

Transcript for Medicaid Managed Care Webinar Series

November 18, 2021

5:30-6:30 pm

Hugh Tilson

Well it's 5:30 in the music's over, so it's time for us to get started. Good evening, everyone and thank you for participating in another one of our back porch chats for Medicaid providers. tonight's webinar is part of a series of informational sessions put on by North Carolina Medicaid and NC AHEC to support providers with Medicaid managed care implementation. Tonight, we'll provide a Medicaid update will also focus on collaborative care. As a reminder, we put on these back porch chats provide timely information to you and also to give you an opportunity to ask questions of DHB and the PHPs. Before I turn over Dr. Dowler, I'll run through some logistics. We got a lot to cover tonight. So I'll be brief. You can adjust the proportions of the slides in the speaker by clicking on the gray bar just to the right of the slide and dragging it to either side to adjust the size of the slide. You can also adjust your video settings to hide people who aren't speaking. Do so click on the View button on the top of your screen. It's like side by side speaker will put these instructions in the q&a for your convenience. have time for questions at the end. As a reminder, everyone other than our presenters is muted. You can ask questions two ways either using the q&a feature on the black bar on the bottom of the screen. Or if you're dialing in you can only do it by sending an email to questionscovid19webinar@gmail.com. Please know that our goal is to respond to as many questions as possible during this webinar. If your question isn't answered live or in the q&a, reach out to the PHP for an answer. And if they're unable to respond, please reach out to the provider ombudsman. We've posted these slides on the NC AHEC website and there's a link in the q&a or record this webinar. I'll add that recording and a written transcript of it with the slides on the AHEC website. Soon As Possible probably tomorrow morning. Dr. Dowler all yours.

Dr. Shannon Dowler

Thank you so much Hugh and thanks for AHEC as always for helping sponsor these back porch chats. This is the last back porch chat of 2021. We really should be having a fireside chat right now which is why the fires in the background it's going to be in the 20s at my house tonight. But we won't have one in December. So we will come together again in January of next year. So we wanted to wrap up the year with some updates that we think are really timely and important for all of you. And to talk a little bit about an opportunity that you have to think about whether you want to engage in using the collaborative care codes to do integrated behavioral and physical health. So lots of information to get through tonight. Navigate you'll go on to the next slide. I wanted to bring everybody's attention back to our focus last month. We spent a lot of time talking about how to move beneficiaries from the standard plans back to Medicaid direct if they need to go back there. So if you miss that episode, and you would like to join us we've got the link at the bottom of the slide to get some back there. You can also Google it and find it pretty easily. This is really important and we've seen that in the last month we've had much

fewer complaints from problems come through the ombudsman. So I think it's going better. But just in case if you missed it, I encourage you to join it. If you go to the next slide.

We also included the links to all of the service authorization requests. One of the things we've done as a part of our administrative simplification, which is always on our minds, is the team has worked on one unified form one service authorization request for all the LME MCOs we hope in the winter that that will be live and we've also made some optimizations to the request to move forum. So look for those coming up in the winter. All right, if you go to the next slide. So public health emergency when will it ever end? I think right now the feds are have said January I haven't heard anything else. There's been a lot of hinting and clues from CMS that we better be ready to unwind. So we are standing ready for that to end but will it who knows? There was a bulletin that came out about our rates. So you know since March of last year, we have increased rates in a variety of places to providers related to the public health emergency, and we have extended those through the end of the year. Um, they weren't going to ever last forever. Unfortunately some of them were great and we're not certain when they're going to end but right now we've only extend them to the end of the year, December 31. If they are going to be extended further, we'll let you know. But I suspect we are we're seeing that things are winding down. As you know, we put our clinical policies in the permanent policy months and months ago. So we wanted to make sure that there's telehealth provisions that were really unique and great. Well not unique, other states have been doing them. But we found the pandemic to be really successful. We went ahead and put in the permanent policy. So when the public health emergency and whenever that date happens. Good news is a lot of those are now in permanent policy. All right, next slide.

Um, many of you have been reading in the news about the budget, that we've got a budget that's been approved to move on for North Carolina and there are some things about Medicaid that are in the budget and I wanted to let you know one of the things that's exciting is the extension of pregnancy Medicaid to 12 months postpartum for women who qualify based on financial need. That happens in the spring of next year. Unfortunately, we didn't get the whole expansion, but at least at this time, but pregnancy Medicaid and that's really a win for those pregnant women to make sure that they have access to all the services they need in the year after having their baby. We've were also able to get Medicaid coverage. For a parent that loses custody if they lose custody of a child and they have Medicaid currently, when they lose custody, they lose that Medicaid benefit. They're going to actually be able to keep that which is really important. So if parents are dealing with substance use disorders or other things, they won't lose access to health care in the time where they're trying to get the child back. We also got some new slots for our waiver programs. 1000 new slots for innovations and 114 for our capda program, lots of investments for home and community based services to support the workforce out there and some capacity funding for tailored care management. So some good things in the budget. If you go on to the next slide, a couple bulletins I wanted to bring to your attention provider contracting reminders. Remember November 30, this last day that everybody is considered in network and folks are moving out of network that is going to be here before we know it. Unfortunately, there are still a lot of you that haven't contracted with all the plans. Maybe don't plan to just know that that is coming. The PHPs are prohibited from reimbursing an out of network provider more than 90% That's in the language of the contracts.

