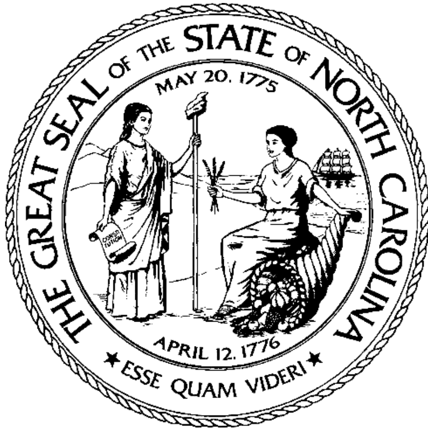

Behavioral Health/IDD/TBI Tailored Plan Provider Forum

North Carolina Department of Health and Human Services

December 5, 2018

Agenda

- Transformation Goals
  - Background
  - Level Setting
- Beneficiary Enrollment in Manage Care
- Overview of Tailored Plans
- Key Provider Transition Topics
- TP Design and Provider Engagement

Medicaid Transformation Background & Level Setting

Medicaid Transformation Goals

DHHS is committed to improving the health and well-being of North Carolinians through an innovative, whole-person centered and well-coordinated system of care that addresses both medical and non-medical drivers of health.

1. Create an innovative, integrated and well-coordinated system of care
2. Support clinicians and beneficiaries during and after the transition
3. Promote access to care
4. Promote quality and value
5. Setting up relationships for success

Guiding Principles for BH I/DD TP Design Work

1. **Person-centered design:** Ensure that enrollees remain at the center of BH I/DD TP design
2. **Whole-person care:** Design BH I/DD TPs 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:** DHHS will rigorously enforce BH I/DD TP contracts. LME-MCOs will transform to fully integrated health plans focused on whole-person health
4. **Consistency:** Leverage the SP design to the maximum extent possible to promote alignment across SPs and BH I/DD TPs 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

Level Setting

- **Managed Care Go Live 2019,** with phased regional roll out
- **DHHS Silent Period** due to procurement activities
- **Individuals who are excluded or exempt** continue in FFS, LME-MCO delivery system
- **Many behavioral health services will be covered** in Standard Plans
- **Open Tailored Plan design decisions** are still being formulated
- **Legislatively mandated** Tailored Plan decisions
  - Closed network for BH/IDD/TBI services in Tailored Plan
  - Open network for primary care services
- **Key partners in managed care** include SPs, EB, Ombudsman, CVO, DSSs

Whole Person Integrated Care

- Co-location is not enough
- Data sharing responsibilities
- Integrated health records
- Staff Infrastructure/recruiting
- Strategic Partnerships
- Advanced Medical Home Model
  - CIN
  - CM/CME

Integrated Care

coordinated physical health, behavioral health, intellectual/developmental disability and pharmacy products, and care models

Beneficiaries in Manage Care

Medicaid Eligibility and Enrollment in Managed Care

Eligibility and Enrollment

- No changes to eligibility or post-eligibility treatment of income.
- DSS retains role in Medicaid Eligibility Determination
- Over time simple, streamlined and integrated eligibility and enrollment process to be implemented
- Maximus will served as State's Enrollment Broker (EB) offering choice counseling
- Future system changes will occur in NC FAST and/or ePASS system

Enrollment in Managed Care

- Enrollment
  - EB Choice Counseling
    - Open enrollment for cross-over population
    - Change period
  - Auto-Assignment Factors
- Disenrollment
  - Without cause disenrollment
- Tailored Plan enrollment
  - Temporary Exemption
  - Transitions between PHPs
  - Rules for Identification for Tailored Plan

Essential Features of Tailored Plans

Plan Functions

DHHS will delegate the direct management of certain health services and financial risks to Prepaid Health Plans (PHPs).

BH I/DD Tailored Plans:

- Standard Plan Requirements served as basis for Tailored Plan design i.e. Care Management, Member Services, Network, NCQA
- PHP responsible for:
  - Whole person care
  - Provider network incl. contracting, oversight, monitoring provider performance and payments
  - Benefits, utilization management and authorizing services
  - Member protections, appeals, advisory committees
  - Submitting “shadow claims” for state-funded services through NCTracks
  - Quality measures, outcomes, VBP

Tailored Plan Benefits

TPs will provide comprehensive benefits, including physical health, LTSS, pharmacy, and a more robust behavioral health, I/DD, and TBI benefit package than Standard Plans.

Other Benefits Information:

- Benefits in Medicaid program are not changing as result of managed care
- PHPs may add "in lieu of" service
- CM assessment is stronger so services work better
- Full range of behavioral health services from outpatient therapy to residential and inpatient treatment:
  - Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)*
  - 1915(b)(3) waiver services*
  - Innovations waiver services for waiver enrollees*
  - New SUD residential treatment and withdrawal services
  - TBI waiver services for waiver enrollees*
  - State-funded behavioral health, I/DD, and TBI services for the uninsured and underinsured*

As part of the State's comprehensive strategy to address the opioid crisis, North Carolina will (1) increase access to inpatient and residential substance use disorder treatment by beginning to reimburse for substance use disorder services provided in institutions of mental disease (IMD), and (2) expand the substance use disorder service array to ensure the State provides the full continuum of services.

