



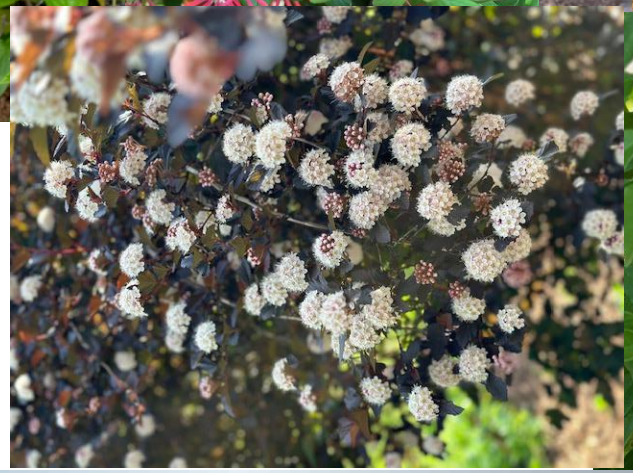
Back Porch Chat

NC Medicaid Updates










RCC (Relay Conference Captioning)
Participants can access real-time captioning for this webinar here:

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May 18, 2023

Logistics for Today's Webinar

Question during the live webinar

Technical assistance

technicalassistanceCOVID19@gmail.com

AGENDA

01 PHE Unwinding Updates

02 Tailored Plan Updates

03 Medicaid Expansion Updates

04 Clinical Updates

05 Sickle Cell Initiative

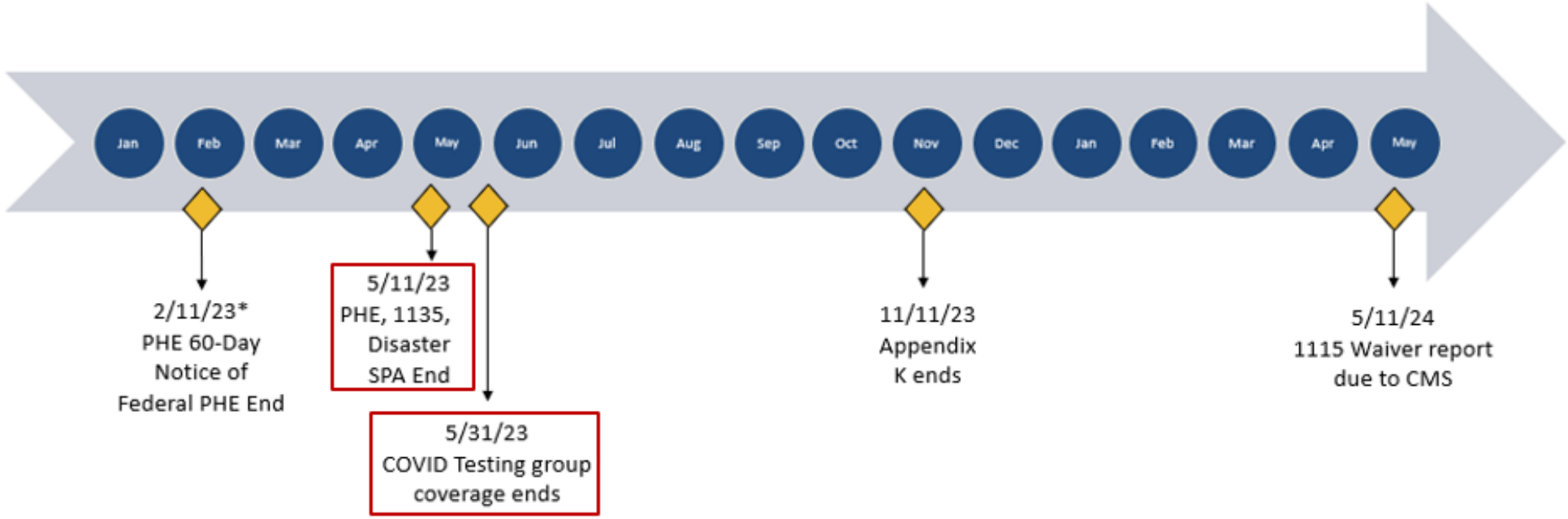
06 Questions and Answers

PHE / Continuous Coverage Unwinding Updates

End of the Public Health Emergency (PHE)

The **federal Public Health Emergency ended on** May 11, 2023

- Coverage will be terminated for the COVID-19 Testing and Treatment (MCV) group as of 5/31/2023.
- Coverage will change for the Family Planning Program (FPP) group to no longer include COVID-19 testing and treatment as of 5/31/2023; coverage for COVID vaccines continues through Sept. 2024.
- Medicaid and CHIP SPAs were submitted and DHB is responding to CMS feedback



Reinstatement of Provider Verification

- CMS requires that all Medicaid providers are recredentialed, a process also referred to as reverification.
- Since March 2020, CMS has allowed for the suspension of reverification due to the Public Health Emergency (PHE), brought on by COVID-19.
- **Provider reverifications resumed May 12th** and includes a special effort to bring the current providers for whom reverification was delayed during the federal PHE.
  - Between now and the end of Nov 2023, approximately 30,000 providers will receive notification to reverify.
- Providers who do not complete the process within the designated timeframe will receive a Notice of Suspension via postal mail and in their NCTracks Message Center Inbox.
- **Voluntary Reverification Program**: Allowed providers to complete reverification before it became required at the end of the PHE and take advantage of the NC Application Fee waiver (expires June 30, 2023).

For more information, please see Medicaid bulletin article Provider Reverification to be Reinstated at End of Federal Health Emergency.

Billing Modifications

- Beginning with date of service May 12, 2023, NC Medicaid will end the temporary emergency flexibilities implemented for the disposition of three claims processing edits. The affected edits include:

- *Edits 02437 and 02425* – "Service Facility Provider Invalid or Not Active on Dates of Service" and "Service Facility Provider Invalid or Not Active on Dates of Service. QMB Recipient" will change from pay and report to deny, as NPI validation will be required once the PHE ends.

- These edits were relaxed during the pandemic to permit any individual practitioner to deliver services at locations not enrolled in NC Medicaid. Providers are encouraged to ensure service facility providers reported on claims are actively participating with NC Medicaid to avoid a claim denial.

- *Edit 07025* – "Rendering Provider Not Affiliated with Billing Provider" will change from pay and report to deny, as the requirement for an individual provider to affiliate with a billing organization will also be required once the PHE has ended. This edit was relaxed during the pandemic to permit any provider group to bill on behalf of an individual provider delivering services at another location/group practice with which the individual is not affiliated.

- For more information, please see Medicaid bulletin Provider Reverification and Billing Modifications Reminder.

