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# Using Data to Improve Access to Behavioral Health Follow-up Care

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### Mira Wang:

We want to welcome you to today's webinar, which will focus on using data to improve access to Behavioral Health Follow-up Care. Before we begin, we wanted to cover a few housekeeping items. Next slide please.

So, 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 on the bottom right corner of your screen. Please select 'Host' in the drop-down 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 at the bottom right corner of your screen. If you'd like to submit a question, please select All Panelists in the drop-down menu and click 'Send' to submit your question or comments. We will monitor the Q&A window throughout today's webinar, and we'll 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 have the floor.

### Michaela Vine:

Thank you, Mira, and welcome again to today's webinar. My name is Michaela Vine and I'm a Senior Health Researcher at Mathematica. I'm going to run quickly through today's agenda before turning it over to Kamila Stanisch for a welcome from CMS.

We'll then hear from two state presenters. First, Mary Shelton and Rebecca Robinson will speak about Tennessee's use of Care Coordination Tool to improve timely access to behavioral health follow-up care. Next, Michele Robison and David Kelly will discuss Pennsylvania's initiatives to improve the state's emergency department seven-day follow-up rate for treatment of opioid use disorder.

We'll leave some time after the state presentations for questions and answers from attendees, and then Mira will wrap up our webinar with a few announcements about the learning collaborative. Next slide please.

Now, I'd like to turn it over to Kamila for a welcome from CMS.

Kamila Stanisch:
Thank you, Michaela. Hello, everyone. I'm very pleased to welcome you to the third webinar in the Improving Behavioral Health Care Follow-up 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 and other state agencies, health plans and providers to drive measurable improvement in quality of care and health outcomes for Medicaid and CHIP beneficiaries. Next slide.

Over the course of this webinar series, and through the affinity group, we hope to provide state Medicaid and CHIP agencies and their partners in behavioral health with the information, state examples, technical assistance support, and the tools you need to expand your understanding of data driven interventions to improve timely and appropriate follow-up care. Through the affinity group opportunity, states will develop, implement, and assess quality improvement projects, network with, learn from and teach peers, and advance your knowledge of quality improvement approaches and skills. Next slide please.

On this slide is an overview of the learning collaborative activities. Webinar 1 was held in May and focused on expanding and ensuring access to behavioral health services. Webinar 2 was held in June and featured state presentations on value-based purchasing arrangements for behavioral health and peer support and care management. We also held an information session about the affinity group opportunity. The recordings of the past webinars are available on Medicaid.gov if you missed it or you want to go back and revisit the content. Finally, for states interested in developing and implementing data driven quality improvement projects focused on improving behavioral health follow-up care, the affinity group expression of interest forms are due today. Now, I'll hand it back to Michaela.

Michaela Vine:
Thank you, Kamila. Next up we have Mary Shelton and Rebecca Robinson from Tennessee's Division of TennCare. Next slide, please.

Mary and Rebecca. The floor is now yours.

Mary Shelton:
Wonderful. Great. Hi, everyone. Good afternoon. I'm Mary Shelton, the Director of Behavioral Health Operations with the division of TennCare and Becca.

Rebecca Robinson:
Hi everybody, good afternoon. My name is Rebecca Robinson. I'm the Director of Primary Care Quality at TennCare.

Mary Shelton:
Right, next slide please.

Up first, a brief overview of TennCare. TennCare is Tennessee's Medicaid program, which provides health insurance coverage to around 1.5 million low-income Tennesseans, and that includes 20% of the state's adult population and 50% of the state's children. TennCare is 100% managed care. We have three statewide Managed Care Organizations and we also refer to them as MCOs. They are Amerigroup, United Healthcare and BlueCare of Tennessee. TennCare has operated under an 1115 waiver since 1994. TennCare is fully integrated, which includes the coverage of physical health, behavioral health, long term services and supports and children. This includes children in state custody. Next slide, please.

