North Carolina Medicaid Transformation

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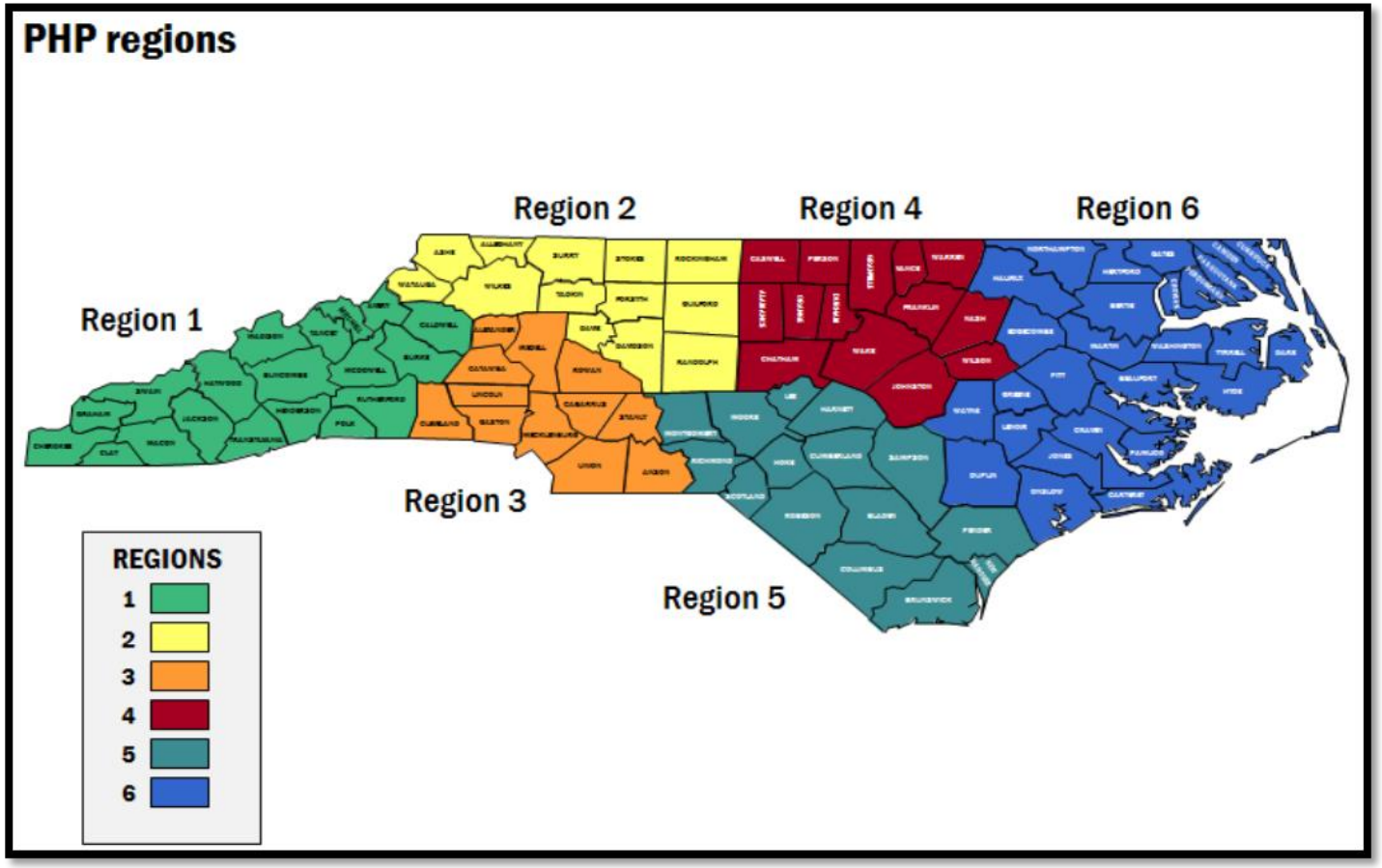
CCR

