



NC Department of Health and Human Services

Joint DMH/DD/SAS & DHB (NC Medicaid)
COVID-19 Update
for
NC Providers

NC Medicaid & Managed Care Update

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January 6, 2022

Current Updates

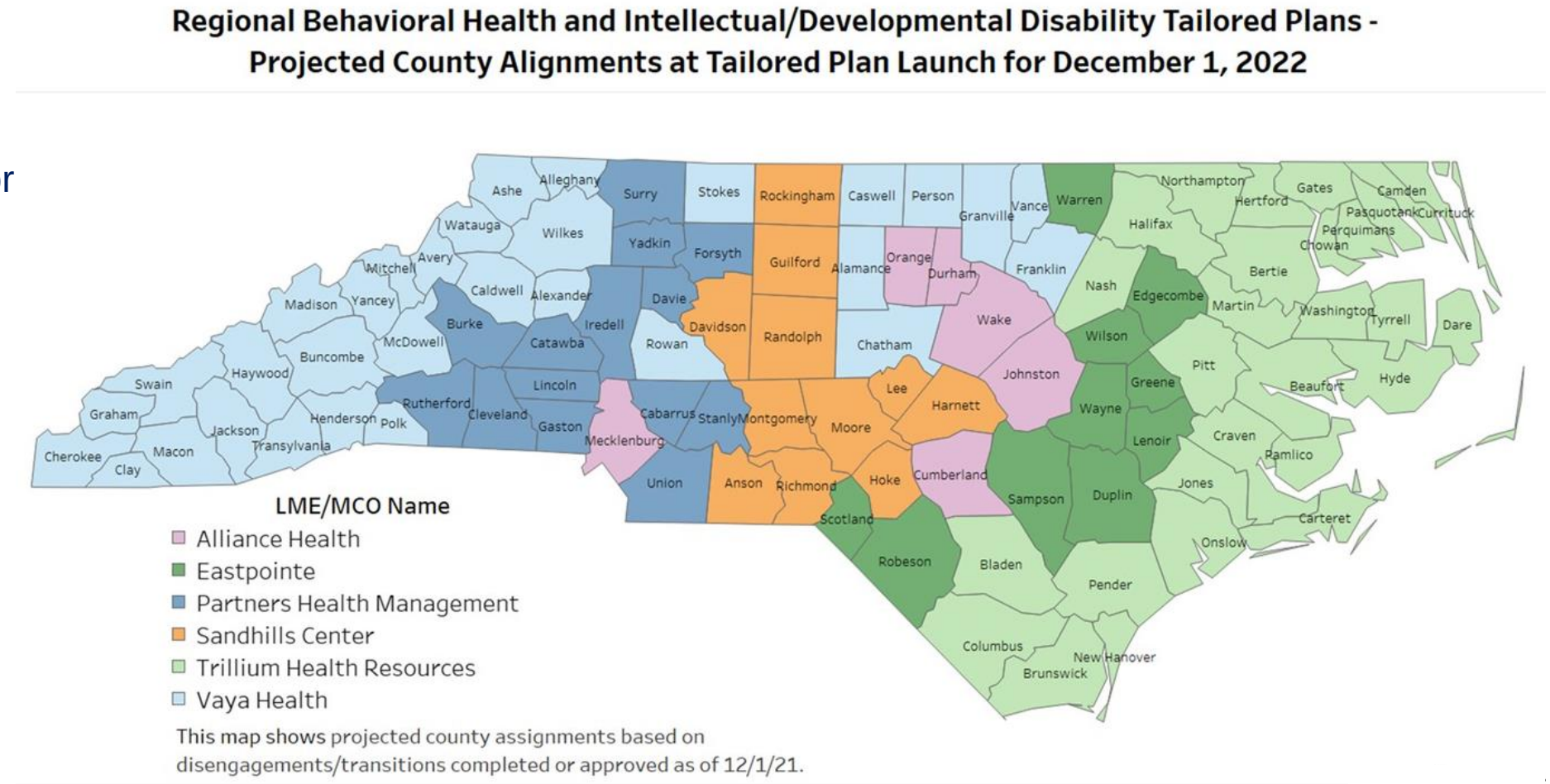
- COVID-19 Surge & Medicaid Response
- Newly Appointed DHHS Secretary
- Medicaid Budget
- County Transitions Complete
- CMS Vaccine Mandate Update

