Back Porch Chat: Medicaid Managed Care Hot Topics

May 6, 2021

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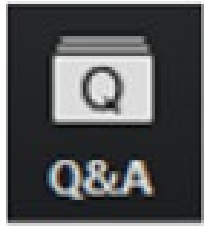
Logistics for today's COVID-19 Forum

Question during the live webinar



Technical assistance

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AGENDA

01 Review BH Fireside Chat Highlights

02 What If's of BH Answered

03 A Few Highlights

04 Questions & Answers

BH Fireside Chat Highlights

Reference the January 7th Behavioral Health webinar recording, slides and transcript at https://www.ncahec.net/medicaid-managed-care/

Webinar Recordings, Slides and Transcripts:

October 1, 2020 | **Better with Time**: **Recording**, **Slides** and **Transcript**

November 5, 2020 | **Advanced Medical Home**: **Recording**, **Slides** and **Transcript**

December 3, 2020 | **Beneficiary Attribution**: **Recording**, **Slides** and **Transcript**

January 7, 2021 | **Behavioral Health (standard plans): Recording**, **Slides**, and **Transcript**

February 4, 2021 | **Quality, Tracking quality performance, outcomes and expectations**: **Recording**, **Slides**, **Transcript** and **Q&A**

March, 4, 2021 | **Medicaid Hot Topics**: **Recording**, **Slides**, **Transcript** and **Q&A**

April 1, 2021 | **Hot Topics in Medicaid Transformation**: **Recording**, **Slides** and **Transcript**

Medicaid Managed Care Overview

Over the next two years, North Carolina will transition from a predominantly fee-for-service delivery system to Medicaid managed care. With this transition, the state will offer four types of managed care products that will provide integrated, whole-person care.

Standard Plan

Standard Plans will provide integrated physical health, behavioral health, pharmacy, and long-term services and supports to most Medicaid beneficiaries, as well as programs and services that address other unmet health related resource needs. Standard Plans will launch in **July 2021.**

EBCI Tribal Option

The Eastern Band of Cherokee Indians (EBCI) Tribal Option will be available to tribal members and their families and will be managed by the Cherokee Indian Hospital Authority (CIHA). The Tribal Option will be a primary care case management entity, which will have a strong focus on primary care and providing care management services. Tribal Option will launch in **July 2021.**

BH I/DD Tailored Plan

Behavioral Health (BH) Intellectual/ Developmental Disability (I/DD) Tailored Plans will provide the same services as Standard Plans, as well as additional specialized services for individuals with significant behavioral health conditions, I/DDs, and traumatic brain injury, as well as people utilizing state-funded and waiver services. BH I/DD Tailored Plan will launch in **July 2022**.

Specialized Plan for Children in Foster Care

A Specialized Plan for Children in Foster Care will be available to children in foster care and children in adoptive placement and adults formerly in foster care up to the age of 26. It will provide integrated physical health, behavioral health, pharmacy, and long-term services and supports. The Foster care plan will launch in **July 2023**.

Standard Plans and BH I/DD Tailored Plans

Both Standard Plans and BH I/DD Tailored Plans will be integrated managed care products and will provide a robust set of physical health, behavioral health, long-term services and supports, and pharmacy benefits.

Standard Plans

- Will serve most of the non-dual eligible Medicaid population

BH I/DD Tailored Plans

- Targeted toward populations with:
  - significant behavioral health conditions—including serious mental illness, serious emotional disturbance, and severe substance use disorders
  - intellectual and developmental disabilities (I/DD),and
  - traumatic brain injury (TBI)
- Will offer a more robust set of behavioral health and I/DD benefits than Standard Plans and will be the only plans to offer current 1915(b)(3), 1915(c) Innovations and TBI waiver, and State-funded services

Key Takeaways: For Providers of BH and I/DD Services

- Behavioral health providers will need to contract with both SPs and LME-MCOs until BH I/DD Tailored Plan launch to be in-network for both types of plans. When BH I/DD Tailored Plans launch, providers will need to contract with both SPs and BH I/DD Tailored Plans. Contracting with both types of plans will better ensure continuity of care, as well as appropriate payment for the services you are providing.
- A subset of high-intensity behavioral health, I/DD, and TBI benefits will only be offered in BH I/DD Tailored Plans (LME-MCOs prior to BH I/DD Tailored Plan launch). It will be important for providers to understand which benefits are offered in which type of plan to provide guidance to their patients.
- Standard Plans will have open provider networks for both Physical and Behavioral Health. Tailored Plans will have closed provider networks for Behavioral Health and an open provider network for Physical Health.
- Once managed care launches, providers will bill the appropriate plan (Medicaid Direct, LME-MCO, or Standard Plan) for services.