If you have no law if you've stopped making good faith efforts and to contract that will also happen. So as long as you're in good faith negotiations, you're going back and forth. There's ongoing dialogue about finalizing some tweaks to a contract. That's great. They can live with that. But if you stopped responding and you're no longer in good faith negotiations, you will be out of network and the plans can put prior authorization on all services provided by out of network providers. So that is coming in December. We're supposed to have happened a long time ago and we extended it because of the COVID surge and we're getting ready to have that happen. All right, next slide. Also, just another bulletin to pull your attention to hopefully your practice managers have seen this around some changes coming in. Within see tracks are around the systems identifying organizational providers enrolled in taxonomies and having an affiliated provider. So that is not something that I spent a lot of time thinking about, but probably somebody in your practices so point that bulletin out to them. Next slide.

One of the things I am spending a lot of time thinking about is this pandemic and how we get vaccines to our members. Our Medicaid rates are very low compared to other members, other people in the state. This is not unique to North Carolina. I met I was up in DC with the National Association of Medicaid directors last week, and all the states are struggling with Medicaid beneficiary vaccine rights. We have done a lot of really cool stuff we were we got a shout out from the White House and a White House call last week around our COVID vaccine counseling code. So we've got all sorts of things happening. To encourage providers that have vaccines in their office to do that counseling to have those hard conversations that we know take time. We're trying to make sure you get reimbursed for that. We've got the incentives went out to the beneficiaries. We're reaching out to the beneficiaries with communication, just all sorts of things happening right now to try to get vaccine rates up if you gone to the next slide. I did want to talk about the COVID vaccine counseling code and whether it makes a difference or not. So our data team did an analysis and they found some pretty cool stuff. So for the population after June 1 everybody that was not vaccinated after June 1 will call that this sort of hesitant population. They looked at their vaccination rate if they had COVID counseling or not. And if someone was counseled by one of you their primary care providers or another provider, they were 25.5% more likely to be vaccinated for the 18 and older. But for the 12 and older, it was almost 50% greater chance so that counseling that you're doing in the office makes a difference. So when we look at that sort of number needed to treat how many people do we have to counsel, what does it cost us? For the 18 plus, 100 People have to be counseled for three beneficiaries to start vaccination in for 12 Plus, it's actually a little bit better. So for 100 people getting cancelled seven beneficiaries years get vaccinated. So the cost of that seems like a lot but not when you look at the cost of one hospitalization for COVID. So this is well worth it. We're glad we're paying for it. We're glad that you're doing it. It is a model that other people around the country are picking up. We have found that people get counseled an average of 1.25 times before they get vaccinated. So you might have to counsel the same person 2, 3, 4 times. That's okay. We don't have limits. We don't have edits on it other than once in a 24 hour period. We do know that in North Carolina based on our data, you're five times less likely to get COVID if you're vaccinated and you're 20 times less likely to die. You guys know all these statistics. So thanks for all your work on the vaccine front and for using this code. Next slide. So if you're still not sure about the code and how to use it, we put a little how to guide in here in the deck, just to make sure that you understand last month we released that outreach code so you can also now get paid to reach out to your unvaccinated patients to

ask them to come in or ask them to schedule an appointment for counseling or to try to get them engaged in vaccination work. So please take a look at this in the deck when you get a second. Next slide. The team looked at who's getting the counseling with the counseling code and it's mostly the younger population weights make sense? We did say that you could bill. If you're counseling parents, you could build that to the child's Medicaid as part of the child's visit. So we do see a shift towards the younger demographic. If you go on to the next slide. You'll see that you know regardless of the age group having the counseling does make a difference in their vaccine rate. And then the more that people are counseled, the more likely they are to get vaccinated. So if you've done it once, don't give up hope. Sometimes it takes two or three or even four times to get that message across and get people comfortable with vaccination. And we know that you as the providers are really the most important person to have success here.

Next slide. The plans have the member incentives. We talked about those last month someone suggested we put them together in a grid so you can see them. So this is in the deck as well. So we hope that you'll take that and look at it. You can go on to the next slide. It's so everybody could read it. We made it in two pages. We'll also have a bulletin with a link to this coming out soon, but we wanted to go on and share it with you now. Let's go on to the next slide. Alright, so I'm going to now turn it over to Kelly to share the results from the provider survey.

Kelly Crosbie

Hi everyone, Kelly Crosbie here and I'm the Chief Quality Officer at Medicaid. So as part of our quality management plan, you've probably heard me say this on other back porch or fireside chats, we will do an annual provider survey. So we actually fielded our first survey from May through September of this year, not the best time to fill the survey we understand but it was actually hard to find a good time to fill the survey. So we're going to do this every year and this was our first year for our provider experience survey. We asked folks to reflect on the last five years of working with Medicaid so to really think hard not just think of this really tumultuous time but we asked them to reflect on their history of working with Medicaid. We targeted primary care practices and OBGYN practices and we asked the respondents to identify themselves. Were you the practice manager the medical director, and we did look at results based on independent practices versus system affiliated practices. So I'm going to share some data with you. So we asked them about Medicaid historical experience with clinical supports. So we've been asked about your experience with CCNC and a because they're valued partners and Medicaid for many years. We asked about their experience with Medicaid processes, things like claims payment and provider enrollment. And then we also asked them to reflect on their early experiences with the health plans during the contracting period. So we will have future iterations as I mentioned, we're going to obviously add other provider types to the surveys. We'll use survey results is more of a leading indicator for quality improvement activities, but also like to do other things like focus studies and other types of explorations of provider experience. We got a really high response rate, which is really cool on the 60% response rate.