Ongoing Monitoring/Problem Solving

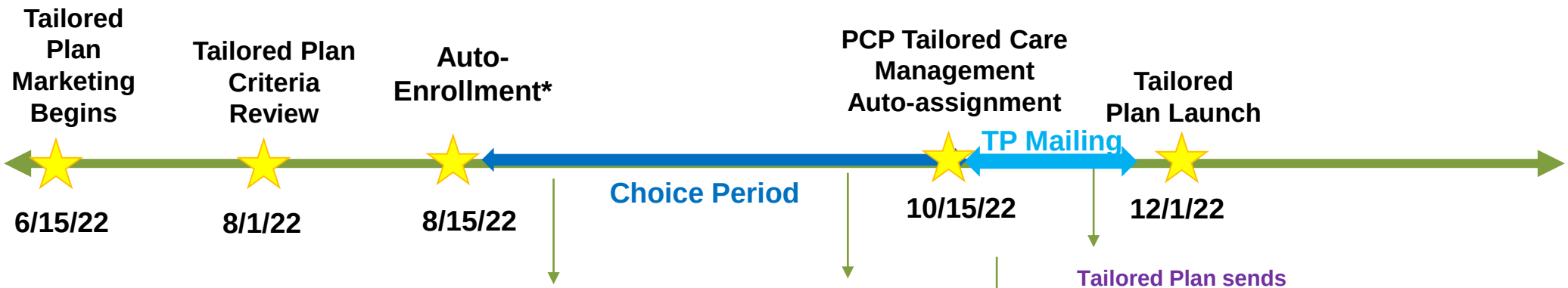
- Contracting
  - NEMT/NEAT
  - Hospitals
- Claims Payment/Dashboards
- Network Adequacy Dashboards Published 12/20/21
  https://medicaid.ncdhhs.gov/reports/network-adequacy-oversight-measures-and-results

Managed Care Tailored Plan Regions

- Tailored Plan contracts awarded to all existing LME/MCOs
- DHHS working with future Tailored Plan to prepare for December 2022 implementation



Overall Milestone Timeline



Enrollment Broker sends letters to members who remain Tailored Plan status with Tailored Plan enrollment and options to select PCP or opt-out

Enrollment Broker sends letters to members who lose Tailored Plan status and become Standard Plan mandatory telling them that they will be auto-enrolled in a Standard Plan effective 12/1 (remain in NC Medicaid Direct until 12/1 unless they choose a Standard Plan early)

Enrollment Broker sends PCP and Tailored Care Management reminder notice

Tailored Plan auto-assigns PCP and Tailored Care Manager to Tailored Plan beneficiaries. New Standard Plan mandatory members are auto-enrolled in a Standard Plan.

Enrollment Broker sends letters to members auto-enrolled in a Standard Plan telling them their Standard Plan starts 12/1. Members have up to 90 days after 12/1 to make a change.

Tailored Plan sends Welcome Packets and ID Cards with PCP and Tailored Care Management assignment

Specialized Plan- Children/Youth in Foster Care and their Families

- Plan Features
  - Single statewide entity
  - July 2023 Launch *
  - Children in foster care, adoptive placements, formerly in foster care
    - Considering other populations
  - All services in Standard and Tailored Plans
  - Leverage SOC approach
  - Trauma Informed Care
  - Close collaboration with DSS
- Next Steps
  - Feb 2022 Policy Paper
  - Workgroup Meeting - Tuesday, January 11, 2022, from 12:00 – 1:00 PM.

Healthy Opportunities Phased Launch Approach

- **Feb 1, 2022: Engagement and NCCARE360 Functionality**
  - Pilot/Unite Us Payments functionality to be ready in NCCARE360. SPs and first 3 CINs will have access to NCCARE360 training environment. HSO onboarding status to Pilot/Unite Us Payments functionality, including services offered, to be communicated to SPs.
  - PHPs to accelerate engagement with Network Leads and HSOs. PHPs to submit an engagement plan to the Department by January 15, 2022 describing how they will engage with Network Leads and Network Lead- contracted HSOs regarding the HO Pilot and payment process.
- **Mar. 15, 2022: Launch food services and 3 CINs**
  - Launch service delivery in all three Pilot regions, but only with food services.
  - Only enroll members into the Pilot from 3 CINs: Access East, Mission Health Partners, and CCPN.
  - PHPs do not have to play “care manager” role of assessing eligibility, enrolling, and recommending services for members assigned to Tier 1 and 2 AMHs or to members assigned to Tier 3 AMHs.
  - If needed, the Department could consider setting expectation or limiting the 3 CINs to only enroll 100 - 250 members each in the first 45 days.
- **May 1, 2022: Launch housing and transportation services and additional CINs**
  - Launch delivery of housing and transportation services.
  - Add any AMH Tier 3s or CINs that can enroll (AMM, Carolina Medical Home Network, etc).
  - If needed, the Department could consider limiting liquidated damages to the first 1,000 members enrolled in the Pilot. No enrollment limits will be applied.
- **June 15, 2022: Launch toxic stress cross-domain services**
  - Launch delivery of toxic stress and cross-domain services. IPV and certain cross-domain services may not be live.
  - PHPs begin “Care Manager” role of assessing eligibility, enrolling and recommending services for members assigned to Tier 1 and 2 AMHs and members assigned to Tier 3 AMHs not conducting Pilot care management

