Beneficiaries and Care Management Focus of Latest NC DHHS Concept Papers

Two new concept papers published by NC DHHS provide a little more "meat on the bones" of the NC Medicaid Transformation Plan. All of the concept papers build upon each other and the concepts are proposals with feedback welcomed. These most recent papers are published with a March 31 turnaround time for feedback.

The "Beneficiaries" concept paper highlights the NC DHHS goals of accessible and real-time application and eligibility resources for beneficiaries and how they will be achieved. The Enrollment Broker is a key player in meeting that goal. NC DHHS expects this increased access and data capacity to be built over the new few years. Local departments of social services will continue to be the central point of access while this capacity is built. A Request for Proposal was already published for the Enrollment Broker role (see *i2i News Brief* edition, March 14th https://conta.cc/2FJoojj) and that includes the multiple responsibilities that this entity will have for education on managed care and benefits, assistance in choosing a Prepaid Health Plan (PHP) and completing applications. If a beneficiary particularly wants to remain with a primary care provider, there will be a Provider Selection Tool available so that the beneficiary will know in which PHP networks his/her primary care provider is included.

Essentially, the beneficiary will have a 90-day timeframe to choose a PHP when he/she initially enrolls and during open enrollment periods. The open enrollment is the time-period when a beneficiary may change his or her PHP without citing a reason. If a change is requested outside of the open enrollment period, the beneficiary must provide one of a number of allowable reasons for the change. Medicaid beneficiaries who do not choose a PHP will be auto-assigned to a PHP. The auto assignment will consider factors such as whether the beneficiary is in a special population, geographic location, family members' already assigned to a PHP and previous relationships with PHPs. The Enrollment Broker will be a first point of access to Medicaid for all beneficiaries, regardless of whether they are assigned to a Standard or Tailored Plan.

The choice of Advanced Medical Home (AMH) will occur at the same time as when the beneficiary chooses a PHP. If the beneficiary does not choose an AMH, the PHP will be responsible for auto-assigning an AMH and notifying the beneficiary of that assignment. The beneficiary has 30 days from that notification to change the AMH without citing a reason as well as a full 30 days from the first visit and one additional time to change the AMH assignment for each 12-month period without cause. Beneficiaries can request to change their AMH at any time with one of the allowable reasons for the change.

PHPs will be responsible for having a 24/7 call center operating for emergency issues. During regular working hours, PHPs will also answer calls from beneficiaries to assist in non-emergency transport and to assist in answering beneficiary questions about benefits and appeals, AMHs, etc.

Finally, the Ombudsman Program will be operating a minimum of six-months prior to the implementation of the Standard Plan. The ombudsman can offer beneficiaries education, advocacy, issue resolution and enrollee assistance and trend monitoring. This will be a contract awarded to an entity separate from NC DHHS, PHPs and AMHs.

Care Management

The second concept paper, "North Carolina's Care Management Strategy under Managed Care" states, "Care management is a team-based, person-centered approach to effectively managing patients' medical, social and behavioral conditions." Not only does the concept lay out who qualifies to be a care management entity, it also provides detail on the Advanced Medical Home.

Care management is not a new concept in North Carolina. Both Carolina ACCESS through Community Care of North Carolina (CCNC), using a primary care case management model, and the Medicaid 1915 (b)(c) waivers through LME/MCOs include care management in Medicaid and, for the LME/MCOs, care management for certain high-risk, high-cost State-funded consumers as well. NC DHHS is building upon the Carolina ACCESS model to provide at least Standard Plan Medicaid beneficiaries access to care management through their PHPs. It is our understanding that the LME/MCOs will continue to do care management for the consumers with high BH/I-DD service needs until the implementation of the Tailored Plan. NC DHHS is proposing that Medicaid beneficiaries with high needs have access to a multi-disciplinary team that is responsible for a written care plan. This standard plan care management model is tied very closely to the Advanced Medical Home (AMH) but can be done either through an AMH, a local health department or other contracted agencies capable of performing the care management tasks. That means that primary care providers can be deemed care managers and paid an additional amount for this service. The PHP will be responsible for paying for care management.

The AMH approach will be based on four tiers. The tiers are related to the experience and capabilities of the AMH entity. Tier one is the most basic and tier four is the highest level of expertise. Tier one will be phased out within two years of Medicaid managed care implementation and tier four will phase in within two years of implementation. AMH entities will attest to their level of capabilities because, at this time, NC DHHS is not considering a requirement of national accreditation.

The component of the care management model that is related to the needs of the consumer is addressed at some length. Keep in mind that the Standard Plan is for enrollees who either do not have high needs in either physical or behavioral health OR have high needs in physical healthcare. The paper also discusses individuals with special health care needs that span from physical to behavioral health and I-DD and long-term supports and services. One can imagine there will be some standardized approaches to care management for Medicaid beneficiaries with high needs across the Standard and Tailored Plans.

The key structure NC DHHS is proposing is for care managers to be responsible for the coordination and care of disease management for all enrollees. They will also focus on identification and assessment of priority populations (Ex. long-term service and support needs, special health care needs, at risk of special health care needs, lacking resources to address social determinants of health). This model also includes care management focus on Medicaid beneficiaries who are transitioning from one health care setting to another.

One additional and important piece of information is that NC DHHS intends to use a two-phase approach to the Standard Plan. One area of the State will implement the Standard Plan and another area of the State will implement it three to five months later. The areas will depend upon several factors, including the Prepaid Health Plans (PHP) that are awarded the contracts.

Both of these papers did give a lot of detail into the beneficiary process for enrollment and navigation of the system. Many individuals who have been involved in the behavioral health and I-DD public system have pondered over the continuation of and inclusion of new meaningful opportunities for beneficiaries to impact the policies and processes of the Medicaid program structure on a daily basis. That has not yet been addressed in concept papers.

Three new DHHS Medicaid Transformation Concept Papers have been posted on Credentialing and Provider Enrollment, Provider Health Plan Quality Performance and Accountability, and draft paper on NC Medicaid Managed Care Quality Strategy – all of these have very short turn-around times for feedback. A synopsis on these papers will be offered in a future article.