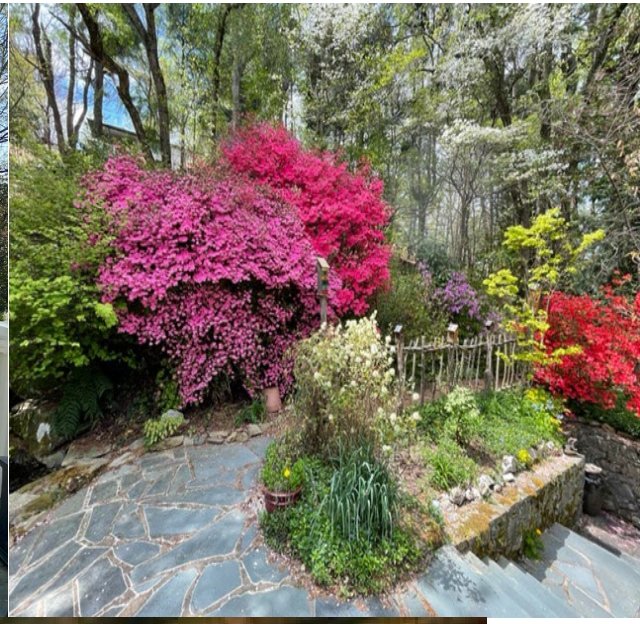
Back Porch Chat

April 21, 2022



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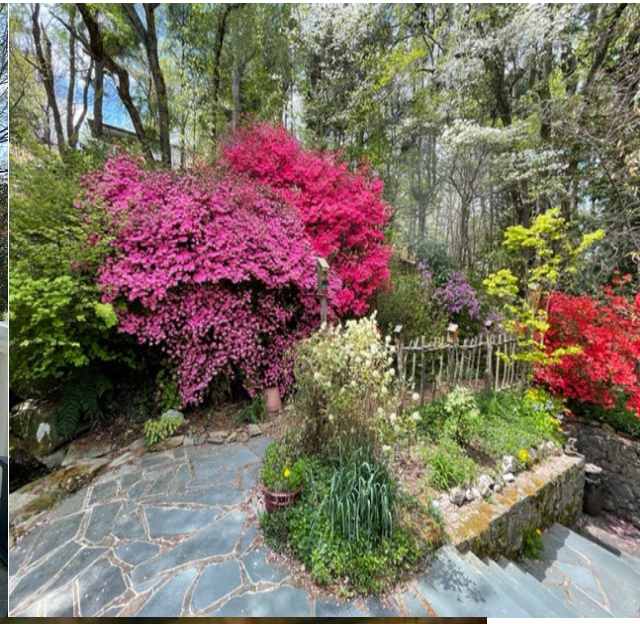

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Logistics for today's webinar

Question during the live webinar

Technical assistance

technicalassistanceCOVID19@gmail.com

AGENDA

01 Overview of Collaborative Care

02 Collaborative Care Codes

03 Perspectives from the Field

04 AHEC Workgroup Initiatives & Training

05 Utilization Data on Collaborative Care Codes

06 Q&A

Collaborative Care is a type of Integrated Care

- An evidence-based intervention founded on the chronic disease model that aids primary care providers in treating patients with psychiatric diagnoses
- Synonymous with the Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) study
- Over 80 RCTs to support the model

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IMPACT

- Significant outcomes:
  - Higher rates of response (50% reduction) and remission ($p<0.5$) on SCL-20
  - More likely to use antidepressants or psychotherapy
  - Greater satisfaction with depression care
  - Improved health related function (MCS or SF12)
  - Greater overall QOL (0-10)
- Having more medical comorbidities did not affect outcomes
- Outcomes persisted at 18 and 24 months (NNT 6 and 9, respectively)

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Unutzer *JAMA* 2002, Harpole 2005

Four Year Direct Health Care Cost Savings With IMPACT

Cost Category	4-year Costs in $US	Integrated Care Service Use in $US	Usual Care Service Use in $US	Savings in $US
IMPACT program cost		522	0	522
Outpatient mental health costs	661	558	767	-210
Pharmacy costs	7,284	6,942	7,636	-694
Other outpatient costs	14,306	14,160	14,456	-296
Inpatient medical costs	8,452	7,179	9,757	-2578
Inpatient mental health / substance abuse costs	114	61	169	-108
Total health care cost	31,082	29,422	32,785	**-$3363**

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Unutzer J, Katon W, Fan M, Shoenbaum M, Lin E, Della Penna R, and Powers D. Long-term cost effects of collaborative care for late-life depression. *American Journal of Managed Care* 2008;14:95-100

What's So Revolutionary?

- Behavioral Care Manager (Nurse, social worker, psychologist) provides patient education, tracks outcomes, monitors side effects and medication adherence
- Use of tracking tool (Measurement-based care)
- Development of a registry to manage caseload supervision
- Stepped-care approach
- Psychiatric consultant
- Problem-solving therapy, motivational interviewing, behavioral activation
- Data sharing between psychiatric consultant and PCP

Five Core Principles of Collaborative Care

- Patient centered team care
- Population based care
- Measurement-based treatment to target
- Evidence-based care
- Accountable care

https://aims.org/

Collaborative Care Model Payor Coverage

Payer Name	Cover CoCM codes?	Medicaid/Medicare Aligned?
Medicaid PHP		
AmeriHealth Caritas	Yes	Yes
Healthy Blue	Yes	Yes
United Healthcare	Yes	Yes
Wellcare of North Carolina	Yes	Yes
Carolina Complete Health	Yes	Yes
Commercial		
Blue Cross & Blue Shield	Yes *	Yes
United Healthcare	Yes	Yes
Aetna	Yes	Yes
Cigna	Yes	Yes
Marketplace (Individual, Health Information Exchange)		
Ambetter of NC (Centene)	Yes	Yes
Wellcare of NC by Celtic	Yes	Yes
AmeriHealth Caritas	Yes	Yes
United Healthcare	Yes	Yes
Blue Cross & Blue Shield	Yes *	Yes
Medicare		
Traditional Medicare	Yes	Yes
Medicare Advantage	Yes	Yes

*

** BCBS will reimburse collaborative care codes effective 7/1/22. The practice will first need to submit an attestation indicating they are able or will be able to provide 4 components of care. This includes a data registry, ongoing psychiatry collaboration, behavioral health screenings and employ a behavioral health care manager*

Coverage for Psychiatric Collaborative Care Management Updated

- **Health Care Professional**: Refers to the treating physician or APP who manages the beneficiary's care and directs the behavioral health care manager.

- **Behavioral Health Care Manager**: Masters or doctoral-level prepared clinical staff member, licensed staff member with behavioral health training (e.g., Licensed Clinical Mental Health Counselor/Professional Counselor, Licensed Marriage and Family Therapist, Licensed Social Worker, Registered Nurse, Nurse Practitioner, Licensed Psychologist, Masters-level licensure candidate/trainee (e.g., LCSW-A) or other designated and appropriately trained member of the care team who provides care management services and assessment of beneficiary needs. The Behavioral Health Care Manager consults with the psychiatric consultant and administers validated rating scales, develops care plans, provides brief interventions, collaborates with other members of the treatment team and maintains a beneficiary registry. Services are provided face-to-face and non-face-to-face and psychiatric consultation is provided minimally on a regular and appropriate basis.

- **Psychiatric Consultant**: Refers to the consulting physician or APP who is trained in psychiatry or behavioral health with full prescribing authority. The consultant advises and makes recommendations and referrals as needed for psychiatric and medical care. These recommendations and referrals are communicated to the treating provider through the behavioral health care manager. The psychiatric consultant typically does not see the beneficiary or prescribe medications. *Please note any prescribing provider must be enrolled in NC Medicaid in order to write prescriptions for Medicaid beneficiaries.*

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More information on this bulletin can be found here

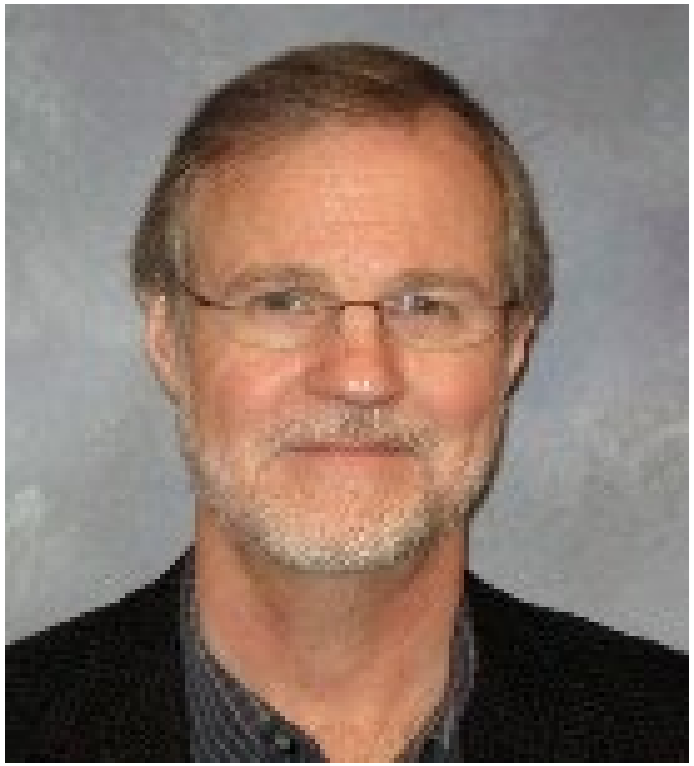
Coding for Psychiatric Collaborative Care by PCP

- 99492 – Initial psychiatric collaborative care management, first 70 minutes in the first calendar month
- 99493 – Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities
- ***G2214 – Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified healthcare professional***
- 99494 – Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month

NOTE: Please see the Medicaid fee schedule for the applicable rate floors.

~~The bulletin provides the required elements for billing psychiatric collaborative care management.~~

Panelists



Steve Buie, MD, DLFAPA

Shauna L. Guthrie, MD, MPH, FAAFP

Julia Kuriger, MSN, CCM, RN

Perspectives from the Field

How did you get this off the ground?

*

Perspectives from the Field

How did you promote, socialize and train your staff on this model? Who was your Champion?

*

Perspectives from the Field

How has collaborative care benefited your patients, your practice, and you as a provider?

