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Convene.
Strategize.
Activate.

A New Approach to Care: The Standard Plan

June 10, 2019

10:30 a.m. – 12:00 p.m.

Goals

- Clear Description of Plan Eligibility for Standard and Tailored Plans
- Identification of Concerns Regarding Transitional Issues
- Identification of Paths to Solutions

Brief Bio of a Credible Outsider

Carol Clayton, PhD

EVP, Population Health, Relias

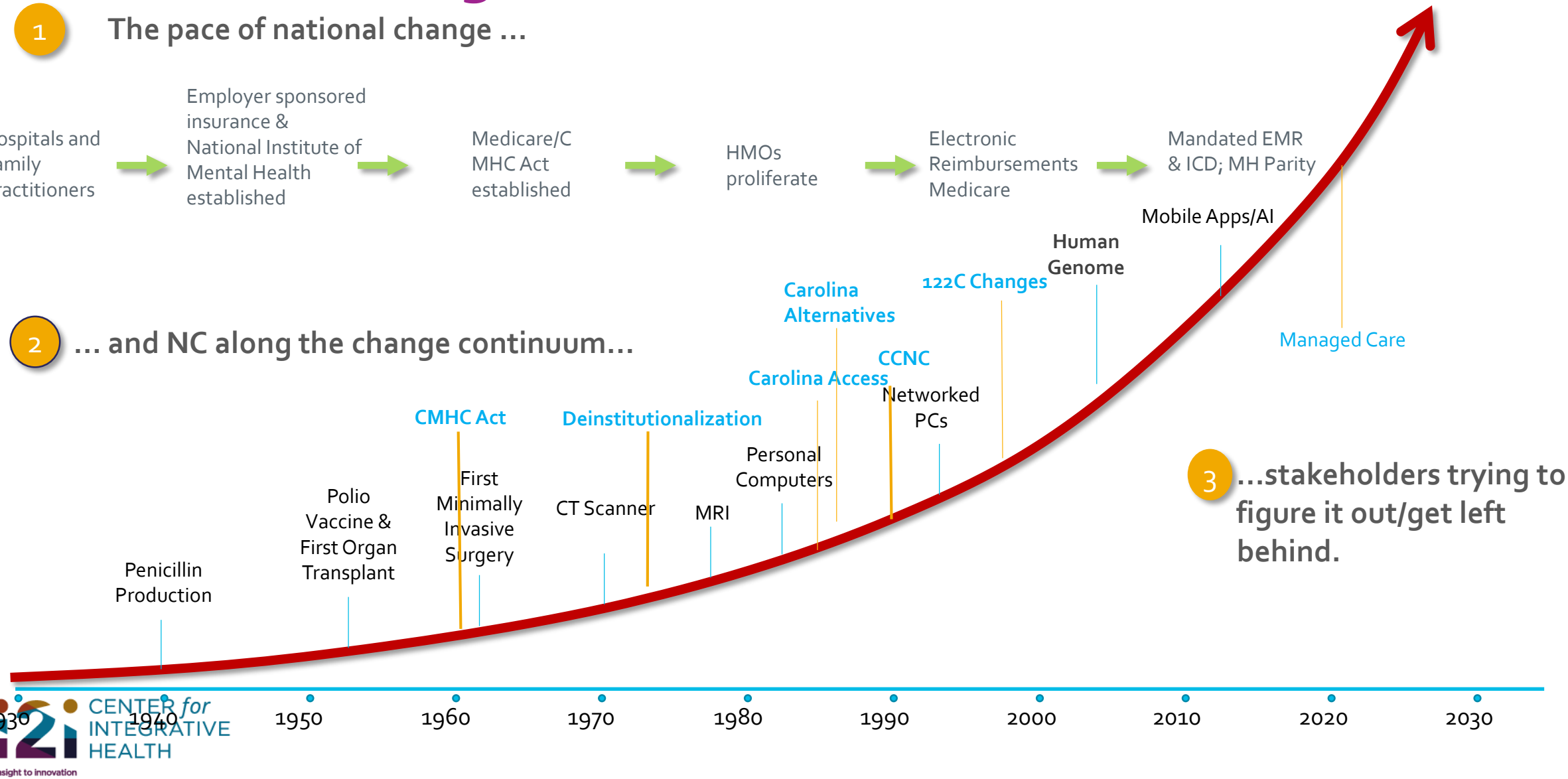
- **Old**: 30+ years experience
- Experienced: JUH, Private Practice, OPCMH, Magellan, NC ASO, NC COUNCIL, Healthcare Tehchnology Sector
- **Diverse**: Public sector, private sector, hospital and agency, nonprofit and for profit, advocacy and management
- **Risk Taker**: Bought and sold a company
- **Survivor**: Raised daughter
- **Educated**: Street Wise and Published
- **Uniquely Distanced:** Vendor/One of You

