Behavioral Health and Intellectual/Developmental Disability (BH I/DD) Tailored Plan Overview

Dave Richard, Deputy Secretary, NC Medicaid
Kody Kinsley, Deputy Secretary for Behavioral Health & IDD

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Agenda

- Level Setting: Medicaid Managed Care Transition
- BH I/DD Tailored Plan Design Process
- Overview of BH I/DD Tailored Plans
- Working with Standard and Tailored Plans
- Service Definition Updates
- Q&A

Level Setting: Medicaid Managed Care Transition

Context for Medicaid Transformation

- In 2015, the **NC General Assembly enacted Session Law 2015-245**, directing the transition of Medicaid and NC Health Choice from predominantly fee-for-service to managed care.
- Since then, the North Carolina Department of Health and Human Services (DHHS) has **collaborated extensively** with clinicians, hospitals, beneficiaries, counties, health plans, elected officials, advocates, and other stakeholders to shape the program, and is committed to ensuring Medicaid managed care plans:
    - Deliver **whole-person care** through coordinated physical health, behavioral health, intellectual/developmental disability and pharmacy products and care models
    - Address the **full set of factors** that impact health, uniting communities and health care systems
    - Perform **localized care management** at the site of care, in the home or community
    - Maintain broad **provider participation** by mitigating provider administrative burden

Overview of Medicaid Managed Care

The goal of managed care is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care.

- NC Medicaid providers will contract with and be reimbursed by prepaid health plans (PHPs) rather than the State directly
- Three types of products:
  - **Standard Plans** for most Medicaid and NC Health Choice beneficiaries; scheduled to launch in February 2020
  - **BH I/DD Tailored Plans** for qualifying high-need populations with a serious mental illness, serious emotional disturbance, substance use disorder, I/DD, or traumatic brain injury; tentatively scheduled to launch in July 2021

    Focus of today's presentation
  - **Statewide Foster Care Plan** for children in foster care; tentatively scheduled to launch shortly after the launch of BH I/DD Tailored Plans *(more information is forthcoming)*
- All three types of products will offer a robust set of behavioral health benefits; however, certain more intensive behavioral health benefits will only be available through BH I/DD Tailored Plans
- Continued focus on high-quality, local care management in all three types of products

Note: Certain populations will **continue to receive fee-for-service (FFS) coverage, also known as NC Medicaid Direct,** on an ongoing basis. In addition, certain benefits, such as those provided by Children's Developmental Services Agencies (CDSAs), will be carved out of managed care.

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	• Medicaid and NC Health Choice-enrolled children • Parents and caretaker adults • **People with disabilities who are not dually eligible for Medicaid and Medicare**
Exempt	• Members of federally recognized tribes
Excluded	• 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	***Until July 2021*** • BH I/DD Tailored Plan-eligible beneficiaries • *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 NC Medicaid Direct until 2023* • Beneficiaries in foster care under age 21, children in adoptive placement, and former foster youth up to age 26 who aged out of care ***Until 2023*** • Long-stay nursing home population • **Dual eligibles who are not BH I/DD Tailored Plan eligible**

To ensure a smooth transition to managed care, DHHS has strategically considered the timing of the managed care transition for all populations.

Managed care enrollment does not impact Medicaid eligibility. DSS will continue to be responsible for Medicaid eligibility determinations.

*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.

Medicaid Transformation Milestones

Milestone	Regions 2 and 4	Regions 1, 3, 5, and 6
Enrollment Packets Mailed	*6/28/2019 (completed)*	10/1/2019 *(completed)*
Open Enrollment Begins	*7/15/2019 (completed)*	10/14/2019
Provider Contracts Must be Signed for Inclusion in Auto-Assignment	**November 15th**	
Open Enrollment Ends	12/13/19	
Auto-Assignment to PHPs and PCPs	Starting 12/16/19	
Standard Plan Effective Date	2/1/2020	

BH I/DD Tailored Plan Design Process

Guiding Principles for BH I/DD Tailored Plan Design Work

1. **Person-centered design:** Ensure that enrollees remain at the center of BH I/DD Tailored Plan design.

