Medicaid Expansion and the Role of Psychiatrists in Public Mental Health

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Discussion Points

• Medicaid expansion overview - structure, timeline, and impact for uninsured North Carolinians

• Anticipated behavioral health and physical health outcomes for individuals in expansion population

• Collaborative and Integrated care for the Medicaid Member

• Call to Action - Opportunities for psychiatrists to support and improve health of North Carolinians in expansion population
At last, at last.
Over 600,000 North Carolinians will gain access to health coverage through Medicaid, including:

- ~300,000 who currently get only the Family Planning benefit

- ~100,000 beneficiaries who could lose full Medicaid coverage over the next year during recertification in absence of expansion

- ~200,000 eligible people not currently enrolled in Medicaid statewide

You must be a North Carolina resident and a legally residing citizen for at least 5 years. Non-citizens may receive emergency services.
Continuous Coverage Unwinding Timeline

Local Departments of Social Services have been completing recertifications throughout the PHE, however, coverage has not been terminated or reduced.
# NC Medicaid Renewals

## Overview of NC Medicaid Renewals (Recertifications) Due June 30, 2023 through May 31, 2024

<table>
<thead>
<tr>
<th>Approximate Statewide Total Due for Renewal</th>
<th>Total Statewide Renewal Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,588,882 Individuals</td>
<td>1,807,949 Not Started</td>
</tr>
<tr>
<td></td>
<td>780,933 Initiated</td>
</tr>
<tr>
<td></td>
<td>484,125 Complete</td>
</tr>
</tbody>
</table>

Medicaid renewal (recertification) is the way a beneficiary’s information is reviewed to make sure they are still eligible for Medicaid health coverage. It takes place every 6 or 12 months based on the Medicaid program.

## Monthly Renewals and Outcomes

### Renewals: Beneficiaries with an Initiated Renewal*

<table>
<thead>
<tr>
<th>Month</th>
<th>Initiations</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2023</td>
<td>134,292</td>
</tr>
<tr>
<td>May 2023</td>
<td>125,702</td>
</tr>
<tr>
<td>June 2023</td>
<td>172,976</td>
</tr>
<tr>
<td>July 2023</td>
<td>165,525</td>
</tr>
<tr>
<td>August 2023</td>
<td>182,438</td>
</tr>
</tbody>
</table>

*A renewal is considered "initiated" when a caseworker or the eligibility system begins processing the recertification. This process begins approximately 90 days prior to the end of the Medicaid certification period (last day of their 6 or 12 month eligibility period).

## Outcomes: Renewal Results as of the Last Day of Each Month

<table>
<thead>
<tr>
<th>Description</th>
<th>June 2023</th>
<th>July 2023</th>
<th>August 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Renewed and Retained in Medicaid*</td>
<td>137,896</td>
<td>124,296</td>
<td>122,008</td>
</tr>
<tr>
<td>Total Renewed Ex Parte</td>
<td>138,846</td>
<td>123,502</td>
<td>121,282</td>
</tr>
<tr>
<td>Total Renewed Using Renewal Form</td>
<td>1,050</td>
<td>794</td>
<td>726</td>
</tr>
<tr>
<td>Total Determined Ineligible for Medicaid**</td>
<td>5,053</td>
<td>3,584</td>
<td>3,980</td>
</tr>
<tr>
<td>Total Coverage Ended for Procedural Reasons***</td>
<td>30,046</td>
<td>29,716</td>
<td>27,546</td>
</tr>
</tbody>
</table>
## Top Reasons for Terminations

<table>
<thead>
<tr>
<th>Reason</th>
<th>Total Losing Coverage</th>
<th>% Beneficiaries Losing Coverage</th>
<th>Procedural/Categorical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to provide requested information/apply for all benefits</td>
<td>32,472</td>
<td>66%</td>
<td>Procedural</td>
</tr>
<tr>
<td>Change in Income/Resources</td>
<td>3,574</td>
<td>7%</td>
<td>Categorical</td>
</tr>
<tr>
<td>Out of State</td>
<td>4,899</td>
<td>10%</td>
<td>Categorical</td>
</tr>
<tr>
<td>Deceased</td>
<td>2,352</td>
<td>5%</td>
<td>Categorical</td>
</tr>
<tr>
<td>Asked that Medicaid be stopped</td>
<td>1,590</td>
<td>3%</td>
<td>Categorical</td>
</tr>
<tr>
<td>Unable to locate beneficiary</td>
<td>942</td>
<td>2%</td>
<td>Procedural</td>
</tr>
<tr>
<td>Other</td>
<td>3,449</td>
<td>7%</td>
<td>Categorical</td>
</tr>
<tr>
<td>Total</td>
<td>49,728</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