Next slide. I'm going to hit some super quick slides just about what we found about overall experience with Medicaid over the past five years. In general practices were fairly satisfied with their experience with Medicaid. So we got a lot of goods. We seem to fare a little bit better on almost every survey question with our independent practices. The next slide is actually on claims processing. So again, we've looked at timeliness and accuracy of claims processing. So in general, most providers were fairly satisfied with Medicaid, timeliness and accuracy of claims processing. Again, we fare a little bit better with independence rather than system and practices. And then of course, we have a lot of information about pain points. So the next slide is gonna tell you the single biggest pain point was actually access to behavioral health, both prescribers and therapists in our system. So in general, this was the lowest rated question. This is a place where our primary care and OB practices said we just had challenges finding prescribers and therapists just access to behavioral treatment general so it was just a tiny taste of what we saw. And we are working on to finalize this recording will actually present publicly. So this behavioral health is really nice segue to tonight's main topic. So if you go to the next slide,

I don't know if folks know, I'm actually a licensed social worker. So I'm really excited about something stopping and I'm really pleased to be part of this and beyond with so many behavioral health experts today. So just to give a really quick kick off an introduction to these experts, they're gonna talk to you tonight. I share some data on our collaborative care management codes. So we actually started covering these back in October of 2018. Some of you may be familiar and not then we really wanted providers to be able to provide evidence based behavioral health interventions in primary care. So this is really covering that psychiatric consultation, the behavioral health brief interventions and care management or care coordination that they would do in the practice. So we opened up some building codes back in October 2018. So let me share with you what we found in terms of the billing. If you look at the next slide, we didn't have a lot. So the codes have been open for a long time, and we've only had about close to 2500 beneficiaries with at least one claim. We did see some folks that have multiple claims, which is good. We paid about a million dollars over the past two years for these collaborative care codes, and the average payment was about \$90. So we had a mix of that first code and second, I'm going to share some quick trends with you. If you look at the next slide. As you can see it this is good, right? So over the past few years billing has actually improved. It's still just really low. We don't see a lot of claims. On the next slide.

This is the map of where we see the billing like with all maps that we show you the bigger the circle, the more billing and orange is the claims that we actually paid. So that's good. You want to see a lot of orange in the circle. But look, I mean, this is what you see. The vast majority of the collaborative code billing is around a major cities and also major hospital centers. So that's where we're seeing this as a billing right now. And on the next slide I'll just give you a little bit of member characteristics that we saw in the claims billing. So overall utilization by plan type, about 43% of claims processing by was by members who were now enrolled in standard plans, which is right that's kind of who we really want this is this is this is behavioral treatment in primary care, but 35% were for members in Tailored plans and 22% are those folks still in Medicaid direct utilization by race a little bit of interesting trends here about 47% of the billing was for white and Caucasian members, but 42% of the billing was for Black and African American members. And that was interesting because that group actually represents about 35% of our

population. So there's a little bit higher billing than overall general percentage of that subgroup in our population. Ethnicity is really interesting, but in some ways, not surprised. 91% of the billing was by non Hispanic or non Latin X populations, while only 9% of the billing was for Hispanic or Latin X populations. Now, those numbers tend to trend younger and often have different behavioral treatment patterns. utilization by age also was fairly interesting. But 29% of billing was for members under age 18, while 71% of billing was from members over 18, and that's a little off from our general Medicaid population, where we have about 40% of our members who were under the age of 18, 53% over the age of 18. And as I mentioned, the majority of the utilization we see clustered around major cities and hospitals. So there's tables for all of this in the appendix if you're interested in seeing the data breakdowns, and I'm going to turn it back over to Shannon.

Dr. Shannon Dowler

Thanks, Kelly. Appreciate it and Kieth I think is going to join me now to talk a little bit about why why. Why aren't people using this collaborative care codes. And just to be clear to set the stage. We recognize that a big part of the problem is the way we set it up. So spoiler alert, we recognize that we didn't make this as a minimal maybe as we could have, and we're getting feedback. So one of the things I'd like to invite you to do, as Keith and I are talking about this is put in the chat if you would, your reason why. If you're not using these codes, why why not like what's the reason you're not? Or if you are maybe suggestions you have for us things we could do differently or better, because we really want to hear from you. And we're going to share some of the things that we are working on. But, Keith, can you share with us some of the things you've been hearing about why collaborative care codes are not being used as broadly as we had hoped?

Keith McCoy

Or happy to so we certainly appreciate the feedback that we've gotten thus far from our primary care providers, from providers that are interacting with CCNC and AHEC. And so it's been invaluable to us to get information about how to improve access and to improve the provider experience in using collaborative care codes. I think one of the first ones and we can talk about it for a second first about what we're what we're looking into. There are some differences between the way Medicare and North Carolina Medicaid, have set up this process both with who can build so who can be part of this collaborative care team, as well as I think Medicaid has added a code or two that North Carolina doesn't have that may be helpful. So want to offer that one up one first.

Dr. Shannon Dowler

Yeah. And we have been talking about that in the last few weeks around matching Medicare so trying to do better at matching Medicare. So I hope you will hear from us you know, nothing happens. As fast as I would like it with as the wheels turn in Medicaid. But I hope by the beginning of the year, you're gonna see us aligning with Medicare and the reimbursement model to make it easier.

