Transcript for Virtual Office Hours for Providers: Carolina Access Health Equity Payments
March 25, 2021
4:00-5:00pm

Presenters:
Chris Weathington
Julia Lerche
Emma Sandoe
Terrell Mouard

Chris Weathington: It's four o'clock. Let's get started. Thank you for participating in today's virtual office hour session with North Carolina Medicaid. Today's topic is the Carolina ACCESS Health Equity Payments.

North Carolina Medicaid and NC AHEC have partnered to ensure that healthcare 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 produces educational programming and AHEC practice support coaches to provide one-to-one assistance directly to practices.

I'm Chris Weathington at North Carolina AHEC Practice Support and I'll moderate today's session. Before I turn it over to the panelists, let me run through some logistics. You can adjust the proportion of speaker and slides by dragging the double gray lines between the slides and the speakers; you can also adjust your video settings to hide people who aren't speaking; and to do so, click on the up arrow for the pull-down menu to the right of the "Stop Video" button in the black bar on the bottom of the screen. Select Video Settings, scroll down towards the bottom of the page, and then click the Hide Non-Video Participants box. We'll also put these instructions in the Q&A for your convenience. Everyone other than our presenters are muted, and the chat function is turned off. You can ask questions or make comments by using the Q&A feature on the black bar on the bottom of the screen.

We have learned in past sessions that the presenters will often address your questions during these presentations; we encourage you to wait until the presenters are through with their brief presentations before submitting a question. Please know that we will send any questions we don't get to answer today to the health plans in North Carolina Medicaid so they can respond directly to you and also incorporate the question into future FAQs. If you have questions that are not related to today's topic, these will be accepted and forwarded to the correct internal folks at Medicaid and will be addressed after the session. We are recording this session and we'll add that recording along with these slides on the NC AHEC website as soon as possible.

Now, I'll introduce our panelists today and then turn it over to them for a brief presentation before we get into the Q&A. Our panelists today are Julia Lerche, Chief Actuary and Actuary Officer at North Carolina Medicaid;

Emma Sandoe, the Associate Director of Strategic Planning for North Carolina Medicaid; and Terrell Mouard, our Provider Engagement Lead at North Carolina Medicaid.

Chris Weathington: So, let me just turn it over to Emma. Emma, would you like to go ahead and take it away on the next steps?

Emma Sandoe: Sure. So, I have a brief presentation here to explain the Health Equity Carolina ACCESS payments. This was also included in a bulletin last Friday, but I'm going to give you an overview of these themes here today.

So, as we've seen as a country and as a state over the last year, COVID-19 has really exacerbated many long-standing health inequities in our healthcare system and these disparities have existed and have led to some horror health outcomes for historically marginalized populations.

This is a graphic from the Robert Wood Johnson Foundation which I'm not sure if you've seen before, but it shows the difference between quality and equity. So, equity, as shown in this picture, is instead of providing a bike to people with different bike needs, you're providing the appropriate bike whether that person needs a taller or smaller-sized bike, et cetera. And this is sort of the foundational that we're bringing into our approach to health equity is about determining what is the most appropriate for the needs of our population. Next Slide.

So, last Friday, we announced these temporary health equity payments for Carolina ACCESS providers; these will be available starting in April and run through June of this year; these are available to Carolina ACCESS 1 and 2 providers, and we have determined the providers that will be receiving these payments based on providers that are serving beneficiaries from really high-need areas. Providers will see an increase per member per month based on the mix of the beneficiaries that are assigned to them. So, this is determined using a poverty rate based on this beneficiary's census tract; and I can go into a little bit more detail about how that payment rate is determined here on the next slide.

So, using the beneficiaries of this tract, we assigned a poverty score based on the average of the beneficiaries that the practice serves; and if the practice's average falls below 17 percent, that is zero-dollar PMPM average, it falls between 17 and 21 percent, the will receive a $9 PMPM, per member per month from April through June; and if the poverty score is greater than 21 percent, the practice will receive an $18 per member per month from April through June. The levels were determined based on a ±2 percentage-point difference from the 19 percent which is around the overall poverty score for Medicaid beneficiaries--average overall poverty score.

