Welcome to the 2020 Virtual Rural Primary Care Conference!

Hosted by the NC Office of Rural Health in partnership with NC Community Health Center Association and NC Rural Health Leadership Alliance

Thursday, October 22, 2020 9:00 am – 2:45 pm
Housekeeping

- Please keep your lines muted when not speaking
- Submit questions in the chat box or use the raise hand feature during designated Q&A sections (click 3 dots on lower panel)
- Use the call-in feature to improve sound quality
  - This can be found in your event registration or if you click the ❓ button on the top left
- Use the active speaker view for best view of panelists
- Take breaks as needed
- Sessions will be recorded
Agenda

• Welcome & Housekeeping

• Keynote –
  Michelle Rathman,
  President & CEO, Impact! Communications, Inc.

• Value-Based Care

• Quality & Value-Based Care Leading to Practice Improved Outcomes

• BREAK: 10:45 am – 11:00 am

• State & Federal Policy Issues impacting NC’s Health Centers

• NETWORKING LUNCH: 12:00 pm – 12:45 pm
  Benson Area Medical Center, Inc. Video presentation & COVID19 discussion

• The Role of CHWs During COVID19 & Beyond

• CARES Act Initiatives through ORH

• Health Information & Technology Overview – Implementing Telehealth, NCCARE360 Plus, Medicaid Transformation

• Wrap up & Adjourn
Welcome from your ORH Rural Health Operations Program Team

Dorothea Brock, MPH
Rural Health Operations Manager
Clinical Quality / East

Monifa Charles, PhD
Rural Health Operations Specialist II
Operations & Policy / South Central

Caroline Collier, MPH
Rural Health Operations Specialist II
Professional Development & Training / West
Objectives

- Understand collaboration’s ripple effect and its power to drive advocacy
- Know how your organization can celebrate National Rural Health Day
- Understand the underlying goals of Value-Based Care
- Recognize current policy issues facing health care centers in North Carolina
- Increase knowledge of additional CARES Act initiatives through ORH for patients, providers and communities
- Identify ORH Health IT initiatives and telehealth
- Increase operational knowledge of NCs transition to Medicaid Managed Care
Introductions

Maggie Sauer
ORH Director

Michelle Rathman,
President & CEO, Impact! Communications, Inc.
Meet Michelle.

Michelle is the founder of Impact! Communications, Inc. In their over 30-year history, Impact! has worked with academic, for-profit, Critical Access and rural hospitals, clinics, primary and specialty care provider practices in over 30 states. Michelle and her team are strategic and creative thought partners with several national rural health focused organizations and serve as strong advocates for programs and policies that ensure access to quality local health care, with an equal focus on improving population health by addressing social determinants in meaningful, equitable and sustainable ways.

“Advocacy is the multiplier for health equity.”
- Michelle Rathman
Solvable Dilemmas.

Multiple organizations serving the health needs of diverse rural populations in the same state with varying and competing priorities—challenges growing, resources shrinking.
Opportunity.

The year of 2020 is an invitation to rethink our individual roles in the creation of the problems before us. Now is our opportunity to see the big picture, putting into place the pieces we need to solve this full-sized puzzle.

It’s bigger than you and me and it begins with **ADVOCACY**.
What are you advocating for?

If you can’t name it, you’ll be hard pressed to claim it.

Name your priorities, challenges, and goals. How are they different from others in your state working in the rural health space?

One Voice & The Power of Advocacy | October 22, 2020
Ensuring High-Quality for All
Rural health organizations must constantly find ways to improve and maintain the highest quality of care and service.

Keeping the Lights On
Rural health organizations are fighting to save programs that keep them viable. Money in fact, is everything.

Removing Barriers to Access
Access to the services and resources that support and promote overall health and wellbeing is a growing crisis.

Communicating your Value
With so many competing voices, it can be difficult to reach and engage stakeholders, including those you need to hear you the most.

What Do You Have in Common?
Competing priorities often share urgency.
What you focus your attention on expands.

Advocacy’s Potential Effect

**Butterfly**
An initial condition in which a small change in one state can result in large differences in a later state.

**Domino**
The cumulative effect produced when one event sets off a chain of similar events.

**Snowball**
An initial state of small significance and builds upon itself, becoming graver and perhaps potentially dangerous or disastrous.

One Voice & The Power of Advocacy | October 22, 2020
The Ripple Effect.

Occurs when an initial disturbance to a system spreads outward to wake up an increasingly larger portion of the system.
Starts with a Stone.

Imagine each of you standing side-by-side on the shore of a body of water with a stone in our hand.
The Power Rural Health Advocacy

Whether your efforts are for your own organization and community, the region or state, stones represent the mission. How you cast them will ultimately determine the reach.
Collaboration Amplifies.

What movement changed the world for the better with only one person seated at the table?
Why Collaborative Advocacy Works.

It frames a more strategic discussion among collaborative members for the work.

Focused
Shared vision diverse talents.

Relationships
Building a breathing culture of trust.

Accountability
Keeps the mission on course.

Infrastructure
Provides the foundation for the work to continue.

Measurable
Shows evidence of progress and success.

One Voice & The Power of Advocacy | October 22, 2020
The Ripple Effect.

Exploring the process for making an impact where you are.

One Voice & The Power of Advocacy | October 22, 2020
Focus First on Stakeholder Engagement.

They support or oppose decisions, can be influential in the organization or within the community, hold relevant official positions or be affected in the long term.
Who are your stakeholders?

- People you haven’t met yet
- Patients and their care partners
- Community Leaders
- Every Employee
- Board Members
- Legislators
Stakeholder Engagement Is a Relay Race. Not a Sprint.

Advocacy efforts are successful when a common goal remains at the forefront.

The way to transform an idea into action, a moment into a movement that sustains and grows is to approach it in the same way brands create loyalty.
Inspired by over 60 MILLION PEOPLE COUNTING ON US

“Never underestimate that even the smallest idea has the potential to make an enormously positive impact.”

Everything begins with a thought, and when that idea becomes a vision worth pursuing, it requires a clear strategy and structure that is strong enough to carry it wherever it leads. National Rural Health Day was an idea that developed out of a vision to formally recognize those whose work and contribute to make a positive impact on rural health.

The call to action of Celebrate the Power of Rural was the stone cast in the water by NOSORH. The ripple effect of this idea to create an annual day of thanks is now positively touching the lives of many, soon to be millions of people caring for those who are living, working, and raising their families across America’s rural landscape.

This customized Strategic Communications Playbook, developed by Impact! Communications, Inc., provides NOSORH with a structured, comprehensive, engaging, and creative communications foundation to help the organization further achieve its goal of increasing the impact of the Power of Rural movement and grow the visibility of the 50 State Offices of Rural Health and their successes within the communities each serves.
The Pledge

The Power of Rural Pledge was designed to help NOSORH strategically align with people and organizations wanting to achieve higher performance and visibility, optimize collective contributions, and realize complementary objectives that advance the rural health mission.

What it did #1
Attracted hundreds of pledge takers.

What it did #2
Converted an idea into a national action.

What it did #3
Awarded NOSORH with National Rural Health Program of the Year by NRHA 2018.
Power of Rural Website.

Advocacy requires visibility. There must be a place for stakeholders to receive information and something of value,

**Inbound Traffic**
2019-27,603-page views in the 30 days leading up to NRHD

**Tangible Engagement**
Nearly 700 people registered for a special screening of The Providers

One Voice & The Power of Advocacy | October 22, 2020
Toolkits

Make advocacy accessible, simple, and fun!

NEW Offerings every year!
In 2019, NRHD toolkits had 800+ downloads from community stakeholders, providers, national partners, and State Offices of Rural Health

One Voice & The Power of Advocacy | October 22, 2020
Social Media.

There is no replacement for the power of social media. The campaign begins in August and runs through December.

NOSORH Driven
16 million Twitter impressions, 3,439 tweets, and 1,711 participants on NRHD.

Collaborator Driven
The Access to Funding for Rural Health Projects Twitter Chat had a potential reach of over 280k with approximately 3.5 million impressions.
What is National Rural Health Day & the Power of Rural Movement?

These fast facts will help you share the impact of NRHD. Since 2011, the National Organization of State Offices of Rural Health, the 50 State Offices of Rural Health, and rural health stakeholders from across the country have set aside the third Thursday of November to celebrate National Rural Health Day (NRHD) and promote the “Power of Rural,” bringing much needed attention to the ongoing efforts to communicate, educate, collaborate, and innovate to improve the health of an estimated 57 million rural Americans. Over the years, NRHD has transformed from a day-long event to a sustainable movement.

**Key Messages**
- Rural America is a great place for mission-minded health professionals to provide individualized care.
- Rural America is fueling an innovative rural health infrastructure.
- Rural America offers a beautiful and challenging landscape, requiring unique approaches.

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**National IMPACT**

Engaging a broad national audience of policymakers, program funders, partners, practitioners, and the press to share and understand the importance of healthy rural communities.

- Members of US Congress
- State Legislators
- Governors
- Agency Leaders
- CDC
- HRSA
- USDA
- Veterans Health Administration
- RWJF
- Helmsley Charitable Trust
- AHA
- Charities Center for Rural Health
- NRHA
- Rural Health Institute
- RMC Collaborative

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**State IMPACT**

Encouraging collaboration among stakeholders, including State Offices of Rural Health and State Rural Health Associations, to educate and communicate about rural health issues.

- Rural health award presentations
- Press releases
- Rural site visits
- Policymaker outreach
- Educational webinars
- Statewide rural health conferences/events
-Charities Center for Rural Health’s Performance Excellence Leadership Awards
-25 gubernatorial proclamations

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**Local IMPACT**

Equipping local communities with the tools and resources to grow engagement and demonstrate how their work to communicate, educate, collaborate, and innovate has a big impact on the health of rural Americans.

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**NRHD Statistics**

The official NRHD hashtag #PowerofRural had 16 million Twitter impressions, 3,439 tweets, and 1,711 participants on NRHD.

The Access to Funding for Rural Health Projects Twitter Chat had a potential reach of over 280k with approximately 3.5 million impressions.

Nearly 200 rural primary care providers attended RME Collaborative's inaugural Rural Health Clinical Congress - a free, virtual, multi-topic CME/CE event.

The HRSA Virtual Job Fair had close to 2,000 participants looking to practice in rural communities.

Community Stars is an annual eBook that tells the inspiring stories of the people and organizations who make a difference in the health of the rural communities they serve.

Since the first book in 2015, NOSORH has honored 181 Community Stars and the books have been viewed over 9,300 times.

In 2019, NRHD toolkits had 800+ downloads from community stakeholders, providers, national partners, and State Offices of Rural Health. Toolkits include templates, social media graphics, logos, celebration ideas, coloring books, and many other opportunities to engage in the Power of Rural.

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For more information, visit PowerofRural.org | #PowerofRural
ONE VOICE
& the Power of Advocacy

October 22, 2020
Thank You!
Aledade ACO

Clay Comprehensive Health Services DBA
Chatuge Family Practice

Carie Free, Practice Administrator
Outreach Priorities

- ** Attribution Risk**: Coordinate with **36 patients** to save them from attribution loss.

- **Medicare Age-In**: Contact **18 eligible patients** to schedule their Welcome to Medicare visits.

- **Transitions of Care**: Coordinate with **1 patient** to decrease the chance of readmission.

- **Annual Wellness Visits**: Contact **154 eligible patients** to schedule wellness visits.

- **Emergency Department Visits**: There are no known Emergency Department Visit opportunities on your worklist.
<table>
<thead>
<tr>
<th>NOT ENROLLED</th>
<th>ENROLLED</th>
<th>CCM COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Reviewed (1)</td>
<td>CCM: high, med, low... (77)</td>
<td></td>
</tr>
<tr>
<td>(M) ....</td>
<td>(M) ....</td>
<td></td>
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<tr>
<td>Not Reviewed</td>
<td>Enrolled</td>
<td></td>
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<td>(F) ....</td>
<td>(M) ....</td>
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</tr>
</tbody>
</table>

**RISK SCORES!!!**
ADT Feeds for both Hospitalizations and ED visits
Places to put in notes to easily follow up on patients.
Sample Questions to reach out to our ED patients and this helps for re-education to patients.

1. Hi this is [your name], I’m calling on behalf of Dr. [provider’s name] office. We understand that you have had a recent visit to the emergency room. I’m calling to see how you are feeling since your visit? (select one)

- Better
- Same
- Worse

2. Would you please share a bit more about what happened leading up to your ER visit? (select all that apply)

- Accident or Fall
- Sudden physical symptoms
- Ongoing Illness that has been worsening over time
- Social care issue (ex. mental health issue, depression, anxiety)
- Access to medication
- Trouble affording co-pay or bill at primary care office
Extra “Helps”

❖ PROVIDED FREE PPE DURING PANDEMIC
❖ FREE TELEHEALTH PLATFORM DURING PANDEMIC AND REDUCED PRICES AFTER PANDEMIC AVAILABLE
❖ FREE RECRUITING FOR JOB POSITIONS ON INDEED.COM
❖ ASSISTANCE WITH CREATING TEMPLATES IN OUR EHR TO MAKE ADVANCE CARE PLANNING AND TRANSITIONS OF CARE EASILY CAPTURED AND DOCUMENTED
❖ ADT FEEDS FROM LOCAL HOSPITALS
❖ OVER AND ABOVE HELP WITH BILLING/CODING/DOCUMENTING
❖ CME FOR PROVIDERS
Questions?
Focus on Quality and Value-Based Care Leading to Practice Improvement Outcomes

North Carolina Virtual Rural Primary Care Conference
October 22, 2020
2019 North Carolina RHCs

RHC Counts

Total RHCs: 76

- Provider-Based: 43 (57%)
- Independent: 33 (43%)
## 2019 North Carolina RHCs
Statewide Medicare Reimbursement

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Costs</td>
<td>$27,921,995</td>
</tr>
<tr>
<td>Medicare Reimbursement</td>
<td>$23,964,640</td>
</tr>
<tr>
<td>(Loss) / Gain</td>
<td>($3,957,355)</td>
</tr>
</tbody>
</table>
Rural Primary Care Practice Checklist
10-Point Checkup

- Cost Report Consolidation
- Productivity Standards
- Optimal Hospital Linkage
- 340B Optimization
- Specialty Care Integration
- Patient Panel Development
- HCC Education and Monitoring
- CCM, TCM and BHI Implementation
- Contracts and Compliance
- Quality Measurement/Benchmarks
Cost Report Consolidation

Hospitals have an option to “consolidate” statistics for rural health clinics on their Medicare cost report submissions.