Keith McCoy

And I think what we're, I think one of the main places we've heard the difference in staffing is around the ability for specially trained staff, like an RN, for example, who has some additional training to be able to participate in that process because Medicare does allow for that. Um, the next one, and you know, we obviously know we just saw in the data that Kelly shared what kinds of challenges we have in accessing psychiatric care in general. There are significant workforce as well as demand issues that are putting a lot of pressure on the behavioral health workforce, but its practices are having difficulty connecting or accessing a psychiatric prescriber partner. And not only that, but making sure that the contracts is something that that is working for everybody.

Dr. Shannon Dowler

And that is a place where we feel like working with our specialty societies in CPS Family Medicine, psychiatry, along with CCNC and a hack and others that we're going to work on trying to build out those networks and make this easier for providers, recognizing that this is a barrier.

Keith McCoy

Right. I think that we know that there's especially challenge around child psychiatry for this and one of the places that we're investing as a state is with our NC Pal program, which is our psychiatric access line if available through Duke as well as UNC for the very part of women. That that is currently available to all 100 counties and can be called it doesn't fit directly with collaborative care, but it is a perfect interprofessional consultation process where generally you can get access to a psychiatric specialist within about 30 minutes of calling and get specific consultation around the case that you may have in your office or that maybe back in your office seeing where you need some support. Another area is in just the administrative burden of managing a population. That's one of the unique aspects of doing the collaborative care model and standing up a registry. You know, just really understanding how best to do that is a challenge for practices.

Dr. Shannon Dowler

So one of the things we thought about is how can we provide some resources for practice supports and other folks to come in and help practices do this knowing that not everybody has extra staff floating around that they can pick up new big projects with so how can we use some of our contractors and levers and partners to help do some of that work for practices and help them get set up? So that's an area we're looking at.

Keith McCoy

Obviously, you know, Shannon, you brought this up at the beginning. There's just a lot going on in North Carolina and endemic we're going through the launch of Medicaid transformation and managed care. So

it's a tough time for folks to take on new projects in the midst of other contracting responsibilities and that practices have indicated the need for some extra time to set up understand and implement something like this.

Dr. Shannon Dowler

Absolutely. And I think to that not everybody has to do this. This may not be something that fits in with your practice pattern or the needs of the people that you serve in your practice. But for some people, this could be a really cool opportunity. Well, not only is it financially sustainable, but it actually brings a lot of satisfaction to the people that you're serving but also to yourself and your staff. And the care that you're able to provide. And we'll certainly I suspect pay for itself as we get more into value based payments, and we're looking at total value of care. So we're going to hear a little bit more about that with our next set of speakers.

Keith McCoy

I think that that payment incentive structure is key to ensuring that this aligns with everybody's collected interest. Instead of just this is another staff person we've got to pay for and hopefully we'll recruit, you know, the money that that we invest in that ftu one of the last places and I think we've covered this somewhat around the support that's needed to help stand up a register and understand the model is once you've got it going, troubleshooting and collaborating with other practices that may have good ideas or getting that additional technical assistance once you're up and going.

Dr. Shannon Dowler

Yep, so talking about how in the state we can create some learning collaboratives and some partnerships so that folks can troubleshoot and have support and doing this work. There's probably something we need to be doing. So So Thanks for going through those with me, Keith. And, and just to let you folks know in the field as you think of things, barriers or challenges you've had please put them in the chat. We want to read it. We want to see if what we've missed. This is sort of what we've heard, but maybe we haven't heard it off, which is highly likely. But now what I want to do is I'm going to turn it over to our behavioral health specialists who work for the PHPs and they're leading the behavioral health work and they feel pretty strongly about this collaborative care work as well. And so they're going to talk a little bit more about sort of making the case for it and helping us all understand how we might be able to use it in our practices.

Andrew Clendenin

Good evening. I'm Andrew Clendenin. I'm Executive Director of Behavioral Health with United Healthcare and I appreciate Dr. Dowlers invitation to speak tonight and and really she she teed up my my couple slides pretty well really laying out the reason why sort of the value of collaborative care the collaborative care model and and why a practice should consider this opportunity and just wanted to

touch really briefly on the problem. So I think most of you on this call know that we are experiencing a mental health crisis not only with the pandemic but we have been for some time and the data continues to show that one in five Americans experience a mental health illness mental illness in the last year. Along with that we see very commonly mental mental illness and substance abuse. Substance use disorders are often co occurring with other healthcare conditions such as heart disease and diabetes. Yet, only 25% of patients receive effective mental health care, including in the primary care setting where the majority of our patients with mental health and -- receive their usual care. So the solution is integrated care and better care coordination via integration mental health and primary care has shown to improve patient access outcomes and reduce costs, as well as, as Dr. Dowler mentioned. improves patient satisfaction and provider satisfaction. specifically related to the collaborative care model. There's over three decades of research and 80 randomized controlled trials so that the collaborative care model is effective and efficient at delivering integrated care, and it's and it's actually far more effective than even the usual care for conditions such as depression. That I want to highlight the text box at the bottom of the slide. The important piece about the collaborative care model that are important information about the collaborative care model that want to make sure I stress tonight is that it's team based, systematic, cost effective, patient centered, and evidence base. Those are all criteria for an integrated care model that that works. Next slide.

