And it turns out that it was because of the place of service and what we thought was going to work for place of service -- it did work but you didn't get paid the right amount, so in essence it didn't work. So we've got some [Indiscernible]. We are going to fix the denials. We're going to help you work through all this. When we come up with a fix we will put it on a bulletin to everyone we know. Just know that I have been forecasting all along that it was going to be messy because we were moving so quickly. Normally a nine or 12-month process, we are doing in a week. So of course it's not perfect. Just stay in touch with us. Use this Medicaid.COVID-19 to send your questions, your concerns. I'm getting a lot of personal phone calls, and emails, and text messages, and Twitter messages, Facebook messages -- people are finding me everywhere to let me know about their coding and billing problems. And I will tell you that this is not my strength area. As a family doctor who's practiced for 20 years, there are a lot of things I'm really good at -- STDs are one of them, I love STDs -- digging into the nuances of billing and coding has never been my strength area. It's like asking my mom to teach you about new technology. So I am learning as fast as I can but you're going to get better answers if you use this Medicaid.COVID email address. They're going to help you much better -- much faster than I will.

Next slide. Just to give you kind of an overall -- if you've been struggling with claims not going through, a couple of the things that we learned this week as we went through is -- we put a couple pearls in here. The main thing is, with dental, specifically, dental is the only place that we are going to actually have you use place of service 02. Because if you use that in the other therapies in care, it actually makes you have a lower reimbursement for some reason. And so we don't want you to do that. So if you're not dental, we want you to use whatever your usual place of service is. RHCs, FQHCs, private practices, hospital-owned practices -- everybody has a usual place of service, and your billing and coding people know that. Dental is the only one we need you to use the 02. Ironically, dental's the only one that you shouldn't use the modifiers on. So that GT modifier should be on everything that's a telehealth, meaning audiovisual visit. You're going to want to use that GT modifier with the CR, that is our catastrophe disaster-related modifier. That going to help us make sure that we don't deny a claim because the length of time is different. We have some funny nuances on [Indiscernible] in these claims, so that CR modifier allows us to know that. And if we get audited down the road no one is going to be coming after you for the money, because we are going to be able to explain why we approved those codes and paid you for it. Ironically though, even though dental is the only place you use 02, you don't use the modifiers there. So if that's not clear as mud.

Next slide. When we are talking about our behavioral health service it's really the same thing. Telemedicine, tele-psych – you're going to want to use your regular place of service. GT modifier telehealth, the audiovisual communication. CR for everything. And then if you're just doing the virtual visits, you don't want to use that GT modifier. So you're doing portal communications or telephone then you don't use GT for that.

Next slide. Saying, tele-psychiatry, we ran into a few funny things there, too. Don't want to use the 02, use your regular place of service. GT modifier for telehealth with audiovisual, CR for everything.

Next slide. So here is the good news. We have been working really hard for a week on a really succinct table that tells you all of this. Because it's so complex, we actually wanted to give it another day or two to finalize it and make sure we have all the places of services right and everything is correct. And then we're going to put it out on the website with our bulletins so that you will be able to reference it by the code, by the type of provider you are, and we're also going to link it to where you can find the bulletin that explains it in full detail. So we hope that's really going to help folks answer the questions and feel a little more empowered doing some of these things. Because I know a lot of people are really worried about doing it wrong or getting in trouble or being audited. We don't want that to stop you. So we are going to put as much information out there for you as we can.

Next slide. There is a specific frequently asked questions guidance that was placed yesterday on the website, I met with the CMOs of the FQHCs as well. But FQHCs and RHCs have a different – they live in a different universe of billing and coding than everybody else does. And they have really unique rules and our systems can be super sensitive. So there is an FAQ out there for you guys on the website right now to help guide you on the nuances you need to be aware of for your billing.