Standard Benefit Plan Contractors

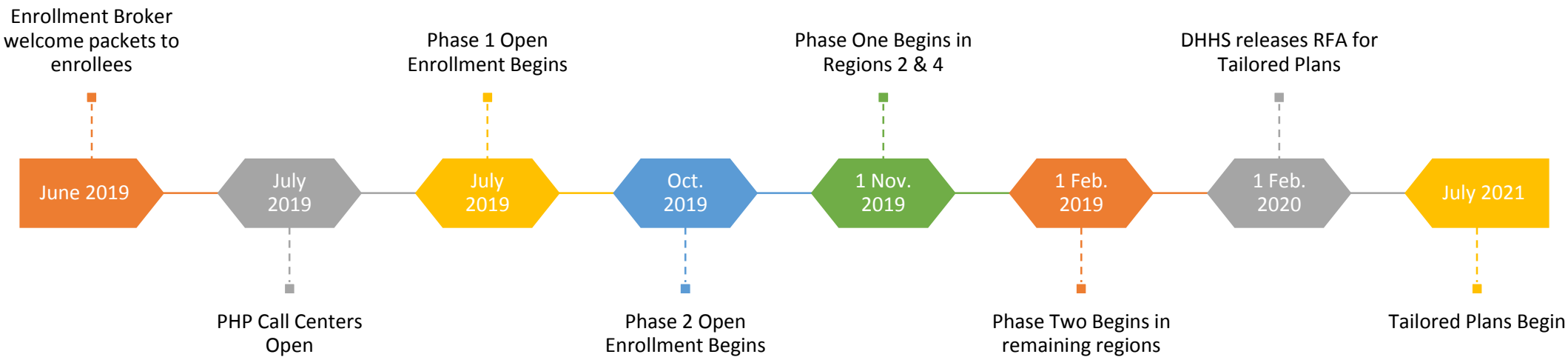
- AmeriHealth Caritas
- Blue Cross and Blue Shield of North Carolina
- United Healthcare
- WellCare Health Plans
- Carolina Complete Health (regional)



Medicaid Transformation Regions

- Regions 2 and 4 go live in November 2019 and include at least one county each from Vaya, Partners, Cardinal, Sandhills, Alliance, Eastpointe, and Trillium
- Regions 1, 3, 5, and 6 go live in February 2020
- Regions 3 and 5 are assigned to Carolina Complete Health, the sole Provider-led Entity PHP

Implementation Timeline



One More PHP:

Tribal Option

Tribal Option is an "Indian Managed Care Entity" under 42 C.F.R. 438.14. Separate RFP released in 2018 by the Cherokee Indian Hospital Authority for the State's only federally recognized tribe: EBCI. GO-LIVE will be 2/2020 when Region 1 goes live.

Approximately 4,000 EBCI individuals enrolled in NC Medicaid and Health Choice. Qualla Boundary in western NC includes Jackson, Swain, Haywood, Graham, Macon counties.

Enrolled Tribal members and IHS eligible individuals in the Qualla Boundary may choose default enrollment in the Tribal Option Plan, Medicaid Fee-for-Service, or "opt in" for enrollment in a PHP Standard Benefit Plan or Tailored Plan.

Enrolled Tribal members and IHS eligible individuals outside of the Qualla Boundary may choose default enrollment in a PHP Standard Benefit Plan or Tailored Plan, Medicaid Fee-for-Service, or "opt in" for enrollment in the Tribal Option Plan. Individuals currently receiving services under the 1915(b)/(c) waiver will default to the Tribal Option Plan and not the Tailored Plans, but may "opt in" for Tailored Plans.

CMS Regulations Specific to Tribal Beneficiaries and Providers

Provider Network & Coverage

See 42 C.F.R. 438.14(b) for additional requirements

- EBCI beneficiaries may obtain services from *out-of-network* Indian Health Care Providers (IHCPs) for services covered under a contract between any PHP and DHHS
- EBCI beneficiaries enrolled in PHPs other than the Tribal Option may select an in-network IHCP as the primary care provider

Provider Reimbursement

See 42 C.F.R. 438.14(c) for additional requirements

- Any PHP must reimburse an in-network or out-of-network IHCP at the federal OMB Encounter Rate published in the Federal Register **or** the DHHS Fee-for-Service rate when no Encounter Rate is available
- DHHS must make supplemental payment to the IHCP if a PHP pays a lesser amount

Additional Waiver Contracts

- **Ombudsman [Beneficiary]**
  - RFP released March 2019
- **Enrollment Broker**
  - MAXIMUS preparing for June soft launch
- **Provider Data Contractor**
  - Wipro Infocrossing preparing for April 2019 go-live

Healthy Opportunities Pilots

Goal: *Improve health and well-being through whole-person centered and well-coordinated care that addresses both medical and nonmedical drivers of health ["Social Determinants of Health"].*

- PHPs will implement standardized screenings to assess enrollees' non-medical needs such as unstable housing, insufficient food, lack of transportation, and experience with interpersonal violence.
- PHPs will then connect beneficiaries to community resources.
- PHPs will also launch Healthy Opportunity Pilots *in select regions to be determined by DHHS*.
- A statewide IT platform will create a coordinated network to refer and connect patients directly to community resources and monitor referral follow through.

