NC Department of Health and Human Services
Division of Health Benefits

NC MEDICAID
UPDATES FROM THE CMO

Shannon Dowler, MD

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

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Telehealth claims adjudication

In-person claims adjudication

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

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 minutes with patient</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 minutes with patient</td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 minutes with patient</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy) with patient present</td>
</tr>
<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
</tr>
<tr>
<td>94664</td>
<td>Demo and/or eval of pt. utilization of an aerosol generator nebulizer, metered dose inhaler or IPPB device</td>
</tr>
<tr>
<td>94760</td>
<td>Noninvasive ear or pulse oximetry for oxygen saturation; single determ.</td>
</tr>
<tr>
<td>99504</td>
<td>Home visit for mechanical ventilation care</td>
</tr>
</tbody>
</table>
## Telehealth Flexibilities in Outpatient Specialized Therapies – Proposed

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

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

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

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).

NC Medicaid's Focus on Health Equity
Carolina Access Temporary Health Equity Payments

How Proposed Payments are Determined

<table>
<thead>
<tr>
<th>Poverty Score Determined by Poverty Level of Beneficiary's Census Track</th>
<th>Enhanced Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;17.4%</td>
<td>$0 PMPM</td>
</tr>
<tr>
<td>17.4% - 21.4%</td>
<td>$9 PMPM</td>
</tr>
<tr>
<td>&gt;21.4%</td>
<td>$18 PMPM</td>
</tr>
</tbody>
</table>

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

Example

<table>
<thead>
<tr>
<th>Census Tract</th>
<th>Poverty Rate for Tract</th>
<th>Patient Dist. by tract PCP1</th>
<th>Patient Dist. by tract PCP2</th>
<th>Patient Dist. by tract PCP3</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>10%</td>
<td>25%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>B</td>
<td>15%</td>
<td>50%</td>
<td>40%</td>
<td>0%</td>
</tr>
<tr>
<td>C</td>
<td>20%</td>
<td>25%</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>D</td>
<td>25%</td>
<td>0%</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>Wtd Avg Score</td>
<td></td>
<td>15%</td>
<td>19%</td>
<td>22.5%</td>
</tr>
</tbody>
</table>

Enhanced Payment

$0- Under Threshold $9 PMPM $18 PMPM

Example 17
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

<table>
<thead>
<tr>
<th>Clinical Policy Area</th>
<th>Example</th>
<th>DHB Position</th>
<th>Utilization Management Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant</td>
<td>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.</td>
<td>POLICY</td>
<td>DENIED. Would not allow absolute stops for criteria explicitly covered in our written policy.</td>
</tr>
<tr>
<td>Outpatient Based Opioid Therapy</td>
<td>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.</td>
<td>POLICY</td>
<td>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.</td>
</tr>
<tr>
<td>Diabetes Testing</td>
<td>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”.</td>
<td>SILENT</td>
<td>APPROVED. Would allow for PA process for testing that happened if ultimately available when medical necessity is demonstrated.</td>
</tr>
<tr>
<td>Colon Cancer Prevention</td>
<td>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.</td>
<td>SILENT</td>
<td>APPROVED. Would allow for denials for frequency that is outside recommended coverage by USPSTF.</td>
</tr>
<tr>
<td>AAA Screening</td>
<td>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.</td>
<td>SILENT</td>
<td>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.</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>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.</td>
<td>POLICY</td>
<td>APPROVED. Acceptable to have site of service preferentially dictated if it meets geographic distance requirements.</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>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.</td>
<td>POLICY</td>
<td>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.</td>
</tr>
</tbody>
</table>
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

NC DHB: Total Tamiflu Claims Sept-Feb 18/19, 19/20, and 20/21 Seasons versus Peak Flu Activity in NC

- 2018/2019: 16999 Tamiflu Claims
- 2019/2020: 58314 Tamiflu Claims
- 2020/2021: 2565 Tamiflu Claims
Questions?