NC Department of Health and Human Services
Division of Health Benefits

NC MEDICAID
UPDATES FROM THE CMO

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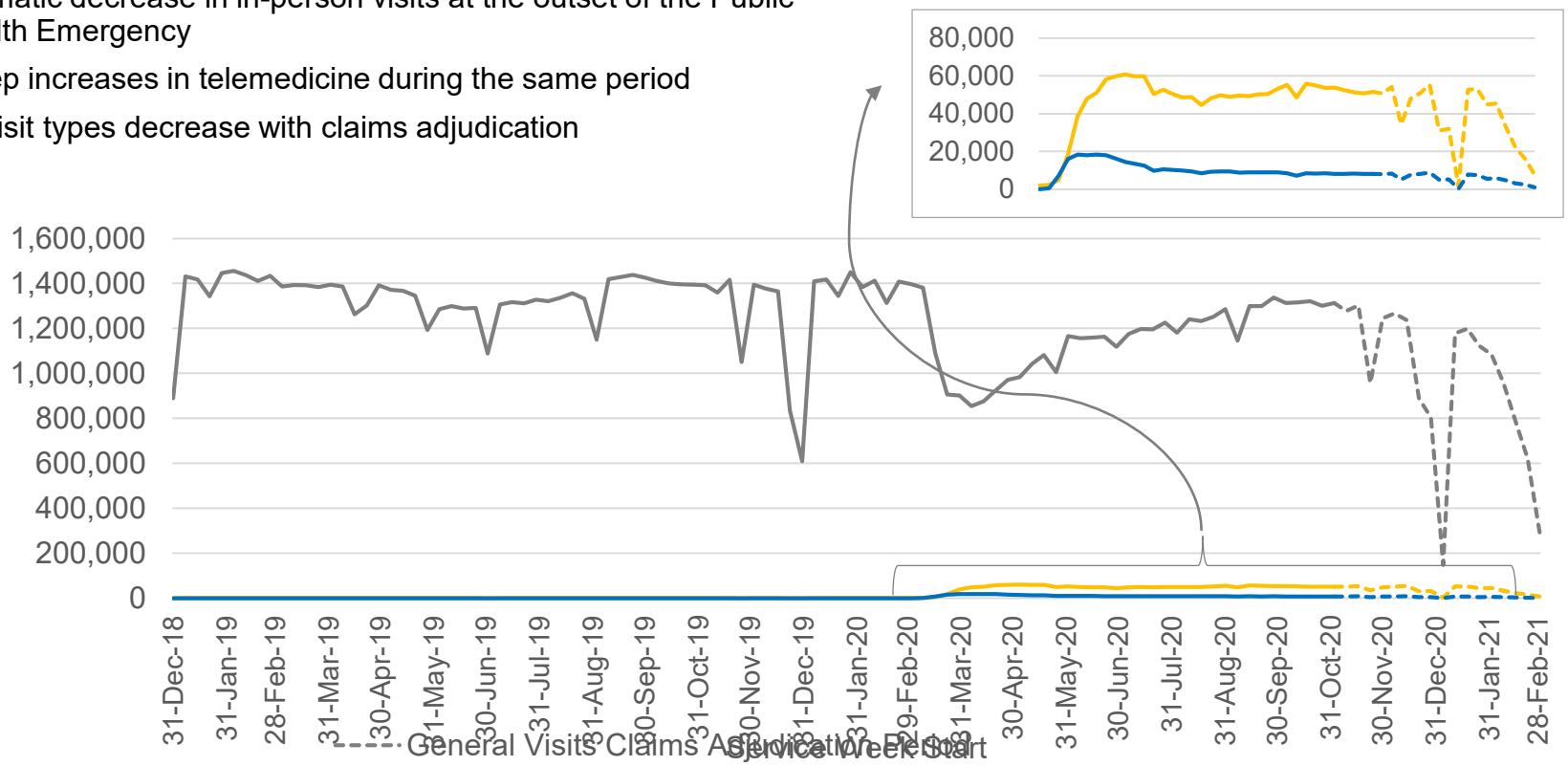
Medical Care Advisory Committee (MCAC) Meeting