Pilot Leaders

- **PHPs** will approve which enrollees qualify for Pilot services (based on State-defined criteria) and which services they qualify to receive.
- PHPs will work with care managers at **Tier 3 AMH practices**, and other contracted local care management entities such as **local health departments**.
- **Care managers** who work with Medicaid enrollees on their full range of physical, behavioral and non-medical needs will identify people who would benefit from and qualify for Pilot services, propose services that may benefit enrollees, and manage and coordinate services.
- **Human service organizations -** community-based organizations or social service agencies will deliver Pilot services to Medicaid enrollees and will receive Medicaid reimbursement and resources to build infrastructure.
- **Lead Pilot Entities** will bridge the gap between health and human service organizations contracting with PHPs to manage a network of HSOs providing Pilot services. DHHS will procure one LPE for each Pilot region and provide resources to support the HSO network.

Healthy Opportunities Pilots

Advanced Medical Homes

- **Contract Structure**: PHPs will contract with and delegate local care management responsibilities and functions to AMH practices. AMHs *may* also contract with Clinically Integrated Networks (CINs). Population health management via IT platforms will be integral: EHRs, HIE connectivity.

- **PCCM Model**: AMHs will replace CCNC network Primary Care Case Management *in the managed care networks*. Existing care management programs for pregnant women (PMH) and at-risk children (OBCM, CC4C) will continue under new names (Pregnancy Management Program (PMP), Care Management for High-Risk Pregnancy (CMHRP), and Care Management for At-Risk Children (CMARC), respectively).

- **Tiered AMH Responsibility**: Level 3 AMHs will be the most autonomous in care management.

- **Tiered AMH payment** for AMH Level 1, 2, and 3 providers (*see next slide*)

AMH Tiered Payments

AMH Tier 1 Medical Home Fee: $1 PMPM – all assigned beneficiaries. Negotiated performance incentive payments from PHPs are optional.

AMH Tier 2 Medical Home Fee: $2.50 PMPM – non-ABD beneficiaries; Medical Home Fee: $5.00 PMPM – members of the ABD eligibility group. Negotiated performance incentive payments from PHPs are optional.

AMH Tier 3 Medical Home Fee: $2.50 PMPM – non-ABD beneficiaries; Medical Home Fee: $5.00 PMPM – members of the ABD eligibility group; Care Management Fee negotiated with PHPs; Mandatory performance incentive payments negotiated with PHPs.

Exempt populations include members of federally recognized tribes, including EBCI. They will “opt in.”

Populations excluded from Medicaid Managed Care:

- Beneficiaries who are enrolled in both Medicare and Medicaid for whom North Carolina Medicaid coverage is limited to the coverage of Medicare premiums and cost sharing;
- Qualified aliens subject to the five-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611;
- Medically needy North Carolina Medicaid beneficiaries;
- Presumptively eligible beneficiaries, during the period of presumptive eligibility;
- Beneficiaries participating in the NC Health Insurance Premium Payment (HIPP) program;
- Beneficiaries enrolled under the Medicaid Family planning program;
- Beneficiaries who are inmates of prisons;
- Beneficiaries being served through the Community Alternatives Program for Children (CAP/C);
- Beneficiaries being served through the Community Alternatives Program for Disabled Adults (CAP/DA); and
- Program of All-Inclusive Care for the Elderly (PACE) participants.

Medicaid Managed Care Eligibility

Delayed Mandatory Managed Care Enrollment for Special Populations

- **Year 3**: Children in foster care and adoptive placements

- **Year 3:** Certain Medicaid and NC Health Choice beneficiaries with an SMI, SUD or I/DD diagnosis and those enrolled in the TBI waiver

- **No earlier than Year 5**: Medicaid-only beneficiaries receiving long-stay nursing home services

- **No earlier than Year 5**: Medicaid-only CAP/C and CAP/DA waiver beneficiaries

- **No earlier than Year 5**: Individuals who are dually-eligible for Medicare and Medicaid