Healthcare Change Timeline

1 The pace of national change …

Hospitals and Family Practitioners → Employer sponsored insurance & National Institute of Mental Health established → Medicare/C MHC Act established → HMOs proliferate → Electronic Reimbursements Medicare → Mandated EMR & ICD; MH Parity

2 … and NC along the change continuum…



3 …stakeholders trying to figure it out/get left behind.

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What We Know

- NC Tides – Plenary 2-Difference between Standard Plan/Kathy Nichols
- NC Tides - Plenary 4- State of the State/Kody Kinsley
- https://i2icenter.org/wp-content/uploads/2019/03/Medicaid-Transformation-Presentation-.pdf/Sara Pfau Cansler Solutions
- MCAC Behavioral Health I/DD Tailored Plan Design Subcommittee/Trish Farham
- MCAC Behavioral Health I/DD Plan Subcommittee Transition of Care/Trish Farham
- MCAC Behavioral Health I/DD Plan Design Subcommittee/Elgibility/Julie Lerche
- https://i2icenter.org/bh-idd-tailored-plan-eligibility-and-enrollment/ Ann Rodriguez
- https://conta.cc/2GQdjhR /Jean Overstreet
- https://files.nc.gov/ncdhhs/documents/files/PopulationProfiles.pdf?oI20B1itRV6ozGxXBzNkaPZPK1zG3jgx/Mercer
- Suggested Draft Communication Message/NC Tides Plenary #2

"Ten crates of data and one little envelope of information. Sign here."

