Provider Network Connection

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Community Care Physician Network

CCPN is a collaborative, non-exclusive Clinically Integrated Network of independent healthcare providers that will enhance the clinical quality and efficiencies of its participating providers, broaden primary care access for patients, and help participating clinicians to succeed in a value-based healthcare system. For more information regarding CCPN please contact **Christine Bohlmann Provider Services 910-487-8414 cbohlmann@carolinaccc.com**

NC Medicaid Preferred Drug List (PDL) Update Effective December 3, 2018

The NC Medicaid Outpatient Pharmacy Program will implement recently approved updates to the Preferred Drug List (PDL) on December 3, 2018. The majority of changes involve switches in the preferred product between the brand and/or generic version. **To access the full content of the Preferred Drug List or prior authorization criteria, please refer to https://medicaid.ncdhhs.gov/documents/preferred-drug-list.**

Each year North Carolina Medicaid publishes their Preferred Drug List. Those agents listed as preferred do not require prior authorization unless clinical criteria apply. Patients must try and fail two preferred agents, unless otherwise noted, within the last 12 months before a non-preferred agent may be prescribed and processed without a prior approval. Exceptions are noted on the full PDL in red text.

For patients who do not meet the above criteria or have a contraindication or intolerance to preferred agents, **non-preferred agents may be obtained through the web portal NCTracks (located at www.nctracks.nc.gov), completing a NC DMA Standard Drug Request Form (located at www.nctracks.nc.gov) and submitting it via fax to CSC at 855-710-1969 or by calling 866-246-8505.**

For more information, please contact Kara Gagnon, PharmD, BCPS, BCPP at kgagnon@carolinaccc.com or 910-495-8478 or visit the sources listed above.

Coverage for Psychiatric Collaborative Care Management Effective October 1, 2018

NC Medicaid added coverage for the psychiatric collaborative care model effective October 1, 2018. The collaborative care model (CoCM) is an evidence-based model of behavioral health integration designed for the primary care medical home. The model is currently billable to Medicare and NC Medicaid; CPT codes record the total monthly time *per patient per month* and use the NPI of the primary care physician. If done correctly, the CPT codes can financially sustain the model in most practice settings. North Carolina is only the second state in the USA to activate these codes for Medicaid.

The model has 4 essential elements:

1. **Team-Driven**: The medical provider is the leader of the CoCM team. The two new members include an embedded BH care manager and a consulting psychiatrist.
2. **Population-Focused**: CoCM uses screening and a registry to treat a defined population.
3. **Measurement-Guided**: Standardized BH rating scales (ex: PHQ-9) are used as BH vital signs.
4. **Evidence-Based**: CoCM literature is extensive, including all ages, different targeted populations, with established return on investment (up to 6:1 ROI).

How does the model work in primary care?

The practice hires a Behavioral Health Care Manager (BHCM), typically a master's level or higher professional with experience in behavioral health. The practice also contracts with a psychiatrist about 2-4 hours per week and typically pays them an hourly rate (typical for NC is between $100-$175). The BHCM is embedded in the practice and a 1.0 FTE would typically handle a registry of 50-90 patients depending on their complexity. **Importantly, neither the PCP, BHCM, nor the psychiatrist needs to be credentialed with a Medicaid LME/MCO to provide CoCM services. The primary care physician simply must be a Medicaid provider.**

The PCP has a standardized screening protocol for BH/MH conditions (most commonly for depression using the PHQ-9) and positive screens are offered participation in CoCM. The PCP will do a brief description of CoCM with the patient, then do a "warm hand-off" of the patient to the BHCM who describes the CoCM in more detail. If the patient accepts participation in CoCM, the BHCM will gather more information, enter the patient in the registry, and start a protocol with consultation with the psychiatrist, brief (15 minute) therapeutic interventions, and frequent telephonic follow-ups. The PCP has the option to discuss cases directly with the psychiatrist, or use the BHCM to facilitate specific treatment recommendations from the psychiatrist (related to medications, psychotherapy, or other treatment options). *It is important to note that the psychiatrist is not doing 1:1 appointments with the patients in CoCM.*

How is it billed?

The BHCM tracks time spent on each patient in the registry on a monthly basis. The CPT code is billed to the PCP NPI once per patient per month. A full CoCM caseload should be financially self-sustaining to the practice, with the potential for a small profit.

CoCM code reimbursement:

- **99492**: Initial psych CoCM, 1st 70 minutes in 1st calendar month
  - $73.86, $130.64 (facility rate, non-facility rate)
- **99493**: Subsequent CoCM, 1st 60 minutes in subsequent month
  - $66.78, $104.54 (facility rate, non-facility rate)
- **99494**: Initial or subsequent CoCM, each additional 30 minutes
  - $35.63, $54.08 (facility rate, non-facility rate)

Additional Resources

- NC Medicaid Bulletin September 2018 (pages 18-21) https://files.nc.gov/ncdma/documents/files/Medicaid-Bulletin-2018-09.pdf
- CCNC CoCM Model Walkthrough – Short Version (2 minutes) https://vimeo.com/293432113/d8a5c96107
- CCNC CoCM Model Walkthrough – Long Version (6 minutes) https://vimeo.com/293432705/4bb4969da5

For more information, please contact Kara Gagnon, PharmD, BCPS, BCPP at kgagnon@carolinaccc.com or 910-495-8478 or visit the sources listed above.

Overview of CCNC's Portal and Data System Changes

CCNC has implemented an exciting upgrade to our care management tools. We are partnered with Virtual Health, a company that has built the leading population health and care management platform. Together, we have built a customized, efficient tool to deliver integrated, value-based care to our populations with an improved end-user experience. This new platform allows CCNC to provide even better service to providers, partners and patients.

