NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

NC Medicaid: COVID-19 Preparedness
Medicaid Policies & Codes Related to COVID-19
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SLIDE 1. Thank you everyone for taking the time out of your day to join us tonight to get an update on what we are doing at North Carolina Medicaid to help the fields get ready for potential increases in infections in North Carolina. My name is on the slide but what I have to tell you is, I'm surrounded by the dream team. I have an amazing group of folks working with me and when we get to questions and answers you will hear their voices helping answer your questions. At the end of our time together, my goal is that everyone feels more comfortable and understands the next steps of how we try to modify the Medicaid program to meet your needs you can best care for your patients. And also so you know how to reach out to us if you're not getting what you need and if you have ideas we haven't thought of yet.

SLIDE 2. On the first slide, I want to share our philosophical approach on how we are coming around our response to the COVID-19 . The approach is around three things, collaboration, coordination and communication. We started working on this weeks ago. I think we had an impressive response at the state level from all of our different divisions. Collaboration has been key from the beginning and we're working hard to coordinate with the fields. And about practices of what you may be doing to share the buckets and how we are bucketing to work here at the state level. There are four we are using, the stuff, staff, space and standards of care. I thought this might be a helpful tool to use in your practice. That you have the right protective equipment and if not, do you know the resources to get to? You have contingency plans, are you taking care of staff safety? Do you have the versus sick areas? My son's family doctor office called us today to say they're moving his appointment for Monday afternoon to Monday morning because they were going to sequester their well patients in the morning and their sick in the afternoon and I thought that was a great idea. One way to create social distancing and to separate

the sick from the well. And the standard of care, are you familiar with protocols and ways different triage options are happening?

SLIDE 3. When we think about Medicaid and what we can do to help function as a policy level, there are strengths. We take care of over 2.1 million people in North Carolina which is about one in five people. We have strong partnerships with payers. Yesterday we had a payer council meeting. We had every payer in North Carolina as well as national at the table with us talking about what we could do and how we could partner to align policies and make sure we are all doing as much as we could together so the field was not confused. Working on sharing best practices with other states. One of our benefits, we partner with a lot of other states and we get to learn from them. Washington state has been sending information for weeks on things they have learned that we may want to put into place so we have a lot a partnerships around the country and as mentioned, Secretary Cohen has approached all of us to make sure we are working across divisions and that has helped us with this response. For positives, there are also challenges. From 20 years in practice there are times when I would get irritated with how slowly change happens. Some is federal and legislative authority. Example, 10 years ago physical therapy was difficult to get for Medicaid patients. That was a change in the legislation where it was limited by law on how many sessions they could cover. We were able to change that last year and now we have expanded physical therapy significantly. That's just an example. Another is around budget limitations. This year is particularly challenging because we didn't get a new budget. We plan to be live with transformation in February and that's on indefinite hold while we wait for a budget. There is also the audit risk. Having just been in the health system, there are times when in practice you want to make big changes due continuous quality improvement and get held up by audit and compliance teams because they were afraid if we do something, we would be out voted. We think about that, not just to protect practices but to make sure we're doing the best for the state.

We have a lot of strengths being a state Medicaid program but we also have challenges. One of my leaders on the team gave the analogy that this is like turning a tanker around in a canal. Moving the Medicaid program is a tremendous challenge. I think you'll be impressed by changes made in 10 days of escalating and ones I will tell you about coming next.

SLIDE 4. Our philosophy within Medicaid as we are responding to COVID-19. Bidirectional medication, I've done some public speaking over the last six months and share this with everyone I've spoken with, we don't you to suffer silently. If you're getting frustrated because of the service you need for patient or your workflows are what you need to do is impossible because of some sort of Medicaid barrier, we want to hear about it. We want

to hear early. We don't want to find out about something three months after their hundreds of frustrated providers around the state. We want to know early so we can be nimble and make changes. We are working closely with CCNC to help partner and get an indication out to the field. They are partners with us and partnered together to make sure no stone is unturned and we are getting information out as quickly as possible.

There will be cycles of improvement we will continually improve the changes we make as we react to COVID-19. It's important it to share with us if something is not working. We are moving much faster than traditionally to make these changes. We need to hear it is not working well so we can be in a cycle of continuous quality improvement just like you are doing in your practices.