https://medicaid.ncdhhs.gov/federally-required-reports
Our Strategic Goals for Expansion

- **Getting people covered**
  - New applicants and existing beneficiaries who meet eligibility have coverage for full Medicaid benefits

- **Getting people care**
  - Eligible beneficiaries can successfully receive care
  - Providers are prepared to provide services and receive payment

- **Supporting our partners**
  - County and community partners have the tools they need to share key information about expansion and help get people enrolled in coverage
Most adults covered by Medicaid expansion are already working or report potential barriers to work


NCDHHS | Dr. Brown & Dr. Dowler: Medicaid Expansion and the Role of Psychiatrists in Public Mental Health | NCPA September 29, 2023
A higher percentage of people in rural areas who experience health disparities would be eligible for Medicaid expansion.

The data represents all uninsured adults in North Carolina according to the American Community Survey (2019).
Veterans and their Families

• North Carolina has 637,790 veterans.
  o Only 338,5050 of those receive care through the VA.

• Even if a veteran receives health care through the VA, their families may remain uninsured.

• Veterans' uninsurance rate decreased 4.3 percentage points in expansion states.

• Medicaid expansion could help approximately 14,000 additional North Carolina veterans gain health coverage.
North Carolina extends health coverage available to more people including adults 19 through 64 through Medicaid expansion

Examples:
- Single adults ages 19 through 64 who have incomes of approximately $20,000 each year (138% of Federal Poverty Level)
- Parents with low incomes: for a family of 3, an annual income below about $34,000 each year (138% of Federal Poverty Level)
  - Pre-expansion cutoff for parents is about $8,000 each year
- Same ways of getting care as existing Medicaid beneficiaries
- Same comprehensive benefits and copays as other non-disabled adults in Medicaid
Paths to Enrollment

People can enroll now, even if they didn’t qualify in the past

How to apply:

- ePASS
  epass.nc.gov
- Paper application
  ncgov.servicenowservices.com
- In person at your local DSS office
  ncdhhs.gov/localDSS
- Call DSS office
  ncdhhs.gov/localDSS
Benefits of Using ePASS

ePASS is North Carolina’s secure self-service website where you can apply for various benefits, including Medicaid.

Apply from ePASS using a computer or mobile device without having to visit or contact your local DSS.

Update Information Online: Create an enhanced account to report changes, updated your information, and upload documents online. More information on creating an enhanced account can be found here: https://medicaid.ncdhhs.gov/media/12236/download?attachment

Providing all information upfront in ePASS can help eligible applicants get access to their benefits more quickly:

- Applications that are complete require less follow up from a caseworker, which helps alleviate the overall workload and results in quicker processing overall.
- Applications can be approved as quickly as one week using ePASS (as opposed to weeks to months).
American Rescue Plan Act

- Fiscal incentive: 2 years of 5% FMAP boost on base FMAP rate
- Could generate $1.8B in additional revenue
What’s NC DHHS doing about Expansion?

• It’s different than COVID.

• We have a large External Implemental Partners Workgroup (EIPW) with 50+ representative organizations in the state.

• We have 4 DHHS Cross Divisional Workgroups that include our EIPW
  – Health Access Workgroup
    • Looking at unique populations like PLWH, MAT, etc…
  – Data Evaluation Workgroup
    • Creating a public facing dashboard
  – Member Enrollment Workgroup
    • Working on enrollment strategies
  – Communications Workgroup
    • Creating external facing communication materials
National Data on Health Status of Medicaid Expansion Group

• **Members of Medicaid expansion group may have more significant behavioral health needs** and service utilization than other Medicaid enrollees, i.e., the traditional Medicaid population.