Next Steps

- Visit the NC Medicaid Managed Care website medicaid.ncdhhs.gov for more information.
- For more information on Tailored Plans, please see Behavioral Health I/DD Tailored Plans on the NC Medicaid Managed Care website.
- Release of Member and Provider Factsheets

Provider Resources to Address Issues in Managed Care

- NC Medicaid Ombudsman
  Call **877-201-3750** or visit ncmedicaidombudsman.org Monday – Friday 8 a.m. to 5 p.m.
- Provider Ombudsman
  Call **919-527-6666** or visit Medicaid.ProviderOmbudsman@dhhs.nc.gov
- NC Medicaid Help Center
  - Internal Team
  - Knowledge Center medicaid.ncdhhs.gov/helpcenter
  - Member Harm Process
- Health Plan Oversight
- Communication & Engagement with Stakeholders
- Provider Claims & Payment Supports
- Request to Move Process & Forms
  - https://ncmedicaidplans.gov/submit-forms-online
- Back Porch Chat
  - https://public.3.basecamp.com/p/Pn8C41JMakRUDiHAta1xdhB6

Resources for Beneficiaries

1

Check to see what health plan you are enrolled in

Beneficiaries were mailed a health plan welcome kit that includes their Medicaid ID card

If you still have questions or didn't receive the welcome kit you can call the Enrollment Broker at **833-870-5500**

2

Call your health plan if you have questions about benefits and coverage

The number is listed on your Medicaid ID card, or you can find contact information at health-plan-contacts-and-resources

3

If you still have questions, reach out to the NC Medicaid Ombudsman

Call **877-201-3750** or visit ncmedicaidombudsman.org

Questions & Answers

Have a question, send it to us. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services is working to centralize questions so we can ensure your questions are answered in a timely manner by the appropriate subject matter experts.

Comments, questions and feedback are welcome at:

- BHIDD.HelpCenter@dhhs.nc.gov
- Medicaid.Transformation@dhhs.nc.gov
- www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse-services

Requests for presentations or to provide feedback:

Medicaid.NCEngagement@dhhs.nc.gov

Appendix

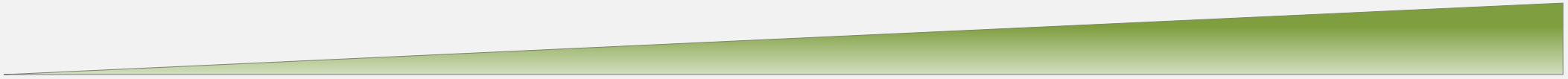
Glidepath to Provider-based Care Management

The Department's vision is to increase, over time, the proportion of actively engaged members receiving care management from AMH+ practices and CMAs (e.g., provider-based care management).

To guide the growth of provider-based capacity, the Department established a multiyear "glidepath" with annual targets to be met by Tailored Plans.

	2022	2023	2024	2025
Target percentage of beneficiaries "actively engaged" in Tailored Care Management based in AMH+ practice/CMA	**30%**	**45%**	**60%**	**80%**

The Department will assess compliance with targets for each contract year during the first quarter of subsequent contract year



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

Tailored Care Management: Capacity Building Overview

Distribution Plan Submission

Behavioral Health I/DD Tailored Plan awardees submit distribution plans, based on assessment of regional needs

DHHS approves plans and distributes some funds

Additional Milestones and Reporting

Distribution plans must include an approach for meeting the needs of historically underutilized providers, building a diverse workforce, and addressing health disparities.

Behavioral Health I/DD Tailored Plan awardees meet targets/milestones and submit quarterly reports on progress to date

AMH+ practices/CMAs demonstrate progress in building their capacity, via quarterly reporting to the Behavioral Health I/DD Tailored Plan awardees

DHHS

Behavioral Health I/DD Tailored Plan Awardees

AMH+s/ CMAs

DHHS distributes funds

Behavioral Health I/DD Tailored Plan awardees distribute funds

The Department expects that at least 90% of funding will be associated with milestones focused on investments at the AMH+ and CMA levels.

Tailored Care Management Webinar Series

Dates *Fridays, 12 -1 p.m.*	**Topics**
October 1, 2021	Introduction to Tailored Care Management
October 8, 2021	Becoming an AMH+/CMA
October 15, 2021	Health IT Requirements and Data Sharing
October 22, 2021	Partnering with a Clinically Integrated Network and Other Partners
October 29, 2021	Delivery of Tailored Care Management
November 5, 2021	Transitional Care Management Community Inclusion Activities
November 19, 2021	Conflict-Free Care Management and Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver
December 3, 2021*	Deep Dive on Tailored Care Management Specifications
December 10, 2021	Introduction to Oversight and Quality and Common Misconceptions on the Tailored Care Management Model

*The **Billing** session originally scheduled for 12/3 will be held early 2022 to include information on acuity tiering, Tailored Care Management rates and billing codes

Tailored Care Management Technical Assistance

The Department is offering a technical assistance (TA) program to help providers become certified AMH+ practices and CMAs as well as prepare them to be successful high-quality providers of Tailored Care Management.