Continuous Coverage Unwinding

The **2023 Consolidated Appropriations Act (Omnibus Bill)** delinked the continuous coverage requirement from the federal Public Health Emergency

NC Medicaid began unwinding recertifications (renewals) on April 1, 2023

- Recertification process takes 90 days, so the first date someone may lose coverage due to a recertification is July 1, 2023. Beneficiaries could lose coverage before this date due to a change in circumstance that impacts their eligibility.

DHB Continuous Coverage Unwinding priorities:

- Beneficiary communications focus on 2 key messages
  - Update your address via county DSS or create an enhanced ePASS account
  - Check your mail

Because we don't yet know when the budget will pass, we don't know the impact of the timing for people who lose coverage during the unwinding who may be eligible for Medicaid as part of Medicaid expansion.

Beneficiary Engagement During Unwinding

The Department is conducting **targeted outreach** to beneficiaries during the Continuous Coverage Unwinding period.

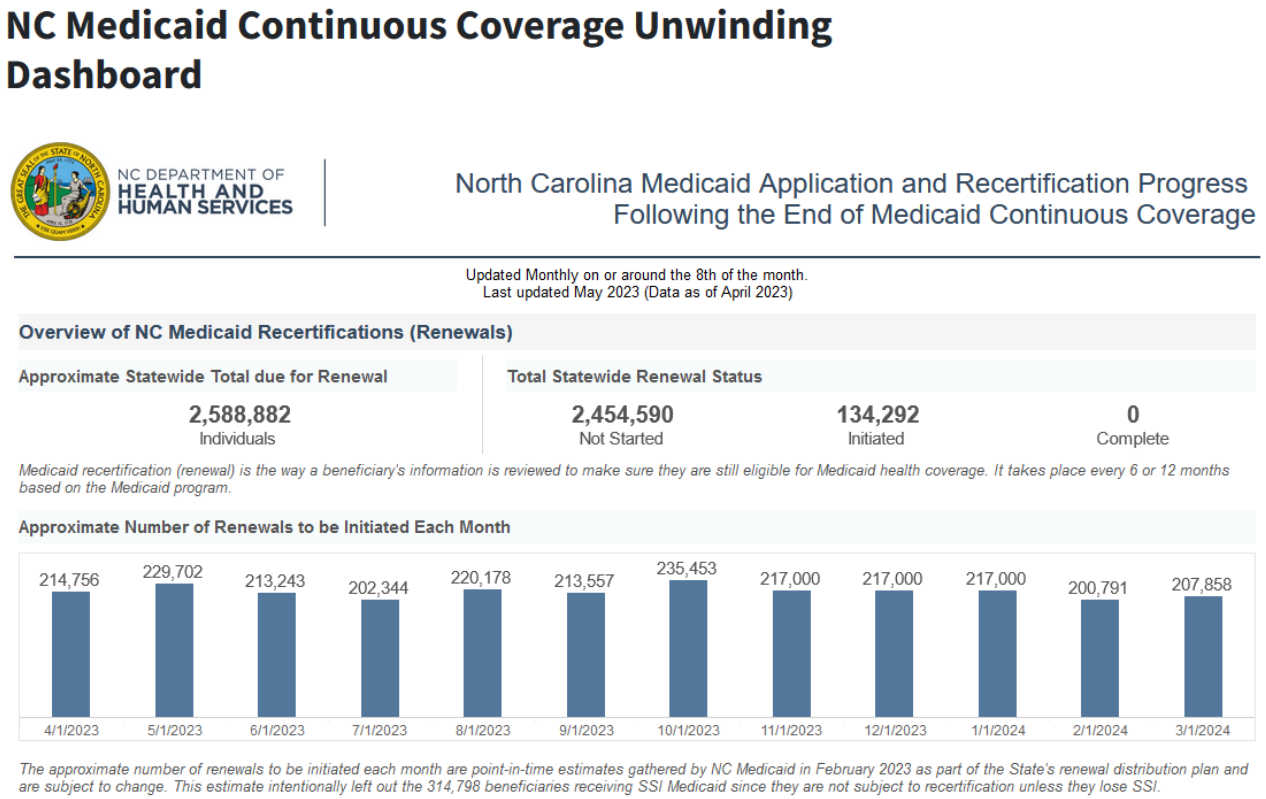
1) **Update Your Information campaign**: Beneficiaries with an upcoming Medicaid recertification due date receive a phone call, text message, and/or email encouraging them to update their contact information using epass.nc.gov or by contacting their local DSS.
2) **Return Information to your DSS**: Beneficiaries for whom a caseworker has mailed a Renewal Form or Request for Information receive a phone call, text message, and/or email encouraging them to check their mail and return the information to their local DSS as soon as possible. This is because their caseworker needs additional information from the beneficiary to complete their recertification.

Changes to Increase Success Rates

Flexibility or Upcoming Change	How it can help
• Straight through processing on redeterminations	Decreases processing time. Reduces need for caseworker interaction.
• Medicaid renewals based on SNAP (FNS) eligibility	Reduces need for contact with the beneficiary to complete processing. Decreases processing time.
• Straight through processing on applications	Decreases processing time. Reduces need for caseworker interaction.
• County assessments	Determines staffing ratios, details county pain points to which we can allocate resources
• Proactive communication	Automates texts, emails, and calls to beneficiaries when more information is needed

Continuous Coverage Unwinding Dashboard

The Department is required to provide **new monthly reports** on application and recertification processing to CMS during the unwinding period. These reports will be posted publicly on our website: https://medicaid.ncdhhs.gov/federally-required-reports



NC Medicaid Continuous Coverage Unwinding Dashboard

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

North Carolina Medicaid Application and Recertification Progress Following the End of Medicaid Continuous Coverage

Updated Monthly on or around the 8th of the month.
Last updated May 2023 (Data as of April 2023)

Overview of NC Medicaid Recertifications (Renewals)

Approximate Statewide Total due for Renewal

2,588,882
Individuals

Total Statewide Renewal Status

2,454,590	134,292	0
Not Started	Initiated	Complete

Medicaid recertification (renewal) is the way a beneficiary's information is reviewed to make sure they are still eligible for Medicaid health coverage. It takes place every 6 or 12 months based on the Medicaid program.

Approximate Number of Renewals to be Initiated Each Month

The approximate number of renewals to be initiated each month are point-in-time estimates gathered by NC Medicaid in February 2023 as part of the State's renewal distribution plan and are subject to change. This estimate intentionally left out the 314,798 beneficiaries receiving SSI Medicaid since they are not subject to recertification unless they lose SSI.