So, we've got some examples here in the purple on the right-hand side. So, for instance, we've got a practice that has--we take four sorts of sets of census tracts and it serves disproportionately from some of the lower rates of

poverty. So, from predominantly Census Tracts A, B, and C, their poverty rate score is less than that 17 percent, and so therefore they fall into the point that is under the threshold. If the distribution, the practice tends to see beneficiaries that are predominantly in higher poverty census tracts, so census tracts with 20 or 25 percent of the individuals living in poverty, then they fall--the weighted average we see is closer to 19, and therefore they receive a $9 PMPM. And then the last practice example sees a lot of patients in the 20 to 25 percent, that's pretty much all of their patient mix, so they would receive the $18 PMPM. Next Slide.

So, we've outlined a few ways in which the CDC and many other organizations have included as ways to improve health equity; and we know that telehealth investments-- and there are a lot of parts of our state that don't have access to telehealth; and we've seen, over the last year especially, that telehealth can be a key tool to managing chronic conditions which disproportionately affects historically-marginalized populations, so investments in telehealth and making these investments permanent beyond the COVID period will be a way that we think might improve health equity, so that's one potential example of ways to spend these funds.

Another is training staff on implicit bias, trauma-informed care, and the concept of health equity. There are many training opportunities available, and we've provided a few resources and some links as well on some of those. We do feel, in a lot of the research, that when a beneficiary has a provider that looks like them, that tends to improve health outcomes; so, recruitment of key staff would be an area that might be a potential way that a practice can make investments, and also, they can be focused on some of the areas that we see a lot of health disparities such as individuals that would focus on diet, health coaches, and focus on the community health workers.

And some practices may need to do a little bit more research to really identify where they can make these investments and where there may be areas that they would like to look into further. So, doing some work on the data analysis of your beneficiaries that you serve and creating action plans from that data could be a good use of these funds. And as well, we've seen with COVID, that there are a lot of holes that need to be filled because of COVID with additional vaccine outreach and really focusing on making sure that historically marginalized populations aren't being overlooked with the COVID vaccine as well as testing and treatment services.

And then improving your infrastructure to address non-medical drivers of care. So, these are social determinants of health working with transportation, food insecurity, making those connections with partner organizations, and any other things that might be needed to make improvements on addressing the non-medical drivers of health would be another area.

And then, finally, we know that behavioral health supports are an area that we often see health disparities based on race and ethnicity. So, making investments in improved behavioral healthcare and integrating that

behavioral and physical health so that beneficiaries have very high quality of healthcare could be another area that a practice may choose to invest these funds.

We will be performing a survey at the end of these, after these payments have been disbursed to providers, and from that, we will understand how practices have made these payments or have used these payments; this list is not the entire list that you could be making or using for your payments; I mean there may be other ideas that work for a particular practice. So, from that survey, we'll have a better understanding of what worked, and where the investments were needed, and what could work on a broader scale.

So, as I mentioned before, the next slide has some additional resources, if there are any questions about guides to practice improvement on health equity or other types of work that can be done with these payments, we've got some great resources here, but we know there are many, many others.

Chris Weathington: Thank you, Emma. That was very helpful. Some of these questions have already started coming in and I'll just go ahead and roll down the list; and if there's a question that we need to get back with folks on, that's fine too. So, the first question is, "How does the practice know if we'll be getting the payment and at what level?" This is probably Julia's; I think Julia would like to answer this one.

Julia Lerche: Actually, I'm going to hand it to Emma.

Chris Weathington: Okay.

Emma Sandoe: So, NC okay so NCTracks will be sending out communication for practices that will be receiving these payments; and so, providers can log into NCTracks to see that. I think it's going to be very close to April 1st for that April payment--I think it's going to be on April 1. So, you can log in on April 1st to see that communication; if there are any questions with them about the specific amounts, we encourage you to reach out to NCTracks or the contact center for more information.

Chris Weathington: The next question is, "Is this just for primary care providers?"

Julia Lerche: Yes, this is for primary care practices that are Carolina ACCESS 1 or Carolina ACCESS 2; it's based on the number of beneficiaries that are assigned to each of those practices at each location. So, any Carolina ACCESS 1 or Carolina ACCESS 2 provider that meets the poverty score threshold.

Chris Weathington: We got an interesting question, "With lactation, IBCLC's count..." I'm not sure if this is a particular specialized provider or this is a primary care practice that has this in their office, I'm just not sure, but do you need more context around that question?