March 19, 2021

Telehealth Updates

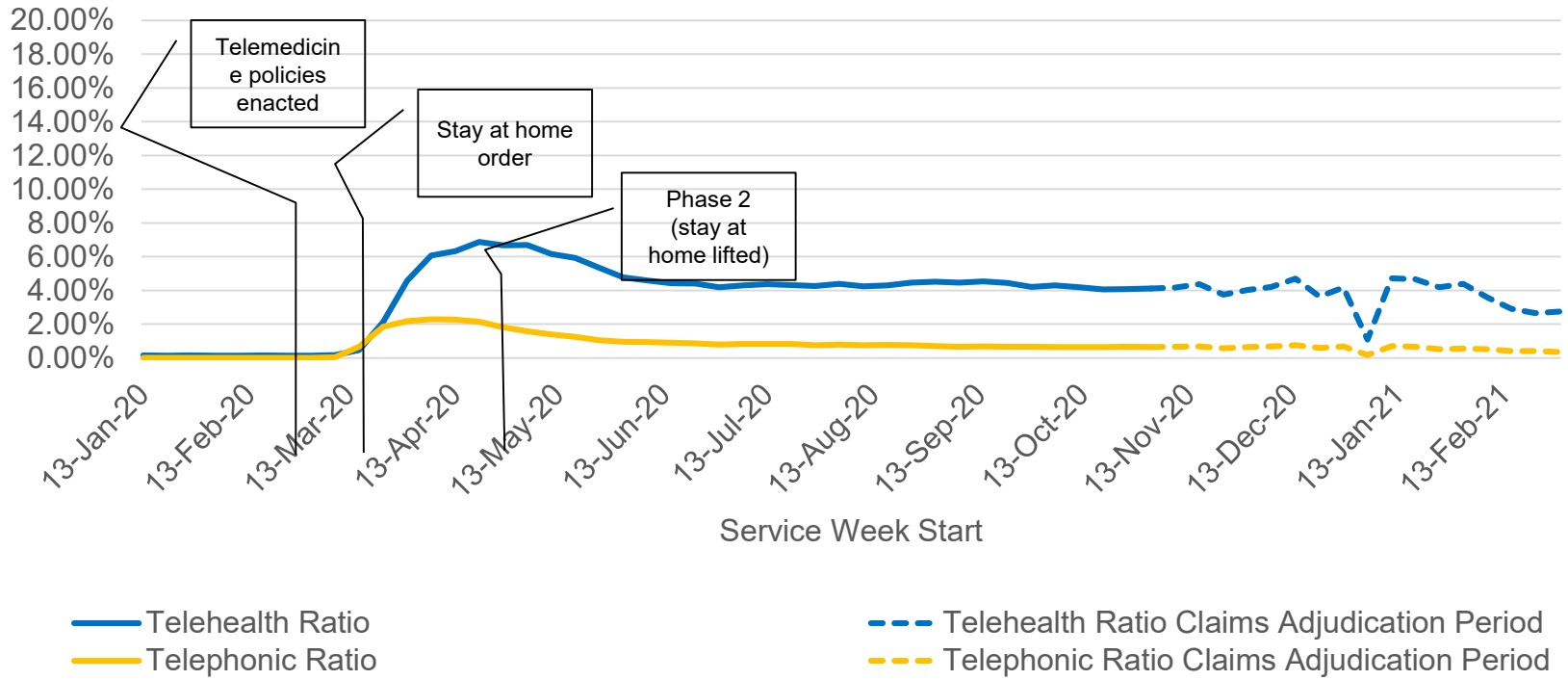
Telehealth, Telephonic, and In-person Claims Volume | 12/31/18 – 03/01/2021

- Dramatic decrease in in-person visits at the outset of the Public Health Emergency
- Steep increases in telemedicine during the same period
- All visit types decrease with claims adjudication

