

Leveraging Key Relationships in Improving Behavioral Health Follow-up Care

Recorded June 29, 2021

Mira Wang:

Next slide, please.

All participants logged into this webinar have been muted for the best sound quality possible. If you have any technical issues, please use the Q&A window located at the bottom right corner of your screen. Please select “Host” in the dropdown menu and click “Send” to let us know how we can help.

We also welcome audience questions throughout today’s webinar through the Q&A window. As a reminder, the Q&A window is located in the bottom right corner of your screen. If you’d like to submit a question, please select All Panelists in the dropdown menu and click “Send” to submit your question or comments.

We will be monitoring the Q&A window throughout today’s webinar and will address as many questions as possible.

Lastly, we want to let everyone know that this meeting is being recorded.

Now I’d like to turn it over to Michaela Vine from Mathematica. Next slide, please.

Michaela, you now have the floor.

Michaela Vine:

Thank you, Mira, and welcome again to today’s webinar.

My name is Michaela Vine. I’m a Senior Health Researcher from Mathematica.

I’m going to run quickly through today’s agenda before turning it over to Deirdra Stockmann for a welcome from CMS. We’ll then hear from two state presenters. First, Laura Boutwell from the Virginia Department of Medical Assistance will speak on behalf of her state’s use of value-based purchasing arrangements. Then Gwen Carrick and Shenal Pugh from New Jersey’s Division of Medical Assistance and Health Services will talk about their state’s use of peer support in care management services to improve timely access to care.

We’ll end the webinar with some time for questions and answers from attendees before Mira wraps up with a few announcements about the learning collaborative. Next slide, please.

Now I’m going to turn it over to Deirdra for a welcome from CMS. Deirdra, you now have the floor.

Deirdra Stockmann:

Thanks so much, Michaela, and hello everyone. I'm pleased to add my welcome to all of you to the second webinar in the Improving Behavioral Health Follow-up Care Learning Collaborative series. This learning collaborative is one of our quality improvement initiatives at the Center for Medicaid and CHIP Services within CMS. The goal of our quality improvement work is to support state Medicaid and CHIP agencies and their partners, such as those in other state agencies like behavioral health agencies, health plans, providers to drive measurable improvement in quality of care and health outcomes for Medicaid and CHIP beneficiaries. Next slide, please.

Over the course of this webinar series and through the Affinity Group which will follow, we hope to provide state Medicaid and CHIP agencies and their various partners with the information, state examples, technical assistance support and tools that you need to expand your understanding of data-driven interventions to improve timely and appropriate follow-up care for people who access an emergency department or are hospitalized with a behavioral health condition. Through the Affinity Group opportunity, states will develop, implement, and assess quality improvement projects to network with and learn from their peers and advance knowledge of quality improvement and skills.

On the next slide is an overview of the learning collaborative activities. So, as you can see and may have participated, and if so, welcome back, our first webinar was held in May and focused on expanding and ensuring access to behavioral health follow-up care. We had, a couple of weeks ago, an information session about the Affinity Group, which I just mentioned. The recording for the first webinar has been posted, and the information session will be posted hopefully a little bit later this week. If you missed those sessions, you can go to our Medicaid.gov page which is there on the slide. We can see if we can drop it into the chat, for the link to access the recordings.

At today's webinar, we'll feature the two states that we're looking forward to hearing from, Virginia and New Jersey, and we wanted to also mention that we've posted the details for the third webinar which will focus on using data to improve access to behavioral health follow-up care. This webinar will be on July 15.

Also due on July 15 are the Expression of Interest forms for the Affinity Group. I'm mentioning that now and I think we'll provide a little bit more detail at the very end of the session today.

So, with that overview and welcome, I'm very pleased to hand it over to Laura Boutwell in Virginia to kick us off with our first state presentation today.

Laura Boutwell:

Good morning. Thank you, Deirdra, and thank you all for joining today. As stated, my name is Laura Boutwell and I am the Division Director for the Office of Quality in the Virginia Department of Medical Assistance Services, here to talk about value-based purchasing arrangements in Virginia. Next slide, please.