Tailored Plan Updates

Audience Response

In general, when you look up your practice on the Provider Directory your practice information tied to your in-network status for health plans is:

A. Usually accurate for both Standard and future Tailored Plans
B. Usually wrong for both Standard and future Tailored Plans
C. Usually right for Standard Plans and wrong for future Tailored Plans
D. Usually wrong for Standard Plans and right for future Tailored Plans
E. Wait, there is a Provider Directory?

Ombudsman Resources

Provider Resources:

- **Provider Ombudsman**
  - Email: Medicaid.ProviderOmbudsman@dhhs.nc.gov
  - Phone: 866-304-7062

Member Resources:

- **NC Medicaid Enrollment Broker**
  - Website ncmedicaidplans.gov
  - Call Center 1-833–870–5500 TTY: 711 or RelayNC.com
    (Monday–Friday, 7 a.m. to 8 p.m., Saturday, 7 a.m. to 5 p.m.)
  - Tailored Plan webpage ncmedicaidplans.gov/learn/get-answers/tailored-plan-services

- **NC Medicaid Behavioral Health I/DD Tailored Plan webpage**
  medicaid.ncdhhs.gov/Behavioral-Health-IDD-Tailored-Plans

- **NC Medicaid Ombudsman**
  - Website: ncmedicaidombudsman.org
  - Phone: 877-201-3750 (Monday–Friday, 8 a.m. to 5 p.m.)

Tailored Plan Launch Update

Tailored Plans will now go live on **October 1, 2023**.

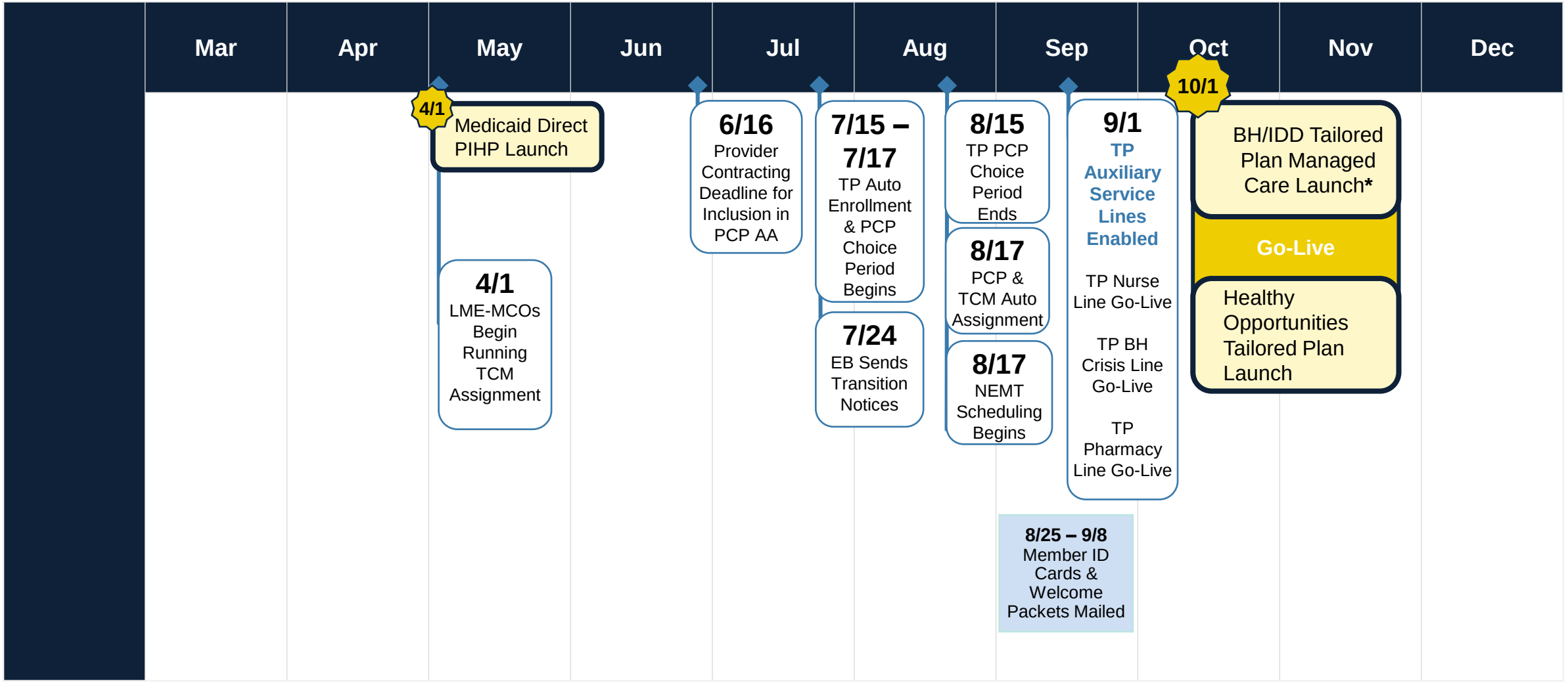
- To make sure that people can seamlessly receive care on day 1, we are delaying the launch of Tailored Plans until October 1. Our highest priority is making sure that the transition to Tailored Plans is as smooth as possible for the beneficiaries they will serve.
- The delayed start will **allow Tailored Plans more time to contract with additional providers** to support member choice.
- DHHS is still committed to rolling out 1915(i) option services upon CMS approval.
- Additional populations covered under the LME/MCO beginning April. 1, 2023
    - 0-3
    - Legal immigrants

Nothing changes for members today—except for the new populations that will be served.

- Beneficiaries eligible for Tailored Plan will receive Notices about the delay **at the end of March.**
- Members still receive behavioral health services, I/DD and TBI supports through their LME/MCO and physical health and pharmacy services through NC Medicaid, just as they do today.

Tailored Plan Transformation Timeline – Major Milestone Dates

The below timeline visualizes key milestones and activities associated with **Tailored Plan Go-Live**



Top Reasons to Contract

By contracting with Tailored Plans:

- It creates greater choice for Medicaid Beneficiaries.
- It creates better access to care for Medicaid Beneficiaries.
- Beneficiaries will not have to choose between their medical home and critical specialty care.

In-Network Providers will be paid a higher rate compared to out of network providers (Tailored Plans must cap OON payments at 90% of fee schedule – typically the FFS fee schedule).

- NOTE: By contracting, providers avoid or eliminate the risk of getting paid less than the full Medicaid rate.

In-network PCPs will receive additional AMH payments.

- NOTE: These payments are not available for OON providers.

Over the past year DHB has worked closely with the Tailored Plans; Tailored Plans understand NC Medicaid better and have improved on early contracting issues.

  - NOTE: If your early experience was not great, consider trying again.
- Some providers are contracting with all 6 plans, recognizing it is in the best interest of the beneficiaries.

Tailored Plan-Standard Plan Partnering

Tailored Plans are partnering with a Standard Plan to provide an integrated plan with behavioral health and physical health services.

