

Medicaid Transformation: Tailored Plan Update

**NC Association of County Commissioners
Health and Human Services Subcommittee
January 15, 2020**

Overview

- BH I/DD Tailored Plan Eligibility and Enrollment
- Behavioral Health Benefits in Managed Care
- BH I/DD Tailored Plan Procurement and Timeline
- Provider Participation/Contracting
- Tailored Care Management
- More Opportunities to Engage
- Q&A

Managed Care Transformation Integrates Physical and Behavioral Health

Under managed care transformation, both Standard Plans and BH I/DD Tailored Plans will be integrated managed care plans that will cover physical health, behavioral health, and pharmacy services for most Medicaid and NC Health Choice enrollees.

Behavioral Health Benefits

- In addition to physical health and pharmacy services, both Standard Plans and BH I/DD Tailored Plans will offer a robust set of behavioral health benefits, including outpatient and inpatient behavioral health services, crisis services, and withdrawal management services.
- Certain higher-intensity behavioral health, I/DD, and TBI benefits—including Innovations, TBI, and 1915(b)(3) waiver services, will only be offered under BH I/DD Tailored Plans (or LME-MCOs prior to BH IDD Tailored Plan launch).

Rationale for Integration

Currently, behavioral health benefits are administered through LME-MCOs, while physical health benefits are administered separately through Medicaid fee-for-service.

Integrating behavioral and physical health benefits will enable plans, care managers, and providers to deliver **coordinated, whole-person care**.

Overview of BH I/DD Tailored Plan Eligibility

Certain beneficiaries with more intensive behavioral health needs (including mental health and substance use), I/DDs, and TBI will be eligible to enroll in a BH I/DD Tailored Plan. Starting in 2021, DHHS will conduct regular data reviews to identify eligible beneficiaries. These beneficiaries will remain in FFS/LME-MCOs at Standard Plan launch unless they choose to opt into a Standard Plan.*

BH I/DD Tailored Plan Eligibility Criteria Identified via Data Reviews

- Enrolled in the Innovations or TBI Waivers, or on the waiting lists**
- Enrolled in the Transition to Community Living Initiative (TCLI)
- Have used a Medicaid service that will only be available through a BH I/DD Tailored Plan
- Have used a behavioral health, I/DD, or TBI service funded with state, local, federal or other non-Medicaid funds
- Children with complex needs, as defined in the 2016 settlement agreement
- Have a qualifying I/DD diagnosis code
- Have a qualifying SMI, SED, or SUD diagnosis code, and used a Medicaid-covered enhanced behavioral health service during the lookback period
- Have had an admission to a state psychiatric hospital or alcohol and drug abuse treatment center (ADATC), including, but not limited to, individuals who have had one or more involuntary treatment episodes in a State-owned facility
- Have had two or more visits to the emergency department for a psychiatric problem; two or more psychiatric hospitalizations or readmissions; or two or more episodes using behavioral health crisis services within 18 months

~30,000 dual eligible beneficiaries and ~85,000 Medicaid-only beneficiaries are expected to be eligible for a BH I/DD Tailored Plan

