Better with Time: Managed Medicaid Update
October 1, 2020
5:30 – 6:30 pm

Hosts:
Hugh Tilson, Director, NC AHEC
Dr. Shannon Dowler, Chief Medical Officer for NC Medicaid

PHP CMO guests:
Michelle Bucknor
William Lawrence
Genie Komives
George Cheely
Michael Ogden

Hugh Tilson

Good evening, everybody. Let's go ahead and get started. Thank you so much for joining us in this evening's webinar for Medicaid providers. tonight's webinar is the first in a series of informational sessions put on by North Carolina Medicaid and NC AHEC to support providers during the transition to Medicaid managed care. We'll put on webinars on the first Thursday of the month on Medicaid managed care. And the third Thursday of the month, Tom Wroth president of CCNC will join us to discuss relevant clinical and quality issues. We'll send out information on the topic for these webinars in the future. The NC Division of Health Benefits and NC AHEC have partnered to ensure the health care providers across all 100 North Carolina counties have the information and support they need to adapt to and thrive under Medicaid managed care. This collaboration will produce educational webinars like these and virtual office hours across a variety of relevant topics. In addition, the partnership will make AHEC practice support coaches available to provide one on one assistance directly to practices.

Our theme for tonight's webinar is Better with Time, Managed Medicaid update. I'm Hugh tilson. I'll be co hosting tonight's webinar with Medicaid Chief Medical Officer, Dr. Shannon Dowler. We'll be joined by some very special guests the CMO's of the Medicaid prepaid health plans. As you can see, we have an ambitious agenda this evening. In addition to getting updates and other timely information, you'll get to know the PHP CMO's do a fireside chat with them a Dr. Dowler. Then we'll turn to your questions. Before I turn it over to Dr. Dowler I'd like to run through some logistics. First, if you need technical assistance with anything, please email us at technicalassistancecovid19@gmail.com. We'll have our PHP CMOs join us by video later in the webinar. You'll see their names on the screen now you can hide those so you don't so you can see the slides better. To do that, click on the up arrow on the right side and video icon in the lower left of the zoom webinar screen. You'll see video settings there, click the hide non video participants icon. Don't worry our guest speakers will appear later when their video comes on. The slides for tonight are available on the AHEC website, follow the link from the main webpage www.ncahec.net. Please also check in the q&a, where you can see a link to those the slides. There are no hot links in zoom. So you have to cut and paste that into your browser. But that'll take you to where those where those slides are.

When we get to questions, just know that everybody other than our presenters is muted. You can ask questions or make comments either by using the q&a feature in the black bar on the bottom of the webinar screen. Or if you're dialing in by phone, send us an email to questionscovid19webinar@gmail.com. We've learned in the past that the presenters will often address your questions during their presentations. I encourage you to wait to the presenters or through their presentations before submitting a question. Please know that we'll send any questions we don't get to Medicaid so that we can work on them into future webinars live We're going to record this webinar. And we'll add that recording and a written transcript of it with these slides on the AHEC website as soon as possible. Probably first thing tomorrow morning. Now, let me turn it over to Shannon.

Dr. Shannon Dowler

All right, thanks so much. So thanks, everybody, for joining us tonight after a long day's work. We appreciate you joining us and getting to know your CMOs and hearing some updates. So we're here today to talk about Medicaid transformation. It had been delayed for several months, and now we have a go live date. And so we've picked up all that work. And we're moving forward. Just to remind you, our goal with transformation that is to improve the health of North Carolinians through an innovative whole person centered and well coordinated system of care that addresses both the medical and non medical drivers of health. That's a pretty tall order. As we move to managed care, we expect somewhere between 1.6 and 1.8 million beneficiaries will move over, the uncertainty of that number is really because of the pandemic. A lot of people have lost health insurance. And we're seeing our Medicaid rolls increase as a function of that, we think we'll have about 200,000 new members of Medicaid as a function of job loss and from the pandemic.

Beneficiaries will have the option to choose from five different PHPs. And this is not new information. This is information that you had before, but specifically Amerihealth Caritas, Healthy blue, United Healthcare, Wellcare and Carolina Complete Health for regions three, four and five, we go live July 1st. So right in the middle of some people's beach trips, it's gonna happen, no one will be taken vacations on our parts for the summer. Some beneficiaries are going to stay in fee for service, because it meets their specific needs, or they're in a limited benefit program. And those beneficiaries will be in what we call Medicaid direct. Next slide.

So in case you've forgotten what region you're in, here's a nice visual overview of the regions in the state. I know there are a lot of different regions for different things. But these are the Medicaid managed care regions. Next slide. So as we're going live with managed care, there are a bunch of things going on in our lives as there are in yours. Certainly COVID-19 has created a lot of extra work and different work for us at the department, you've been really engaged, a lot of the providers out there have listened in and participated and given feedback on the ongoing work around telehealth. But we're rapidly responding to things as they come up still. And then at the same time that we're going live with standard plans, we're getting our tailored plans geared up. And so our Request for Application for our

tailored plans to be ready for July 2022 launch, which seems like far away, it's really not, that's going to be coming out soon. We're also working on a very unique program with the Eastern Band of the Cherokee Indians to have a tribal option. And that's going to go live in July with the standard plans as well. So lots of work happening in the Medicaid team. Next slide.

