Tailored Plan Update

Department of Health and Human Services

Deputy Secretary for Behavioral Health & IDD
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Session Objectives

- Review the newest information on the Medicaid Tailored Plan
- Discuss Department progress on Tailored Plan implementation details
- Review key recommendations outlined in new Medicaid Transformation Policy Papers
- Review plan eligibility, benefits, care management
- Discuss the work related to service rates and governance

Agenda

- Overview of Tailored Plans
- Timeline
- Implementation
- Eligibility and Enrollment
- Benefits
- Care Management
- Provider Enrollment, Credentialing and Contracting
- Behavioral Health Network Adequacy
- Providing Feedback
- Question and Answer

Tailored Plans –Legislative Requirements

- Will be implemented 1+ year after Standard Plans go-live[1]
- Only LME-MCOs may operate BH I/DD Tailored Plans[2]
  - Responsible for total cost of care
  - Must contract with licensed PHP that covers services required under a Standard Plan contract
    - DHHS will develop parameters to support integration and the beneficiary and provider having a single point of contact for questions, concerns, assistance
- After the first four-year period, non-profit prepaid health plans (PHPs) may also operate BH I/DD TPs
- Serves specific populations
- Certain services only available in Tailored Plans
- Licensure and Solvency requirements will be developed
- Require additional revisions to GS 122-C to support success and transition of LME-MCOs to Tailored Plans

[1]At the start of the first fiscal year that is one year after the implementation of the first contracts for Standard Benefit Plans.
[2] For four years beginning one year after launch of SP and who meet the criteria established by DHHS

Key Differences: LME-MCOs vs. Tailored Plans

	CURRENT	FUTURE
Scope	Behavioral Health, IDD,TBI	Behavioral Health, IDD,TBI Physical Health, Pharmacy
Entity	Pre-paid Inpatient Health Plan	Prepaid Health Plan
Waiver Type	1915(b)(c)[3]	1115[3]
Health Home	Does not exist in LME-MCOs	New Tailored Plan Health Home care management model
Designation	LME-MCOs as designed in current legislation	Tailored Plans selected based on requirements in RFA
Organization Type	Local political subdivisions	To be determined

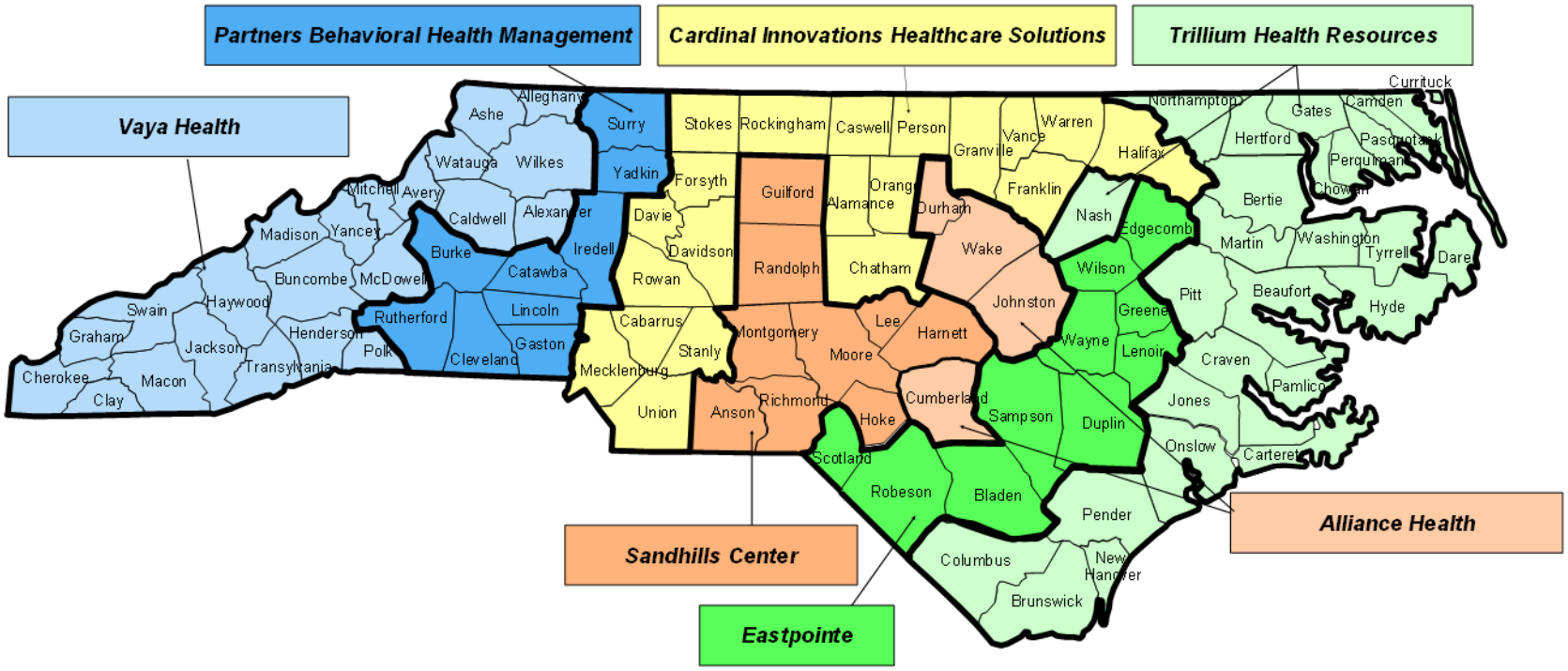
[3] Includes Innovations, TBI waiver; with managed care implementation the (c) waiver will operate under the 1115