2. **Whole-person care:** Design BH I/DD Tailored Plans to reflect the entire continuum of care—physical health, long-term services and supports, pharmacy, behavioral health, I/DD, traumatic brain injury, and healthy opportunities interventions, including both Medicaid and state-funded services—while recognizing the specific needs of each target population.

3. **Accountability:** Hold LME-MCOs accountable for transforming to fully integrated health plans focused on whole-person health and establish the expectation that DHHS will rigorously enforce BH I/DD Tailored Plan contracts.

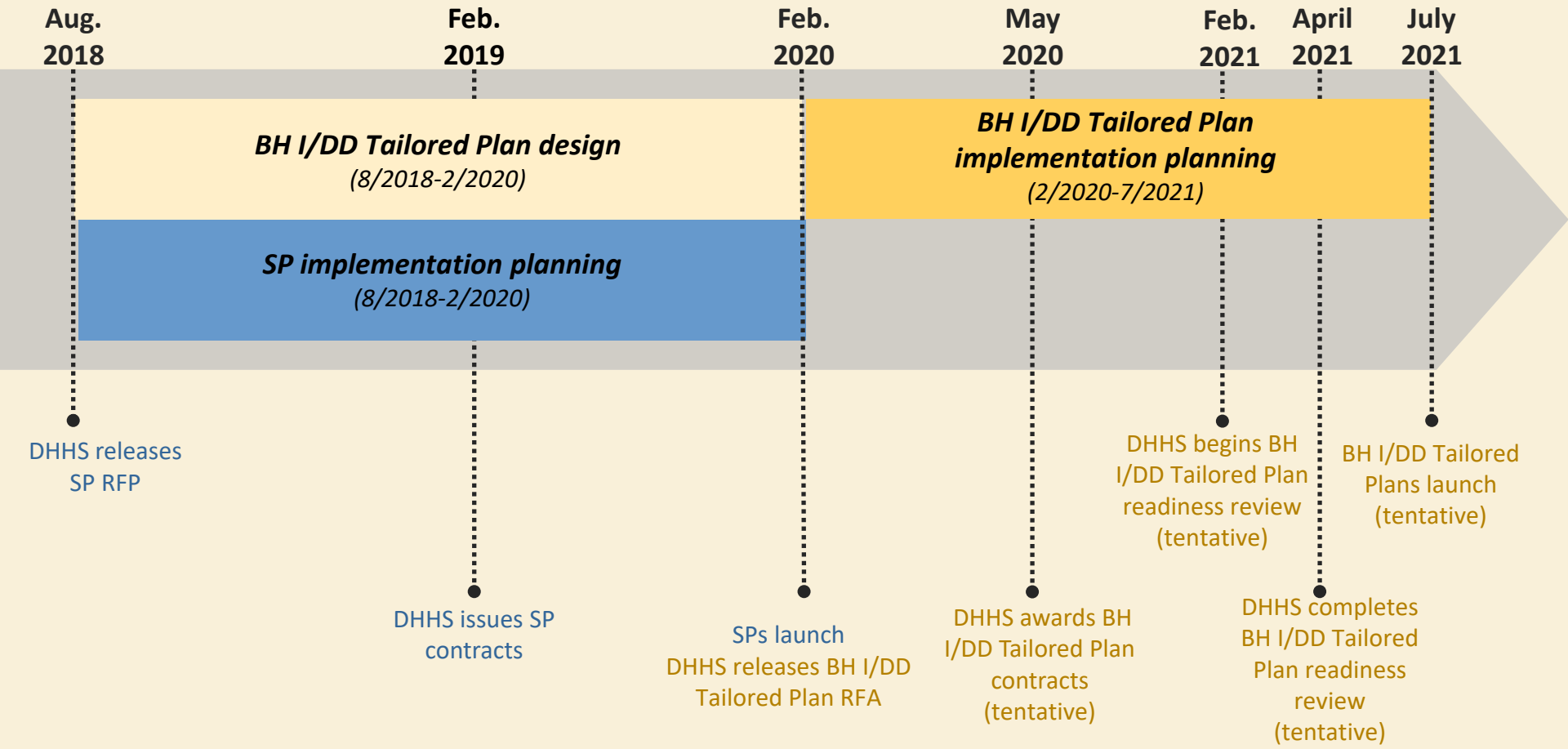
4. **Consistency:** Leverage the Standard Plan design to the maximum extent possible to promote alignment across Standard Plans and BH I/DD Tailored Plans while building on effective LME-MCO design elements.