- NC Medicaid contracted NC Area Health Education Centers (AHEC) to provide education, practice support services and TA across all 100 counties to providers who applied for AMH+ practice/CMA certification and passed the desk review.
- NC AHEC Tailored Care Management TA will prepare AMH+ practice and CMA candidates for a successful site review and certification and help AMH+ practices and CMA succeed before and after Tailored Plan go-live (Dec. 1, 2022).
- Practice support coaches with expertise in behavioral health and I/DD provide TA and education at **no cost** to AMH+ practice and CMA candidates through:
  - 1:1 TA
  - Tailored Care Management Gap Analysis Tool (*approved by NC Medicaid and required*)
  - Learning collaboratives, with opportunity to earn continuing education (CE) credits
  - Education modules, with opportunity to earn CE credits

NORTH CAROLINA AHEC

Tailored Care Management Technical Advisory Group (TAG)

The Tailored Care Management TAG will be the primary venue for dialogue among providers, Tailored Plans, consumers/families/guardians, the Department, and other key stakeholders for evolution of the Tailored CM program.

- The Tailored Care Management TAG has the following members:
  - Representatives from future Tailored Plans
  - Representatives from provider organizations that are certified or are candidates to become certified as Advanced Medical Home Plus (AMH+) practices or Care Management Agencies (CMAs)
  - Representatives reflecting the Tailored Plan consumer population – i.e., Medicaid enrollees or family members/guardians of individuals who expect to be in Tailored Care Management
- Tailored Care Management TAG members will advise on topics including:
  - Workforce
  - Capacity building
  - Conflict-free care management
  - Quality measurement and incentives
  - Member engagement
  - Data strategy
  - Other ongoing program design

AMH+/CMA Provider Landscape: So Far

The AMH+/CMA certification process is underway now, with Round 1 desk reviews completed.

AMH+/CMA applications as part of round 1

- **63** total provider applications **(7** AMH+ applicants and **56** CMA applicants).
- **54 of the 63 providers advanced to the site review stage**
  - **22** counties have no sites. Most counties with no sites are in the Northeast, in Trillium's region.
  - Of those that applied, there are **399** prospective brick-and-mortar AMH+ or CMA sites across most of North Carolina's counties.
  - 11 applicants (20%) identified as Historically Underutilized Providers (HUP) (all applicants passed the desk review)
  - Wake County has the most prospective sites (25 CMA sites).

AMH+/CMA applications as part of round 2

- **39** providers submitted applications (limited information available to date).

  - **Round 1** providers that passed the desk review are receiving **technical assistance** to support preparations for delivering Tailored Care Management starting on Dec. 1, 2022.
    - These providers will receive more information on **site reviews in December** and **readiness reviews** in late 2021/ early 2022 (exact timing TBD).
  - **Round 2 desk reviews** are currently in progress now and expected to be completed by late-December 2021. **Site reviews** will be Winter 2022 and **readiness reviews** Spring/Summer 2022.

Tailored Care Management: Successes & Challenges

DHHS is always trying to listen, learn, and improve as we move forward in Tailored CM Implementation

Successes

- Lots of interest from providers, members
- Creation of Tailored Care Management Technical Advisory Group (TAG)
- Way to get on-going advice/guidance from Members, Providers, Tailored Plans
- General Assembly approved Capacity Building Funding!
- Providers are engaging with AHEC TA
- DHHS got Capacity Building requests from all

Challenges

- Finding a Technology partner/system
- Potential shortage of qualified care management staff
- Certification is a new process with a few bumps
- Concerns about the rates
- Concerns about ability to engage members into a new service/lack of clarity around ‘true’ case loads

Tailored Plan Eligibility

DHHS will regularly review available data to identify Standard Plan beneficiaries who meet Tailored Plan eligibility criteria and auto-enroll them in NC Medicaid Direct/LME/MCOs or Tailored Plans depending on timing. Beneficiaries identified as Tailored Plan eligible prior to Standard Plan launch remain in Medicaid Direct/LME/MCOs.
Beneficiaries are also able to request a transfer to Tailored Plans.

Tailored Plan Eligibility Criteria

- ✓ Individuals with I/DD or TBI
- ✓ Beneficiaries who have a qualifying SUD or mental health diagnosis code as who used a Medicaid-covered enhanced Behavioral Health service during the lookback period
- ✓ 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 Behavioral Health I/DD Tailored Plan
- ✓ Have used a behavioral health, I/DD or TBI service funded with state, local, federal or other non-Medicaid funds in addition to the services covered by Medicaid.
- ✓ Children with complex needs, as defined in the 2016 settlement agreement
- ✓ Individuals known to the Department or an LME/MCO to have had one (1) or more involuntary treatment episodes within the prior 18 months
- ✓ 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
- ✓ Children aged zero to three years old with, or at risk for, developmental delay or disability.
- ✓ Children and youth involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs who meet criteria established by the Department.