Side by Side	Standard Plans	Tailored Plans
Scope	Fully integrated Care	Fully Integrated Care
Entity	Prepaid Health Plans	Prepaid Health Plan
Waiver Type	1115	1115[4]
Procurement	Competitive RFP	Request for Application (RFA) to existing LME-MCOs[5]
Contracting	Accept any willing provider	Any willing provider- physical health Closed network – behavioral health
Plans available to beneficiaries	4 statewide & 1 regional	1 per region[6]
Additional Services/Funding	In-lieu & value added services	Innovations, TBI, In-lieu, value added, State-funded, Federal and State Block Grants, current (b)(3), a subset of the more intensive behavioral health enhanced services

[4]The (c) waivers which currently operates under the 1915(b) waiver, will after Tailored Plan go live, operate under the 1115 waiver
[5]After initial four-year contract term, competitive RFP for Tailored Plans
[6]unless beneficiary makes an informed choice to go to SP

LME-MCO Map as of 7/1/19

Local Management Entity - Managed Care Organizations (LME-MCOs)
DHHS currently has -- Seven- LME-MCOs operating under the 1915 b/c Waiver

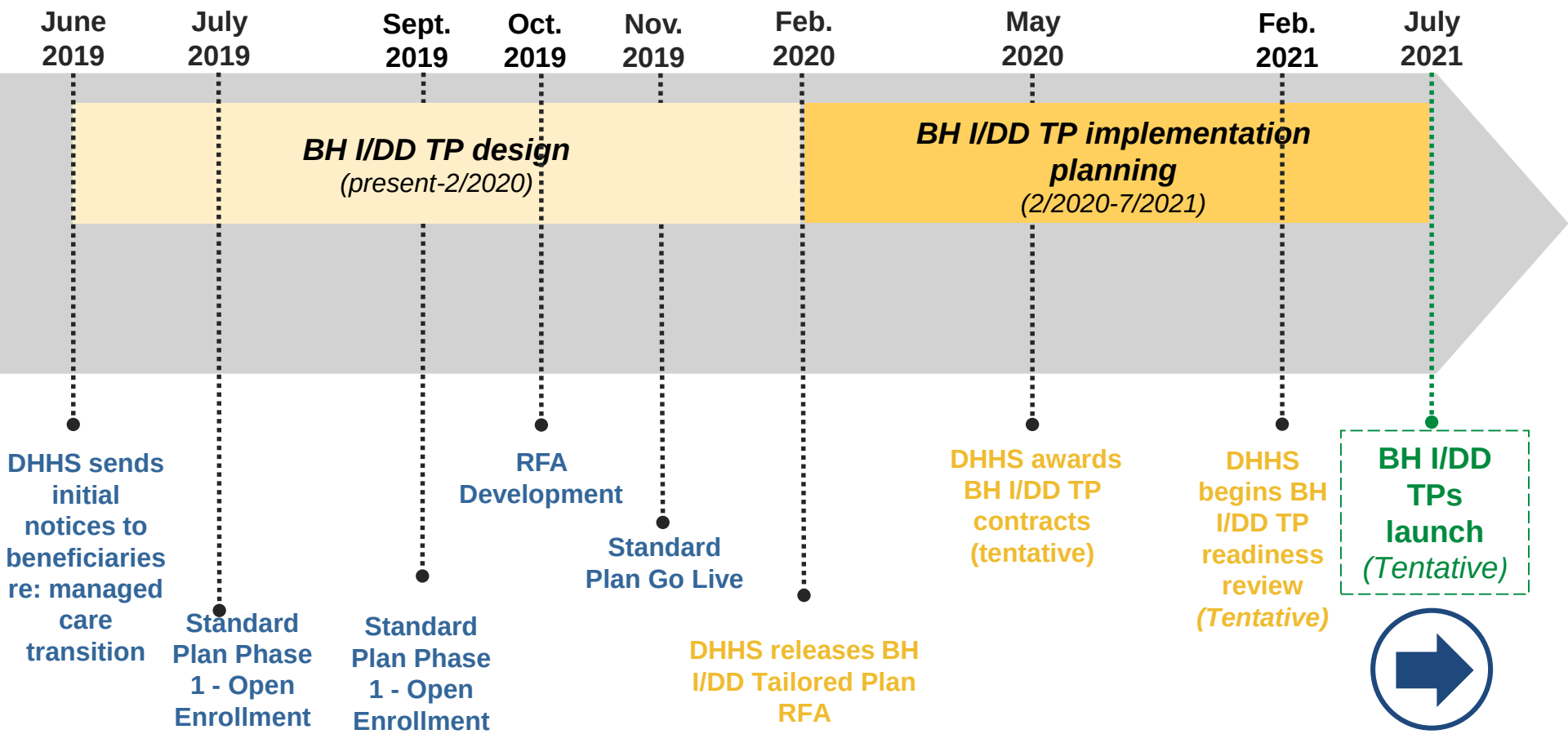


- *Reflects LME-MCOs as of 7/1/19.*
- *Includes the Alliance Health name change (January 2019) and realignment of Rutherford County to Partners Behavioral Health Management on 7/1/19.*

Regions

- No more than 7 and no fewer than 5 Tailored Plan regions
- NC Association of County Commissioners provided recommendations for establishing Tailored Plan regions
  - Must consider certain factors including financial sustainability