A little more information about the collaborative care model just some areas where it can it has been shown to be effective safety net FQHC practices as well as OB GYN and rural care settings. collaborative care model addresses disparities and access to quality treatment for mild to moderate behavioral health conditions experienced by racial and ethnic minority groups. It also enhances treatment for those with cancer, diabetes, cardiovascular disease and other physical conditions. And Dr. Benson will discuss later but another important fact is that observational studies and clinical trials show that the collaborative care model improves screening referral and treatment for STD and primary care so I hope I hope this information and what follows my my talk will encourage you to at least look into the model and consider reaching out for support on how to implement. I'm gonna pass it over to Dr. Dunham to share a little more.

Ken Dunham

Everybody I'm Dr. Dunham, I'm a psychiatrist internal medicine doctor and Behavioral Health Medical Director for Carolina complete health. It's good to be here today. So I'm going to share the slide with you as basically, you know the state that we're in right now to the state of going to collaborative care. You know, on the left hand side of the screen, you see that there's three people involved in the care of a patient you got the patient themselves you got the primary care provider, and you got the psychiatrist. And you know, if you refer to a psychiatrist in North Carolina, what is really difficult to find a psychiatrist and then once you refer them, you may never hear back from that person again. You know, that's one of the failings we have in psychiatry for better or worse is that, you know, my cardiology, you know, gi rheumatology dermatology, you know, sometimes the records can't get integrated. And sometimes, you know, you don't get information back about well, what are we doing with the patient? And so that's the model that we have and it's kind of a you know, a frustrating model. And so the idea behind the clap clap of care model is to integrate more of the psychiatry knowledge into the primary care practice upstream up front, and so adds two key, you know, two key parts that aren't usual and that is behavioral

health care coordinator, and a registry. The baby health care coordinator is kind of the mastermind in the clan that kind of goes around and make sure that all the patients that you're that you have will have depression, ADHD, generalized anxiety disorder or anything like that, especially the mild to moderate range that they are, they're taking care of this patients are calling them up, they're getting their --, ---. They're creating a list and then they're putting that list of patients and the scores in the registry. And then they're reviewing that with the psychiatrist, consultant, or the psychiatric nurse practitioner. And they're going through like hey, Yeah, doctor, psychiatrist, this patient's generalized anxiety disorder they're on, you know, --at this dose this this, their scores. Yeah, did well at first but they are kind of hanging out in the kind of mild and moderate range. Now in psychiatry. They will out in my practice, I just increase it so increase that dose or add this augmentation strategy or something like that, and then they send that information back to the primary care provider. And so in that way, and a half day a psychiatrist in instead of having to see you know, patients at 15, 30 minute bundle, they can see you know, 75, 100 patients in theory through a registry working with behavioural care coordinator that in your practice by giving, going through the list, you know, hit the trouble spots, and then focusing that psychiatrist and focus on how the hardest people, the people that aren't progressing and kind of troubleshoot there and so you're pushing all of that work kind of upfront, before the patient gets in the crisis. And it's a yes, as he heard earlier, this has been shown to be better actually than this saying some way to get treatment especially the amount of moderate cases, because it is research base is yes, party metric driven, and it works. And so, I'd like to hand it over now to Dr. Brian Smith, my colleague, Dr. Smith

Dr. Brian Smith

Hey, thank you, doctor. Down. Hey, Brian Smith from AmeriHealth Caritas I'm the Behavioral Health Medical Director, and I want to go over case scenarios to just kind of walk through how collaborative care may help a patient. So Anna is a 56 year old woman with a history of depression and fibromyalgia presenting to the PCP with worsening symptoms in the context of caring for her ill father and increase work stress, the symptoms of sleep difficulty and Adonia, fatigue, difficulty concentrating at work and social withdrawal for the past six weeks. She's been taking an SNRI duloxetine 90 milligrams daily for the past five years for depression fibromyalgia, but it was not as helpful as it was in the past. The PH -- score was 16 out of 27 and or PCP referred the patient to the in house care manager who obtained a more detailed assessment and provided some on the spot brief psychotherapy. Next slide.

The care manager contacted the consultant psychiatrist, psychologist verify the diagnosis and work with the care manager to formulate a formal treatment plan, including some short term evidence based psychotherapy that could be performed on a frequent basis by the care manager over the past over the next three months while we're waiting for the next PCP appointment, the consultant psychiatrist also recommends -- for change 120 milligrams daily, but consider augmentation strategies to -- next PCP visit in three months. And as added to the registry in the PCPs EMR to track clinical outcomes and progress and every visit. So during the third visit with a care manager she mentioned some improvement in mood but continues to have trouble with concentrations she's noticed some side effects and restless leg since her increase in medication. So the care manager documents this is back to the consultant psychiatrist who communicates with the care manager and the PCP to discuss alternatives. In this case,

lowering the medication back to the previous day, but adding another medication Wellbutrin to a regimen by the next follow up PCP visit and reports and proven and all are symptoms including better concentration and those side effects.