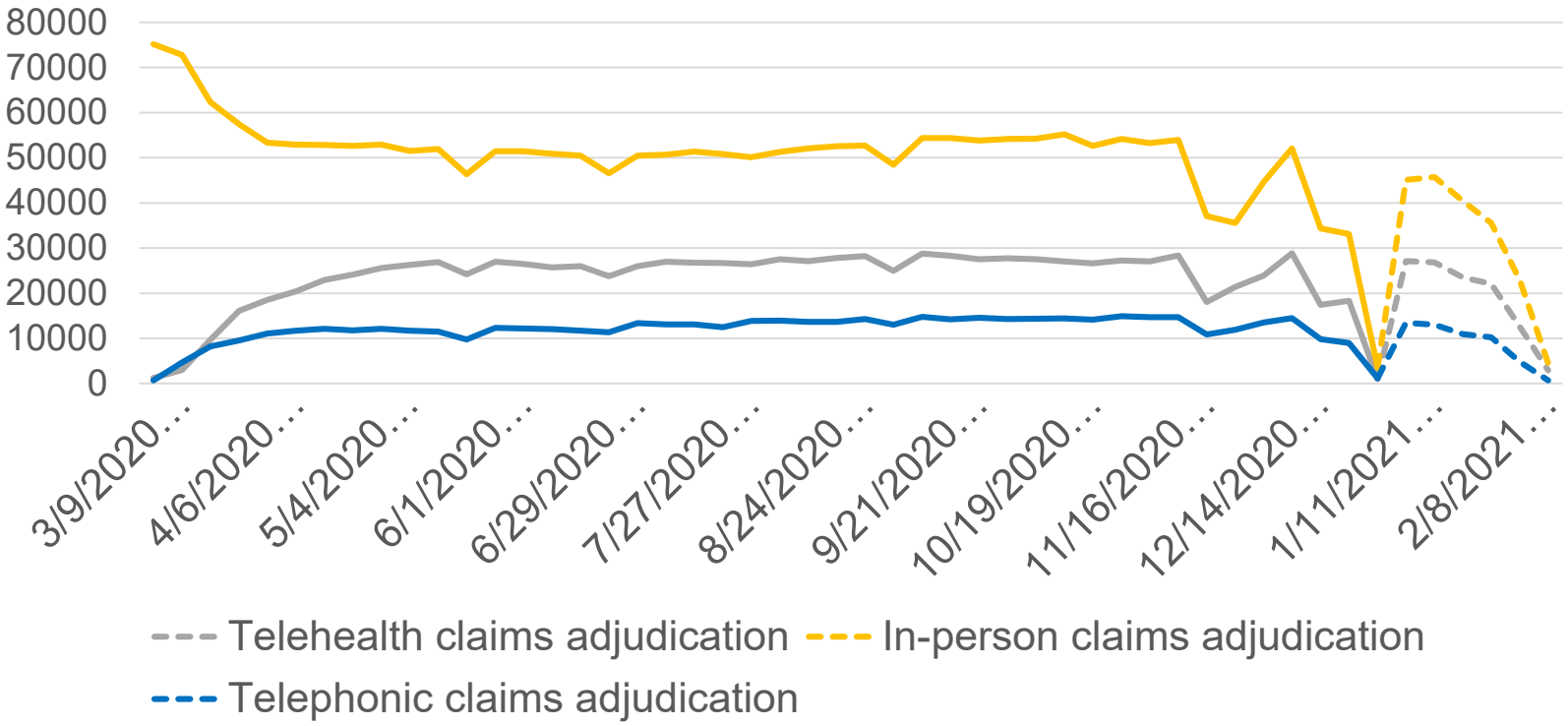


Ratio of Telehealth and Telephonic Claims to General Claims | 12/31/18 – 03/01/2021

Ratios jump after DHB's March 10th implementation telehealth/telephonic policy changes



Telehealth, Telephonic, and In-person Behavioral Health Encounters Volume 03/09/2020 – 2/15/2021



Telehealth Flexibilities in Outpatient Specialized Therapies (Jan 1, 2021)

Psych/counseling in school, and respiratory therapy codes activated for telehealth outside of PHE:

CPT code	Description
90832	Psychotherapy, 30 minutes with patient
90834	Psychotherapy, 45 minutes with patient
90837	Psychotherapy, 60 minutes with patient
90847	Family psychotherapy (conjoint psychotherapy) with patient present
90853	Group psychotherapy (other than of a multiple-family group)
94664	Demo and/or eval of pt. utilization of an aerosol generator nebulizer, metered dose inhaler or IPPB device
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determ.
99504	Home visit for mechanical ventilation care

