Transcript for Medicaid Managed Care Fireside Chat: Beneficiary Attribution

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5:30-6:30 pm

Presenters:

Medicaid Team:
Kelly Crosbie, Director Quality and Population Health NC Medicaid
Shannon Dowler, Chief Medical Officer
Jay Ludlam, Associate Medicaid Director NC Medicaid

Tribal Team:
Casey Cooper, Chief Executive Officer for Cherokee Indian Hospital Authority (CIHA)
Richard Bunio, Executive Clinical Director for Cherokee Indian Hospital Authority (CIHA)
Tara Larson, Vice President Cansler Collaboration Resources, Inc – Consultant with CIHA

Hugh Tilson
Well it's 530 so let's go ahead and get started. Good evening, everyone and thank you for participating in this evening's webinar for Medicaid providers. Tonight's webinar is the third in a series of informational sessions put on by North Carolina Medicaid and North Carolina AHEC to support providers during the transition to Medicaid managed care. As a quick reminder, we'll put on these fireside chat webinars on the first Thursday of the month on Managed Medicaid. And on the third Thursday of the month, Tom Wroth president of CCNC will join us for a chat about relevant clinical and quality issues. NC DHB and NC AHEC have partnered to ensure that health care providers across all 100 North Carolina counties have the information support they need to adapt to and thrive under Medicaid managed care. This collaboration will produce education webinars like these in virtual office hours across a variety of relevant topics. In addition, the partnership will make AHEC practice support coaches available to provide one to one assistance directly to practices. Tonight, as you can see, we have a great panel of presenters both from the Medicaid team and the Tribal team. You'll hear about an overview of initiatives of the Eastern Band of Cherokee Indians, EBCI tribal option, eligibility requirements, Indian Health Service eligibility, and how members are attributed to prepaid health plans and primary care providers.

Next slide, please. Let me run through a couple of quick logistics. First of all, if you need technical assistance, you can see that it's at technicalassistancecovid19@gmail.com. We're gonna have some poll questions tonight. We'll keep the poll open for about 15 or 20 seconds, so please be prepared to respond when they come up. For some of you the responses to the poll might stay on your screen just click on the red button to minimize results, clear them off your screen. We will have questions for time or time for questions at the end. Everybody's can be muted. So you can ask questions two ways. One is if you're on the phone through questionscovid19webinar@gmail.com or using the q&a feature in the bottom of the screen. We've learned in past webinars that the presenters will often address your questions during their presentations. I encourage you to wait until the presenters are through their presentations before submitting a question. And anything we don't get to we will send to Medicaid so they can respond. We're going to record this webinar and put it in the transcript of it with the slides on the NC AHEC website as soon as possible. Probably tomorrow morning, first thing and for your

convenience the slides are in the q&a, you can click on them and follow along yourself. Now let me turn it over to Shannon.

Dr. Shannon Dowler
All right. Thanks. Excited to be here with everyone tonight. First Thursday of December. It really is the right time for fireside chats. I got five inches of snow this week at my house, which is very exciting, not to brag, but it was pretty awesome. We have a big night tonight. And I'm really excited for one reason, because we're not talking about COVID. And that's exciting. But we've got two really great learning opportunities and really different discussions tonight. So we're going to start off learning about the tribal option, which I think everyone is going to really enjoy learning about. And then we're going to go on to talk about how beneficiaries get attributed to plans on the primary care providers. So a lot of information coming through tonight, two very important and interesting topics. And as always, we like our poll questions. So first poll question, Nevin. This is a true false question. So based on what you know, right now about the tribal option, knowing that you're getting ready to learn a lot more. Any American Indian/Native American in North Carolina can qualify to sign up for the tribal option. Is that true? Or is that false? We're just curious about what you think right now, we know some of you may not know anything about the tribal option, which is why we're covering it tonight. As people are voting and choosing their answer of true or false, I do want to tell you about who's going to be talking with you. We've got three folks from the tribe that are going to be on tonight. Casey Cooper is leading the discussion. He's the Chief Executive Officer for Cherokee Indian Hospital. He's also joined by Dr. Rick Bunio who's a family physician and the Chief Medical Officer there. And Tara Larson, who is a consultant to the tribe. And Tara, interestingly, I've learned has a long history with Medicaid, and even served as Deputy Director at Medicaid in the past and is filled multiple roles in the past with Medicaid and so she's really knowledgeable, not only about the tribal work with our partnership with them, but also about Medicaid and how we do things. So let's see, Nevin, what did people say? Oh, interestings what audience? Well, Casey, I think it's time for you to tell everybody how it is.

Casey Cooper
Okay, thank you, Shannon. And first, I'd like to start by saying hello, very special people and welcome. I'm Casey Cooper, and I'm the CEO of the Cherokee Indian Hospital, I'm going to talk to you a little bit about the tribal option. But by way of introduction to this topic, I'd like to tell you just a little bit about us. Here at the Eastern Band of the Cherokee Indians, we are the descendants of the original Cherokee Nation. Most of us are the descendants of the Oconaluftee Cherokees that were split off in the early 1800s. The Cherokee Nation is a is a tribe that was traditionally structured on using a matrilineal clan system, which means that we, we adopted the clan of our mothers, which, oddly enough, and interestingly enough, this is what made it so easy for the Scots and Irish to assimilate into the tribe. It's my understanding that one of our chiefs John Ross and his father and his grandfather who all married Cherokee women, were able to do so because they too shared a matrilineal clan system from their home countries.