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

Tailored Plan Eligibility Criteria

Eligibility for Tailored Plan will be based on the following criteria:

- Be enrolled in:
  - The Innovations or TBI Waivers, or on the waiting lists**
  - The Transition to Community Living (TCL)
- Have used:
  - a Medicaid service that will only be available through a Behavioral Health I/DD Tailored Plan
  - a behavioral health, I/DD or TBI service funded with state, local, federal or other non-Medicaid funds
- Have a qualifying:
  - I/DD diagnosis code
  - Mental illness or SUD diagnosis code and used a Medicaid-covered enhanced behavioral health service during the lookback period
- Children with complex needs
- Have a diagnosis of:
  - a psychotic disorder, use of clozapine or a long-acting injectable antipsychotic medication or receive electroconvulsive therapy during the lookback period
- Have had an admission:
  - to a state psychiatric hospital or 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
  - psychiatric hospitalizations
  - or two or more episodes using behavioral health crisis services within 18 months

Tailored Plan I/DD and TBI Waiver Services

Tailored Plans will be responsible for determining eligibility for the I/DD and TBI waivers and managing access to their Department-allocated waiver slots.

- Tailored Plans will administer I/DD Waiver and TBI Waiver services to eligible members.
- All provisions of the Contract shall apply to Tailored Plan members who are enrolled in the I/DD or TBI waiver unless otherwise noted.
- Beneficiaries who are enrolled in the I/DD or TBI waiver and are also medically needy or participants in the NC HIPP program shall enroll in a Tailored Plan at Tailored Plan launch for all Medicaid-covered services.
- Tailored Plans that do not offer the TBI waiver will not be subject to provisions of this contract that apply to the TBI waiver.

Behavioral Health, I/DD and TBI Benefits

Tailored Plans will cover all Medicaid covered behavioral health, I/DD and TBI services, as well as state-funded services

Behavioral Health, I/DD and TBI Services Covered by **Both** Standard Plans and Tailored Plans

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
- Psychological services in health departments and school-based health centers sponsored by health departments
- Peer supports
- 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
- Substance abuse comprehensive outpatient treatment program (SACOT)
- Substance abuse intensive outpatient program (SAIOP)
- 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

Behavioral Health, I/DD and TBI Services Covered Exclusively by Tailored Plans (or LME/MCOs Prior to Launch)

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 (ACT)
- Community support team
- Psychosocial rehabilitation
- Substance abuse non-medical community residential treatment
- Substance abuse medically monitored residential treatment
- Intermediate care facilities for individuals with intellectual disabilities (ICF-I/ID)
- 1915(i) services

Waiver Services

- Innovations waiver services
- TBI waiver services

State-funded behavioral health and I/DD Services

State-funded TBI Services

Tailored Plan HIT & Data Exchange

Tailored Plans must meet certain HIT requirements and exchange data with DHHS and AMH+ practices and CMAs

HIT Requirements

Tailored Plans must:

- Have the IT infrastructure and data analytic capabilities to consume, use and share a variety of data types (claims, encounters, event notification, clinical, etc.) in support of Tailored Care Management
- Use a care management data system
- Use NCCARE360 (once operational)

Data Exchange Requirements

Tailored Plans are required to share the following data with DHHS:

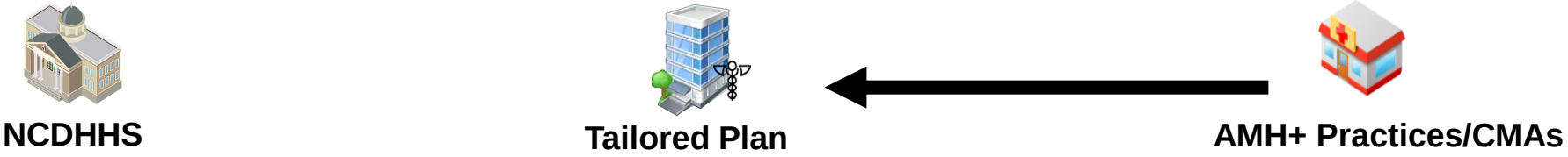
- Encounter data
- Member enrollment and insurance data
- AMH+ practice/CMA assignment data
- Provider network data
- PCP assignment data
- Pharmacy lock-in data

Tailored Plans are required to share the following data with AMH+ practices/CMAs:

- Beneficiary assignment information in a standard format
- Acuity tiering and risk stratification data in a standard format
- Member claims/encounter data in a standard format
- Quality measure performance information (measures TBD)

AMH+ Practice/CMA HIT & Data Exchange

AMH+ practices and CMAs must meet certain HIT requirements and exchange data with Tailored Plans



HIT Requirements

AMH+ practices/CMAs must:

- Use an electronic health record (EHR) or clinical system of record
- Use a care management data system
- Use NCCARE360 (once operational)