Next slide. One of the things we did with the payer counsels, we have been working with all the different payers around the state, trying to make sure we were as aligned as possible. I think I've shared this with you in prior weeks, this is now on the website available for you to see, where each payer in North Carolina is saying whether they cover telephonic, e-visits, and whether they are doing parity payment with telehealth, and what their telehealth restrictions are. We are -- our next meeting with them is next week. And we are going to try to come up with the same guidance we have created for everybody related to the modifiers and place of service. We're going to try to do that for all the insurers for you, so you can see what everybody is asking for. That's our next goal.

Next slide. All right. I'm going to turn it over to Tom and Hugh to talk to you about how you can get the information and help you need to be superstars in this virtual and telehealth world.

Hugh Tilson:
Great, thank you Shannon. This is Hugh. I'll take it. You mentioned how quickly you are moving and I think every call we say thank you for moving so quickly. We recognize that it's messy and far from perfect. But boy, without you moving quickly we'd be in a world of hurt. So thank you so much and all your team for doing that. So CCNC and AHEC are partnering with you to put this information forward. We also partner with you to make resources available to practices out in the community. I'm going to talk about some of those.

So Nevin, will you go to the next slide. We're talking about -- sorry, I got the slides wrong. Can you go back, Nevin? Tom are you talking about telehealth or am I? I'm sorry.

Dr. Tom Wroth:
I think you are, unless you'd like me to.

Hugh Tilson:
Yeah, would you mind?

Dr. Tom Wroth:
Yeah, so, this is really just describing that the CCNC and AHEC teams on the ground are developing a bundle of services for the primary care delivery system out there, to really help you implement telehealth, figure out billing, figure out the best practices around workflow and around the technology. And this is just sort of a list of those services that are being developed to be ready for you.

Hugh Tilson:
Next slide. So we are also working on regular practice support services, we have coaches and experts that are out intersecting with you, physically when we can when we're not socially distancing. And when we are, we do it virtually, providing all the updates you need from DHHS, from Medicaid Public Health, from CMS, from CDC. We're also providing financial assistance updates on federal programs from loans and grants, loan forgiveness, and stimulus package. We've updated information about that and we are actually working on some specific communications together that should come out next week that can be very helpful. Also helping to do COVID-19 specific education skills, triage guidance and testing protocols, other relevant skills and supports. As well as overall operational efficiency. We know many of you have already worked with us on all of these but we are still around to help with those in the COVID-19 environment.

Next slide, please. Also providing technical assistance on billing and collection, EHR optimization and how to connect to NC health connects. Working on coordination of care issues. Making sure you're able to continue to provide that great care in this new environment, as well as care management, quality improvement, and helping you to access community resources as we increasingly are dealing with social determinants of health.

Next slide. That is what we are doing. How do you get up with us? Our practice support coaches, and experts can be reached at any of these email addresses or these phone numbers. And just know that just like these webinars are designed to help you navigate what you need for your practices to be successful, we want to make sure that as you need specific information, either CCNC or AHEC are here to help you with that. Next slide.

Dr. Tom Wroth:
Thanks Hugh. This is Tom Wroth from CCNC. I just have two announcements we are excited to let you know about and few reminders. The first is that CCNC in partnership with the state is starting a COVID triage plus nurse advice line. This is going to go live on Monday, there'll be lots of information coming out about it tomorrow and leading up to Monday. So this is an inbound call center to provide information to North Carolina residents regardless of payer status. And also, individuals that are experiencing symptoms, it also will be a clinical triage line. This is staffed by CCNC RN care managers. And those care managers will

also able to link individuals to services through the 211 system as well. So here is the phone number that will be going live on Monday. It will be staffed from 7:00 a.m. to 11:00 p.m., seven days a week, including holidays. We're very excited to get this up and going and there'll be more information coming out about that.