**Sample A**
4 clinics, **NO** consolidation

4 Schedule M

**Sample B**
4 clinics, **FULL** consolidation

1 Schedule M

**Sample C**
4 clinics, **PARTIAL** consolidation

2 Schedule M

**Note:** Hospitals need to indicate they will consolidate clinics prior to the start of the cost report year

**Note:** Consolidation of clinics makes financial sense approximately 90% of the time

**Note:** Hospitals can elect to consolidate all, some or none of their rural health clinics
## Consolidation Case Study

<table>
<thead>
<tr>
<th></th>
<th>Clinic A</th>
<th>Clinic B</th>
<th>Combined</th>
<th>Consolidated</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs</td>
<td>$1,440,287</td>
<td>$910,724</td>
<td>$2,351,011</td>
<td>$2,351,011</td>
<td>--</td>
</tr>
<tr>
<td>Visits</td>
<td>8,644</td>
<td>4,788</td>
<td>13,432</td>
<td>11,031</td>
<td>(2,401)</td>
</tr>
<tr>
<td>Adjusted Cost/Visit</td>
<td>$166.62</td>
<td>$190.21</td>
<td>$169.14</td>
<td>$231.13</td>
<td>$43.99</td>
</tr>
<tr>
<td>Medicare Visits</td>
<td>2,919</td>
<td>349</td>
<td>3,268</td>
<td>3,268</td>
<td>--</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>$486,372</td>
<td>$66,383</td>
<td>$522,755</td>
<td>$696,501</td>
<td>$143,746</td>
</tr>
</tbody>
</table>
### 2019 North Carolina RHCs

Cost Report Consolidation

<table>
<thead>
<tr>
<th></th>
<th>Sites</th>
<th>Cost Reports</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider-Based</td>
<td>43</td>
<td>37</td>
<td>86%</td>
</tr>
<tr>
<td>Independent</td>
<td>33</td>
<td>19</td>
<td>56%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>76</strong></td>
<td><strong>56</strong></td>
<td><strong>74%</strong></td>
</tr>
</tbody>
</table>
Productivity Standards

CMS defines a minimum expected number of patient visits for physicians and advanced practice providers (i.e. Nurse Practitioners and Physician Assistants)

The goal is always to maximize visit volumes

<table>
<thead>
<tr>
<th>4,200</th>
<th>2,100</th>
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</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>APPs</td>
</tr>
</tbody>
</table>

Note: Only employed providers are subject to the Minimum Productivity standards
Note: Contracted physician volumes are not included in the calculation
Note: If clinics do not meet productivity standards, the clinic does not get cost-based reimbursement
2019 North Carolina RHCs
Meeting Productivity Standards

Total RHC Cost Reports: 56

- Cost Reports: 37
  - Meeting Standard: 15 (41%)
  - Provider-Based: 22

- Cost Reports: 19
  - Meeting Standard: 15 (79%)
  - Independent: 4

Lilypad®
Annual Work RVUs

Physicians (n=561)  3,276 RVUs
APPs (n=564)        2,338 RVUs
Optimal Hospital Linkage

PB-RHC and hospital should maintain operational, financial and quality alignment

<table>
<thead>
<tr>
<th>RHC</th>
<th>Hospital</th>
<th>Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Quality Improvement Program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ER Re-Direct Program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Overhead Allocation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Electronic Health Record</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Financial and Reporting Systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Budgeting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>System-wide Clinic Alignment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCM, TCM, BHI</td>
</tr>
</tbody>
</table>
340B Optimization

Federal government program that requires drug manufacturers to provide outpatient drugs to eligible health care organizations at significantly reduced prices.

For every 10,000 patient visits equals $300-$400k of Net Revenue

20,000 Patient Visits \rightarrow \text{Up to } $800,000 Potential Net Revenue

Note: Practices have to qualify for the 340B Program
Specialty Care Integration

Rural Health Clinics were designed to increase access to primary care in rural communities but RHCs also can offer access to specialty care.

Primary Care
At least 50% of all services rendered in the RHC need to be “primary care services”

Specialty Candidates
- General Surgery
- Orthopedics
- ENT
- GI
- Neurology

Note: RHCs should prioritize specialties that require clinical time to support surgical volumes.
Patient Panel Development

Develop a 1:1 assignment of all RHC patients to a provider to create defined patient “rosters”

Using the EHR, establish a consensus-driven methodology for assigning patients to providers

Create a field in the EHR for primary provider to facilitate future reporting and analysis

<table>
<thead>
<tr>
<th>Provider</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider A</td>
<td>1,200</td>
</tr>
<tr>
<td>Provider B</td>
<td>1,700</td>
</tr>
<tr>
<td>Provider C</td>
<td>900</td>
</tr>
<tr>
<td>Provider D</td>
<td>2,100</td>
</tr>
</tbody>
</table>

Note: Internal Target = Count of annual wellness visits equal to Patient Panel size for each provider
Patient Panel Benchmark

Physicians (n=561)  1,345 patients
APPs (n=564)  1,033 patients
HCC Education and Monitoring

Hierarchical Condition Category (HCC) coding is a risk-adjustment model driven by ICD-10 coding and originally designed to estimate future health care costs for patients.

Patient A
A 68-year-old patient with type 2 diabetes with no complications, hypertension, and a body mass index (BMI) of 37.2

RAF = 0.00

Patient B
A 68-year-old patient with type 2 diabetes with diabetic polyneuropathy, hypertension, morbid obesity with a BMI of 37.2, and status post-left below knee amputation (BKA)

RAF = 1.18

Note: HCC scores need to be re-computed every year
CCM, TCM and BHI Implementation

Chronic Care Management services are integral to the mission of Rural Health Clinics

CCM
- CCM services are non-face-to-face care management and coordination services for Medicare beneficiaries with two or more chronic conditions
- CCM services can be billed by adding the general care management G code, G0511, to an RHC claim, either alone or with other payable services
- Payment is the average of the national PFS payment rate for CPT codes 99490, 99487, 99491, and 99484
- CCM or General BHI (HCPCS code G0511) services are paid at the rate of $67.03 for 2019
- A minimum of 20 minutes of CCM or general BHI services must be furnished within the calendar month

TCM
- TCM services support patient’s transition from inpatient, SNF, inpatient rehab, outpatient observation or partial hospitalization settings to home or community settings
- TCM services can be billed by adding CPT code 99495 or 99496 to an RHC claim
- If it is the only medical service provided on that day with an RHC practitioner, it is paid as a stand-alone visit
- If it is furnished on the same day as another visit, only one visit is paid
- For 2019, TCM (CPT code 99495 or 99496) is paid the same as an RHC Visit

BHI
- General BHI is a defined model of care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions
- General BHI services can be billed by adding the general care management G code, G0511, to an RHC claim, either alone or with other payable services
- Payment is the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, and 99484
- CCM or General BHI (HCPCS code G0511) services are paid at the rate of $67.03 for 2019
- A minimum of 20 minutes of CCM or general BHI services must be furnished within the calendar month
### Contracts and Compliance

Provider Compensation is critical but mistakes are common

<table>
<thead>
<tr>
<th>Inconsistency</th>
<th>Contracts, valuation opinions, and payroll are not standardized, documented, or executed consistently.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasonableness</td>
<td>Desperation leads to throwing money at recruitment and retention rather than stepping back and determining what makes sense. Often opportunities for non-monetary compensation are overlooked.</td>
</tr>
<tr>
<td>Wrong People</td>
<td>Organizations take a top down approach with compensation and do not involve the practice administrator or the physicians.</td>
</tr>
<tr>
<td>Benchmarks</td>
<td>Hospitals assume MGMA (or POND) median will protect them from a compliance standpoint - it won’t. The OIG has consistently come out saying surveys are not the final word on Fair Market Value.</td>
</tr>
<tr>
<td>Monitoring</td>
<td>When compensation requires supervision, minimum clinical hours, or administrative duties, monitoring of scheduling and documentation is critical.</td>
</tr>
</tbody>
</table>
### Annual Compensation (per FTE)

<table>
<thead>
<tr>
<th></th>
<th>Base Salary</th>
<th>Variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>$165,000 (n=285)</td>
<td>$75,000 (n=184)</td>
</tr>
<tr>
<td>APPs</td>
<td>$85,000 (n=292)</td>
<td>$35,000 (n=143)</td>
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</tbody>
</table>
Quality Measurement/Benchmarks

Relevant quality measures for rural primary care practices have been elusive but there is a research-based set of NQF measures that all clinics should track – at the provider level.

<table>
<thead>
<tr>
<th>NQF 0018</th>
<th>NQF 0028</th>
<th>NQF 0038</th>
<th>NQF 0059</th>
<th>NQF 0419</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling Blood Pressure</td>
<td>Preventive Care: Tobacco</td>
<td>Childhood Immunization</td>
<td>Diabetes: Hemoglobin A1c</td>
<td>Current Medications</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Good</th>
<th>Better</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor Something!</td>
<td>Quarterly Clinic-wide Just quality</td>
<td>Monthly Physician Scorecards</td>
</tr>
</tbody>
</table>
Lilypad® and POND®

Gregory Wolf
gwolf@lilypad207.com
(207) 232-3733
Next session begins at 11:00 am
State and Federal Policy Issues Facing NC’s Community Health Centers

Chris Shank, President & CEO, NCCHCA
featuring Brendan Riley, Mel Goodwin, and Leslie Wolcott

Kim Schwartz, CEO, Roanoke Chowan Community Health Center
• 42 Community Health Centers in North Carolina
• 270+ clinical sites across the state
• 631,000+ patients served in 2019, over 40% of which were uninsured
NC’s Health Insurance Coverage Gap
Affordable Medications and the 340B Drug Discount Program
The Impacts of COVID-19 on FQHCs

Telehealth
Provider Loan Repayment Programs
Community Health Centers and Community Partnerships
Questions?

Thanks!

shankc@ncchca.org
Join us for an optional chat & chew 12:15
Focus for the discussion is to highlight one of our RHCs that received funding to be used in the community for COVID testing and related activities and sharing the successes as well as challenges the clinic encountered in the process.

Next session begins at 12:45

https://bensonmedical.org/
NC DHHS COVID-19 Support
<table>
<thead>
<tr>
<th></th>
<th>1 Welcome and Introduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>NC DHHS COVID Support Overview</td>
</tr>
<tr>
<td>3</td>
<td>Community Health Worker Overview</td>
</tr>
<tr>
<td>4</td>
<td>Non-Congregate Shelter Overview</td>
</tr>
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<td>5</td>
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<td>6</td>
<td>Partner Collaboration</td>
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<td>7</td>
<td>Next Steps</td>
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<td>8</td>
<td>Q&amp;A</td>
</tr>
<tr>
<td>9</td>
<td>Appendix</td>
</tr>
</tbody>
</table>

Questions?
Submit questions through the chat
Our Speaker

John Resendes
Analytics and Innovation Manager
Office of Rural Health
NC DHHS
<table>
<thead>
<tr>
<th></th>
<th>Section Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Welcome and Introduction</td>
</tr>
<tr>
<td>2</td>
<td>NC DHHS COVID Support Overview</td>
</tr>
<tr>
<td>3</td>
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</tr>
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<td>Appendix</td>
</tr>
</tbody>
</table>

**Questions?**
Submit questions through the chat
NC DHHS COVID-19 Strategy

Goals

- Protect ourselves, our loved ones, and our neighbors from getting seriously ill
- Restore our economy and get North Carolinians back to work safely
- Get our children back to school so they can learn, play, and thrive
- Address the disproportionate impact of COVID-19 on historically marginalized populations

<table>
<thead>
<tr>
<th>Strategy to Combat COVID-19</th>
<th>What the State is Doing</th>
<th>What the Public Can Do</th>
</tr>
</thead>
</table>
| **Slow the Spread:**
  Prevention                | • Phase reopening of sectors/activities to minimize spread of COVID-19
  • Require face coverings that cover the nose and mouth (indoors and outdoors) when physical distancing of 6 feet is not possible
  • Promote the 3Ws (Wear, Wait, Wash) | • Practice the 3Ws and encourage friends and family to do the same
  • Employers should follow NCDHSS guidance for specific settings |
| **Know Who Has COVID-19 and Who Has Been Exposed:**
  Testing and Tracing        | • Build a statewide testing and contract tracing infrastructure
  • Surge resources in hardest hit communities and populations | • Get tested if symptomatic or if you think you are exposed to COVID-19
  • Answer the call from the contact tracing team |
| **Support People to Stay Home:**
  Quarantine and Isolation  | • Ensure access to non-congregate shelters for people who need to isolate
  • Enact policies to enable people to stay at home, leverage NCCARE360 to connect to supports | • Stay home when you can, especially when sick
  • Support employees to stay home when sick to minimize the spread of COVID-19 |

CHW and Support Services partners connect the public to vital resources and services helping the state achieve its COVID-19 goals
Innovative new program to assist individuals in targeted counties who need access to primary medical care and supports such as food or a relief payment to successfully quarantine or isolate due to COVID-19:

1. **Nutrition assistance**, including home-delivered meals and food boxes
2. A one-time COVID-19 relief payment to help supplement lost wages or the inability to look for work while in isolation/quarantine and to be used on basic living expenses
3. **Private transportation** provided in a safe manner to/from testing sites, medical visits, and sites to acquire food
4. **Medication delivery**
5. COVID-related over-the-counter supplies, such as face masks, hand sanitizers, thermometers, and cleaning supplies
6. Access to primary medical care to manage COVID recovery will also be provided through telehealth services through Community Health Workers (CHWs).

Collaborative effort between the State, counties and local partners to secure non-congregate shelter for individuals with no other safe place to quarantine, isolate, or social distance due to COVID-19.

2 options for reimbursement:
1. Local partners desiring state-centric coverage through NCEM (required MOA)
2. Local partners seeking direct reimbursement from FEMA
The separation and restriction of the movement of people who were exposed to a contagious disease, such as COVID-19, to see if they become sick. These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms.

The separation of people who are sick from those who are well. People who have tested positive for COVID-19 in North Carolina should be in isolation.

Social distancing, also called “physical distancing,” means keeping a safe space between yourself and other people who are not from your household.
| 1 | Welcome and Introduction |
| 2 | NC DHHS COVID Support Overview |
| 3 | Community Health Worker Overview |
| 4 | Non-Congregate Shelter Overview |
| 5 | Support Services Overview |
| 6 | Partner Collaboration |
| 7 | Next Steps |
| 8 | Q&A |
| 9 | Appendix |

Questions?
Submit questions through the chat
Community Health Worker Program

Create a robust infrastructure of Community Health Workers (CHWs) and Peer Support Specialists that can provide access to primary health care and coordinate social support needs for individuals quarantining and isolating.

Overview

- CHWs are frontline public health workers who are trusted members of the community and trained to support disadvantaged individuals.
- CHWs are responsible for connecting North Carolinians to medical and social support resources including diagnostics testing, primary care, case management, nutrition assistance, and behavioral health services.
- CHWs coordinate with LHDs, contact tracers, and others to leverage NCCARE360 and to identify and connect individuals with needed services through NCCARE360.

Partners

NCDHHS selected seven vendors* (Curamericas Global, Kepro, One to One with Youth, Vidant Health, Mount Calvary Center for Leadership Development, Catawba County Public Health, Southeastern Healthcare NC) to recruit, train, and manage Community Health Workers deployed to areas with high COVID-19-related needs.

Process

Community Health Workers will follow this workflow to assist individuals:

1. Review notes and triage for high priority cases
2. Engage with patient and ask clarifying questions
3. Identify available patient resources using NCCARE360 and primary care provider list
4. Conduct additional research and advocacy
5. Connect patients to available services
6. Note that needs are met in NCCARE360 or hand off to PCP or Resource Navigator or work with LHD/NCCARE360 to address resource deficits

*Note: See appendix for vendor coverage across the state
Community Health Worker Vendor Coverage
### Survey Results

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total CHWs employed</td>
<td>336</td>
</tr>
<tr>
<td>Total CHWs deployed</td>
<td>334</td>
</tr>
<tr>
<td>Total CHWs who speak Spanish</td>
<td>84</td>
</tr>
</tbody>
</table>

Note: Data as of October 19
Community Health Worker Operations

Work in coordination with Local Health Departments (LHDs) and contact tracers to identify and connect with individuals who require assistance both virtually and face to face.