• Across states, coverage expansion has been associated with increased prescriptions and hospitalizations for **anxiety, depression, and conduct disorders**, and decreased likelihood that enrollees screen positive for depression.

  • **Minnesota reported higher rates of mental illness, SUD, and homelessness** among members of the expansion population with incomes ≤75% FPL as compared to traditional Medicaid enrollees, in addition to substantial comorbidities among individuals with these conditions.

  • States have not seen new providers enroll in significant numbers with expansion. However, existing providers remain enrolled in Medicaid and may take on new Medicaid patients.

**NC Implications**
Consistent with other states’ experiences, 2021 North Carolina BRFSS survey data indicates uninsured individuals in the State had lower rates of common chronic conditions than insured individuals, but higher rates of behavioral risk factors.

### Co-Occurrence of Homelessness, Substance Use Disorder, and Major Mental Illness Among Very Low-Income Medicaid Expansion Enrollees in Metropolitan Minnesota

- **Major mental illness**: 15%
- **Homelessness**: 11%
- **SUD**: 4%
- **None**: 44%

**NC should consider outreach and support to historically underutilized providers**, recognizing they may play an essential role in ensuring access to primary care.
Medicaid Expansion and Behavioral Health

• Results from 2023 “Medicaid in Montana” Annual Report*:

  - Number of Medicaid expansion enrollees with behavioral health diagnosis increased over time. In 2021, nearly one-third of expansion enrollees had one or more behavioral diagnoses recorded on claim.


  - Medicaid funding for SUD treatment services increased by a factor of five since implementing Medicaid expansion, increasing from $5.1 million in 2016 to more than $24 million in 2021.

*Medicaid in Montana: How Medicaid Impacts Montana's State Budget, Economy, and Health - Montana Healthcare Foundation (mthcf.org)
Medicaid Expansion and Behavioral Health

Montana Medicaid Expansion Enrollees with a Behavioral Health Diagnosis (CY 2016-2021)*

 Montgomery Medicaid Expansion Enrollees with a Behavioral Health Diagnosis (CY 2016-2021)*

*Medicaid in Montana: How Medicaid Impacts Montana’s State Budget, Economy, and Health - Montana Healthcare Foundation (mthcf.org)
Measuring Program Impact: Examples of Public Reporting from Montana

Medicaid expansion increased Montana’s capacity to support the prevention and treatment of substance use disorders.

Behavioral Health Services Delivered in Primary Care Settings

• 70% of primary care appointments for psychological issues, e.g., anxiety, panic, depression and stress.*

• Primary care physicians increasingly addressing patients’ behavioral health concerns.

• 2023 report noted between 2006 and 2018, the number of visits with primary care physicians that managed mental health concerns increased by 50% (~11% of visits to ~16% of visits).**


Psychiatrist Full-Time Equivalents per 10,000 Population, North Carolina, 2017

Psychiatry FTEs per 10,000 Population
(# of counties)

- ≥ 8.49 (2)
- 2.31 to 8.49 (7)
- 1.20 to 2.31 (9)
- 0.41 to 1.20 (44)
- < 0.41 (28)
- No Psychiatrists (10)

Notes: Data include active, licensed physicians in practice in North Carolina as of October 31 of each year who are not residents-in-training and are not employed by the Federal government. Physician data are derived from the North Carolina Medical Board. Population census data and estimates are downloaded from the North Carolina Office of State Budget and Management via NC LINC and are based on US Census data. Physicians with a primary area of practice of Psychiatry include the following: Child & Adolescent Psychiatry, Pediatrics - Psychiatry, Addiction Medicine, Addiction Psychiatry, Forensic Psychiatry, Geriatric Psychiatry, Hypnosis, Internal Medicine - Psychiatry, Psychiatry, Psychiatry - Family Practice, Psychoanalysis, Psychosomatic Medicine. Source: North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
Do you accept Medicaid Patients Now?

• IF SO, WHY……?