Kicking us off here with the delivery system transformation, TennCare designed and launched two care coordination programs in late 2016, early 2017. This was part of the larger delivery system Transformation Program at TennCare. Integration and collaboration are the guiding principles within the TennCare program. As our MCOs are fully integrated, we wanted to work towards a provider-level care coordination model, where we could promote primary care and behavioral health collaboration integration. The goals here being to improve outreach to TennCare members and also improving their health outcomes. A couple of other abbreviations: for the Patient-Centered Medical Home, you may hear Becca and I say PCMH, and for Tennessee Health Link, THL.

These are the two programs that we're talking about today. Patient-Centered Medical Home has a holistic approach towards care coordination for all patients, and Tennessee Health Link is a care coordination focus specifically on the highest need behavioral health patients. The key principles here, ensure access to a range of physical and behavioral health related supports aligned with the level of need; foster joint decision making across health providers, instill awareness of the interaction and behavioral and physical health needs, expected sources of value including appropriateness of care setting, choice of behavioral healthcare providers, referrals to the high value providers and medical management, improved access to patient specific information, and increased resources and training to support optimal patient care.

For PCMH, there are over 400 locations serving over 40% of the TennCare members, and for THL, there are 19 community mental health centers providing services that serves approximately 70,000 TennCare members. There is an overlap of members being in both the PCMH and the THL program. With the overall goal of the delivery system transformation to help the provider level care coordination, care coordinators from the PCMH and the THL programs, better meet the needs of the TennCare members, we knew that there were gaps in care, and that the providers wanted to ensure the members were getting the services. We needed a product that would solve for this. While designing these in-person care coordination programs, a third care coordination model was being designed via a web portal, which would allow for better communication to the providers about the members gaps in care, hospital admissions, diagnosis, medications and et cetera.

The purpose is a mass communicator for providers in the THL and PCMH programs. The overall catalyst of designing the care coordination tool was ensuring that there was a communication mechanism that the PCMH and THL providers could access. This information sets the foundation for the care coordination tool, and then Becca will now review the function and impact of the care coordination tool. Next slide please.

### Rebecca Robinson:

Thank you so much Mary. As we already mentioned, our care coordination tool is a large part of our delivery system transformation for our Tennessee Health Link and PCMH providers. This care coordination tool provides actionable, near-real-time information in a secure online portal to providers participating in those programs. Not only do our providers, such as primary care physicians or behavioral health providers, have access to this tool, but also our managed care organizations are users and they can log into this tool and receive information, as well as our state users at the Medicaid level. We also have a third program that utilizes a tool called our medication therapy management. We're not going to focus as much on that, but I do want to let you know that they also are involved in this tool as well.

The primary functions of our care coordination tool include allowing organizations to view their full attributed member panel across all of the MCOs in which they're contracted with, alerting providers of their attributed members hospital admission, discharge and transfer of from hospitals, identifying the providers' attributed members risk score, generating and displaying gaps in care linked to the HEDIS quality measures, and also some of our own TennCare custom measures, or the PCMH and THL program, because both of these programs are value-based programs. This allows our users to see the gaps in care for the specific quality measures, and then do outreach and care planning for those specific members who are in need of care.

Then, managing high risk members medications related to chronic conditions through the MTM program, the Medication Therapy Management Program. This visual here is just to show kind of our different data sources, which I'm going to talk a little bit about in the next slide, but you can see here that we do have hospitals submitting ADT feeds. We have claims and attribution data coming from our payers, our managed care organizations, that all flows into eventually to the State Medicaid Office, and then we transmit that or share that with our Care Coordination Tool center. Next slide, please.

There are several data feeds, like I said that support the CCT. Our MCOs are responsible for submitting attribution files on a weekly basis, and those attribution rules are determined based on our program guidelines that we have created and were created at the inception of the program back in 2017. We've modified those files, especially over the past year and a half, to make them more accurate, to make them provide better data that can be seen in the tool. This is especially helpful for our THL providers, just because there's these different statuses that are going into those numbers. So, the THL users are better able to see what status that number falls into.