Leverage NCCARE360, the nation’s first statewide technology platform uniting traditional healthcare settings and organizations, to address non-medical drivers such as food, housing, transportation, employment, and interpersonal safety.

Help individuals connect with community resources for safe housing, culturally competent healthcare, and financial assistance.
## CHW Responsibilities

### What CHWs Can Do

- Call cases/contacts that were identified as vulnerable during the home assessment
- Help the case/contact identify what they need for safe/isolation quarantine and connection to primary care and use of telehealth services
- Research and identify available services that meet the needs of cases/contacts both within and outside of NCCARE360. Enter referral data in NCCARE360 or work with support personnel to make sure data is entered accurately.
- Connect with local service agencies to ensure they are functioning and able to meet the type of needs presented
- Link cases/contacts to support services, ensuring a "warm handover". Please note that CHWs can call service agencies on behalf of cases/contacts if they have been given legal consent by the patient. Examples include, speaking with the housing authority, connecting someone with an outpatient quarantine facility, or arranging food delivery.
- Follow-up with cases/contacts to ensure their needs were met (in close collaboration with CTs doing follow-up during the home monitoring phase)
- Continue to look for place-based solutions even when barriers appear
- Identify resource deficits and collect data to inform advocacy efforts and policy change through leadership
- Share lessons learned and trends with supervisors and LHDs to ensure quality improvement

### What CHWs Cannot Do

- Provide long-term case management beyond the scope of COVID-19
- Complete benefits applications on an individual’s behalf (including unemployment and Medicaid)
- Provide medical advice or direct, clinical interventions – CHWs are NOT called in a medical emergency
- Guarantee that all needs will be met
How does an individual who needs to quarantine/isolate get connected to primary medical care services through a CHW?

1. **Identify**
   - CHW receives individual cases from many different channels:
     - Testing sites
     - Contract tracers/Case investigators
     - LHDs
     - PCPs
     - Outreach workers
     - CBOs
     - Self referrals
   - CHW creates a referral and enters individual information into NCCARE360.
   - CHW identifies Support Service Vendors in NCCARE360 (instructions on slides 35-37).
   - CHW attaches the completed attestation form to the referral in NCCARE360 (example attestation forms on slides 30-32).
   - CHW submits the referral for Support Services to these vendors.
   - CHW submits referrals in NCCARE360 for any additional services based on the needs of the individual.

2. **Refer**
   - CHW completes attestation form with the individual to determine eligibility for DHHS-funded Support Services.
   - CHW completes needs assessment in NCCARE360 to determine if additional services are needed.
   - CHW stays in contact with the individual throughout their quarantine/isolation.
   - CHW provides additional support if needed.

3. **Deliver**
   - Support Service Vendor receives referral through NCCARE360 with attached attestation document.
   - Vendor delivers support services to individuals and closes the referral.
   - Support Service Vendors complete invoicing, reimbursement and reporting.

CHW provides individual with their contact information during first interaction so that the individual may reach out to the CHW if new needs arise.
How an individual can connect with primary medical care services:

**Individual With Insurance**

Individual researches what physician(s) are in-network and/or are eligible for them to see and schedule an appointment.

CHW will coordinate their care and make referrals if needed.

**Individual Without Insurance**

Individual can establish a Physician or Family Nurse Practitioner (FNP) or Physician Assistant (PA) as primary care provider when they get a full physical at a Federally Qualified Health Center (FQHC), Free Clinic, or any clinic that accepts Medicaid or other uninsured care payment.

Please see the 'Reimbursement for COVID Related Services Fact Sheet' resource below on how providers can be reimbursed for these visits to see these patients free of charge.

- Safety Net Site Dashboard - [Link](#)
- North Carolina Community Health Center Association - [Link](#)
- North Carolina Free and Charitable Clinics – [Link](#)
- Reimbursement for COVID Related Services Fact Sheet – [PDF](#)
## Survey Results

### Support for Patients with COVID-19 Related Needs through Community Health Workers

<table>
<thead>
<tr>
<th>Performance Measure Data</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of NCCARE360 Patients Served</td>
<td>1,999</td>
</tr>
<tr>
<td>Number of NCCARE360 Referrals</td>
<td>3,911</td>
</tr>
<tr>
<td>Number of Successful NCCARE360 Referrals</td>
<td>413</td>
</tr>
<tr>
<td>Total Number of Patients Served</td>
<td>11,828</td>
</tr>
<tr>
<td>Total Number of Referrals</td>
<td>4,678</td>
</tr>
<tr>
<td>Total Number of Successful Referrals</td>
<td>1,832</td>
</tr>
<tr>
<td>Percentage of Successful Referrals</td>
<td>39%</td>
</tr>
<tr>
<td>Total Number of Telehealth Encounters</td>
<td>1,579</td>
</tr>
</tbody>
</table>

### Map of North Carolina

© 2020 Mapbox, © OpenStreetMap

**Note:** Data self-reported as of October 15
Total Grant Spending

<table>
<thead>
<tr>
<th>Grant Award Total</th>
<th>Number of Payments</th>
<th>Remaining Funds</th>
<th>Spend Rate</th>
<th>Funds Spent</th>
</tr>
</thead>
<tbody>
<tr>
<td>$13,251,830</td>
<td>17</td>
<td>$9,859,245</td>
<td>26%</td>
<td>$3,392,585</td>
</tr>
</tbody>
</table>

Note: Data as of October 15
## Community Health Worker Vendor Contact Information

<table>
<thead>
<tr>
<th>Counties</th>
<th>Vendor</th>
<th>Contact</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catawba</td>
<td>Catawba County Public Health</td>
<td>Honey Estrada</td>
<td>(828) 695-6683</td>
<td><a href="mailto:honey@catawbacountync.gov">honey@catawbacountync.gov</a></td>
</tr>
<tr>
<td>Alamance, Buncombe, Chatham, Craven, Davidson, Davie, Durham, Forsyth, Franklin, Gaston, Granville, Guilford, Harnett, Henderson, Johnston, Lee, Onslow, Orange, Pitt, Randolph, Surry, Vance, Wake, Warren, Wayne, Wilkes</td>
<td>Curamericas Global</td>
<td>Andrew Herrera</td>
<td>(919) 801-0612</td>
<td><a href="mailto:Andrew@Curamericas.org">Andrew@Curamericas.org</a></td>
</tr>
<tr>
<td>Cabarrus, Gaston, Mecklenburg, Montgomery, Rowan, Stanly, Union</td>
<td>Keystone Peer Review Organization (KEPRO)</td>
<td>Lisa Bennett</td>
<td>(720) 724-0098</td>
<td><a href="mailto:lbennett@Kepro.com">lbennett@Kepro.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renee White</td>
<td>(919) 523-7999</td>
<td><a href="mailto:stwhite@Kepro.com">stwhite@Kepro.com</a></td>
</tr>
<tr>
<td>Bladen, Columbus, Duplin, Pender, Robeson, Sampson</td>
<td>Mt. Calvary Center for Leadership Development</td>
<td>Jimmy Tate</td>
<td>(910) 284-9382</td>
<td><a href="mailto:jitate@mtcalvarycenter.org">jitate@mtcalvarycenter.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carol Highsmith</td>
<td>(910) 789-1886</td>
<td><a href="mailto:chighsmith@mtcalvarycenter.org">chighsmith@mtcalvarycenter.org</a></td>
</tr>
<tr>
<td>Duplin, Greene, Johnston, Lenoir, Sampson, Wayne, Wilson</td>
<td>One to One with Youth</td>
<td>Danny King</td>
<td>(919) 922-7713</td>
<td><a href="mailto:dking@adlainc.org">dking@adlainc.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inonda Kind</td>
<td>(919) 987-2798</td>
<td><a href="mailto:kone2one@aol.com">kone2one@aol.com</a></td>
</tr>
<tr>
<td>Johnston, Orange, Wake</td>
<td>Southeastern Healthcare of NC</td>
<td>Joyce Harper</td>
<td>(919) 987-2798</td>
<td><a href="mailto:jharper@sehnc.com">jharper@sehnc.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Evelyn Sanders</td>
<td>(919) 987-2791</td>
<td><a href="mailto:esanders@sehnc.com">esanders@sehnc.com</a></td>
</tr>
<tr>
<td>Beaufort, Bertie, Chowan, Dare, Duplin, Edgecombe, Halifax, Hertford, Northampton, Pitt</td>
<td>Vidant Health</td>
<td>Melissa Roupe</td>
<td>(252) 847-9350</td>
<td><a href="mailto:myroupe@vidanthealth.com">myroupe@vidanthealth.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Crystal Dempsey</td>
<td>(252) 847-5162</td>
<td><a href="mailto:Crystal.Dempsey@vidanthealth.com">Crystal.Dempsey@vidanthealth.com</a></td>
</tr>
</tbody>
</table>
Community Health Worker and Support Services Workflow

Scenario: How an individual who needs to quarantine or isolate gets connected to Support Services through a Community Health Worker

<table>
<thead>
<tr>
<th>NC CHW and Support Services Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Receive</strong></td>
</tr>
<tr>
<td><strong>Review</strong></td>
</tr>
<tr>
<td><strong>Engage</strong></td>
</tr>
<tr>
<td><strong>Research</strong></td>
</tr>
<tr>
<td><strong>Advocate</strong></td>
</tr>
<tr>
<td><strong>Connect</strong></td>
</tr>
<tr>
<td><strong>Close or Handoff</strong></td>
</tr>
</tbody>
</table>

1. CHW picks up assigned patients from a variety of channels:
   - Testing sites
   - Contract tracers
   - LHDs
   - DSS
   - PCPs
   - Outreach workers
   - CBOs
   - Self referrals
   - Also receives patient lists from contact tracing tool (CCTO)

2. CHW performs a needs assessment, determines the person’s eligibility for support services through a standardized attestation form, and makes a support plan. The CHW triages high priority cases first.

3. Patient Engagement: CHW asks clarifying questions and presents options

4. CHW researches available resources using NCCARE360 and DHHS sites (Check My Symptoms, Find My Testing Place), and primary care provider list

5. CHW conducts additional research and advocacy

6. CHW sends referrals to Support Service Vendors and subcontractors through NCCARE360 or other mechanism and includes the individual’s eligibility attestation form.

   - CHWs may call vendors on behalf of the patient and continue to communicate directly with the patient.
   - Support Service Vendors deliver services to individuals and note that their needs have been met in NCCARE360 or with CHW.
   - Support Service Vendors conduct ongoing invoicing, reimbursement, and reporting (to be discussed in more detail).

7. Support Service Vendors deliver services to individuals and note that their needs have been met in NCCARE360 or with CHW.

---

**Individuals can be referred to CHW organizations via DSS and LHDs or may reach out directly to a CHW organization**
• All Support Service Vendors and their subcontractors will be included in NCCARE360 and able to accept electronic referrals

• All Support Service Vendors and subcontractors will be identified in NCCARE360 as “COVID Support Services: [ORGANIZATION NAME].”
  • CHWs can search for “COVID Support Services” in the “Provider Name” field in NCCARE360 and a list of organizations delivering these particular, federally-funded services will appear. CHWs must refer individuals to these particular organizations in order for the support services to be provided at no cost to the individual and their family.
ORH HIT regional contact should be the primary point of contact for counties in the respective region to ask questions about NCCARE360 and telehealth as well as technical assistance on electronic health records (EHR), telehealth, and other state-supported HIT.

Primary responsibilities:
- Recruit LHDs currently not in NCCARE360 and connect LHD to NCCARE360 Regional CEM for onboarding.
- Help vendors and CHWs with telehealth and NCCARE360 questions.
- Technical Assistance around Electronic Health Records, Telehealth, and other state supported Health Information Technology.

Contacts:
Lakeisha Moore
Lakeisha.Moore@dhhs.nc.gov

Sebastian Gimenez (East)
Sebastian.Gimenez@dhhs.nc.gov

Adonnica Rowland (South Central)
Adonnica.Rowland@dhhs.nc.gov

Gretchen Ramirez (Western)
Gretchen.Ramirez@dhhs.nc.gov

Robyn McArdle (Telehealth Specialist)
Robyn.McArdle@dhhs.nc.gov
NCCARE360 Community Engagement Managers can support NCCARE360 efforts

NCCARE360 Community Engagement Managers (CEM)

Primary responsibilities:
• Directly support the community through every step of joining the network
• Regularly review data and network performance, solicit feedback and input on processes, and provide ongoing technical assistance
• Act as the main resources for technical assistance
• Host strategy sessions (variety of audiences, including LHDs)

Contacts:
Regional Field:
Dionne Greenlee-Jones
dionne.greenlee-jones@uniteus.com
Mikayla Gaspary
Mikayla@uniteus.com
Abbie Szymanski
abbie@uniteus.com
Abi Bussone
abi@uniteus.com
See next slide for regions

Network health managers:
Kate Geouge Brown (kate@uniteus.com)
Kristena Armwood (kristena@uniteus.com)
Increase coverage of non-congregate shelter (NCS) statewide and particularly within counties that have been identified as needing additional assistance due to high volumes of positive COVID cases

NC received approval from FEMA to provide housing alternatives, such as hotels, motels, and dormitories, for individuals with unstable housing who may need to quarantine, isolate, or social distance in response to COVID-19. FEMA reimbursement is renewed on a monthly basis at 75%/25% FEMA/State match. Covers the cost of shelter plus certain wraparound supports, such as laundry, food, cleaning, and security at the discretion of the County, which operates the program.

Overview

- A collaborative effort between the State, counties and local partners to secure hotel and motel rooms, as well as essential wrap-around services, for individuals with no other safe place to quarantine, isolate, or social distance due to COVID-19
- Jurisdictions and agencies (Indian Tribal and local governments, non-profits, COC, and homeless shelters) may choose to partner with NC Emergency Management (NCEM) for expedited reimbursement of non-congregate shelter expenses
- All counties or organizations operating non-congregate shelter must complete a report for each operational site every Friday by close of business

Eligibility

Individuals are eligible for non-congregate shelter if they meet these categories:
1. Test positive for COVID-19, do not require hospitalization, but require isolation
2. Exposed to COVID-19, do not require hospitalization, but should be quarantined
3. First responders and healthcare workers who need to avoid direct family contact
4. Are at a high risk for COVID-19 and need services as a precautionary measure

Process

An individual or health worker should follow these steps for non-congregate shelter:

1. If an individual meets one of eligibility requirements and has no way to safely distance from others, they or a Community Health Worker should check the list of non-congregate shelter access points across the state
2. Connect with the shelter provider for information about eligibility and location and bed availability
3. If an individual is not eligible for the site, or a county is not listed, contact the county Emergency Management Agency, Local Health Department, or NC 2-1-1 to ask for assistance

A non-congregate shelter program does not currently exist in every county
Current Non-Congregate Shelter Coverage
Support Services Overview

1. Welcome and Introduction
2. NC DHHS COVID Support Overview
3. Community Health Worker Overview
4. Non-Congregate Shelter Overview
5. Support Services Overview
6. Partner Collaboration
7. Next Steps
8. Q&A
9. Appendix

Questions?
Submit questions through the chat
Support Services Program

An innovative program to provide primary medical care and five key support services in target counties to help people safely quarantine or isolate

Overview

- Innovative new program funded by the CARES Act to assist individuals in targeted counties who need access to primary medical care and support services
- Frontline workers may be unable physically distance or may be unable to take paid sick leave, leading to higher rates of infection
- Targeted service areas are segmented into four regions: Region 1 (Mecklenburg, Gaston), Region 2 (Rowan, Stanly, Montgomery, Randolph, Chatham, Lee), Region 3 (Durham, Granville, Vance), and Region 4 (Robeson, Columbus, Bladen, Sampson, Duplin, Wayne, Johnston, Wilson, Greene)

Eligibility

Individuals must first be identified by a health professional because the individual:
1. Tested positive for COVID-19
2. Is waiting for the results of a COVID-19 test
3. Was exposed to someone who has tested positive for COVID-19
4. Needs to do so as a precautionary measure since they are in a high-risk group

Individuals must also attest to certain criteria, such as needing the services to successfully isolate or quarantine and not having another means to obtain these services.