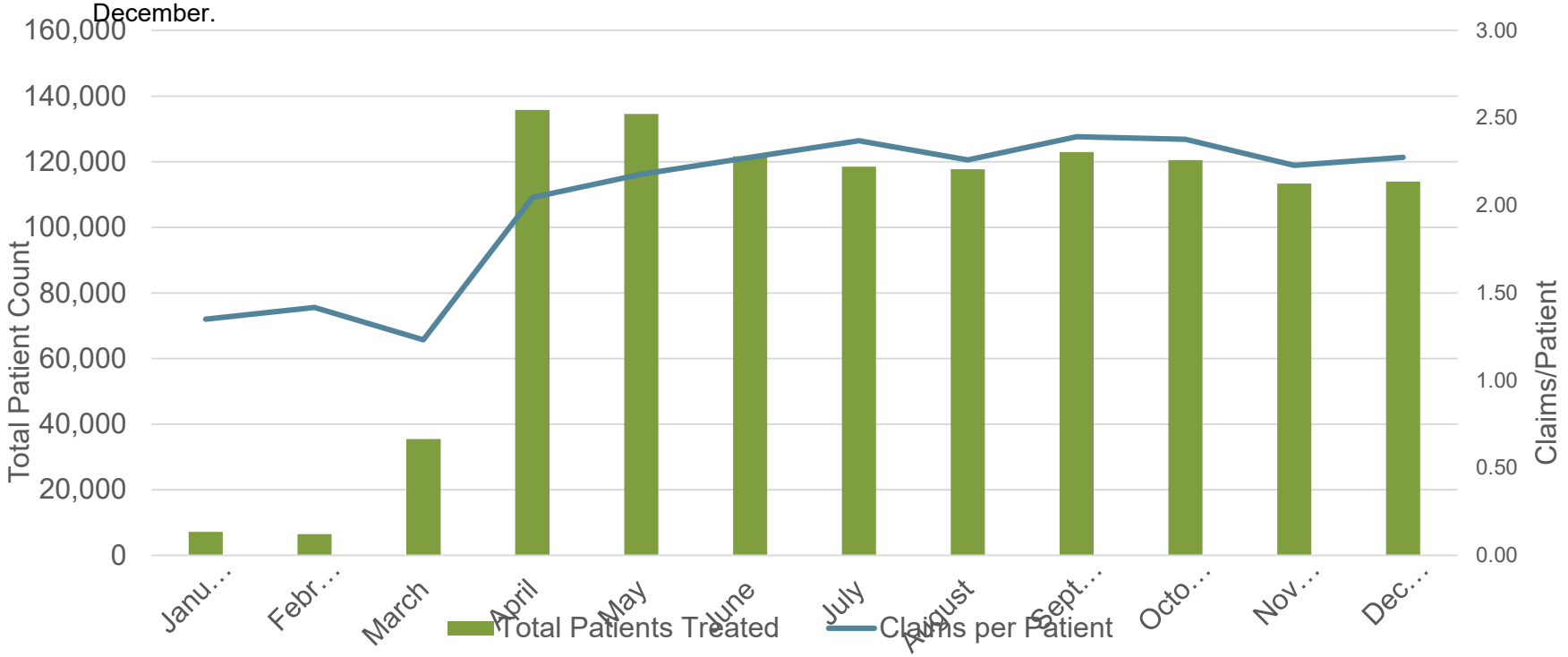
Telehealth Flexibilities in Outpatient Specialized Therapies – Proposed

Speech/language eval & treatment codes proposed for telehealth outside of PHE, for March PAG Review:

CPT code	Description
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production
92523	Eval of speech sound production, w/eval of language comp, expression
92524	Behavioral and qualitative analysis of voice and resonance
92607	Eval for prescription for speech-generating augmentative and alternative communication device, first hour
92608	Evaluation for aug-comm device, each addt'l 30 minutes
92507	Tx of speech, lang, voice, comm, and/or auditory processing disorder
92526	Tx of swallowing dysfx and/or oral function for feeding (feeding only)
92609	Therapeutic services for use of speech-generating device, including programming and modification

Telehealth Service Patient Utilization

Risk: An aberrant increase in patient utilization via telehealth may increase the risks of over-utilization given the increased access to patients.
Observations: Across all DHHS payers and services, patient utilization of telehealth services logically increases in March – April in correlation with the onset of COVID-19 pandemic quarantine measures, followed by a consistent trend through December.



Medical Homes

Who's Your Doctor?

- DHB is currently testing panel assignment lists with volunteer practices (Peds, Internal Med, Family Med, FQHCs)

- DHB is testing ability to switch assignment prior to launch
  - Looking at members who did not see assigned PCP but did see another PCP
  - Look-back at 24 months of claims at any PCP visit
  - Consider any site under the NPI 'same PCP'
  - Looking at last seen*, most seen, geographic proximity
  - Timeline for completion: March/April 2021
  - Members will get new Medicaid cards

- DHB is working on cheat sheets/potential areas for alignment across Health Plans to help navigate panel management after managed care launch

AMH Tier 3 Glidepath Overview

In the three months prior to Managed Care launch, the Department will make an $8.51 PMPM payment available to AMH Tier 3 practices that successfully attest to glidepath requirements.