Just to give a bit of context to the Virginia Medicaid program here in the Commonwealth, as of June 1, 2021, we have 1.8 million members enrolled. More than

90% of our member population is enrolled in a managed care program and we have two managed care programs here in the Commonwealth. One is the Commonwealth Coordinated Care, or CCC Plus, and the second program is Medallion 4.0. The CCC Plus program is our managed long-term services and supports program and Medallion 4.0 covers pregnant women, children, including foster care and adoption assistance members.

As you can see on this slide, there's also a snapshot of our enrollment dashboard available on the DMAS website that shows a little bit more of breakdowns regarding our member population. Just to speak a little bit more about the two programs, of those 1.8 million members enrolled, approximately 1.4 million are in the Medallion 4.0 program and approximately 250,000 are in our CCC Plus program. Additionally, we have six managed care organizations that offer services for both of the programs. Next slide, please.

Just to step back a moment to talk about a little bit of the catalyst for some of the work that we've been doing to improve behavioral health follow-up care, we wanted to give a little bit of a background on Virginia and the work that we've done historically. One, behavioral health quality initiatives have been central to the mission of DMAS for many years. We've included them in performance improvement projects in the past and have included them in measures and focus in our previous quality strategy 2017 to 2019.

One of the big catalysts for a number of our changes from our quality strategy came with a number of rapid-fire population changes that happened in the Commonwealth of Virginia between 2018 and 2019. One I mentioned previously, our CCC Plus program, which is our managed long-term services and supports, was actually implemented in 2018. We also re-procured our MCOs for Medallion 4.0 from our Medallion 3.0 program, and we also implemented Medicaid expansion which went live January 1 of 2019. All of these changes brought in new populations, new services, additional coverage, and provided a pretty swift succession of population changes here in Virginia.

At the same time, looking at the quality strategy in 2019, we decided to leverage the opportunity to take a deep dive and look at the work that we've been doing in previous years. We did this in order to coordinate current and future efforts in behavioral health, as well as other domains of the quality strategy, to look for opportunities for continuity, while also looking to the future and fostering key collaborative relationships, both with internal and external stakeholders, to make sure that we could align our quality strategy to address the needs of our changing population while also continuing to move towards the future. Next slide, please.

We arrived to the 2020 to 2022 quality strategy framework outlined on this slide, to go through and detail and demonstrate how we chose to approach that framework for the topic of today's conversation, which is follow-up after behavioral health care. In this case, we started with our aims. Now, in our quality strategies, we have four overarching aims that include enhancing the member care experience, effective patient care, and smarter spending. This one is improving population health, and with our goals of improving behavioral health and developmental services for members, in order to increase the visits after emergency department visits for mental illness. We chose to use the two HEDIS measures for this example, the follow-up for 30-day and 7-day total

measures for Follow-up Visits After Emergency Department Visits for Mental Illness, and the intervention of discussion today is our utilization of value-based purchasing arrangements. Next slide, please.

The value-based purchasing arrangement that we are discussing today was called our Performance Withhold Program. It is a one percent capitation withhold program and we have separate arrangements for both managed care programs. We have a separate capitation withhold for Medallion 4.0 and a separate one for CCC Plus program. The measures cover a variety of healthcare domains and not just behavioral health-specific, but for our example today, we are going to focus on the behavioral health-specific measures. The two follow-up visit measures, those HEDIS measures, are actually present in both programs from CCC Plus and Medallion. Additional measures that are in this program were selected based on the individual needs of the program population as well as alignment with the CMS Core Set measures. Next slide, please.

This is where we dive into the details a bit about the Performance Withhold Program. We're using this to further the Commonwealth's mission of providing high quality, cost-effective care for our members. For the performance evaluation of this program, the MCOs must meet a minimum threshold performance standard to qualify to earn back a withhold. For the example today, we're using HEDIS measures. We have a floor performance standard, as well as the standard by which the MCO would receive a full score. Each measure is weighted with an individual weight and the maximum score for each measure has a scale from zero to one. One being 100% of that measure and performance being met, and zero none of that. In order to at least meet minimum threshold, they have to earn at least the twenty-fifth percentile in a HEDIS measure in order to have a minimum performance standard.