*

Perspectives from the Field

What are some lessons learned, tips & tricks?

*

Collaborative Care Model Pro Forma

Revenue

CMS Codes	CPT Code	Payment *	Days / month	Sessions per day	# of sessions/month	Monthly revenue	Yearly revenue
Initial psychiatric collab care mgt, first 70 min in first calendar month	99492	$0.00	0	0	0	$0.00	$0.00
Subsequent psychiatric collab care mgt, first 60 min in subsequent month of BHCM activities	99493	$0.00	0	0	0	$0.00	$0.00
Initial or subsequent psychiatric collab care mgmt, each additional 30 min in calendar month For new pts	99494/G2214	$0.00	0	0	0	$0.00	$0.00
Projected Monthly/Annual Revenue						$0.00	$0.00

Expenses

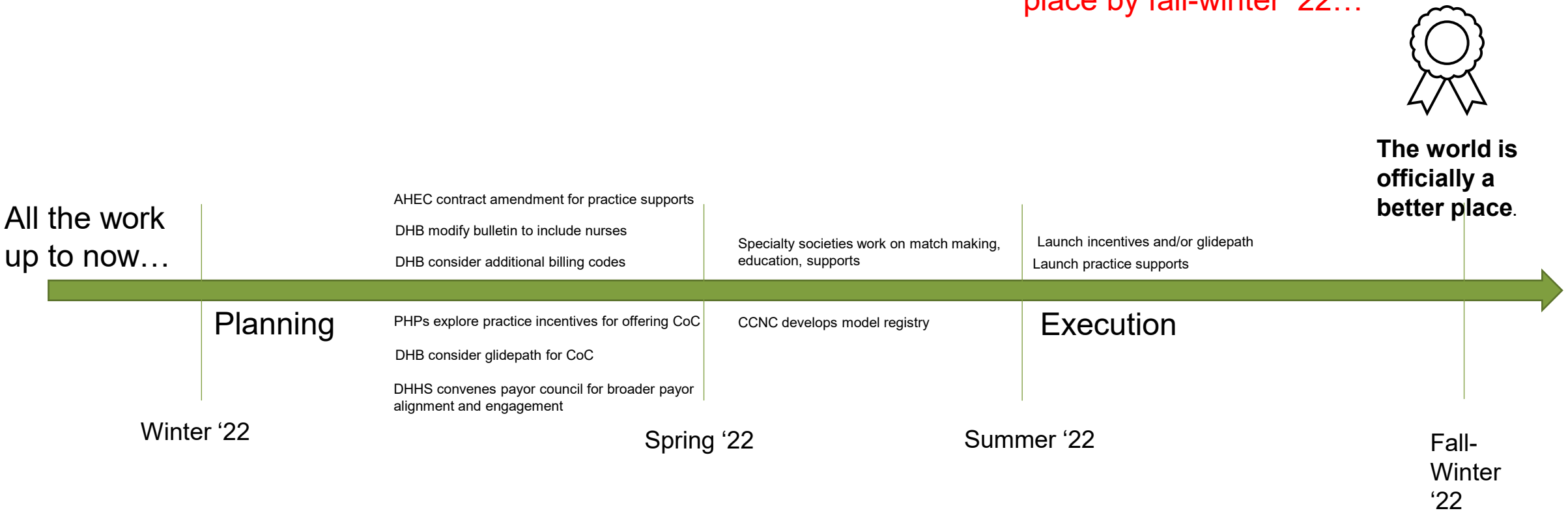
	Hrly Rate	Hrs per month	Monthly Expenses	Yearly Expenses
Psychiatric Consultant Contract	$0.00	0	$0.00	$0.00
Behavioral Health Care Manager Salary	$0.00	0	$0.00	$0.00
Behavioral Health Care Manager Benefits	$0.00	0	$0.00	$0.00
Other Expenses	$0.00	0	$0.00	$0.00
Monthly Expenses/Annual Revenue			$0.00	$0.00
Operating Surplus/Deficit			$0.00	$0.00

*** Payment- confirm CPT reimbursement by payor.**


QUESTIONS?

Goal & Timeline

Very optimistic timeline!
The world will begin to be a better place by fall-winter ’22…



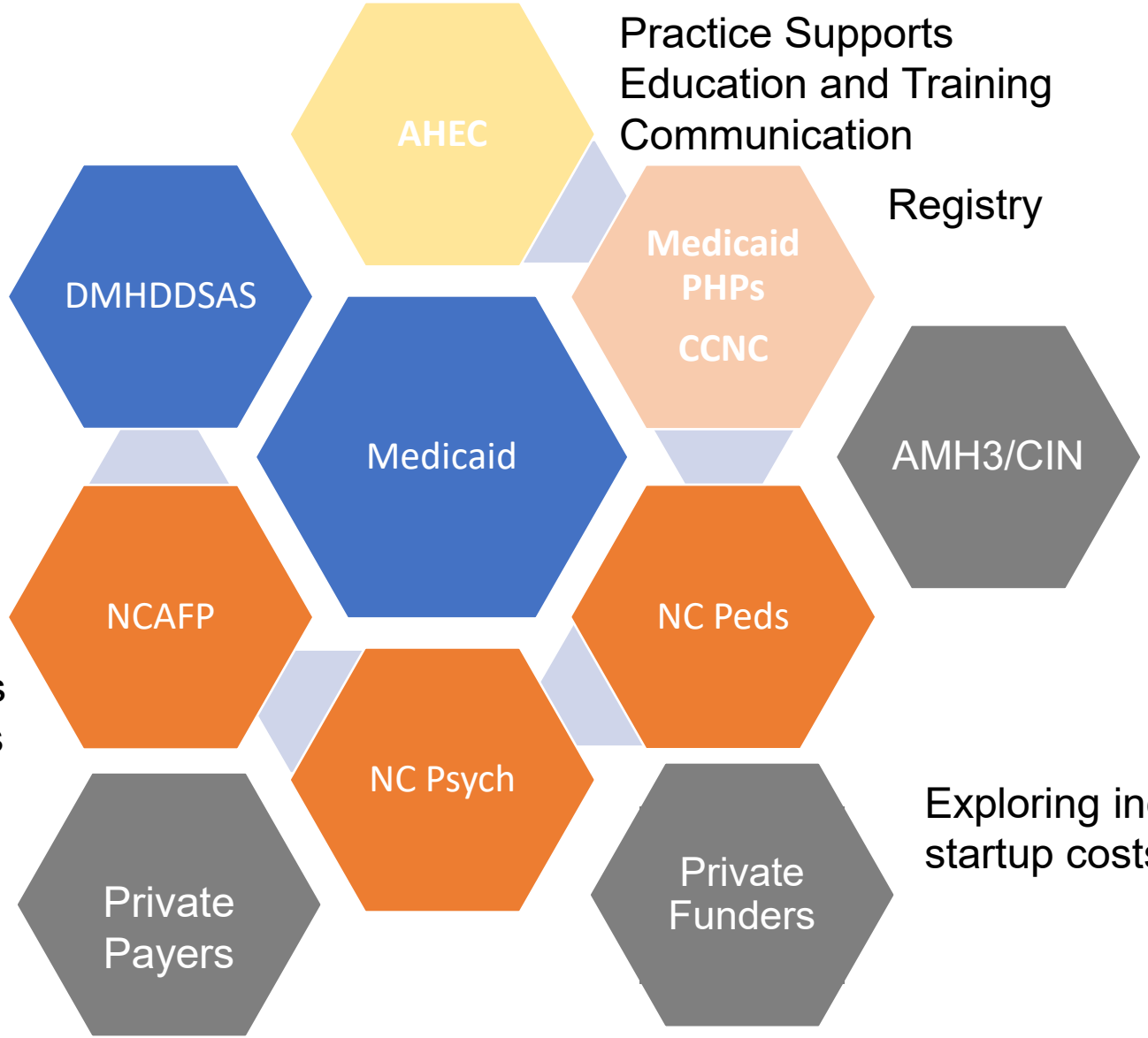
Goal: To align work to support the utilization of Collaborative Care as an approach to integrating physical and behavioral health* so Collaborative Care is more consistently used to benefit patients and providers

Collaborative Care Consortium

Practice Supports
Education and Training
Communication

Registry

Coordination with NCPAL
Tracking data and
outcomes



Potential to
develop hub
and spoke
model.

Associations will create
“matches” to create relationships
between PCPs and Psychiatrists

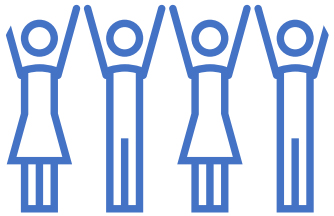
Exploring incentive/glidepath for
startup costs for highest need.

Medicaid is aligning coverage
with Medicare and encouraging
Private Payers to add
coverage.

Collaborative Care Steering Committee & Subcommittees

Steering Committee

Members:
Hugh (AHEC)
Tom (CCNC)
Shannon (DHB)
Keith (DMHDDSAS)
Michael (HB)
George (AMHC)
Genie (WCHP)
Will (CCH)
Michelle (UHC)
Greg (NCAFP)
Robin (NC Psych)
Elizabeth (NC Peds)
Larry(BCBS)
Ish Bhalla(BCBS BH)



Comms and Training
- Practice supports
- Trainings & Webinars
- Enduring materials

Members: Hugh

Clinical Advisory Group
- Supporting best practice modeling
- Creating connections

Members: Robin

Logistics
- Registry Development
- Contract

Members: Tom

Alignment
- Connecting and coordinating payers and other partners

Members: Genie

AHEC Collaborative Care Model Training & Supports

Goal: to support primary care providers in implementing the Collaborative Care Model.

Timing: will begin in Summer 2022 via practice support and continuing professional development opportunities.