5. **Stewardship:** Consider the implications for DHHS staffing, financial resources and provider commitment while making design decisions.

6. **Aspirational and achievable:** Strive for creative and transformational design, while recognizing that planning must consider existing LME-MCO and provider capabilities.

Draft Timeline for BH I/DD Tailored Plan

Until early 2020, DHHS will be conducting intensive planning for both Standard Plans and BH I/DD Tailored Plans. After Standard Plans launch, DHHS will continue implementation planning for BH I/DD Tailored Plans.



Overview of BH I/DD Tailored Plans

What is a BH I/DD Tailored Plan?

Key Features of BH I/DD Tailored Plans:

- BH I/DD Tailored Plans are designed for those with **significant behavioral health (BH) needs**—including both serious mental illness and severe substance use disorders—and **intellectual/developmental disabilities (I/DDs)**
- BH I/DD Tailored Plans will also serve other special populations, including **Innovations and Traumatic Brain Injury (TBI) waiver enrollees** and waitlist members
- BH I/DD Tailored Plan contracts will be **regional** (5-7 regions), not statewide
- **LME-MCOs are the only entities** that may hold a BH I/DD Tailored Plan contract during the first four years; after the first four years, any non-profit PHP may also bid for and operate a BH I/DD Tailored Plan
- LME-MCOs operating BH I/DD Tailored Plans **must contract with an entity that holds a PHP license** and that covers the same services that must be covered under a standard benefit plan contract
- BH I/DD Tailored Plans will manage **State-funded** behavioral health, I/DD, and TBI services for the uninsured and underinsured

Overview of BH I/DD Tailored Plan Eligibility

Certain beneficiaries with more intensive behavioral health needs, 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 NC Medicaid Direct/LME-MCOs at Standard Plan launch unless they choose to opt into a Standard Plan.*

BH I/DD TP 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 mental illness or SUD diagnosis code, and used a Medicaid-covered enhanced behavioral health service during the lookback period, such as enhanced crisis services
- 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

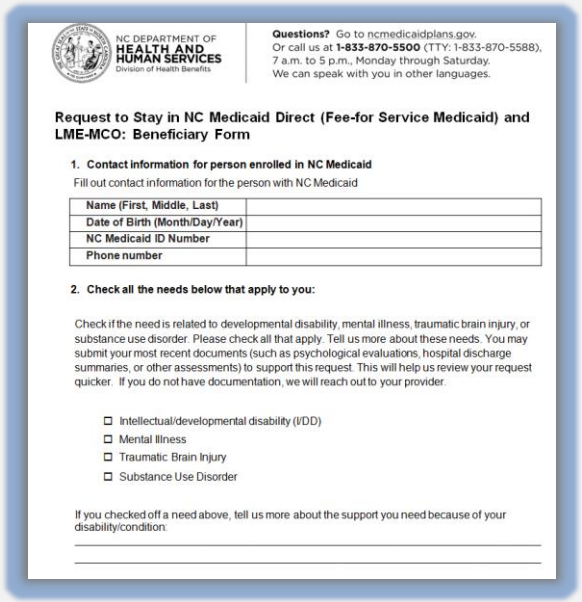
*Populations excluded from LME-MCOs today will continue to obtain behavioral health services through NC Medicaid Direct.
**Currently, there is no waiting list for the TBI waiver.