So when we think about timeline, and you think about what your beneficiaries or patients are going to experience, it really starts for them in March. And that's when open enrollment happens. And during that time, they'll have the chance to choose on what plan they want to be in and choose you as their provider. If they don't choose, there's a whole very complex process where they will get enrolled into another plan. And then we go live with managed care. And there will be a period of time where they can change that. So if they don't sign up, or they sign up and they change their mind, there's going to be a period of time where they can modify that. But for you, providers in the field, and for us the DHB and with the PHPs t he fun starts way before March. Next slide. So there is a ton of work to do to get ready for implementing managed care. One of the big things is stakeholder engagement and how we work with the beneficiaries to make sure they understand what's getting ready to happen with their Medicaid benefit, and in how they're best situated to sign up for a plan and a primary care provider and other things. But there's a ton of background work around developing rates, working on the CMS approval for a lot of the things that we have to get the federal authorities to do. We've got this provider directory that many of you are familiar with. We have to finalize our auto assignment what to do with those beneficiaries who don't pick a provider we've did it goes on and on. And I'm not going to read this whole slide but leave it, the bottom line is a tremendous amount of work has to happen for this to roll out smoothly. Next slide.

We want you to be involved in understanding what's happening every step of the way as much as possible. I think one of the things I saw as I joined the Medicaid team. just over a year ago, I guess I've had my one year anniversary, a lot of people lost bets on that. I did make it more than a year. One of the things that we want to make sure is that the provider field really understands what's happening as it's going on. So much like we do with telehealth and COVID, we want to have public facing webinars bi-directional feedback, we want you to be able to ask questions and get answers, and make sure it goes as smoothly as possible for you. So we're gonna have this monthly webinars first Thursday of every month, we're going to talk about a managed care topic. And then the third Thursday of every month, we're going to talk about a clinical quality focus topic, we're going to publish that agenda ahead of time. So you can see which ones make the most sense for you or someone from your practice to join us on. But next month after, we're going to be talking a lot about AMH. So next slide.

So advanced medical home timelines are a really important thing right now, in October, we're excited that we're going to be launching our AMH tag, that advisory group with your peers and colleagues from around the state that are helping with AMH decisions, as well as the data subcommittee and we're going to be releasing some modifications to the Medical Home program. So the coaching program through AHEC will start in November, and in June AMHs will be getting their data. But there's again, a lot of work to do between now and then next slide.

So now the part you've all been waiting for. Nevin is gonna do the big reveal, and turn off the camera or turn on the camera so that you can see your PHP CMOs. These are colleagues of mine that I have gotten to know very well in the last year in our monthly meetings where we sit around the table, although it's been virtual lately, and I get to know each other. But also get to know our goals and ambitions and how we want managed care to look in North Carolina. And I think what you'll find, as you get to know them is what I found, and that they're really pretty awesome group of physicians. We're very lucky in North Carolina. So it looks like they're all showing up now. So I'm going to ask them some questions. I have some note cards with questions. Question one. I'm going to have you just tell us your basics. who you are, and what what organization you're with, what you're doing. So Genie, we'll start with you on that one.

Genie Komives

Sorry, I needed to unmute. Genie Komives, I'm the Chief Medical Officer for wellcare in North Carolina. I'm a family doctor by training, most recently practicing at Duke.

Dr. Shannon Dowler

All right, George

George Cheely

George Cheely. I'm the Chief Medical Officer at Amerihealth Caritas in general internist by training, worked at Duke at the hospital for 10 years and medical director for 3.

Dr. Shannon Dowler

All right, Michelle.

Michelle Bucknor

Hi, Michelle Bucknor, I'm the Chief Medical Officer for United Healthcare, Medicaid, and general pediatrician and most recently was at CCNC.

Dr. Shannon Dowler

Alright, right, Michael.

Michael Ogden

Michael Ogden, I'm the Chief Medical Officer for Healthy Blue. Out of High Point North Carolina, and prior to the role, healthy blue was with Cornerstone health care.

Dr. Shannon Dowler

All right, well,

William Lawrence

Hi everyone, I'm William Lawrence Jr., I am a general pediatrician and I am the Chief Medical Officer for Carolina Complete Health. We're based out of Charlotte.

Dr. Shannon Dowler

Alright, great. So now you know where everybody is. The most important question that I might ask tonight. What song are you most likely to be caught singing in the shower? And I'll tell you mine. It's a tie between till I collapse by m&m or Les Miserables. Love something from the soundtrack. Genie, what are you going to get caught singing?

Genie Komives

I'm glad you were allowed to have to because that means I can too. My first one is the room where it happens which is Aaron Burr's song from Hamilton because we just watched that over the weekend and it stuck in my head. And the other one is it's so hard to be a woman Tammy Wynette because we watched a key drama with the family. And that song played at least 100 times during vacation. I haven't been able to lose it.

Dr. Shannon Dowler

All right, George, what are you gonna sing in the shower?

George Cheely

Well, I need to start with a preface that no one in my family would describe what I do as singing but you could probably pick up a beat or tune. Something Jimmy Buffett I'm a big Buffet fan and like some of the obscure stuff but lately have needed something a little silly and a little escapist, so Cheeseburger in paradise has been better for me.

Dr. Shannon Dowler

Nice. I love that jellyfish song he has we sing that a lot of my house. Yeah. Michelle.

Michelle Bucknor

Yeah, so anyone that knows me knows my heart is always half in Jamaica, so it's gonna be a reggae song in the shower. And for me right now in these times to be the little birds and don't worry about a thing.