Key Takeaways: Tailored Plan Eligibility and Enrollment

- Most non-dual beneficiaries, including those with mild to moderate behavioral health needs, will enroll in Standard Plans.

- Beneficiaries may come to their provider to understand their options with regards to the managed care transition and the differences between Standard Plans and BH I/DD Tailored Plans (or FFS/LME-MCOs prior to BH I/DD Tailored Plan launch). Providers should refer any beneficiaries with questions to the Enrollment Broker.

- Providers will play a key role in helping beneficiaries who believe they may be eligible for a BH I/DD Tailored Plan or need a service only offered in BH I/DD Tailored Plans to complete the process to transition to a BH I/DD Tailored Plan (or FFS/LME-MCO prior to BH I/DD Tailored Plan launch).

Comparing Plan BH/IDD/TBI Benefits

Available In Both SPs and BH I/DD Tailored Plans	Available Only in BH I/DD TPs (or LME-MCOs Prior To Launch)
State Plan 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 • Research-based intensive BH treatment for Autism Spectrum Disorder • Diagnostic assessment • EPSDT • *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* • *Non-hospital medical detoxification* • *Medically supervised detoxification crisis stabilization*	**State Plan Services** • Residential treatment facility services • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) • *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)* • *Psychosocial rehabilitation* • *Substance abuse non-medical community residential treatment* • *Substance abuse medically monitored residential treatment* • *Substance abuse intensive outpatient program (SAIOP)* • *Substance abuse comprehensive outpatient treatment program (SACOT)* **Waiver Services** • Innovations waiver services • TBI waiver services • 1915(b)(3) services **State-Funded behavioral health, I/DD and TBI Services**

Enhanced Behavioral Health Services are Italicized

Standard Plans and Behavioral Health

Under managed care transformation, Standard Plans will function as integrated managed care plans that will cover both emergent and lower-intensity behavioral health and substance use services.

Standard Plans will Offer:

1. A set of low intensity behavioral health and Substance Use services, including:
   - Outpatient behavioral health services
   - Psychological services
   - Peer supports
   - Diagnostic assessments
2. A set of emergent behavioral health and substance use services to support members with emergent needs, including:
   - Mobile and facility-based crisis services
   - Inpatient behavioral services
   - Partial hospitalization
3. A set of substance use services, including:
   - Outpatient opioid treatment (including OTP and OBOT)
   - Ambulatory detox
   - Non-hospital medical detox

Why Emergent Services?

Including emergent behavioral health services in the Standard Plans ensures that members with emergent needs can receive their needed services, in a timely manner, and do not have to transition to a new plan. Standard Plans must contract with all crisis BH providers to help ensure access to services and support continuity of care.

Transformation Seeks to Integrate Physical & Behavioral Health

Under managed care transformation, both Standard Plans and BH I/DD Tailored Plans will be integrated managed care plans that will cover physical health, behavioral health, and pharmacy services for most Medicaid and NC Health Choice enrollees.

Behavioral Health Benefits

1. Both Standard Plans and BH I/DD Tailored Plans will offer a robust set of behavioral health benefits including:
   - Pharmacy Services
   - Outpatient & inpatient behavioral health services
   - Crisis Services
   - Withdrawal management services
2. Certain higher-intensity behavioral health, I/DD, and TBI benefits , will only be offered under BH I/DD Tailored Plans (or LME-MCOs prior to BH IDD Tailored Plan launch). These services are:
   - Most of the enhanced and residential BH services
   - Innovations
   - TBI
   - 1915(b)(3) waiver services

Why Integrate?