Cost: DHB is contracting with AHEC so all support and trainings will be **free** to providers and practices

*

AHEC Collaborative Care Model Training & Supports

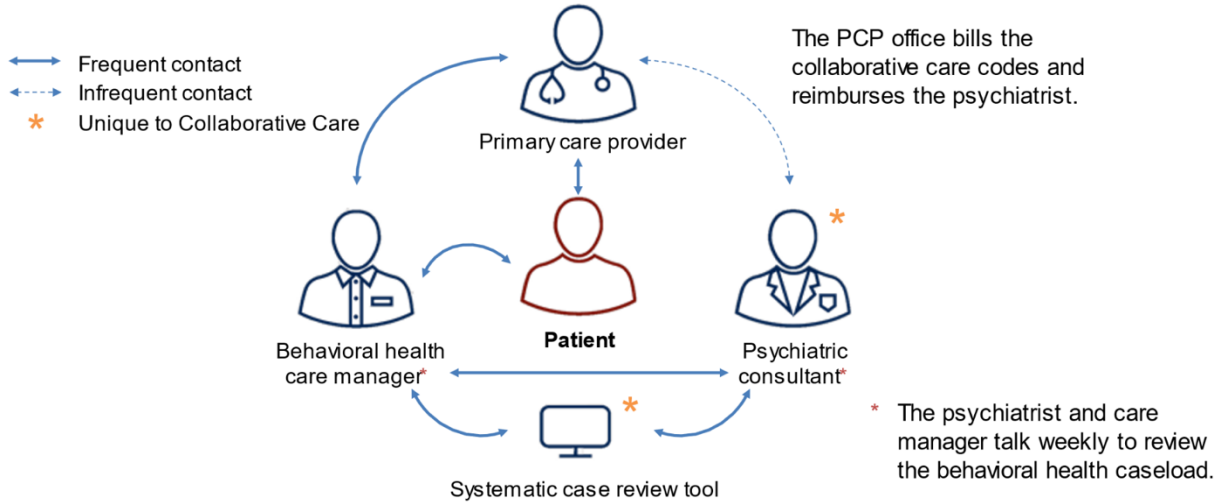
There are three prongs to the NC AHEC Learning Collaborative:

- **Practice Support:** NC AHEC Practice Support coaches with expertise in primary care and behavioral health integration will work 1:1 with practices to implement the model based on best practice standards.
- **Educational Courses:** Courses addressing important Collaborative Care topics are provided online to any provider or practice with continuing education credits offered.
- **Regular virtual peer collaboratives:** Monthly collaboratives provide both a learning and networking opportunity to interested practices with Subject Matter Experts providing the presentation and facilitating discussion.

*

AHEC Collaborative Care Model Training & Supports

- **Scope:** Trainings and support will be available to all members of the Collaborative Care Team
- **Topics:**
  - Implementation Keys
  - Workflow redesign
  - Care Coordination
  - Registry
  - Billing



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Collaborative Care (CoC) Summary

7/19-3/22

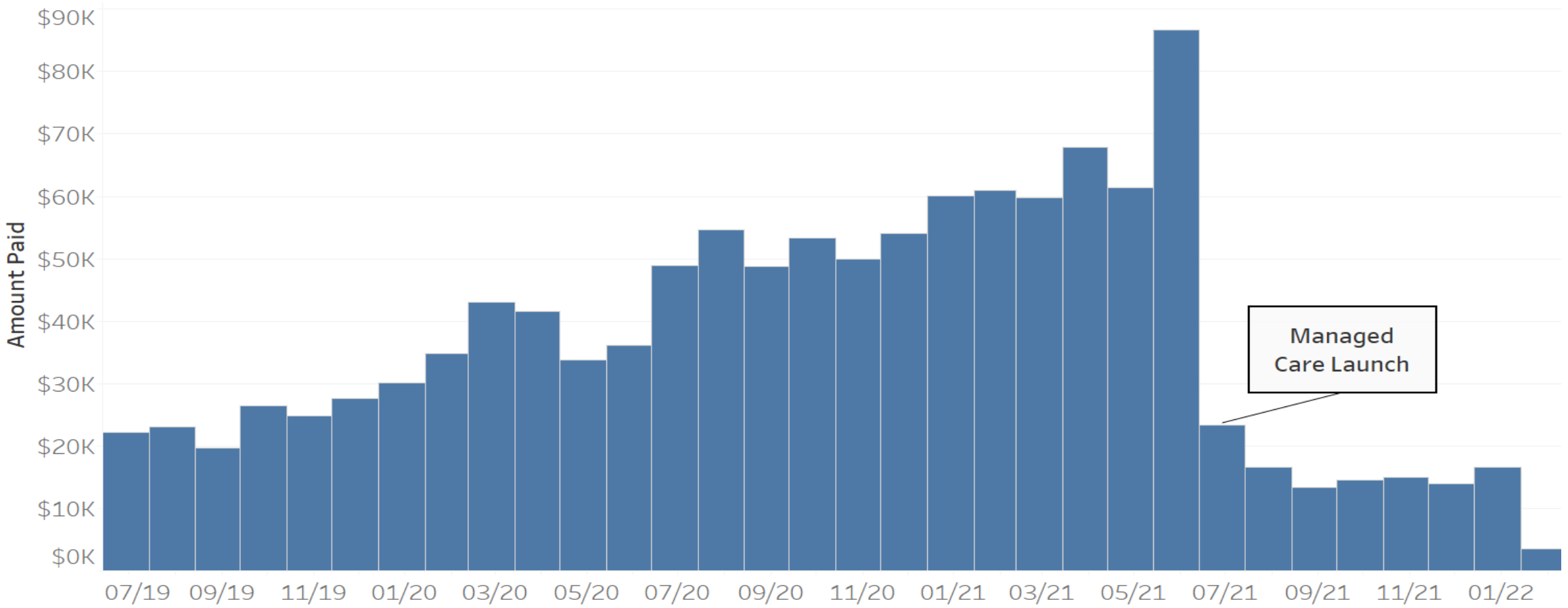
- 2,762 beneficiaries have 1 or more claim
  - 232 of these beneficiaries are no longer enrolled in a Medicaid program
- $1.2m paid out over a 2.5-year period
- 13,653 claims paid; 6,619 claims denied
- Average payment of $88.91 per claim

99492 – Initial psychiatric collaborative care management, first 70 minutes in the first calendar month
99493 – Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities
99494 – Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month

Monthly Collaborative Care (CoC) Payments*

7/19-2/22

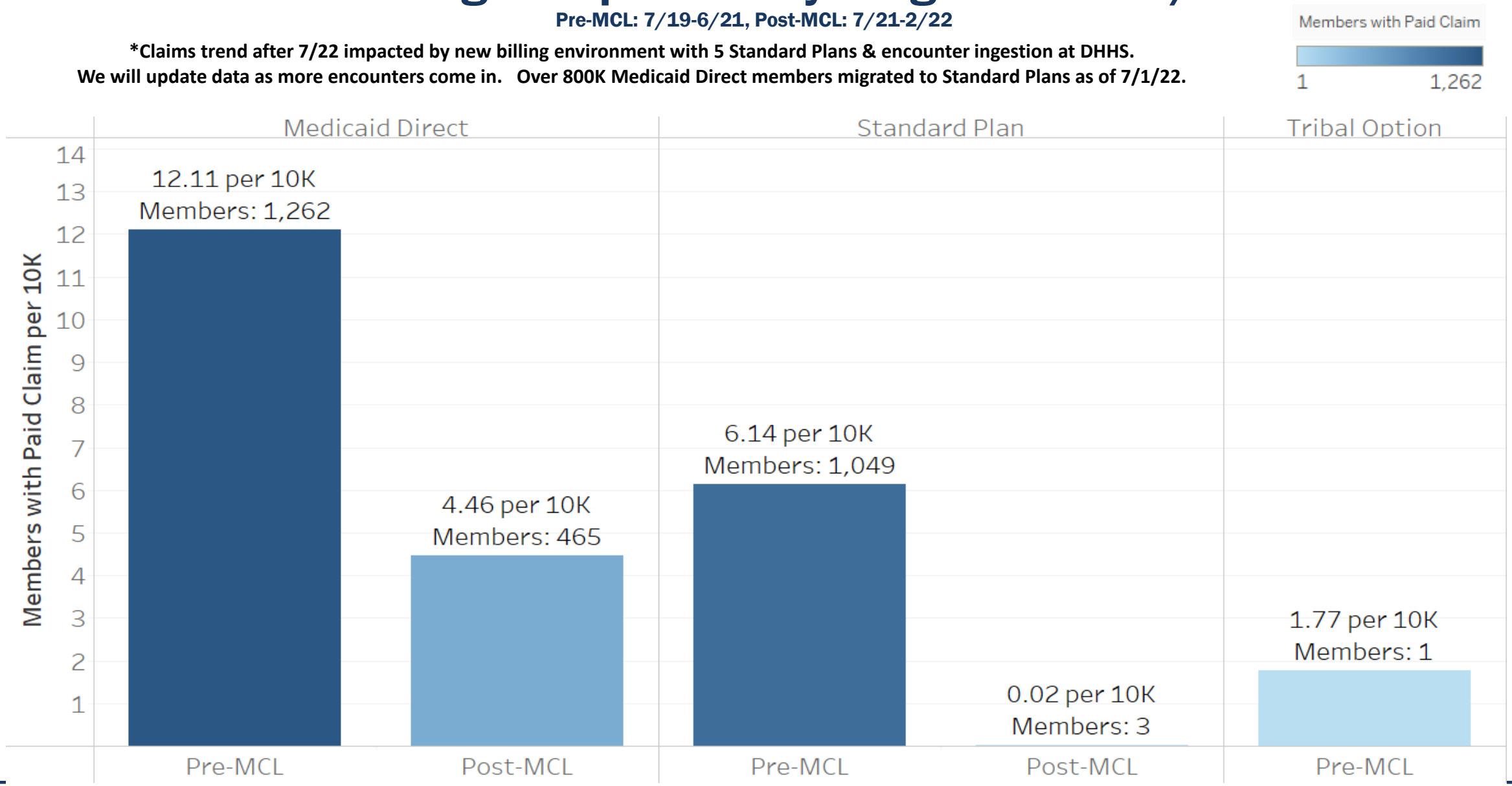
***Claims trend after 7/22 impacted by new billing environment with 5 Standard Plans & encounter ingestion at DHHS. We will update data as more encounters come in.**