So this case illustrates two things. One, it's responsive, there's more immediate or quicker feedback when the office and patient between PCP appointments that's really critical waiting for medications. If you're starting something new, maybe the patient, the patient's mood or symptoms are worsening. In some cases, there may even be safety concerns. But that kind of immediate response is really helpful. And it's the kind of thing that can be the difference between the patient presenting to the ED or not. It's also a better allocation of resources as Dr. Dunham mentioned, you know, now you have a consulting psychiatrist. I mean, there just aren't very many of us per capita unless you live in Manhattan, but for most of the world or and that's psychiatrist and in this case, you have the psychiatrist impacting you know, many patients with the registry in the mild to moderate behavioral need range, which really could with guidance be handled in a PCP office, then conceivably, that would open up the schedule for other psychiatrists outside collaborative care to focus on those patients to have more complex medication management needs. Patients with severe or persistent mental illness. For example. Now I'll pass along to my colleague, Dr. Garrett, from WellCare to illustrate a pediatric case.

Dr. Therese Garrett

Hi, my name is Dr. Therese Garrett and I'm an adult and child psychiatrist. And we go over an example of a pediatric case for collaborative care. And I think it's really important that we get more collaborative care in peds. As you saw in the slides that were presented earlier about where the collaborative care billing codes are being used. They're being used less in pediatrics as compared to the overall pediatric population within Medicaid. And so this case is a case of Jorge who's a 13 year old brought in by his father and grandmother due to reasons school challenges. Before COVID He was an easygoing young man doing well in school and his his parents thought he was doing well. It limited knowledge just what he was doing because he spent the day in his room on class during the 2021 year with a return to in person school this year. He's having a difficult time learning and focusing. His parents and grandparents have noticed that he's more isolated, and he's increasingly uncomfortable around his peers. PH2Q was done as a screener in the pediatricians office and due to the positive screen he was administered the PHQ9, which is for highlight. His pediatrician spoke with him about his symptoms and invited him and his family to meet with a behavioral health care manager for an initial assessment and a review of his and his family's needs.

Next slide. In discussion of engagement with grief therapy due to the level of his depression, antidepressant options will also reviewed family but they wanted to hold off as they were wary of psychotropic and also he hadn't tried any therapy yet. So he was added to the registry in the clinic and completed four sessions of CBT. His symptoms and his response to treatment have been tracked and discussed in consultation both with his pediatrician as well as the child and adolescent psychiatrist, consulting and unfortunately continued with isolation, low mood, no suicidality or no panic but the

bigger issues that come in academics as Anhedonia low energy and motivation have been impacting his functioning, his grades have also been declining. So when they looked at a PHQnine score, it remained elevated with only a minimal change and due to his ongoing symptoms, and its ongoing impairments. It's recommended for him to reconsider the option of an SSRI and the guidance provided by the consultant child psychiatrist of dosing and the management of some of the side effects that he had with starting the medication, as well as with the dose escalation for his symptoms to improve.

At this point, the family remained somewhat uncomfortable with the idea of connecting the specialty clinical health care, but we're fully engaged with receiving care for the primary care office with the behavioral health care manager and the therapist and the pediatrician with the consultation. He also at that time engaged in some additional therapy sessions with the CBT the medication the phone, contact the care management with his parents and himself he was showing an improvement in mood lifting of the fog improvements academics, and his PHQNine showed a significant decline. After this as things were improving, he remains on the registry and his treatment and the scores are continuing to attract Medicare manager PCP and consultant child psychiatrist with the ability and awareness of stepping back up to CBT or transitioning specialty mental health care if needed.

Next one. So overall, and looking at some of the improvements of collaborative care management, there are benefits that relate to access and Engagement Services as well as benefits that relate to some specific certain disease states. And some of the overall benefits include less stigmatizing connections to care with greater access, or an increased likelihood of initiating referred treatment. Increased odds and engagement with and receipt of treatment, greater uptake of psychotherapy and longer duration of treatment. Some of the benefits as far as direct symptom improvement include improvement in depressive symptoms decrease in internalizing and externalizing behaviors, including hyperactivity, as well as gains in pro social behaviors and decreased parental stress. pediatricians who were surveyed in terms of their response and how they found a collaborative care management report, a perceived positive change in their own efficacy and in their own skills in treating mental health disorders. I'm going to now pass to Dr. Benson who's going to review some information related to collaborative care on substances.

Dr. Benson

Well, thanks so much. I'll take this opportunity to really spend a few minutes to discuss why if your provider-- health collaborative care, you should consider providing substitutes collaborative care, as you can see, starting in the graph on the on the far right, in North Carolina, members that present for substance use treatment. The majority of them are also have problems with emotional well being. And we can see with NIH data that approximately 20% of patients with primary mental health issues have an underlying substance use disorders and 40% of members with primary substance use disorders have behavioral health issues. Coming current conditions have become the norm especially with the effects of COVID on the prevalence of substance use disorders and behavioral conditions. Current evidence based treatment is to treat both of these conditions concurrently. Yet when we see who gets treatment, less

than 10% of people receive treatment for both conditions at the same time. For comparison, 85% of patients with diabetes received medical care. The majority of members with undiagnosed substance use issues do see their PCP for other conditions creating an opportunity for engagement. Substance use treatment through collaborative care can help close the care gap improve behavioral health and fiscal outcomes and move sevens used into the chronic disease model. Next slide.