Process

Individuals who need access to primary medical care and support services to successfully quarantine or isolate due to COVID-19 will follow this process:

1. A health care worker will identify an individual who should quarantine or isolate. If the individual may require support services to do so effectively, the health care worker refers the individual to a Community Health Worker (CHW) or LHD.

2. The CHW or LHD team member will be responsible for supporting the individual through the quarantine or isolation process. The CHW or LHD will perform a needs assessment, determine eligibility for support services, make a support plan, and connect individuals to organizations that can provide support services.

3. The support services vendor will directly provide, or subcontract with local Community Based Organizations (CBOs) to provide, the needed support services.

CHWs will serve as the individual’s point of contact throughout isolation or quarantine

Anticipated Performance Period: August 25, 2020 through December 30, 2020
Support Services Vendors

Piedmont Health Services and Sickle Cell Agency

- Mission is to provide outreach, education, screening and case management for people with high-risk health problems; focusing on sickle cell services, HIV/AIDS prevention & wellness.

- Services include: sickle cell services, HIV outreach and education, wellness services, child development programs, etc.

Duke University Health Systems

- A world-class academic and health care system that strives to transform medicine and health locally and globally

- Services include: complete care, COVID-19 testing and treatment, urgent care, etc.

Quality Home Care Services
doing business as
Quality Comprehensive Health Center

- A multi-faceted organization with five locations that has been serving Charlotte, NC, community for over 16 years.

- Services include: primary medical care, counseling, case management, substance abuse treatment, homeless initiatives, telehealth counseling, etc.

ADLA, Inc.

- Mission is to help local youth acquire the needed behavior and employability skills to function in a changing global society, while promoting the understanding and practice of the universal values of honesty, integrity, and respect in all we do.

- Services include: academic enrichment, after school programs, homework assistance, nutrition assistance, etc.
Support Services Vendor Coverage

County Map by Cases per 10,000 residents
As of August 24, 2020

Piedmont Health Services and Sickle Cell Agency
Region 2: Rowan, Stanly, Montgomery, Randolph, Chatham, Lee

Duke University Health Systems
Region 3: Durham, Granville, Vance

Quality Home Care Services
doing business as
Quality Comprehensive Health Center
Region 1: Mecklenburg, Gaston

ADLA, Inc.
Region 4: Robeson, Columbus, Bladen, Sampson, Duplin, Wayne, Johnston, Wilson, Greene
CHWs are vital to the Support Services Program - all Support Services counties must overlap with CHW counties

**Piedmont Health Services and Sickle Cell Agency, Region 2:** Rowan, Stanly, Montgomery, Randolph, Chatham, Lee

**Duke University Health Systems, Region 3:** Durham, Granville, Vance

**ADLA, Inc., Region 4:** Robeson, Columbus, Bladen, Sampson, Duplin, Wayne, Johnston, Wilson, Greene

**Quality Home Care Services** doing business as **Quality Comprehensive Health Center, Region 1:** Mecklenburg, Gaston

- Catawba County Public Health
- Curamericas Global
- KEPRO
- Mt. Calvary Center
- Vidant Health
- One to One with Youth
- Covered by Multiple Vendors
  - Southeastern Healthcare and vendors listed above
- No Coverage (50 Counties)
- Contractors and Subcontractors
  - 50 Counties Supported
Attestation Form: Deep Dive

Attestation for COVID-19 Isolation/Quarantine Support

If you have not been directed by a medical professional or state/local public health official to quarantine or isolate due to COVID-19 but believe you need support, you may be eligible for assistance covered by the MC Department of Health and Human Services (DHHS) for you and your family.

Please complete this form if your COVID-19 isolation/ or quarantine is not covered by your employer. Your community health worker may contact you for more information.

1. Your Information [* required]
   - Full Name (First, Last) or Anonymous Identifier*
   - County Where you Currently Live*: check this box if you are currently homeless
   - Street Address of Where You Will Isolate/Quarantine*: this is needed so that supports may be mailed/delivered to you.
   - City*: State*: Zip Code*
   - Mailing Address of Where You Will Isolate/Quarantine*: Leave blank if the same as your current address. This is needed so that supports may be mailed to you.
   - City*: State*: Zip Code*
   - Phone Number: Email
   - Primary Language: Age:
   - Gender:
   - Race:
   - Ethnicity:

2. Additional Information
   - Financial assistance
   - Meals or groceries
   - Transportation
   - Medication delivery
   - COVID-19 supplies (e.g., face mask, hand sanitizer, cleaning supplies)

3. Additional attestation if you qualify for financial assistance:
   - I understand that I must sign the back of this form to indicate I am aware of the forgivable loan terms.
   - I declare that I am aware of the terms and conditions of the forgivable loan.
   - I acknowledge that I am responsible for repaying the loan in full.

4. Additional attestation if you qualify for medical delivery:
   - I declare that I am aware of the terms and conditions of the medical delivery service.
   - I acknowledge that I am responsible for repaying the service in full.

5. Additional attestation if you qualify for support services:
   - I declare that I am aware of the terms and conditions of the support services.
   - I acknowledge that I am responsible for repaying the support services in full.

6. Additional attestation if you qualify for quarantine support:
   - I declare that I am aware of the terms and conditions of the quarantine support.
   - I acknowledge that I am responsible for repaying the quarantine support in full.

7. Additional attestation if you qualify for isolation support:
   - I declare that I am aware of the terms and conditions of the isolation support.
   - I acknowledge that I am responsible for repaying the isolation support in full.

8. Signature of Applicant:
   - Date:

   (Signatures and Dates of people who are dependent on the applicant)

   (Signatures and Dates of people who are dependent on the applicant)
An individual should isolate or quarantine because the individual:

- Tested positive for COVID-19, or
- Is waiting the results of a COVID-19 test, or
- Was exposed to someone who has tested positive for COVID-19, or
- Needs to do so as a precautionary measure because the individual is in a high-risk group

- Lives in the Target Service Area
- Has been directed by a health care professional to quarantine or isolate
- Will only be able to safely and effectively quarantine or isolate with one or more of the Support Services
- Does not have alternative means of accessing the Support Services
- Agrees to remain in quarantine or isolation for the entire length of time he or she is directed to do so

- COVID relief payment: the individual does not have access to financial support during the quarantine or isolation period
- COVID relief payment: the individual will use the funds for basic living expenses and will keep receipts
- COVID relief payment: the individual could be required to pay back the payment if they do not comply with quarantine or isolation requirements
- Medication delivery: the individual must attest that any medication to be delivered has been authorized by a medical professional
- Support services at the Family-Level: the individual must attest that they live in the same household with family members who require support

Individuals may receive Support Services for up to 14 days beginning the day of their needs assessment or longer if approved by a HCP

- If an individual originally attested that they do not need a Support Service but later requests it, that individual is eligible for that Support Service
- Individuals may receive Support Services other than a COVID relief payment more than once if needed during their quarantine or isolation period
- If an individual lives in the Target Service Area but chooses to isolate in a county that is not part of the Target Service Area, they remain eligible

Note: HCP: Health Care Professional
Referrals to Support Services Vendors

**NCCARE360**

- NCCARE360 is the first statewide network that unites health care and human services organizations via a shared technology platform that enables a coordinated, community-oriented, person-centered approach for delivering care in North Carolina.
- NCCARE360 helps health and community-based organizations in all 100 North Carolina counties make electronic referrals, communicate in real time, securely share client information, and track outcomes together.
- NCCARE360 has a community engagement team located across the state working with community-based organizations, health plans, health systems, and government agencies to create a statewide coordinated network and to train and onboard partners.
- Anyone in North Carolina can request services and be connected to community resources. A referral can be added to NCCARE360 even when the service organization is not registered with NCCARE360.
- Undocumented persons are eligible to receive services and NCCARE360 does not track, record, maintain, or report on the documentation status of any individual.

**Referral Process**

- The Support Services Vendor and its subcontractors are strongly encouraged to use NCCARE360 to accept electronic referrals.
- If the Support Services Vendor/subcontractor does not have the capability to accept electronic referrals in NCCARE360, it can accept referrals through another method such as telephone or secure e-messaging system.
- The Support Services Vendor/subcontractor must be able to receive and use information in the referral to provide the appropriate service, including knowing which Support Service to provide, whether at an Individual-Level or Family-Level and to whom at what location.
Covered Services

The Contractor will either directly provide, or subcontract with Community Based Organizations (CBOs) to provide, all of the Support Services described in the RFA to eligible individuals and their families, if applicable, except that the Contractor may not sub-contract for the delivery of the COVID relief payment Support Service.

Covered Services Scenarios

**Individual Eligible for Support Services**

**Individual-Level Services**
- Nutrition Assistance:
  - Health Food Box – Delivered
  - Healthy Meal – Delivered
  - Medically Tailored Meal – Delivered
- COVID Relief Payment
- Private Transportation
- Medication Delivery
- COVID-Related Supplies

**Family Members Eligible for Support Services**
- **Family-Level Services**
  - Nutrition Assistance: Healthy Food Box – Delivered
  - Larger food boxes for either a family of up to 2 members or a family of 3+ members
  - COVID Relief Payment ($800/family vs. $400/individual)
  - Private Transportation
  - COVID Related Supplies

**Individual Eligible with Family Members in Need**

**Family-Level Services**
- Nutrition Assistance: Healthy Food Box – Delivered
- Larger food boxes for either a family of up to 2 members or a family of 3+ members
- COVID Relief Payment ($800/family vs. $400/individual)
- Private Transportation
- COVID Related Supplies

**Family Members Eligible for Support Services**
- If multiple family members in the same household are eligible for Support Services, the Contractor may provide only one family member with Family-Level Services
- The Contractor must provide all other family members eligible for Support Services with Individual-Level Services

**ALL support services must be offered in ALL counties.**
Priority counties may change over time as the COVID-19 pandemic and areas of North Carolina with high case rates change.
### Support Services Vendor Service Delivery Responsibilities

<table>
<thead>
<tr>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver services to eligible individuals and their families, if applicable, based on referrals from CHWs/LHD team members within fourteen (14) calendar days of contract award</td>
</tr>
<tr>
<td>Deliver services based on guidelines in the COVID-19 Quarantine and Isolation Support Services Reimbursement Rates (refer to appendix)</td>
</tr>
<tr>
<td>Provide the COVID relief payment as defined in the COVID-19 Quarantine and Isolation Support Services Reimbursement Rates (refer to appendix) and not subcontract for this service</td>
</tr>
<tr>
<td>Make every effort to provide the recommended Support Service(s) to the individual and family, if applicable, within 24 hours of receiving a referral, but must provide the service(s) within 72 hours of receiving a referral</td>
</tr>
<tr>
<td>Be intentional in providing Support Services in a culturally and linguistically appropriate manner to those disproportionately impacted by COVID-19, such as African American/Black, LatinX/Hispanic, Native American/American Indian, Immigrant, and Refugee populations</td>
</tr>
</tbody>
</table>
## Support Services Vendor Communication and Collaboration Responsibilities

<table>
<thead>
<tr>
<th>Responsibilities</th>
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</thead>
<tbody>
<tr>
<td>Demonstrate understanding of the local community and the needs of its populations</td>
</tr>
<tr>
<td>Provide culturally and linguistically appropriate services to individuals (e.g. interpreters or technology-assisted interpreter solution; sign language services).</td>
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<tr>
<td>Ensure all personnel are comprehensively trained to perform their duties in accordance with the RFA, including but not limited to cultural sensitivity</td>
</tr>
<tr>
<td>Prioritize creating a representative staff of the communities being served</td>
</tr>
<tr>
<td>Collaborate with organizations, including CHW organizations and LHDs, that employ individuals who are assigned to support and coordinate referrals for individuals who are quarantining and isolating.</td>
</tr>
<tr>
<td>Develop and distribute communications to key stakeholders, including CHW organizations and LHDs regarding which CBOs in addition to itself it has selected to provide Support Services and other updates</td>
</tr>
<tr>
<td>Send all materials to NCDHHS for review and guidance prior to use</td>
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</tbody>
</table>

Questions?
Submit questions through the chat
Community Staff should Refer Individuals with COVID-19 Related Needs to a CHW Vendor

Community Health Worker and Support Services programs are specialized programs aimed to serve and support individuals living in NC who need assistance quarantining and isolating successfully. Vendors managing the programs are intended to alleviate DSS’ and LHD’s staff and resources, so they can be allocated to other pressing areas. CHW vendors will connect individuals with COVID-19 related needs to supports to help them isolate or quarantine.

**Communication**

- Community staff can communicate directly with the CHW operating in their counties to ensure referrals are made.
- Community staff can communicate with NCDHHS regarding vendors to provide feedback on the referral process.

**Collaboration**

- Community staff should understand CHW and Support Services programs and eligibility to be able to inform individuals.
- Community staff should refer individuals to CHW organizations through NCCARE360 if they are onboarded to the platform or connect individual directly via email/phone.
Community staff can search for CHW vendors in the “Provider Name” field in NCCARE360. A list of CHW vendors can be found in the appendix of this slide deck.

The CHW Vendor contact will connect the individual to COVID-19 related resources, including federally-funded Support Services to help the individual isolate or quarantine.
One federally-funded Support Service that individuals living in NC may be eligible for is a **one-time COVID-19 relief payment**, provided in response to the federally-declared COVID-19 public health emergency. This payment is meant to assist the individual and his or her family in meeting basic living expenses such as housing, food, utilities, medical costs, childcare costs, and household bills to help them isolate or quarantine.

The individual in isolation or quarantine may receive $400 and if that individual has a family that also needs financial assistance, the family may receive $800.

**This one-time COVID-19 relief payment should NOT be counted toward taxable income in determining the individual or family’s eligibility for public programs, such as Medicaid, SNAP, or WIC.**
## Playbook scenarios

<table>
<thead>
<tr>
<th>Overview</th>
<th><strong>Summary</strong>: CHW receives individual case and coordinates referral to support services</th>
</tr>
</thead>
</table>
| Identify | **Scenario 1**: LHD receives case and refers individual to CHW to receive support services  
**Scenario 2**: Contact tracer/case investigator refers an individual to a CHW to receive support services  
**Scenario 3**: CHW performs needs assessment, obtains attestation and refers individual to eligible services |
| Refer    | **Scenario 4**: Support service vendor receives referral and delivers services to individual |
| Deliver  | **Scenario 5**: CHW and support service vendor confirm service delivery to individual |
Overview: CHW receives individual case and coordinates referral to support services

How does an individual who needs to quarantine/isolate gets connected to Support Services via a CHW?