• IF NOT, WHY NOT……?
Unknown: Number of Psychiatrists in Public Mental Health Accepting Medicaid in NC

North Carolina Psychiatric Association reports 127 psychiatrists in NC accept some form of insurance - 18% of qualified NCPA members

- 12% report accepting Medicare
- 10% report accepting Medicaid
- .009 or 7 members report cash only

~82% of NCPA members do not report anything. What this means is unknown!

- could take insurance, but did not list it
- could accept self-pay

Out of network rate higher for behavioral health than physical health*

JAMA Psychiatry: Medicaid Acceptance by Psychiatrists Before and After Medicaid Expansion.

Opportunities for Psychiatrists to Support and Improve Health of North Carolinians in Medicaid Population

• Enroll as Medicaid provider

• Adapt and use telehealth to address behavioral health workforce shortages and increase access to care

• Adopt principles and strategies effective in transforming clinical practices for improved healthcare delivery and patient outcomes, e.g., CMS Transforming Clinical Practice Initiative (TCPI)

• Practice culturally competent research and treatments with appropriate treatment recommendations

• Respond to professional and association surveys. More information is needed to effectively advocate and educate.

• Integrate psychiatric care with primary care, including Collaborative Care model
The Roadmap to Promoting Collaborative Care

<table>
<thead>
<tr>
<th>Reimbursement Alignment Across Payors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong> Align coverage, requirements and payment across payors to validate that CoCM is an endorsed model worth adopting and reduce administrative burden for providers.</td>
</tr>
</tbody>
</table>

1. **Ensure Coverage of the Same CoCM Codes**
   - Medicaid added coverage of G2214 (care management in consultation with psychiatric consultant) and G0512 (RHC- and FQHC-specific code for clinical staff time) to align with Medicare
   - BCBS of NC adopted CoCM codes in July 2022

2. **Align Requirements**
   - Medicaid and other insurers aligned with Medicare requirements on who can serve as the behavioral health care manager.

3. **Make Reimbursement Sustainable**
   - Medicaid increased reimbursement for CoCM codes from 70% to 120% of Medicare

4. **Remove Beneficiary Copays**
   - Medicaid and other insurers removed beneficiary copays for CoCM services

<table>
<thead>
<tr>
<th>Promoting Streamlined Operations for Practice Adoption and Ensuring Fidelity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong> Encourage uptake by providing primary care practices with practice resources to make adopting CoCM as easy as possible and ensure that CoCM is implemented to fidelity.</td>
</tr>
</tbody>
</table>

1. **Provide and Fund 1:1 Training For Providers**
   - Medicaid contracted with NC AHEC to provide 1:1 TA and educational modules to practices. NC AHEC has engaged in 850 1:1 encounters with practices and developed 10 online education modules focused on different CoCM issues (e.g., best practices in pediatric care, billing codes, brief therapeutic interventions) that 680 participants have completed.
   - Consortium members have created learning opportunities for their members (e.g., working sessions at annual meetings, peer-to-peer “solutions” sessions for practice managers)

2. **Establish Psychiatry Connections**
   - NCPA identified 20 psychiatrists willing to act as psychiatric consultants.
   - Consortium members developed a model contract for psychiatrists and primary care providers to use.

3. **Customize and Fund a Statewide Registry**
   - Develop a customized registry with a set of assessments for adults, children and adolescents. As of June, have 9 practices using the statewide registry.
   - Medicaid contracted with CCNC to provide Medicaid enrolled providers with free access to the customized state registry ($4K-$7.4K per practice per year) for up to 3 years
Collaborative Care Claims 1/1/19-7/19/23

<table>
<thead>
<tr>
<th></th>
<th>Medicaid Direct</th>
<th>Standard Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>69.9 Per 10K</td>
<td>41.1 Per 10K</td>
</tr>
<tr>
<td>Members: 1,546</td>
<td></td>
<td>Members: 1,525</td>
</tr>
<tr>
<td></td>
<td>46.7 Per 10K</td>
<td></td>
</tr>
<tr>
<td>Members: 1,067</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>22.7 Per 10K</td>
<td></td>
</tr>
<tr>
<td>Members: 1,045</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Pre-MCL
- Post-MCL
CoC Claims per 1K by Race