In order to demonstrate improvement or high performance, for example, in order to earn a bonus on top of that score, if the MCO demonstrates improved performance trends year over year, that will allow the MCO to potentially earn a .25 point score bonus on top of each one of their individual measure scores.

As well as a high-performance bonus, if an MCO demonstrates a strong and sustained performance such as a year-over-year performance over national performance benchmarks, in this case the sixty-sixth percentile for NCQA, meaning that will also get a .25 bonus score.

With all of the details of individual scoring, as far as falling in between some of these thresholds and percentiles, I would highly encourage, if you all are interested in some of the math behind all of this, the details of the Performance Withhold Program methodologies are available on our website, and the link is on the slide.

I know I talked a bit about 2018 and 2019, and we have not gotten yet to the changes that occurred for all of us in 2020 with the COVID-19 pandemic and the public health emergency. Initially 2020 was going to be our first performance year, but due to COVID-19, that has changed now to have 2021 to be our initial performance year. Our baseline year of data will be 2019 for this arrangement. Next slide, please.

Some of the ongoing lessons learned, especially with the COVID-19 pandemic and all the changes to our population that have happened over the years, Virginia has really focused on some of our core values of adaptability and problem solving in order to remain focused on our north star of improving access to behavioral health care follow-up even with all the changes that are happening, both externally to our program, as well as what's happening internal to our program. This really emphasizes the importance of ongoing communication and engagement with our MCOs and with our internal and external stakeholders, our sister agencies, so we've really been trying to make sure that we keep all of these communication channels and collaborations open so that as we navigate things such as evaluating the 2021 data as it comes in for this Performance Withhold Program arrangement, we are able to have those discussions to make sure that we are all in alignment.

We also have other changes that we are currently still unpacking with the COVID-19 pandemic specifically related to access for behavioral health care, is the uptick in utilization of telehealth services for our Medicaid members here in the Commonwealth. Over 200,000 Medicaid members received a telehealth service, seventy percent of those for us were behavioral health, and that is a 1700% increase in telehealth claims from February to June of 2020.

We've also seen an increase in telemedicine claims for African American members by ten percent in this time period. You can also tell that our overall population has increased during the state of emergency by over 200,000 members within a less-than-12-month period. Navigating the changes in the landscape of accessibility for behavioral health, as well as continuing to evaluate the needs of our population that has been growing and changing, is really key for ongoing lessons learned. Next slide, please.

In terms of future plans, we have a lot of in this space under way here in Virginia. As we mentioned previously, we have the initial performance year. We're looking at 2021 for that, so we are moving forward with Performance Withhold Program there.

We are also reevaluating the use of behavioral health PIPs and looking at assessment of telehealth utilization and its impact on access for our members.

We have a very large project that is very soon to start, called Project Bravo, which is our behavioral health enhancement, with the goal of implementing a fully-integrated series of behavioral health services that provide a full continuum of care to Medicaid members in the Commonwealth. This is a multi-agency, Commonwealth initiative. As you can see in the graphic on this slide, it involves a number of our sister agencies to really bring all of these pieces together. We are very excited to continue the work forward on our enhancement.

We are also enhancing our data analytic and visualization capabilities to help with those communications and collaborations with our stakeholders so that we can demonstrate and show our work moving forward.

I also want to say, if you have any questions on Project Bravo specifically, I'd encourage you to go to the DMAS website with the link on the slide to take a look at that for additional information.

With that, thank you very much for your time. I really appreciate it. And I will turn it back over to the CMS team. Thank you very much.

Michaela Vine:

Thank you, Laura, that was great.

As we mentioned at the top, we're going to hold off on answering questions from the audience until after both of the state presentations, but please feel free to use the Q&A function at the bottom right of your WebEx window to send the questions in to our team, and then we will respond to them in a little bit. Next slide, please.