There are three phases I will tell you about. The first phase is isolated cases that I will really be focusing on tonight. We will be having these webinars every couple weeks and if you will, you will hear about the messages that go live. We will put information out in every way we can so you can do the best job you can taking care of staff and patients. Will maintain access to proactive policy. The fundamental quarter is how do we make sure the beneficiaries that depend on us for care are able to have access. Some of the things I will tell you about our nontraditional. We think it will help with access. We will be action oriented. We plan to move quickly. You will see lots of changes, things you been hoping Medicaid would do for a long time, we will be able to do. I can't promise we get to keep doing it. Some of the things we make changes for will be specifically related to the COVID-19 response and whether we are able to continue those services will depend on those things I spoke about earlier.

SLIDE 5. I'm going to tell you about our first wave of initiatives that we are planning to release. Initiatives fall into three different buckets, the first around increasing patient access, the second on decreasing exposure to vulnerable populations. The third is on how we strengthen our foundation and that's for us in the Medicaid program also our entire field of providers out there.

There are two ways are working on patient access initially. The first is a broad set of telephonic codes we will give you more information about. The second is a telephonic pharmacy. Initially, these things go live tomorrow, Friday the 13th. We didn't realize that when we picked that day that it was a Friday the 13th. Next time we'll pick a less risky date. We hope it goes well. Pharmacy, we will extend emergency supplies for beneficiaries waiting on authorization. Right now you have 72 hours they can get supply; we are extending that to 14 days. The same is true for emergency supply for our locked in medication. Right now, it's 4 days extending to 14 days. The other thing we'll do around access is constantly monitoring our PDL. Will be able to move drugs from the preferred

side to nonpreferred side if we start seeing drug shortages happen. That will happen on the backend. The pharmacy team is monitoring this daily paying close attention to it. They will know by edits hitting the pharmacy quickly if we have a drug shortage problem. The plan is they will put those edits in place and it will happen seamlessly so will come back to you and it won't be a burden to the pharmacist.

SLIDE 6. Around reducing exposure to vulnerable populations, some pharmacy things we are doing is we're allowing for 90 day fills for generic and brand-name drugs. We are live early refills for non-controlled substances and we are removing will currently exist today for 30 day qualification to get the 90 day supply. Right now, in order to get 90 days you have to have gotten the drug for 30 days first and I think philosophically, that is to make sure the patient tolerates the drug well before you go on and give them a three month supply. We are getting rid of that area.

One of the other things we're doing is covering the cost of face masks for patients that might be high risk that require frequent transportation. We think about our dialysis patients who might have to leave the home 3-5 times a week and we want to make sure they're protected as much as possible. We are building in the lab code you can test for COVID-19 in your practice. We're using the UU0002 code but CMS is not put a reimbursement rate on that. It will be reimbursing at the influenza rate until we get guidance from CMS and then we will retroactively correct those for everyone. Not to worry, everyone will be made whole based on these lab costs. We are removing limits for certain durable medical equipment. Let's make sure patients aren't hitting any barriers getting out of the office of the home from the hospital to the home having to get out in the public any more than they have to. Gloves are an example, there are a lot of oxygen supplies we have that have prior authorization than we have limits around incontinence supplies for patient so we want them to get a longer duration of supplies if possible and not have prior authorizations to get in the way if they need respiratory supplies.

SLIDE 7. From a basic standpoint and how we strengthen foundation, we commit to you to be doing here the department, we will actively monitor that drug shortage list and being really nimble with modifying the PDL so your patients don't get hung up, unable to get medicine or your practices get stuck with a lot of administrative burden they don't need to have right now. Will be studying and developing telehealth changes in modernizing our telehealth policies. This is one of those turning the tanker in the canal challenges for us. We have fairly restrictive telehealth right now when we compare North Carolina to other states. We have actually started leading a team in December about modernizing our telehealth. This is pushing us to do this work faster. We have started meeting but this will get us moving quickly.

Will be setting the impact of other ways we may use our resources differently. An example is paramedics. Right now when they go to see a patient and they get a 911 call and they go to the home and maybe they treat a patient and the patient is really well, they don't need to go to the hospital or they refuse. They get to the home and the patient refuses, they cannot code for that work. They had to take her to the hospital in order to get paid. We're looking at how can we pay them to do that work instead of having them go to the hospital unnecessarily.