Julia Lerche: I think we can respond I think this is about lactation consultants. So, I think it's safe to assume that lactation consultants may work within a primary care practice but are not necessarily the primary care provider. So, the payments go to the primary care practice based on beneficiary assignments for Carolina ACCESS 1 and 2 providers.

Chris Weathington: Thank you. Next question, "Are the payments an aggregate of the practice's attributed patient's overall score to determine the payments rather than the patient by patient on the attribution list?"

Julia Lerche: I can take that one. So, we look at the poverty rate for the census tract of each beneficiary for each practice at the location level, and then we average it across all beneficiaries at that practice location. So, each practice location has one score, but it's based on where each of the individual beneficiaries resides. So, a practice location will qualify or not--and if they qualify, they will get that per member per month enhanced payment across all of the beneficiaries assigned to that location.

Chris Weathington: The next question is, "How does the practice determine the minimum beneficiary poverty score?"

Emma Sandoe: So, the practice doesn't need to determine the minimum beneficiary poverty score; we've done that on our end based on the, as Julia was saying, based on the beneficiary's address and a census tract in which the beneficiary lives and then weighted based on the weighted average. And, as I mentioned earlier, whether or not a practice will be eligible for that payment will be communicated through NCTracks.

Chris Weathington: Another question is, "Will a practice be required to submit any records of how the payments would be used such as pay records, pay registers, receipts, invoices, or anything like that?"

Emma Sandoe: No, although providers need to make sure that they are using these payments appropriately, and if there are any inquiries that it's not being spent on buying a boat or something to that extent, we reserve the right to do investigations if there are any discrepancies or something like that. But for the survey, there's no requirement to do any invoicing or any things like that; these payments will go directly to the providers without having to invoice for anything.

Chris Weathington: So, basically, it's an honesty policy and an audit would occur should there be a complaint or something that would trigger that audit, basically.

Emma Sandoe: Uh-huh.

Chris Weathington: So, this question came in, "If we won't know till April 1 if we're getting the payment, how long do we have to spend the payment? Will we have to report how it was used?"

Emma Sandoe: So, we will be sending the survey after the June payments are already made; we haven't quite determined the exact date, but it will be sometime after the payments are made. There's no time limit on when you need to make these payments or need to use these funds, they will be disbursed by June 1. But if you, for instance, have something planned for August--that you've already made the investment or the plans, but it just isn't happening until August, that's information that you can provide on the survey. So, there is no time limit to spending the funds; but when we do send the survey--which I anticipate will be sometime after June in the summer--we would like a good understanding of what you plan on doing at least.

Chris Weathington: "Would pediatric practices be included in this?" I'm assuming yes given they're primary care, is that right?

Julia Lerche: Yes, all Carolina ACCESS 1 and 2 practices that meet that poverty threshold will be receiving their payment, that includes FQHCs, local health departments, pediatricians, all Carolina ACCESS 1 and 2 providers would be beneficiaries.

Chris Weathington: Thank you. "How do we find out what or which the poverty level is for our beneficiaries given that they're listed as...?" Let me rephrase that question, "How do we find out what the poverty level our beneficiaries are listed as for what percentile we fall in the increased PMPM?"

Emma Sandoe: So, this goes back to the question earlier in terms of the NCTracks communication; we'll be letting our practices know whether they'll be receiving these payments or not. And happy to do any follow-up if it's unclear about which level your particular practice is in by reaching out to the contact center after that payment is made.

Chris Weathington: Perfect. "Do the payments come with the monthly PMPM payments that they receive on the second week of the month?"

Julia Lerche: Yes, they'll be included in that same check, right.

Chris Weathington: "An earlier DHHS webinar implied that the payments could be called back if the summer survey was not returned, is that accurate?"

Julia Lerche: We've reserved the right to do so if the survey is not returned.

Chris Weathington: So, they really need to fill out that survey. Alright. "If a primary care office would like to hire an IBCLC lactation consultant with the funds, would that count similar to the dietitian or the health coach, that suggestion?"

Emma Sandoe: That would be something that we'd love to hear; if that's something that practices would like to do and that's within... again, the list that we provided is not meant to be exclusive. If that works to address health equity and you think that there is a need for that at the practice level, we would love to make additions to this list.

Chris Weathington: Yeah, I remember hearing you provided a list of all the criteria or the examples of things that they could perform, and you said that earlier, that that was not an exhaustive list as long as the intervention is something to help address health equity, they can be as creative as they want to be.