Dr. Shannon Dowler:
Can I just jump in, Tom? This is really exciting. And I think this is going to help unload your practices, all of them, because you're getting a ton of calls and if patients start looking at this as the reliable place to get information, hopefully they'll unload your practices and then you'll just get the ones that you need to be getting in your practices. So we are really excited about this partnership. And also that it's for everybody. They are going to help guide anybody who calls no matter whether they are Medicaid, Medicare, uninsured, or what. So this is, I think, a really exciting development.

Dr. Tom Wroth:
Thank you, Shannon. That's great.

Nevin, next slide, for the next announcement. And as we are all trying to convert to telehealth, that's a lot of the major topic of this call, CCNC as part of our services are going to be putting out a telehealth platform in partnership with DocsInk, which is a North Carolina based telehealth company. So we'll be providing that telehealth platform at no cost to CCNC and rolled providers. And again with the supports with AHEC and our practice support folks, will be helping you implement and use it most effectively. There will be information coming out about that on our website. And just an additional announcement to remind you that North Carolina Medical Society announced today that they'll be launching a platform as well called Presence and there's more information on their website.

Next slide. So some reminders, Shannon mentioned some of these but some of the resources, you've got the Medicaid.COVID email, the website, the bulletins. These are just reminders for you all. When you get a copy of the slide set.

Next slide. And another reminder that AHEC and CCNC are creating a website that has general information about COVID and some of the Medicaid billing two-pagers to help you navigate some of those complexities Shannon was talking about. And other resources including some resources around financial assistance.

Next slide. And again, here are some links, I'm really excited to hear about the DHB package that will bring together all the coding changes with links to the Medicaid bulletin, because that is really the best place to go. But you can see here Communicare has put together a couple of two-pagers as well, which we'll keep updated.

Next slide. And some reminders on webinars, remember that tomorrow, Friday -- every Friday -- there is a DPH AHEC webinar to provide updates with providers. We will also continue these Thursday webinars and next week, look out for an announcement around helping practices navigate the new financial assistance available through the Cares Act and other loan and grant programs. That webinar is planned for Tuesday at 6:00 p.m. and there will be more information coming out on that as well.

Next slide. All right, Shannon, what is next for Medicaid?

Dr. Shannon Dowler:
Alright, let's see. So we have got exciting things coming. Sorry, I was looking at the -- I get so excited by all the questions and I want to answer all of them.

Next slide, this is my visual dump from yesterday when I was feeling sort of overwhelmed by everything that was going on and all the changes we were making and wanting to coordinate it. So the way this is working in my mind from the Medicaid clinical response to COVID is we have phase 1 which was the early work we did. Phase 2 which is what we are just wrapping up this week with the third wave of the telehealth provisions. And moving into this whole new phase, which is phase 3. We have a bunch of federal authority

issues that are still pending. We have an emergency disaster spa that's going to have a lot of things in it. We have got our 1135 waiver that has been submitted and is pending. We have now submitted an 1115 waiver, so I need to add that as well. And then we have our appendix Ks. All of these things are still pending CMS to sign off on completely. But as those things are released we're going to have access to a lot more resources. That is where our insured fund comes, where we are going to be able to pay for cared for uninsured patients and help with housing and food and all sorts of things we can't do yet because we're waiting on CMS authority.

From the pharmacy, I told you about the stimulant and the MIT 90-day supply change. We are looking at how we could allow home delivery for medications. Medicaid in North Carolina hasn't paid for that before or allowed for that but we are looking at that. From a DME standpoint we are thinking about can we get scales for pregnant women. I sent an email right before this call, saying what about pulse oximeters, what about Dopplers, what are the things we can put in the hands of patients to keep them out of the hospital or even out of our clinics. So we can do telehealth visits and feel more comfortable with it. We are creating a transport reimbursement for ambulances that go out into a home but don't need to take somebody to the hospital. That's requiring a state plan amendment. There's CCNC's triage line which goes live, which is really exciting. And all the practice support that AHEC and CCNC are doing to try to get practices where they need to be, so they are doing as much as the work is they can.