Tailored Plan	Standard Plan Partner*	Leveraging Standard Plan Partner's PH Network
Alliance	WellCare Health Plan	No
Eastpointe	WellCare Health Plan	Yes, at least partially
Partners	Carolina Complete Health	Yes, at least partially
Sandhills	AmeriHealth Caritas of NC	Yes, at least partially
Trillium	Carolina Complete Health	Yes, at least partially
Vaya	WellCare Health Plan	No

More information on the Tailored Plan-Standard Plan partnering can be found in the Contracting with Tailored Plans fact sheet

Find contact information for contracting with each Tailored Plan

New Claims Fact Sheets

The Department continues to work with both internal and external partners to put together fact sheets to address frequently asked questions from the field and new changes that the provider community should be aware of.

Please review our latest fact sheets below.

- **Tailored Plan Fact Sheets**
  - Managed Care Claims Submission: What Providers Need to Know – Part 1
  - Tailored Plan Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2
  - Prompt Payment Fact Sheet
  - Provider Payment and Reimbursement Fact Sheet

Medicaid Expansion Updates

Audience Response

To accommodate the expansion population, we are going to stretch our patient panels to accept new Medicaid members.

A. True
B. False

Medicaid Expansion Overview

- Covers adults aged 19 – 64 with incomes up to 138% FPL who are legally residing in the US
  - (5-year bar applies to some groups)
- More than 600,000 individuals expected to enroll
  - 300,000 currently enrolled in Family Planning Program (limited benefits)
  - 100,000 currently receiving full Medicaid benefits but expected to be terminated as part of continuous coverage unwinding
  - 200,000 new members
- 90% federally funded (~$5b); non-federal share to be covered by hospitals and premium tax generated by PHPs
- 5% Overall FMAP bonus on current populations for eight quarters under American Rescue Plan Act (ARPA) = $1.8b additional benefit to NC
- Same comprehensive benefits and copays as other non-disabled adults in Medicaid
- Same managed care delivery systems as others in Medicaid: Standard Plan, Tailored Plan (Medicaid Direct/PIHP prior to TP launch), EBCI Tribal Option

Who is Covered under Expansion?

Low-income parents
(above current coverage levels and with income less than $34,000 each year for a family of 3)

Low-income childless adults
(with income less than $20,000 per year for a single adult)

Low-wage workers (agriculture, childcare, construction, etc.)

Some veterans and their families

Children who age out of Medicaid

Women who would be covered if they were pregnant

Audience Response

Our practice plans to do the following to support enrollment of the newly eligible Medicaid Expansion population:

A. Offering enhanced care management, community health worker or navigator supports at our office
B. Offering access to computers to complete enrollment electronically at our office
C. Actively providing outreach to our uninsured population to alert them to new coverage once it is launched
D. All of the Above
E. None of the Above
F. Wait, we are expanding Medicaid?

CAHPS Survey

Overview of the CAHPS Survey

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are administered annually.
  - CAHPS surveys:
    - Are the national standard for assessing members' health care experience.
    - Provide feedback that is actionable and will aid in improving overall care for Medicaid beneficiaries.
- The survey was administered to:
  - Members in the five Standard Plans (SPs):
    - AmeriHealth, Carolina Complete, Healthy Blue, UnitedHealthcare, and WellCare
  - Four specific NC Medicaid populations:
    - SP enrollees receiving behavioral health services, American Indian or Alaska Native individuals enrolled in the EBCI Tribal Option, members receiving care through Medicaid Direct, and Medicaid Direct enrollees projected to be eligible for Tailored Plans (TPs).
- Beneficiaries completed surveys between June 7 and October 11, 2022, by mail or telephone.

CAPHS Survey (2022) Adult and Child Response Rates[1]

	Total Surveyed	Total Surveys Completed	Overall Response Rate (%)
Adult	12,257	1,029	8.3
Child	14,415	1,305	9.3

[1]The completion rate and response number do not include Black or Hispanic targeted oversamples and the CCC supplement for the child sample.

Key Takeaways

2022 CAHPS results (when compared to previous years' data) provide no indication that the transition to managed care has significantly impacted the overall experience of care being provided to Medicaid beneficiaries relative to the quality of care received prior to the transition.

- NC Medicaid Program and NC PHP Aggregate performed well across the measure domains for the adult populations; however, both scored poorly across the measure domains for the general child and children with chronic conditions (CCC) populations.
  - Rating of Health Plan and Getting Needed Care were the lowest performing measures for all three populations (i.e., adult, general child, and CCC).

NC Medicaid and NC PHP Aggregate Star Ratings When Positive Ratings Results Were Compared to NCQA National Percentiles (2022)

	NC Medicaid Program Compared to NCQA National Percentiles			NC PHP Aggregate Compared to NCQA National Percentiles		
Measure	Adult	General Child	CCC	Adult	General Child	CCC
Rating of Health Plan	★★ 76.3%	★ 83.5%	★ 80.3%	★ 73.2%	★★ 84.1%	★★ 82.6%
Getting Needed Care	★★★ 83.9%	★★ 83.6%	★★ 86.5%	★★ 81.2%	★★ 82.8%	★★ 86.4%

Star Assignments Based on Positive Ratings Compared to NCQA National Percentiles: ★★★ 50th-74th Percentiles ★★ 25th-49th Percentiles ★ Below 25th Percentile
***NC Medicaid Program* is the combined results of all five standard plans, the Eastern Band of Cherokee Indians Tribal Option, and Medicaid Direct.**
***NC PHP Aggregate* is the combined results of all five standard plans.**

Key Takeaways

- 88.5% of adult respondents who utilized Telehealth at least once had all questions answered and 88.8% felt they understood how to take care of their health after the appointment.

- Perceptions or beliefs about the COVID-19 vaccine were the largest reported reasons for not vaccinating for adult and child populations. The most frequently reported reasons for not vaccinating include:
  - Common misconceptions regarding long-term side effects of the vaccine and that the vaccine was developed too quickly.

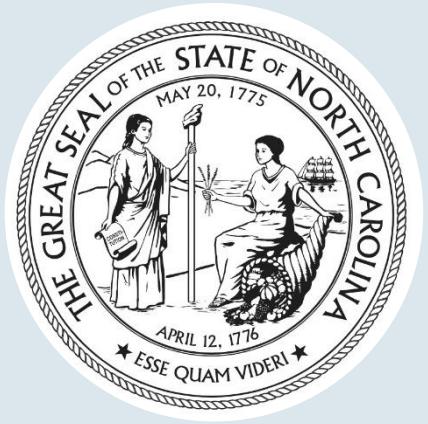
- Hispanic members reported significantly lower positive ratings for majority of the measures across both the adult and child populations.