We use a lot of claims to judge the quality measures and gaps in care and the CCT calculates and displays all of the state approved PCMH and THL HEDIS quality measures, including diabetes screening, well-child visits, child immunizations, high blood pressure, and many more. The ability to view the count of members with care gaps and the total number of members that are up to date on care milestones is really helpful to our organization. Again, getting the real time feed is really nice, and to be able to have up-to-date information on quality and gaps in care. Our tool also uses, we're bringing them up somewhere with the CDPS plus Rx or chronic illness and disability payment system to apply risk scores to our attributed population. We use this for both PCMH and THL program.

Our managed care organizations also use this as they're implementing the program, providing reports, et cetera, and then our care coordination tool vendor also uses this to show a risk score within the care coordination tool. One of the most impactful areas of the tool is the admission discharge and transfer fees. Anytime we talk with our users and try and get feedback on the tool, the ADT portion of the tool is just always something that everyone is very excited about and they use on a daily basis. So, TennCare partners with our Tennessee Hospital Association. We require all of our hospitals to submit real time data from those hospitals and emergency rooms and right now, we have 100% of Tennessee's fiscal and behavioral health hospitals submitted data. It's allowed our providers and our programs taking back the necessary outreach, following those hospital events. Again, this has just been a very impactful part of our tool, we get really great feedback on this from our users. It really allows them to outreach their population in a way that wasn't available to many of them before they had access to the care coordination tool.

Although we do capture immunization information via claim with our new tool, we made the decision to work with our Department of Health to incorporate data from our Tennessee vaccine information system for kids under age two and also those ages nine to 13. Those age ranges as you may know correspond to childhood and the HEDIS measures for childhood immunizations and Allison immunizations and those are those are two quality measures that are used for our program. This is just a good overview, like I said, of the different types of data coming into the tool, how it is used by our users, our providers in those program and again, we've gotten really great feedback, of course. Next slide.

I want to take a second and talk to you guys a little bit about some of our lessons that we've learned. We've already done two versions of the tool, and we're on our second version of the tool. So, I mentioned in my previous slide, I said new tool and it is still somewhat new to us, in 2017 started with a CCT vendor and after a couple of years, we realized that we could improve this platform and we could make it better for our users. We decided that in order to do that, it was best to move to a new vendor. So, 2019 was really spent deciding on a vendor and working with our contractors to execute that.

Some important things that we wanted in that vendor and things that we had learned from our first iteration of the care coordination tools, that we needed someone that had certification through the NCQA for further HEDIS platform. We wanted something that had a little more analytic capability. We also wanted to continue to build upon the success of our ADT and have a better interface with that information, so providing more data points if possible, and allowing the CCT users to really engage with that information. I will be very honest with you that designing and implementing the care coordination tool is not an easy task. We decided on the vendor right at the end of 2019 and we met with this new vendor, January or February in 2020, and got ready to kick off this whole project and then COVID hit.

Like everyone else, we had to make the shift to virtual. It was definitely a tall order to design and implement this tool, do everything virtually, and I think that's something that we're really proud of is that we were able to design and implement this new CCT in about nine months. We went live with our new version in Q4 of 2020 and so far, so good. We've gotten really good feedback from our users. There were several things though that helped us to be successful. One of those is really understanding what we needed for this platform in order for our users to be successful and to really use this tool to impact care outcomes for our members. We wanted to make sure at the start as a foundation that all parties that were involved really had a clear understanding of what our goal was in the end. We held numerous requirements gathering sessions and these were really helpful again, to set that foundation as well.

One thing that probably could have been done a little bit better, is if it had more actual design sessions with other vendors, so that we could see what these requirements were going to look like in the end. We had multiple teams working on this project. We had internal teams from TennCare from the State Medicaid office, the vendor obviously had multiple teams, and we had various contractors that work with Medicaid here in Tennessee that assisted. All in all, I would say at any point in time, there were probably around 40 people on this project at least.

So, as we got closer to go live with this new tool, we also knew that a really strong user engagement strategy was going to be necessary. Early on, we laid out a whole training plan that would cover the next 12 months once we went live with this tool. Early on we also utilize super users from our PCMH and THL organizations to give us input on the design and implementation process. They sat in on UAT sessions as well, so all of that has been really helpful as we've launched this tool, and our users, I think have had really smooth transition to the new tool.