- Qualifying practices will receive payment for each month in which they meet the eligibility requirements.
- $8.51 PMPM payments will flow to practices as an addition to practices' current CA II Payments.
- If practices are not ready by "Opportunity 1" they can attest ahead of "Opportunity 2" or "Opportunity 3."
- **Practices only need to attest once.**

Healthy Opportunities Screening, Assessment and Referral Payment (HOSAR) Overview

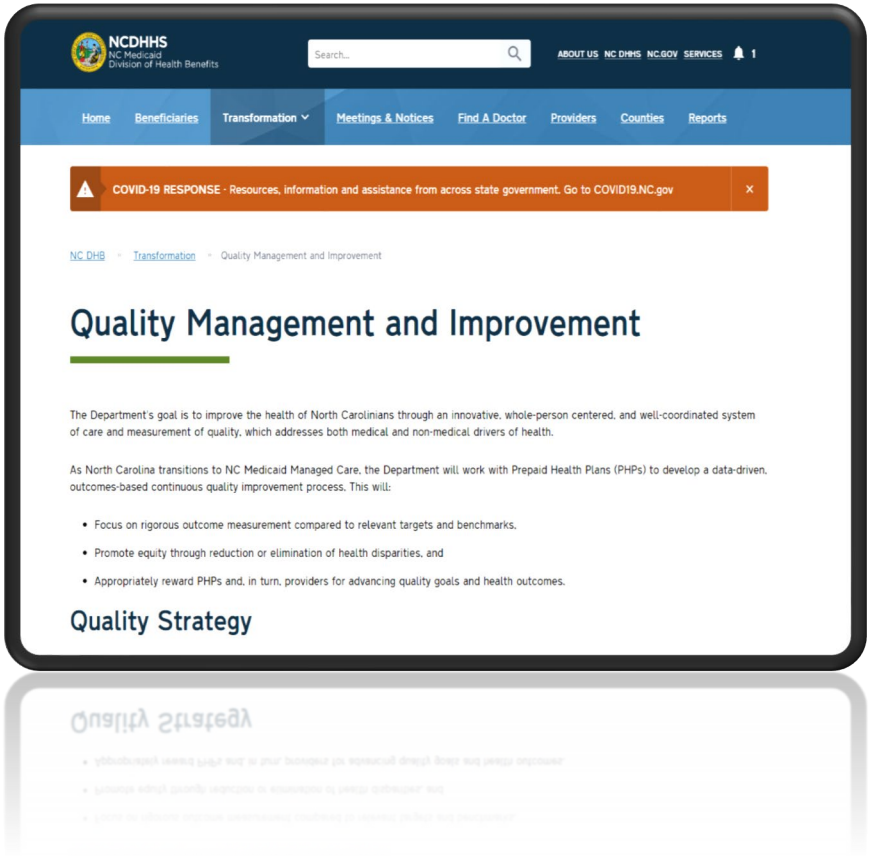
- Effective January 1, 2021, NC Medicaid and NC Health Choice is temporarily covering **Healthy Opportunities screenings** to encourage providers to gain capacity for screening Medicaid beneficiaries for unmet health-related resource needs and referring them to appropriate community-based resources, prior to the launch of Medicaid managed care.

- **Current Carolina Access (CAII) providers** are eligible to bill code **G9919** for positive healthy opportunities screenings conducted using the Department's standardized screening questions or equivalent questions. Coverage of this code will continue through June 30, 2021; continued coverage after managed care launch will be at the discretion of the Health Plans.

Please see DHHS website for more information about HOSAR:
https://medicaid.ncdhhs.gov/blog/2021/02/01/temporary-clinical-policy-modifications-payment-healthy-opportunities-screening-and