Next slide. So as I mentioned, we're the descendants of the Cherokee Nation and the Oconaluftee Cherokees. We have a long history here in Western North Carolina, where there's approximately 16,000 of us enrolled in the Eastern Band today. And we have about 12,000 active American Indian Alaskan Native patients who are part of our active user population here at the Cherokee Indian Hospital. Next slide, please. So that the original Cherokee Nation covered about the majority of the southeastern states as represented, represented by this red map that you see. And you can see the original Cherokee homeland was very vast and large covering more than 250,000 square miles. And on the next slide, you'll actually see how that entire land base was eventually seated away through a series of successive

treaties. Next slide, please. This map shows all 36 of the areas of land that was actually lost in what is known as forced legal retraction, I think is the term if we could go back to the map slide for just a second. So each of those colored spots on that map shows the land that was actually lost as a result of that treaty. And then the this piece at the bottom of the map, where you see the number 36 that is the final bit of the Cherokee Nation, original homeland that was lost as a result of the Treaty of New Echota. And this series of treaties actually sets the foundation for health care for all American Indians and Alaska Natives in this country. And I'll share a little bit more with that in just a minute. So next slide, please.

So, Indian Health has a very long legislative history. And the Indian Health actually began on the previous slide, you'd be able to see that the the provision of health care services to American Indians and Alaska Natives began, actually, before the foundation in the United States and continued on during the the treaty period after that. And has memorialized more than 22 treaties with between the United States and American Indian tribes across the country, and memorialized in these treaties is the provision of health care is recompense for the horrible atrocities that happened to Indian tribes, including the the seating of land and the genocide that took place and a number of other horrible things. And this legislative kind of history continues on. And most relevant for this conversation tonight, I believe are the amendments that were made to the Social Security Act that made it possible for Indian health systems to bill and be paid, paid from Medicaid and Medicare as a way to supplement the horribly underfunded Indian Health System. Next slide, please.

Again, there were additional amendments to the Social Security Act, one of which that is extremely important for tonight's topic was the establishment of a 100% FMAP, or federal match for all health care provided to American Indians and Alaska Natives when provided in an Indian Health System, which is a big reason that we think that we're going to be able to build this first Indian managed care entity in the country, and have a model that is sustainable. In addition to that, there were some very specific protections for Indian country in the stimulus bill are the ARA, and that was passed in 2009. That implemented some very specific protections for Indian health systems for managed care. Next slide. So as most of you already know, American Indians, American Indians and Alaska Natives have very significant health disparities and suffer from very high rates of chronic diseases like alcoholism, diabetes, depression, and a number of other things. And in Cherokee, we believe that our diabetes prevalence rate is somewhere around 24%. And we think the number of patients we have that are diagnosed with depression, or have a substance use disorder is actually higher than our diabetes prevalence. Next slide, please.

So, we are located, of course, in western North Carolina, and the Eastern Band basically resides on the Qualla boundary, which is a land that is held in trust by the by the tribe, and it's about 56,000 acres and it's scattered over five of the Western counties. So essentially, to be eligible for enrollment in the PCCM that we're building or that the tribal option. individuals will have to be American Indians, Alaska Natives or otherwise eligible for Indian health services, and reside in the six Western counties that are listed here. And that of course, is Clay, Cherokee, Graham, Swain, Macon, Haywood, and Jackson. So in order to be eligible, you'll not only have to be American Indian, Alaskan Native or otherwise eligible for IHS but you'll also have to live in this catchment area. Next slide, please.

So, here's what we're up to. We've had an interesting evolution of our health system since taken over our health system from the Indian Health Service in 2002. We began as an Indian health primary care service, if you will, and Indian health primary care services are a little bit different than traditional primary care because they are also an Indian Health Service Unit also includes ER, inpatient, clinical support services and a number of other services. But one thing that's very interesting and unique for

Indian health is a program known as purchase and referred care. And this is a program that we use to actually refer into the market and then acquire and purchase specialty care for our patients when that care is not available through the directly provided services that we provide at home. So not only have we been involved in the Direct provision of care for a number of decades, we've also been involved in the acquisition of care from the market, which lent itself to a natural progression to become a PCCM. So the next step for us, of course, like many of you was a PCMH III. And then we partnered with South Central foundation out of Anchorage, Alaska to redesign our primary care model, and to implement the Nuka system of care or the integrated care model. And then the next version of this that we're building that will go live in July 2021, will be the AMH III and PCCM. All of this, delivered within this cultural organizational culture, defined as Du yu ga dv, Du yu ga dv is known it the Cherokee translation means the right way, or the right path. Following these four guiding principles, U wa shv u da nv te lv means to to be perceived as giving always from your heart, with authenticity, and the second guiding principle of Ni hi sta ste li, this principle means that the service belongs to you, it already belongs to the people. As I mentioned, Indian Health Care is the first pre purchased health plan in this in this country. And we believe that we're stewards of the people's health care. The third guiding principle is To hi, which means to be in a state in a state of perfect balance with each other and in harmony and in relationship. And then finally, our fourth guiding principle is Di gwa tse li i yu s di which means to be perceived as or to have a relationship as if you are a member of our own family. So we believe that by reorganizing ourselves and redesigning our systems, and delivering care within this culture, we believe that we will be able to establish the influential relationships necessary to improve population health. Next slide.