- Parents or caretakers of Black children reported significantly lower positive ratings on Rating of Health Plan (78.8%) when compared to parents or caretakers of White children (87.0%).

Audience Response

If you are an Advanced Medical Home(AMH), with your next contract do you plan to:

A. Upgrade to AMH + from AMH 3
B. Upgrade to AMH 3 from AMH 2
C. Downgrade from AMH 3 to AMH 2
D. Wait, what's an AMH again?
E. Change something but not one of those options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Telehealth

Telehealth Update

NC Medicaid put permanent policy into place in October 2022 to incorporate many telehealth provisions that were temporary in the pandemic.

Current clinical policy DOES NOT allow providers who are virtual only; the option must exist for a member to have an in-person visit if required or desired based on the clinical need.

NC Medicaid enrolls providers who have a physical address in state.

Out-of-State providers may apply retroactively for emergency care or enroll but must have a prior authorization for services to be considered for reimbursement.

https://medicaid.ncdhhs.gov/blog/2023/03/13/special-bulletin-covid-19-265-ending-clinical-policy-flexibilities-associated-federal-public-health

Clinical Policies with Telehealth Services Components Made Permanent

1A-24: Diabetes Self-Management Education	3G-2: Private Duty Nursing for Beneficiaries Under 21 Years of Age
1-I: Dietary Evaluation and Counseling and Medical Lactation Services	3D: Hospice Care
1-M3: Health and Behavior Intervention	3H-1: Home Infusion Therapy
1E-7: Family Planning Services	10C: Local Education Agencies (LEAs)
1M-2: Childbirth Education	10D:L Respiratory Therapy Services
1A-34: Dialysis Services	5A-2: Respiratory Equipment
1E-6: Pregnancy Medical Home	5A-3: Nursing Equipment and Supplies
3A: Home Health Services	8P: NC Innovations
8G: Peer Supports	8F: Research-based Behavioral Health Treatment for Autism Spectrum Disorder
8-J: Children's Developmental Service Agencies (CDSAs)	1D-4: Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
8C: Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers	4A: Dental Services
9: Outpatient Pharmacy	4B: Orthodontic Services
3G-1: Private Duty Nursing for Beneficiaries Age 21 and Older	1E-5: Obstetrical Services

TELEHEALTH QUESTIONS AND OBSERVATIONS

QUESTIONS FROM THE FIELD

- Are you still covering telephonic care?

CPT codes 90785, 90832, 90834, 90837, 90839, 90840, 90846, 90847,90849, and 90853 were made telehealth- and telephonic- eligible

- Are you still covering interprofessional consultation? Hybrid Home-Telehealth?

Interprofessional Assessment and Management 99446, 99447, 99448, 99449

99347, 99349, 99349, 99350 (Hybrid Model*)

- Are you paying telehealth at parity?
- Can we prescribe controlled substances with telehealth visits in NC?
- Are all payers covering telehealth permanently?
- What about providing care out-of-state(for member or doctor)?

https://medicaid.ncdhhs.gov/ending-clinical-policy-flexibilities-associated-federal-public-health-emergency/download?attachment

OBSERVATIONS DEPARTMENT DATA

- While there is an equity argument to made for removing barriers to care, our data suggests:
  - White urban members more likely to receive Telehealth
  - Black and Latino members less likely to be OFFERED Telehealth
- Utilization has decreased dramatically over the past 18 months
  - How do we keep the "extras" telehealth gave us and build on it?
  - Why are providers less likely to use it now?
- The department continues to monitor utilization with Red Flags such as:
  - Providers who provide 100% telehealth and have no in person care
  - Billing patterns for provider types that are inconsistent

Clinical Updates

Collaborative Care Consortium

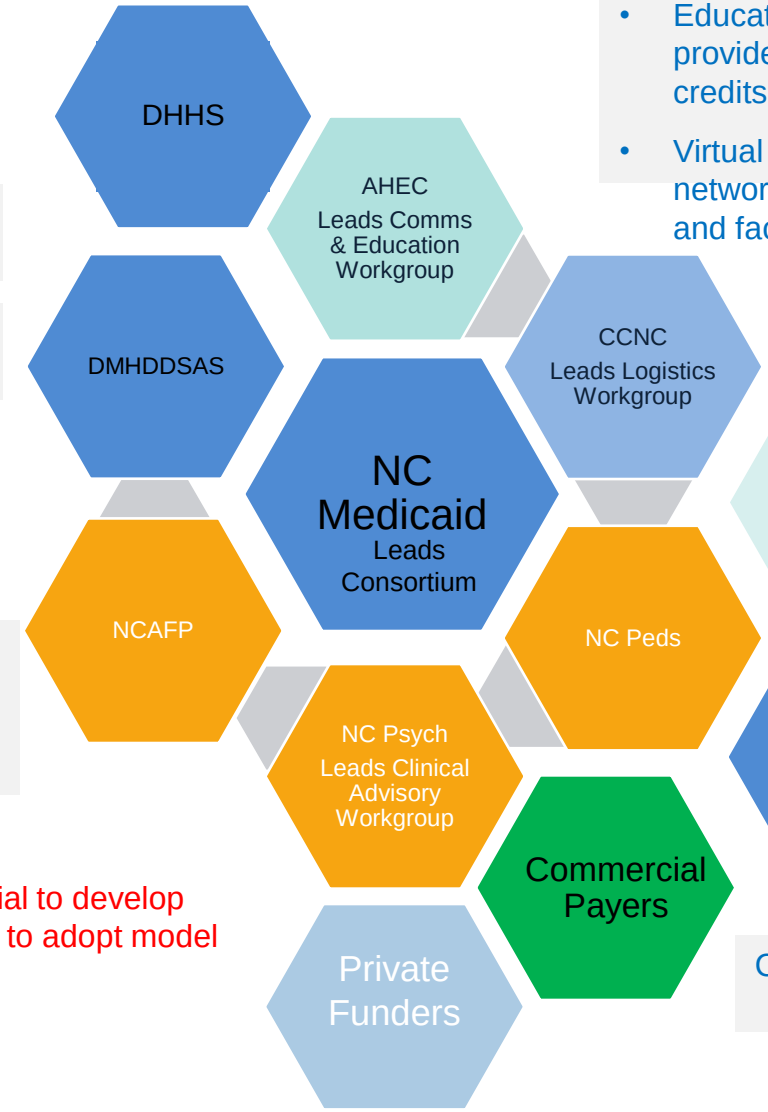
DHHS Strategic BH Priorities include advancement of the model

DMHDDSAS Coordination with NCPAL, Supporting Work Groups, Advising Consortium

NC Medicaid Alignment of clinical coverage policies to Medicare
12/1/22:Reimbursement increased to 120% of Medicare(previously 70%, primary care 100%)

Provider Associations (Family Medicine, Pediatrics, Psychiatry) creating "matches" between PCPs and Psychiatrists
Hosting Kick Off and Training at Annual Meetings
Promoting CME and Best Practice Models

Opportunity for Private Funders potential to develop Capacity Building incentive for practices to adopt model



NC AHEC Learning Collaborative(supported with Medicaid funding):

- Practice Support: coaches with expertise in primary care and behavioral health work w/practices to implement the model w/best practice standards.
- Educational Courses: important Collaborative Care topics are provided online to any provider or practice; continuing education credits offered.
- Virtual Peer Collaboratives: provide both a learning and networking opportunity with Subject Matter Experts presenting and facilitating.