BH I/DD Tailored Plan Eligibility Request Process

New Medicaid applicants and Standard Plan beneficiaries not identified as BH I/DD Tailored Plan-eligible by DHHS data reviews can request to "stay in NC Medicaid Direct/LME-MCO" or enroll in a BH I/DD Tailored Plan after launch

- The beneficiary (or legally responsible) person can submit the form themselves or work with their provider to complete the form indicating the reason why they are eligible and indicate that they understand if the request is approved, the beneficiary will be moved automatically

Beneficiary Form



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 (Fee-for Service Medicaid) and LME-MCO: Beneficiary Form

1. Contact information for person enrolled in NC Medicaid

Fill out contact information for the person with NC Medicaid

Name (First, Middle, Last)	
Date of Birth (Month/Day/Year)	
NC Medicaid ID Number	
Phone number	

2. Check all the needs below that apply to you:

Check if the need is related to developmental disability, mental illness, traumatic brain injury, or substance use disorder. Please check all that apply. Tell us more about these needs. You may submit your most recent documents (such as psychological evaluations, hospital discharge summaries, or other assessments) to support this request. This will help us review your request quicker. If you do not have documentation, we will reach out to your provider.

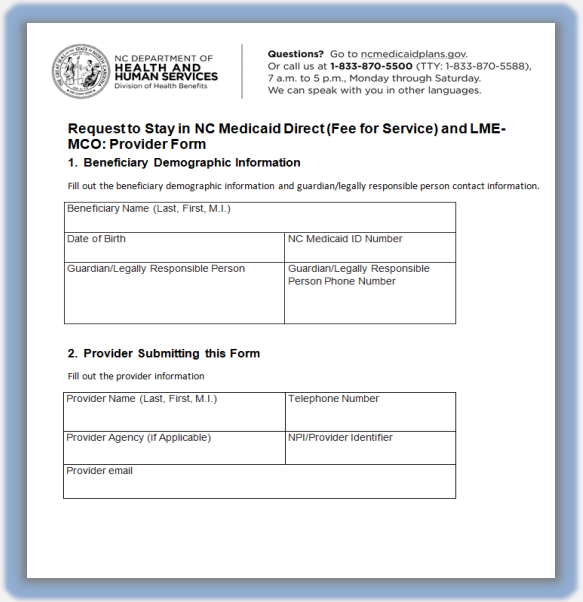
- ☐ Intellectual/developmental disability (I/DD)
- ☐ Mental Illness
- ☐ Traumatic Brain Injury
- ☐ Substance Use Disorder

If you checked off a need above, tell us more about the support you need because of your disability/condition:

_____

_____

Provider Form



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Request to Stay in NC Medicaid Direct (Fee for Service) and LME-MCO: Provider Form

1. Beneficiary Demographic Information

Fill out the beneficiary demographic information and guardian/legally responsible person contact information.

Beneficiary Name (Last, First, M.I.)	
Date of Birth	NC Medicaid ID Number
Guardian/Legally Responsible Person	Guardian/Legally Responsible Person Phone Number

2. Provider Submitting this Form

Fill out the provider information

Provider Name (Last, First, M.I.)	Telephone Number
Provider Agency (if Applicable)	NPI/Provider Identifier
Provider email	

BH I/DD Tailored Plan Benefits

BH I/DD Tailored Plans will cover a more robust behavioral health, I/DD, and TBI benefit package than Standard Plans.

BH I/DD Tailored Plan Benefits Include:

- Physical health services
- Pharmacy services
- State plan long-term services and supports (LTSS), such as personal care, private duty nursing, or home health services
- Full range of behavioral health services ranging from outpatient therapy to residential and inpatient treatment
- New SUD residential treatment and withdrawal services
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)*
- Current 1915(b)(3) waiver services*
- Innovations waiver services for waiver enrollees*
- TBI waiver services for waiver enrollees*
- State-funded behavioral health, I/DD, and TBI services for the uninsured and underinsured*

Telemedicine and Telepsychiatry Services

Members can be referred to a consulting provider for the purpose of diagnosis and treatment via either telemedicine or telepsychiatry.