AMH+ practices/CMAs may meet the HIT requirements by:

- Implementing or using their own systems;
- Partnering with a Clinically Integrated Network (CIN) or Other Partner; or
- Using the Tailored Plan's care management data system

Data Exchange Requirements

AMH+ practices/CMAs must share the following data with Tailored Plans using a standardized format:

- Care manager contacts
- Dates of completion of care management comprehensive assessments and care plans and individual support plans (ISPs)
- Quality measure and reporting (potential—based on measure set TBD)

Community Inclusion: In-Reach & Transition

Tailored Plans must identify members* receiving care in an institutional setting and help transition them to the community, if their needs can be met safely in the community

Eligible populations for in-reach and transition services include members residing in:	Required in-reach activities include:	Required transition activities include:
• State Psychiatric Hospitals • Adult Care Homes (ACHs) (individuals with SMI only; excludes family care homes) • State Developmental Centers • Psychiatric Residential Treatment Facilities (PRTFs) • Residential Treatment Levels II/Program Type, III • ICF-IIDs (not state operated)* **In-reach and transition requirement for members residing in ICF-IIDs not operated by the state are slightly different for members in other residential settings.*	• Ensure members know about available community-based options, including supportive housing. • Identify and address barriers to transition, including addressing concerns of members/their family who decline or are ambivalent about transitioning. • Provide opportunities to meet with peers who are living, working and receiving services in integrated settings. • Support facility staff to ensure smooth transitions.	• Conduct transition planning in collaboration with the member, their family/guardian and other providers as appropriate. • Help members select a PCP and clinical specialists and ensure appointments and arrangements for individualized supports are in place. • Address barriers to transition (e.g., access to providers and services; training and treatment needs of family/guardian; transportation).

Tailored Care Managers or specialized Behavioral Health I/DD Tailored Plan-based in-reach and transition staff will be responsible for providing in-reach and transition activities, depending on the setting and population.

*Additional Transition Activities for Children/Young Adult Medicaid Members are included in the appendix

Community Inclusion: Diversion

Tailored Plans must identify members at risk of institutional care and help them remain in their community

- Medicaid members who have transitioned from an institutional or correctional setting within the previous six months or are seeking entry into an institutional setting are eligible to receive diversion services.
- Other members (e.g., members with an I/DD or TBI with an aging caregiver or deceased parent/guardian and children/youth with I/DD or TBI with co-occurring complex behavioral health needs) are also eligible for diversion services.
- Diversion activities include screening and assessing the member for community-based services, educating the member on the choice to remain in the communities and facilitating referrals and links to community-based and other social supports.
- Diversion activities are the responsibility of the assigned organization providing Tailored Care Management (e.g., the Tailored Plan, AMH+ practice or care management agency) if a member who is eligible for diversion services is not actively engaged in Tailored Care Management, the Tailored Plan will conduct outreach to engage the member in Tailored Care Management and conduct diversion activities.

Additional Transition Activities for Children/Young Adult Medicaid Members

Activities are part of Tailored Care Management

- **Engage the member's Child and Family Team** through the entire transition planning process, including the member's PRTF Family Peer Partner if applicable (for members with SED only)
- Provide the member and their family or guardian **links to relevant state agencies and systems** that support the development and well-being of children, including local school and child welfare systems
- Provide the member and their family or guardian links to **community-based services and supports that address health-related resource needs** such as disability benefits, food and income supports, transportation, education and services for justice-involved populations
- Collaborate with the member and their family or guardian and service providers to ensure needed **school-related services, recreational and pro-social activities, supervision plans and family supports** are in place upon discharge
- Work with the member and their family or guardian to **assess and prepare the member's home** so it is a safe and appropriate community setting
- Identify and **address any barriers to active engagement** of a member's family or guardian in transition planning
- Educate and train the member and their family or guardians on available resources and how to **independently access those resources**
- If the member has no permanent family or guardian, work with supervising care manager to **request that a DSS guardian locate a permanent placement** and escalate to DSS supervising staff if permanent placement is not being pursued

Quality

The Department seeks to improve outcomes for enrollees by focusing on rigorous and innovative outcomes measurement, promoting equity through reduction or elimination of health disparities and rewarding Tailored Plans and providers for advancing quality goals

- Tailored Plans must:
  - Meet all Standard Plan relevant standards, as well as meet additional standards unique to their members
  - Develop Quality Management and Improvement Programs, Quality Assessment and Performance Improvement Plans and at least three Performance Improvement Projects.
  - Achieve NCQA Health Plan Accreditation with LTSS Distinction for Health Plans by the end of Contract Year 3.
  - Report a wide range of quality metrics, including outcome metrics, with variations depending on whether the enrollee is receiving Medicaid or State-funded Services.*
  - Quality metrics also reflect the unique needs Tailored Plan members
  - For the first two years, work towards a benchmark of 105% of the prior year's NC Medicaid overall performance for each measure and address measure disparities for specified population groups.
- DHHS intends to measure a range of meaningful outcomes, including patient reported outcomes.
- DHHS will report Plans' performance on measures and finalize a withhold program for a small subset of priority measures to reflect Medicaid performance.