We have continued to get feedback too. We wanted to make sure that we were taking the feedback from our users and doing something with that information. After about three to four months after we launched, we actually launched a survey and held feedback back sessions. Instead of waiting a year and letting this tool run for a year, we jumped out into getting feedback from our users to say, “what's working for you what's not?”

I can honestly say that maybe a month after we launched, we've already restarted enhancements and fixes, working to take those things that were identified by our users, by our internal teams, and working with our vendor to make it better. And we will continue to do that. We've just been very meticulous about capturing feedback and using that to improve the tool. Next slide, please.

A few quick notes on future plans, and Mary I think you're going to jump in here as well, as I mentioned we are going to continue to improve based on our feedback. Mary, I'll let you take the next one here.

### Mary Shelton:

Yeah, sure. We're looking at possibly integrating assessments into the care coordination tool. We're looking at various assessments that maybe would be helpful to the program; if all of the THL providers completed those assessments on the members, having it in the care coordination tool would of course be useful and convenient, and they wouldn't have to have it necessarily in their EHR. Having the assessment within the care coordination tool, then TennCare and the managed care organizations could pull the aggregated data and also have access to the assessment information. We're working with the care coordination tool vendor right now to see what the possibilities are.

Another possible future plan is expanding the care coordination tool to additional TennCare member populations or programs. TennCare runs a couple of other programs with a care coordination component. One of those is our medication assisted treatment program, both for buprenorphine and methadone, and within those programs, care coordination is required. We are looking at the possible expansion, of course we need to also look at what's allowable under 42 CFR Part Two, and if those providers could have access to the care coordination tool, it would be a lot of the same information that, of course, the PCMH and THL programs have and even more member overlap between PCMH, THL, and then the medication assisted treatment. Again, we're just building the layers of which care coordinators have access to this information. Becca, turning it back over to you.

### Rebecca Robinson:

Sure. The last thing here in terms of future plans is we really are continuing to work on how we have better data integration across our delivery systems and information programs, and how do we make receiving that data and interpreting and analyzing that data for our providers easier. We know that there's a lot of crossover and overlap between our THL and our PCMH, as well as our episodes of care program. So, thinking about how do we incorporate that and how do we make that a more streamlined process for our users within the care coordination tool is something that we're also thinking about as well. Next slide.

This is our contact information to share with you, if you have any questions or want to reach out. I will just mention that if you Google or go to TennCare, CCT, there are a lot of videos, there are a lot of quick reference guides and information about the care

coordination tool. You can watch those videos, anyone can watch those videos, and you can kind of get an idea of what the tool looks like. Thank you.

Michaela Vine:
Thank you very much, Mary and Rebecca. As I mentioned at the top, we're going to hold off on answering questions from audience members until both of the state presentations have wrapped up but please feel free to use the Q&A function at the bottom right of your WebEx window to send questions to our team if you have any. Next slide, please.

Next up we have Michele Robison and Dr. David Kelly from Pennsylvania's Department of Human Services Office of Medical Assistance Programs. The floor is now yours.

David Kelly:
Thank you so much and I want to thank Mathematica and CMS for the opportunity to share a program that we developed. I'm Dr. David Kelly. I'm the Chief Medical Officer for the Office of Medical Assistance Programs, which is Pennsylvania Medicaid. Michele, do you want to introduce yourself?

Michele Robison:
Good afternoon. I'm Michele Robison. I am the Director of Quality and Special Needs for the Office of Medical Assistance Programs.

David Kelly:
Thanks, Michele. Next slide, please.

This is just a very brief overview of Pennsylvania Medicaid. Department Human Services administers our program that serves over three million individuals, 1.1 million children and we pay for over 45,000 deliveries per year. We're a Mandatory Managed Care Program HealthChoices, which is for children under 21 and adults under 65. We're also a carved-out state; we have five behavioral health managed care organizations and we have eight physical health managed care organizations. We expanded Medicaid starting in 2015, and since then, we now have enrolled over 900,000 as of June of 2021. Next slide, please.