• Collaborative Care Claims: 1/1/2019-7/19/2023
CoC Volume per 1K by Age Group

• Collaborative Care Claims: 1/1/2019-7/19/2023
Targeting support for delivery of the Collaborative Care model in NC Medicaid AMHs

- NC Medicaid administrative data through 5/24/2023

These maps identify:
1. Whether a practice is delivering Collaborative Care services (triangle=yes; circle=no)
2. The degree to which Medicaid beneficiaries assigned to the AMH need Collaborative Care services (blue=low need; red=high need)
3. The number of beneficiaries assigned to the AMH (relative size of the shape)

**Equity Focus** - Need for Collaborative Care services (shading of shapes on these maps) is measured by the % of the AMH’s assigned beneficiaries that:
1. Have given birth in the prior 12 months
2. Have been diagnosed with anxiety or depression in the prior 12 months
3. Are members of an historically marginalized population
Future Opportunities

Funding Startup Costs

• Adopting CoCM has a startup cost of roughly $30,000 per practice over the first few months. NC has explored opportunities to cover these costs, and some insurers offer capacity-building programs.

Developing a Pipeline for Necessary Workforce

• One of the biggest barriers to implementation is hiring a behavioral health care manager (BHCM).
• Creating a pipeline of BHCM – such as through new education/training programs, virtual vendors and loan repayment – will be a long-term opportunity to encourage adoption of the model.

Engaging New Partners

• While the consortium has been inclusive in its efforts, there are additional partners, like health systems, that have been less engaged thus far and could be important to promoting additional uptake given their reach across the state.

Encouraging Peer-to-Peer Opportunities

• Connecting with peers is one opportunity for practices to troubleshoot challenges in real time, and learning about positive experiences with the model could encourage practices on the fence to adopt CoCM.
## Integrated Care: Key Performance Indicators

<table>
<thead>
<tr>
<th>KPI</th>
<th>Group5</th>
<th>Past</th>
<th>Current4</th>
<th>County Disparities2</th>
<th>Race/Ethnicity3,4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Jan-Mar 2023</td>
<td>Apr-Jun 2023</td>
<td>Apr-June 2023</td>
<td>Apr-June 2023</td>
</tr>
<tr>
<td>1</td>
<td>Primary care visit within 12 months</td>
<td>82.6%</td>
<td>84.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SP</td>
<td>81.5%</td>
<td>82.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Behavioral health emergency department use per 1k members</td>
<td>11.0 per 1k</td>
<td>13.3 per 1k</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SP</td>
<td>1.3 per 1k</td>
<td>1.4 per 1k</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Collaborative Care Claims/Encounters per 1K members</td>
<td>14.3 per 1K</td>
<td>11.2 per 1K</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SP</td>
<td>2.0 per 1K</td>
<td>3.3 per 1K</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Use of psychosocial services in 1st year of medication-assisted treatment for SUD</td>
<td>45.0%</td>
<td>48.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SP</td>
<td>28.6%</td>
<td>29.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Community-based SUD visits that had a PCP visit in the 30 days after</td>
<td>37.8%</td>
<td>35.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SP</td>
<td>72.4%</td>
<td>78.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Metabolic monitoring for children and adolescents on antipsychotics (metabolic testing)</td>
<td>36.2%</td>
<td>37.13%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SP</td>
<td>19.9%</td>
<td>19.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Behavioral health service usage in a PCP setting</td>
<td>*</td>
<td>48.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SP</td>
<td>*</td>
<td>13.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Notes:
1. Current rates:
   - ■ = improving (>10% relative difference from previous quarter)
   - ■ = steady
   - ■ = worsening (>10% relative difference from previous quarter)
2. Maps gradients demonstrate if counties are better (blue) or worse (orange) than the average (white). Numerators smaller than 11 are suppressed.
3. Not all race/ethnicity categories shown.
4. Haw./PI = Native Hawaiian and Other Pacific Islander
5. TP rates are for TP eligible populations.
SHOW ME THE MONEY!
Budget Updates: What did we get?