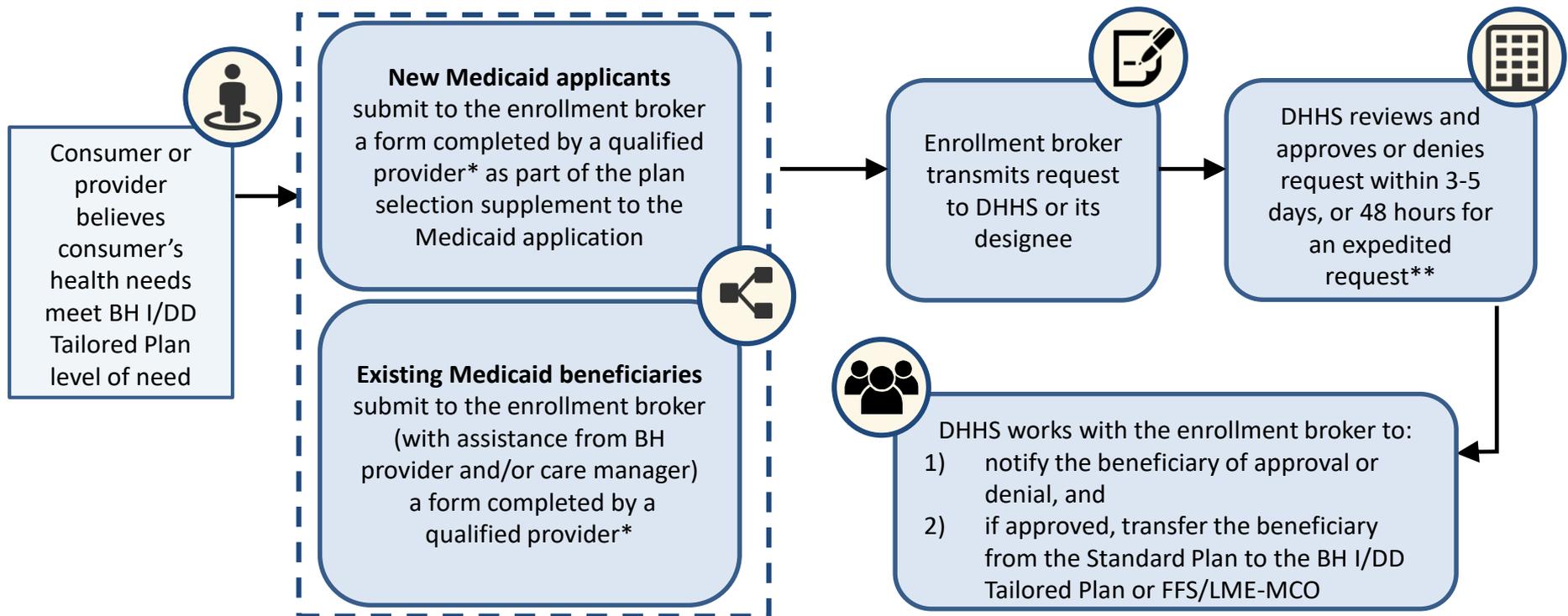
*Populations excluded from LME-MCOs today will continue to obtain behavioral health services through Medicaid FFS.

**Currently, there is no waiting list for the TBI waiver.

Transitions Between Standard Plans and BH I/DD Tailored Plans

Beneficiaries not identified as BH I/DD Tailored Plan-eligible by DHHS data reviews can request a review of their BH I/DD Tailored Plan eligibility at any time. Prior to BH I/DD Tailored Plan launch, individuals found BH I/DD Tailored Plan-eligible through this process will obtain physical health services through FFS and behavioral health, I/DD, and TBI services through their current LME-MCO.

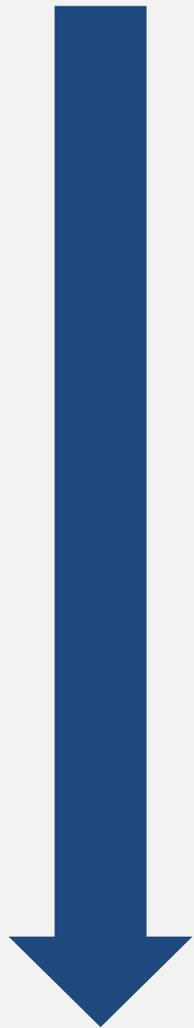
DHHS is developing a form to collect information to determine whether the beneficiary's health care needs meet BH I/DD Tailored Plan eligibility criteria. Beneficiaries will likely reach out to providers for assistance in completing this form and in providing documentation for this process.



*The form will be available online, by paper, by telephone, and in-person.

**Expedited review will be available when a beneficiary has an urgent medical need.

BH I/DD Tailored Plan Timeline



Timeline	Milestone
March 2020	BH I/DD Tailored Plan request for applications released (<i>tentative</i>)
September 2020	BH I/DD Tailored Plan contracts awarded (<i>tentative</i>)
Fall-Winter 2020	BH I/DD Tailored Plans contract with providers and meet network adequacy (<i>tentative</i>)
July 2021	BH I/DD Tailored Plans launch (<i>tentative</i>)

RFA

- Pre-Release Policy Paper
- RFA – March 2020
- Capitation rates – not bids
- 5-7 Regional Contracts
- Readiness Reviews (post award)

Administration

- Governance
- PHP licensure
- Accreditation

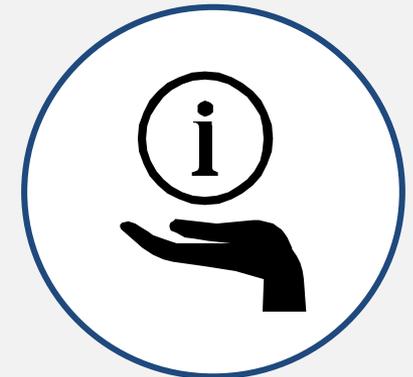
Provider Participation/Contracting

- Networks
- Access
- Payment

Guiding Principles for Tailored Care Management

The Tailored Care Management model is a pathway to ensuring BH I/DD Tailored Plan beneficiaries have access to the best whole-person care possible.