CHW receives individual cases from many channels:
- Testing sites
- Contract tracers/Case investigators
- LHDs
- PCPs
- Outreach workers
- CBOs
- Self referrals

1. Identify
   - CHW identifies Support Service Vendors and subcontractors in NCCARE360 and submits referrals for federally-funded Support Services.
   - Once the CHW enters the patient into NCCARE360, the CHW then completes an attestation form with the individual to see if they are eligible for federally-funded Support Services.
   - The CHW then assesses if the individual needs any additional supports outside of these federally-funded services through the needs assessment in NCCARE360.

2. Refer
   - CHW submits referrals for any other services needed to any organizations identified in NCCARE360 based on the additional needs of the client outside of the Support Services referrals.

3. Deliver
   - The CHW continues to be the individual’s point of contact throughout the isolation/quarantine period if they need additional support.
   - Support service vendor receives referral through NCCARE360 with attached attestation document.
   - Support service vendors deliver services to individuals. Once complete, the vendor closes the referral in NCCARE360.
   - Support service vendors conduct invoicing, reimbursement and reporting.

*CHW provides individual with their contact information during initial interaction so that the individual may reach out to the CHW if new needs arise.
Scenario: LHD receives case and refers individual to CHW to receive support services

If an individual in need of support services has been connected to their LHD, how does the LHD refer the individual to a CHW to coordinate support services delivery?

1. The individual is in contact with the LHD and has expressed a need for support services to help quarantine or isolate safely.

   Individual should be in quarantine or isolation because he/she:
   • Tested positive for COVID-19
   • Is waiting on test results
   • Has been exposed to COVID-19
   • Is a member of a high-risk group

2. The LHD may choose to fulfill the request internally or refer the request to a CHW vendor.*

   If LHD can meet the requested Q&I need:
   The LHD completes the attestation form on behalf of the individual to determine if the individual is eligible for DHHS-funded support services.
   ➢ If yes, the LHD searches for a Support Services Vendor in NCCARE360. The LHD creates a referral in NCCARE360 and attaches the individual’s attestation form to the referral. If the individual has needs in addition to DHHS-funded support services, the LHD submits referrals for any other services needed to any organizations identified in NCCARE360, based on the individual’s needs.
   ➢ If no, the LHD submits referrals for any services needed to any organizations identified in NCCARE360 based on the individual’s needs.

   If LHD cannot meet the requested need:
   LHD enters referral to CHW in NCCARE360 or calls the CHW agency to initiate a referral.

3. CHW agency obtains referral from NCCARE360 or directly from LHD.

   CHW agency assigns the work to an CHW who will follow up with individual and complete the attestation form for the individual and determine individual’s needs.

   After completing the attestation form, if the individual is not eligible for Support Services:
   The CHW searches other services the individual may be eligible for.

   If the individual is eligible for Support Services:
   The CHW continues to step 4.

4. CHW connects individual to found resources via NCCARE360 or direct referral.

5. Scenario #4: Support service vendor receives referral and delivers services to individual.
## Next Steps

| 1 | Welcome and Introduction |
| 2 | NC DHHS COVID Support Overview |
| 3 | Community Health Worker Overview |
| 4 | Non-Congregate Shelter Overview |
| 5 | Support Services Overview |
| 6 | Partner Collaboration |
| 7 | Next Steps |
| 8 | Q&A |
| 9 | Appendix |

**Questions?**
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Next Steps and Expectations

- Connect with the CHW vendor in your county, and begin referring individuals. *Contact information in Appendix*

- Enroll in NCCARE360 (if not currently enrolled) and contact community engagement manager.

- Contact John Resendes (<John.Resendes@dhhs.nc.gov>) and Amanda Van Vleet (<Amanda.VanVleet@dhhs.nc.gov>) to learn more about the CHW and SS programs.
| 1 | Welcome and Introduction |
| 2 | NC DHHS COVID Support Overview |
| 3 | Community Health Worker Overview |
| 4 | Non-Congregate Shelter Overview |
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Appendix

1. Welcome and Introduction
2. NC DHHS COVID Support Overview
3. Community Health Worker Overview
4. Non-Congregate Shelter Overview
5. Support Services Overview
6. Partner Collaboration
7. Next Steps
8. Q&A
9. Appendix

Questions?
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## Quarantine and Isolation Support Resources

### Community Health Worker
- **Community Health Worker resources:** [https://www.ncdhhs.gov/divisions/office-rural-health/community-health-workers/resources](https://www.ncdhhs.gov/divisions/office-rural-health/community-health-workers/resources)

### Support Services
- **Webpage:** [https://covid19.ncdhhs.gov/information/human-services/assistance](https://covid19.ncdhhs.gov/information/human-services/assistance)
- **Health insurance options:** [https://covid19.ncdhhs.gov/information/human-services/health-insurance-options](https://covid19.ncdhhs.gov/information/human-services/health-insurance-options)
- **Food and nutrition services:** [https://covid19.ncdhhs.gov/information/human-services/changes-food-and-nutrition-services](https://covid19.ncdhhs.gov/information/human-services/changes-food-and-nutrition-services)

### Non-Congregate Shelter
- **Webpage:** [https://covid19.ncdhhs.gov/information/housing-sheltering/non-congregate-sheltering](https://covid19.ncdhhs.gov/information/housing-sheltering/non-congregate-sheltering)
- **Reporting:** [https://app.smartsheet.com/b/form/add5cf0fdafa67b4bd3d0707ea5d875](https://app.smartsheet.com/b/form/add5cf0fdafa67b4bd3d0707ea5d875)
# Community Health Worker Vendor Contact Information

<table>
<thead>
<tr>
<th>Counties</th>
<th>Vendor</th>
<th>Contact</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catawba</td>
<td>Catawba County Public Health</td>
<td>Honey Estrada</td>
<td>(828) 695-6683</td>
<td><a href="mailto:honey@catawbacountync.gov">honey@catawbacountync.gov</a></td>
</tr>
<tr>
<td>Alamance, Buncombe, Chatham, Craven, Davidson, Davie, Durham, Forsyth, Franklin, Gaston, Granville, Guilford, Harnett, Henderson, Johnston, Lee, Onslow, Orange, Pitt, Randolph, Surry, Vance, Wake, Warren, Wayne, Wilkes</td>
<td>Curamericas Global</td>
<td>Andrew Herrera</td>
<td>(919) 801-0612</td>
<td><a href="mailto:Andrew@Curamericas.org">Andrew@Curamericas.org</a></td>
</tr>
<tr>
<td>Cabarrus, Gaston, Mecklenburg, Montgomery, Rowan, Stanly, Union</td>
<td>Keystone Peer Review Organization (KEPRO)</td>
<td>Lisa Bennett</td>
<td></td>
<td><a href="mailto:lbenettt@Kepro.com">lbenettt@Kepro.com</a></td>
</tr>
<tr>
<td>Bladen, Columbus, Duplin, Pender, Robeson, Sampson</td>
<td>Mt. Calvary Center for Leadership Development</td>
<td>Jimmy Tate</td>
<td>(910) 284-9382</td>
<td><a href="mailto:jitate@mtcalvarycenter.org">jitate@mtcalvarycenter.org</a></td>
</tr>
<tr>
<td>Bladen, Columbus, Duplin, Pender, Robeson, Sampson</td>
<td>Mt. Calvary Center for Leadership Development</td>
<td>Carol Highsmith</td>
<td>(910) 789-1886</td>
<td><a href="mailto:chighsmith@mtcalvarycenter.org">chighsmith@mtcalvarycenter.org</a></td>
</tr>
<tr>
<td>Duplin, Greene, Johnston, Lenoir, Sampson, Wayne, Wilson</td>
<td>One to One with Youth</td>
<td>Danny King</td>
<td>(919) 922-7713</td>
<td><a href="mailto:dking@adlainc.org">dking@adlainc.org</a></td>
</tr>
<tr>
<td>Duplin, Greene, Johnston, Lenoir, Sampson, Wayne, Wilson</td>
<td>One to One with Youth</td>
<td>Inonda Kind</td>
<td>(919) 987-2798</td>
<td><a href="mailto:kone2one@aol.com">kone2one@aol.com</a></td>
</tr>
<tr>
<td>Johnston, Orange, Wake</td>
<td>Southeastern Healthcare of NC</td>
<td>Joyce Harper</td>
<td>(919) 987-2798</td>
<td><a href="mailto:jharper@sehcnc.com">jharper@sehcnc.com</a></td>
</tr>
<tr>
<td>Johnston, Orange, Wake</td>
<td>Southeastern Healthcare of NC</td>
<td>Evelyn Sanders</td>
<td>(919) 987-2791</td>
<td><a href="mailto:esanders@sehcnc.com">esanders@sehcnc.com</a></td>
</tr>
<tr>
<td>Beaufort, Bertie, Chowan, Dare, Duplin, Edgecombe, Halifax, Hertford, Northampton, Pitt</td>
<td>Vidant Health</td>
<td>Melissa Roupe</td>
<td>(252) 847-9350</td>
<td><a href="mailto:myroupe@vidanthealth.com">myroupe@vidanthealth.com</a></td>
</tr>
<tr>
<td>Beaufort, Bertie, Chowan, Dare, Duplin, Edgecombe, Halifax, Hertford, Northampton, Pitt</td>
<td>Vidant Health</td>
<td>Crystal Dempsey</td>
<td>(252) 847-5162</td>
<td><a href="mailto:Crystal.Dempsey@vidanthealth.com">Crystal.Dempsey@vidanthealth.com</a></td>
</tr>
</tbody>
</table>
### Support Services Reimbursement Rates

<table>
<thead>
<tr>
<th>Service</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home-delivered healthy food box (Individual)</td>
<td>$90.04/food box</td>
</tr>
<tr>
<td>Home-delivered healthy food box (Family up to 2 members)</td>
<td>$90.04/food box</td>
</tr>
<tr>
<td>Home-delivered healthy food box (Family more than 2 members)</td>
<td>$141.06/food box</td>
</tr>
<tr>
<td>Home-delivered healthy meal (Individual)</td>
<td>$4.87/meal</td>
</tr>
<tr>
<td>Home-delivered medically-tailored meal (Individual)</td>
<td>$5.05/meal</td>
</tr>
<tr>
<td>COVID Relief Payment (Individual)</td>
<td>$400/individual</td>
</tr>
<tr>
<td>COVID Relief Payment (Family)</td>
<td>$800/family</td>
</tr>
<tr>
<td>Private, safe transportation to/from non-congregate shelter, medical visits, and testing sites (Individual)</td>
<td>$50 cap per ride, 6 one-way ride cap per individual</td>
</tr>
<tr>
<td>Private, safe transportation to/from non-congregate shelter, medical visits, and testing sites (Family)</td>
<td>$50 cap per ride, 6 one-way ride cap per family</td>
</tr>
<tr>
<td>Medication Delivery (Individual)</td>
<td>$1.50/medication mailed</td>
</tr>
<tr>
<td></td>
<td>$3/medication courier-type delivered</td>
</tr>
<tr>
<td>COVID-Related Supplies (e.g. face mask, hand sanitizer, cleaning supplies) (Individual)</td>
<td>$50/package</td>
</tr>
<tr>
<td>COVID-Related Supplies (e.g. face mask, hand sanitizer, cleaning supplies) (Family)</td>
<td>$50/package</td>
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</tbody>
</table>

Contractors and subcontractors may invoice certain operational expenses separately, up to a cap.
## Individual Level Services (1/4)

<table>
<thead>
<tr>
<th>Service Available to Individual</th>
<th>Service Description &amp; Reimbursement Requirements</th>
<th>Rate</th>
</tr>
</thead>
</table>
| Nutrition Assistance: Healthy Food Box – Delivered | • A healthy food box for delivery consists of an assortment of nutritious foods that is delivered to an isolating/quarantining individual's place of shelter.  
• Food selection should generally adhere to Dietary Guidelines for Americans, but is not required to.  
• Food selection should include meat/protein and other refrigerated foods.  
• Food may be tailored to meet cultural preferences or specific medical needs.  
• To receive this reimbursement rate, the healthy food box must constitute sufficient food for 3 meals and two snacks per day for one week (7 days).  
• Support Service Vendors and nutrition assistance organizations may establish a proportional amount of food and reimbursement if it is more appropriate to deliver less than one week's worth of food. For example, if an individual only has two days left in their isolation/quarantine period a food box may be delivered with two days' worth of food at a proportionally lower rate.  
• Individuals are eligible for up to 14 days' worth of food boxes if they isolate or quarantine for up to 14 days. This may be delivered via 2 food boxes that each cover 7 days or a different combination of proportional food boxes and reimbursements.  
• The reimbursement rate for a healthy food box is inclusive of all direct and indirect costs related to providing the service, including staff time and materials needed for preparing and delivering the service. | $90.04/food box |
| Nutrition Assistance: Healthy Meal – Delivered | • A healthy, home-delivered meal consists of a hot, cold, or frozen meal that is delivered to an isolating/quarantining individual's place of shelter.  
• Meals should generally adhere to Dietary Guidelines for Americans, but is not required to.  
• Meals may be tailored to meet cultural preferences or specific medical needs.  
• This reimbursement rate is for one meal. Individuals are eligible for up to 3 meals per day.  
• The reimbursement rate for a healthy meal is inclusive of all direct and indirect costs related to providing the service, including staff time and materials needed for preparing and delivering the service. | $4.87/meal |
| Nutrition Assistance: Medically-Tailored, Delivered Meal | • A medically-tailored, delivered meal must be targeted to a specific disease or condition and developed in accordance with nutritional guidelines established by the National Food is Medicine Coalition or other appropriate guidelines.  
• Medically-tailored meals generally include an evaluation with a Registered Dietitian Nutritionist or Licensed Dietitian Nutritionist to assess and develop a medically-appropriate nutrition care plan and the preparation and delivery of the prescribed nutrition care regimen.  
• Food may be tailored to meet cultural preferences.  
• This reimbursement rate is for one meal. Individuals are eligible for up to 3 meals per day.  
• The reimbursement rate for a medically-tailored meal is inclusive of all direct and indirect costs related to providing the service, including staff time and materials needed for preparing and delivering the service. | $5.05/meal |
| COVID Relief Payment | This service is a one-time disaster relief payment provided to the isolating/quarantining individual in response to the federally-declared COVID-19 public health emergency. The intent of the payment is to assist the individual in meeting their basic living expenses such as housing, food, utilities, medical costs, child care costs, and household bills.  
The Support Service Vendor is responsible for managing this service and should bill administrative expenditures such as staff time to execute the COVID Relief Payments and mailing costs as operational expenses. | $400/individual |
### Individual Level Services (3/4)