Dr. Shannon Dowler

Alright, nice, Michael.

Michael Ogden

Well, that's a tough one. And I'm gonna actually go one above and instead have to do three So so then it comes in the train theme. So usually it's Cat Stevens Peace train. Occasionally, when I'm feeling upbeat, there's Come on ride that train by Quad City DJs. More often lately, it's been crazy train.

William Lawrence

Fair enough. All right, Will what are you singing in the shower?

Well, anybody who knows me knows that I'm a true music head, so depending on my mood, it could be anything from -- to Public Enemy, but I guess in current and COVID times the song has been reverberating with me is one day I'll fly away by way by Laila Hathaway and Joe Sam.

Dr. Shannon Dowler

Alright, so now on to a slightly more serious question. I'd like you to share the one overarching you feel driven to improve in health care from your leadership perch. Genie, you willing to go first on this one?

Genie Komives

Sure. Yeah. So I'm, people that have worked with me in the past, and that I'm really passionate about the relationship between physicians and health care providers and health insurance companies. And I've been on both sides of that my whole career, but only through that kind of collaboration, can we really improve the outcomes for our patients and our and our members?

Dr. Shannon Dowler

All right, George.

George Cheely

Yeah, so you know, I mean, I think my my focus on improvement and what's been a real real sense of true north, for me has been the importance of keeping what it means to be a good doctor intact. And, and really kind of using that Sense and Sensibility to kind of be a front and center, thinking about the type of work that lies ahead for all of us. And maybe I can just share kind of an aha moment that I had, as an early leader, when I was charged to lead a project focused on improving value. And, and for me, I really hadn't learned about concepts of quality and cost in med school or residency, what I learned about was what it meant to be a good doctor. And that means diagnosing efficiently, treating based on evidence, but but most importantly, building a relationship with that person in front of you so that your education and your counsel can help them stay healthy and help them avoid complications and exacerbations. And the AHA happened, as I was thinking about kind of the interplay of those concepts. And I realized that, gosh, you know, you actually can deliver good care. And when you do that, you avoid extra expenses, and you maintain high quality. And that's really been kind of a guiding force, for me working with peers and colleagues to do keeps me energized, about the work that lies ahead. And, you know, kind of really relying on the idea that by making the right information available, we can work together to make small changes that that feel good and, and have real impact for patients. So yeah, hope to make this work more manageable and really built in line with the profession.

Dr. Shannon Dowler

Michelle?

Michelle Bucknor

Yeah, for me, it has always been even in my primary care experience, as a general pediatrician been about disparities. So I really think I'm in the right place at the right time now, especially given the fact that the department's really focusing on that area, and actually is the reason I'm in an administrative role. My entry into administration was with the patient centered medical home model. And I got excited about that model, because it was actually a model that people felt could actually eliminate disparities. So that has always been my mission, my North Star. And so I'm really excited about the opportunity here with the Medicaid population and to address disparities and improve outcomes across the whole population.

Dr. Shannon Dowler

Great, Michael?

Michael Ogden

Great. Yeah, for me, it's pretty simple. It's ensuring that we're all all of our stakeholders that are on the line here. Everyone has to take care of takes care of patients or as an administrative role on patient care is aligned around the needs of the patient. For me, it's always about the patient. While it sounds simple, and really intuitive, you know, all stakeholders can sometimes will lose sight of the goal and it's about improving the health and the quality of life for patients. That's something I think we can all get around.

Dr. Shannon Dowler

All right. Will?

William Lawrence

Well, I would be mirroring Michelle, because when I took this job a little over almost a year and a half ago, you know, the idea of improving health disparities was a big part of what made me want to be here. And obviously, current circumstances have increased the opportunities for us to have those courageous conversations. At the same time, you know, really, if you know me, you know, I've had a pretty long history with North Carolina Medicaid and taking care of children in this state. So just seeing this Medicaid transformation will be positive, and move forward in the successful fashion is really important role.

Dr. Shannon Dowler

And if I recall correctly, were you were you sat in my seat several moons ago? Or were you the director? Were you CMO or director or all of those?

William Lawrence

Correct, I came in in your seat and during my last year of a four year term, served as the admin director.

Dr. Shannon Dowler

All right, watch out David. Here I come. All right. Another very serious question. If you were an animal, what would you be and why Genie?

Genie Komives

love that question. So I had to think long and hard actually, about 30 seconds. My terrier named Frodo and you know, he's got it pretty good these days. He manages to get dinner out of me at noon. And then

he sleeps the rest of the day. And with the 12 and 14 hour days, I'm like, man, I just want to curl up and go to sleep at one o'clock in the afternoon.

Dr. Shannon Dowler

Fair enough. All right, George.

George Cheely

Yeah, for me it was a it was an easy one to I would be a trout and that's mostly because many of my zen moments happen in the Hatteras surf chasing speckled trout or, or in the pool at that the Davidson chasing rainbow trout, I just find a lot of peace in the setting. Where where fish love to live. So yeah

Dr. Shannon Dowler

I just picked up some speckled trout from herb seafood and Raleigh, but I'm going to make for dinner. Michelle?

Michelle Bucknor

Yeah, for me, it would be an elephant, you know, just the commitment, the herd mentality, the leave no one behind. If I had to choose to be choose to be an animal. That's what I would be. I think others might assign a different animals to my personality, but I would choose to be an elephant.