*The measure set may change based on modifications to the underlying measure sets (e.g., HEDIS) or changes in state policy priorities

Healthy Opportunities: Overview

Select Tailored Plans will help implement the pilots which test evidence-based, social interventions designed to improve health outcomes and reduce health care costs for a subset of Medicaid enrollees

Pilot funds will be used over the demonstration period to:

- Support capacity building for key entities participating in the Pilots
- Cover the cost of federally-approved Pilot services in four priority domains (see below)

Housing | Food | Transportation | Interpersonal Safety

For more details on the Healthy Opportunities Pilots—see Appendix

Key Tailored Plan Pilot Roles and Responsibilities

Tailored Plans serving members in a Pilot region will work with communities in three geographic areas of the state to implement Healthy Opportunities Pilots. Not all Tailored Plans will participate in the Pilots.

- Approve which of their enrollees are eligible and which services they qualify to receive
- Ensure the provision of integrated care management to Pilot enrollees
- Manage a Pilot budget and pay community-based organizations *(called "human services organizations or "HSOs")* for the delivery of Pilot services
- Participate in Pilot-related training and convenings

Healthy Opportunities Pilot Regions

DHHS has procured three Network Leads (NLs) that will contract with HSOs to serve eligible Medicaid members in select counties. Pilot regions will overlap with, but not perfectly align to Tailored Plan service areas.

Awarded Healthy Opportunities Network Leads and Tailored Plans

Access East Inc.
Counties: Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt
Tailored Plan(s) Operating in Pilot Region: Trillium, Eastpointe

Community Care of the Lower Cape Fear
Counties: Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender
Tailored Plan(s) Operating in Pilot Region: Trillium

Impact Health/Dogwood Health Trust
Counties: Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey
Tailored Plan(s) Operating in Pilot Region: Partners Health Management, Vaya

Healthy Opportunities: Pilot Eligibility

To qualify for pilot services, Tailored Plan members must live in a Pilot Region and have:

At least one Physical/Behavioral Health Criteria:
(varies by population)

- **Adults** (e.g., having two or more qualifying chronic conditions)
- **Pregnant Women** (e.g., history of poor birth outcomes such as low birth weight)
- **Children, ages 0-3** (e.g., neonatal intensive care unit graduate)
- **Children 0-20** (e.g., experiencing three or more categories of adverse childhood experiences)

At least one Social Risk Factor:

- Homeless and/or housing insecure
- Food insecure
- Transportation insecure
- At risk of, witnessing or experiencing interpersonal safety

Meet service specific eligibility criteria, as needed.

Healthy Opportunities: Key Pilot Entities

Tailored Plans

- TPs will maintain ultimate responsibility for all Pilot activities
- Approve which members qualify for Pilot services and which services they qualify to receive—based on care manager recommendations
- Pay for Pilot services delivered by HSOs

Care Management Teams

- Frontline care managers interacting with Members based at the TP, AMH + or CMA
- Assess member eligibility for the Pilots and coordinate Pilot services as part of ongoing care management, in addition to managing physical and behavioral health needs
- Manage members' care plan, inclusive of Pilot services, and track enrollee progress over time

Network Leads

- Organizations that serve as the essential connection between TPs and HSOs.
- Develop, manage, and oversee a network of HSOs
- Provide support and technical assistance for HSO network
- Convene Pilot entities to share best practices

Human Service Organizations

- Frontline social service providers that contract with the NL and deliver authorized, Pilot services to Pilot enrollees
- Coordinate with care management teams on the delivery of Pilot service to enrollees

Healthy Opportunities: Services

The federal government has approved 29 services to be offered through the Pilots in the four priority service domains. Examples include:

Housing

- Tenancy support and sustaining services
- Housing quality and safety improvements
- One-time securing house payments (e.g., first month's rent and security deposit)

Food

- Links to community-based food services (e.g., SNAP/WIC application support)
- Nutrition and cooking coaching/counseling
- Healthy food boxes
- Medically tailored meal delivery

Transportation

- Links to existing public transit
- Payment for transit to support access to pilot services (e.g., bus passes, taxi vouchers, ride-sharing credits)

Interpersonal Safety

- Links to legal services for IPV related issues
- Evidence-based parenting support programs
- Evidence-based home visiting services

Populations Delayed or Excluded from Medicaid Managed Care

When Tailored Plans launch Dec. 2022, several populations will remain delayed or excluded from managed care and will obtain their Medicaid coverage through NC Medicaid Direct and a limited benefit plan offered by an LME/MCO.