The collaborative care model also embraces the prescribing of medication assisted treatment, the focus of collaborative care in substance use is typically is on alcohol related disorders and opiate related disorders. And there are evidence based medications that that patients are not receiving. An embedded case manager and an external substance abuse expert provide regular contact with the patient verification of adherence and not found linkage to psychosocial supports, even therapies and advice on medications. They also address the barriers of the lack of behavioral health and say this, this addresses kind of the barriers a provider has, with the lack of behavioral health and psychosocial supports. It also addresses limited time that providers feel they have to deal with substance use disorders and also especially back then, and again competence and treatment the primary care doctor has built up over time with with these embedded supports. Stigma to is a major issue and suddenly his treatment and this is reduced by primary care oversight. With treatment, as well as routine screening being part of the practice as a provider in the US in the rural southern US system in North Carolina, as there are many patients refusing to sign consent forms to their primary care doctors as they were embarrassed to let them know they're receiving some sort of treatment or were fearful of being discharged from the practice. So coordination of treatment between the PCP office and the substance use providers will promote greater acceptance adherence to treatment as well as treatment the whole person for care coordination. Next slide.

This the challenges in the substance use model of care is that the PH Q nine does not measure substance outcomes. And that is really the hallmark in in clever care is that there are outcomes that are measured. This is on an individual basis on a population basis to assess whether people are getting better with treatment. with substance use Outcomes usually measure to treatment adherence and negative drug screens. The brief addiction monitor is a tool. It's called the BAM that takes about five minutes to use and assesses the past seven to 30 day use, risk and protective factors factors that specifically the rate to substance abuse treatment and this is being this is evidence based and a lot of practices or documents. Another issue is a limited availability of somebody with combined behavioral health and substance use experience, sometimes reaching out to substance abuse provider can help fill this gap. Your care manager also needs to have knowledge of brief interventions, motivational interviewing, help engage people in substance use treatment. And also your care manager or nurse needs, the abilities to have the ability to understand the levels of care for substance use treatment whether treatment should occur in office or sugar or elsewhere. Next slide.

Finally there there were very few unfortunately, good outcome studies with collaborative care in substance abuse, the summer trial actually is quite the best. It's had a really followed 300 patients with care as usual versus care within the collaborative care model. And it showed what's clever care 39% of

patients receiving treatment. Also, the use of evidence based treatment was three fold in collaborative care model versus the control model which was a self referred model. And abstinence is absent sick at six months out was also markedly improved at 33% which is 22. And finally you know treatment adherence is a major outcome measure and subdues treatment is covered and within the healthcare system majority of patients trust their primary care provider the most with health care decisions. So having the primary care provider promote treatment, check in and assess response to treatment on a routine basis. For substance condition can be a powerful tool, really, to for treatment adherence, as many patients with this divisions have very limited support. Thank you. I don't think I'm turning this over to you. But I think this was the last move the questions correct.

Hugh Tilson

I think that's right. That's right. Okay. Thank you. Shannon, I was going to ask the PHPs if there were any other questions that came in that they wanted to throw out some answers to, is that a good next step for this?

Dr. Shannon Dowler

Yeah, that sounds great. And I want to say thanks to everybody for presenting and all the information that you covered I certainly found myself getting sort of excited and I loved all the comments and questions and the thoughts that are happening in the chat as people are thinking about this topic. So it's kind of nice to be thinking about this instead of some of the other things you've been thinking about. But yeah, why don't we open it up? Maybe pop on your video if you've got a question. From the chat you wanted to answer.

Dr. Eugenie Komives

Hey, Shannon, so there were a number of questions in the chat about telehealth. And I was just gonna come in sort of generically, I think, on behalf of all of the PhDs that the PhDs are required to call cover telehealth services the same way that the department and see Medicaid covers them and the Medicaid policy around telehealth coverage is actually really nicely written and very comprehensive. Most of us have our own policy, I would imagine are largely drawn off of that policy as well. And so if you are experiencing any difficulty with telehealth coverage in your practice, and you think that something's not quite right compared to what Medicaid is doing, you know, definitely feel free to reach out to the individual health plan. Please send us specific examples, claims or member information or what have you. We will be more than happy to dig into that and make sure that we got our systems all programmed correctly. As you can imagine, it's pretty complex endeavor and we want to make sure we're getting it right.

Dr. William Lawrence Jr

Hey, Shannon, I think I might bring up a question that maybe the state it held back me up on I may not necessarily be able to answer it, but I think you did present the slide that talked about the fact that are in network. Exception and waivers will end as of November 30. I think there are some folks who wonder whether that waiver is also going to impact the alternatives that the state put in place around newborn care to make sure that when a newborn is born and they're seen by an out of network provider, that that flexibility is still there until the PHP is established, a you know new PCP for that individual. So can we validate that the newborn protections do not go away on November 30?

Dr. Shannon Dowler

That's right. We had done a special back in June, I think we said we wanted to make sure that newborns had access to care. And so they have their own special sort of carve out so to speak. Great, Michael, did you have something?

Michael

Yeah, absolutely. So I want to actually take us back to the beginning of your presentation. I Shannon. And this is a question that actually got by email. And it deals with you know, we've heard about your patient incentive. But what are you doing to improve the vaccination rate in collaboration with providers across the state? I thought that was a really great question. And and I can answer a few different ways but let me let me start by saying you know, for healthy blue, we're doing focused outreach and and making phone calls. Both live IVR phone calls, outbound texts, and we're also hosting h two u community based events, which are in partnership with providers and community leaders across the state. One of the things we're also working towards as we have about 80 82% or more of our patients are or have their care management services delivered by age level three. We're also working on deepening our relationship. Their aim is three partners to employ the the partnership we have with them to better outreach and connect with our members to ensure they have all the information we need, that they need to make those decisions. And that coupled with our our incentive program. The bottom line is it's going to take all hands on deck, it's gonna take all all folks in North Carolina working together to improve our vaccination rates to get it out of the sand trap, so to speak.