- After Tailored Plan contracts begin, counties will not be able to change regions
- Final recommendations to Secretary Cohen to be released this week

Tailored Plan* Timeline –Next Steps



Tailored Plan Implementation

- Financing
  - Current model fiscally sound
  - Rate setting process with launch of Standard Plan Launch
  - Care Management PMPM
- Request for Application
    - Development in Oct 2019
    - Minimum standards
    - Detailed requirements for E&E, Contract with SPs, Uninsured/State Funded, Care Management, Financial Requirements
    - Release Feb. 2020 (Tentative)
- Tailored Plan Onboarding
- Implementation Plans
- Readiness Review
  - Consider Standard Plan readiness review components (desktop review, onsite review, Tailored Plan interviews)

Tailored Plan Eligibility

- Eligibility determined by SL 2018-48
- Enrollment estimates
  - ~ 30,000 who are dually eligible
  - ~ 85,000 who are Medicaid only
- How identified?
  - Claims review
  - Data Reconciliation with LME-MCOs
  - Self Identification *(process under development)*
- Policy decision- once individuals are in Tailored Plans, no one automatically moved out for 1st two years
- Assignments will occur before and after launch of Standard Plans

Notices Regarding Managed Care Transition

In late June, DHHS will send notices to individuals in Regions 2 and 4 regarding November 2019 managed care enrollment.

There will be different notices for beneficiaries who will be required to enroll in a Standard Plans v. those eligible for a BH I/DD Tailored Plan who will by default remain in Medicaid FFS/LME-MCOs.