Medicaid Quality: Public Reporting of Performance

- ✓ ***Medicaid Quality Strategy*—outlines aims, goals, objectives and interventions to assure, monitor, and improve quality**
- ✓ ***Annual Quality Report*—4 years of data on Medicaid quality**
- ✓ ***Quality Measure Technical Specifications:* Standard Plan and Tailored Plan measure sets with technical specifications and targets**



https://medicaid.ncdhhs.gov/transformation/quality-management-and-improvement

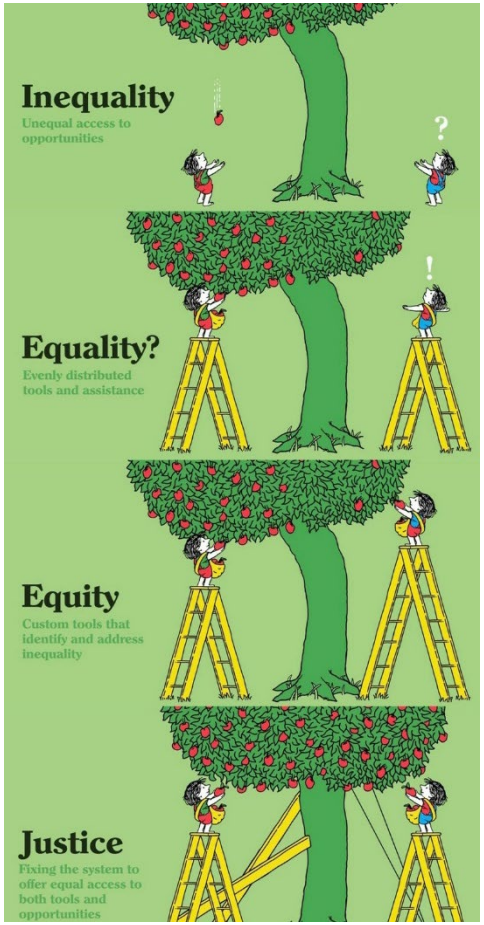
Combining Overall and Disparity Targets

Each year the proportion of AA/Black beneficiaries in health plan B that receive the flu vaccine (blue icons) increases by 10% while the proportion of white beneficiaries that receive the flu vaccine (orange icons) increases by 5%. Health plan B's performance goes from 65% (650/1000) in 2019 to 81% (810/1000) in 2022 and the disparity has been reduced.

Driving Equity

Carolina Access Temporary Health Equity Payments

NC Medicaid's Focus on Health Equity



Proposed Payments

- **Available: April – June 2021**
- **Eligible providers: Carolina Access I and II providers serving beneficiaries from high needs areas.**
- **Increased PMPM based on practice's mix of beneficiaries (measured by poverty rate at beneficiary's census tract).**

Carolina Access Temporary Health Equity Payments

How Proposed Payments are Determined

Poverty Score Determined by Poverty Level of Beneficiary's Census Track	Enhanced Payment
<17.4%	$0 PMPM
17.4% - 21.4%	$9 PMPM
>21.4%	$18 PMPM

+/- 2 percentage points of 19.4% (Medicaid beneficiary overall Poverty Score)

Example

Census Tract	Poverty Rate for Tract	Patient Dist. by tract PCP1	Patient Dist. by tract PCP2	Patient Dist. by tract PCP3
A	10%	25%	0%	0%
B	15%	50%	40%	0%
C	20%	25%	40%	50%
D	25%	0%	20%	50%
Wtd Avg Score		15%	19%	22.5%
Enhanced Payment		$0- Under Threshold	$9 PMPM	$18 PMPM

Carolina Access Temporary Health Equity Payments

Suggested Uses of Payments to Address Health Equity for PCMH payments

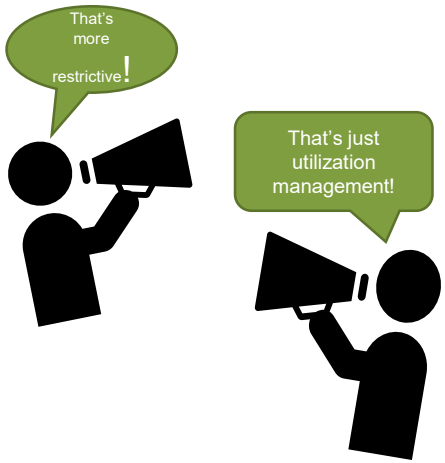
- **Telehealth:** enhancements to telehealth access
- **Health Improvements:** additional patient engagement in key health areas such as prevention of chronic disease, supporting behavioral health needs, and maternal and child health
- **Staffing:** staff training, data analysis, and recruitment of key staff working to reduce health inequity such as community health workers
- **COVID-19:** response to the pandemic to close care gaps resulting from deferred services or vaccine outreach
- **Social Drivers of Health:** improving the capacity to address non-medical drivers of health

Resources

- CDC Practitioners Guide for Advancing Health Equity
- AAFP Addressing Social Determinants of Health in Primary Care
- IHI Achieving Health Equity
- NCHA Resource Center

Clinical Policy in Managed Care

What is the Floor vs. What is UM?