The Evening Call mentioned a survey that had to be completed regarding how the funding was spent or else money could be recouped. Is this the case? I think we just answered that, so I'll just take that off the queue. The question was, so Tier 3 is not included, so, basically, this is for Tier 1 and 2 practices, what about Tier 3 practices?"

Julia Lerche: I can take that one. So, the AMH, the Advanced Medical Homes Tiers 1, 2, and 3, are really effective when managed care launches on July 1st. These payments are in our fee-for-service program from April through June as Emma mentioned, which is before the launch of our managed care system. So, Carolina ACCESS 2 practices--for the most part AMH Tier 3 are already Carolina ACCESS 2 practices. So, if you think about Carolina ACCESS as what happens in fee-for-service and these payments are under fee-for-service which is where all of our beneficiaries are until through June, and then AMH starts really in July.

Chris Weathington: So, this could apply for practices that are Tier 3 because there in order to be Tier 3, you've got to meet the Carolina ACCESS 2 requirements, so that's what you're basically saying. "Will you make available a copy of the survey prior to June 1st so that practices can see in advance what they will be answering?"

Emma Sandoe: That is a great question and a great suggestion, and I think we'll work to get that out as soon as we can. Thank you for that question.

Chris Weathington: Alright, we learn something as we go here, don't we? "Is there any scenario in which a practice would have to pay back the funds?"

Julia Lerche: I think we're still evaluating that; I don't think we have a definitive answer. These payments are meant to support primary care medical home functions for our Medicaid beneficiaries; the intention is that by targeting these payments to practices with beneficiaries and high poverty areas of the state, that it will support health equity overall. So, in our targeting of processes, we're working to support health equity and then in the recommendations about how the payments might be used, we're also trying to advance our health equity objectives within the program.

Chris Weathington: Would you recommend a practice manager or the medical director just sort of have something in place where they took the money and they used it for a health equity strategy, just have some kind of documentation or paperwork just to sort of internally, if it was ever asked for, they could show what they did with the money? Would that be a recommendation?

Julia Lerche: I think it would be helpful. I mean we would love for practices to be intentional about how this money is used within their practices to advance the department's objectives; there will be--some processes have more beneficiaries assigned than others, so that how meaningful the investment can be will depend somewhat on the size of the practice and the number of Medicaid beneficiaries assigned to that practice. But I think it would be, especially for those with large Medicaid beneficiary practices, that will likely be where we'll be focusing our time with respect to follow-up. I don't know, Emma, if you want to add anything.

Emma Sandoe: No, that was great.

Chris Weathington: Okay. So, it could be a good--it's a suggestion or a good practice, but it's not like you're going to be asking for this paperwork; but it's probably good to have it on hand just in case if it was ever needed.

Julia Lerche: I think it would be very good practice; and I think, again as I mentioned, especially for those with a larger volume of assigned Medicaid beneficiaries.

Chris Weathington: Does the practice have to do anything to sign up for it? Unlike the Glide Path where they've got to go in and sign up; for this one, they don't need to sign up, right?

Julia Lerche: No, so this one will be added to that check and there's no action that the practice needs to take.

Chris Weathington: And this is really interesting; it seems like from the numbers I saw on the slides, this is actually more money than the Glide Path Payment Program, so it's quite attractive, I think, to participate in this program. What email address will you use to send the survey?

Emma Sandoe: There's an email through NCTracks that is for the contact that we have that has access to NCTracks and they should be receiving; it typically tends to be a provider coordinator or a coordinator within the office or somebody that manages the financials, that tends to be that email address.

Chris Weathington: So, this is a good reminder to the practices that are on this webinar, is that another reason to update your information into NCTracks because a lot of folks are doing that to make sure their practice information is showing up in the provider directory appropriately; they want to make sure that that they're ready for Medicaid managed care also do this. So, if you've had a point of contact lead in the office or what have you, you really need to make sure that information is up to date because that person will be getting the email.

"So, if we have 5000 patients and they have an average poverty score for payment, will we be paid for all 5,000 patients or just those that are in the poverty guideline?"

Julia Lerche: So, if the practice location meets the poverty threshold, they will get the enhanced per member per month payment for all of their assigned beneficiaries at that practice level. So, it would be the full 5,000 in that example.