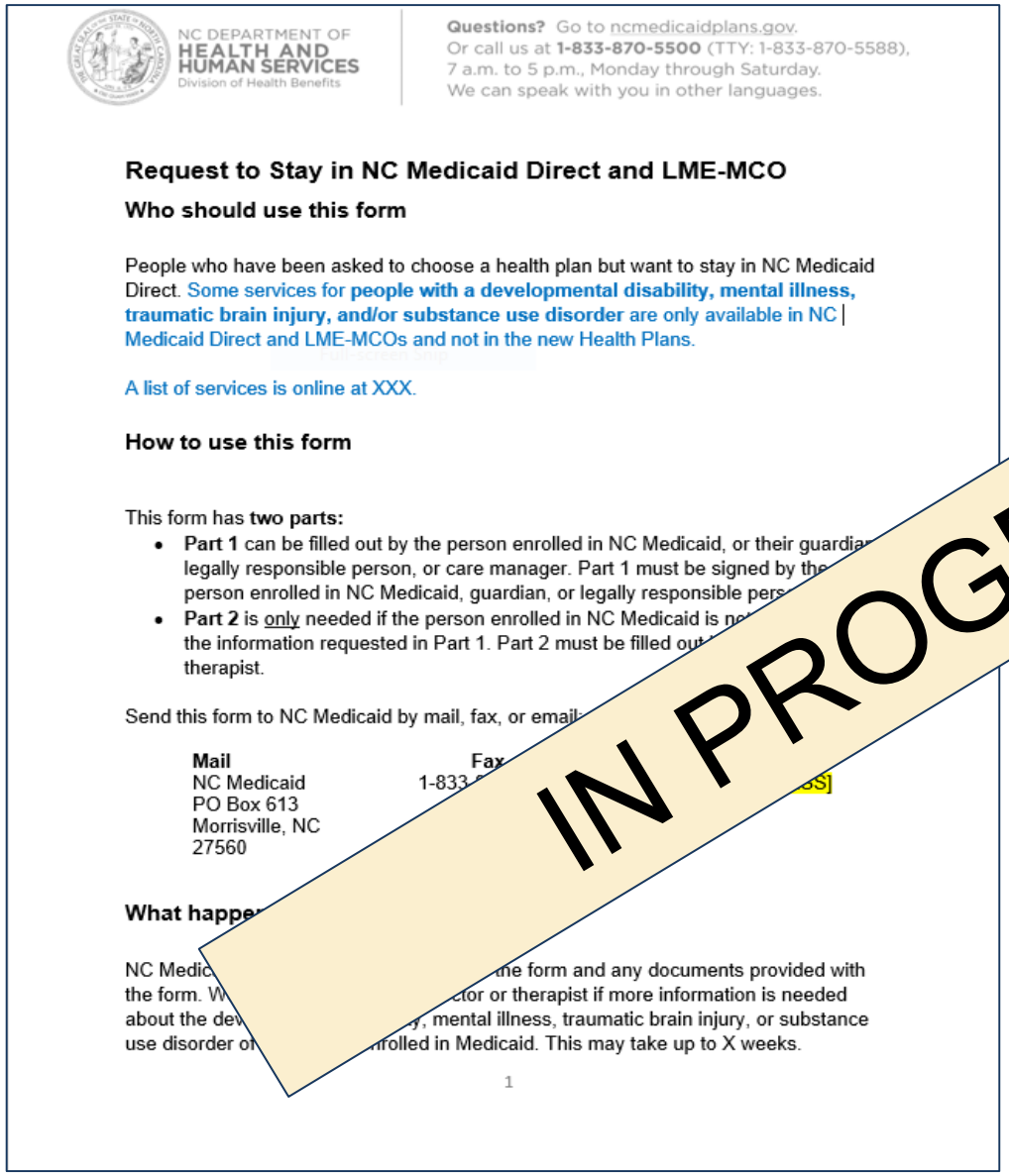
Notices for beneficiaries slated to enroll in Standard Plans will include information about:

- Enrollment Timeline
- Selecting a primary care provider and a health plan
- Steps to take if beneficiary believes they need Tailored Plan services
- Contact information for enrollment broker

Notices for beneficiaries who are eligible for a BH I/DD Tailored Plan will include information about:

- Beneficiary's continued enrollment in FFS/LME-MCO
- Option to enroll in a Standard Plan with explanation that Standard Plans will offer a more limited set of benefits
- Contact information for enrollment broker

What if a person believes they should not be in a Standard Plan?



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

Questions? Go to ncmedicaidplans.gov.
Or call us at **1-833-870-5500** (TTY: 1-833-870-5588),
7 a.m. to 5 p.m., Monday through Saturday.
We can speak with you in other languages.