So we redesigned our health system, when we partnered with South Central Foundation to have fully integrated health care. And we moved away from the traditional sequential interdependent system to have a system that is more reciprocal, interdependent, like the model that you see in the upper right hand side of the graph. And I'll show you a little bit more about what that means on the next slide. On the next slide, if we could go to that slide, you get to see a an example of what one of our fully integrated care teams looks like. So within this pod, you'll see the primary care team or the the nucleus of the team, which is the primary care provider, or the PCP. The LPN supports the PCP, you know, in the treatment rooms, today, and every day and then in the back of the pod, you have the registered nurse case manager, or care manager, and she has a full time dedicated assistant. And this pod, this primary care team would be responsible for a panel of about 1000 to 1200 patients. And then fully embedded with the primary care team is a full time clinical pharmacist, a registered dietitian and a master's level therapist. And they are not only co located but they are embedded. And those shared resources. They're the the pharmacist, the dietitian in the master's level therapist, they are essentially engaged to wait so that the system can really be truly reciprocal and interdependent. Not to oversimplify, but basically that means the patient who you know presents because they just need their medications refilled. And we actually find out that they have a positive PHQ9, we can have a brief intervention with a master's level therapist, while the patient is here at the same time without having to refer that patient, you know, to a behavioral health clinic on another day to another sequential interdependent system. Next slide, please.

So we redesigned the system this way. And we have banked or we based our entire strategy on our ability to be influential with our patients, because we believe that in primary care acuity level is very low and patient control is very high. And the single most important thing for us to be successful is to be influential with patients when they maintain 100% control. On the next slide, if we can go to that one, I'll show you kind of what this looks like. It's not terribly complicated. But basically, we believe that in order to improve the health of the population while controlling costs, we have to have patients actively engaged in healthy choices and behaviors. And in order for them to be in order for us to motivate them to be engaged, they have to have an amazing experience of care and be in relationship with a primary

care team and enjoy a relationship that has a foundation on trust. And so that's why this this emphasis this this real extreme vigilance, if you will to be in trusting influential relationships with our patients is the primary motivation for us to to pursue becoming our own PCCM. Because we don't want care management to be extracted from the primary care team, we want to preserve those relationships inside the medical home, where they're closest to the primary care provider. Next slide, please.

So the next iteration for us will be to strengthen our care management processes as we make the as we evolve to this next level in our system. And essentially, we have partnered with Health Access and, and Milliman. So that we'll be building a more robust care management platform that will allow us to receive information from referrals and claims data and care need screening and ADT feeds and all that will go into our care management platform. It'll run through this algorithm that we're that we're purchasing for milman, so that it kicks out a risk stratification score, so that we can then identify those proportions of our population that really need a comprehensive assessment, that comprehensive care plan and more intense care management. Next slide. So the website should be up, we're hoping the website will be fully launched in in February, ready for go live in March when open enrollment starts. So that when open enrollment starts, our patients will be able to go straight to the website, find all the information that they need. Select well, they will already have selected a PCP but they'll be able to get the information they need to help inform their decisions. Next slide.

Dr. Shannon Dowler
All right, looks like we've got a poll question. Let's see what the question is. Members who live in the westernmost five counties may be enrolled in the tribal option if they're a member of the EBCI. They're members of another federally recognized tribe, they're eligible for Indian health services or all of the above. Let's see how you guys do with that. And while you're answering that question, I will say that North Carolina Medicaid is so super excited to be part of something like this. It's the first of its kind in the country, and what we hope will be a national leader that others will emulate and so it's exciting times here to be working on this. Alright, Nevin let's see how people did. All right, Casey, what do you think?

Hugh Tilson
So that was pretty effective.

Dr. Shannon Dowler
Pretty good. Yeah. Nice. All right.

Hugh Tilson
Okay, so I think there's just a few more slides. So just to be to expand on this a little bit, and more specifically, beneficiaries who are eligible to enroll, they must be eligible to receive Indian health services as described at 25 USC section 1603. And, and also be eligible as defined at 42 CFR 136.12, which includes all the following and need to be federally recognized members, including members of the tribe, as defined by tribal code, or other federally recognized tribes or Alaska Natives. They could be direct lineal descendants, and it's very specific 42 CFR Part 136 actually expands on this to say they have to be defined as a lineal descendant by the the respective tribe. So you can't just say you're a descendant, the tribe has to agree that you are a lineal descendant. And then, of course, there's a few other categories here where we also take care of adopted or foster children or legal wards are orphans of an eligible Indian. And we also take care of non Indian pregnant women who are pregnant within eligible Indians child for the duration of the pregnancy. Next slide. So why are we doing it? This is probably obvious now as a result of the information that I shared. But really, our core purpose is to

ensure the prosperity of the next seven generations, we're all about improving population health and reducing health disparities. And we believe that we first have to be of course, technically competent. But more importantly, we also have to be influential and have trusting relationships with our patients. And we are doing this so that we can drive engagement and improve population health. We want to remain the provider of choice for the tribe, enhance care quality, and protect our tribal sovereignty and the principles of self determination. And then finally, we believe that if we have a healthier population, like many of you will also lower the cost per capita. Next slide.