Members Receiving CoC per 10K by Program Before/After MCL*

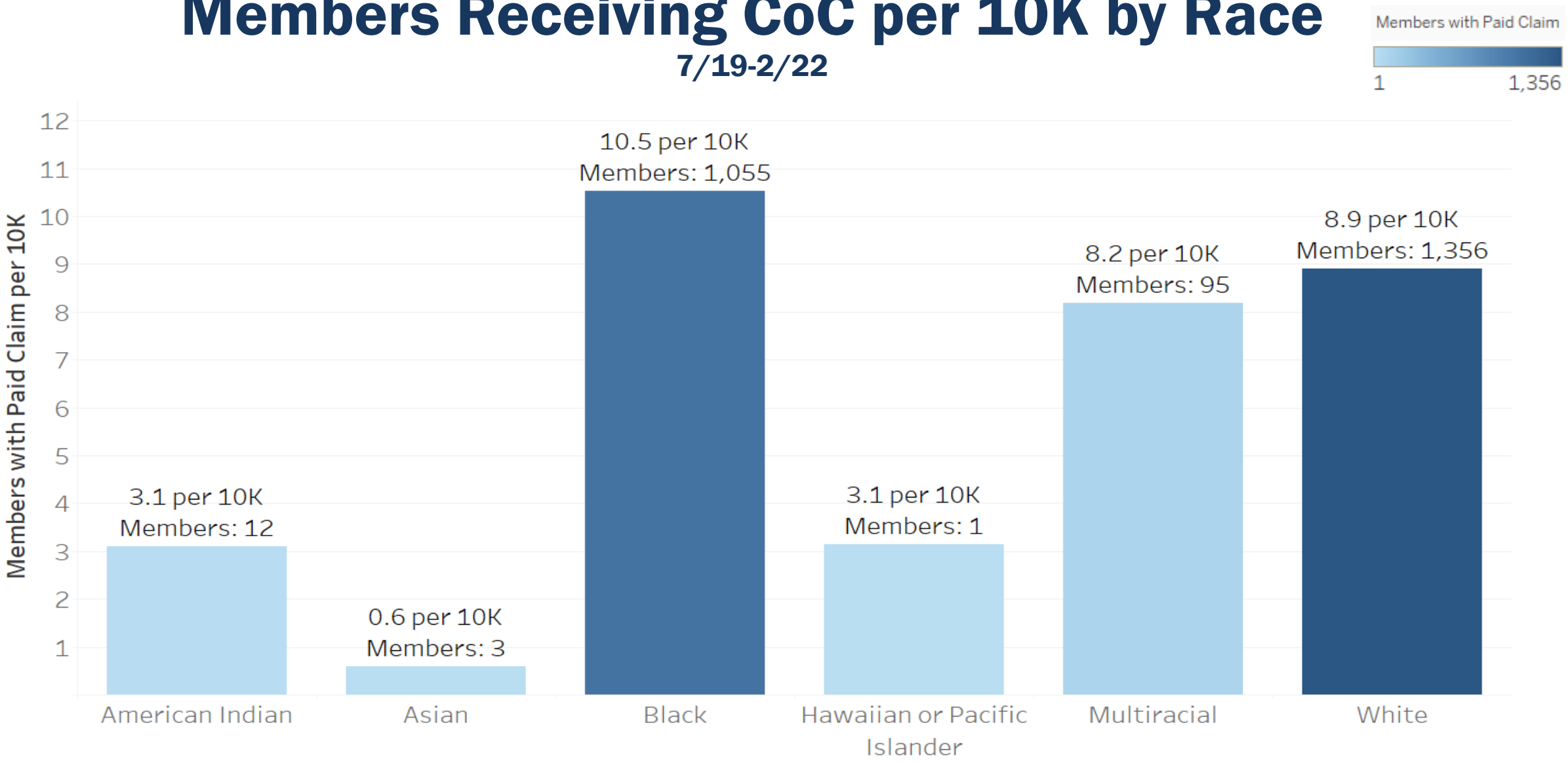
Pre-MCL: 7/19-6/21, Post-MCL: 7/21-2/22

***Claims trend after 7/22 impacted by new billing environment with 5 Standard Plans & encounter ingestion at DHHS.**
We will update data as more encounters come in. Over 800K Medicaid Direct members migrated to Standard Plans as of 7/1/22.



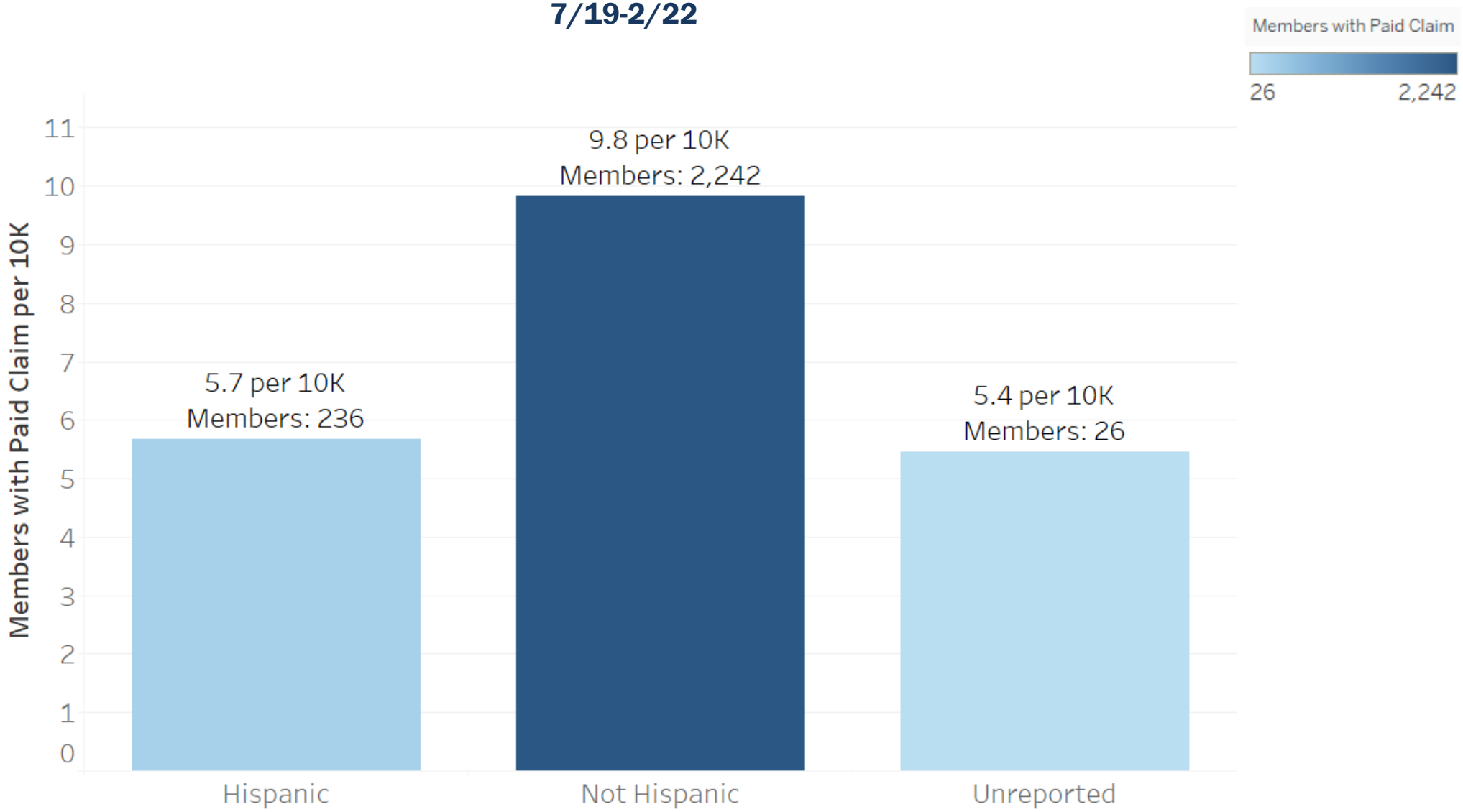
Members Receiving CoC per 10K by Race

7/19-2/22



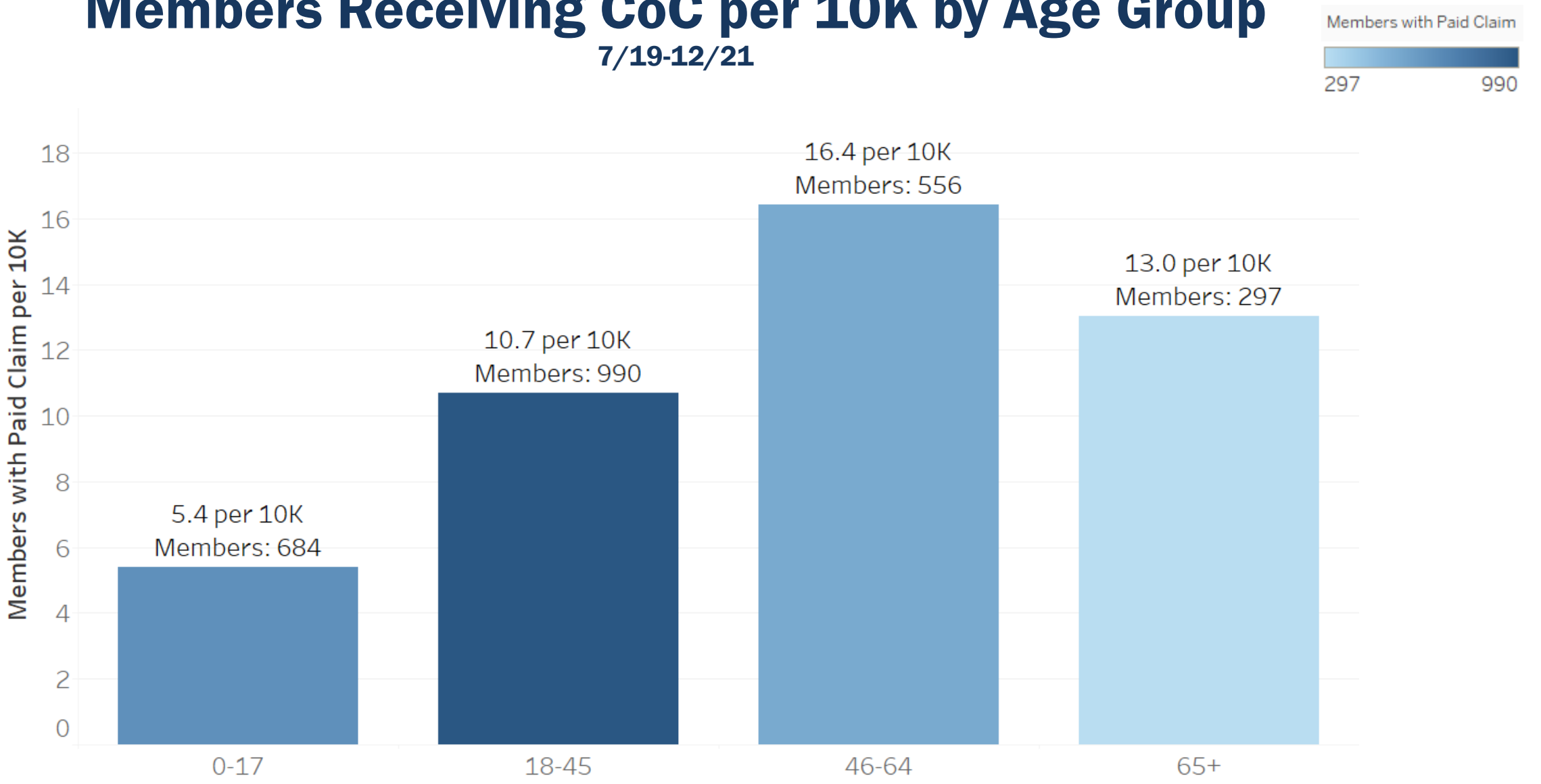
Members Receiving CoC per 10K by Ethnicity