CCNC Hosting Custom, State-of-the-Art Registry for all Medicaid Enrolled Providers(supported with Medicaid funding)

Opportunity for ACO/CINs to build hub and spoke models to engage more medical homes in this model.

Opportunity to develop financial incentives in value based care.

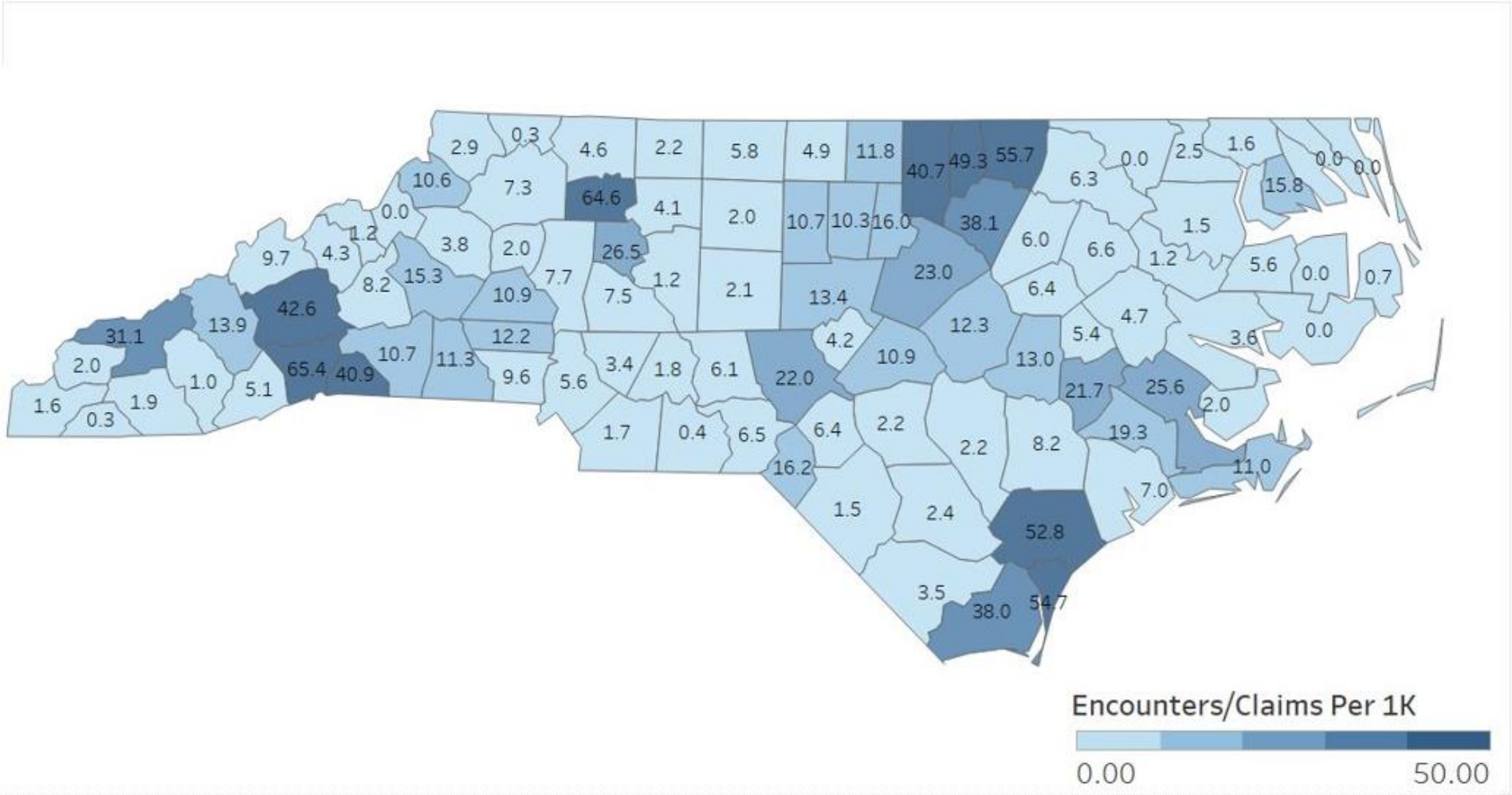
Medicaid PHP CMOs and BH Directors supporting workgroups and coverage.