Dr. Shannon Dowler
All right, so we got a poll question. Let's see what we got. Oh, you're gonna have to pronounce this Casey. I'm gonna do it wrong.

Casey Cooper
Du Yu ga dv

Unknown Speaker
Do Yu ga dv? closer? All right. Does this mean continue in this direction anyway is a good way, the right way or everyone has their own way? Let's see who picked up this knowledge tonight. I will give you a few seconds to answer. And then Nevin. Show us what people say. Well done. 76% chose the right way. Very nice. I personally like my mantra is I do it my way. That gets me in trouble a lot of the time so fantastic. So Casey, you want to wrap up your section?

Hugh Tilson
Sure. That actually concludes our section. And I understand that we're gonna stick around till the end of the entire webinar. And we'll answer any questions that you have about the tribal option at that time. So thank you for your time.

Dr. Shannon Dowler
Yeah, thank you so much. Great learning, great opportunities. This is just one more example where North Carolina Medicaid is getting to do some pretty cool things. And that's exciting. All right, let us shift gears.

Jay Ludlam
Good evening. Hey, can you hear me?

Dr. Shannon Dowler
Yeah, we gotcha.

Jay Ludlam
All right. Sounds great. So I'm gonna bring up the the North Carolina vision slide. This, I'm gonna, I'm gonna go ahead.

Dr. Shannon Dowler
I was gonna say, Jay, we can't see you right now. I don't know if you have your video on? Or if it's just me.

Jay Ludlam

I do. All right. Sounds good. All right. So those of you have heard a presentation that I've done in the past, you've you've seen this slide in the past. This is North Carolina's vision for Medicaid transformation. So tonight, I'm going to be talking, I'm going to start with I'm going to pass it off to Kelly Crosbie. We're going to talk about the enrollment process that beneficiaries, people can't see me. So that beneficiaries, the beneficiaries are going to go through to get enrolled in a health plan. And then once they're enrolled in a health plan, how to get assigned a PCP if they don't have a PCP already assigned to them. So the North Carolina vision for Medicaid transformation is of course 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. So you've heard a lot of the different things that that we are working on in order to meet that vision. In there I I'm trying to start my video to see if that works. So we're, all right, Nevin. Send that link again, and I'll click it while you while you do it. And then we're going so yeah. All right, next slide.

Hopefully, that works. Alright, so with with North Carolina, Medicaid managed care, we expect approximately 1.6 to 1.8. And maybe a little higher because of the pandemic. And not just enrolling individuals, but we expect approx we expect approximately 1.6 to 1.8 million beneficiaries who will be enrolled in our standard plan product, which we'll talk about today. Beneficiaries will of course be able to choose from five different health plans. Four of them are statewide, and then Carolina Complete health as in regions, three, four, and five. So it's great to see Casey using our regional map of North Carolina. So that has region three, four and five. All the health plan will go live on July 1 of 2021. So those of you who are paying attention over the last year, of course, you remember we intended to go live with two phases the first time. This time, we feel ready and capable. We believe that health plans will be ready and capable on July 1 2021. So we will be we will be going live on that family. Some beneficiaries will stay in fee for service not everybody goes into managed care. Eventually another there will be future phases. So for example tailored plans, which will, we will not talk about today. But that is targeted to go live on July 1, 2022. So there's gonna be a lot of work here in North Carolina Medicaid. Next slide.

So this slide is, is our standard plan, transformation timeline. I'm not going to go through everything here. But I do want to call out a couple of important provider related events. So in January of 21, we will be releasing more tools for providers to verify their information with the enrollment broker. Of course, right now you can go to NC tracks and verify your information and make any updates there. We do recommend that by about February 1, that providers who want to be fully engaged in the open enrollment process, that they have their contracts signed with the health plans by that time, there are subsequent actions that the health plans are gonna have to take to load those contracts up. So you want to give them as much time as possible, we've estimated approximately 45 days, but it could take longer, they could be faster. So we encourage you to be contracting now, we'll begin sending out packages to beneficiaries. And then open enrollment formally begins on March 15. That will go through February 14, which is the conclusion of open enrollment. And then we will begin a process which we'll talk about in just a second auto enrollment. So then we'll begin auto enrolling those individuals who did not actively select a plan. And then we will do some subsequent activities and then go live on July 1, of 2021 with standard plans. So let's go to the next slide, which is Poll four.

Dr. Shannon Dowler
All right, I'm not fast enough at turning my camera on and off. Poll four question. Let's see what we have. Okay, this is an opinion question for everyone out there. How confident are you that your patients will select their current PCP during open enrollment? So not only that, they will kind of respond to open enrollment and get on the phone? Or do it online or manage open enrollment, but that they will select

their current PCP? Are you super confident? Do you think most will probably half, some might or you're pretty sure they're gonna all go through this auto assignment? So I'm curious, we are curious, what do you think your patients are going to do, your Medicaid beneficiaries? Nevin, let's see what people had to say. Interesting. So I have a real split. This is sort of like the DNA test we did on my rescue dogs, breed makeup, lots of different things. So it looks like a third or most will a third or probably half and a third or so might, a few of you out there are superduper confident and I love that. And a few of you are thinking, Man, this is not going to happen. So very interesting. All right.