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Reimbursement</th>
</tr>
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<tbody>
<tr>
<td><strong>Private Transportation</strong></td>
<td>Provision of private transportation for the individual isolating/quarantining through one or more of the following services: (a) community transportation options (e.g., locally organized), (b) direct transportation by professional, private or semi-private vendor, or (c) account credits for taxis/ridesharing apps.</td>
<td>$50 cap per ride, 6 one-way ride cap per individual</td>
</tr>
<tr>
<td></td>
<td>Transportation services are only permissible to directly support the ability to isolate or quarantine and are subject to CHW approval. Examples of permissible transportation include, but are not limited to, transportation to/from: (a) non-congregate shelter, (b) medical visits, and (c) testing sites.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rides must be provided in a safe manner, with both the driver and passenger wearing face masks, cleaning employed between each rider, and, when applicable, with a service provider that has explicitly agreed to provide rides to a potentially or confirmed COVID-19 positive individual. Sub-contractors that provide transportation services are strongly encouraged to use large vehicles, such as vans, that allow six feet of distance between the driver and passenger.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sub-contractors providing transportation services may charge their standard meter rate, plus an additional 20% of the total ride fare to account for added costs related to taking appropriate COVID-19 precautions and cleaning the vehicle between riders.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Support Services Vendor is responsible for communicating with CHWs to coordinate transportation services and monitor caps.</td>
<td></td>
</tr>
</tbody>
</table>
| **Medication Delivery**         | Delivery of prescription medication(s) to isolating/quarantining individual at their place of shelter.                                                                                                       | • $1.50/medication mailed  
• $3/medication courier-type delivered                                                                 |
|                                 | Reimbursement is for the delivery of the medication (not the medication itself) and may be directed to a pharmacy that mails or directly transports a medication to an individual. The reimbursement may also go to other organizations that facilitate the pick-up and direct delivery of a medication to an individual. |                                                                                        |
|                                 | The reimbursement rate for medication delivery is inclusive of all direct and indirect costs related to providing the service, including staff time and materials needed for preparing and delivering the service. |                                                                                        |
Individual Level Services (4/4)

<table>
<thead>
<tr>
<th>COVID-Related Supplies</th>
<th>Service consists of a package of COVID-related over-the-counter supplies known to help mitigate the spread and treat symptoms of COVID, including but not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Face masks</td>
</tr>
<tr>
<td></td>
<td>• Hand sanitizer</td>
</tr>
<tr>
<td></td>
<td>• Sanitizing wipes or liquid sanitizer with paper towels</td>
</tr>
<tr>
<td></td>
<td>• Thermometer</td>
</tr>
<tr>
<td></td>
<td>• Tylenol</td>
</tr>
</tbody>
</table>
|                        | The reimbursement rate for COVID-related supplies is inclusive of all direct and indirect costs related to providing this service, including for sourcing, preparing, purchasing and delivering the supplies. | $50/package


## Family Level Services (1/3)

<table>
<thead>
<tr>
<th>Service Available to Individual with Family Members in Household</th>
<th>Service Description &amp; Reimbursement Requirements</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition Assistance: Healthy Food Box – Delivered</td>
<td>A healthy food box for delivery consists of an assortment of nutritious foods that is delivered to an isolating/quarantining individual’s place of shelter or to the individual’s household members’ place of shelter.</td>
<td>$90.04 for food box delivered to a household with up to two family members</td>
</tr>
<tr>
<td></td>
<td>Food selection should generally adhere to Dietary Guidelines for Americans but is not required to.</td>
<td>$141.06 for food box delivered to a household with more than two family members</td>
</tr>
<tr>
<td></td>
<td>Food selection should include meat/protein and other refrigerated foods.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Food may be tailored to meet cultural preferences or specific medical needs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>To receive this reimbursement rate, the healthy food box must constitute sufficient food for 3 meals and two snacks per day for one week (7 days).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support Service Vendors and nutrition assistance organizations may establish a proportional amount of food and reimbursement if it is more appropriate to deliver less than one week’s worth of food. For example, if an individual only has two days left in their Q/I period at the time the healthy food box is delivered.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If an individual isolating: (a) requires nutrition assistance, (b) has household/family members that also require nutrition assistance, and (c) is isolating separately from the household/family members, that individual may select to receive either healthy food boxes or meals for themselves. Service descriptions and rates in “Nutrition Assistance: Healthy Food Box – Delivered” for individuals (Appendix A) apply. Under these circumstances, the household/family members are only eligible for healthy food boxes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If the individual and the household/family members require food assistance and are located in the same household during the isolation/quarantine, they collectively are only eligible for healthy food boxes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The reimbursement rate for a healthy food box is inclusive of all direct and indirect costs related to providing the service, including staff time and materials needed for preparing and delivering the service.</td>
<td></td>
</tr>
</tbody>
</table>
### COVID Relief Payment
- This service is a one-time disaster relief payment provided to isolating/quarantining individual and their household members in response to the federally-declared COVID-19 public health emergency. The intent of the payment is to assist the individual and their household members in meeting their basic living expenses such as housing, food, utilities, and household bills.
- If more than one household member is required to quarantine or isolate and is in need of and eligible for this Support Service, only one household member may receive the Household-Level benefit. All other household members required to quarantine or isolate in need of and eligible for this Support Service must receive it at the Individual-Level.
- The Support Service Vendor is responsible for managing this service and should bill administrative expenditures such as staff time to execute the COVID Relief Payments and mailing costs as operational expenses.

| $800/individual (individual quarantining or isolating receives $800 regardless of number of family/household members) |

### Private Transportation
- Provision of private transportation for the individual isolating/quarantining or a family member through one or more of the following services: (a) community transportation options (e.g., locally organized), (b) direct transportation by professional, private or semi-private vendor, or (c) account credits for taxis/ridesharing apps.
- Transportation services are only permissible to directly support the ability to isolate or quarantine and are subject to CHW approval. Examples of permissible transportation include, but are not limited to, transportation to/from: (a) non-congregate shelter, (b) medical visits, and (c) testing sites.
- Rides must be provided in a safe manner, with both the driver and passenger wearing face masks, cleaning employed between each rider, and, when applicable, with a service provider that has explicitly agreed to provide rides to a potentially or confirmed COVID-19 positive individual. Sub-contractors that provide transportation services are strongly encouraged to use large vehicles, such as a van, that allow six feet of distance between the driver and passenger.
- Sub-contractors providing transportation services may charge their standard meter rate, in addition to 20% of the total ride fare to account for added costs related to taking appropriate COVID-19 precautions and cleaning the vehicle between riders.
- The Support Services Vendor is responsible for communicating with CHWs to coordinate transportation services and monitor caps.

| $50 cap per ride, 6 one-way ride cap per family |
Service consists of a package of COVID-related over-the-counter supplies known to help mitigate the spread and treat symptoms of COVID, including but not limited to:

- Face masks
- Hand sanitizer
- Sanitizing wipes or liquid sanitizer with paper towels
- Thermometer
- Tylenol

- Up to two COVID-Related Supplies packages may be provided when an individual who needs to isolate: (a) chooses to isolate outside of his/her primary residence, and (b) attests to having family members in the primary residence that require a second COVID-Related Supplies package.

- The reimbursement rate for COVID-related supplies is inclusive of all direct and indirect costs related to providing this service, including for sourcing, preparing, purchasing and delivering the supplies.

<table>
<thead>
<tr>
<th>COVID-Related Supplies</th>
<th>$50/package</th>
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</thead>
<tbody>
<tr>
<td>Service consists of a package of COVID-related over-the-counter supplies known to help mitigate the spread and treat symptoms of COVID, including but not limited to:</td>
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<tr>
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</tr>
<tr>
<td>- Sanitizing wipes or liquid sanitizer with paper towels</td>
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<tr>
<td>- Thermometer</td>
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<td></td>
</tr>
</tbody>
</table>
Benefits for Uninsured Individuals Living in North Carolina

October 5, 2020
Welcome and Introduction

1. Welcome and Introduction
2. COVID-19 Testing Benefit for Uninsured Individuals Living in North Carolina
3. COVID-19 Related Primary Care Benefit for Uninsured Individuals Living in North Carolina
4. Q&A

Questions?
Submit questions through the chat
Our Speakers

Maggie Sauer
Director
Office of Rural Health
NC DHHS

Allison Owen
Deputy Director
Office of Rural Health
NC DHHS
Where are North Carolina's New COVID-19 Cases?

Source: @gmarkholmes calculations using NYT GitHub data & 2013 NCHS Urban-Rural
There are multiple funding programs available to support providers who are treating patients with COVID-19 or COVID-19 related needs.

- NC Medicaid Optional COVID-19 (MCV) Testing Program
- Reimbursement for COVID-19 Related Primary Care Services for Uninsured Individuals Living in North Carolina
- Health Resources and Services Administration (HRSA) COVID-19 Claims Reimbursement for the Uninsured
- North Carolina Medical Society Foundation Financial Recovery Program
## Resources to Support NC Providers Responding to the COVID-19 Pandemic

There are multiple programs available to support providers who are responding to the COVID-19 pandemic. The below table outlines the different COVID-19 related needs reimbursable through eligible programs. For more information, please visit the program websites.

<table>
<thead>
<tr>
<th>Covered COVID-19 Related Costs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing</td>
</tr>
<tr>
<td>Telehealth, ventilation, staff, etc.</td>
</tr>
</tbody>
</table>

### Support Programs:

#### REIMBURSEMENT FOR COVID-19 RELATED PRIMARY CARE SERVICES FOR UNINSURED INDIVIDUALS LIVING IN NORTH CAROLINA

First-come first-serve reimbursement to primary care providers who are providing COVID-19 related primary care services to uninsured individuals living in North Carolina (SS not required). Services provided on or after Sept. 1 through Dec. 30, 2020 or until funds are exhausted, whichever comes first. [Link for more information](#)

#### NC MEDICAID OPTIONAL COVID-19 (MCV) TESTING PROGRAM

Funding can be used for individuals who are uninsured and residing in North Carolina and who meet the citizenship and legal immigration status requirements of the Medicaid program. [Link for more information](#)

#### HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) COVID-19 CLAIMS REIMBURSEMENT FOR THE UNINSURED

Health care providers who have conducted COVID-19 testing or provided treatment for uninsured individuals with a COVID-19 diagnosis on or after Feb. 4, 2020 can file for reimbursement. [Link for more information](#)

#### NORTH CAROLINA MEDICAL SOCIETY FOUNDATION FINANCIAL RECOVERY PROGRAM (NCMSF FRP)

Funding will be based on reimbursement for COVID-19-related expenses incurred between March 1 and Nov. 30, 2020. Additional costs may be eligible for reimbursement. [Link for more information](#)

#### CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY (CARES) ACT PROVIDER RELIEF FUND

Qualified providers of health care, services, and support may receive Provider Relief Fund payments for healthcare-related expenses or lost revenue due to COVID-19. [Link for more information](#)
# COVID-19 Testing Benefit for Uninsured Individuals Living in North Carolina

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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<td>Welcome and Introduction</td>
</tr>
<tr>
<td>2</td>
<td>COVID-19 Testing Benefit for Uninsured Individuals Living in North Carolina</td>
</tr>
<tr>
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<td>COVID-19 Related Primary Care Benefit for Uninsured Individuals Living in North Carolina</td>
</tr>
<tr>
<td>4</td>
<td>Q&amp;A</td>
</tr>
</tbody>
</table>

Questions?
Submit questions through the chat
Many individuals living in North Carolina lack health insurance and require access to COVID-19 testing without financial barriers.

**Program Overview**

- Medicaid providers can be reimbursed for COVID-19 testing of uninsured individuals under the **NC Medicaid Optional COVID-19 Testing (MCV) program**

- States have the option via the Families First Coronavirus Response Act (FFCRA) to pay COVID-19 testing for uninsured individuals

- An application and approval for participation is required prior to payment for testing services

- States may accept self-attestation of all enrollment factors, except citizenship/immigration status

*The program will end when there is no longer a COVID-19 federal declaration of emergency*
### Eligibility and Enrollment

<table>
<thead>
<tr>
<th>Individual Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding can be used for individuals who are uninsured and residing in North Carolina and meet the citizenship and legal immigration status requirements of the Medicaid program; Medicaid is required to verify citizenship and immigration status</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals who qualify for the MCV program will remain in the program throughout the federal declaration of the emergency period; Costs for COVID-19 tests are covered retroactive to Jun. 1, 2020, provided individuals were uninsured at the time of the test</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals currently enrolled in NC Medicaid’s limited “Family Planning Only” benefit and who have no other health insurance coverage are automatically enrolled in the MCV program and do not need to complete an application; Others must complete an application to enroll</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing site providers and labs must be enrolled in NCTracks to be reimbursed for COVID-19 testing costs for an individual enrolled in the MCV program</td>
</tr>
</tbody>
</table>
**Implementation Approach**

### Testing Site Provider Options

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
</table>
| • Check NCTracks Portal to confirm Medicaid eligibility  
• Bill NCTracks for testing provided | • Allow beneficiaries to apply online or collect paper applications at testing location  
• Submit applications to DHB for processing  
• Wait 2-6 weeks for application processing*  
• Check NCTracks Portal to confirm Medicaid eligibility  
• Bill NCTracks for testing provided, as eligibility is retroactive to first of the month in NC Medicaid | • Bill HRSA for individuals who are not eligible for Medicaid |

*Or other time period as determined by DHB*
Implementation Flow

START

Verify Medicaid Eligibility in NCTracks Portal

Individual enrolled in Optional Testing Group?

YES

Individual ineligible for Optional Testing Group

Provider bills NCTracks

NO

Individual fills out online/paper application

Where online application not available, provider faxes paper application to central location and waits for processing

Provider Bills HRSA

Key:

Individual

Testing Provider
Next Steps

Ensure organization is enrolled in NCTracks

Refer individuals to complete the online application for COVID testing

Ensure testing sites and provider offices have paper application available for individuals

File eligible reimbursement claims to NCTracks (claims are covered retroactive to Jun. 1, 2020)
<table>
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Questions?
Submit questions through the chat
Many individuals living in North Carolina have lost their health insurance due to the COVID-19 pandemic and still require healthcare.

North Carolina developed a program to support uninsured individuals living in North Carolina get access to healthcare for COVID-19 related needs.

The program is aimed to quickly distribute reimbursement funds to primary care providers (PCP) who are providing COVID-19 related services to uninsured individuals living in North Carolina.

The program provides $150 for each eligible claim to PCPs while the fund lasts or until Dec. 30, 2020, whichever comes first.
Primary Care Provider Process

Provides COVID-19 related services (e.g. follow-up appointments)

Confirms that the individual has no other healthcare coverage (e.g. Medicaid, Medicare, or other health insurance) and completes the attestation form in NCTracks

Files reimbursement claim through NCTracks portal

Receives $150 payment/encounter not per service

IMPORTANT: If you are attesting that you are not receiving any other funding to support the encounter, this includes co-payment or any other forms of payment from the individual.