Next up we have Gwen Carrick and Shenal Pugh from New Jersey's Division of Medical Assistance and Health Services. Gwen and Shenal, the floor is now yours.

Gwen Carrick:

Thank you. Excuse me. Thank you very much.

My name is Gwen Carrick, and I'm a Program Specialist for the New Jersey Division of Medical Assistance and Health Services in our Behavioral Health Services Department. Shenal, do you want to introduce yourself?

Shenal Pugh:

I'm Shenal Pugh, and I'm a Program Support Specialist also in the Division of Medical Assistance Health Services.

Gwen Carrick:

Next slide.

Shenal Pugh:

We'll dive right in. The bulk of the Substance Use Disorder Treatment services are covered services in the state of New Jersey. A brief timeline of substance use disorder treatment services in New Jersey: In July 2017, the New Jersey Renewal Team Comprehensive Medicaid Administration was granted.

In October 2017, New Jersey was authorized to expand opioid use disorder, substance use disorder benefit package to combat prescription drug use and opioid disorders by treatment services.

In October 2018, New Jersey went into creating Managed Long-Term Services and Supports, that's MLTSS, Fully-Integrated Dual-Eligible Special Needs Plans (FIDE SNP) mental health and Substance Use Disorder benefits to be covered by MCOs, the Managed Care Organizations, sorry.

Michaela Vine:

Shenal, I'm sorry to interrupt. Would you mind speaking up just a little bit? It's a bit hard to hear you.

Shenal Pugh:

New Jersey implemented the peer support and care management services which is a part of our 1115 waiver demonstration.

Is that better? I'm sorry.

Gwen Carrick:

Yeah. Are we on the next slide, Shenal?

Shenal Pugh:

I'm sorry, yes. Next slide.

Deirdra Stockmann:

Can you try getting any closer to your mic? Sorry, Shenal. People really want to hear you. We're getting lots of chat saying they can't hear you, and they want to hear what you're saying.

Shenal Pugh:

I'm sorry. We're not on the next slide, I'm sorry. Can you go back? Can you hear me? I don't know what's going on, why it's so low.

Gwen Carrick:

Do you want me to do this one, Shenal?

Shenal Pugh:

Can you hear me? Can we go back, or no?

Gwen Carrick:

Yeah.

Shenal Pugh:

Okay. Okay. So, can you hear me now or no? I apologize everyone.

Deirdra Stockmann:

It's still pretty quiet. You could either use your outside voice or people are suggesting turning up your speaker. I don't know what that means.

Shenal Pugh:

I'm literally yelling like really loud. I'm sorry about that. Let me see if there is anything that I can do.

Gwen Carrick:

Shenal, do you want me to pick up from there for now?

Shenal Pugh:

Yes, would you?

Gwen Carrick:

Okay. In New Jersey, the bulk of our SUD treatment services are covered under Medicaid Fee for Service, and they're carved out of the Managed Care Organizations. New Jersey has five Managed Care Organizations and services for mental health, and substance use disorder treatment are carved into our MCOs for our Managed Long-Term Services and Supports population, Fully Integrated Dually Eligible Special Needs Plans, and our developmentally disabled populations. They have fully integrated services through our managed care.

Our Medicaid population for the first three quarters of 2020 were approximately 1,800,000. Of that population, about five percent received an SUD treatment service or a substance use disorder diagnosis during that same time period. Next slide.

As part of our 1115 Waiver, that Shenal was discussing, for substance use disorder and opioid use disorder, part of the services we proposed were to develop a peer services and a care management benefit. In our 1115 Waiver, we opted to do that under a state plan amendment. So, in late 2019, we implemented peer services with a goal of increasing access to care, improving transitions in care, and into the community, reduce overdose deaths in the state, and to promote long-term recovery in the community.

Shenal, do you want to see if you can do the care management or let's see how your volume is?

Shenal Pugh:

Can you hear me? Hello? Hello? Hello?