Jay Ludlam
All right, next slide. So now what we'll do is we'll talk about that auto enrollment process, that's going to start kickoff on May 15. Next slide. So it is, it's not, it's never easy in a verbal presentation to have a forked process flow that and to be able to describe it. So I'm going to bear with me for a second. There are as members, there are two ways that a member can get enrolled in a health plan. One is they actively participate and select, and the other is that they don't select. So we're going to go through both of these and then discuss the impact in a minute. So for those individuals, as as Shannon described, that call in to the enrollment broker, go to the go to their website, use their smart the smartphone application and find their PCP, they'll be able to do that. And then they'll find a PCP that's contracted with either a health plan or is in the tribal option. So that's, that's their way of connecting to a health plan. There are of course, a large number of individuals, beneficiaries, who may not have the time, may be working two jobs and may not be able to select the plan for whatever reason. And so there is a different process for those individuals and some states that can be over 50% of total beneficiaries may not select a plan. If they do not select a plan, they will go through what we call auto enrollment and we'll talk about the logic in just a second. Once auto enrollment is completed, we have like 45 days for us to transmit information to the health plans and then kick off our transition of care processes where we will send previous claim history, open prior authorizations, information care management records information that we feel will assist the beneficiary in transitioning to the health plan, really minimize that, that patient disruption as much as possible. Given that we are we do have this large system delivery system change.

If a beneficiary so then one of the the questions that will happen after the fact is that has the member selected a PCP. So once all of these records go to the health plan, they will then kick off the logic that Kelly will discuss in just a few minutes. If they have, of course, they'll get they'll get the welcome packaging all all of the accoutrements that a health plan will send them. If they haven't, we will run what's called an auto assignment algorithm to assign beneficiaries to to a PCP that is contracted with the health plan. So we'll go to the next slide, actually. Oh, yeah, the next slide.

Health Plan auto enrollment. I don't think that there's this is a poll question. So then I'm going to go to the next slide. All right. Here it is. This is what an algorithm looks like. Or at least this is how you describe it in the presentation. So there are a couple of considerations that we make, and that we we utilize to try to align beneficiaries to health plan that will minimize kind of the burden on the beneficiary as much as possible. So there we go, we go through some stepwise logic. So the first is we consider geographic location. So where the where the beneficiary lives, matters. As we discussed before, there are there is a health plan that is only in three regions. So we would want to make sure that we don't assign a beneficiary that is not in those regions. So that's just a geographic check. We do have a an a special populations decision. That's next. And that helps us expand this logic as we add new programs. So in this one, we have already talked today about the tribal option. So this is where we would identify qualified tribal members. And we'll talk about that in just a second. Or in the future. This is where individuals who

might be enrolled in a tailored plan would would split off and have a different logic than somebody who would be who would qualify for a standard plan.

Moving down to rule number three, rule number three is that historical PCP relationship, so all North Carolina, Medicaid beneficiaries should have a PCP assigned to them. And sometimes it's described it as on the card, it's really in the system in fast, who is the beneficiary assigned? We want to look at that historic relationship, again, we're trying to minimize as much as possible, those historic relationships that a beneficiary has. So if a health plan has contracted with a PCP, this is this logic will pick up those historical relationships that you have had with beneficiaries. So this is a very important thing, probably rule for many of the people on the call today. Another consideration, let's let's imagine that the PCP maybe hasn't contracted with anyone. What we'll look at also is to determine which health plan is best for a family member, we'll look at where are other members of the family? Which health plan are they have they chosen? Again, this is to create almost administrative simplicity for the family. You don't want to have to have two or three different 800 numbers to call, you know, you know, it's somewhat organized with it. For the family that has not chosen a health plan. Of course, the family member or any of the family members can choose a different health plan during a subsequent process. But here we're looking to keep the families in the same health plan.

Rule number five is, is a rule that we don't anticipate kicking off initially in July 1 2021, but you could imagine it kicking off in say, 2023 we have beneficiaries who come on and off of Medicaid. We again where we believe that people who may not choose a health plan, go through all this logic and hit this rule that one common sense approach would be to assign them to a previous health plan that they've been enrolled in. Again, they could change that. Hopefully, if they don't like that selection, but but all things being equal, this is where where we would, we would assign somebody to their previous health plan. Rule number six is the round robin. So none of these rules kick off, we will then effectively randomly assign beneficiaries based on based on that, based on just randomness. All right, I'm gonna go to the next slide. Next slide is a blowout of rule two. So rule two, if you remember is about special populations. So this is where as we are going live with the tribal option on July 1 of 2021, we want to make sure that qualifying members of the tribe are able to access through the auto enrollment process, the tribal option. So this is the kind of micro logic that we have here for the tribal, the qualifying tribal members, we're going to look at county and residents. Of course, as we talked about, as Casey talked about earlier, we're also going to within the tribal option, we're going to look at historic PCP relationship. And then they're assigned and the information is transmitted to the EBCI. And they will be enrolled in the in the tribal option. I'm going to now hand it over to Kelly for the next part.