Request to Stay in NC Medicaid Direct and LME-MCO

Who should use this form

People who have been asked to choose a health plan but want to stay in NC Medicaid Direct. Some services for **people with a developmental disability, mental illness, traumatic brain injury, and/or substance use disorder** are only available in NC Medicaid Direct and LME-MCOs and not in the new Health Plans.

A list of services is online at XXX.

How to use this form

This form has **two parts:**

- **Part 1** can be filled out by the person enrolled in NC Medicaid, or their guardia… legally responsible person, or care manager. Part 1 must be signed by the… person enrolled in NC Medicaid, guardian, or legally responsible pers…
- **Part 2** is only needed if the person enrolled in NC Medicaid is n… the information requested in Part 1. Part 2 must be filled out… therapist.

Send this form to NC Medicaid by mail, fax, or email:

Mail
NC Medicaid
PO Box 613
Morrisville, NC
27560

Fax
1-833-…

What happe…

NC Medic… …he form and any documents provided with the form. W… …ctor or therapist if more information is needed about the dev… …y, mental illness, traumatic brain injury, or substance use disorder o… …rolled in Medicaid. This may take up to X weeks.

1

IN PROGRESS

- **Request to Stay in NC Medicaid Direct and LME-MCO Form**
  - Impl… …the … …ndard Plans
  - … individuals are …igned to the right plan in timely manner
  - Two (2) part form
  - Beneficiary or provider may complete
  - EB receives
  - State (or vendor reviews)
  - Qualifying reasons
  - Appeal Rights

Benefit Packages

Only BH I/DD TPs will cover a subset of high-intensity State Plan BH services; TBI, Innovations and 1915(b)(3) waiver services; and State-funded BH, I/DD, and TBI services

BH, TBI and I/DD Services Covered by Both SPs and BH I/DD Tailored Plans	BH, I/DD and TBI Services Covered Exclusively by BH I/DD Tailored Plans (or LME-MCOs Prior To Launch)
Enhanced behavioral health services are italicized	
State Plan BH and I/DD Services • Inpatient behavioral health services • Outpatient behavioral health emergency room services • Outpatient behavioral health services provided by direct-enrolled providers • Partial hospitalization • Mobile crisis management • Facility-based crisis services for children and adolescents • Professional treatment services in facility-based crisis program • Peer supports (move from(b)(3) to state plan)* • Outpatient opioid treatment • Ambulatory detoxification • Substance abuse comprehensive outpatient treatment program (SACOT) • Substance abuse intensive outpatient program (SAIOP)** pending legislative change • Clinically managed residential withdrawal (aka social setting detox)* • Research-based intensive behavioral health treatment • Diagnostic assessment • EPSDT • Non-hospital medical detoxification • Medically supervised or ADATC detoxification crisis stabilization	**State Plan BH and I/DD Services** • Residential treatment facility services for children and adolescents • Child and adolescent day treatment services • Intensive in-home services • Multi-systemic therapy services • Psychiatric residential treatment facilities • Assertive community treatment • Community support team • Psychosocial rehabilitation • Substance abuse non-medical community residential treatment • Substance abuse medically monitored residential treatment • Clinically managed low-intensity residential treatment services* • Clinically managed population-specific high-intensity residential programs* • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) **Waiver Services** • Innovations waiver services • TBI waiver services • 1915(b)(3) services (excluding peer supports if moved to state plan) **State-Funded BH and I/DD Services** **State-Funded TBI Services**

*DHHS will submit a State Plan Amendment to add this service to the State Plan, ** Pending legislative approval

BH/IDD Tailored Plan Care Management

- Available to all members*
- Throughout duration of enrollment
- Delivered by plans, Certified CMA, Behavioral Health Tier 3 AMH +
- 4-year Glide Path to build workforce
- Minimum Qualifications for care managers
- Tiered Payments
- Quality Measures
- Technology Requirements

*limited exceptions i.e. person does not want care management, individual in ICF

Overview of Tailored Care Management Approach

DHHS Establishes care management standards for BH I/DD Tailored Plans aligning with federal Health Home requirements

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The BH I/DD Tailored Plan will act as the Health Home and will be responsible for meeting federal Health Home requirements

BH I/DD Tailored Plan Health Home

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Care Management Approaches

BH I/DD Tailored Plan beneficiaries will have the opportunity to choose among the care management approaches;
all must meet the Department's standards and be provided in the community to the maximum extent possible.