1. All policy must meet the NC Medicaid definition of Medical Necessity, as defined in 10A NCAC 25A.0201.
2. Policies from PHPs cannot be more restrictive than current DHB policy; however, pursuant to 42 CFR 438.210(a)(3), an MCO may place appropriate limits on a service for the purpose of utilization control as outlined below:
   - Amount/Duration/Scope: If medical necessity is evaluated and it is a covered service, it is acceptable to have limitations placed for UM so long as the service is ultimately able to be provided in the amount, duration and scope that reasonably achieves the purpose.
   - Location: There are no limitations applied to policies if medical necessity is met. UM standards can direct a beneficiary to preferred locations so long as the covered service is available within the Department's defined network adequacy standard for that specialty (example: ≥ 2 providers within 15 miles urban, 30 miles rural) AND does not create undue transportation or access barriers. Additionally, continuity of care standards should apply and allow for continued service in an existing therapy relationship regardless of location of service.
   - The utilization management criteria (e.g., InterQual, MCG, and other national and state standards) must be reviewable by the state and based on a medical necessity standard.
3. The "floor" of coverage for prevention services is as defined by USPSTF guidelines. PHPs may choose to cover more services based on evidence-based guidelines that are more clinically permissive than defined in USPSTF guidelines but not fewer.

CASE EXAMPLES: Floor Vs. UM

Clinical Policy Area	Example	DHB Position	Utilization Management Approval
Transplant	Existing DHB policy states a patient may have a transplant if they have abstained from alcohol for 1 year. A PHP policy may not have criteria that requires 5 years abstinence.	POLICY	DENIED. Would not allow absolute stops for criteria explicitly covered in our written policy.
Outpatient Based Opioid Therapy	Existing DHB policy states a patient may have 24 urine drug screens in a calendar year. PHP policy may place a PA on drug screens after 18 to demonstrate medical necessity.	POLICY	APPROVED* Would allow for PA process for testing that happened starting at a lower utilization level if current policy limit available when medical necessity is demonstrated.
Diabetes Testing	Existing DHB policy is silent on HgA1C testing. PHP policy may place a PA on HgA1C based on medical necessity. i.e., 4 a year covered, but to have more frequent than q3 months must meet criteria such as “adjusting insulin, frequent low sugars”.	SILENT	APPROVED. Would allow for PA process for testing that happened if ultimately available when medical necessity is demonstrated.
Colon Cancer Prevention	DHB policy is silent on frequency of colonoscopy for screening purposes. PHP policy may place a PA on colonoscopies that occur more frequently than USPSTF guidelines.	SILENT	APPROVED. Would allow for denials for frequency that is outside recommended coverage by USPSTF.
AAA Screening	DHB policy is silent on AAA screening. PHP proposes excluding all women from AAA screening. PHP policy may place a PA on AAA for women who meet USPSTF criteria but could not deny all women AAA screening.	SILENT	DENIED for 2 Reasons. 1. Excluding a gender entirely would be discriminatory. 2. Would not allow absolute stops for women to receive AAA screening but would allow denials if not USPSTF Grade A or B recommendation.
Physical Therapy	DHB currently reviews all specialized therapy services for medical necessity but does not impose site criteria on hospital outpatient clinics. PHP policy may place a PA on PT/OT services in a hospital-based facility if lesser cost, clinically equivalent services are provided in the same community at a non-hospital-based site of service.	POLICY	APPROVED. Acceptable to have site of service preferentially dictated if it meets geographic distance requirements.
Pharmacy	DHB requires all appropriately submitted PDP drugs to be approved without PA. PHP policy want to add clinical criteria or prior authorization to PDP drugs.	POLICY	DENIED. Pharmacy policies are listed as required policies for the PHPs to follow as stated in the contract V.C. Table 6. PHPs must match PA criteria for all required policies.