Dr. George Cheely

Yeah, Shannon, I was just gonna chime in with a with a question that's come up a few times for us. And that focuses on some of the things that we we have in place to protect privacy for members. And so I just wanted to delineate those for the group in case that question is coming up for your practice as well. And the first is that we do not mail EOB to our members. The second are a couple questions related to our member portal, and for people's awareness, the AmeriHealth member portal is a single user access point that must be created by that user. And so if your patient has created the access your patient is the only person that can access the portal. Or if the access hasn't been created, your patient can create the access in it will be the sole person to have the access of the additional layer of protection that we have is a mechanism to suppress clinical information related to a host of sensitive diagnoses. And so that's kind

of the third component and and third layer as well. And so I want to request that if your practice has additional questions or wants to confirm that certain clinical information is being suppressed, or if your practice is learning from patients that there's information is that's appearing that they weren't expecting to see. Please contact your Account Executive or contact me we can work together to identify those diagnoses and help you all ensure that you're doing the right thing providing good care to your patients and not concerned about some of those privacy considerations. I know we all have.

Dr. Michelle Bucknor

So I just want to speak to a comment that people have made in the chat. One is that this is essential to performing well with quality measures. And I think it's really important to think about that as you're thinking about how to use support behavioral health and primary care and you know, we don't know the links between diabetes and depression and linking to behavioral health services can improve on the physical health outcomes. What that another there's plenty of questions or comments around integrated behavioral health and how can we best support development of that beyond a collaborative care relationship? And I do think that's probably a next step that the PHPs could collaborate with the departments to see how we can or with the department to see how we can incentivize and support integrated behavioral health within the primary care setting. Thank you.

Hugh Tilson

Thank you. So Shannon there, go ahead.

Unknown Speaker

There was one question I'm sorry that I accidentally click the answer why? And it will take me two seconds. If we're network with all PHPs but the patient has a different PCP selected but we see them anyway. Will these claims be denied after 11/30/21? The answer is no. It should be paid. Thank you.

Hugh Tilson

Shannon. How about this one how will providers know if continued good faith negotiations meet the standard to prevent produced reimbursement being applied by a Medicaid php.

Dr. Shannon Dowler

That's that's a great question. And I believe that the plants have to send them a letter telling them that is that right plants. How are you letting somebody know that they're good faith negotiation times over? Anyone, Bueller,

Dr. Michelle Bucknor

We are sending letters. I believe that's correct.

Dr. Shannon Dowler

So you're gonna let them know you're not gonna just suddenly say Just kidding. We're not negotiating anymore, though. They'll know before that happens to him.

Hugh Tilson

I see heads nodding. That is correct. Okay. All right. Well, how about this one? I'm excited to hear that collaborative care billing codes will allow billing for Rn similar to Medicare, in encouraging sustainability for collaborative care model across the state. Is there any way to encourage private insurance companies? In North Carolina to adopt and pay for these codes?

Dr. Shannon Dowler

Yeah, that's a great. That's a great question. And as we make our changes to Medicaid, we also meet with a group called the payers Council where we're all the payers come together, and we will sometimes bring things to them and really encourage them to adopt, like the counseling than I meant for one COVID counseling code. That was something we took to them some of the telehealth stuff early on, and I'd be happy to take that up as a payer Council topic to bring to them to see if we get more alignment across the state. And we could do that maybe in partnership with some of the associations. We're working with, around getting the collaborative codes more accessible to people.

Hugh Tilson

So we're just about out of time. There are a couple of questions in here, but are there any that you particularly want to respond to? If not, there's this conversation that I think Michelle was talking about earlier, her practices being incentivized under Medicaid managed care to integrate and what roles in the state and PHPs play in supporting clinical integration

Dr. Michelle Bucknor

I don't Yeah, I can elaborate on that. I do think that it's something that one PHP alone couldn't do. It's something that I think we could develop a system with input from the provider community, about what we can put in place with the support of the department, to incentivize practices to integrate care. I think we've had a lot of collaborative efforts thus far and I think we can continue on those efforts with behavioral

Dr. Shannon Dowler

health. Can I think as we move more to value based payments, you know, we get this you know, our foot out of that fee for service canoe into the value canoe, we're gonna find that the payoffs are huge when we are able to impact the total cost of care and the value of the care we provide. And so things like this where you're not really thinking about it as a per click basis reimbursement, but broadly, how are we taking care of the population? I think it's going to be I think having this infrastructure is going to really help practices thrive.

Hugh Tilson

I think we've touched on just about all the questions that I see that have come in there are a number of barriers that have come in and you guys have copies of those. Shannon, I think we're pretty much done unless there are other questions that come in.

Dr. Shannon Dowler

Now, I think we're at 630.

Hugh Tilson

Okay, well, then let's call it thank you guys so much for a great presentation. As always wonderful information. And thank you everybody for your time. Shannon. Let me turn it over to you to say goodbye.

Dr. Shannon Dowler

Yeah, thank you, um, all of you for all the hard work you do taking care of the Medicaid beneficiaries of the state that bragged about you up in DC this week about what an amazing provider network we have. So thanks for all you do. I hope we get some rest over the holidays and we'll see you next year at the fireside chat.