Gwen Carrick:

Well, somebody said no. Okay.

For the other service we implemented is care management with the goal to also increase access to care, improve care coordination and transitions between levels of care and into the community, improve access to care for physical health conditions for individuals with an SUD or an opioid use disorder. Next slide.

The interventions were peer services. Certified peer recovery services are non-clinical services. They are strength based. They are designed to help individuals with a substance use disorder stay engaged in their own recovery. Certified peer recovery specialists are professionals with lived experience. They have the, “I’ve been in your shoes and have been successful” approach to an individual with a substance use or an opioid use disorder.

For our care management intervention, we designed care management to be a behavioral health service that would support individuals with a substance use disorder who also have complex physical or psychosocial needs. Care managers may assist members as they transition throughout the continuum of care in New Jersey by matching their needs to the available resources and access care and services independent to meet their individual needs. Next slide.

The intended outcomes for these services were to implement strategies that would address opioid use disorder and substance use disorder within the state, implement comprehensive treatment and prevention strategies to reduce overdose deaths, improve care coordination and transitions between levels of care, and support our New Jersey family care beneficiaries with a substance use disorder throughout the continuum of care and into the community.

As part of the intended outcomes, part of our 1115 Waiver, for any states that are applying for that, there’s a lot of monitoring requirements and performance metrics that we track. We were proposing to use some metrics that would look at these services. These services, right now, are in the process of implementation, so we don’t have metrics to support or show any anticipated changes, but the metrics that we plan to look at are going to be follow-up after emergency department visits, initiation and engagement in treatment for opioids, alcohol, other drugs, and the total initiation and engagement. We hope that the engagement numbers will improve as well as the initiation. We have a metric for CMS that looks at readmissions, and, of course, we have metrics related to overdose death counts and rates for Medicaid beneficiaries that we hope will show improvement based on the peer and the care management interventions as well as other interventions we utilized as part of our 1115 Waiver. Next slide.

Lessons learned. To develop these services, the stakeholder processes were very different. For peers, we developed a work group made up of peer specialists. We had some family members who had lost children related to opioid overdoses. We had the New Jersey Prevention Network became part of our stakeholder group. Medicaid was part of it, and our sister Division of Mental Health and Addiction Services. So we formed the stakeholder group, and around the same time, SAMHSA was offering their BRSS-TCS Policy Academy, so all of the members of the stakeholder group were also part of the SAMHSA BRSS-TCS Policy Academy. As part of that, we conducted surveys with peer services and providers. We looked at all aspects of peer services from every varying perspective.

We became a very tight-knit group because we spent a lot of time together working on projects as part of the BRSS-TCS Policy Academy. One of the successes was that we were actually able to, and are still working on, long-term workforce development for peer specialists that is turning into a best practice guidance for the state. Living wages

for peer specialists translated to the rate development for Medicaid rates. Sustainability of the service; we currently have grants and state funding that paid for peers, and now have incorporated Medicaid reimbursement into that.

Some of the challenges were the peer certification board. Everyone sort of agreed that we felt it was best for peers to be certified for the long-term workforce development and Peer Certification Board changes their requirements from time to time. It became a challenge, just as we were rolling it out, they made a change. We had to adapt to that.

Provider enrollment processes within the state have been challenging. We still have some issues that we're working through. We wanted all the peers to get NPI numbers, and our system is a little challenging to navigate to get in all the edits for the system billing. Next slide, please.

Care management. Some of the challenges related to that were very different. We had changes in gubernatorial leadership. We had changes in Medicaid. We had changes in our contracted billing agency. Those all sort of impacted our process for care management and fiscal budget approval. We were finally able to work through all of those challenges, and we ended up starting the care management program with an existing state-funded contracted program. That program was limited to individuals with an opioid use disorder and homelessness, or at risk of homelessness.

We started there, and then built the benefit out. We worked very closely with the Department of Mental Health and Addiction Services. They are our sister agency, and they worked very closely with us on that.