The next wave of telehealth that we just started working on today is what are we doing around well-child care, prenatal care, remote patient monitoring, and another set of non-licensed provider work. Those are going to come out a little more slowly. Next week is actually a week where we're going to try to make sure we got everything working; that all the claims you're sending in are getting paid appropriately. Work on that rate change, we are going to be kind of tweaking and doing our research. Then the following week we hope to have remote patient monitoring things and some prenatal care things coming out. One of the things for instance right now, the prenatal risk assessment and the postpartum assessment are going to be made available as virtual care. That is one of the things we are exploring. We are also thinking how do we get immunizations to kids who are high risk or whose families don't want to bring them to the office or have transportation problems, same with pregnant women. How do we the get care to them so that they don't end up missing important visits? Knowing that people are sheltering at home. We are getting kind of creative.

We are also going to continue to, as we hear from people and hear about codes we didn't approve, folks are giving us explanations and reasons why we need to approve them, they're going to continue to come out as we identify the things we might have missed or we were skeptical about but we decided we were going to cover. Just know we'll to continue to update you weekly on the new things that are allowed. So lots of work coming up. We are not stopping, not by any stretch of the imagination. But I do think next week will be a slightly slower week where we're going to just really make sure that we're doing everything we said we were going to do as well as possible, so that we are ready for the next wave of work. Okay.

Next slide. So this is where we ask you guys, what are we missing? So Hugh, do you want to pull up -- or are there any questions you want to hit or, I know there were some for Betsey in there. If people are throwing out some ideas of things that they think will be helpful to cover that we haven't yet covered. And we have got Kate Menard who is one of our OB leads in the state, on the phone. Originally we were going to do some cases until [Indiscernible] sideways this week.

Kate, I would be curious of -- are there other things around the OB world and pregnant women that you would like to see us do that we haven't talked about yet? If you can unmute yourself. You may not be able to.

Dr. Kathryn Menard:
I did put some ideas forward previously that you have seen already, and thank you for accepting those. But I think the things that you mentioned tonight, that you're acting on -- it'll be so helpful. The one thing I am hearing from folks that practice in rural areas is that the telephonic and even the virtual telehealth option are not available. So, so many women as you're aware. So thinking about creative ways to tackle that, I know with your waiver you may be able to pay for food, and pay for different -- what about different options for

self-service that rural areas might not have available, that might be -- I don't know the different networks and different places, but I understand some networks cover in some areas, I think that might be worth attention. If there's an opportunity to see where it is and isn't and sure that up. We have had a lot of success with limiting the number of prenatal -- these are well women we don't want bringing into an office. Right? And we have had a lot of success with telephonic and virtual visits in our practice. And I'm hearing that across the state as well.

Dr. Shannon Dowler:
That's great. Terrific. The Q&A list.

Hugh Tilson:
So do you want to start with Medicaid or the clinical? How do you all want to handle that?

Dr. Shannon Dowler:
Just surprise us, throw them out there.

How about substance abuse intensive outpatient program and SACOD telehealth, is that being looked at or something that's not yet addressed?

Dr. Shannon Dowler:
Carrie, are you able to talk, are you on the phone? Beth, are you able to pick up on that one?

[Beth Daniel]
I think we are looking at these other -- in the next wave two weeks from now, but I am not sure for sure.

Hugh Tilson:
If you keep sending in your opportunities, then we can focus on those.

Somebody said Medicaid expansion something that's not on your list and we know that it something that is being worked on, but couldn't pass up the opportunity not to talk about that.

Dr. Shannon Dowler:
You got it. At this time, I will tell you that we have decided we don't want to politicize COVID. Really what we want to do is take care of as many people, the best way possible without getting into partisan politics. So we are doing everything we can to find ways to cover patients. So a lot of these waivers we have asked CMS for is asking for funding for the uninsured. One of the things I've asked for is to turn all family planning Medicaid patients into full Medicaid patients during this time. Some people can say that the same thing as expansion but we are not calling it that. I think really just want to be as effective as possible with what we are doing.