Dr. Shannon Dowler

How about you Michael?

Michael Ogden

Well, that was that this was a tough one. But thank you think it's probably our would be an owl. Wisdom, seeing the big picture. Oftentimes staying up late at night thinking about stuff and occasionally gets, you know, get asked to enjoy a tootsie pop.

Dr. Shannon Dowler

Will, how about you?

William Lawrence

For me, actually, it would be a Black Panther. And that's actually before the movie. So not just saying, I think it'd be that I tend to be somewhat quiet and observant, tend to blend into my environment pretty well. But I believe in, you know, precise and decisive action when the time comes.

Dr. Shannon Dowler

Fair enough. I would be a black bear. Because I think I was made to hibernate. So I think it's like I can go really hard and forage and be busy, busy, busy. But then I am all about the crash and the long winter nap. So I feel very akin to black bears. Okay, last question. And then we're going to go into some Medicaid updates. This is a tough one. Because I'm asking you for a positive and a negative. So what is your greatest hope on the positive side, or your greatest concern on the negative side that can come from Medicaid managed care, Genie

George Cheely

So having come from an organization where we were doing care management, right upside to providers for Medicare members. I really learned the value of care management with the provider with the patient which is really quite different than the traditional health plan care management which is centralized and telephonic, most often not right with the patient, and oftentimes not really having access to the knowledge that the patient's primary care provider, and other treating physicians have about the patient. So I'm really hopeful that this model of delegated care management is really gonna prove to be a game changer for North Carolina members and honestly think it's better for the providers as well, because they have access to the care manager to help them with some of the tasks which honestly, they probably don't need to be doing and having those data to help support that'll give everybody better care and better outcome. The negative, I don't think we can shy away from the fact that there's five of us CMOs on this call. And there's five health plans and providers in North Carolina, and you're dealing with one and we are all going to do things a little bit differently. There's really no way around that and so there is going to be increased administrative burden and complexity for the providers. And I know we you know, we're working hard. William is leading a group that helping us do that to think about the things that we can do to simplify that, but we just need to acknowledge that.

Dr. Shannon Dowler

George?

George Cheely

Yeah, I mean, you know, I think thinking about the positive side. I came from a practice setting where I had great primary care colleagues had the resources and subspecialty complemented the big, academic. And again, I think that the problems that I found toughest to tackle were a realization gosh you know this this person would be much better off with assistance getting stable housing, assistance finding food, assistance getting transportation and so I mean I felt like I had a great degree of insight but but very

little power to affect changes in social drivers of health so I'm really excited about healthy opportunities. About this decided focus from the state and in the renewed focus on health equity that that's coming out of COVID that keeps me really enthusiastic about the prospects of what's coming. And my negative um, you know, I'll probably add some voice to what Genie said that you know providers are going from one system to that system plus now five new systems and if we're not careful and thoughtful about the ways we can eliminate duplication redundancy administration that doesn't have an impact on Patient care, we're going to make this really frustrating in a hurry, so, you know maybe I'll just end on a positive and say the opportunity to work together with CMOs on the call in with Dr. Dowler, two to really find ways that we can avoid that has been another a real breakpoint.

Dr. Shannon Dowler

Right? All right Michelle?

Michelle Bucknor

Yes so for me with my sort of North Star is the opportunity and I'm hopeful that we're able to eliminate disparities in at least one area and for me it would be disparities in infant mortality. I would love to see that happen and using the levers that George has mentioned and being able to address those healthy opportunities and look at health in a holistic way. I think we'll be able to achieve that. I think the key item that needs to happen with that is the model needs to work. I am such believer in the AMH model to you know what Jamie has put out there that provider lead care management and provider directed care management can resolve some of those disparities so with that is my concern and you know, I said this long ago that you know I am concerned about providers and the state and only because I come from a state and was a provider on the border between Kansas and Missouri. And had as many as 6 medicaid MCOs plus fee for service. Is that we're in a much better place. So I think all of us as CMOs agree and Genie mentioned the work that Will is doing around providers simplification. It really is the focus for all of us. So while it's a worry, I think we are in a really good place as the prepaid health plans to support the providers and getting through this transition period so that we're in a better place. So my negative is really a positive.

Dr. Shannon Dowler

All right Michael.

Michael Ogden

Absolutely so I'm actually going to start with my concern my negative. And that is actually echoing what I think you've heard from from all of our CMOs the concern that our the way we engage with our provider partners around the increased administrative burden that will be placed upon their shoulders as a result of going to five PHPs. It needs to be a priority with the health plan. And certainly, we think there's a path to ensuring that we'll have a way to minimize and optimize most of that. My positive I'll

also give some of my colleagues the AMH program is it's not just a game changer for North Carolina. It's a game changer for the country and putting the the right tools the right accountability the right resources and the right information at the fingertips of the primary care provider who can build that relationship that goes outside the two front doors of their office and takes advantage have all sorts of resources and programs that are going to be part of this transformation gets me up in the air. Gets me excited about Medicaid transformation North Carolina. I think we have an opportunity to be a beacon for the rest of the country as well.

Dr. Shannon Dowler

Okay, Will?

William Lawrence

Actually, second what Michael just said. My greatest hope is that the uniqueness of our model and the boldness of our model can be a true beacon for the rest of the country and I think we can set the stage for other plans. My fear really is that North Carolina historically has had strong access for it's Medicaid population and I do not want to see the environmental factors in the challenges of having files which drive a wedge and that in any way decreases that access over time.