NCTracks Attestation Statement

By submitting this transaction to the NC Department of Health and Human Services, I attest that the service performed is accurately represented as shown, and the patient was uninsured and the service was a COVID-19 related primary care service. I further attest that claims have been either submitted to the HRSA portal and denied or were not submitted because they were ineligible for HRSA reimbursement. I understand this transaction is a request for payment from CARES Act funding and is subject to audit by the Office of the State Auditor and other oversight organizations.
Uninsured Portal Communications and Training High Level Timeline

**Key Audience:**
- Providers
- Health Care Partners
- CCNC/AHEC
- LHDs
- CHWs

**Begin eligibility**  
*Sept. 1*
Eligible claims from Sept. 1, 2020 can be retroactively submitted for reimbursement

**Inform partners**  
*Sept. – Oct.*
Inform providers via webinars: PCAC (9/18), Healthcare Coalition (10/7), AHEC Open House (10/9), CHW Vendor Meeting (10/28)

**Open portal**  
*Late Oct.*
Portal opens late Oct. and providers can retroactively submit claims and regularly submit new claims

**Announce program**  
*Oct. 2*
Send announcements to providers, healthcare partners, CCNC, AHEC and LHDs (e.g. DHHS Medicaid website updates, fact sheet, email announcement, special bulletin, NCTracks e-blast) about new program

**Train users**  
*Nov. 9 – 20*
Conduct 6 training sessions to educate primary care practices on reimbursement process in NCTracks

**Remind providers**  
*Nov. – Dec.*
Send regular reminder emails to providers to submit claims and update website with status of available funds

**End program**  
*Dec. 30*
Program ends Dec. 30, 2020 or sooner if funds are depleted
### Next Steps

<table>
<thead>
<tr>
<th>PCP Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure practice is enrolled in NCTracks as a provider; Enroll in NCTracks through the portal.</td>
</tr>
<tr>
<td>Hold previous and ongoing claims backdated as of Sept. 1, 2020 until portal is live; Submit claims regularly when portal is live on Oct. 30, 2020.</td>
</tr>
<tr>
<td>Expect additional communications regarding the uninsured portal including an email announcement, Fact Sheet, webinar and training before and after Oct. 30, 2020.</td>
</tr>
<tr>
<td>Continue to check DHHS website for next steps, updates, and status of available funds.</td>
</tr>
</tbody>
</table>
# COVID-19 Related Primary Care Benefit for Uninsured Individuals Living in North Carolina

<table>
<thead>
<tr>
<th></th>
<th>Section</th>
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Questions? Submit questions through the chat
NC Department of Health and Human Services

Office of Rural Health

Lakeisha Moore
Health Information Technology (HIT)
Program Manager

October 22, 2020
ORH Health Information Technology (HIT) Program
HIT Team Projects

**NC HealthConnex**
Health Information Exchange

**NCCARE360**
Community Information Exchange

**Tele-Health**
ORH Telehealth Initiatives

**EHR TA**
Electronic Health Record (EHR) Technical Assistance

---

**NC HealthConnex Statewide Health Information Exchange (HIE)** - Assisting ORH Grantees and Safety Net Providers with connecting to and utilizing the Statewide HIE (NC HealthConnex).

**NCCARE360 Community Information Exchange (CIE)** – Assisting ORH Grantees and Safety Net Providers with Enrolling and utilizing the Statewide Healthy Opportunities Resource Platform.

**Telehealth (TH) Initiatives** – Providing safety net providers with telehealth technical assistance, creating a statewide telehealth inventory and working with DIT Broadband Team on an ARC Grant Telehealth and Digital Literacy Implementation Project.

**EHR Technical Assistance (TA)** – Providing technical assistance to Rural Health Centers and other ORH Grantees with reporting Clinical Quality Measures.
In the blink of an eye, telehealth and health care became synonymous.

**Question:** Who led your practice’s most recent telehealth efforts?

A. Chief Technology Officer

B. Multi-stakeholder Digital Transformation Team

C. COVID-19
NC Office of Rural Health Telehealth Initiatives

➢ Appalachian Regional Commission (ARC) Grant Lead for ORH
  ➢ Connect ARC Broadband and Telehealth (TH) feasibility study results to ARC Implementation Grant
  ➢ Implement Year 1 of ARC POWER Grant
  ➢ Develop a digital literacy curriculum for Telehealth
  ➢ Implement TH at three pilot sites with economic development and improved health outcomes as performance measures

➢ Create statewide Telehealth Inventory
  ➢ Obtain current data on TH usage across ORH Grantees and Safety Net sites, and measure against DHHS TH Strategic plan growth goals
  ➢ Create a resource that includes NC TH best practice models and NC specific TH case studies

➢ Telehealth 101
  ➢ Deploy TH 101 workshop, TH playbook and TH Training materials
  ➢ Incorporate NCCare360, NCHealthConnex, and other value based care initiatives into TH workflow models
  ➢ Include NC Band information and other Broadband opportunities in TH 101 Workshop
  ➢ Conduct assessment for CAHs of gaps in care that could be addressed through TH (telecardiology in ED, telestroke, etc.)

➢ Community Paramedicine (CP) Pilot
  ➢ Educate CP programs about telehealth workflows to advance CP goals
  ➢ Create sustainable telehealth funding opportunities between CP and Primary Care Practice
  ➢ Develop Chatuge as telehealth CP model in the state as best-practice example
    ➢ Incorporating NCCare360 and NCHealthConnex into CP workflow
ORH HIT Team Coverage

**EASTERN – SEBASTIAN GIMENEZ**  
SEBASTIAN.GIMENEZ@DHHS.NC.GOV

**CENTRAL – ADONNICA ROWLAND**  
ADONNICA.ROWLAND@DHHS.NC.GOV

**WESTERN – GRETCHEN RAMIREZ**  
GRETCHEN.RAMIREZ@DHHS.NC.GOV

**STATEWIDE – ROBYN MCARDLE, TELEHEALTH SPECIALIST**  
ROBYN.MCARDLE@DHHS.NC.GOV

**HIT PROGRAM MANAGER – LAKEISHA MOORE**  
LAKEISHA.MOORE@DHHS.NC.GOV

Request HIT Technical Assistance Here
DHHS Resumes Implementation of Managed Care for Launch on July 1, 2021

More information about transformation to managed care will be shared in the future. Until Managed Care goes live in 2021, Medicaid beneficiaries get care and Medicaid provider submit claims as they do today.

Learn More
Rural Health Updates from NC Medicaid

Shannon Dowler, MD
Chief Medical Officer
NC Medicaid
October 2020
Our Time Together

- Medicaid Telehealth Temporary and Permanent Provisions
- What the Data Has Taught Us
- Medicaid Transformation Updates
- BCCCP and FP Medicaid Changes
Telehealth Before the Pandemic:
In the beginning, there was 1.

- Baseline Telehealth/Virtual Health Policies 1
- Global Pandemic
  Over 7 weeks...
- Total Flexibilities >367 +
  Telehealth Flexibilities 135+
  Codes Impacted 482+
  Permanent Telehealth Policies >34++

Weekly Plan Projected Publicly to Providers
- High Priority Modifications First
- Innovative Modifications Second
- Preventive Care Modifications Last

Concurrent Rate Changes to Support Providers
- Safety Net Providers First
- LTC/Hospitals Second
- Broad Rate Changes Last
Telehealth and Telephonic Ratios | 03/03/20 – 08/17/20

Ratio of telehealth and telephonic to in-person claims jump after NC Medicaid implements telehealth/telephonic policy changes.
• Rate starts to decrease in late April coinciding with Phase 2 and rebound in in-person services
• Over the course of this time period, **309,966** beneficiaries have had at least one telemedicine encounter
Medicaid Telehealth, Telephonic and In-Person Professional Claims Volume | 12/30/19 - 08/31/20

- Steep increases in telehealth and telephonic claims and an even steeper decrease in-person claims combined to produce dramatic increases in telehealth and telephonic claims ratios.
- All modalities decrease with claims adjudication.

Data pulled from DHHS dashboard, contains ALL professional claims
• While in-person behavioral health (BH) claims (grey line, left chart) have decreased, telehealth claims (yellow line, left chart) have jumped. This relationship produces the spike in the ratio of telehealth to in-person services represented by the yellow line in the chart on the right.

Data pulled from CCNC behavioral health dashboard
• Counties’ rates of primary care and OB services that were telehealth:
  • decrease as the percent of counties’ populations living in rural areas increases
  • increase as the percent of counties’ populations with broadband access increases
• These relationships do not hold for behavioral health telehealth services

Rurality and Broadband data pulled from the Federal Communication Commission’s Mapping Broadband Health in America project - https://www.fcc.gov/health/maps-developers
Combined Telehealth/Telephonic to In-Person Ratios by Ethnicity | 12/30/19 – 08/30/20

Data pulled from CCNC dashboard, containing mainly primary care and OB claims
Combined Telehealth/Telephonic to In-Person Ratios by Race | 12/30/19 – 08/30/20
Combined Telehealth/Telephonic to In-Person Ratios by Age Group 1 | 12/30/19 – 08/30/20

1. The ratio for the 65+ age group for the week of 8/24/20 has been suppressed due to a small number of claims.

Data pulled from CCNC dashboard, containing mainly primary care and OB claims.
Combined Telehealth/Telephonic to In-Person Ratios by Gender | 12/30/19 – 08/30/20

Data pulled from CCNC dashboard, containing mainly primary care and OB claims.
Using Teleservices to Close Care Gap

Primary care practices that adopted teleservices at higher rates saw a much larger proportion of their patients during the first three months of the COVID-19 period.

<table>
<thead>
<tr>
<th>Primary care practices' level of teleservice claims through May 2020</th>
<th># of Practices</th>
<th># of Patients Receiving Primary Care</th>
<th>Est. % of Panel Accessing Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH (100+)</td>
<td>91</td>
<td>111493</td>
<td>32%</td>
</tr>
<tr>
<td>MED (20-99)</td>
<td>357</td>
<td>87059</td>
<td>22%</td>
</tr>
<tr>
<td>LOW (1-19)</td>
<td>586</td>
<td>60922</td>
<td>20%</td>
</tr>
<tr>
<td>NONE</td>
<td>586</td>
<td>64829</td>
<td>16%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1620</td>
<td>324303</td>
<td>22%</td>
</tr>
</tbody>
</table>
Teleservice Utilization Odds by Geography, Race and Disease Type

Odds of Teleservice Utilization Among Groups

- Urban vs. Rural: 1.2
- White vs. Black: 1.2
- Non-Hispanic vs. Hispanic: 1.4
- Chronic vs. Non-Chronic: 2.9

Blue bar: Teleservice Utilization More Likely
Orange bar: Teleservice Utilization Less Likely
Teleservice Utilization Odds by COVID-19 Diagnosed Groups

Odds of Teleservice Utilization Among COVID-19 Diagnosed Groups

- Urban vs. Rural: 1.6 times more likely
- White vs. Black: 1.0 times likely
- Non-Hispanic vs. Hispanic: 5.7 times more likely
- Chronic vs. Non-Chronic: 1.1 times likely

Teleservice Utilization More Likely: Blue
Teleservice Utilization Less Likely: Orange
## Rates of Telehealth Among ABD Beneficiaries

<table>
<thead>
<tr>
<th>Total Patients</th>
<th>Total Telehealth</th>
<th>Client ABD Status</th>
<th>Percent Telehealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>21,124</td>
<td>2,797</td>
<td>NULL</td>
<td>13.24%</td>
</tr>
<tr>
<td>410,777</td>
<td>86,848</td>
<td>No</td>
<td>21.14%</td>
</tr>
<tr>
<td>114,680</td>
<td>31,745</td>
<td>Yes</td>
<td>27.68%</td>
</tr>
</tbody>
</table>
Providers engaged in teleservices were slower to bill

Lookback Period (Sept.-Dec. 2019)

COVID-19 Period (March-May 2020)
A Second Visit Was Less Likely After Teleservices
A Second Visit Was **MORE** Likely After Teleservices for ILI Symptoms
Hospitalization Following Primary Care Visit

*Chi-square table calculations indicated the relationship between teleservice utilization and a decrease/increase in ED/INPT visits among frequent flier populations was not statistically significant.
DME and Physiologic Monitoring

• Physicians/APPs may be reimbursed for management of patients’ blood pressure via self-measured blood pressure monitoring (SMBPM).
• Reimbursement for Remote Physiologic Monitoring (RPM)
• DME coverage is available when deemed medically necessary by the physician/APP for the following:
  – Automatic blood pressure monitors
  – Scales
  – Portable pulse oximeters
• Special Bulletin #43 (Self-measured Blood Pressure Monitoring)
• Special Bulletin #48 (Remote Physiologic Monitoring)
• Special Bulletin #29 (DME coverage for automatic blood pressure monitors) Special Bulletin #52 (Weight Scales and Portable Pulse Oximeters)
Hybrid Telemedicine with Supporting Home Visit

- Physicians/APPs may be reimbursed for a telemedicine visit conducted with a simultaneous home visit made by an appropriately-trained delegated staff person.
- Special Bulletin #78 (Hybrid Telemedicine with Supporting Home Visit)
- Special Bulletin #49 (Interim Perinatal Care Guidance)(specific to perinatal providers)
Consultation

• Interprofessional consultation between a consultative physician and a treating/requesting physician or other qualified health care professional may occur via telemedicine.
  − Primary Care to Specialty
  − APP to Supervising Physician
  − Specialty to Specialty

• Special Bulletin # 34 (Telehealth-Definitions, Eligible Providers, Service and Codes) (all Medicaid providers)
Portal Communication

• Communication between a physician/APP and a patient through secure EHR portal.

• Special Bulletin # 34 (Telehealth-Definitions, Eligible Providers, Service and Codes) (all Medicaid providers)

SHOULD IT STAY OR SHOULD IT GO?
Using Data to Inform Policy Change
Challenging Assumptions & Getting Past the Noise

NC Medicaid COVID-19 Monitoring
Telecode Utilization by Modality - Service Category

### Telehealth Claims by Service Category Trend

<table>
<thead>
<tr>
<th>Month</th>
<th>Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb 2020</td>
<td>0</td>
</tr>
<tr>
<td>Mar 2020</td>
<td>50</td>
</tr>
<tr>
<td>Apr 2020</td>
<td>100</td>
</tr>
<tr>
<td>May 2020</td>
<td>150</td>
</tr>
<tr>
<td>Jun 2020</td>
<td>200</td>
</tr>
<tr>
<td>Jul 2020</td>
<td>250</td>
</tr>
</tbody>
</table>

### Telehealth Claims by Service Category Counts

<table>
<thead>
<tr>
<th>Service Category</th>
<th>March 2020</th>
<th>April 2020</th>
<th>May 2020</th>
<th>June 2020</th>
<th>July 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech Evaluation and Therapy</td>
<td>4,948</td>
<td>16,937</td>
<td>57,357</td>
<td>43,350</td>
<td>22,289</td>
</tr>
<tr>
<td>PT &amp; OT Evaluation and Therapy</td>
<td>2,206</td>
<td>20,779</td>
<td>18,726</td>
<td>22,035</td>
<td>6,405</td>
</tr>
<tr>
<td>Nutrition/Dietetic Eval &amp; Counseling</td>
<td>35</td>
<td>30</td>
<td>138</td>
<td>134</td>
<td>100</td>
</tr>
<tr>
<td>Audiology</td>
<td>30</td>
<td>147</td>
<td>119</td>
<td>152</td>
<td>113</td>
</tr>
<tr>
<td>Outpatient Respiratory Therapy</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

Data refreshed as of 6/30/2020; and claims data reflective of 7/06/2020 service begin date.
The Department analyzed 367 flexibilities across multiple functional areas. LME-MCO team further updated their recommendation on 16 flexibilities. The summary tables below provide insight into the current round 1 Recommendation status.

### Circuit Breaker Recommendations: Round 1 Outcome

The Department analyzed 367 flexibilities across multiple functional areas. LME-MCO team further updated their recommendation on 16 flexibilities. The summary tables below provide insight into the current round 1 Recommendation status.