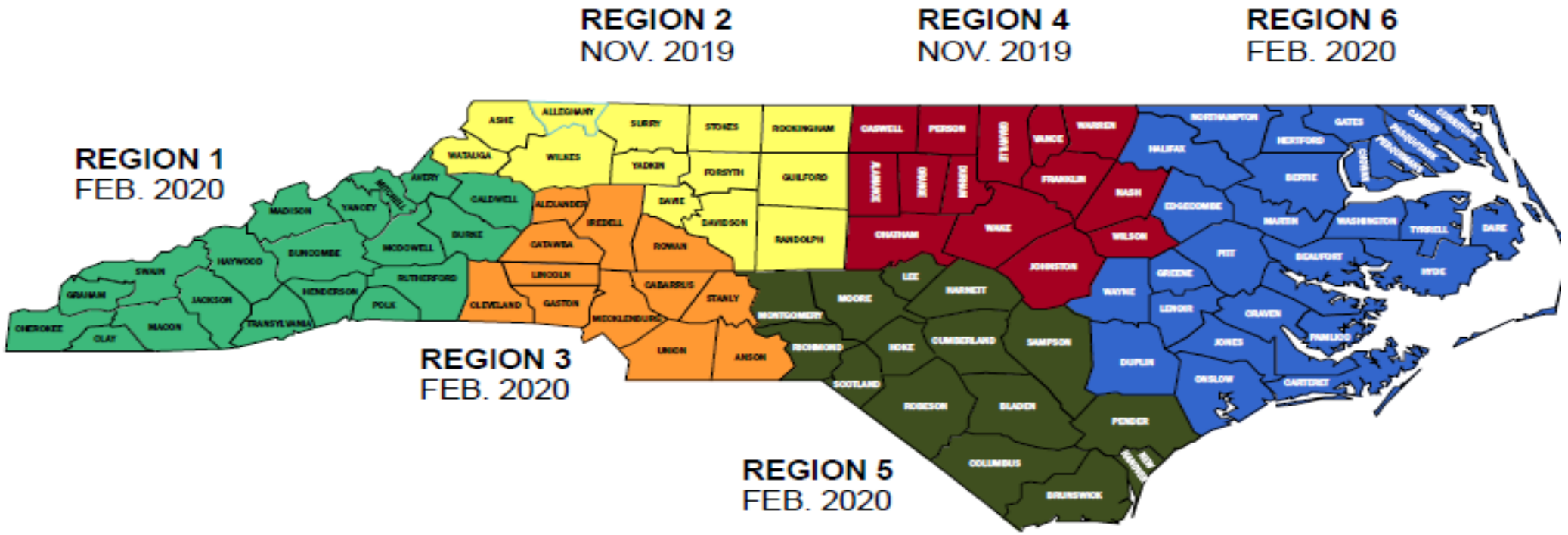
What I learned

- Standard Plan Selection
- Standard Plan Geography
- Standard Plan Eligibility
- Timeline for Transition
- Tailored Plan –Who Are They
- Tailored Plan Selection
- Tailored Plan Eligibility
- Tailored Plan Benefits
- Enrollment
- Roles and Responsibilities of Tailored Plan
- Tailored Plan Care Management Models
- Advanced Medical Homes
- Authorization Guidelines

Standard Plans

- Ameritas Caritas: **Katey Weaver, MSW, LSW, MBA**, Corporate Director, Population Health, New Business
- United Health: **Dr. Elizabeth Peterson-Vita**, Behavioral Health Executive Director
- Centene/Carolina Complete Health: **Jeremy Riddle,** Vice President of Business Development
- Wellcare Health Plans: **Courtney Cantrell, PhD,** Senior Director of Behavioral Health
- Amerigroup/Healthy Blue: **Joel Axler, MD,** Managing Medicaid Director, Government Business Division

Managed Care Regions and Rollout Dates



Rollout Phase 1: Nov. 2019 – Regions 2 and 4
Rollout Phase 2: Feb. 2020 – Regions 1, 3, 5 and 6

Standard Plan Populations

- Populations eligible for Standard Plans, not otherwise excluded or delayed and who do not meet BH I/DD Tailored Plan criteria will phase-out of the LME-MCOs at Standard plan launch.
- Some enrollment for these populations will remain for enrollment periods prior to PHP enrollment.

Standard Plan COA	Standard Plan Detailed Population Groups
ABD[1]	• Aged • Blind • Disabled
TANF and Other Related Children/Adults[1]	• Aid to Families with Dependent Children • Other Children • Pregnant Women • Infants and Children • Breast and Cervical Cancer (BCC) • Legal Aliens (Full Medicaid)[2] • NC Health Choice[2] • Medicaid- Children's Health Insurance Program (M-CHIP)

[1]ABD & TANF and Other Related Children/Adults based on eligibility coverage codes consistent with the LME-MCO rate cell structure.
[2]Not applicable to the LME-MCOs as Legal Aliens and NC Health Choice members are not currently enrolled with the LME-MCOs.

EXCLUDED POPULATIONS FROM STANDARD PLANS

- Populations that are excluded from managed care under Medicaid Transformation legislation will remain with the LME-MCOs until the BH I/DD Tailored Plan launch.

Excluded Population Groups	Identification
Medically Needy (excluding Innovations / TBI waiver)	Fourth digit of "M" for program category
Health Insurance Premium Program (excluding Innovations / TBI waiver)	Beneficiary roster provided by DHHS
CAP/C Waiver	Setting of Care codes (HC, IC, or SC)
CAP/DA Waiver	Setting of Care codes (CI, CS, ID or SD)
Others – Family Planning, Partial Duals, Aliens, Refugees, Inmates, PACE *Not currently enrolled in LME-MCOs*	Varies

Delayed (or Future) Managed Care Populations

- Populations that are delayed for managed care enrollment will remain with the LME-MCOs until the BH I/DD Tailored Plan launch.