Some of the challenges were the fiscal approval. Just as we were ready to start working on this, COVID hit, so we were impacted in the state very early. The services are currently being rolled out right now. Next slide.

Plans to sustain and expand the intervention. Currently the services are being paid Medicaid fee-for-service. We also have our special populations covered under the MCOs. We have five managed care organizations: Horizon, United, WellCare, Amerigroup, and Aetna. The certification for care specialists and working with our sister agency and the workgroup on the state best practices for peers.

We also plan to continue to monitor and evaluate through the metrics that we are reporting for our 1115 Waiver.

In addition to the required metrics for CMS, we do plan on doing some internal checks to make sure that the services are rolling out effectively, and they're being billed, and providers are using the services, and our beneficiaries are benefitting from receiving the services. Next slide.

Michaela Vine:

Thanks so much, Gwen and Shenal. Really appreciate your presentation and for your flexibility with the audio issues. Next slide, please.

Here are some references from New Jersey's presentation. Next slide, please.

We are now going to open the floor up for questions. As a reminder, to submit a question, please type the question in the Q&A box at the bottom of your WebEx window, and then select All Panelists in the dropdown before pressing “Send.” Only our presentation team will be able to see your questions, and we’ll do our best to get through as many as possible during the time we have. We already have a few questions in the queue, but please keep them coming.

So, more of a housekeeping question: someone asked whether it would be possible to email slides to participants in the webinar. Yes, we will be posting the slides actually on Medicaid.gov within about a week of the webinar, and we will be sending out a reminder for the next webinar in the series that Deirdra mentioned and that will also include a link to where you can download the slides, and a transcript from this webinar.

Here’s another question, and this one is for our New Jersey panelists. Someone asks, how will New Jersey be tracking follow-up services after ED admission? Will you be looking at enrollment in ongoing services or simply a follow-up phone call? Is that something that someone from New Jersey could answer?

Gwen Carrick:

Yes. For follow-up services after ED, this is one of those HEDIS measures, so there is standardized claims data that we’re collecting on services that a person would receive within 24 hours of an emergency department visit. One of the procedure codes will be for peer services as well so that we can keep track of that.

Michaela Vine:

That’s great. Thank you, and then another question that I believe is for New Jersey, since you’re already answering. Someone wondered what were the changes that the state board made and how successful was the transition to this being a billable service?

Gwen Carrick:

The certification board changed. I believe it was high school diploma, they must have a high school diploma, which caused a lot of feedback from some of our existing peers who do not have high school diplomas and are employed by prevention agencies or recovery groups currently using the service. What we’ve done is modified our language; we reference the certification board requirement rather than having to change our requirements every time they change their requirements. We’re supporting the requirements of the certification board in New Jersey for peer specialists.

Does that answer the question?

Michaela Vine:

I think that does. Thank you. If the person that submitted this question has any follow-up questions, please feel free to submit them.

Let’s switch gears now. I think we have a question for Virginia here, and Laura, hopefully you can answer this one around whether Virginia can speak to any strengths,

weaknesses, or lessons learned from the past performance improvement projects that have happened related to follow-up care?

Laura Boutwell:

Hello. Thank you. It is a little bit difficult to transition between our population from 2015 to what we are doing now, six years later. We're really looking to refocus our efforts on bringing the performance improvement projects to our current population and looking at some of the changes that are occurring in our population today. Looking at telehealth access utilization, looking at the different needs from our different population groups that have been added from Medicaid extension to our managed long-term services and supports, to make sure that as we look at the performance improvement projects, we are continually taking that thread of trying to focus on that north star of improving access while taking into consideration some of those other factors.

Michaela Vine:

Thank you so much, Laura. One other question for you while we have you. I think in your presentation you noted that the withholds are currently .25%. This person was wondering how the state came to that withhold amount. Did you facilitate a workgroup or some other approach to getting there.?

Laura Boutwell:

Yeah and to clarify, I apologize, the withhold amount is one percent capitation withhold. Those scores are based on a zero to one, and some of those bonuses are that .25, and something like that improvement bonus or the high-performance bonus fall into that.