Care Management

BH I/DD TPs will offer care management that will align with the following key principles:

Care management is:

- foundational for achieving and supporting health outcomes
- **Team-based, person-centered approach** to effectively managing patients' medical, social and behavioral conditions.
- **Defined and differentiated from care coordination, case management** https://files.nc.gov/ncdhhs/documents/CareMgmt-AMH_ConceptPaper_FINAL_20180309.pdf

Care management will:

- be **community-based** to the maximum extent possible
- align with overall statewide priorities for achieving quality outcomes and value

Health home: BH I/DD TPs will serve as the Health Homes.

Provider Design Features (Standard Plans)

Provider Transition to Medicaid Managed Care (Standard Plans)

- Network Adequacy Standards
- Enrollment
- Credentialing
- Contracting
- Payments

Changing how Medicaid benefits are delivered from predominantly fee-for-service program to Medicaid managed care model

Network adequacy

- Building provider networks is a standard business operation for health plans
- PHPs must maintain sufficient provider networks for adequate access to covered services
- The Department has developed network adequacy standards; e.g., time/distance, "realized access"
- Law requires Standard Plan PHPs to contract with all "essential providers"

Provider Enrollment and Credentialing

- Enrollment process similar to today
- Centralized credentialing and recredentialing policies uniformly applied
- Nationally recognized, third-party credentials verification organization (CVO)

Provider Participation

Providers must be enrolled as a Medicaid or NC Health Choice provider to be paid for services to a Medicaid beneficiary

Credentialing is a central part of the federally regulated screening and enrollment process

2016 Medicaid Managed Care Final Rule
21st Century Cures Act

Centralized Credentialing – Full Implementation

APPLICATION & VERIFICATION

Department Process

Provider applies

- Application is single point-of-entry for all providers
- Required to participate in Medicaid Fee-for-Service or Medicaid Managed Care
- Follows Medicaid rules

PDM/CVO verifies credentials

- Managed by accredited PDM/CVO
- Required to contract in Medicaid Managed Care
- Follows national accreditation standards (e.g., NCQA)

PROCUREMENT & CONTRACTING

PHP Process

PHP PNPC reviews & approves/denies

- Established and maintained by PHP
- Reviews & makes “objective quality" determinations
- PHP Provider Network Participation Committee
- Cannot request more information for quality determinations
- Monitored by the Department

PHP and provider negotiate contract

PHP network development staff secures contracts with providers credentialed & enrolled in Medicaid

Before PHP contracts are awarded

Pre-Award Period

Build relationships with health plans

Understand contract terms, conditions, payment and reimbursement methodologies

Contracting Guidance

- **Letters of intent**
  Non-binding indication of health plan and provider's intent to enter into contract negotiations
- **"Any willing provider"**
  PHPs must contract with providers willing to accept reimbursement unless "objective quality" concerns
- **Department-approved contracts**
  Mandated clauses and specific provisions

Standard Plan Provider Payments and Covered Services

Rate Floors

- 100% of Medicaid Fee-For-Service for selected provider types
  - Physicians
  - Hospitals
  - State Operated Facilities
- Nursing Facility payments
- Negotiated rates
- Cost Settled payments
- Payment Timeliness

Other Payment requirements

- DHHS will hold PHPs to prompt pay requirements
- Out-of-network services will be covered if PHP provider network is unable to provide necessary services covered under the contract
- Out-of-network provider of emergency or post-stabilization services will be paid no more than Medicaid FFS rates

TP Design and Provider Engagement

Opportunities to Engage

DHHS values input and feedback from stakeholders and will make sure stakeholders have the opportunity to connect through a number of venues and activities.

Ways to Participate

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

Groups DHHS Will Engage

- Consumers, Families, Caregivers, and Consumer Representatives
- Providers
- Health Plans and LME-MCOs
- Counties
- General Public

Comments? Questions? Let's hear from you!

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

Questions for Provider Feedback

? What key concerns do providers have about contracting/credentialing?

? When do BH providers who contract with LME/MCOs move to the centralized process ?

? What are priority areas for provider education to support the transition to managed care?

? What role can BH providers play in educating and preparing beneficiaries for move to manage care?

? What do providers need to prepare for coordination/integration with physical health and care management services

To share comments: Medicaid.Transformation@dhhs.nc.gov

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To share comments, email: Medicaid.Transformation@dhhs.nc.gov

For NC Medicaid managed care information and documents:

www.ncdhhs.gov/nc-medicaid-transformation