Commercial Payers aligning coverage
BCBS NC Announced Coverage Effective 7/22

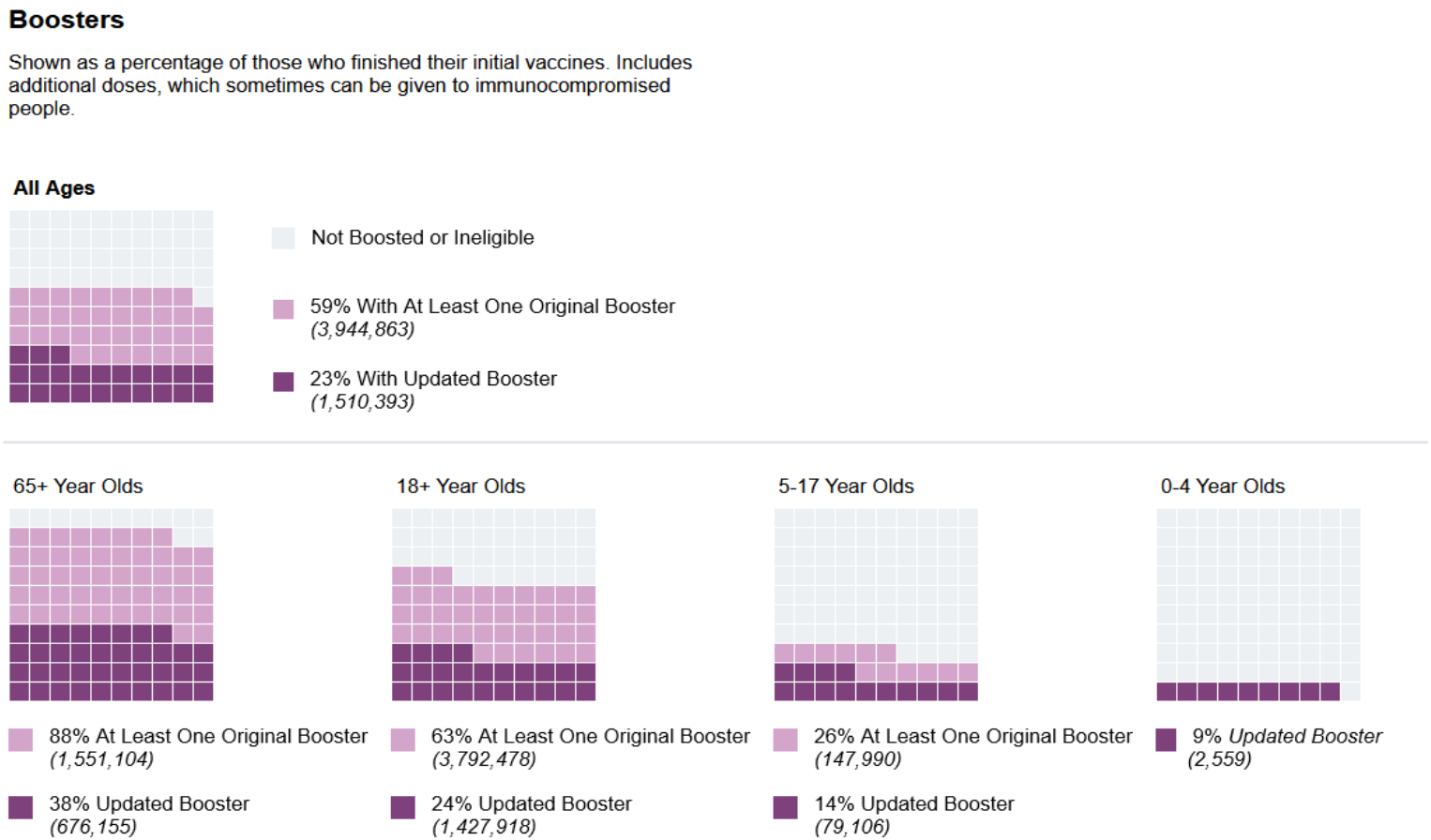
Link to NC Medicaid Bulletin on Updated Clinical Coverage for Psychiatric Collaborative Care Management

CoC Claims per 1K County Map

Based on January 2023 member file and collaborative care data beginning January 2019



COVID Vaccine



Federal match will allow the enhanced reimbursement for COVID vaccines to continue for NC Medicaid until September 2024.

FLASHBACK

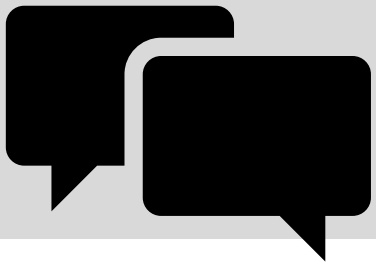
Update on Vaccination Counseling Code Reimbursement 99401

NC Medicaid recognizes the importance of vaccinating Medicaid beneficiaries for COVID-19. We also understand the additional administrative responsibilities this places on Medicaid providers due to providing the vaccine in your offices and the additional time it takes for counseling and informed consent, as well as post-vaccine observation. NC Medicaid reimburses for the provision of the vaccine at the same rate as Medicare and is creating an additional payment to encourage access to vaccines during the Public Health Emergency (PHE).

Effective June 22, 2021, CPT 99401: Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual, up to 15 minutes has been added to counsel Medicaid beneficiaries regarding the benefits of receiving the COVID-19 vaccine.

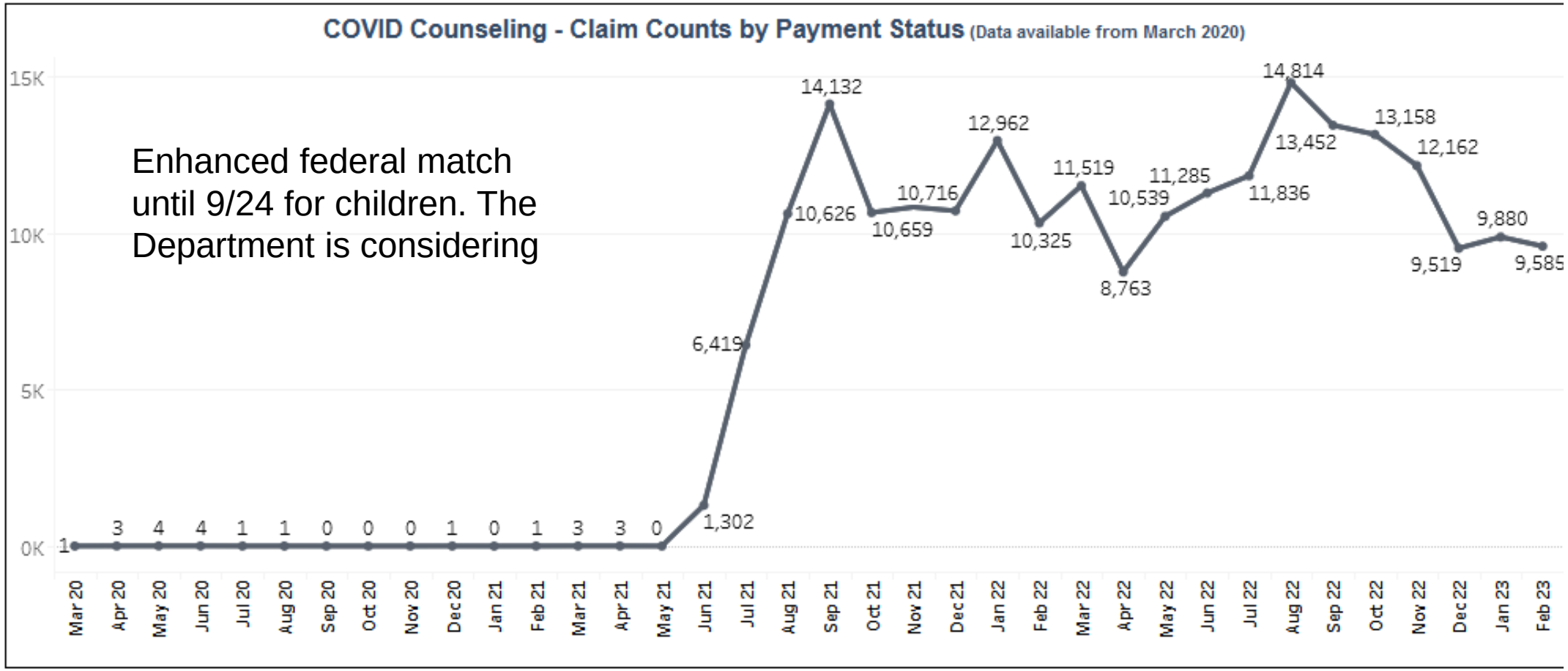
CPT 99401 can be billed at only one visit for each beneficiary per day, but there are not quantity limits for the number of times this education can be provided to an individual beneficiary. Counseling may be provided in person, via live audio/video (telehealth) or telephonically. Additionally, this service can be billed by multiple providers and can be billed multiple times on different days. Providers must bill CPT 99401 with a CR modifier to indicate a PHE code. There is no requirement for a specific diagnosis code. The following coding criteria will apply:

Requires 25 modifier if in addition to OV E&M, if applicable
Requires CR and GT modifiers if provided via telehealth
Requires CR and KX modifiers if provided telephonically



For more information, please reference the special bulletin:
Update on Vaccination Counseling Code Reimbursement

COVID Counseling Codes



Sickle Cell Initiative

Audience Response

I take care of patients with Sickle-cell disease?

A. True
B. False

Why is Sickle Cell an Equity Opportunity?

- Approximately 70,000 to 100,000 Americans have sickle cell disease(SSD), the most common form of an inherited blood disorder
- SSD causes the production of abnormal hemoglobin.
  - Normally, the hemoglobin protein, which resides inside red blood cells, attaches to oxygen in the lungs and carries it to all parts of the body.
  - Healthy red blood cells are flexible so that they can move through the smallest blood vessels.
  - In sickle cell disease, the hemoglobin is abnormal, causing the red blood cells to be rigid and shaped like a "C" or sickle, the shape from which the disease takes its name.
- Complications of sickle cell disease occur because the sickled cells block blood flow to specific organs.
  - Sickle cells can get stuck and block blood flow, causing pain and infections.
  - The worst complications include stroke, acute chest syndrome (a condition that lowers the level of oxygen in the blood), organ damage, other disabilities, and in some cases premature death.
- Sickle cell disease is more common in certain ethnic groups, including:
  - People of African descent, including African-Americans (among whom 1 in 12 carries a sickle cell gene)
  - Hispanic-Americans from Central and South America
  - People of Middle Eastern, Asian, Indian, and Mediterranean descent

Sources: https://www.youtube.com/watch?v=fIIJmg_1hv0 VIDEO TUTORIAL 8 minutes
https://www.hematology.org/education/patients/anemia/sickle-cell-disease

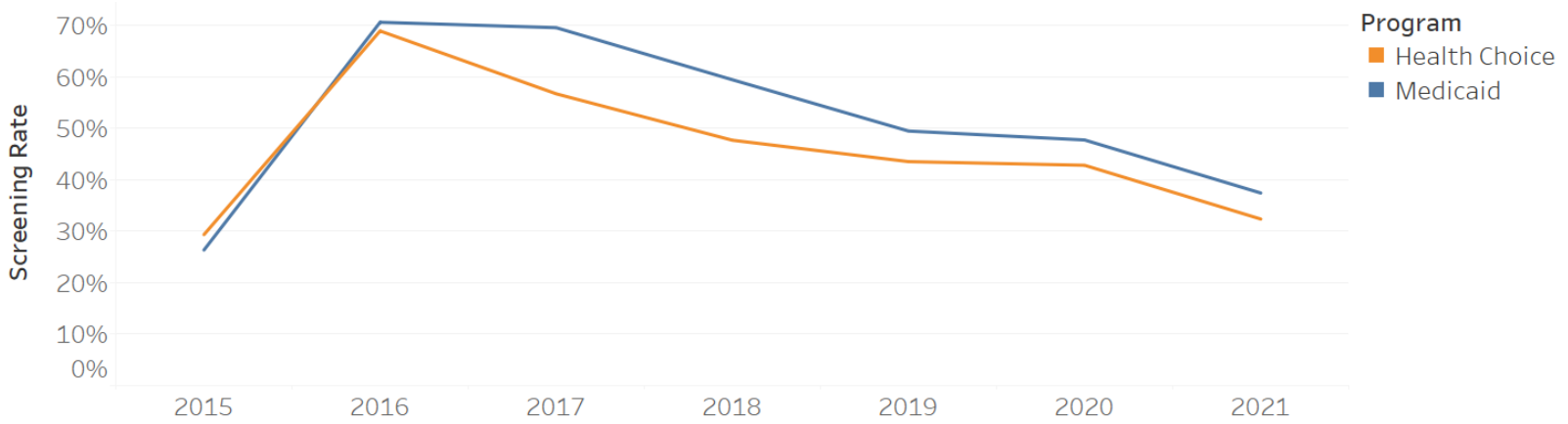
How Can Medicaid Drive Health Equity Using our Levers

- Review and potentially remove utilization management barriers that drive care gaps
- Identify existing gaps in care relative to clinical standards
- Evaluate broader(all population) strategies that also impact people living with SSD
- Ensure access to high value care for everyone living with SSD
- Prepare for next wave of high-cost drugs in SSD

Transcranial Doppler (TCD) Screening Rate

Age 2-16, Full Enrollment During Measurement Year

- Over the past seven years, on average 51.2% of Medicaid individuals age 2-16 diagnosed with SCD in CY 2021 received TCD each year they were fully enrolled
- Over the past seven years, on average 46.0% of Health Choice individuals age 2-16 diagnosed with SCD in CY 2021 received TCD each year they were fully enrolled



	% with TCD in CY2015	% with TCD in CY2016	% with TCD in CY2017	% with TCD in CY2018	% with TCD in CY2019	% with TCD in CY2020	% with TCD in CY2021
Medicaid	26.4%	70.7%	69.6%	59.5%	49.5%	47.8%	37.5%
Health Choice	29.4%	69.0%	56.8%	47.7%	43.6%	42.9%	32.4%
Average	**26.9%**	**70.4%**	**67.7%**	**58.0%**	**48.9%**	**47.4%**	**37.1%**

Activities

- Monthly Workgroup meetings with multidisciplinary stakeholders
- Provider and Beneficiary Listening Sessions
- MAHEC Diversity, Equity, and Inclusion (DEI) for Primary Care Clinical Providers and Non-clinical Staff: NC Action to Address Health Inequities Project ECHO program
- Dr. Tilson's Blood Issues Roundtable presentation to Admiral Levine
- NC Governor's Council Research Sub-Committee to Improve ED Vaso Occlusive Event Care
- EMBRACE SCD Network Annual Meeting

Audience Response

Are there other disease-specific states for which the Department should launch an Equity initiative?

A. True

B. False


QUESTIONS?