Kelly Crosbie
Hi everyone, Kelly Crosbie. Nevin I can't seem to start my video, so I don't know if there's anything that you can help me with. So, hi everyone, um, I'm going to do one slide on PCP auto assignment, the guiding principles, really for auto assignment is there two. It's really to try to maintain continuity of care, so individuals who are already connected to a primary care physician, we want that to stay in place and the second is we want families to have continuity of care and not to have to go to multiple different practices so those are those are kind of the two guiding principles for this. So, if you could go to the next slide. The funnel is fairly simple. It starts with looking at prior PCP assignments. And so I'll say PCP but that also means advanced medical homes which are primary care offices. So at the top of the funnel, we look to see are the health plans, we'll look to see if the beneficiary has a prior assigned primary care physician so the vast majority of beneficiaries going into managed care in July will have an assigned primary care physician, so they'll look for that, and then they'll look for evidence of relationship so we'll look for claims, they'll look for ADD beneficiaries remember that's our individuals in the age one to

disabled category so individuals with very complex needs. They'll look in the past year, they've had a physician visit with that PCP. And then for, for all other groups, they'll look in the past 18 months and so if the beneficiary has evidence that they saw that primary care practice. Then they will assign to that primary care practice because they have evidence of relationship.

If they don't have that they'll go to the next part of the funnel. And again, they'll look across all PCPs, and they'll say, Do I have evidence of of the beneficiary having a relationship with other PCP. If the beneficiary has a relationship with another PCP again that same 12 and 18 month claim limit the beneficiary will be assigned to that practice, if there is nothing, the beneficiary has no claims history on par with primary care. The next thing we'll look at is family members. So if the individual has a family member who's in Medicaid, with an assigned PCP, they'll look to that PCP and they'll say okay does that family member have any claims history with that PCP. If so, that family member will be assigned to that family members PCP. That one's imperfect, and you have to think about that one right because sometimes the family member is a child who goes to a pediatrician who does not accepted all patients. So just throwing that caveat out.

Next, if that assigned family members PCP if there's no established history relationship to claims. They'll just look in general at all claims. So does that members family member, have a PCP history and relationship in the last 12 to 18 months if so, we'll assign to that family members PCP that they have a relationship with. So again, the whole way through this funnel we're trying to look at historical assignment and then evidence of a relationship based on care with those two overriding principles let's keep folks connected to the primary care that they're connected with, and let's try to keep families in the same place can, if there's just no history anywhere in there. There's nowhere where there's historical relationships that we can assign to, we go to the final part of the funnel which ultimately means that people will just be assigned probably to the closest primary care office that meets their cultural needs or other special needs that they might have as a member. That's my slide.

Dr. Shannon Dowler
All right, so we've got a couple more poll questions for everybody before we get into the questions and answers, which is coming quickly. So, Nevin hit it. Okay, this is a big poll question, you get to pick three of these, we want to know what what your worries are about auto assignment and auto enrollment, and so we want you to pick the three biggest worries you're feeling about the process. There's a bunch of selections on here they'll select the plan we're not contracted with, they'll come to my office but I'm not their PCP. The plans will make me take new patients I can't accommodate my practice. The beneficiaries won't know where to go, the beneficiaries will know how to change their plan or PCP, the beneficiaries open enrollment choices won't be honored. Are you worried, you're going to lose your existing panel. Are you afraid the assignment just won't work at all. Are you worried about disruption and continuity of care, or are you just have no worries, which is also an acceptable, though, highly unrealistic option, but go for it. We really do want to know what you're thinking and how you're feeling about this process to help guide our teams and doing everything we can to make this as painless and successful as possible. So take a minute to ponder that, and then Nevin will tell us what people said. All right, so, um, wow, kind of all over the place. Let's see, it looks like. Number one is maybe at 46% there's a tie, people are worried that their patients are going to select a plan that they're not contracted with, or they won't know how to change their plan or PCP, so that's really good information for us to be thinking about. And then there's another tie, they'll come to my office but I won't be there PCP. Fair enough. And then disruption and continuity of care follows really right behind that one. But, but lots of other concerns but those are the big ones. Great. All right, we have one more poll question and then we go to questions. Nevin.

Nope, maybe we don't have another poll question, we used to have another poll question, but that's fine. We will jump right into scenarios. So what we're going to do before we want to take you through some really basic scenarios that we think these are some of the questions that are in the chat actually that will help you. We're going to do them at a super high level, knowing that they're going to be lots of caveats and what ifs and what ifs, but we want to just let you see sort of as simplistic as possible a way that the algorithm can work. So, Jane has a nine year old who's generally healthy she last saw her primary care provider. Five months ago she had strep throat. Her family missed the memo about open enrollment. So what's going to happen how she's going to get assigned to a plan and a PCP.

Jay Ludlam
Jay? All right, so, yeah. So this makes me all sweaty and nervous because this is the technical. So Jane will be assigned to a health plan that includes her current PCP as is contracted and with her current PCP.