Hugh Tilson:
Can I do telehealth to an established patient traveling out of state? Are there any legal implications or concerns about that?

Dr. Shannon Dowler:
That is a really good question. My gut is to say if they are your established patient in your practice, then you can. It's different for a provider that's not in the state and that's not a licensed person in the state, they are not allowed to practice in the state. But the other way around, Tom, what is your reaction, or Betsey?

Dr. Kathryn Menard:
I might be able to respond. I have just been reading and haven't implemented it but reading that nationally, the requirement of billing across states has been waived. Is that your understanding? With telemedicine, you need a license in telemedicine for example for me to go to West Virginia I would need that license. But that that requirement has been waived.

Dr. Tom Wroth:
This is Tom. The advice I've heard as well is to also check that state's medical board. Most of the state medical boards are waiving it. But you might want to go to that states website and ensure the waiver is there.

Hugh Tilson:
Can you define COVID-related care? It seems like tele-visits for diabetes are COVID-related because they are 'tele' because of COVID. How do you define COVID-related?

Dr. Shannon Dowler:
That's really vague in this federal guidance. It's more specifically related to a COVID infection. And so we are interpreting it that way. To say, if someone is coming in COVID positive and you're doing follow-up care we ask you not collect co-pay for those patients. But if it's routine care, you could go on and do that.

[Beth Daniel]
Dr. Dowler?

Dr. Shannon Dowler:
Yes, ma'am? Am I wrong?

[Beth Daniel]
We did put in the methodology for people who are following people with chronic diseases like diabetes to do their follow-up visits through these different mechanisms we put in place and we did ask them to put the CR modifier on there because they are having to do that visit because of COVID.

Dr. Shannon Dowler:
This is something different. This is around the requirements for F-map, say at the federal level that we are not allowed to collect co-pays in order to get the F-map, if it's COVID-related visits. So I think the guidance, and there is more coming out, we will have something in writing next week about this, was that we are just going to say if it was COVID-related care you should not collect the copay.

Hugh Tilson:
Moving to more clinical public healthy stuff, is it possible to share the expected case growth curve so we have some perspective of the potential length of the state of emergency?

Dr. Betsey Tilson:
That is something that we are working on with our modeling team. Of course we all want to have that answer. We are needing that answer to think through our planning, our surge capacity, thinking through the policy decisions, if we need to implement more social distancing, when can we lift social distancing? I will say that the precision on this is not going to be great. There is not great data to put into these models. I think you have seen, there are different models that are coming out across the country. There are a lot of different models that are actually coming out of our own North Carolina institutions. Every model shows a different peak, different lengths. We have convened a team with a bunch of our university partners as well as RTI and some of our own internal science to really look at -- and using North Carolina's data -- to help us think through what's our North Carolina model look like? We are working on that. We are hoping to get more of that modeling data, a little bit more precise, we are hoping soon. Because we all need that answer, when will the peak hit, how high will the peak be, and how long will this last? And then what is the effectiveness of our social distancing so that we can lift that up. So, it's a great question. It's one we all want and are working hard on. It's not ready for prime time. But as soon as we feel a little bit more confident in some of that, then we're going to start releasing that publicly as well, and that is something we will be putting on our website and we'll be releasing that once we are a little bit more confident in that.

Hugh Tilson:
Focusing on a little more specific, questions about when to release somebody from isolation. Complete resolution of symptoms for three days or improvement? Some cough after viral illnesses can last three or four weeks. How do you define improvement?

Dr. Betsey Tilson:
Yeah, so, the wording -- improvement in symptoms is what CDC says. I think that certainly resolution of fever. And then it doesn't have to be complete ending of any symptoms but pretty significant improvement, I know that a wiggle room but that's the wording from CDC. Pretty significant improvement in respiratory symptoms.