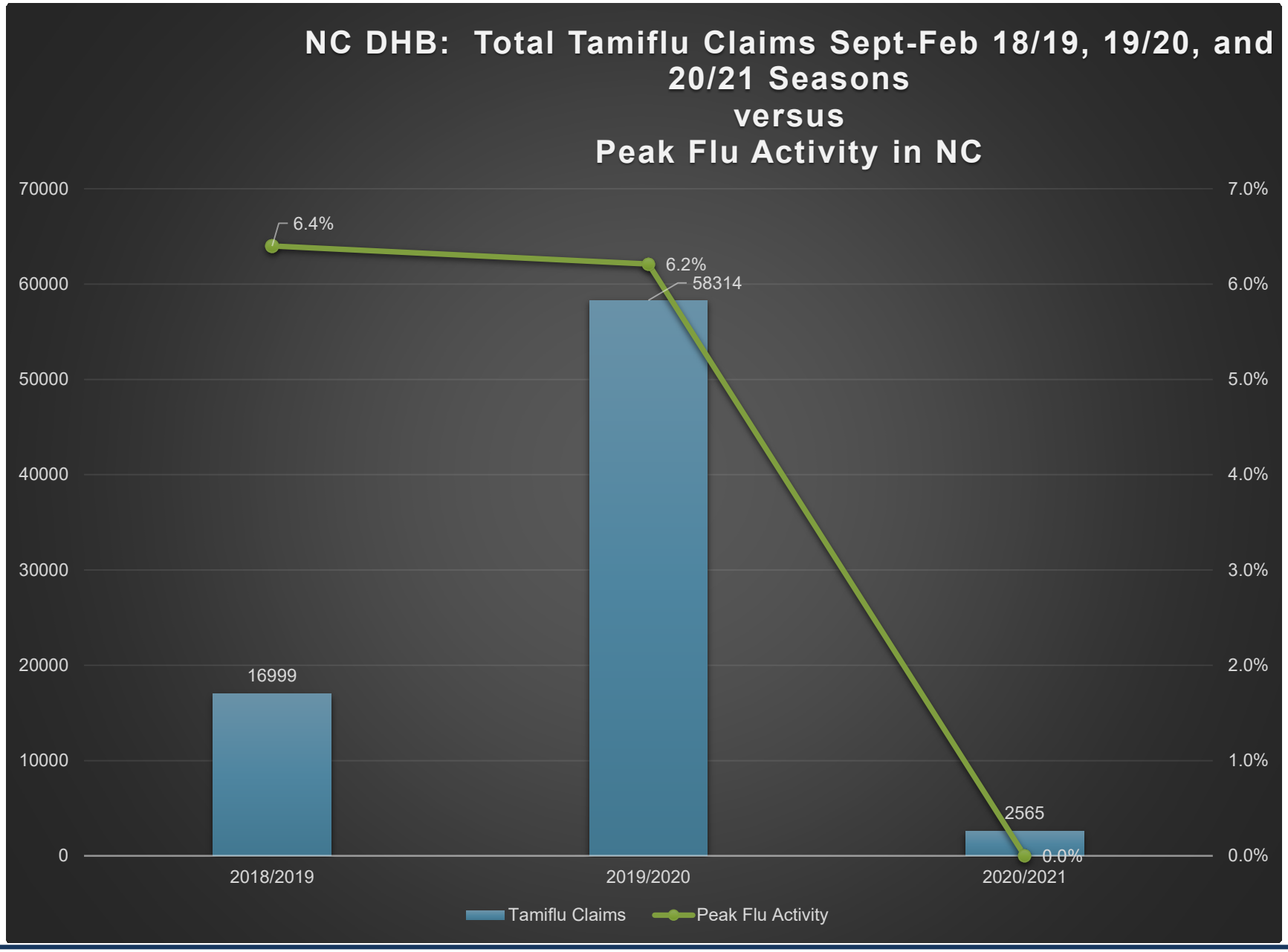
Oversight of Attestation

- **Post-Managed Care Launch, in addition to random policy audits the Department will also review utilization data including PAs, member and provider grievances and appeals, and claims data to identify outliers in service denials.**
  - **The Dept may request to review associated policies based on detailed framework to confirm adherence to attestation.**
  - **If found to be out of compliance, PHP would be subject to Liquidated Damages as defined under the contract and may be required to submit additional policies for review and approval by the Department.**
    - **PHPs would have the option for an adjudication process to review Liquidated Damages prior to finalization.**

- **In Lieu of Services (ILOS) and Value-Added Services (VAS) will not be incorporated into the proposed attestation process. All ILOS & VAS will be reviewed and approved by the Dept in accordance with a separate process that is currently being developed.**

Pandemic Positives?

How A Pandemic Changes Flu Season



Questions?