The program that Michele and I are going to describe really was driven by the opioid crisis. Pennsylvania is one of those states that quite honestly, this has been extremely problematic, our death rates have been extremely high, and this is a very complex problem. In 2018, our Governor Tom Wolf actually issued an opioid disaster declaration in January 2018. That allowed us to do several things, we formed an opioid command center that consisted of 14 state agencies actually working together and we had put together several programs prior to 2018.

One of them was our Centers of Excellence Program that we'll maybe get to a little bit later, but one of the things that we also started to see from our Medicaid data was an individuals with opiate use disorder were repeatedly coming into the emergency

department for opioid related events. They were repeatedly coming in and they really weren't getting any good follow-up and less than 30% actually initiated any form of treatment after an ED visit. We actually did some analytics to look at that that's increased use of the emergency room really was a possible risk factor for overdose death.

We started the emergency department to open use warm handoff incentive program in 2018. The whole premise of this program was for the department to work with our health system and Hospital Association partners, and all of our EDs across the Commonwealth of Pennsylvania, to really build infrastructure and to incent them to really make sure that individuals coming into the emergency room were getting necessary treatment, but were also then being either initiated into treatment right there in the emergency room or they were being sent to outpatient or inpatient, the appropriate levels of care within seven days of an emergency department visit. Next slide.

I'm going to turn this over to Michele to describe some of the key tenants of the program. Michele.

### Michele Robison:

In the first year of our initiative, the focus was on health systems development of the warm handoff pathways. The Department of Human Services funded $35 million for the health systems to develop up to four warm handoff pathways, for OUD treatment within seven days of emergency department visit. The number of pathways developed was left up to each health system, once the health system determine which pathways they were going to develop, they needed to have them operation by spring of 2019. Another thing is the number of warm handoff pathways the health system developed determine their incentive payment. The greater number of pathways develop the higher incentive payment earned. Next slide.

As I mentioned in the previous slide, health systems can develop up to four warm handoff pathways, the pathways the health systems could choose from were ED initiation of buprenorphine with a warm handoff to the community. Direct warm handoff from medication assisted treatments or abstinence-based treatment and established a specialized protocol to address pregnant women with opioid use disorder and or establish direct inpatient emission pathways for methadone or observation for buprenorphine inductions. Next slide.

So, the results of the first year were very encouraged. We had 120 Hospital EDs participate in the program. The hospital emergency departments that participated were large size affiliated with other hospitals in the Health Network located in areas with high overdose rates and were mostly located in central or western Pennsylvania. The warm handoff pathways that were implemented by the hospital ED departments were 92 initiated buprenorphine in the ED with the warm handoff to the community. An example of one of these warm handoffs is to our opioid use disorder centers of excellence, as Dr. Kelly mentioned earlier and we'll touch on later. 120 of the hospital EDs implemented

direct warm handoff for MAT are abstinence-based treatment. 114 develop specialized protocols for pregnant women with OUD and 92 implemented observation or acute inpatient stay for initiation of buprenorphine or methadone. Overall, 77 Health Systems implemented all for warm handoff pathways. In addition, if you'd like to see a complete list of the participating hospitals and which pathways they tested to, you can click on the link at the top of the page. Next slide.

In the second year of the emergency department opioid use disorder warm handoff incentive program, we added a performance measure follow-up treatment after emergency department visit with opioid use disorder within seven days of discharge. The hospital emergency departments were evaluated for initiating treatment of OUD within seven days using claims data for 2018 versus 2019. Again, we funded 35 million incentive dollars to health systems who met target targeted benchmarks and or demonstrated incremental improvement. Next slide.

This slide demonstrates the incentive payment timeline. In January of 2019, the health systems emergency departments began operating the warm handoff pathways and had to attest to implementing them in early spring 2019, which the department validated in late spring 2019. I just like to mention again the number of hospitals that did implement at least one warm handoff pathway was 120 and 77 hospitals have developed all four warm handoff pathways. Payment for implementing the warm handoff pathways was made in July of 2019. In the second half of 2019 and early 2020, we started analyzing the seven-day follow-up for opioid use disorder treatment data and calculated each health systems rates and incentive payout which be paid in October of 2020. Next slide please.