Emma Sandoe: If those five thousand are Medicaid beneficiaries. Your private insurance patients are not eligible.

Julia Lerche: Thanks for that clarification, Emma; it's based on the assigned beneficiaries in our system to that practice for Medicaid.

Chris Weathington: Okay. "Do you anticipate that there will be any practices in the state that will not, at least, meet the Level 1 poverty level?"

Julia Lerche: Yes, there are practices that do not qualify.

Chris Weathington: Can a practice decline these payments?

Julia Lerche: We don't believe we have a process for that. I don't know, Emma, if you have any other different answer.

Emma Sandoe: I don't believe we have one and are happy to follow up with that particular question, or if they've got specific questions that they would like.

Chris Weathington: Well, maybe that's good, because if they don't intend to use the money for a health equity strategy, they probably want some recourse to turn down the money if that's their overall aim. But, okay, that's another idea. Thank you for that.

"Will it be the OA?" I think what they're referencing is, is the person who receives the email in NCTracks, is the OA or, otherwise, the Office Administrator? I'm taking that as yes, but please confirm.

Emma Sandoe: I think a lot of practices put their office administrator as their point of contact; I think it varies based on the practice of who you put in NCTracks as the individual that's the point of contact.

Chris Weathington: "Do plans currently exist to provide future equity payments?"

Julia Lerche: I don't think we have any hard plans yet; but part of this exercise and the purpose of this temporary initiative is to learn from it; we want to learn how good the targeting approach is, we want to learn what kind of impact these payments have. So, this will inform our future strategies; but there are no hard plans for future initiatives; but we hope that this will show an impact in ways that will advance health equity in the program, that we'll be able to use to, again, inform future decision-making.

Chris Weathington: So, not that practices should have this as an expectation, but all the more reason to really do this well and be creative and effective, because if there are

a lot of practices doing this really well with this additional money, that could lead to some type of long-term program implementation around this area.

Julia Lerche: That's the hope.

Chris Weathington: Well, that's another incentive to do this. I think we've gone over this question. Here's another one: "Our RAs show that we have a little over 9,000 patients; NCTracks shows that we have over 10,000. Which number will be used?"

Emma Sandoe: For the group, if there is clarity on the RAs--what's that referring to?

Julia Lerche: I think the RA is the detail that comes with the payment. So, it will be based on the number of beneficiaries on which you're paid, your current per number per month amount. So, think of this as you may get a dollar right now--or actually, it's been doubled under COVID--$2, if you're a Carolina ACCESS 1 practice; or $5 or $10 for Carolina ACCESS 2 practices; the $5, is for our beneficiaries who are not aged, blind, or disabled; and $10 for our ABD populations. So, think of this as an add-on to that payment; and mechanically, it's just bumping up the per member per month using the same formula and number of beneficiaries that you're currently getting paid on.

Chris Weathington: A question that came in is, "Where did you all get the poverty score information? What was the resource you used to determine where these poverty areas are in our state?"

Julia Lerche: It's the American Community Survey; it's really part of the--I believe it's part of the census process and it's a five-year average of information from that survey.

Chris Weathington: And a question here is, "Do all the providers in the practice need to participate or can it be some or one provider in terms of the health equity intervention?"

Emma Sandoe: So, as we mentioned earlier, the list that we have is non-exhaustive, but it has a number of items that are might be investments made at the practice level rather than the individual provider level; so, investments in telehealth infrastructure or investments in improving social connections with social determinants of health and the non-medical drivers of care; this could be investments that the practice is making and not necessarily each individual provider is being a part of it; or hiring community health workers, for example, would not affect each individual provider. So, the answer is no, all providers wouldn't necessarily be making changes--or it depends on what the needs of your beneficiaries are and how you want to go ahead and address them.

Chris Weathington: Perfect. Here's a question: why are the payments not based on race if the payments are meant to address health equity?

Emma Sandoe: Sure. So, we are limited in a lot of what we could do in terms of how we can direct payments to practices; and we've done a lot of work to analyze the data of what the census has; and unfortunately, in North Carolina and in the rest of the United States, poverty is very closely correlated with race, and we were able to do some analysis, and poverty is a pretty good indicator that is very closely related to the race of the beneficiaries.

Chris Weathington: Another question is saying--and maybe this is more of a statement--"All Medicaid providers serve high-need beneficiaries, why are these payments not available to all providers?"