Why is CCNC making the change to Virtual Health?

We're taking on this effort because the benefits will boost CCNC's ability to serve our patients and partners. The benefits of the new system include:

1. Enhanced communication through standardized patient education and provider tools, including new portals for Care Managers, Administrators, Providers, and Members, and additional features such as electronic referrals to care management.
2. Streamlined Care Manager workflow, allowing enhanced service to patients and providers.
3. A better end-user experience with CCNC's systems.
4. A highly stable, state-of-the-art system with the flexibility needed to keep pace with changes in workflow, customer needs and regulatory requirements.
5. Strong data quality and governance.
6. System and data documentation to support maintenance and future enhancements
7. Improvements in functionality and integration over existing systems (CMIS, Provider Portal, Mobile Offline, and PharmaceHome.)

Thank you in advance for your continued partnership.

We look forward to an exciting and successful launch of Virtual Health, a system that will meet the needs of CCNC and its partners now and in the new Medicaid managed care system to come. Please reach out at any time to let us know your thoughts and concerns.

If you have specific questions, please contact: **Darryl Young, Information Technology/Compliance Coordinator 910-495-8476, dyoung@carolinaccc.com**

Advanced Medical Home (AMH) Designation and Attestation for CCNC/CA Practices

Dedicated to improving the health and well-being of all North Carolinians, the North Carolina Department of Health and Human Services (Department) will transition its Medicaid program (including NC Health Choice) from a predominantly fee-for-service environment to a managed care model. Contingent on federal approval, Medicaid managed care will become effective in 2019. For more information on Medicaid transformation, see https://www.ncdhhs.gov/medicaid-transformation.

In this new model, most Medicaid and NC Health Choice beneficiaries will be required to enroll in prepaid health plans (PHPs) that will integrate physical and behavioral health services, long-term services and supports, pharmacy benefits, as well as address individual's health-related resource needs.

AMHs will be the primary vehicle for delivering care management as the state transitions to managed care. The AMH program requires PHPs to delegate certain care management functions to the local level, where they will be performed directly by physician practices or affiliated clinically integrated networks (CINs) or other partners designated by physician practices. The difference between these options is described in NC's Care Management Strategy under Managed Care policy paper available at https://www.ncdhhs.gov/concept-papers. In order to ensure that beneficiaries across the state are receiving satisfactory care management, the Department has developed standards for AMHs and will be responsible for initially certifying that practices meet AMH criteria.

Initially, AMH certification will be based on the practice's current CCNC/CA status. Effective Sept. 1, 2018 practices currently enrolled as Carolina ACCESS I provider will be grandfathered with an AMH Tier 1 status. Similarly, practices currently enrolled as a Carolina ACCESS II provider affiliated with a Community Care of North Carolina (CCNC) network will be grandfathered with an AMH Tier 2 status.

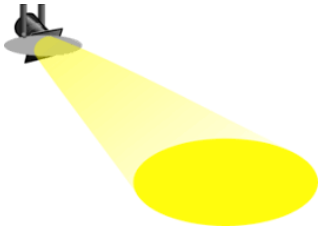
For more information on AMH and all related attestation processes, please see the Medicaid transformation website. Instructions on the NCTracks Advanced Medical Home Attestation Process will be provided via Job Aid and Instructor Led Training in Skillport closer to the implementation date. Future communication will announce when this training and other resources are available. Additional assistance and clarification may be accessed by contacting the CSRA Call Center at 800-688-6696.

Archived webinars will be posted on the AMH training webpage.

For times, locations and registration for all training, visit the AMH training webpage at: https://medicaid.ncdhhs.gov/amh-training

Thank you,

The NCTracks Team



Community Partner Spotlight

BETTER HEALTH

Better Life. Better Community.

November represents Diabetes Awareness Month, and Better Health is offering additional services this month to help your clients succeed in managing their diabetes in compliance with your directives. The program is open to all patients with diabetes and pre-diabetes, regardless of insurance or income, although diabetic supplies such as glucometers and test strips are available to the uninsured.

Better Health offers several free diabetes education classes each week, taught by a Registered Nurse and Registered Dietitian (both are Certified Diabetes Educators) at 1422 Bragg Boulevard, and a rotating session in Spring Lake and Gray's Creek. Clients can walk-in for the classes and 1:1 education or be referred by their medical provider with a simple form available at www.betterhealthcc.org. Better Health receives numerous physician referrals for 1:1 diabetes education per day.

Diabetes Awareness Month, or "Blue November", will kick off with a free Diabetes Symposium on Saturday, November 3rd at DSS. Pre-registration is required for this free event, which includes lunch and break out sessions on topics like Foot Care, Gastroenterology, Carbohydrate Counting, Exercise, Cooking Demonstrations and more.

The week of November 5th marks a new Take Charge of Diabetes 7 week course, which averages 1 percentage point decrease in A1C for clients completing the course. Pharmacy residents from SRAHEC will be on site November 6th, 7th and 8th to provide medication reconciliations.

The week of November 13th will include Cooking Demonstrations and nutritional education on the 13th and 15th.

Tuesday, November 20th the class will focus on Thanksgiving Carbohydrate Counting and healthy meal choices.

A free vision screening is offered by Cape Fear Eye Associates at Better Health on Thursday, November 29th. Pre-registration is required for this event.

Last, but not least, Better Health's sixth annual Red Apple Run for Diabetes is scheduled for Saturday, November 17th in Downtown Fayetteville.

A monthly calendar and additional information on all of these classes and events is available at www.betterhealthcc.org or by calling 910-483-7534. We look forward to helping your clients learn to successfully manage their diabetes!