7/19-2/22



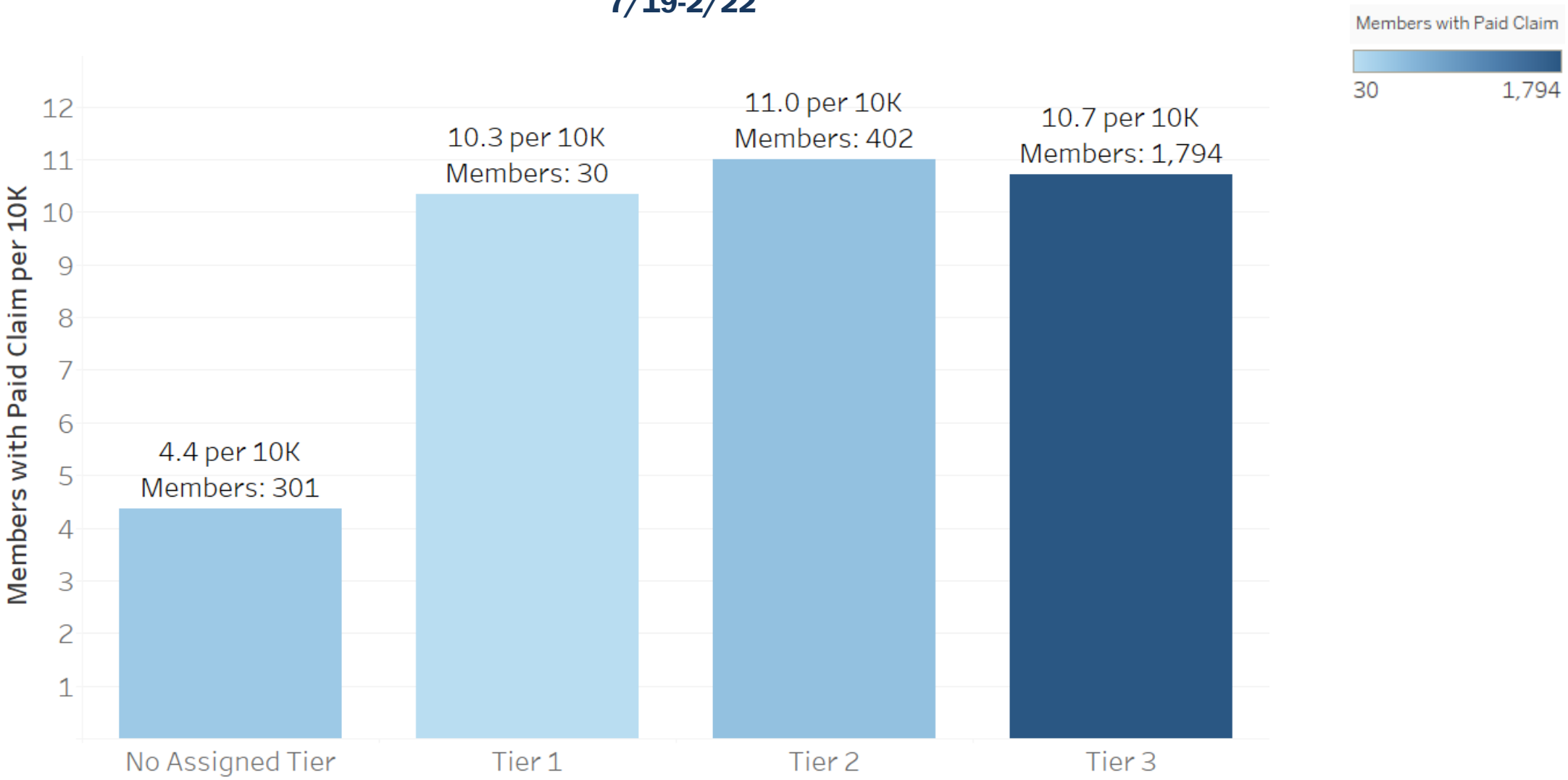
Members Receiving CoC per 10K by Age Group

7/19-12/21



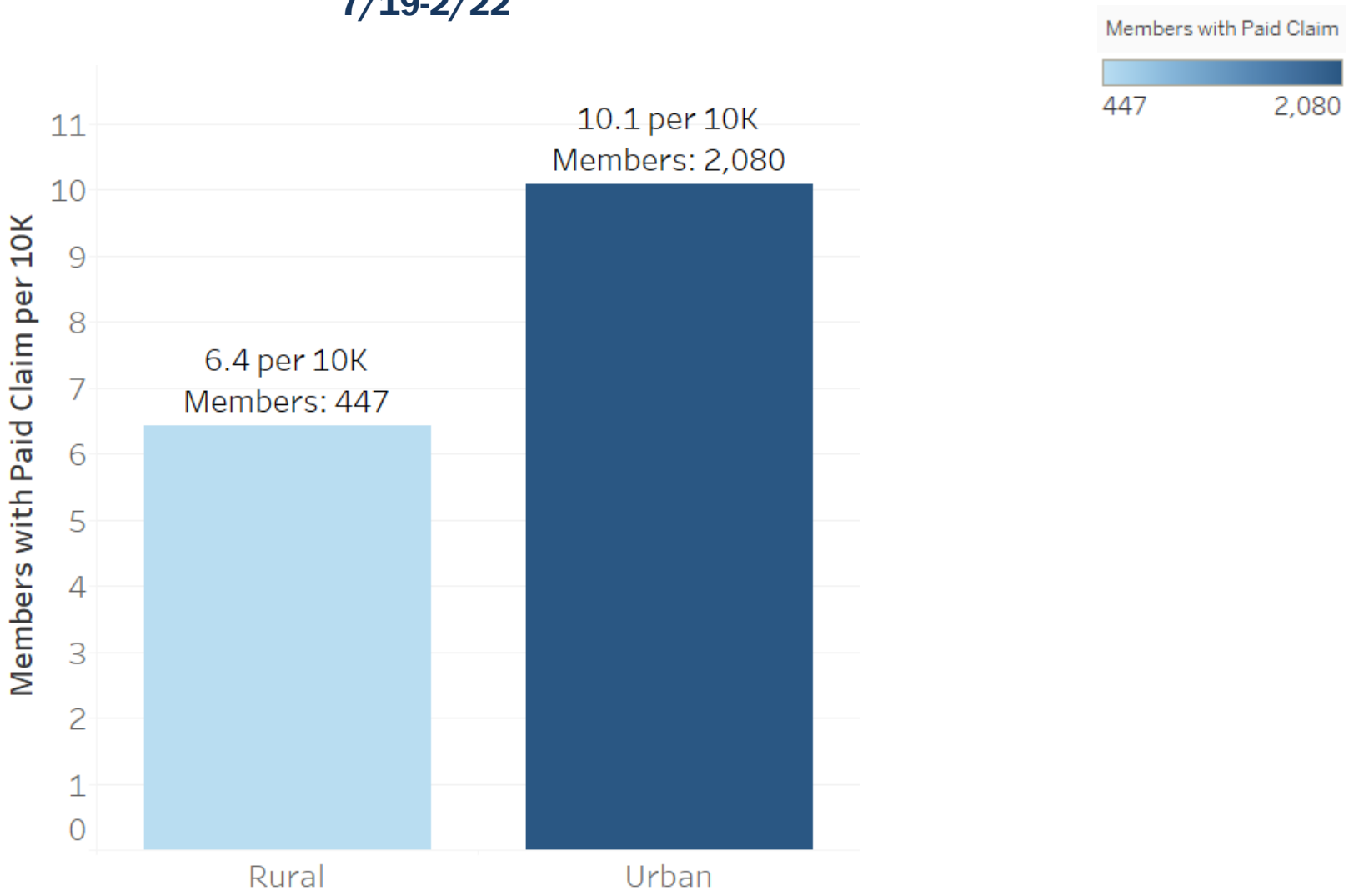
Members Receiving CoC per 10K by PCP AMH Tier