Emma Sandoe: So, every practice has different needs and we're limited in the sort of size and scope of what we can do. So, we're trying our best to direct these payments, as much as possible, to the practices that they're very, very high-needs beneficiaries, and have a lot of areas in the state where we see health disparities, and we've mapped those out and health disparities are in pockets that often are places with higher levels of poverty. So, we're working to address these health disparities and targeting these standards to places that really could make differences.

Chris Weathington: One of the things I just want to let the audience know is, as you work on these health equity interventions, just know that you've got the AHEC Practice Support coaches that are available to you, they're at no cost to the practice; it's through a collaboration between NC AHEC and North Carolina Medicaid. So, if you're working on an immunization clinic, or a well-child clinic, or you're working on a quality measure and you need some help with clinical workflow redesign or figuring out how to pull the data out of your EHR, we're there to help; and, of course, you can also work with your CINs as well.

But just know that we're there to help; we've got the practice support coaches--around 32 of them, at least--around the state of North Carolina and in nine different centers around the state, so we should be able to help you. And also, if you have questions related to this program, we can help facilitate the answers to these questions if they haven't been covered through today.

The other thing that was asked is, "Do these payments disproportionately advantage certain types of providers?"

Emma Sandoe: So, we did some analyses, as I mentioned earlier, of where we see health disparities and those--if folks are familiar with where in North Carolina there a lot are more health disparities, we really see that in the eastern portion of the state in some of the rural communities; and correspondingly, those are parts of the state that also do have high levels of poverty in the various parts of the census tracts. And so, we do see that some providers in that area are receiving those $9 or $18 payments; and then other providers that are serving some of the higher-income portions of the state aren't eligible for these payments.

Chris Weathington: Thank you. I think I wanted to see if there were any other questions that have come in. "If you sign up, can you pick and choose which patients to see?"

Emma Sandoe: I don't quite understand the question.

Chris Weathington: Let me ask them to clarify.

Emma Sandoe: And just to clarify, these payments will be through Checkright, so there's no real signing up for these payments; practices will be receiving them through the Checkright system, and it's based on the number of patients that you serve. We encourage you to provide improvements to your practice that benefit your patient population.

Chris Weathington: Is there any criteria where--I'm assuming independent practices, Federally Qualified Health Centers, rural health centers, health departments with primary care clinics, can a health system primary care apply or is this for the non-health system?

Julia Lerche: All Carolina ACCESS 1 and 2 practices are eligible to receive the payment if they meet the poverty that we're calculating based on the census tract information. So, there are no exclusions, by any provider type, from eligibility as long as there are Carolina ACCESS 1 or 2 and meet the poverty score threshold.

Chris Weathington: Okay, I think we got a little clarity on that earlier question, "Can we only see Medicaid patients that are established with this or do we have to continue to take new Medicaid patients also?"

Julia Lerche: There are no requirements around taking new Medicaid patients related to the health equity payment.

Chris Weathington: "Are there any requirements in terms of participating with a certain number of health plans effective July 1?"

Julia Lerche: Not for this health equity payment.

Emma Sandoe: And again, it runs through from April to June, so this is prior to the launch of managed care on July 1.

Chris Weathington: Another question is, "Will using the funds toward the connection to the NC HIE be appropriate since that assists with care management, sharing of patient health information, and also helping to address health equity disparities?"

Emma Sandoe: I feel like that might have just answered the question. If it's an activity that you think improves or addresses health equity--and as I mentioned earlier, one of the things that we brainstormed in our very non-exhaustive list, was improvements to your data information flow; if you need more data in order

to better provide care management, that is definitely an area that we understand could require some investment.

Chris Weathington: Well, I think that's a great question and it seems like the answer is yes, and I can see a big need for this because it is not easy for practices to pay for the interface fees between their EHR and the HIE. So, that's a wonderful solution to that issue, so I thank you guys for offering that; that's going to be great.

Another question is, "So, to clarify, this is a payment just for having patients that meet a certain poverty level; it's just a payment just for having patients that meet a certain poverty level."

Julia Lerche: The determination of the practice locations eligibility is based on the average across all of the beneficiaries assigned to that practice location. So, the payment is not made at the beneficiary level; if a practice location has ten beneficiaries and the practice location qualifies, they would get the enhanced payment for all ten beneficiaries, including if, at the beneficiary level, they fall below the threshold. So, the threshold is determined, on average, across all of the beneficiaries assigned to that practice location. And if they qualify, they get the enhanced payment for all of the beneficiaries assigned.