Delayed Managed Care Populations	Identification
Foster Children	HSFCY, HSFMN, HSFNN, IASCN, IASCY, MFCNN – Expanded identification under review
BH I/DD Tailored Plan - Eligible *Includes both non-dual and dual eligible*	Clinical criteria applied to historical fee-for-service and LME-MCO encounter data used to identify beneficiaries as Tailored Plan eligible
Long-Stay Nursing Home Population	Identify 3 months of consecutive nursing home utilization; mark member as being Long-Stay Nursing Home from first month of 3 month consecutive utilization forward
Dual Eligible *Excludes members eligible for BH I/DD Tailored Plan*	Identified as dual eligible in the State eligibility data; does not meet BH I/DD Tailored Plan clinical criteria

Member Timeline– Phase 1

2019

Feb
- Initial letter sent to beneficiaries in 2 counties
- Address verification letter sent to remaining counties

March
- Flyers posted at DSS
- Address corrections to DSS

April
- 2nd letter to members
- Member Outreach activities

May
- Public Service Announcements
- PHP marketing materials

SOFT LAUNCH

June 3RD
- EB Call Center Open
- Welcome Packets mailed

July

Aug

- Open Enrollment Begins - July 15th

Sept
- Open Enrollment Ends - Sept 13th
- Members auto assigned to PHPs based on algorithm

Oct
- Member ID cards
- Member Handbooks

Day 1 - Regions 2 & 4

Nov 1ST Managed Care Launch- Phase 1

Dec
- Member feedback
- Evaluation of materials, process

Member Timeline– Phase 2

2019

June 3RD
- EB Call Center Open
- Outreach Activities

July
- Flyers posted at DSS
- Address corrections to DSS

Aug
- Letters to members
- Member Outreach activities

SOFT LAUNCH

Sept 2nd Enrollment Welcome Packets

Oct

Nov

Dec
- Open Enrollment Begins- Oct 14th
- Open Enrollment Ends- Dec 13th

2020

Jan
- Member ID cards
- Member Handbooks

Day 1 - Regions 1, 3, 5 & 6

Feb 1st Managed Care Launch- Phase 2

March
- Member feedback
- Evaluation of materials, process

Tailored Plan Eligibility

- Alliance Behavioral Health
- Cardinal Innovations
- Eastpointe Human Services
- Partners Behavioral Health Management
- Sandhills Center
- Trillium Health Resources
- Vaya Health