Tailored Plan Eligibility

- I/DD beneficiaries;
- TBI individuals, including newly diagnosed/injured and those already on the TBI waiver waiting list;
- Individuals currently receiving *Medicaid-funded* BH, I/DD, or TBI services under LME-MCOs that won't be covered under Standard Plan PHP contracts;
- Individuals currently receiving *non-Medicaid funded* BH, I/DD, or TBI services under LME-MCOs *in addition to* Medicaid-funded services;
- Beneficiaries with a serious mental illness;
- Beneficiaries with a serious emotional disturbance;
- Beneficiaries with a severe substance use disorder;
- Children with complex needs as defined in the 2016 DHHS settlement agreement with DRNC;
- Children ages 0 – 3 with, or at risk for, developmental delay or disability;
- Children and youth 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 DHHS;
- Individuals with SMI or serious and persistent mental illness who are enrolled in the Transition to Community Living Initiative settlement agreement;
- Individuals with $\geq$ 2 psychiatric hospitalizations or readmissions within the prior 18 months;
- Individuals with $\geq$ 1 involuntary treatment episode within the prior 18 months;
- Individuals with $\geq$ 2 psychiatric ER visits within the prior 18 months; and
- Individuals with $\geq$ 2 behavioral health crisis services within the prior 18 months. Each individual must be assessed by DHHS within 14 calendar days of the 2nd episode for the need to disenroll in an SP and enroll in an LME or operational TP. If the individual does not qualify for SP disenrollment, then a subsequent episode within 12 months of the assessment will qualify the individual for SP disenrollment and LME or operational TP enrollment (no second assessment required in the legislation).

Tailored Plan Enrollment

- All beneficiaries who are eligible for Tailored Plans will remain enrolled with LME/MCOs until Tailored Plans go live.

- **DHHS anticipates that 30,000 dual-eligibles and 85,000 Medicaid-only beneficiaries will be eligible for Tailored Plans.**
  - Enrollment requests to move from a Standard Benefit Plan to a Tailored Plan may be regular *or* expedited.
  - Enrollment requests from an SP to a TP must be filed through the Enrollment Broker contractor, and will be reviewed by *DHHS* – not the Standard Benefit Plan PHPs or the Tailored Plans.
  - Enrollment in a Plan category will be appealable.

- **Medicaid beneficiaries on the Innovations Waiver waiting list will be Tailored Plan eligible.**
  - Registry of Unmet Needs individuals *may* enroll in a Standard Benefit Plan while on the waiting list and *will not* lose their place on the waiting list.
  - DHHS does not anticipate that the duration of wait time on the Registry of Unmet Needs will be any shorter after Tailored Plans are implemented.

- **Medicaid beneficiaries already enrolled in the Innovations Waiver program will have options:**
  - Remain in the Innovations Waiver program under a Tailored Plan
  - Formally disenroll from the Innovations Waiver program and enroll in a Standard Benefit Plan at go-live

Standard *and* Tailored Plan Covered Services

Inpatient behavioral health services	Outpatient behavioral health emergency room services	Outpatient behavioral health services provided by direct-enrolled providers	Mobile crisis management	Substance abuse intensive outpatient program	Facility-based crisis services for children and adolescents
Professional treatment services in facility-based crisis program	Psychosocial rehabilitation	Outpatient opioid treatment	Ambulatory detoxification	Non-hospital medical detoxification	Medically supervised or alcohol drug abuse treatment center detoxification crisis stabilization
Substance abuse comprehensive outpatient treatment program*	Research-based intensive behavioral health treatment	Diagnostic assessment	Early Periodic Screening Diagnostic Treatment (*Medicaid only; not NC Health Choice*)	Pharmacy Services	Partial Hospitalization

* *DHHS proposing legislation to add SAIOT to Standard Benefit Plan covered services.*

Tailored Plan Covered Services

All Medicaid benefits	Residential treatment facility services	Child and adolescent day treatment services	Intensive in-home services	Multi-systemic therapy services	Psychiatric residential treatment facilities (PRTFs)
Assertive community treatment (ACT)	Community support team (CST)	Substance abuse non-medical community residential treatment	Substance abuse medically monitored residential treatment	• Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)	TBI waiver services
	• Innovations waiver services	• 1915(b)(3) services	All State-funded BH and I/DD Services	State-funded TBI Services	

* *Therapeutic Foster Care services will be covered under Tailored Plans.*

2019 NCGA Bills of Interest

- H70 Delay NC HealthConnex for Certain Providers
- H75 School Mental Health Screening Study
- H471 Reduce Admin. Duplication MH/DD/SAS Providers
- S3 Close the Medicaid Coverage Gap
- S212 Suspend Child Welfare/Aging Component/NC FAST
- S361 Health Care Expansion Act of 2019

If You Have Follow Up Questions. . .

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