Emma Sandoe: And it's not the income of the beneficiary themselves, it's the income of the area in which they live; because we know that a beneficiary environment is very much a determination of their health, as well as very closely correlated with their race and ethnicity.

Chris Weathington: Another question is, "Do I have to be part of a CIN to receive these payments or can I be independent of the CIN?"

Julia Lerche: You do not have to be part of a CIN to receive these payments.

Chris Weathington: "Is there an example of how this program has worked in other states?"

Emma Sandoe: I think once again, North Carolina is at the forefront of providing high-quality care to beneficiaries, and we have not heard of any other state that has taken on an initiative like this. If anyone else has, we'd love to hear it, but I think we are the first to make a headway in this area.

Chris Weathington: Well, this is kind of interesting because this is kind of like CMS, how they have their innovation lab where they try very innovative and creative approaches, some that work out wonderful and get rolled out across the country, and others they just... they tried something, it didn't work, okay. So, I think it's really cooled that North Carolina Medicaid is trying these innovative approaches to addressing a variety of different needs for the Medicaid population, so thank you.

Chris Weathington: The slides, by the way, were shared earlier. It was put into the answered Q&A box, but you can also access the slides on our ncahec.net website, so just want to let you all know that.

"Did you say that the first payment would be on April 1st?"

Emma Sandoe: So, I should clarify that the NCTracks communication will be up on NCTracks on April 1, but I think the Checkright comes a little bit after, and I don't know the exact date.

Chris Weathington: "If a practice needs equipment, for example, new refrigerators to store additional vaccines, would that meet the requirement for use of the funds?"

Emma Sandoe: I would say that if the practice is working to get vaccine to populations that are historically underserved, that definitely, if a refrigerator is needed, that makes sense as a way of spending those funds.

Chris Weathington: But probably keep the receipt just in case, right? I know you're not asking for receipts, but we talked about earlier, if someone were to complain, you can show what you did with the money. Alright. "Will the beneficiaries be aware of these payments and poverty scores?"

Emma Sandoe: If they read our bulletins on a regular basis, they may see that these payments are going out; and certainly, if they've been involved in other communications, they may know about them as well. But they are unlikely to know specific practice-by-practice information, but we're not doing a beneficiary outreach to let them know.

Chris Weathington: Well, your website is public information and I know there's information on your website about this too. Okay. I don't see any more questions yet; we'll give it a few more moments to see if anything else comes in. Is there anything you would like to mention, the three of you, that maybe we haven't yet covered or an aha moment that you've learned from all these questions that you want to share some additional details?

Emma Sandoe: Chris, I would love to just expand on your comment about that this is--I don't want to call it an "experiment", but it's something that we're testing and evaluating, and we do rely on our provider partners to make this program great and something that’s meaningful, and significant, and serving our marginalized beneficiary communities. And so, we do hope that one, practices will find this payment to be helpful in advancing our joint goals around increasing equity in North Carolina and that they will certainly let us know how it how it's working and if it doesn't work, so that if we're able to continue this into the future or do something in the future, that it will be informed by this experience.

Chris Weathington: That survey that you're going to send out, are you asking them what they did with the money, so that way, you could publicize examples of how this money was utilized?

Emma Sandoe: Yep, we will include a question of how the practices use these funds; and if practices would like to share their information more broadly, that would be

one great thing to work with us all on to take maybe something that was successful and share it more broadly with more groups.

Chris Weathington: Great. We'll just give it a few moments to see if there's anything else that comes in through... looking to see if there's anything else. What might be helpful is if you show those slides earlier. Can you move that to the earlier slide and some examples of how this money can be used? And this is not meant to be an exhaustive list, but... Emma, would you like to--I can actually do that for us and just kind of go through the examples of the different ways you can use the money.

So, you said some of the ways is you can make permanent enhancements to telehealth access; you just talked about, earlier, you can use this money to purchase an HIE connection to your EHR; staff training on implicit bias or cultural sensitivity, and ended on health equality: recruitment of key staff to reduce health and equity such as dietitians, health coaches; we talked about lactation consultants, community health workers, quality and clinical analysis, and actually quality improvement; COVID-19 specific responses such as additional vaccine outreach--while we're on that topic, pediatric vaccines are certainly an area that need to be addressed given that vaccination rates got worse during COVID-19, although I think that's getting a little bit better, but there's still plenty of room for improvement.