One of the things you ask you to do in the field is to remember a few things. One, office visit copays are not required at the time of visit for Medicaid patients. That has always been true with Medicaid, there is a federal guidance. We want to make sure there aren't any barriers to care for our patients. Will ask you to write prescriptions for 90-day supply. We will encourage pharmacies to fill that prescription for 90-day supply. I had the experience myself when I have written for 90-day supply and the patient only gets 30-day supply, we may want to have you follow-up if you see that happen, follows that the pharmacy and encourage them to fill the 90 days. Pharmacy teams will work with the Pharmacy to reinforce that as well.

We want you to consider limiting home visiting protocols that already exist. For patients that are vulnerable populations or in group living.

SLIDE 8. I will tell you about these telephonic codes. There are key features for these that are true for everyone. The code is only applied to existing patients in your practice. You cannot use this telephonic code for a new patient that calls your practice. The codes can only be provided by designated provider type. You will see that varies by code. There are different sets of codes that only certain providers can use. The third thing we will actually give you a way to get around it. For CMS guidelines, the visit, telephonic visit can't be paid if the patient has been seen in your practice in the prior seven days for the same problem or if they are seen within 24 hours. We would like to change that for the field because they don't think they'll be particularly helpful for you. I can think of examples where you may want to have a telephonic visit three days in a row for high risk patient with symptoms you want to keep out of the hospital and out of your exam room by doing telephonic calls. Maybe two or three days in a row and that next day you may say, you have to come in. I need to see you in person. We want to make sure you get paid for the work you did on those other days. If you use the CR modifier at all this will be in the Bulletin coming out tomorrow so don't worry about trying to learn all this on the fly tonight. If use the modifier, that will alert us that we will waive that exception around the 7 days in 24 hours related to this COVID-19 pandemic. I want to make sure your practice managers who are very cognizant of the rules of coding and your compliance teams and those of you in health systems really hear that. The modifiers will allow you to have some

flexibility. If they are just reading what the guidelines say, they will be nervous about this code. We would like to give you some cover and say we will be authorizing it.

SLIDE 9. Here's the list of codes. These will be in the Bulletin published tomorrow. We have a couple unique circumstances. Historically, telephonic codes were not allowed for federally qualified health centers or rural health centers. For a variety of reasons, those places could never use any of the codes. We have identified one telephonic code they can use: G0071. This is a code where the provider type is a physician, nurse petitioner, PA or midwife. Our purpose today, we will advise once you set for established patients and also those with COVID-19 symptoms.

If you have a vulnerable patient who has reasonably controlled hypertension but do for the six-month follow-up, if you want to bring them into your office for routine care. You have a telephonic visit and charge for that care that way and provide the refills.

We are at practices that are not RHC, FQHC. We have one code for the sick patient, we want you to use for COVID-19 patients. That's brief communication for those with COVID-19 . There are three codes time-based. 99441, 99442 and 99443 and that is around the amount of time you spent on the telephonic visit. They may see a young person has just a number of birth control pills in the prior year and they're due for refills, and want to make sure they don't run out of their birth control pills but not to come in to your office unnecessarily. Lots of ways we can use these codes. One of the reasons we decided to implement this was because there's a good chance a lot of health care providers will end up quarantined. They will end up having been exposed to the infection even though they feel great, and are happy to work, they will not be able to come into work. These will be a great way to maintain access for the state and your patients because you can be working from home. And if schools close down and you have to work from home because your children that need to be there, this allows you to stay in contact with your patients and provide care even though you may not be in the office.

The next set of codes are unique set we use for licensed non-physician behavioral health providers. These are the folks, your LPC, psychologist, associate levels of all those were they will be able to bill for time-based services on the phone as well.

We want you to remember to use that CR modifier, that lets us know even though you might not be following the time limits, we will not look at that twice and for audit purposes, there won't be any concerns.