Dr. Shannon Dowler

Yeah, here, here All right, excellent. So I'm going to move on to some Medicaid updates and then we're going to go to the question and the answers. So, Nevin is going to turn off the video for the CMOS for a few minutes while I do some updates. So one of the things I wanted you to be able to bring from tonight were some really tangible things that you can be thinking about right now, to get you ready for transformation.

Dr. Shannon Dowler

Next slide. When you're able to Nevin number one thing you can be doing right now. And by you I mean probably your practice manager let's be honest, is update your information in NCTracks,that provider directory is so important and in round one we saw it did not always go smoothly there were some real challenges with the provider directory. We do not want to repeat that. The team has done a tremendous amount of work to improve the provider directory so we're in some ways that delay was great and allowed us to make a lot of changes. But it's only as good as your information is in our system. So having your practice look at both individual and organizational records in NC tracks and all this list of things that we have on this slide will ensure that once this goes into the provider directory and your patients are getting the chance to pick you as a provider. They have the options that they need.

Next slide number two finalize your contracts, I would say that delaying really doesn't create much benefit. There may be amendments, not a problem, you'll have an opportunity to review changes with amendments. Once you're contracted there's still a whole other process that has to happen before your information is populated to the department, and then make it into the provider directory. So getting it right now and getting into the system now will minimize disruption to your practices to your practice and to your patients later. We'd like you to contract with all five PHPs I think that having that opportunity for your patients to continue to follow you no matter what plan they pick is really important. But understanding that not all of you will, but you should all be having conversations with the PHPs now, if your practice has not engaged in dialogue and started that relationship. I really wouldn't delay on that. You need to really be signed by March 15. I mean, really need to be signed by March 15 to be part of the auto assignment process, and that's for the beneficiaries that don't pick what what provider they want to go to. That's going to become a selection based on a whole series of criteria. But you need to be an enrolled provider with the plans that you're going to contract with, and so the sooner you can do that, the better chance you're going to show up in that the right way. You can sign later you can sign even after July 1, but there are some disadvantages to your practice, if you do that. So I guess the one other thing I would say is we don't know what's in your contracts with the plans, that's between you and the PHPs, DHB doesn't have insight into that so a lot of times we'll get questions about it and just making you aware that we actually sit outside of that.

Alright, number three. The, the number three thing you can be doing now next slide is getting ready for AMH. Don't put off making changes to perform as a tier three if you've signed up as a tier three. And really I would say question yourself, did you sign up for tier three because you're like that embarrassment, why not. But you really probably aren't ready for it. If so, I think I would have that real honest conversation with your practice, but if you're committed and you're going to be one of these tier three practices, and I'll reiterate what my colleague said the whole country is watching. They want to see what happens with this AMH model that we've developed, then don't delay getting set up and ready for. We are going to be making some updates to the AMH program based on feedback we heard, we actually had a set of updates ready to go out in February, and then the delay happened and we just decided to put it off. There is going to be a glide path that we're going to tell you about in the near future to help you get ready, a little bit faster but it's going to be contingent on you having finished your contracting and being ready to go. Next slide.

So there are a handful of Medicaid hot topics I wanted to tell you about why I had you in the room and then we'll go to questions and answers I'm sure there are some in the queue. Next slide. We have approved coverage of antigen testing for Medicaid, so that has happened. There's a special bulletin that gives you all the details about it, there are some important things to note on that from a reporting standpoint, but we are covering image and testing. Next slide. One of the special visits we turned on. As a result of the pandemic in our telehealth space is the hybrid telemedicine with home visit. This is where a physician or advanced practitioner can bill for a home visit, even though they're sitting in the office doing telemedicine. If they send a trusted staff member into the home to help facilitate that telemedicine visit and provide what other services, giving an immunization, measuring a fundal height, checking vital signs whatever that thing is that you need that staff person to be doing hands on gets that

really enhanced reimbursement rate to cover that staff person's time, and really can improve access and quality for some of your patients that are scared still to get out, or because of immune system issues or other challenges, shouldn't get out of the house. This is the way you can stay connected with them. I think it's a really cool opportunity. It is something we're going to keep on after the temporary provisions go away so I hope your practice we'll look into it. Next slide.

This is another one we turned on that's gotten almost no utilization. It's an interprofessional consultation. That's where a provider to provider consultation happens on a Medicaid beneficiary that person that's being consulted for that, that sort of hallway phone call consult, as long as it's appropriately documented is eligible for reimbursement. So, specialty Doc's who have a phone Person of the day that sits there and answers call after call after call from people like me in primary care. You can get reimbursed for that. So I hope your practice is we'll look at that as well. Next slide. Another one of the things we turned on early on that I thought would be a big win, I was really excited about was that portal communication so you can now bill for doing work. I think about my days when I'd see patients all day long go home feed the kids tuck them in, sit down on the couch and start writing my notes and dealing with portal communications now you could bill for that, with get RVU credit for that it could be to contribute to the work that we know you're doing, and we think you should get paid for. Not a lot of people are using that code, I don't know if it's because they're not aware of it, or if it's too complicated or why but I would love for you to consider using it. Next slide.