Dr. Shannon Dowler
All right, so we'll get into one of those plans that's contract with a PCP so PCP is a contractor with plans, A, B and C. It will, how does it know which one of those three to pick?

Jay Ludlam
It will, it will randomize between those three.

Dr. Shannon Dowler
All right, Nevin switch for us. So she's saying with your primary care provider. Jay, what if she received specialized services for intellectual or developmental disabilities what happens then.

Jay Ludlam
Right so she, it sounds like she'd be tailor planned qualified in. On July, 1 2021, because we don't have a family plan, she would actually stay in Medicaid direct so stay in the fee for service program, currently and continue to get services to her LME MCO.

Dr. Shannon Dowler
So she won't be part of this chaos. Next scenario. I didn't mean use the word chaos that sounded negative I don't mean to sound negative. John is a 23 year old who qualifies for Medicaid after a bad accident and while he sees a trauma surgeon surgeon on the regular, he's not seeing a primary care provider. How often does this happen, both of his children have Medicaid, and they have a pediatrician, so not someone John would be able to see. So how is he going to get assigned to a plan and to a PCP.

Jay Ludlam
So he'll be assigned to a health plan that also includes his children's pediatrician. And then, all right. And then, Kelly?

Kelly Crosbie
PCP yeah as Shannon said it's highly unlikely that he will be able to be assigned to his, his children's pediatrician. He'll he'll just go through the nearest PCP, that's closest to him, because this is assuming he has no PCP on file, and he has no claim history with primary care.

Dr. Shannon Dowler

All right, so Nevin quick for me. What if he had emergency Medicaid that's all he had from his accident. He didn't qualify for regular Medicaid. Just had emergency what does that mean for.

Jay Ludlam
He will not be assigned to a health plan, he will not qualify for managed care. Right.

Dr. Shannon Dowler
All right, next slide Nevin. Wanda delivers a perfect baby girl on July, 1, because some people are going to do this, but she has pregnancy Medicaid and she got her prenatal care at a fabulous Community Health Center, and she had her baby delivered with a fabulous local residency program. She has an older son, who has a doctor at the same community health center she went to. So, how is her daughter getting assigned to a plan and a PCP, and then how is mom gonna know where to take her on day three when she needs to Bilirubin check?

Jay Ludlam
I'll started and Kelly if you want to fill in on the PCP part but. So the daughter will be assigned to the mothers.

Kelly Crosbie
And so also be assigned to her to the same health center where her brother gets care. And that's where she needs to go. That's where Wanda will need to take her big girl on day three to get her billing check.

Dr. Shannon Dowler
All right. Like for me 11. What if her son, for a doctor and another practice and mom so the son sees a different primary care provider. Where does Wanda's baby go?

Kelly Crosbie
Wanda's baby will go to her siblings her brother's pediatrician. Okay.

Dr. Shannon Dowler
What if her mom had regular Medicaid and not pregnancy Medicaid,

Jay Ludlam
And that and that wouldn't matter, she qualified for Managed care.

Dr. Shannon Dowler
Managed care for pregnancy Medicaid and regular Medicaid. Absolutely. All right, next one was in our last example we get to questions. Deanna is a 48 year old patient with Medicaid her primary care provider of many years. Only contracted with one health plan, but Deanna did not select a provider or a plan during open enrollment. So what happens with her. How does she get assigned to a plan and a PCP?

Jay Ludlam
So I apologize and I apologize Shannon, go ahead Kelly.

Kelly Crosbie
Yes, she''ll can assign to a plan that has her PCP and as Jay said before if that's multiple plans, they'll do round robin to pick a plan that her PCP is in, and she'll get assigned to that PCP, and this is assuming that

her long standing healthcare provider she has history of claims for that I'm assuming she does. So she'll get assigned to that PCP as well.

Dr. Shannon Dowler
Yeah, This is all very complicated stuff. All right, so click for me Nevin. And what if she signed up for a plan during open enrollment, but she didn't pick a plan that her PCP accepts, what happens then?

Jay Ludlam
So she, she selected a plan. Yep. So then how would she get a PCP?

Dr. Shannon Dowler
Yeah so she. So, can she go to her current PCP if she selected a plan that her PCP does not accept?

Kelly Crosbie
So that PCP wouldn't be a network. So, the health plan would look for evidence of claims for another primary care physician, that's in network to assign her to. And if there was no history of claims. Then she would just get assigned to the nearest PCP that meets her cultural and specialized health needs. But she could change it if she wants to chest and I was gonna say she could change, she could say, oops I made a mistake I wanted to stay with my PCP that was primarily important for me so she absolutely can change your health plan.

Dr. Shannon Dowler
Big deal, the beneficiaries are going to have a good amount of time to change at this crossover to get make sure we get this right. All right, next click Nevin. What if her PCP did not sign up with any plans?

Kelly Crosbie
Yeah, so she'll just use it the health plan will use the primary care algorithm so they'll try to find a PCP that she has seen in the past year, to see she has any relationship. And then they'll use family assignment and family plans if there's any history of that. And then if there is nothing she'll just be assigned to the nearest PCP. All right.

Dr. Shannon Dowler
I think there might be one more click. What if she hasn't been to the doctor in two years so she has a primary care provider she likes a lot. She's signs up for a health plan that that primary care provider takes, but she's not actually been at the office in a couple of years, what might happen then.