The results of the incentive payout for the follow-up treatment for ED, for OUD within seven days of discharge, so the hospital's performance is measures based on rates of health choices members with the seven day follow-up treatment. The denominator is the number of any health choices member at the ED for opioid use disorder and the numerator consists of any member counted in the denominator seen for OUD treatment within seven days of discharge from the emergency department. Each hospital emergency department has the opportunity to earn an incentive and incremental improvement incentive.

The incremental improvement incentive pieces, the hospital must have at least a 0.5 percentage point increase from 2018 to 2019. The greater the incentive, the greater the incremental improvement, the greater the incentive payout was. So, if a hospital had a 0.5, greater than 0.5 and less than one percentage point improvement, they earn 70% of the value and if they were greater than three percentage point improvement, there was 100% payout. I like to note is that the average improvement rate was 3.4% and that this rate varied from health systems and that we had some health system that had actually decreased their rates where other health systems had double digit increases. Overall, 93 hospitals did receive an incentive payout. For the benchmark achievement piece of it, we came up with a benchmark and depending if the hospital emergency

department met that benchmark, they received an incentive payout and we had approximately 100 hospitals receive an incentive payout. Next slide, please.

This slide is showing the statewide rate for follow-up treatment after emergency department visits for OUD within seven days of discharge. In 2018, 5,068 out of 14,439 individuals, which is 35.1% initiated treatment for opioid use disorder within seven days. In 2019, the numbers increased to 5,840 out of 15,157 individuals and this equated to 38.5% initiated treatment within seven days. Overall, this was a 3.4 percentage point improvement, and then overall, the 79 hospitals showed an improvement of greater than 3%, while we had 62 Hospital EDs showing an improvement of greater than 5.0%. Next slide.

I'm going to turn it back over to Dr. Kelly and he can finish up here just dusting a little bit over the timeline of how our rates have improved.

### David Kelly:

Thanks, Michele, and just see in the slide here, we were able to over time improve our rates. I'll point out that in 2015, we saw a huge denominator increase in our Medicaid population because of expansion. We actually saw a huge denominator increase in 2016 and part of what we did was we put in place also a Centers of Excellence Program, a hub and spoke outpatient treatment program, 45 of them across the state to really help address this increased demand and increase need, but over time, as you can see, we've been able to increase that follow-up after emergency department utilization or visit for opiate use disorder. Next slide.

In summary, we had overall improvement in seven-day follow-up and actually had a fairly high participation by the hospital health systems in these pathways. There were some of the smaller, more rural hospitals that were a bit more challenged, but again, we really wanted to develop this program to develop that, that infrastructure. One of the interesting things about this program is we went from hardly any emergency department physicians being engaged in prescribing buprenorphine to, you saw the number of those that attested, to actually developing a program or buprenorphine is now being prescribed.

So, we saw this paradigm shift, we saw a reduction in stigma, and we attributed some of that to this program. When we talked to some of the clinical leaders that had these emergency departments, they were elated that, we put the program together they could go to their CFOs and say, we really need to step up to the plate. This is our obligation to address the opioid crisis here in Pennsylvania. Also, there was a learning network that was developed with some funding from the Bloomberg foundation. There's actually an ongoing learning network that the EDs and health systems participate in on a regular basis to share best practices and to really talk about challenges as well. The other thing is, I want to tie this into the adult core measures and the measures that we developed really does feed into the three measures here that are listed, and I'm not going to go into

the nuances of each of these measures, but part of what we wanted to also do is to actually as a program be able to improve in these adult core metrics.

I mentioned our Centers of Excellence Program. We actually are in the process; we have expanded it starting in 2021. We now have, I think over 200 clinical sites, there are still about 50 entities, but we've been able to expand the clinical sites significantly and again, this is a hub and spoke model where we are paying care management monthly fee for care management to occur. Again, this really provided an opportunity for the EDs to have a high-quality high fidelity set of providers to refer to as folks were leaving the emergency department. We're going to have some ongoing analysis. Again, we'll be looking at the 2019 results versus calendar 2020 and we'll have those results in the fall. We'll be making some additional payouts sometime this fall. Some of the challenges and barriers again, initially, especially early on there were still some challenges with prescribing buprenorphine in the emergency department.