All right, we have said all along we want to give you 30 days notice before things change before temporary provisions change. There are a few things we are literally not able to do that for, and that's about the federal public health emergency. Some of the things we applied for certain waivers expire on the day that the public health emergency expires. Other things go 60 days after the public health emergency while others go like nine months afterwards, it's all very complicated and exactly what you would expect. But there's a special bulletin that goes into specifics on that and so I hope you will look at that and see most of these things are for telehealth how specifically are not going to impact you. But quite a few of the behavioral health modifications could potentially end right now it's slated to end October 23. We have not heard from the feds that they're planning to extend it last time and waited till the very last minute, in July when they extended it, I hope they are, but it's hard to know so weird year.

We also took your public comments on our telehealth permanent changes, and there's so many we had hundreds of comments it was fabulous. We listened we read every single one and talked about every one of them. We made some changes to the policy based on your feedback. It's up for one more week of public comment if you have any other comments you want to make on it. We also took a whole slew of telehealth specific policies that were up for public comment for six weeks that have come down and they all got good feedback so those will go into permanent policy, and we're taking a third set and final set to consider over the next month so we're not done yet still more coming on permanent telehealth changes. Rates we did extend, we announced that we extended the rate increases that's that per member per month and other increases that you've experienced for Medicaid during COVID until the end of October, at least, we'd like to continue until the end of the year, and that's our goal. We've got to

sort of see what happens and how this public health emergency plays out and how our budget and funding plays out. But we are guaranteeing them to the end of October, possibly longer. Next slide.

This is something I'm so excited about. I, if you know what I'm talking about, you're going to know what I'm talking about. And if you don't, it's because you don't have to deal with this, but for those of you out there that take care of women and diagnose breast cancer or cervical cancer or they're your patients and you get them after their diagnosis or in the process of the diagnosis. You know that historically uninsured women could experience a Medicaid benefit, where even though they didn't otherwise qualify if they get a breast or cervical cancer diagnosis, they get immediately qualified for Medicaid coverage, but they had to have been diagnosed by a BCCCP provider of breast cancer cervical cancer prevention BCCCP is what we call it. And that left a lot of women out, it's a diagnosis happen and their primary care provider wasn't an enrolled BCCCP provider. They wouldn't qualify or if they went to an emergency room and had a biopsy in the emergency room and they had a diagnosis they wouldn't qualify. We have changed that. So as of October, 1, we have changed who can refer women into the BCCCP program, and do not have to be in be set before the diagnosis to qualify. So all those women out there who made too much for regular Medicaid, but not enough to pay for a breast cancer diagnosis are now covered. This is very exciting news to those of us that have had to give, bad, bad news on coverage in the past. Next slide.

We are looking at all of our clinical policies and in our whole program and managed care with a really specific equity lens right now, we're going through a scrub of all of our prior authorizations, and we're most of the way done with that, on where does our Medicaid policy or process inadvertently contribute to a health inequity. And so we're asking ourselves some really tough questions, the great classic examples pharmacy team came up with a sickle cell drug that had a prior authorization. It was approved like 96% of the time. Why would we put a barrier in that place for a disease process that is, it's a historically marginalized population almost exclusively and have something that we approve anyway, get rid of the prior authorization get rid of the barrier. So we're looking at everything we're doing with that lens and trying to figure out where are there ways we might improve health equity or maybe we've caused health inequities without even meaning to. Next slide.

But there is some exciting news coming out in the next couple of days around a benefit for uninsured for COVID related services. About a month ago we started covering testing for uninsured, for COVID, but now it's a much broader benefit and you're going to be able to apply for it. This is really focused I believe on primary care practices, although I understand the medical societies also gotten a big chunk of money to help with this as well. A lot of dollars gonna be coming down for reimbursement for uninsured with COVID, so making you aware that there should be some big press releases this week. Next slide. All right, COVID vaccine is on everybody's mind. It's possible that as early as November North Carolina might get some vaccine. It's not going to be a lot. And so there's a team of people working on how to prioritize who gets that early vaccine really looking at high risk health care workers, people in long staff at Long Term Care and congregate living in critical infrastructure workers. But there are quite a few vaccines

that are in phase three trials. I just let you know that we're tracking it and we hope to have some updates in a couple of weeks at our next update. All right. Next slide.

All right now for the fun part. Hugh is going to jump back on the screen, and he is going to help us navigate the questions and answers and this time I did not compulsively answer questions in the chat queue sometimes I sit on the side while other people are talking and I answer all the questions on the chat, but I have not done that today so Nevin's gonna unveil our CMOs so they show up again on your screens and Hugh's gonna direct some questions.

Hugh Tilson

So while everybody's coming up there's some just general questions, Shannon maybe that you can answer, just to confirm that all regions will be implemented on July, 1, 2021, there will not be regional rollouts as the original implementation.

Dr. Shannon Dowler

Correct. Big Bang, we're doing it all at once.

Hugh Tilson

Gotcha. So lots and lots of comments about the moving from one to five and got some amens to your comments but thought I'd read a couple of these let y'all respond to them as a primary care provider it's tough to deal with everyday hassle with insurance we expect that our miserable misery will multiply by five. Should we thinking about closing our doors. And then got one that says, We have one administrator cannot afford more working complexity she's working overtime just to listen to this webinar costs are already going up. Please help make sure that we can continue to stay in business. So, again, you all commented on that but just wanted to reiterate that that's really important and Shannon I don't know how you want to manage response to those or, but I did that was a huge response to a lot of these

Dr. Shannon Dowler

Yeah I think anyway I want to jump in and then make a comment on that i mean i certainly hear it. And it's scary to me to think that, you know, COVID has been hard enough on practices, and this you know the burden that's coming is big and I will let you know that from a department standpoint, we're really thinking about how to support practices, and what's what's meaningful support we can provide that help you through these transitions, but any of our CMOs want to make any other comments.