Tailored Plan Member Eligibility

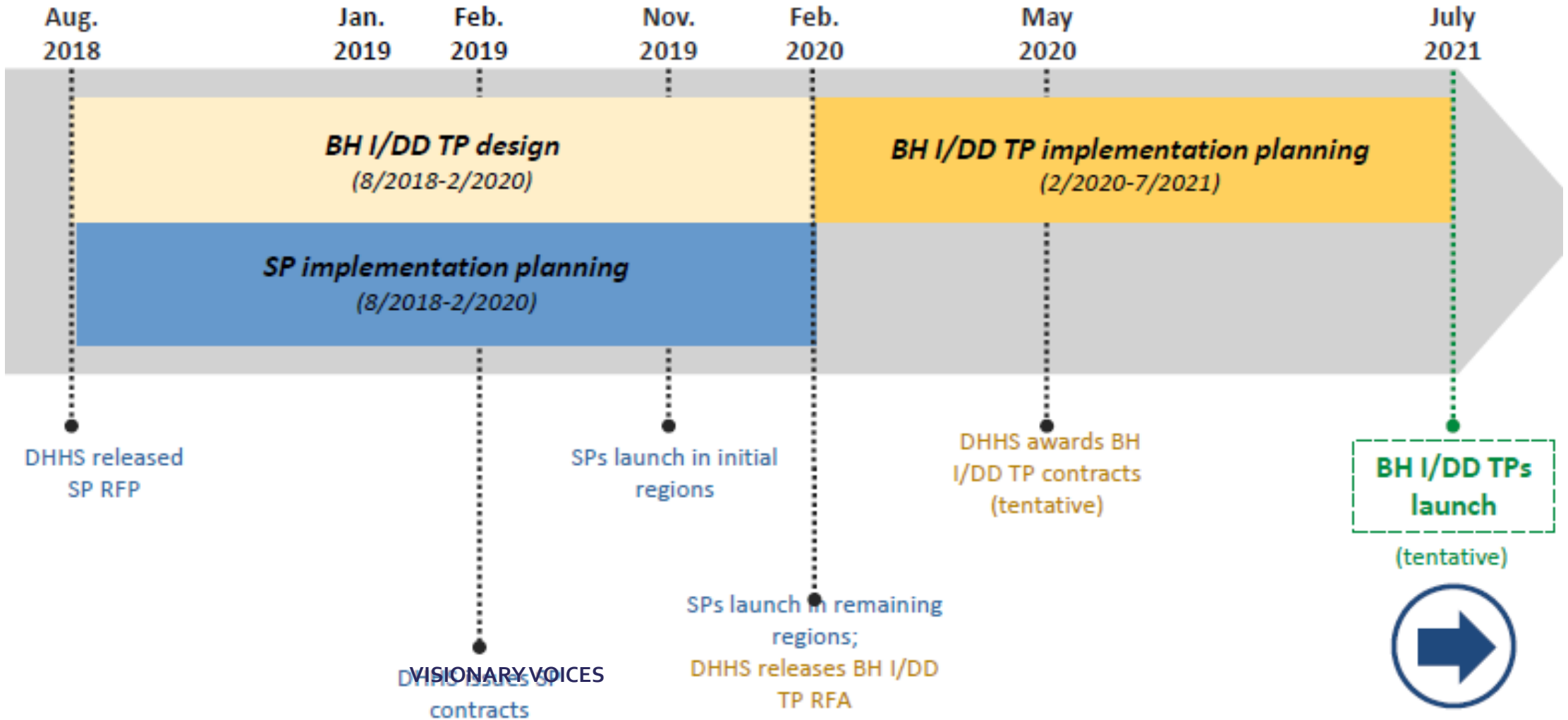
Overview of Eligible Population

TP Populations:

- Qualifying I/DD diagnosis
- Innovations and TBI Waiver enrollees and those on waitlists
- Qualifying Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) diagnosis who have used an enhanced service
- Those with two or more psychiatric inpatient stays or readmissions within 18 months
- Qualifying Substance Use Disorder (SUD) diagnosis and who have used an enhanced service
- Medicaid enrollees requiring TP-only benefits
- Transition to Community Living Initiative (TCLI) enrollees
- Children with complex needs settlement population
- Children ages 0-3 years with, or at risk for, I/DDs who meet eligibility criteria
- Children involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs who meet eligibility criteria
- NC Health Choice enrollees who meet eligibility criteria

Tailored Plan Design and Launch Timeline

Until early 2020, DHHS will be conducting intensive planning for both Standard Plans (SPs) and TPs. After SPs launch, DHHS will continue implementation planning for Tailored Plans.



Tailored Plan Enrollment

How Plan Enrollment Works

There are two ways in which an individual will be identified for enrollment in a TP:

DHHS Data Review

DHHS will review several sources of data to determine if an individual is TP-eligible:

- Medicaid claims and encounter data
- State-funded Behavioral Health (BH), Intellectual/Developmental Disabilities (I/DD), and Traumatic Brain Injury (TBI) data
- Innovations and TBI waiver enrollment and waitlists

These individuals will remain in their current delivery system (generally Fee-for-Service/LME-MCO) until TPs launch. When TPs launch, these individuals will be defaulted into TPs, but have the option to enroll in a SP.

Self-Identification

Individuals can self-identify as potentially TP-eligible at any time:

- Individuals may request an assessment from a qualified provider to determine if their health needs meet TP eligibility criteria
- A qualified provider can also submit an assessment form for enrollees who need a TP-only service
- DHHS reviews and provides approval or denial of request within 3-5 days, or 48 hours for an expedited request

Each year, TP enrollees will be re-enrolled in their current plan, unless they have meet both of the following criteria:

- Have Serious Mental Illness (SMI) or Substance Use Disorder (SUD) diagnosis, and
- Have not used any Medicaid or State-funded behavioral health service in the 24 months besides outpatient therapy or medication management

Enrollees who meet these criteria will be transitioned to a Standard Plan (SP), but will have the opportunity to obtain an assessment to move back to a TP at any time.