Delayed / Excluded / Exempt Populations

- Populations eligible for the Foster Care plan
- Dual eligible with full Medicaid
- Long-stay nursing home beneficiaries
- CAP/C and CAP/DA 1915 (c) waiver enrollees
- Medically Needy (Spend Down)
- Health Insurance Premium Payment (HIPP)
- Members of Federally-recognized Tribes and those eligible for IHS

Medicare (Dual Eligible)

NC Medicaid Direct Coverage

NC Medicaid Direct
- Physical Health
- Pharmacy
- CAP/C & CAP/DA Waiver
- State Plan LTSS

Prepaid Inpatient Health Plan LME/MCO
- State Plan Behavioral Health
- 1915 (i) HCBS
- ICF, I/ID

Dual eligible and HIPP population obtain primary coverage through other payers (Medicaid is the payer of last resort).

Employer-Sponsored Insurance (HIPP)

Tailored Plans Engagement with Members

Tailored Plan Engagement Strategy – Key Messages

DHHS is intentional about engaging members and ensuring key communications and engagements are centered around the following messages.

Beneficiaries receive the services they need at the right time in the right place.	Some members enrolled in a Tailored Plan can choose a different NC Medicaid Managed Care health care option at any time without a reason.
The Tailored Plan is an NC Medicaid Managed Care health plan that will begin providing health care services for members on Dec. 1, 2022.	Beneficiaries who may need certain services for a mental health disorder, SUD, I/DD or TBI will be enrolled in the Tailored Plan offered in the county that manages their Medicaid case on Aug. 15, 2022. There is only one Tailored Plan available in each county, so members cannot choose a different Tailored Plan.
The Tailored Plan will provide physical health, pharmacy, care management, mental health, I/DD, TBI and SUD support services.	Once a member has been enrolled in a Tailored Plan, they need to choose a PCP with the Tailored Plan. If the member does not choose a PCP by Oct. 15, 2022, the Tailored Plan will choose one for them.
The Tailored Plan offers certain services for mental health disorders, SUDs, I/DDs or TBIs that Standard Plans do not offer.	The Tailored Plan offers services for a mental health disorder, SUD, I/DD or TBI that are funded by the state or federal government outside of Medicaid, known as State-funded services. Members will not have access to State-funded services if they leave the Tailored Plan.

Member Engagement Requirements

- The Tailored Plan will be responsible for assisting members and their families with understanding:
  - NC Medicaid Managed Care
  - The benefits and services available to them and how to access those benefits and services
  - How to navigate the health care system
  - How to improve overall member health and well-being
  - Members rights and responsibilities
- The Tailored Plan will conduct member and community engagement to include online/printed materials, outreach events, health fairs, etc.
- Member engagement will begin Oct. 17, 2022, with the mailing of Welcome Packets, and will continue after Tailored Plan implementation.

Department Oversight – Member Engagement

The Department will oversee the Behavioral Health I/DD Tailored Plans in:

- Engaging with CFACs as required by Chapter **122-C-170** and Chapter **122-C-171**, to understand the potentially unique resources and needs of each community.
- Establishing an ongoing partnership with CFACs with the primary goals of receiving feedback from members, families and advocates to improve service delivery, access and outcomes within their contracted region
- Providing support staff to local or regional CFACs to assist CFACs in performing their statutory duties and statutory provisions with the goal to address service barriers, identify system gaps and assess relevant policies.
- G.S. 122C -171 The State CFAC shall be a self-governing and self-directed organization that advises the Department and the General Assembly on the planning and management of the State's public mental health, developmental disabilities and substance abuse services system.

State and Local CFACs

Member Education and Outreach

Requirements:

- Tailored Plans shall provide education and outreach to members and potential members through hosting and participating in:
  - Outreach Events
  - Community Events
  - Health Fairs
- Tailored Plans shall develop educational materials for use by the Enrollment Broker to support Tailored Plan and PCP selection.
- Tailored Plans shall provide I/DD and TBI Waiver education and training for members and families.

Inbound: (documents Tailored Plans will submit to DHHS)

- **Member/Recipient Educational Strategy and Approach**: Planned member education efforts are due for review and approval 60 days after Contract Award and annually thereafter.
- **Educational materials** need to be reviewed and approved by the Department at least 90 calendar days before distributed to members.

Problem Solving

- Reliance on partnerships for on the ground member experiences
- Escalations paths used for DHHS to get involved when local solutions not working. Will engage with Tailored Plans early and often
- Customer Service/Consumer Rights Team
- Consumer specific complaints
- Non-Medicaid Appeals
- Consumer specific service issues
- Working on interface with the NC Medicaid Ombudsman
- Community Engagement & Empowerment Team
- System specific issues or complaints
- Liaison to Local and State Consumer and Family Advisory Committees
- Outreach to community stakeholders for input into DHHS policy decisions
- Work closely with Customer Service/Consumer Rights Team
- Facilitate Joint DMH/DHB Consumer & Community Stakeholder and Joint DMH/DHB Provider Calls