7/19-2/22



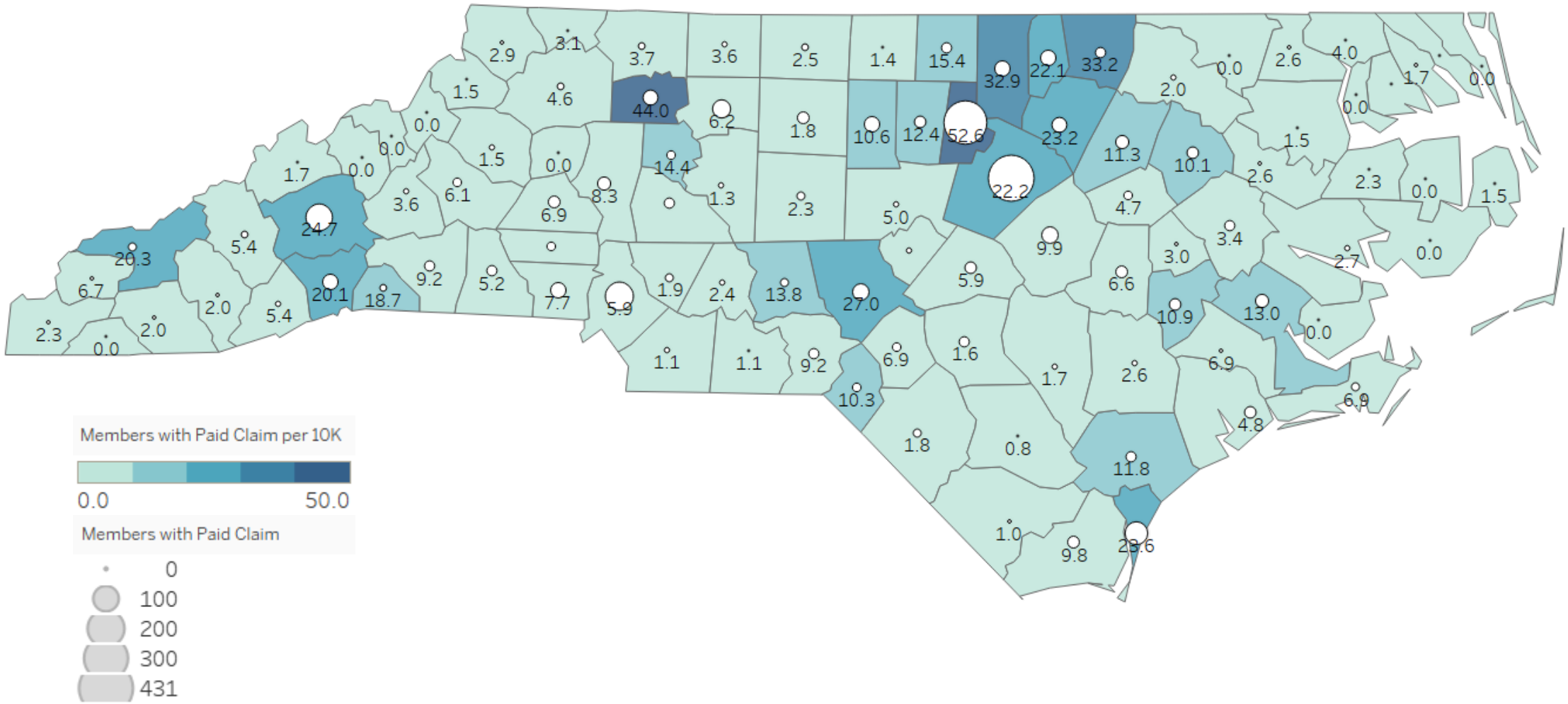
Members Receiving CoC per 10K by Geography

7/19-2/22



Members Receiving Collaborative Care (CoC) per 10K by Geography

7/19-2/22



Updates on Other Hot Topics

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Postpartum Coverage Extended to 12 Months for NC Medicaid Beneficiaries Beginning April 1

Medicaid postpartum health care coverage will be extended from 60 days to 12 months for eligible people in North Carolina beginning April 1, 2022. Medicaid will also provide 12 months of continuous postpartum coverage to eligible people who are currently pregnant or gave birth between Feb. 1, 2022, and March 31, 2022.

The American Rescue Plan Act of 2021 gave states the option to increase postpartum coverage to 12 months. The extension was included in the state budget which was approved in November 2021. The option for the 12-month extension of postpartum coverage is available to states for five years, through March 2027.

Beneficiaries will now be eligible to receive 12 months of ongoing postpartum health care coverage beginning on the date their pregnancy ends through the last day of the month 12-months after the last date of the pregnancy. Beneficiaries will remain eligible for ongoing postpartum health care coverage even if certain changes occur that may affect eligibility — such as a change in income or household/family unit.
Most pregnant and postpartum beneficiaries will have access to full Medicaid benefits. This may include services like doctor's visits, prescription drugs, dental, vision and hearing, as well as behavioral health care and substance use services.

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Please see the press release for more information as well as NC Medicaid's Postpartum Coverage Extension webpage.

Dental Provider Educational Sessions

Dental Provider Educational Sessions
Friday, April 22, 2022 – 9-11 a.m. and May 6, 2022 – 1-3 p.m. | Register

The NC Medicaid Dental Policy Team and the Office of Compliance & Program Integrity (OCPI) Team will host a dental provider educational session. NC Medicaid Dental Policy Team will inform providers of any new updates in the dental policy. OCPI will give a breakdown of what OCPI does, how OCPI works, and how OCPI handles compliance in Medicaid. The dental pre-payment vendor (Carolinas Center for Medical Excellence) and the dental post-payment review program (Public Consulting Group) will expound on the process of pre-payment and post-payment review.

*


QUESTIONS?

APPENDIX

Making the Case for Collaborative Care

Problem

- One in five Americans experienced mental illness in the past year. [1]
- Mental health and substance use disorders (MH/SUD) are often chronic conditions that people experience with other health conditions, such as heart disease and diabetes.
- Yet only 25 percent of patients receive effective mental health care, including in primary care settings, where the majority of patients with MH/SUD receive their usual care.[2]

Solution

- Better care coordination via integration of mental health and primary care has been shown to improve patient access, outcomes, and reduce costs.
- Three decades of research and over 80 randomized controlled trials (RCT) have identified one model in particular — the Collaborative Care Model — as being effective and efficient in delivering integrated care.[3]
- In the Collaborative Care Model, a primary care physician treating patients' behavioral health problems leads a team that consists of a behavioral health care manager and psychiatric consultant.
- It is estimated that $26 – $48 billion could be saved annually through effective integration of mental health and other medical care.[4]

Team-based	**Systematic**	**Cost-effective**	**Patient-Centered**	**Evidence Based**

Making the Case for Collaborative Care

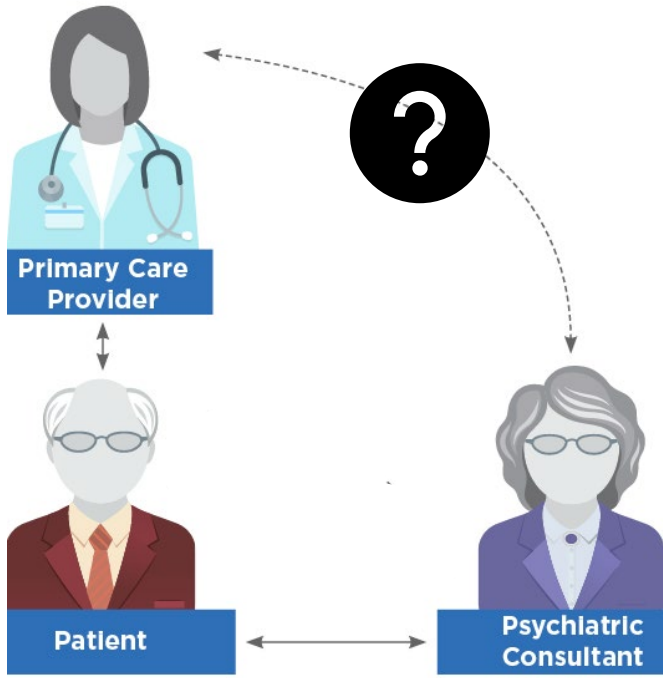
- Shown to be affective in a variety of settings, safety net and FQHCs, OB/GYN and rural care settings
- Disparities in access to quality treatment for mild to moderate BH conditions experienced by racial and/or ethnic minority groups can be alleviated with CoCM.
- CoCM can enhance treatment for patients with cancer, diabetes, cardiovascular disease and other physical conditions.
- Observational studies and clinical trials show how CoCM improves screening, referral and treatment for SUD in primary care.