Enrollment

Enrollment Features Promoting Integration

- TP-eligible beneficiaries will be enrolled in a single managed care plan for physical, behavioral health, I/DD, TBI, and Innovations Waiver services and will go through one plan enrollment process and receive notices from one plan
- Enrollees will use one insurance card to access all these TP services
- Enrollees will reference one plan's member handbook, provider directory and coverage policies
- Enrollees will interface with one enrollment broker, which will be trained to meet the specific needs of the TP population. The enrollment broker will also support outreach and education to TP enrollees to help ensure a smooth transition.

As required by state statute, some limited services (e.g. dental services or Children's Developmental Service agency services) will be carved out of the Tailored Plan and offered through Medicaid fee-for-service.

Tailored Plan Benefits

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.

TP 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)*
- 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*

Note: Dual eligible enrollees will receive behavioral health, I/DD, and TBI services through the TP and other Medicaid services through FFS

**Services will only be offered through TPs; in addition, certain high-intensity behavioral health services, including some of the new SUD services, will only be offered through TPs*

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Roles and Responsibilities: BH I/DD TPs

BH I/DD TPs will carry out all functions typical of a health plan.

BH I/DD TP Responsibilities Include:

- Conducting utilization management;
- Overseeing member services (e.g. hotlines, member handbooks, provider directories) and provider services (e.g. provider manuals, online portal, trainings and technical assistance);
- Developing and managing the provider network;
- Managing the benefit package across the full continuum of physical and behavioral health, pharmacy, and I/DD and TBI services, including Innovations and TBI waiver services;
- Monitoring for fraud/waste/abuse;
- Conducting risk stratification to identify intensity of enrollees' needs;
- Paying care management organizations a tiered PMPM for care management based on assessment of level of care management services required to assist client in meeting care plan goals;
- Paying claims from providers and submitting encounter data to the State;

Overview of BH I/DD TP Care Management Approach

NC DHHS

Establishes care management standards for BH I/DD TPs aligning with federal Health Home requirements

The BH I/DD TP will act as the Health Home and will be responsible for meeting federal Health Home requirements

BH I/DD TP Health Home

All approaches will be subject to one set of requirements and will provide care management across physical health, behavioral health, I/DD, and other services and the enrollee's unmet health-related resource needs.

Care Management Approaches

BH I/DD TPs have flexibility in how they provide care management, as long as the approach meets DHHS standards and care management is provided in the community to the maximum extent possible.

Approach 1: Tier 3 AMH with BH and/or I/DD Certification*

DHHS will create specialized BH and I/DD certifications for Tier 3 AMHs that serve a substantial number of BH I/DD TP enrollees and have experience serving these populations

Approach 2: Care Management Agencies (CMAs)*

BH I/DD TPs contract with agencies such as those that provide BH or I/DD services (e.g., mental health or substance use agencies, home care agencies, etc.) that obtain CMA certification

Approach 3: BH I/DD TP-Employed Care Managers

BH I/DD TPs may provide care management in certain circumstances that will be outlined in more detail by DHHS.

AMH Tiers Compared

Tiers 1 and 2

- SP **retains** primary responsibility for care management
- Practice requirements are the same as for Carolina ACCESS
- **Providers will need to coordinate across multiple plans:** practices will need to interface with multiple SPs, which will retain primary care management responsibility; PHPs may employ different approaches to care management

Tier 3

- PHP **delegates** primary responsibility for delivering care management to the practice level (see next slide)
- **Single, consistent care management approach:** Practices will have the option to provide care management in-house or through a single CIN/other partner across all Tier 3 SP contracts
- **Initial attestation process closed 1/31:** based on attestation data, majority of SP beneficiaries are expected to be attributed to Tier 3 practices

Tier 4: To launch at a later date

Deep Dive on Tier 3 AMHs

Tier 3 AMHs are responsible for delivering care management at the practice level including:

Tier 3 Responsibilities

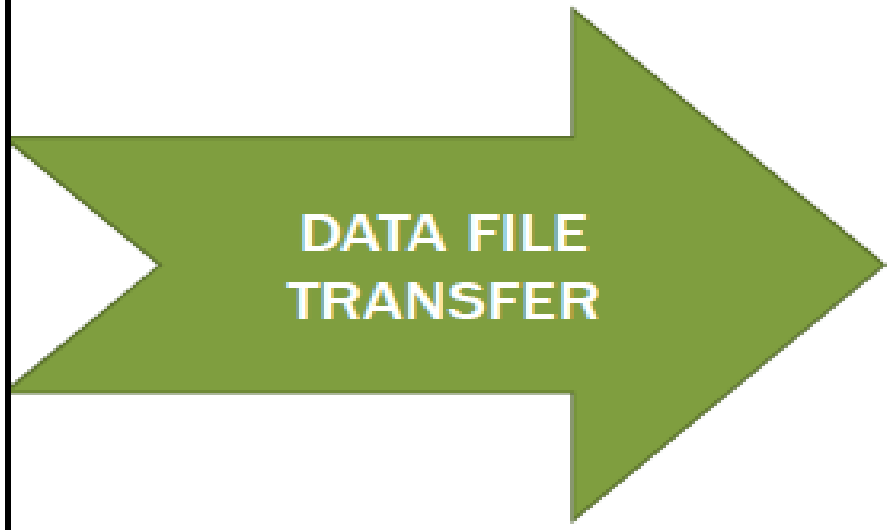
- **Risk stratify** all empaneled patients
- Provide **care management to high-need patients,** which includes (but is not limited to):
  - Conducting a **comprehensive assessment** of enrollees' needs
  - Establishing a **multi-disciplinary care team** for each enrollee
  - Developing a **care plan** for each enrollee
  - **Coordinating all needed services** (physical health, behavioral health, social services, etc.)
  - Providing **in-person assistance securing unmet resource needs** (e.g. nutrition services, income supports, etc.)
  - Conducting medication management, including regular medication reconciliation and support of medication adherence
  - Providing **transitional care management** as enrollees change clinical settings
- **Receive claims data feeds** (directly or via a CIN/other partner) and meet state-designated **security standards** for their storage and use

AUTHORIZATION CONSIDERATIONS

Transition of Care Dynamics Related to the BH/IDD Community

- A beneficiary who is currently served by the LME-MCO but who will enroll in the Standard Plan.
- A beneficiary who defaults to remaining in the LME-MCO but chooses to move to the Standard Plan.
- (After MCL): A beneficiary ("Member") served by the Standard Plan but is identified as eligible to be served by the LME-MCO/Tailored Plan.
- A Member who elects to transfer between Standard Plans.
- Other circumstances .

Crossover to MCL: Activities Underway



- A PHP will receive ongoing claims/encounter data on all enrolled members, including its members currently served by the LME-MCO.
- A PHP will receive open and recently closed Prior Authorizations on all enrolled members.
- As needed, PHPs will have access to Member's most current care plan and assessment information.
- Data transfer will continue after MCL.

Crossover to MCL: Specific Prior Authorization Considerations

Honoring Prior Authorizations

- PHPs must honor open FFS PAs for at least the first 90 days after MCL
- The Department will track the service disposition of FFS PAs with open units that extend beyond 90 days and establish protocols for navigating identified high-risk members through PA modifications made by PHPs after 90 days.

Non Participating Providers

- For the first sixty (60) days after MCL, PHPs required to pay claims and authorize services for Medicaid eligible nonparticipating/out of network providers equal to that of *in network* providers until end of episode of care or the 60 days, whichever is less.*
- *Note: N.C. Gen. Stat. § 58-67-88 also applies

Crossover to MCL: Specific Prior Authorization Considerations (continued)

Unmanaged Visits for Outpatient Behavioral Health Services

- For members who are authorized for services under this Clinical Coverage Policy at Managed Care Launch (MCL), the unmanaged visit count shall reset to zero.

"Pass Through" Prior Authorization Period for Substance Abuse Comprehensive Outpatient Treatment (SACOT)

- For members who are currently receiving SACOT at Managed Care Launch (MCL), the PHP shall allow for a full 60 days of services without requiring a Prior Authorization.

Crossover to MCL: Specific Prior Authorization Considerations (continued)

Primary Goal of Crossover to MCL: To Ensure Member Continuity of Care.