<table>
<thead>
<tr>
<th>Circuit Breaker Recommendations</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended Keep</td>
<td>43</td>
<td>11.7%</td>
</tr>
<tr>
<td>Recommend keep with changes</td>
<td>68</td>
<td>18.5%</td>
</tr>
<tr>
<td>Consider Keep</td>
<td>4</td>
<td>1.1%</td>
</tr>
<tr>
<td>Recommend to not keep</td>
<td>252</td>
<td>68.7%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>367</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

### Workstream Recommendations

<table>
<thead>
<tr>
<th>Workstream Recommendations</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits</td>
<td>121</td>
<td>33.0%</td>
</tr>
<tr>
<td>Recommended Keep</td>
<td>14</td>
<td>3.8%</td>
</tr>
<tr>
<td>Recommend keep with changes</td>
<td>39</td>
<td>10.6%</td>
</tr>
<tr>
<td>Consider Keep</td>
<td>3</td>
<td>0.8%</td>
</tr>
<tr>
<td>Recommend to not keep</td>
<td>65</td>
<td>17.7%</td>
</tr>
<tr>
<td><strong>Finance and Rate Setting</strong></td>
<td><strong>20</strong></td>
<td><strong>5.4%</strong></td>
</tr>
<tr>
<td>Recommended Keep</td>
<td>6</td>
<td>1.6%</td>
</tr>
<tr>
<td>Recommend keep with changes</td>
<td>3</td>
<td>0.8%</td>
</tr>
<tr>
<td>Recommend to not keep</td>
<td>11</td>
<td>3.0%</td>
</tr>
<tr>
<td><strong>LME-MCO</strong></td>
<td><strong>200</strong></td>
<td><strong>54.5%</strong></td>
</tr>
<tr>
<td>Recommended Keep</td>
<td>19</td>
<td>5.2%</td>
</tr>
<tr>
<td>Recommend keep with changes</td>
<td>24</td>
<td>6.5%</td>
</tr>
<tr>
<td>Consider Keep</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>Recommend to not keep</td>
<td>156</td>
<td>42.5%</td>
</tr>
<tr>
<td><strong>Member Services</strong></td>
<td><strong>8</strong></td>
<td><strong>2.2%</strong></td>
</tr>
<tr>
<td>Recommend to not keep</td>
<td>8</td>
<td>2.2%</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td><strong>9</strong></td>
<td><strong>2.5%</strong></td>
</tr>
<tr>
<td>Recommended Keep</td>
<td>3</td>
<td>0.8%</td>
</tr>
<tr>
<td>Recommend to not keep</td>
<td>6</td>
<td>1.6%</td>
</tr>
<tr>
<td>Provider Operations</td>
<td>6</td>
<td>1.6%</td>
</tr>
<tr>
<td>Recommend to not keep</td>
<td>6</td>
<td>1.6%</td>
</tr>
<tr>
<td><strong>Command Center</strong></td>
<td><strong>2</strong></td>
<td><strong>0.5%</strong></td>
</tr>
<tr>
<td>Recommend keep with changes</td>
<td>2</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Contact Center</strong></td>
<td><strong>1</strong></td>
<td><strong>0.3%</strong></td>
</tr>
<tr>
<td>Recommended Keep</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>367</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

### Status of Circuit Breaker Recommendations

| Final Recommendation Complete                  | 348  | 95% |
| Workstream Recommendation Revised              | 16   | 4%  |
| Workstream Recommendation Complete             | 3    | 1%  |
| **Grand Total**                                 | **367** | **100.0%** |

- Final Recommendation Complete
- Workstream Recommendation Revised
# Pandemic Clinical Policy

- **Dependent on Federal Public Health Emergency**

<table>
<thead>
<tr>
<th>Waiver Document</th>
<th>Expiration</th>
<th>Implementation Requirement (e.g., State <em>may</em> vs. State <em>must</em> implement)</th>
<th>Authority to End Early (e.g., State <em>may</em> end early vs. must remain through end of Waiver period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1115 Waiver</td>
<td>Expires at end of PHE + 60 days (evaluation due 1 year after end of demonstration completion)</td>
<td>State <em>may</em> implement granted flexibilities</td>
<td>State <em>may</em> end early</td>
</tr>
<tr>
<td>1135 Waiver</td>
<td>Expires at end of PHE</td>
<td>State <em>may</em> implement granted flexibilities</td>
<td>State <em>may</em> end early</td>
</tr>
<tr>
<td>Medicaid Disaster SPAs</td>
<td>Expires at end of PHE</td>
<td>State <em>must</em> implement granted flexibilities</td>
<td>State <em>may</em> end early</td>
</tr>
<tr>
<td>CHIP Disaster SPA</td>
<td>Expires at end of PHE or state-declared emergency</td>
<td>State <em>must</em> implement granted flexibilities</td>
<td>State <em>may</em> end early</td>
</tr>
<tr>
<td>CMS Blanket Waivers</td>
<td>Expires at the end of the PHE</td>
<td>State <em>must</em> implement granted flexibilities for Medicare*</td>
<td>Flexibilities remain through PHE**</td>
</tr>
<tr>
<td>Concurrence Letter</td>
<td>Expires at the end of the PHE</td>
<td>State <em>may</em> implement granted flexibilities</td>
<td>State <em>may</em> end early</td>
</tr>
<tr>
<td>Appendix Ks</td>
<td>Expires on March 12, 2021</td>
<td>State <em>must</em> implement granted flexibilities</td>
<td>State <em>may</em> end early</td>
</tr>
</tbody>
</table>
Coronavirus Disease 2019 (COVID-19)
Number of New Cases per 100,000 in the past 2 weeks,
by U.S. County, 01 October–14 October, 2020

Incidence
- Low
- Moderate
- Moderately high
- High
- 1-5 cases in the past 2 weeks
- 0 cases in the past 2 weeks
- No reported cases

Purpose of this map
Describes recent incidence of COVID-19 capture the potential burden of currently may be infectious and/or accessing heal

Main Findings
- COVID-19 infection remains prevalent country.
- Elevated incidence of disease during remains widespread, including in the Midwest, and the West.

s: Defined using the number of new cases per 100,000 in the past 2 weeks. Low is >0 to 10, moderate
0 to 50, moderately high is >50 to 100, and high is >100. Jurisdictions denoted as 0 cases in the past 2 weeks
had at least 1 case previously.
ces: HHS Protect, US Census
North Carolina’s Vision for Medicaid Transformation

“To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health.”
SAVE THE DATE

MEDICAID MANAGED CARE
FIRESIDE CHAT WEBINAR SERIES

The North Carolina Department of Health and Human Services and North Carolina AHEC are offering a twice-monthly evening webinar series to help prepare providers, practice managers, and quality managers for Medicaid Managed Care going live on July 1, 2021.

Hosted by Chief Medical Officer of the NC Division of Health Benefits, Shannon Downer, MD, the series will feature changing subtopics on Medicaid Managed Care on the first Thursday of each month and clinical quality on the third Thursday of each month. The series kicks off on October 1 with a high-level introduction to Medicaid Managed Care followed by a webinar reviewing pediatric immunization trends during COVID-19 on October 15.

THURSDAY, OCTOBER 1 | 5:30–6:30 PM
Better with Time: Medicaid Transformation State of Things
continues on the first Thursday of each month

- Hosted by Shannon Downer, MD, Chief Medical Officer, NC Division of Health Benefits
- Moderated by Hugh Tilson, Director, NC AHEC Program

THURSDAY, OCTOBER 15 | 5:30–6:30 PM
Immunizations and Keeping Kids Well: Trends and COVID-19
continues on the third Thursday of each month

- Hosted by Shannon Downer, MD, Chief Medical Officer, NC Division of Health Benefits, and Tom Verity, MD, CEO, Community Care of North Carolina
- Moderated by Hugh Tilson, Director of the NC AHEC Program

CONTACT US

For questions about provider trainings and other NC Medicaid resources, please contact medicaidpractice-support@ncdhhs.gov

Moving to Managed Care

• 1.6 - 1.8 million Medicaid beneficiaries will enroll in Standard Plans.

• Beneficiaries will be able to choose from 5 Prepaid Health Plans (PHPs)
  – AmeriHealth Caritas, Healthy Blue, United HealthCare, WellCare, Carolina Complete Health (Regions 3, 4, 5)

• Some beneficiaries will stay in fee-for-service because it provides services that meet specific needs or they have limited benefits. This will be called NC Medicaid Direct.
Our Dance Card is Full

• **COVID-19**
  – Uncertainty about provider’s prioritizing contracting
  – Complexity in project planning – rapid evolving conditions

• **Other Program Changes**
  – Tailored Plan Request for Application (RFA) and operational transition in preparation for July 2022 launch
  – DHHS is working with the Eastern Band of Cherokee Indians to develop a PCCM “Tribal Option” to go live in Region 1
Medicaid Transformation Timeline

BEGIN OPEN ENROLLMENT

3/15/21

OPEN ENROLLMENT

5/14/21

Begin State-wide Open Enrollment

AUTO ENROLLMENT

5/15/21

Conclude State-wide Open Enrollment

TRIBAL OPTION & MANAGED CARE LAUNCH

7/1/21

END OF CHOICE PERIOD

9/29/21
A new, redesigned, Provider Directory will be available January 1, 2021. In preparation, providers are encouraged to fully review their NCTracks provider record, and pay particular attention to the following sections:

- Basic Information
- Health Benefit Plan Selection (i.e. Medicaid and NC Health Choice)
- Addresses and the associated Taxonomy Classification
- Accreditation
- Hours of Operation
- Services (i.e. Accepting New Patients, Siblings, and Physically Handicapped indicator, Languages Supported, Ages Served)
- Affiliation Provider Information
  - Confirm that individual providers are correctly affiliated to organizations billing on their behalf and to each appropriate location within that organization.
  - When a beneficiary searches for an individual doctor at a specific organization's location, the affiliated information from NCTracks is used in the search. Therefore, all individual providers should check their affiliations not only to the group NPI, but also to the specific location(s) where services are rendered.

Both Individual and Organization records should be reviewed.

The NCTracks Manage Change Request (MCR) process is used to view and update record information.

- Assistance with completing this process is available on the NCTracks User Guide & Fact Sheets webpage, or by calling the CSRA Call Center at 800-688-6696.
How can Vaccines today prepare you for Managed Care tomorrow?

- Showing your quality as a provider and value to a plan
- Honing your population health skills and strategies
- Engaging developing care management capabilities you need for AMH Tier 3
- Showing your patients how committed you are to their wellness by reaching out
- Solidifying the medical home for your patients for attribution in managed care
Equity Lens in Clinical Policy

Where and when does Medicaid policy and/or process inadvertently contribute to health inequities?
Breast Cancer and Cervical Cancer

• Modification to the criteria to qualify for BCCCP Medicaid
  – No longer requires enrollment prior to diagnosis
  – Women still need to go through the BCCP program in LHDs to facilitate enrollment

THIS IS BIG
Changes to Family Planning Medicaid
Family Planning Medicaid Clinical Policy

- Changes up for public comment and received several comments so are posting again for 15 days to reflect changes


How is NC doing with HIV prevention?

Hidden Messages…
Rates of People Living with HIV 2018
Number of new HIV diagnoses, 2018: 1,187

Rate of new HIV diagnoses per 100,000 population, 2018: 14

New HIV Diagnoses

Percent of people newly diagnosed with HIV, by Sex, 2018:
- 80.2% Male
- 19.8% Female

Percent of people newly diagnosed with HIV, by Race/Ethnicity, 2018:
- 62.6% Black
- 10.7% Hispanic/Latinx
- 22.9% White

Percent of people newly diagnosed with HIV, by Age, 2018:
- 25.9% Aged 13-24
- 32.4% Aged 25-34
- 16.4% Aged 35-44
- 14.3% Aged 45-54
- 10.9% Aged 55+
PEOPLE LIVING WITH HIV, BY TRANSMISSION CATEGORY, 2018

Percent of People Living with HIV, by Transmission Category, 2018

Male Transmission Categories
- Injection Drug Use (7.5%)
- Heterosexual Contact (12.7%)
- Male-to-Male Sexual Contact (73.2%)
- Male-to-Male Sexual Contact & Injection Drug Use (5.6%)
- Other* (1.0%)

Female Transmission Categories
- Injection Drug Use (18.4%)
- Heterosexual Contact (79.0%)
- Other* (2.6%)

*Includes risk factor not reported or identified, along with hemophilia, blood transfusion, perinatal exposure, or missing/suppressed data
Is there less HIV out there or are we missing it?
PrEP (Pre-Exposure Prophylaxis)

Number of PrEP users, 2018: 3,771
Rate of PrEP users per 100,000 population, 2018: 43

Percent of PrEP users, by Sex, 2018:
93.1% male | 6.4% female

Percent of PrEP users, by Age, 2018:
16.1% aged 13-24 | 38.3% aged 25-34 | 22.5% aged 35-44 | 17.2% aged 45-54 | 7.9% aged 55+

Number of PrEP Users, 2012-2018

- 2012: 283
- 2013: 343
- 2014: 743
- 2015: 1,627
- 2016: 2,009
- 2017: 2,539
- 2018: 3,771
PrEP-to-Need (PNR)

The 2018 PrEP-to-Need Ratio (PNR) is the ratio of the number of PrEP users in 2018 to the number of people newly diagnosed with HIV in 2017. PNR serves as a measurement for whether PrEP use appropriately reflects the need for HIV prevention. A lower PNR indicates more unmet need.

PNR, 2018
2.88

PNR, by Sex, 2018
3.33 male | 0.95 female

PNR, by Age, 2018
1.86 aged 13-24 | 3.19 aged 25-34 | 3.98 aged 35-44 | 3.80 aged 45-54 | 2.03 aged 55+

PNR, 2012-2018
North Carolina prescribes PrEP at 50% of the rate of the US
How many men enroll in FP Medicaid?

Untapped potential!

Medicaid Eligibility by Gender for MAFD
1E-7 Family Planning Services Policy Updates

- NC Medicaid is also adding coverage for the following services for “Be Smart” Family Planning Medicaid (MAFDN) beneficiaries:
  - Total Salpingectomy procedure (CPT 58661)
  - NAAT diagnostic testing for Trichomonas Vaginalis (CPT 87661)
  - NAAT diagnostic testing for Mycoplasma Genitalium (CPT 87563) and treatment medication Moxifloxacin
  - Kyleena IUD (CPT J7296)
  - Scabies diagnostic testing (CPT 87220)
  - Amines vaginitis screening (CPT 82120)
  - Comprehensive Metabolic Panel (CPT 80053)
  - Added pertinent diagnosis codes for services added.

SOURCE:
How FP Medicaid Benefit Can Help Men and Women Prevent HIV Infection?

What NC Holds

• Addition of CMP allows the chemistry to be covered for monitoring PrEP
• Allows men to have 6 visits a year covered including a comprehensive physical
• Reimburses cost of all STD screening except Hepatitis B, Allows developing a PrEP program to generate a positive ROI for your clinics

What You Hold

• Enroll your young men in the FP Medicaid benefit
• Use HRSA PrEP benefit or MAP to cover cost of the drug
• Use State Lab for Hepatitis B testing
• Learn from colleagues around the state already doing this!
Questions?
Shannon.dowler@dhhs.nc.gov

https://shannondowlermd.com/

https://youtu.be/wMFRM1bkEDg
Thank you for joining us today! Please complete the post-event survey.