William Lawrence

I'll Jump. William Lawrence you know that you've heard several of our colleagues mentioned that we all recognize that going from one agency to five agencies, is a challenge, and we are truly committed and we have been working collaboratively, not just the CMOs but many of the leaders of all plans to look at all aspects of operations and find those places where there's unnecessary duplicity that can be consolidated down into one process or one pathway. So we are meeting on a regular basis, and having lots of discussions about various aspects prior approval processes. Some of the forms that is some of the education materials, even our orientation materials were taken a solid look at everything to find where we have the ability to align across the five PHPs and make those processes as aligned and as seamless as possible.

Genie Komives

Thanks, William The other thing I would add is that one of the most challenging parts of my practice was not necessarily what I was doing medically for patients, but all the barriers that they had to being able to do the things that they needed to do to improve their health, whether it was, transportation, homelessness issues, not having access to the food that they needed on the table or having to lay out some of those issues with whether they were going to pay for their next prescription and plans are all being required to screen for the social determinants of health there's a standard set of questions that we're all going to be asking, and our members enrolled. And we're on the hook to put resources behind addressing those things. And so I'm hopeful that that may in, absolutely. We all are going to have policies there's going to be --. That stuffs not going away although hopefully we won't be silly about it and do it on things like for example Shannon maybe we're giving. But if we can get rid of some of the other pieces of things that make it harder for providers to take care of patients. Maybe there's a little bit of a trade off.

Hugh Tilson

So got a couple of comments about PAs in particular, is there any way that PA and billing could say through a central point and be redirected to the individual PHP for approval payment as a way to decrease administrative burden.

Dr. Shannon Dowler

Anyone want to comment on that.

Genie Komives

But it's Shannon it's a little bit about the way that the program was designed. So it really wasn't designed to do that. One of the pieces that, William and the Administrative Simplification group we're working on though is a standard format for what we all call our quick resource guide, there are QRG that help our providers know where to go. In order to get the authorization as efficiently as possible and so we're trying at least to standardize that. And, But I think, unfortunately, having you go to the Medicaid

agency they're going to have to staff for that and then they come, choose a PHP. Probably a more efficient approaches to make sure that you have easily at your fingertips, how to get to us in the first place.

George Cheely

This is George I was also going to offer that the information for PA is standardized, and is another topic of discussion that all the CMOs are talking about you know what are their suggestions we might be able to make for information that not going to impact how, how we manage our internal processes and so to the extent we could could remove or reduce some of those fields you know we're hopeful and optimistic we may be able to make that happen. And I'd also say, you know, this is not intended to be something that's happening in the back room if there are issues, burning questions, concerns charges you will you want to communicate to us. I think we're all committed to keeping our ears open and keeping that list as figuring out what we can try to tackle together.

Dr. Shannon Dowler

Create a lot of work went into the planning for transformation and to have there be as little administrative burden as possible. Knowing that administrative burden was going to be an inevitable factor, and a lot of us were not there in the early days, you know, and so we're inheriting, you know the work that was done but a lot was done by physicians across the state, who weighed in on different committees and groups to help design the program so there was a lot of provider feedback in the development of it and I think that's really important and it shows and I've definitely heard that we are being far more persnickety in North Carolina compared to some other states on how we are really trying to put protections in place to protect providers from the burdens of the transformation.

Hugh Tilson

I'm going to pivot a little to contracting. One question is, if you've already signed contracts with PHPs do you need to resign.

Dr. Shannon Dowler

So I'm seeing lots of head shaking no. So, is anybody saying that he will have to resign. I'm not seeing that anybody is. Anybody want to speak to their process and how they're handling it.

Hugh Tilson

Okay, there's a follow up question which is, I haven't gotten a contract Are you going to send us contracts, how are you sending them to us we have one admin and nobody's contacted us.

Dr. Shannon Dowler

Yeah, so how do practices find out about getting a contract with you guys.

Genie Komives

So that makes me wonder a little bit because I think most of us got access to information out of NCTracks and other provider databases and broadly blanketed providers with standard contracts, where we could and, you know, obviously, then, not all of them get signed but if you haven't heard from anybody I'm a little worried about why that would be. And, yeah,

Michael Ogden

It could be my question is are you registered NCTracks.

Unknown Speaker

And is your information updated to Shannon's point.

Unknown Speaker

That sounds like first step is making sure your information in NCTracks is accurate.

Genie Komives

But I believe Shannon on the website down that you all still have there's contact the PHP is still a page out there. And so for whoever that individual was, contact the PHPs. I mean, we are all about contracting with every provider that's going to contract so it wasn't by any intention I would think that any of us would have left somebody out.

Hugh Tilson

Got a follow up question, are the MCOs required to accept providers we tried to apply to all when first announced and some said the network was full, it would not allow us to become a provider with them has this changed.

Dr. Shannon Dowler

Okay, so that's a different so that's managed care in the behavioral health space. And those behavioral health networks can have limited networks and they can keep people out of them by saying they have enough providers already. Some are more apt to do that than others. I'm learning, there are some that are are pretty open and others that keep it a little more rigid if you feel like in your region, the service is not available that needs to be available that you can provide and your LME MCO is still saying that it's closed I would get that feedback to someone a DHB

Hugh Tilson

Got some questions about what is an AMH, can you talk about what an AMH is and why that matters.