Hugh Tilson:
Are there requirements to alert contacts of the COVID-19 positive patients?

Dr. Betsey Tilson:
So if someone is positive the health department is the one that does that contact tracing. And so, that is when you report a positive to your health department. That is a conversation you want to have with the health department to understand what they can be doing, what the extent of their investigation will be. That is a conversation with your local health department and their capacity. Typically, that happens through the health departments, but if you are in health department that they are so overwhelmed with multiple congregant settings, then understanding where they are with that and how you can play a role in that contact tracing, that's a conversation you're going to want to have with your local health department.

Hugh Tilson:
So Tom, will your call center be able to handle Spanish speaking callers?

Dr. Tom Wroth:
Yes, they will. I'm pretty sure that is true but I will confirm whether that is covered through all the shifts.

Hugh Tilson:
Betsey, a couple questions about daycare. Why are they still open and how are practices supposed to respond to questions from parents, about that?

Dr. Betsey Tilson:
We have a whole tab on daycare on our website. We consider daycare really an essential workforce, especially when we think about healthcare workers, or front-line workers needing daycare. So our guidance for daycare is for people who don't have to send their kids to daycare, we recommend that they don't. Again, part is that opening up that essential infrastructure for our healthcare workers, for people who have to send their kids to daycare. We have healthcare guidance for daycares if they are staying open and they have to be adhering to these health guidances. That is all there on that website as well. We want to be sure that some daycare stays open, stays open safely. It is an essential infrastructure and again especially for our first responders and our healthcare workers, needing to have that option. But if you have a family who does not need to send their child to daycare, we recommend they keep them home. Mostly because we want to be sure daycare is available for our healthcare infrastructure and again that we are working with our daycares and we have guidance on -- health and safety guidance if they are going to keep the daycare open. All of that is on our website under our childcare tab.

Hugh Tilson:
Shannon we've got a question about the public outreach to encourage telehealth. We know you're doing a mailing directly to Medicaid patients and recipients. Any thought about doing a more public media blast type of approach?

Dr. Shannon Dowler:
Yeah, I had a meeting with some family doctors and some pediatricians last night and what I really encouraged them to do was, a lot of doctors have good relationships with their local media. What I would say is go to your local -- I am up here in Asheville where we have WLOS. I would say call WLOS and say I think you should do a story on telehealth and how easy it is to do and why folks should do it, I'd be happy to do that for you. So I think if folks can reach out to their local media to encourage this it would be far more effective than us at Medicaid doing that. I'd be happy to but I think you'll be -- local media usually likes that a lot more. So letters to the editor, gets one demographic, but I think getting on your local news station would really be the way to do it. We are open to suggestions. We are going to have an entire list of web links for people to go to, to understand telehealth. We are looking at what's out there as far as nationally, high quality, this is what you can expect in a telehealth visit. Things to help patients feel less anxious about it. So we are looking for some of those resources now.

Can I jump in? I was getting a couple questions around pressure monitors. And this is just a reminder we did approve those, last week. So as of Monday you can order blood pressure devices for your patients, we didn't limit the codes. The idea was more for pregnant people, folks with hypertension, and chronic kidney disease. You order it through DME, so it's through a durable medical supplier, it's not through a regular pharmacy. We can't do it that way. Just to let you know that is available and we want folks to use that while we've got the resource.

[Beth Daniel]
Shannon, I will jump in that we have been working hard to contact the major DME carriers and that sort of thing to bring them on board. It's just taking a little bit of time to get the processes in place, particularly for the patient's we're working really hard to disseminate the how to. They are not used to ordering [Indiscernible].

Dr. Shannon Dowler:
That's great. And I have asked our head of DME to see if he can make the paperwork a simple as possible. I know one of the things I can't stand in practices all the forms to order things. If we can simplify it so we are looking at that right now as well.

[Beth Daniel]
That's great. Can I add a question, ask a question I have heard from others regarding, do you mind?