Supported employment will be included in the BH I/DD Tailored Plan benefit package and will be covered as a Medicaid and state-funded service.

Note: Dual eligible enrollees will receive behavioral health, I/DD, and TBI services through a BH I/DD Tailored Plan and other Medicaid services through NC Medicaid Direct.

**Services will only be offered through BH I/DD Tailored Plans; in addition, certain high-intensity behavioral health services, including some of the new SUD services, will only be offered through BH I/DD Tailored Plans.*

Substance Use Disorder (SUD) Waiver

As part of the State's multifaceted Opioid Action Plan, DHHS is in the process of implementing its waiver of the institution for mental diseases (IMD) exclusion for SUD treatment to expand access to and Medicaid reimbursement for critical services.*

Key Activities

- Adding four SUD benefits to further expand access to SUD treatment and residential services and offer a complete continuum of services according to the American Society of Addiction Medicine (ASAM):**
  - Substance abuse halfway house (ASAM 3.1)
  - Clinically managed population-specific high intensity residential services (ASAM 3.3)
  - Ambulatory withdrawal management with extended on-site monitoring (ASAM 2-WM)
  - Social setting detoxification withdrawal management (ASAM 3.2-WM)
- Building provider capacity for new and existing SUD services
- Providing training for SUD providers on ASAM criteria

SUD waiver implementation includes working with the Division of Health Services Regulation (DHSR) to update administrative licensure rules for SUD providers to align with ASAM criteria.

*Medicaid law precludes payment for services delivered to individuals ages 21-64 residing in facilities classified as institutions for mental diseases (IMDs). This provision of Medicaid law is commonly referred to as the IMD exclusion. SSA Section 1905(a)(B).

**The waiver of the IMD exclusion applies to both Standard Plans and BH I/DD Tailored Plans, but certain SUD services will only be offered in BH I/DD Tailored Plans.

BH I/DD Tailored Plan Network Adequacy

DHHS is developing network adequacy standards for all services that will covered by BH I/DD Tailored Plans, with a particular focus on those that will only be covered by BH I/DD Tailored Plans. For services covered across both Standards Plans and BH I/DD Tailored Plans, network adequacy standards will largely be consistent.

Division of State Operated Healthcare Facilities (DSOHF)

BH I/DD Tailored Plans will be required to contract with all DSOHF facilities, including:*

- ✓ Alcohol and Drug Abuse Treatment Centers (ADATCs)
- ✓ Developmental Centers
- ✓ Psychiatric Hospitals
- ✓ Residential Programs for Children

**Individuals residing in Neuro-Medical Treatment Centers are excluded from managed care*

Rural Network Adequacy Standards

- DHHS has established different network adequacy standards for urban and rural areas.
- In general, the Standard Plan time and distance standards require members in rural areas to be able to access services within 40 minutes or 40 miles.
- Standard Plan time and distance standards will be augmented where appropriate for BH I/DD Tailored Plan members.

*Standard Plans are required to contract with ADATCs and psychiatric hospitals, but not other types of DSOHF facilities.

Tailored Care Management Model

The care management model in BH I/DD Tailored Plans will be known as "Tailored Care Management."

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

Care Management Will Be Delivered By:

- Advanced Medical Home Plus (AMH+) Primary Care Practices
- Care Management Agencies
- BH I/DD Tailored Plan-Employed Care Managers

Roles and Responsibilities of Care Managers

- Completion of care management assessments/care plans
- Coordination of services, including those addressing unmet health-related resource needs
- Management of beneficiary needs during transitions of care
- High-risk care management
- Chronic care management
- Management of rare diseases and high-cost procedures
- Management of high-risk social environments

State-Funded Services and Federal Block Grant

DHHS will transfer responsibility for managing State-funded and federal block grant non-Medicaid services from LME-MCOs to the regional BH I/DD Tailored Plans.