As far as the background, I would have to get into some of those specifics, but I do know that we worked closely with our EQRO on the development of this work. I can do a little bit of research into where the one percent came from, but just be clear, it is one percent not .25. Thank you.

Michaela Vine:

Thank you very much for clarifying.

I think we have another question here for New Jersey. This person asks whether Medicaid is now providing reimbursement for certified peer support services, and if so, where they could potentially find information on how Medicaid is reimbursing for certified peers.

Gwen Carrick:

New Jersey's fiscal agent, or we have www.njmmis.com, and on that website you can access newsletters. We do have a newsletter for reimbursement on peer services that can be found on the website.

The service is a 15-minute unit. It's billable to independent clinics is what New Jersey designates our substance use disorder treatment providers as. The service is only billable through them.

We are currently also working on a peer service that is a program for opioid overdose recovery program. They are peers that got called to the emergency department following a Narcan reversal, but that service has not been implemented yet. We're currently in the process of working out issues with that.

Michaela Vine:

Thanks, so much, Gwen. I think that actually answers this person's other question around where they can find more information about New Jersey peer certification programs. Yeah, they're asking if we can share a link, so we will post that link. Thank you.

We have a question that I'm told is for Virginia around whether there have been challenges getting the providers to submit the required data for the measures that you are tracking?

Laura Boutwell:

As far as challenges related to the information that we gather, we do work closely with the MCOs, and we have posted methodology documents so that we can make sure that we have clear communication about the expectations and background. As far as any specific challenges from providers submitting the information, I would have to circle back to that specifically, but thank you for your question.

Michaela Vine:

Thank you. We have one other question for Virginia, which is around whether and how the MCOs are working together in any way to achieve the intended outcomes and meet the performance thresholds. Sharing information about the kinds of interventions that they are implementing.

Laura Boutwell:

Yeah. That is a great question. There is some collaboration that we do through ongoing communication collaborations that we have with our MCO quality teams and quality leads. There is a mix of that. We do have a great set of quality team members from the MCOs in Virginia that do work together, but there are limits to that collaboration with the financial incentives related to this program. There are some challenges with the collaboration, but for the most part we are very lucky that the MCOs have worked together as much as they have with our team.

Michaela Vine:

Thank you so much, Laura.

Please continue to submit your questions through the Q&A if you have any additional questions. As I mentioned before, we will be posting the slides, and the recording, and a transcript from this webinar to the Medicaid.gov landing page for the learning collaborative. I think we've already sent out the link to that site and we can send it again. Usually we get the slides, and everything posted within about a week or so after the webinar, so please, please check back. We will also send out a communication letting you know when they've been posted.

If you have any questions that you come up with after we wrap up, please feel free to submit them along to us at MACQualityImprovement@mathematica-mpr.com. We will also send that email address at well. We'd be happy to respond via email.

Unless anyone has any last questions, we will probably move along now to give you a few last-minute updates and announcements about the learning collaborative. Next slide.

Mira, I'll turn it back over to you now.

Mira Wang:

Thanks, Michaela. As Michaela noted, we'll post the webinar recording and slides from today's webinar on Medicaid.gov—next slide, please—at this link on this slide. We also encourage you to attend our final upcoming webinar, webinar three, which will discuss using data to improve access to behavioral health follow-up care. You can also register for this webinar on the Medicaid.gov URL on this page. Next slide, please.

Finally, the Affinity Group Fact Sheet and Expression of Interest form are available on the Medicaid.gov link on this page. We encourage you to use the Google form to submit your responses but also have a PDF that you can use if needed. Please submit your Expression of Interest form by Thursday, July 15, at 8:00 p.m. Eastern Time. Next slide, please.

We want to thank you again for attending today's webinar. Please complete the post-event evaluation as you exit. Again, if you have any questions or if we didn't have time to get to your question, please email us at MACQualityImprovement@mathematica-mpr.com.

With that we will conclude today's webinar. Have a great rest of your day.