Approach 1:
"Tier 3 AMH+" Primary Care Practice
Practices must be certified by the Department to provide Tailored Care Management.

Approach 2:
Certified Care Management Agency (CMA)
Organizations eligible for certification by the Department as CMAs include those that provide BH or I/DD services.

Approach 3:
BH I/DD Tailored Plan-Employed Care Manager

The Department anticipates allowing—but not requiring—CMAs and AMH+ practices to work with a **CIN or other partner** to assist with the requirements of the Tailored Care Management model, within the Department's guidelines.

Provider Enrollment, Credentialing & Contracting

- **Providers must be enrolled with Medicaid or NC Health Choice to be paid for services to beneficiary***
- **Credentialing is a crucial part of federally regulated screening and enrollment process**
- **Centralized credentialing approach will be used to maximize efficiency among plans**

- Behavioral health providers will need to contract with both SPs and LME-MCOs until launch of BH I/DD Tailored Plans to be in-network with both plans.
- Enrollment process similar to today
- Centralized credentialing and recredentialing policies uniformly applied
- Nationally recognized, third-party credentials verification organization (CVO)
- Providers will bill the appropriate payor for services.

*Source: 2016 Medicaid Managed Care Final Rule; 21st Century Cures Act

Behavioral Health Network Requirements

- Tailored Plans will have closed networks for BH/IDD and TBI services, other network adequacy standards have not been developed
- Network adequacy standards for Standard Plan developed to ensure beneficiaries' have access to behavioral health services. Standard Plans will maintain an open network for all services, including behavioral health services.

# 1	Service Type	*Urban Standard	*Rural Standard
1	Outpatient Behavioral Health Services	2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of Members	2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of Members
2	Location-Based Services (Behavioral Health)	2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of Members	2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members
3	Crisis Services (Behavioral Health)	1 provider of each crisis service within each PHP region	
4	Inpatient Behavioral Health Services	1 provider of each inpatient BH crisis service within each PHP region	
5	Partial Hospitalization (Behavioral Health)	1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of Members	1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of Members

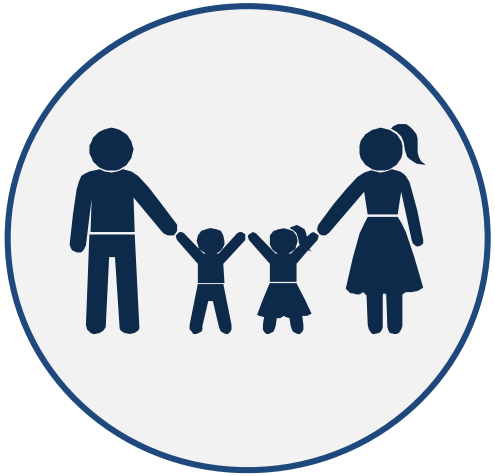
* SP Network Adequacy standards, full requirements can be found at https://files.nc.gov/ncdhhs/30-19029-DHB-2.pdf

Important Links

- **Care Management Paper**
  - https://files.nc.gov/ncdhhs/TailoredPlan-CareManagement-PolicyPaper-FINAL-20180529.pdf
- **County Fact sheets**
  - https://medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care
- **Provider Trainings**
  - https://medicaid.ncdhhs.gov/provider-transition-managed-care

Providing Feedback

- **Meetings**
  - Medical Care Advisory Committee - Behavioral Health and Intellectual and Developmental Disability Subcommittee June 13th
- **Policy Papers**
  - Care Management Feedback June 28th
  - Data Strategy released pending June 2019



Additional Ways to Participate

- Regular webinars, conference calls, meetings, and conferences
- Comments on periodic white papers, FAQs, and other publications
- Regular updates to website: https://www.ncdhhs.gov/assistance/medicaid-transformation

Comments? Questions? Let's hear from you!

Comments, questions, and feedback are all very welcome at Medicaid.Transformation@dhhs.nc.gov

Questions & Answers

NC MEDICAID TRANSFORMATION WEBSITE

www.ncdhhs.gov/medicaid-transformation