BH I/DD Tailored Plan Functions Include:

- Overseeing the provider network authorizing services
- Paying providers
- Submitting "shadow claims" for state-funded services through NCTracks
- Monitoring provider performance
- Authorizing medically necessary services
- Care coordination
- Managing local health functions (e.g., crisis systems, disaster response, community relationship and prevention efforts)
- Member services

Local Health Functions

- Work is underway to develop an approach for the future provision of "local health functions," which generally focus on health promotion and prevention to improve the health of the population
- Continued collaboration and coordination across DHHS divisions will be critical to ensuring the smooth transition of these functions at managed care launch

Working with Standard and Tailored Plans

Behavioral Health, I/DD, and TBI Benefits

- **Some services are available in both plans**
- **Other services available only in Tailored Plans**

Behavioral Health, I/DD, and TBI Services Covered by Both Standard Plans and BH I/DD Tailored Plans	**Behavioral Health, 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 Behavioral Health 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* • *Outpatient opioid treatment* • *Ambulatory detoxification* • *Research-based intensive behavioral health treatment* • *Diagnostic assessment* • Early and periodic screening, diagnostic and treatment (EPSDT) services • *Non-hospital medical detoxification* • *Medically supervised or ADATC detoxification crisis stabilization*	**State Plan Behavioral Health 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 comprehensive outpatient treatment program (SACOT)* • *Substance abuse intensive outpatient program (SAIOP)* • *Substance abuse non-medical community residential treatment* • *Substance abuse medically monitored residential treatment* • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) **Waiver Services** • Innovations waiver services • TBI waiver services • 1915(b)(3) services **State-Funded Behavioral Health and I/DD Services** **State-Funded TBI Services**

*DHHS plans 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)

Standard Plans/Tailored Plans Side by Side Comparison

- **Many similarities exist between Standard and Tailored Plans**
- **Providers who deliver outpatient services encouraged to contract with both**

Similarities	Key Differences
• Fully Integrated Care • Operate under 1115 waiver • Consistent Departmental Oversight • Provider Contracting and Rates Negotiation • Community Based Care Management • Network Adequacy Requirements	• Regions • Entry into Open Network (open vs. closed) • State Funded, Block Grant, current (b)(3) services • Procurement method RFP vs. RFA

Provider Opportunities with Standard and Tailored Plan

- New model leverages best of existing system while creating opportunities to improve on current issues
- Departmental priorities
  - Minimizing provider burden
  - Sustaining current crisis system

• New Contract Opportunities • Rate Negotiation • Value Based Payments • Centralized Credentialing	• Addressing unmet social needs • Interface with new entities i.e. enrollment broker, ombudsman (member and provider) • Becoming a Care Management Agency

Service Definitions Update

Community Support Team

- **CST service definition approved CMS on 10-3-19**
- **Policy will be reposted for 15 days due to changes**
- **Final policy will then be posted with 11/1/19 effective date**

Essential Elements of Revised Service Definition

- Staffing increase from three (3) to four (4) positions.
- 12:1 Ratio of individuals/staff with a team maximum of 48
- Functional assessment and housing assessment now required
- 36 unmanaged units for initial 30 calendar days to engage the individual early in treatment
- Added components of Permanent Supportive Housing (PSH), such as:
    - Assist with beneficiary housing search
    - Assist with connecting beneficiaries to financial and in-kind resources to set up and maintain household;
    - Prevent and mitigate housing crises;
    - Assist with rehousing beneficiaries if they are no longer able to stay in their unit due to eviction or risk of eviction;
    - Assist in developing daily living skills to stabilize and maintain housing
    - Requires 15 hours of training in PSH.

Peer Support

- **SPA submitted September 16, 2019**
- **Initial Call resulted in informal questions**
- **Anticipate shorter than normal approval time**

Proposed Changes in Service Definition

- 24 unmanaged units in the first 30 calendar days per episode of care for fiscal year.
- Peer Support Specialists must be NC Certified.
- QP supervisor required – one QP to eight Peer Support Specialists.
- Service can be provided to individuals or groups
- Service can be provided in the ED

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Q&A