- All UM Vendors (including LME-MCOs) will continue to receive PA requests up to 11:59 the night before applicable MCL.
- UM Vendors will continue to review and process these PA requests under their standard requirements until completion.
- The UM Vendors will NOT be authorized to review PA requests for Standard Plan members submitted on or after MCL.
- So, what if despite education efforts, a provider attempts to submit a Prior Authorization request after MCL to the UM vendor instead of the Member's PHP?

What I Couldn't Find as Easily: Top 20

1. Qualifying Definition of SED, SUD, SMI, IDD
2. Does the definition of complex needs of "SMI and IDD" mean concurrent diagnoses and if so, for how long is the concurrency window?
3. What is the distinction between being enrolled in Family Planning Medicaid and full Medicaid?
4. What are the specific performance measures for health plans and providers?
5. What are the specific requirements for APM and how will they be evaluated? Does healthplan have complete discretion for establishment of APMs?
6. What happens in the time period between 2/20 when standard plan implementation ends and 7/21 when tailored plans begin?
7. Limits for existing authorizations and expectation for consistency across health plans for such
8. Impact analysis of increased copay on provider rate setting
9. Can a BH Provider qualify as an AMH?
10. Information about CIN's –where to find info, how to engage? Are CIN's for tailored or standard providers or both?
11. 3 models of care management—who certifies?
12. What is role of the care mgr vs the plan mgr vs the enrollment broker?

(oops Top 22)

11. About how many people are expected (what percent of total) to transition between standard and tailored plans?
12. When transitioning to a tailored plan, what is the time frame and who will assess need/eligibility?
13. Does any BH crisis automatically result in an evaluation for tailored plan enrollment?
14. Will authorization parameters be consistent across plans?
15. Are IDD habilitative services held to same 90 day limit of authorization as rehabilitative services?
16. What is the training for DSS workers? What is the expected response time for DSS regarding enrollment and how will they be tracked and measured?
17. What is the role of the county DSS in assessing SDOH and their impact on tailored vs standard plan enrollment?
18. What is the actual role of the broker? Who do they serve? What is their expertise in assessment/evaluation?
19. What is the education/communication plan for members beyond letters?
20. What is the education plan for DSS workers and providers, particularly in how to help the member?

Other Items Of Concern:

- Community Floor of Services such as disaster response, crisis walk in funded with uninsured dollars
- How Relationship with local DSS is defined/evaluated;
- How is an interdisciplinary team defined?
- Can others besides Murdoch do evaluation for complex needs status? If so, where do I find that info?
- How will the data exchange requirements for APMs be tested/validated?
- Who qualifies as the independent assessor in the "raise your hand" scenario?
- Will the eligibility portal be accurate?
- Will rates (MCO and providers) be sufficient?

Panel Discussion (and the Fun) Begins

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Scenario 1:

I own a child serving agency serving. I plan to be in-network with the PHPs in my area. If I am an in-network provider, will the PHP let me know if someone in their Standard Plan has been disenrolled from Medicaid? Will there be a way to bill for services that were prior authorized and provided before I was informed that the person was disenrolled? Will you have a claims appeal process for providers?

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Scenario 2

I run a walk-in crisis clinic. The clinic serves anyone, regardless of funding source. People often show up at the clinic without having contacted their Plan beforehand. How will crisis service agencies interact with your managed care plan? Will your Standard Plan contract with crisis service providers? Do you have to be in-network to be reimbursed? Do crisis services have to be pre-authorized?

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Scenario 3

There are a lot of questions about how the Standard Plan managers will be supporting members who experience acute crises of a behavioral health/substance use nature. Can you talk about how, in your experience, your PHP handles moving people into and up the continuum of services. If there needs to be a hand off to a Tailored Plan, how does your PHP envision doing that?

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Scenario 4

I work for a large comprehensive agency. We serve a family that uses multiple services we offer. The Mother gets med management for her depression and anxiety and we know she has COPD, one child is receiving preventive SUD services and engaged in family-based therapy and the father had a DUI and is getting SUD services. What does your managed care organization do to coordinate services for families? When you have multiple people in one family using services do you expect a provider to do anything above and beyond the service? Can a provider recommend to your PHP when we think an individual or family should have a care manager?

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Scenario 5

What happens when a member shows up at PCP office and they are not a provider in-network or the selected provider?

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Thank You

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