Emma Sandoe: Yeah, and I would add that even prior to 2019, there have existed disparities in pediatric vaccination rates, so working to get a higher level of vaccination rates amongst historically marginalized populations certainly would be an effort that would be a great way to improve health for historically marginalized populations.

Chris Weathington: Absolutely. And there's some other things too: adult diabetes, hypertension, infant mortality with prenatal and postpartum care; those are just some examples--cancer screenings, behavioral health screenings, there's a lot of that need as well. Also, improving practice infrastructure to address non-medical drivers of health, I think those are those social determinants of health that we talk about; and just investing in behavioral health supports and integrating behavioral health and physical health, so whether that's in-house or through partnerships with other resources in the community.

So, I want to see if there are any other questions that have popped in as we get ready to wrap this up. I don't see anything. Alright, just as I spoke, somebody brought in another question which is great. "Will we have a list of those patients that are determined to be in the poverty census or is it not at the beneficiary level?"

Julia Lerche: So, eligibility is defined at the practice location level. I don't know, Emma, if you want to expand on that. Maybe I’m not making it clear.

Emma Sandoe: So, it's at the practice location level based on the average of your beneficiaries you serve; so, you don't receive $9 if one beneficiary is in a very

high-poverty census tract and then zero dollars for a beneficiary that is in a lower-poverty census tract; it's based on the average of the beneficiaries that are assigned to you. And if you've got specific questions about your practice or where you fall, again, NCTracks will provide information about whether you're qualified; and then if you've got further questions, reach out to the contact center.

Chris Weathington: The other thing I would offer is that if--I mentioned about the AHEC Practice Support coaches, you can just email practicesupport@ncahec.net and we will make sure it gets to the right coach in your region to follow up, and we will follow up with Emma, Julia, and Terrell if there are questions that we don't already know the answer to.

But the last question--well, two more questions: "Will the recorded session be available?" Yes, it will; it'll be posted on our website so we will take care of you there. It should be most likely posted by tomorrow.

A question came in, "If we do not qualify, will we be notified of that as well?"

Emma Sandoe: I believe NCTracks only will inform practices that qualify; I don't think it will inform practices that don't.

Chris Weathington: So, it will notify you if you qualify; but if you don't qualify, then you just won't get a notification.

Emma Sandoe: Right.

Chris Weathington: And did you say NCTracks will notify us on April 1?

Emma Sandoe: I believe that's the date that they plan on sending that out and I would not get too worried if on April 2, you didn't see something right away because it may take them a little bit longer to get that notification out there.

Chris Weathington: But that's the intent. Alright. So, that covers it. So, we appreciate everybody's time, we're going to go ahead--alright, two more questions just came in and we've got a few minutes to spare. "After April 1, who can I contact to find out if I qualified?"

Emma Sandoe: The contact center would be happy to answer individual practice questions.

Chris Weathington: Is that the Medicaid contact center you're talking about?

Emma Sandoe: Uh-huh.

Chris Weathington: Okay. I don't know if you have that number, but if you do, that's great. If you don't, that's okay. It'll be on the website, I'm sure, for North Carolina Medicaid. "Will everyone be notified, even practices who don't get the payment?" I think we just answered that question: you will be notified if you

get it, if you're going to get it; and if you're not going to get it, you won't be notified. So, that's the cue.

And then, "Will some locations qualify and some not even if we are under one NPI?"

Emma Sandoe: Yes. So, we look at the eligibility at the location level; so, if an NPI has multiple locations, they may qualify for some locations but not other locations.

Chris Weathington: Alright. I think that covers it. So, thanks to all of you--Emma, Julia, and Terrell--thank you for this great work. I think it's wonderful that we're able to help address health equity in North Carolina, but also provide some kind of relief and resources to primary care practices that want to do right by their communities. So, thank you for this innovation. I'm looking forward to seeing the results of this.

And so, everyone, we will have a copy of the slides as well as the recording, the transcript, and answers to your questions posted onto our website pretty soon, probably by tomorrow at the earliest. And just thank you for your time and I appreciate all that everybody's doing to serve the state of North Carolina.

Have a good night, everybody.

Julia Lerche: Thank you.