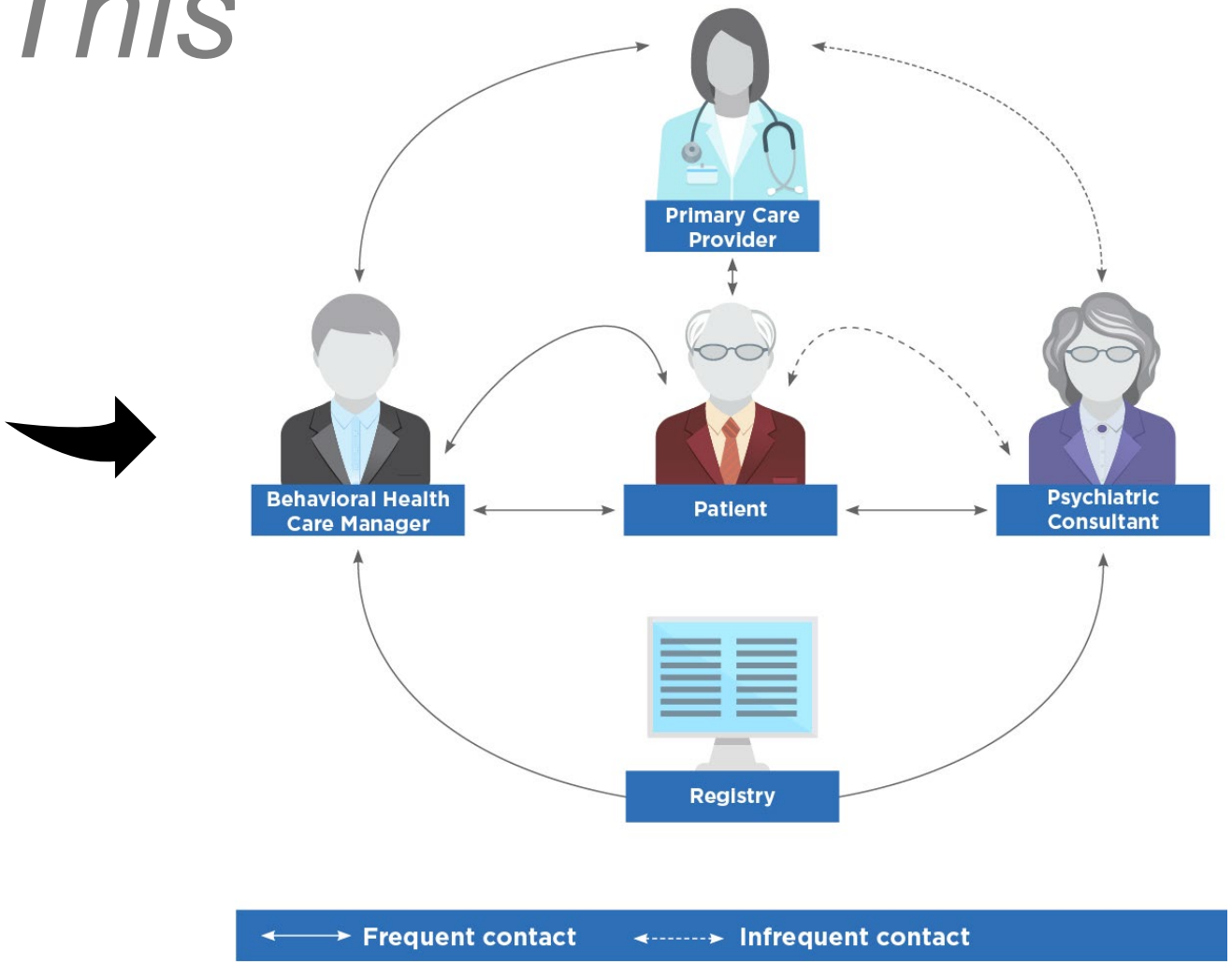
References

1. Department of Health and Human Services. "Mental Health Myths and Facts." http://www.mentalhealth.gov/basics/myths-facts/
2. Unützer J et al. "The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes." Health Home Information Resource Center Brief. Centers for Medicare and Medicaid Services. May 2013.
3. Advancing Integrated Mental Health Solutions (AIMS) Center. "Evidence Base." https://aims.uw.edu/collaborative-care/evidence-base
4. Milliman, Inc. "Economic Impact of Integrated Medical-Behavioral Healthcare. Implications for Psychiatry." April 2014.

The Collaborative Care Model in Primary Care

From This to This





Case Studies: Adult Behavioral Health

- “Anna” is a 56yo F with history of depression and fibromyalgia presenting to PCP with worsening symptoms in the context of caring for her ill father and increased work stress.
- Recent symptoms include worsening sleep difficulty, anhedonia, fatigue, difficulty concentrating at work, and social withdrawal for the past 6 weeks. Rx Duloxetine 90 mg daily x 5 years for depression and fibromyalgia, but feels not as helpful as in the past.
- Anna’s PHQ-9 score was 16/27 (moderately severe depression) and PCP referred patient to Care Manager who obtained a more detailed assessment and provided brief psychotherapy.

Case Studies: Adult Behavioral Health

- CM contacted consultant Psychiatrist who verified the diagnosis and worked with CM to formulate a formal treatment plan, including short-term evidence-based psychotherapy (CBT and grief therapy in this case) to be performed by CM weekly for the next 3 months and recommended the PCP increase Duloxetine to 120mg daily while considering augmentation strategies if no improvement by next PCP visit in 3 mos.
- Anna added to registry in PCP's EMR in order to track clinical outcomes at every visit.

Case Studies: Adult Behavioral Health

- During Anna's third visit with CM, she mentions some improvement in mood, but continues to have trouble with concentration, and has noticed side effect of restless legs since increase in medication.
- CM documents and reports this to consultant Psychiatrist, who communicates with CM and PCP to discuss alternatives, in this case lowering Duloxetine back to previous dose of 90mg daily and adding low dose Bupropion to her regimen.
- By next FU PCP visit, Anna reports improvement in all symptoms including better concentration and no RLS.

Case Studies: Adult Behavioral Health

Improved patient access, outcomes, and satisfaction	Anna received BH care quickly with feedback in between PCP appointments
Better allocation of healthcare resources	Allowing Psychiatrists to impact patient care on population level and allows more time in their schedule to see patients with requiring more intensive or complex psychiatric care

Case Studies: Pediatric Care

- Jorge is a 13 year-old struggling with school. Pre-pandemic, he was a good student, easygoing around his peers. However, after 18 months at home with remote schooling, he is having a difficult time learning and focusing, and his parents have noted that he seems incredibly uncomfortable around peers, isolative.
- Due to Jorge scoring positively on the PHQ-2, a PHQ-9 was completed, and with Jorge's elevated score, he and his family were invited to meet with the BH care manager for brief 4 session CBT with the CM. Medication was discussed with Jorge and his parents, but they wanted to hold off.

Case Studies: Pediatric Care

- Jorge's symptoms and response to treatment was tracked and discussed in consultation with the pediatrician and consulting psychiatrist
- Jorge is continuing to have some isolation and low mood, but the bigger issue has become his academics. His PHQ-9 score had only dropped a few points, and so the consulting psychiatrist recommended addition of an SSRI medication and provided guidance to his pediatrician on dosing and managing side effects.
- With the combination of brief CBT, phone contact and care management with the parents and the SSRI, Jorge is doing better in school and his PHQ-9 score is improving.
- He remains on the registry and his treatment, and scores are continuing to be tracked by the BHCM, PCP and consulting psychiatrist with ability to step him up back up to CBT or transition to specialty MH care if needed.

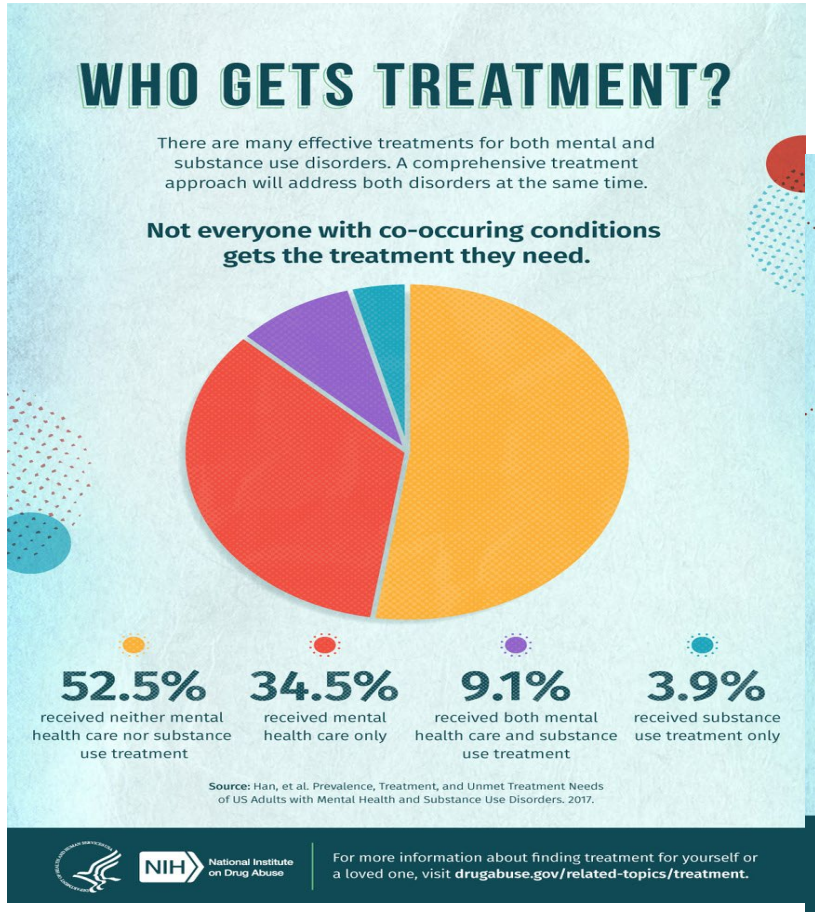
Collaborative Care Outcomes in Pediatrics

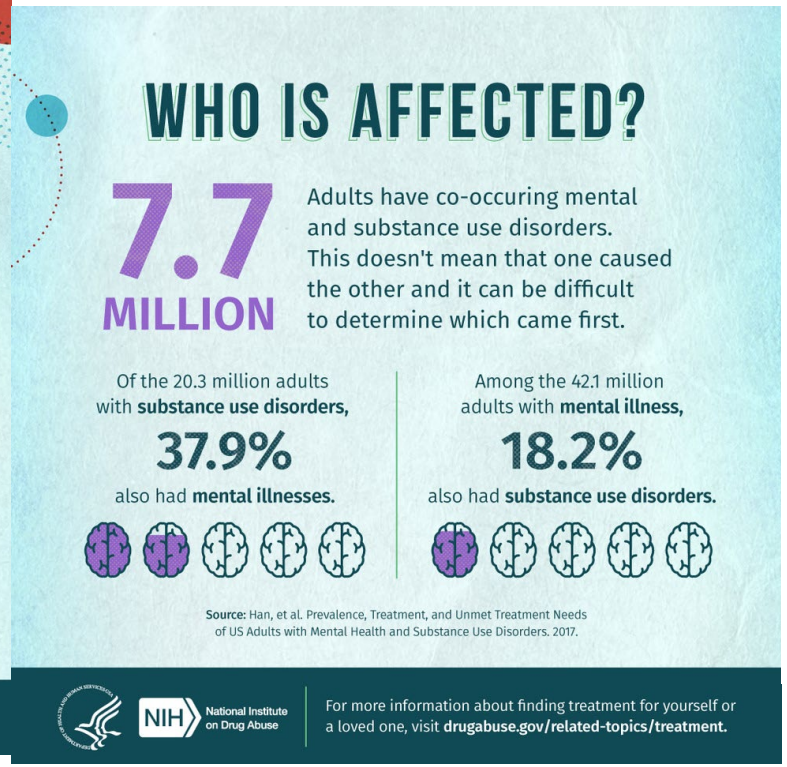
- Greater access to care, less stigmatizing through stepped collaborative care
  - More likely to initiate referred treatment
  - Longer duration of treatment
  - Increased likelihood of receipt of treatment
  - Greater uptake in psychotherapy vs. solely medication
  - Increased odds of engagement
- Symptom improvement
  - Decrease in externalizing/internalizing problems, gains in social behaviors
  - Improvement in depressive symptoms
  - Decreased hyperactivity
  - Decreased parental stress
- Pediatricians participating perceived change, efficacy and skills in treating MH disorders