- All BH I/DD Tailored Plan beneficiaries need integrated, whole-person care management.
- **Provider-based care management** promotes **integrated care** and offers beneficiaries **choice** in how they receive care management.*
- **Community-based care management** facilitates frequent **face-to-face** interaction between beneficiaries and their care managers, who will live and work in the same communities as the individuals they serve.
- All BH I/DD Tailored Plan beneficiaries should have access to **consistent, high-quality care management** regardless of geography or where their care manager is employed.



*Beneficiaries will be able to switch care managers at any time.

Care Management

- Certification of AMH+ and CMAs
- Payment/Medical Home Fees

Glide Path to Provider-based Care Management

Tailored Care Management will require a multiyear effort to enhance the workforce at the AMH+ and CMA level. The Department will establish a “glide path” to guide the growth of provider-based capacity.

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 \text{Numerator:} \\
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 \frac{\text{Number of enrollees actively engaged in care management and served by care managers based in CMAs/AMH+ practices}}{\text{Total number of beneficiaries actively engaged in care management}} \times 100 = X\%$$

Department will compare X to annual targets:

	Year 0 (May 2020)	Year 1 (Mid 2021)	Year 2 (Mid 2022)	Year 3 (Mid 2023)	Year 4 (Mid 2024)
Target percentage of beneficiaries served by care managers/supervisors based in CMA/AMH+	N/A	Target 1	Target 2	Target 3	Target 4 = 80%

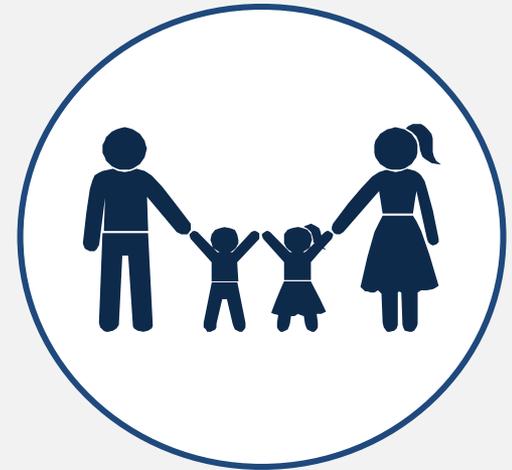
The Department believes that provider- and community-based care management is critical to the success of fully integrated managed care.

More Opportunities to Engage

DHHS values input and feedback and is making sure stakeholders have the opportunity to connect through a number of venues and activities.

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



Q&A

Appendix

Medicaid Managed Care Eligibility

Most Medicaid beneficiaries will enroll in Medicaid managed care—either in a Standard Plan or a BH I/DD Tailored Plan. There will be beneficiaries with behavioral health needs in both Standard Plans and BH I/DD Tailored Plans.

Status of Medicaid Managed Care Enrollment*	Populations
Included	<ul style="list-style-type: none"> ▪ Medicaid and NC Health Choice-enrolled children ▪ Parents and caretaker adults ▪ People with disabilities who are not dually eligible for Medicaid and Medicare
Exempt	<ul style="list-style-type: none"> ▪ Members of federally recognized tribes
Excluded	<ul style="list-style-type: none"> ▪ Medically needy beneficiaries (have a spend-down or deductible they must meet before benefits begin)* ▪ Health Insurance Premium Payment program** ▪ CAP/C waiver enrollees ▪ CAP/DA waiver enrollees ▪ Beneficiaries with limited Medicaid benefits– family planning, partial duals, qualified aliens subject to the five-year bar, undocumented aliens, refugees, and inmates ▪ PACE population
Delayed	<p>Until July 2021</p> <ul style="list-style-type: none"> ▪ BH I/DD Tailored Plan-eligible beneficiaries <ul style="list-style-type: none"> ▪ <i>Medicaid-only beneficiaries not enrolled in the Innovations/traumatic brain injury (TBI) waivers can opt into a Standard Plan. Dual eligibles will obtain only behavioral health and I/DD services through their BH I/DD Tailored Plan; they will receive all other Medicaid-covered services through Medicaid FFS until 2023</i> ▪ Beneficiaries in foster care under age 21, children in adoptive placement, and former foster youth up to age 26 who aged out of care <p>Until 2023</p> <ul style="list-style-type: none"> ▪ Long-stay nursing home population ▪ Dual eligibles who are not BH I/DD Tailored Plan eligible

Managed care enrollment does not impact Medicaid eligibility.