SLIDE 10. I want to provide you with some resources you can learn more as your practice and teams respond to COVID-19. We have some Medicaid sites up here. Our Bulletin will

be out tomorrow on the website. It will have everything I've covered in more detail and links to the payment. You can see what the reimbursement will be for all these different codes. There are a lot of variables so I didn't want to go through them out loud on this call to save you that time but they are easy to access on the website.

We have a state COVID-19 website as well. I want also to let you know about a provider call that will happen every Friday from 12:30-1:30. That is partnership between Public Health where they will give updates on COVID-19. For the time being, that'll happen every Friday. We will have a Thursday evening provider webex every Thursday night. Medicaid will be on every other week. Our team will be on with policy folks answering questions and tell you about the next phases of work we will do. The in-between weeks, CCNC and AHEC will be hosting. Education they have done so healthy practices understand how to use these codes.

SLIDE 11. What I have shared today is our phase I intervention. We have a long list of phase 2 and phase 3 policy changes we're working on right now. As a matter fact we sent a list to the Secretary today for her to consider and help us decide which to move forward on. I will tell you, some of the virtual care we looked at, providers will be really pleased with. We are looking at being able to have physician to physician consult, a great use of that might be primary care provider who has a patient with refractory depression who doesn't want to go see a psychiatrist and you feel like you have maxed out everything you can do. We can then pay for there to be a psychiatric consultation on the phone or an infectious disease community where there can only be two or three docs and they need to be in the hospital. There are a lot of sick patients. Maybe primary care will pick up a lot of follow-ups they would otherwise have done. May need to consult with that doc.

We're looking at telehealth broadly and changing a lot of the restrictions we currently have in our telehealth policies. We would like to expand. Those are in legislation over the last session and they did not move forward. There are numerous reasons for that. We know that is our future and as I told you, we are leading teams on modernizing telehealth so this is an area on our work list of things to do. It will be something we will do faster because of COVID-19. We are looking at reimbursement for providers to communicate with patients through the secure patient portal. We know a lot of you are practicing medicine using the EMR after hours late at night, early in the morning when you're working those lists. We want to see if there's a way we can pay for that work you're doing in caring for patients.

We are looking at modifications of our personal care, private duty nursing, visit limits. As we get into a more widespread COVID-19 if that should happen in North Carolina, we will

look at eligibility and see if we could do anything to modify how we do eligibility in the state.

SLIDE 12. Things you can do to help make sure we are all doing our best work. Communicate. Don't just suffer silently. Let us know when things aren't working. Keep the ideas flowing. A lot of you have terrific ideas. That is a mixed blessing. Sometimes I'm noticing my inbox is getting flooded. By reading that email and responding I'm not able to act on some of the things we are acting on and I think everyone is feeling very stressed right now. I will tell you from a telehealth standpoint, we are digging in and talking about everything. I want to reassure you that we are working incredibly diligently on our telehealth policies. Work for your specialties. If you have ideas, whatever society you work with, have them help pool your recommendations together and send it to us as one document.

Stay healthy. We want you to model the behaviors you want your patients and staff to exhibit. Here at the department, we are all starting to telework. We are working remotely which in some ways is great. I can climb back up the mountain and go to Asheville and get my job done without feeling guilty. Is difficult to do that telework. Make sure you're doing the things you can to stay healthy, especially when you're in the clinic, seeing the patients. We know you're taking care of the sick people. We want you to stay well. And take care of your families. This has been a stressful time for everyone. Emotionally, stressful for a lot of people, certainly our patients with behavioral health needs are feeling heightened anxiety. Ensure everyone is taking care of each other.

Keep being amazing. I am a North Carolinian, born and raised. I am proud of the health care environment we have and always have been. We do tremendous work, we believe in quality and outcomes. I think it's important to say that. North Carolina has an incredible health care workforce. We also have more providers that take care of Medicaid patients than probably any other state. That's one of the unique aspects in North Carolina. Working together is really important. You sure we're still taking care of North Carolinians with a high quality of care. I think this is a chance to band together and reunite and some of those disparate workflows that happen over the last couple years. I'm excited we are partnering so closely with CCNC and AHEC. Together we will do everything to make sure the providers are caught up and you know what's going on and you're getting your needs met.

On here, I have an email address that if you have input questions, concerns, if these codes are working, if you're running into problems, we want to hear all of them. I put my contact information on there, that's my cell phone, email address.
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