Kelly Crosbie
She might get assigned to another primary care practice if she has claims that another primary care office. She is not she might get assigned to a family member's primary care office if there's evidence of claims. And if there's just no evidence of claims history anywhere, she will get assigned to the nearest the nearest PCP. Again, if that she's not happy with that she'll be able to choose another PCP that is in network with that health plan. Yeah.

Dr. Shannon Dowler
So I think we're under a real big bottom line story here that I think practices it is so important for practices to help patients know that they have choice and that they, we want them to exercise their choice, really important. And we're going to be doing everything we can to help them do that. Oh there's here's my final poll question, much excitement and then we get to the questions, hit it Nevin.

This is the chance for you to be honest, not that you aren't always honest, it says, Okay, I get it, but I'd still like to have additional education opportunities with more examples. I'd like to have an interactive educational opportunity where we can bring examples. I want to know who to call if it goes sideways. I still are there to influence the process so cure isn't disrupted or you feel good and you feel solid on this content, where it How do you feel now at the end of this time that we've had together and I'm gonna let you think about that for a minute and while you're thinking about that and answering that I do want to say one thing that I think is important for everyone to understand.

The Medicaid team doesn't have control over the grand scheme of whether and how and how Medicaid go live happens with managed care. We are here the team is working incredibly hard around the clock to make sure that we do this as well as possible for you the providers and for our beneficiaries. And so I think it's important. I know people are really stressed, I mean understatement of the year really stressed. And I've gotten several calls from colleagues I love, saying Dowler can't you make this happen differently. And the truth is the Medicaid team doesn't hold those controls we don't hold those levers, our job is to make this happen the best way possible. With, and so we are working around the clock for that so we really want to engage with you and do what we can to help ease your burden over these next six months, and into this to make this this possible. So Nevin What do people say what do they need. I love it, I love it, they want to know who to call if it goes sideways and we are going to be making sure that this crystal clear to everybody. We do not want this going sideways and so we want early indicators if things aren't quite right. All right, Hugh you got any questions in the chat.

Hugh Tilson
So, that may be the understatement. We have so many questions. And I think a lot of them have to do with the enrollment piece. And I think probably the best thing for me to do is just forward these to y'all, because I don't think we can get to them in the next three to five minutes. So, we have a couple that are related to the ECBI option, maybe we'll start off with one of those. And I know that the Tara has been answering them and Casey has been feverishly. But one of the questions is how do we reach out to the, to, to, Casey and his colleagues, if we want to enroll in the tribal option.

Casey Cooper
Thank you. I'll begin as well. It's a terror to fill in anything that I missed but essentially will be, we're looking at all of the claims data now to see if any of our patients are already an active patient in another practice, and where that data exists, we will proactively reach out to those practices to execute an agreement with that practice to be in network. And then if by some chance that we know miss a practice with caring for our patients, if you'll just contact us. We will. We'll come out and visit with you and we'll execute an agreement.

Hugh Tilson
Sounds great. Thank you, Tara, do you have if you want to add. So one of the questions that has, one of the suggestions is and I think this is perfect, but it's lots of questions four minutes to go, need to do this again. So, I think there are lots of questions that are out there and we probably need to figure out how to provide specific answers to many of these questions in a more intentional way.

Dr. Shannon Dowler
I think, I think it's really instructive. Honestly for us Hugh that we see all these questions and all these scenarios and, because this is what we need to be working through, and we have test processes where we're testing this to make sure it works the way it's supposed to work. And that's on the technical side but but technical doesn't always make up for the little nuances of human experience and so we are

going to be hard at work on this I know that the eligibility and membership teams are going to be doing some webinars coming up. So they're going to be lots of other opportunities for outreach on this and it sounds like really we need interactive sessions where people can raise their hand and say, What about this scenario. And so we can help go through them that way.

Hugh Tilson
We are happy to help you with that. Um again, I think there are just so many questions in here, Shannon I don't even know where to start. Other than thanking everybody for their time tonight they're submitting of these questions. This incredible information. You've seen the questions Shannon Is there anything in here that jumps out at you that you particularly want to respond to?

Dr. Shannon Dowler
I think, I want to say that we are, we will definitely take these questions, and we are going to answer them and we are going to put them we'll make them available broadly so everybody so we're not just going to respond to one person at a question, we'll make the questions and the answers available for everybody to see. So that hopefully they working through the scenarios will help everybody. There are a ton question more questions we've ever had on a webinar so that that's just a big flag to the team that we need to do more education and helping folks understand how this impacts you and your beneficiaries, your patients. So we're on it, it has been such a privilege to share the stage tonight with our folks from EBCI, and thanks for my colleagues at Medicaid who were started on this work some of them five years ago six years ago, this has been a long time in the making so much work going on and I want to say that we, I am acknowledging that I see that a lot of the comments in the chat are around concerns around the pandemic and the impact that's having on your practices in, and that this feeling like a lot. It is a lot. And so we acknowledge that. And thank you for, for sharing your feedback honestly, because that's really important to us. Who as always thanks to a heck for helping set this up for us and I hope everyone has a great night and we will be in touch soon.

Hugh Tilson
Thanks everyone.