I think all of us had been affected by the COVID pandemic and some of those challenges to entering into care and coming into the emergency department and getting appropriate follow-up and in an outpatient setting. So, one of the things that we did was we expanded our telemedicine capabilities during the COVID public health emergency so that that individuals could continue their treatment via telemedicine as needed. Again, those are just some of the challenges and barriers that we've had to face. We'll see what the results show for 2020, but we're very excited about this program and we feel that thus far, it's been successful. The buy in from the provider community has been very, very positive and we really feel strongly that we can get individuals suffering from OUD and to initiate treatment. There's potential there to move them towards recovery, as well as save lives. So, I think next slide.

I think that's the end of our slides and just want to thank CMCS and Mathematica for allowing us to share our program with you. We'll turn it back over to Michaela or Mira at Mathematica.

### Michaela Vine:

Thank you very much, Dr. Kelly and Michelle for your presentation and to all the state panelists today. At this point, we're going to open the floor up for questions. As a reminder, to submit a question, please type it into the Q&A box at the bottom right of your WebEx window and then select ‘All Panelists’ in the drop down. 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 that we have today.

So, the first question that we have is for our Tennessee panelists, which is did TennCare have experience with the care coordination tool prior to the launch of the Patient Centered Medical Home and Tennessee Health Link program?

### Mary Shelton:

Hey, this is Mary, I'll start off. The short answer is no, we didn't. This was something brand new that we took on as we were designing the PCMH and THL program. So, we

talked with several vendors at the onset, but during the procurement of a vendor and we're really wild about oh, my goodness, cannot believe that we will be able to access that type of information, and as Becca said, in her presentation, I mean, asking a lot of questions and working closely with the vendor is key. So, yes, no experience.

Michaela Vine:
Thank you. So, now we have a question for Pennsylvania, which is can you tell us a little bit about how this program is funded and who has paid the health systems?

David Kelly:
Sure, thank you. This is actually funded through a hospital assessment that the state of Pennsylvania puts on hospitals. So, that's the funding mechanism. Thus, we had to work very closely with our hospital and health care system association to collaboratively develop the program and then this was actually a directed payment. Once we got the results and figured out the dollars, we actually did a directed payment through our managed care plans to specific hospitals and again, the directed payment was approved by CMS. I know that's sounds like a lot of complicated steps, but that's how we funded this program and that's how we paid the hospitals.

Michaela Vine:
Thank you, Dr. Kelly. We'll move back over to Tennessee now. We have another question for you, which is can you talk a little bit about TennCare is using or plans to use the care coordination platform to improve access to follow-up care for members with behavioral health conditions?

Mary Shelton:
And…

Rebecca Robinson:
I'm sorry, go ahead. No, Mary, you can jump in.

Michaela Vine:
No, go ahead, go ahead.

Rebecca Robinson:
I was just going to say I mean; I think that's exactly for the most part, a lot of the follow-up that's being done. Again, we do have behavioral health hospitals submitting ADT data and so there is some follow-up already being done using the tool. Then Mary, I don't know if you want to add to that.

Mary Shelton:
Not much that except we're looking, like I said, in the future plans, possibly adding the assessment, and then building in other programs. I don't know if that's answering the question or not, but that's what we have on the horizon.

Michaela Vine:
Yeah, no, I think that's, that's really helpful. Thank you, and while we have you unmuted, we'll ask another question, which is, what barriers, if any, did you experience in using the care coordination platform and how did you overcome any opposition to it? Then also, how you've differentiated documentation between the EHR and the care coordination platform? So, I guess, two questions there really.