Dr. Shannon Dowler:
Jump in.

Hugh Tilson:
The use of surgical masks in the ambulatory arena is little bit by little bit getting out there. Some organizations have adopted it completely, I understand admission they have the supply and they're doing that, they just kind of turned it on two days ago at UNC. Is there guidance from the state related to that? That's the first question. The second question is what about individuals in public places, is there any movement toward or thought toward putting out recommendations about that?

Dr. Shannon Dowler:
That's a Betsey question.

Dr. Betsey Tilson:
There are lots of conversations about masks today, including -- I was sitting quietly and in popped the governor and he said 'hey Dr. Tilson what you think about masks?', so I've had the conversation today. A couple things. One, again, we think widespread community transmission, we also know that there will be people who are -- will forever be asymptomatic with their illness, we also know that there is some pre-symptomatic shedding. So as much as possible in a healthcare setting, is thinking through universal

precautions, would be great. Now, we also have a national PPE scarcity. So you have to balance those two. But thinking through, surgical masks are more for source containment. So preventing an infected person from pushing out stuff. Sure, masking all your respiratory patients could be a strategy of masking all patients because they potentially are sources in asymptomatic. I think also in our provided guidance we also said that if you have the supplies then also routine mask and gloves for all providers for all patients encountered is recommended as well. Kind of universal precautions. We think we have widespread disease. We know there is some asymptomatic people. Kind of universal respiratory precautions if you can achieve that would be great. Publicly. So, boy it's getting a lot of attention and I was deep into a paper on all the science behind face masks. Again, masks are more source control – so what we are saying to people was at first stay home, stay home, stay home -- if you're sick stay home, stay home, stay home. Really them -- but if someone is sick and really leaving their house, then using a mask then would be recommended. I think that we want to be sure that we are preserving what surgical masks we have for our healthcare workers in healthcare settings, so there is a preservation piece in terms of recommending it to the public. How much the idea of asymptomatic spread and then therefore somebody in the public wearing it to protect the world from them, if they're asymptomatic, we will have to think through the risk of benefit of that. There is also some downside of -- if you wear a mask, then maybe there's this kind of false sense of security and then you're doing social distancing and you are not doing other precautions. So there is some risk of mask-wearing for the general public. And then finally the idea of these homemade and cloth masks, in the article that I just read about two hours ago is that cloth masks are really not terribly effective and then can give a false sense of security so they may do more harm than good. However, I will say that, in the course of this call I did get a text from one of my colleagues saying that the CDC might be putting out something about cloth masks for the public. I am not sure if that was a rumor. I'm not sure what science they are basing that on. But I think we are in a fair amount of un-science territory right now with the recommendation for masks for the general public, especially cloth masks for the general public. I think we are messy right now. How about that?

Hugh Tilson:
That is a great way to tie everything up. It is 6:30. We need to put an end to this. I will tell you we got a lot of questions we did not get around to responding to. We will print all these out and try to get answers to you.

Dr. Shannon Dowler:
Hugh, also if folks will just send their questions we didn't get to that Medicaid.COVID-19 at DHHS.nc.gov, we have got a team of people working on answering questions.

Hugh Tilson:
Can you go back to the slide and put that up? Keep going. Keep going.

Dr. Shannon Dowler:
There you go, at the top there. Medicaid.COVID-19.

Hugh Tilson:
Do you have anything you want to say before we hang up?

Dr. Shannon Dowler:
We just appreciate everyone's engagement and that you're taking time after hours to listen to this and to give us feedback and to be so involved, we couldn't do it without you. Keep the great ideas coming and know that teams are working around the clock to make sure that you're getting what you need so you can take care of our folks in the state.

Hugh Tilson:
Thank you all very much for making the time to do this and thank you everybody for making the time to participate. Everybody have a nice evening.

Dr. Shannon Dowler:
Thanks.

[Event Concluded]