Dr. Shannon Dowler

Yeah so so our advanced medical home is really that focus on the primary care, medical home, where a patient gets more than just shows up for their visits when they have a problem, you know as you get into the higher tiers of AMH. It's, it's more increasing ownership on the part of the provider for that whole populations health care. And so thinking about how to do care management in the practice. If you're a small practice, sometimes we're seeing small practices band together, tie into other organizations to help support them but how are you providing that full scope of services that your patient needs. If you're doing that, and that means responding to the data, doing those transitions of care between the hospital and the ambulatory setting really kind of owning the full care of that population, then you can qualify for a higher reimbursement rate, some of my colleagues, you would you like to describe it in your words.

Unknown

Absolutely I will take the, especially with AMH three. It's taking on responsibility your patient, not just in the four walls of your office. But, and, you know, seeing to their needs, outside of the office seeing their needs were with, you know, social determinants of health, with with coordination of care with specialty care with proactively outreaching to members that may not have been engaged recently. There's a stipend that goes with this as well as a set of responsibilities.

Hugh Tilson

Interesting question. What is the chance this transformation we've postponed again.

Dr. Shannon Dowler

That's a great question. I think it's extremely low, I think it's really exceptionally low I am having said that, I you know I don't have control in the legislature and there. I don't have control and a lot of things that I probably would like to have control of. But I think we're fully kind of in it to win it. I don't think it's

getting delayed again, that's that's my impression I have no reason I've seen no signs or indicators to make me think it's getting delayed. Does anybody else have a crystal ball.

Hugh Tilson

While you're thinking about a kind of follow up question about the adverse effect COVID is having on practices and whether that will affect the ability actually to roll it out. In addition to the legislature's approach.

Dr. Shannon Dowler

I don't think so I'm not we're not seeing any reason why we wouldn't move forward we gave ourselves a fairly large ramp up for the July go live. And so the teams are working hard but we had done a lot of when we were ready to go in February, you know of this year. So, the truth is, we're taking this extra time and just making things better than it probably would have been in February, we're just making it better. So, I, I don't think COVID unless something, you know really devastating and unexpected happens with flu season, you know, in COVID, which I don't think anyone can predict I don't see that stopping us.

Hugh Tilson

Last time the provider directory did not always match what was in NCTracks and plans were different from each other. Will this be different in round two.

Dr. Shannon Dowler

I can tell you that the teams have been working really hard in this time in between. to have that provider directory, a way better experience for everybody. I don't know the specifics because it doesn't live in my, my clinical policy domain that I spend most of my time in other than I hear about it all the time, and the teams have really dug in they took the feedback from the field of which they got lots and lots and lots of feedback from round one. And I think they've tried to really optimize it and make it better. So, so, so I really feel confident that it's gonna be a much better experience for everybody this time.

Hugh Tilson

What will the impact be for Medicaid Long Term Care beneficiaries, how will this rollout be handled in nursing homes across North Carolina, what do long term care providers need to do to be prepared.

Dr. Shannon Dowler

Well that's a hard question. Specifically, I'm not sure I know how to answer that is Genie, you want to take that.

Genie Komives

Yeah, I can take a stab at it. So in this first. Go Live, the Medicaid beneficiaries or what we call dual eligibles so they have both Medicare and Medicaid, which is either going to be because they're elderly or because they have a disability. And many times that also attaches to you needing long term services and supports including nursing home care, they're not moving into managed care initially. Now there will be regular members regular, you know, aged blind disabled adult Medicaid members who may need a nursing home today. And there are members that are currently receiving PCS services that all of us are going to be keeping a very careful eye on as part of our care management work that we do and, and with our medical homes as well. And it is possible that those members will end up in nursing homes for sometimes short stays, which the PHPs will just manage, and sometimes those shorts days will turn into long stays and if they turn into one stays. Then, at that point, these numbers actually move back into Medicaid fee for service. So until such time as they become dual and then their Medicare, Medicaid, know down the road. My understanding is the intent is to move those dual eligibles into Medicaid and there's committees and all kinds of planning I think that's going to go on between here and there to to prepare for that. Okay.

Dr. Shannon Dowler

Yeah, that was a very eloquent answer and mine would not have been that eloquent

Hugh Tilson

Thanks. Speaking of eloquent. We're out of time. So, let me thank you guys for all participating tonight both as participants as well as our honored and special guests so Shannon let me turn it back over to you for closing comments remarks.

Dr. Shannon Dowler

Yeah, thanks. Thanks as always Hugh and Nevin on the, doing all the background work and to my colleagues from the plans that join me tonight and all of you at home, who are may be still at the office or driving home or sitting in your driveways before you go in your house. Thank you for tuning in and listening and being part of the dialogue. I know there are a lot of questions that we did not get to. And so I think we're gonna work on having some question and answers following these webinars that we'll put up and post so that we can make sure that we answer people's questions. So we will take that as homework, to make sure that your questions get answered, be looking for future webinars and we'll try to publicize them ahead of time we'll try to be really specific about what's going to be covered, so you'll know if they really apply to you and impact your practice or if it's one that you can skip. So we'll try to be

respectful of your time and attention, but know that you're always welcome at the table so thanks all, and have a great night.