Rebecca Robinson:
Yeah. And I can start on this one as well. And Mary, feel free to add in or chime in too. So, bigger challenges. I think the first tool, a large amount of our challenge had to deal with quality measure data, and again, that's why we really focused in on having a vendor that had certification through NCQA for HEDIS, because it was a very difficult process. Our quality measures were just not showing correctly in that first version of the tool, and actually weren't able to be used and that was really frustrating for our users. So, we lost a lot of trust in that time. I would think that that was probably the biggest barrier, using that first tool, moving to the second tool, is regaining the trust of our users, because of the poor quality of data for our quality measures in that first tool. We really wanted to make sure that the users could trust the data in this new tool, could rely on it, use it to do outreach.

With regards to EHR and CCT, honestly, that can be considered a challenge as well, right now the two do not talk. Right. So, there's no interface between that EHR and the Care Coordination Tool and we do get requests, and have talked to several organizations, and this is something that they would love to have, just so that they are not having to input data in multiple platforms. We're just not there yet and hopefully, that could be something that we add to one of our future plans.

Michaela Vine:
Great, thank you, Becca. Okay. So, I will turn it back over now to Pennsylvania and we have a question for you, which is, what services are captured in claims data that reflect actual follow-up for opioid use disorder treatment?

David Kelly:
Thanks. So, the type of claims that we look at and again, we get claims from both our physical health plans and our behavioral health plans, we’re actually able to look at all levels of care associated with opiate use disorder treatment, from intensive inpatient all the way through partial to outpatient treatments, so all of the ACM levels of care. We actually built logic to look at those provider types and then look at claims that would be associated with OUD care. We also pay for methadone clinics and so we also included from an MAT standpoint, the methadone clinic claims, and then we also from a pharmacy standpoint, on the physical health side, we also included buprenorphine and naltrexone. All forms of buprenorphine. So, we were trying to look at from both provider base and from a pharmacy-based standpoint to look at the claims and counters. So, we tried to have a very comprehensive look in how individuals were being followed up.

Michaela Vine:
Thank you, Dr. Kelly. We have a couple more minutes, I think. So, we did have one question for Tennessee, which was if you could provide the link to the website with additional information that you mentioned.

Rebecca Robinson:
Absolutely. Can I enter that into the chat to everyone? Would that work?

Michaela Vine:
Yes.

Rebecca Robinson:
Okay, perfect. I can do that right now.

Michaela Vine:
Yep and the links will also be in the slide deck that will be posted on medicaid.gov in the next week or so. Then Tennessee, we have one other question for you, which is since you've collected consumer information on the care coordination tool, can you talk a little bit about how it's been received and what percentage of consumers have liked the tool?

Rebecca Robinson:
I don’t think I have an exact percentage on who liked the tool. So, I surveyed with now and we had fairly good response after that first survey that was submitted. What I can say without having it right here in front of me, what I can say is that majority of the feedback that we received on that survey was positive. Then to second that, a lot of the requests or concerns with the tool that were included on that survey were things that maybe were already included in the current work plan to enhance or fix over the next six months or so. Does that answer the question or Mary, do you have anything to add to that?

Mary Shelton:
I don't. I heard consumer, and I just wanted to, maybe I was misinterpreted; it's only used for by the providers, not our TennCare members. Just wanted to clarify.

Michaela Vine:
Thank you for clarifying, that's great. All right. Well, thank you so much. I think that's about all the time that we have for questions today. We apologize if we weren't able to get to one of your questions and if you do have a question that you didn't have time to ask or we didn't have time to answer please feel free to submit it to the QI TA mailbox at MACQualityImprovement@mathematica-mpr.com and we will put that link in the chat as well. So, I'm going to turn it back over to Mira now for a couple of announcements before we wrap up today's event. Next slide.

Mira Wang:
Thanks, Michaela. Next slide, please.

We'll post the webinar recording and slides from today's webinar on medicaid.gov at the link on the slide.

We've also posted the affinity group factsheet and expression of interest form 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 you can use if you need to.

Please submit your expression of interest form by tonight at 8:00 p.m. Eastern, and again, we just want to emphasize that if you'd like to join the learning collaborative and focus on improving behavioral health follow-up care, please complete the expression of interest form that we have linked on this page. If you need additional time to complete the form, please let us know through the MACQualityImprovement mailbox. Next slide please.

Thank you so much 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 can conclude today's webinar. Hope you have a great rest of your day.