*Per legislation; **Beneficiaries enrolled in the Innovations or TBI waivers are not excluded from Medicaid managed care, and will default into BH I/DD Tailored Plans upon their launch. 16

Behavioral Health, I/DD, and TBI Benefits

If a beneficiary needs a service that is only offered in a BH I/DD Tailored Plan/LME-MCO, he/she will need to transition to a BH I/DD Tailored Plan (or LME-MCO prior to BH I/DD Tailored Plan launch) to obtain the service using the BH I/DD Tailored Plan Eligibility Request process.

Behavioral Health, I/DD, and TBI Services Covered by <u>Both</u> Standard Plans and BH I/DD Tailored Plans	Behavioral Health, I/DD and TBI Services Covered <u>Exclusively</u> by BH I/DD Tailored Plans (or LME-MCOs Prior To Launch)
<i>Enhanced behavioral health services are italicized</i>	
<p>State Plan Behavioral Health and I/DD Services</p> <ul style="list-style-type: none"> • Inpatient behavioral health services • Outpatient behavioral health emergency room services • Outpatient behavioral health services provided by direct-enrolled providers • <i>Partial hospitalization</i> • <i>Mobile crisis management</i> • <i>Facility-based crisis services for children and adolescents</i> • <i>Professional treatment services in facility-based crisis program</i> • <i>Outpatient opioid treatment</i> • <i>Ambulatory detoxification</i> • <i>Substance abuse comprehensive outpatient treatment program (SACOT)</i> • <i>Substance abuse intensive outpatient program (SAIOP)**</i> • <i>Research-based intensive behavioral health treatment</i> • <i>Diagnostic assessment</i> • Early and periodic screening, diagnostic and treatment (EPSDT) services • <i>Non-hospital medical detoxification</i> • <i>Medically supervised or ADATC detoxification crisis stabilization</i> 	<p>State Plan Behavioral Health and I/DD Services</p> <ul style="list-style-type: none"> • Residential treatment facility services for children and adolescents • <i>Child and adolescent day treatment services</i> • <i>Intensive in-home services</i> • <i>Multi-systemic therapy services</i> • <i>Psychiatric residential treatment facilities</i> • <i>Assertive community treatment</i> • <i>Community support team</i> • <i>Psychosocial rehabilitation</i> • <i>Substance abuse non-medical community residential treatment</i> • <i>Substance abuse medically monitored residential treatment</i> • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) <p>Waiver Services</p> <ul style="list-style-type: none"> • Innovations waiver services • TBI waiver services • 1915(b)(3) services <p>State-Funded behavioral health and I/DD Services</p> <p>State-Funded TBI Services</p>

*DHHS plans to submit a State Plan Amendment to add the following services to the State Plan:

- Peer supports and clinically managed residential withdrawal (to be offered by both Standard Plans and BH I/DD Tailored Plans); and
- Clinically managed low-intensity residential treatment services and clinically managed population-specific high-intensity residential programs (to be offered by BH I/DD Tailored Plans only).

**DHHS is seeking legislative approval to add SAIOP to the Standard Plan benefit package.

BH I/DD Tailored Care Management Model

Key Principle: Behavioral and physical health are integrated through the care team.

Overarching Principles

- Broad access to care management
- Single care manager taking an integrated, whole-person approach
- Person- and family-centered planning
- Provider-based care management
- Community-based care management
- Community inclusion
- Choice of care managers
- Consistency across the state
- Harness existing resources



Roles and Responsibilities of Care Managers

- Management of rare diseases and high-cost procedures
- Management of beneficiary needs during transitions of care
- High-risk care management
- Chronic care management
- Management of high-risk social environments
- Identification of beneficiaries in need of care management
- Development of care management assessments/care plans
- Development & deployment of prevention and population health programs
- Coordination of services