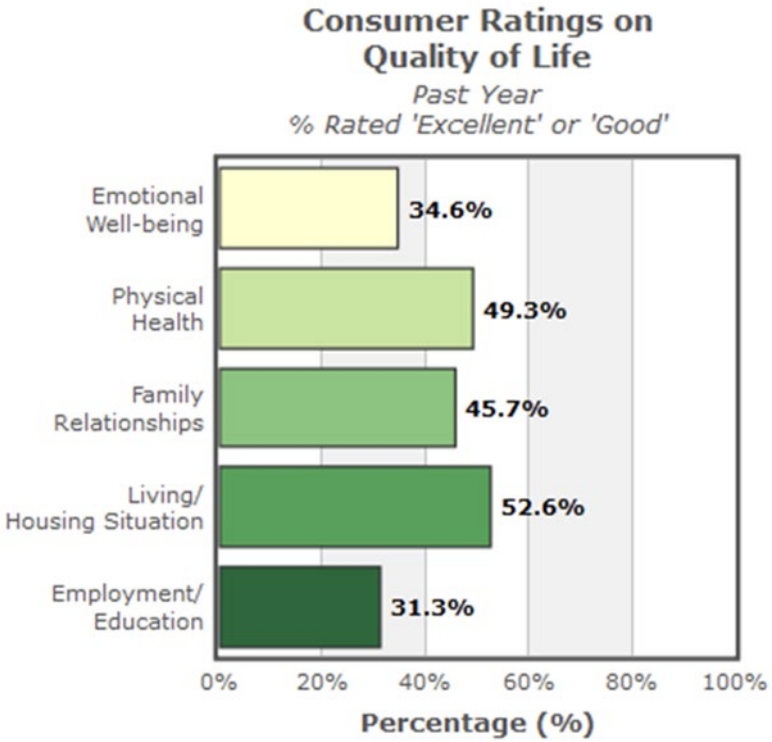
Pediatric Integrated Care Models: A Systematic Review. Burkhart et al. Clinical Pediatrics 59 (2): 148-153

Collaborative Care

- MAT for Opioid **and** alcohol conditions







NC Topps data – All SUD members, initial interview

Major identified barriers for PCP MAT prescribing addressed in Collaborative Care

BARRIERS

- Lack of BH and psychosocial support
- Limited time
- Stigma - difficult patients
- Lack of specialty backup
- Lack of confidence
- Funding

SOLUTIONS Within Collaborative Care

- CM/ addiction specialist., weekly review caseload, discuss medication and therapy issue, review needed BH/SUD services, written recommendations, level of care connections
- BH care manager screens for conditions, frequent contact, psychosocial support, adherence, monitors, maintains registry
- Specialist can provide direct consultation services outside of collaborative care, telehealth changes for SUD may remain post Covid
- Collaborative care codes support oversight

SUD Model Challenges

PHQ –9 does not measure SUD outcomes.

- Retention major measure-treatment adherence, drug screens
- Brief Addiction Monitor- Assesses past 7-30 day use, risk and protective factors.

Limited availability of BH/SUD expert

- CM development of linkages to SUD provider system, knowledge of brief interventions, motivational interviewing, brief action planning, FRAMES, etc.
- monitor outcomes to outside provider with initial induction, possible transfer to PCP for maintenance treatment

CM knowledge to monitor treatment phases.

- CM or RN with ability to screen/assess for appropriateness office-based treatment and induction, stabilization, maintenance phase.

SUD Model Challenges

OUTCOMES

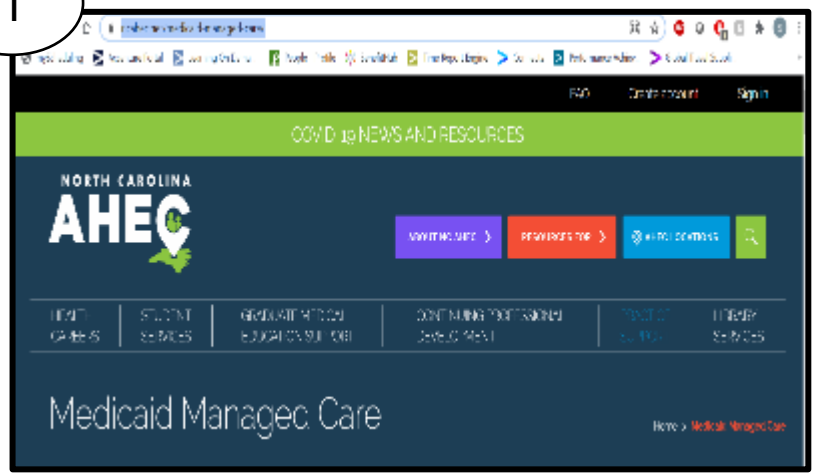
SUMMIT
Randomized Trial

39% received treatment in collaborative care vs. 16% control

33% abstinence vs 22% control

How To Sign up for the Back Porch Chat Webinar Series

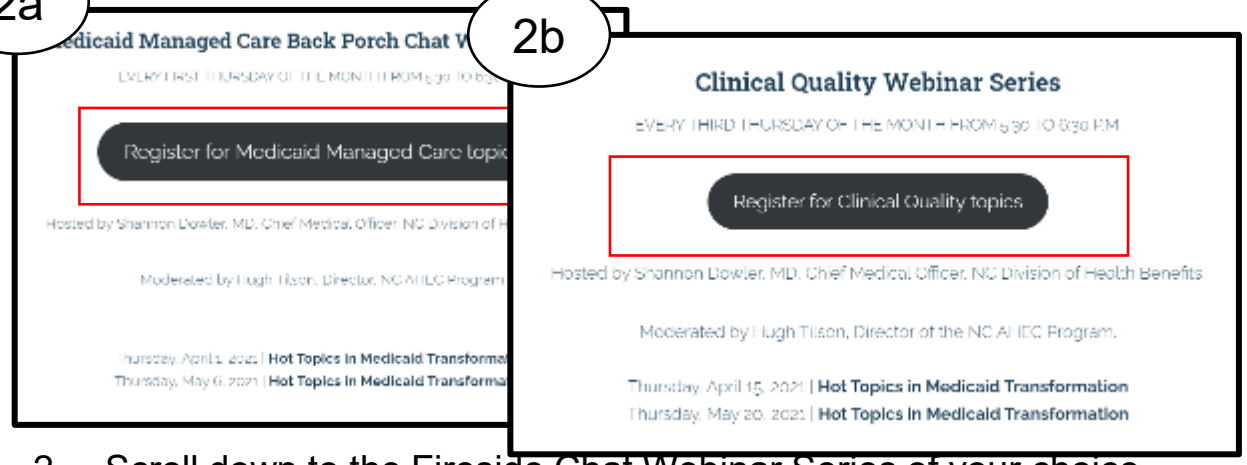
1



1. Navigate to the North Carolina AHEC Medicaid Managed Care page

2a

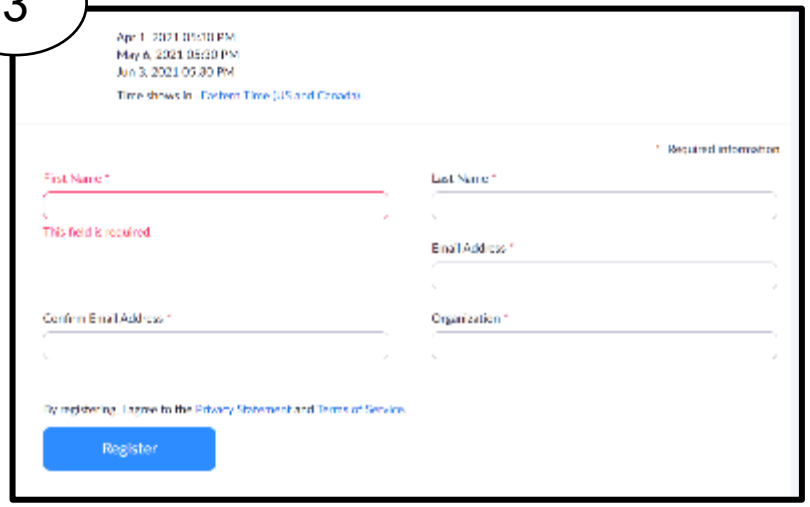
2b



2. Scroll down to the Fireside Chat Webinar Series of your choice

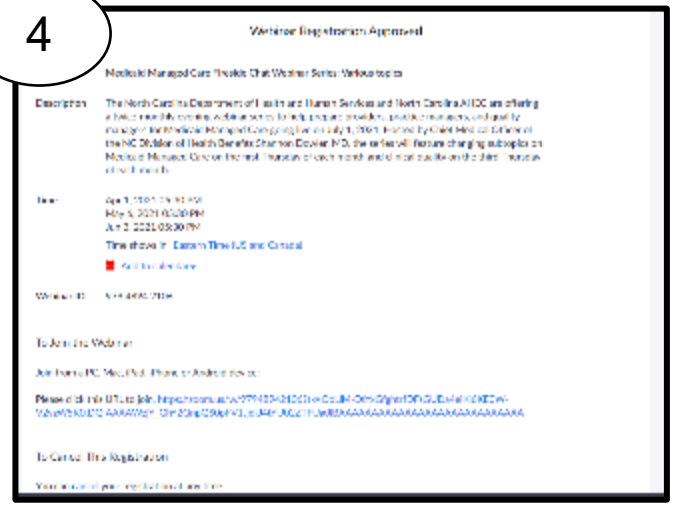
2b. Click on “Register for Medicaid Managed Care topics” or “Register for Clinical Quality topics”

3



3. Fill out all the required information and click register

4



4. When you see this page, your registration is successful.

Provider Resources

- NC Medicaid Managed Care Website
  - medicaid.ncdhhs.gov
  - Includes County and Provider Playbooks
  - Fact Sheets
- NC Medicaid Help Center
  - medicaid.ncdhhs.gov/helpcenter
- Practice Support
  - ncahec.net/medicaid-managed-care
  - NC Managed Care Hot Topics Webinar Series, hosted by Dr. Dowler on the first and third Thursday of the month
- Regular Medicaid Bulletins
  - medicaid.ncdhhs.gov/providers/medicaid-bulletin

What should Providers do if they have issues?

1

Check in NCTracks for the Beneficiary's enrollment (Standard Plan or Medicaid Direct) and Health Plan

If you still have questions, call the NCTracks Call Center: 800-688-6696

2

Connect with the Health Plan (PHP) for coverage, benefits, and payment questions.

You can find a list of health plan contact information at health-plan-contacts-and-resources
Also, please refer to the Day One Provider Quick Reference Guide for more information on how to contact PHPs

3

Consult with the Provider Ombudsman on unresolved problems or concerns.

Call 866-304-7062 or email Medicaid.ProviderOmbudsman@dhhs.nc.gov