Behavioral Health Rates

Integrated Care (Collaborative Care, NCPAL)

Workforce Investments (DSP wages, Center of Excellence, DSOHF, loan forgiveness)

Justice (diversion, re-entry, capacity restoration)

Crisis system (mobile, FBC, BHUC, respite, NCSTART, BH SCAN, non-law enforcement transportation)

Child Well-Being (family peers, specialized PRTF, crisis stabilization beds)

I/DD & TBI Supports (Innovations slots, statewide TBI waiver, CIE)

Approximately three-quarters of the Governor’s $1B Behavioral Health Roadmap funded.
Medicaid Reimbursement Rate Increases for Behavioral Health Providers

- **Rate Increase in FY 2022 and/or FY 2023 (27 states + D.C.)**
- **No Rate Increases in 2022 and 2023 (16 states)**

**NOTE:** Rate increases include states with at least one temporary or permanent FFS rate increase to one or more behavioral health provider types in FY22 and/or planned for FY23. Non-response states are colored in grey. TN does not set FFS rates, but indicated an increase in direct payments.

**SOURCE:** Behavioral health supplement to the annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2022 • [PNG](#)
Key Principles for Implementing Rate Increases

• Align with Medicare wherever possible (e.g., outpatient, OTP)
• Bring more uniformity across the state
  • Prioritize increasing rate floors rather than uniform % increases (consistent with approach we have for medical services for PHPs)
• Uniformly account for inflation
  • Services with recent updates (e.g., mobile crisis) do not need as large of an inflationary increase compared to services which have not been updated for some time
• Magnitude of increases based on Medicare rate levels or inflationary impacts will be scaled as needed depending on ultimate level of funding
## What this means for Psychiatrists!

<table>
<thead>
<tr>
<th>Service</th>
<th>Service Code</th>
<th>Service Description</th>
<th>FY23-24 Average PIHP MD/Psychiatrist Fee Schedule¹</th>
<th>DHHS Fee Schedule²</th>
<th>2023 Medicare Physician Fee Schedule³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Diagnostic Evaluation</td>
<td>90792</td>
<td>Psych diag eval w/med srvcs</td>
<td>$122.62</td>
<td>$101.44</td>
<td>$191.36</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>90833</td>
<td>Psytx w pt w e/m 30 min</td>
<td>$37.93</td>
<td>$33.86</td>
<td>$67.73</td>
</tr>
<tr>
<td></td>
<td>90836</td>
<td>Psytx w pt w e/m 45 min</td>
<td>$61.63</td>
<td>$55.02</td>
<td>$85.87</td>
</tr>
<tr>
<td></td>
<td>90838</td>
<td>Psytx w pt w e/m 60 min</td>
<td>$99.51</td>
<td>$88.84</td>
<td>$113.56</td>
</tr>
<tr>
<td>Office visit E&amp;M</td>
<td>99204</td>
<td>Office o/p new mod 45-59 min</td>
<td>$148.59</td>
<td>$125.39</td>
<td>$160.17</td>
</tr>
<tr>
<td></td>
<td>99205</td>
<td>Office o/p new hi 60-74 min</td>
<td>$187.42</td>
<td>$158.51</td>
<td>$211.53</td>
</tr>
<tr>
<td></td>
<td>99213</td>
<td>Office o/p est low 20-29 min</td>
<td>$66.51</td>
<td>$54.26</td>
<td>$86.78</td>
</tr>
<tr>
<td></td>
<td>99214</td>
<td>Office o/p est mod 30-39 min</td>
<td>$97.56</td>
<td>$81.76</td>
<td>$122.93</td>
</tr>
<tr>
<td></td>
<td>99215</td>
<td>Office o/p est hi 40-54 min</td>
<td>$128.66</td>
<td>$110.58</td>
<td>$172.48</td>
</tr>
</tbody>
</table>

¹PIHP MD fee schedule rates are based on the SFY 23-24 rate schedules published on each health plans websites, specific to Medicaid and MD/Psychiatrist provider type/specialty.

²DHHS fee schedule rates are based on the Physician Services fee schedule published on the DHHS website, updated as of 8/31/2023.

³Medicare fee schedule rates are based on the Medicare physician fee schedules effective January 1, 2023, calculated using NC geographic factors and applicable relative value calculations.
TIME FOR ACTION IS NOW....

CONSIDER BECOMING A MEDICAID ENROLLED PROVIDER!
Questions?