Currently, behavioral health benefits are administered though LME-MCOs, while physical health benefits are administered separately through Medicaid fee-for-service.

Integrating behavioral and physical health benefits will enable plans, care managers, and providers to deliver **coordinated, whole-person care**.

What Ifs

What is the utilization management criteria for behavioral health hospitalizations and admissions under Standard Plan? Will this be consistent across plans or will each plan get to use their own criteria?

Will behavioral health services offered vary across health plans?

What will change with mobile crisis and assessment services with managed care?

How will the State ensure the health plans are following appropriate utilization management standards/ guidelines?

What Ifs

How will the Innovations Waiver program work with Standard Plan and Tailored Plan? It seems that patients may qualify for a CAP waiver and Tailored Plan at the same time.

What If a member qualifies for Tailored Plan based on the severity of their behavioral health issue; will they still be able to see the provider that was providing their opioid use disorder treatment if it is different from their behavioral health provider?

Do patients have the right to refuse certain Tailored Plan labels and diagnoses, but still receive the treatments (e.g., a parent with a 2-year-old with a positive M-CHAT that is evaluating options and perhaps seeking 2nd and 3rd opinions)? Can providers provide Tailored Plan services to patients who are not in Tailored Plan?

What happens when a child presents with a mental health emergency (e.g., suicide crisis) and I am OON? Will I still get paid?

What Ifs

Will providers still be able to bill the same collaborative care codes that we currently bill?

What If a standard plan does not approve request for peer supports?
Will this be a covered service?
What are my rights to contest or appeal a health plan decision?

Will compliance with mental health parity regulations be enforced by the State and if so, what are the mechanisms to enforce?

Many behavioral health providers support delivery of primary care and care provided by community health centers through telehealth. Will telehealth remain after the public health emergency?

Standard Plans and BH I/DD Tailored Plans Networks

Both Standard Plans and BH I/DD Tailored Plans will be required to maintain a network of providers that is sufficient to ensure that covered services are available and accessible to all members in a timely manner.

Purpose of Network Adequacy and Accessibility Standards

- To ensure that Standard Plan and BH I/DD Tailored Plan members have access to providers, and offer an important tool for DHHS to monitor that access

Types of Standards Utilized for Behavioral Health Services

- Standards include:
  - The maximum distance, measured in an amount of time or miles, a beneficiary must travel to a network provider
  - A minimum number of network providers within a specified region
  - Appointment wait times
- Standards are set by county and can vary according to whether the county is considered an urban or a rural county. Designation is based upon the population density of the county

DHHS Standard Plans Network Oversight

DHHS has developed robust behavioral health network adequacy standards to ensure Standard Plan members' access to behavioral health services and will monitor Standard Plans for compliance before managed care launch and afterwards.

Network Oversight for Standard Plans

- DHHS will collect network data detail information from plans and will:
  - Perform geo-mapping analysis on the data to confirm compliance with time/distance standards
  - Confirm the Standard Plan has contracted with the minimum number of providers in a region and has proper coverage across the entire region

- Before managed care launch, DHHS will use criteria to monitor network adequacy progress on a regional and county basis for each Standard Plan
  - If deficiencies are identified, DHHS will require submission of a mitigation strategy from the Standard Plan
  - DHHS will monitor the mitigation strategy effectiveness and may request Corrective Action Plans, if adequate progress is not made

DHHS Standard Plans Network Oversight (continued)

DHHS has developed robust behavioral health network adequacy standards to ensure Standard Plan members' access to behavioral health services and will monitor Standard Plans for compliance before managed care launch and afterwards.

Network Oversight for Standard Plans (continued)

- DHHS will use network analysis:
  - To assist in decisions around auto-enrollment and managed care launch
  - To determine when/whether to require a Standard Plan to submit a mitigation strategy submissions or a Corrective Action Plan (CAP)
  - To determine when to take other steps to mitigate deficiencies in a network, such as spot data submissions to demonstrate progress or evidence adequacy

- Shortly after managed care launch, Standard Plans will make an official submission of their networks as part of a regulatory submission
  - For any county in which a Standard Plan cannot meet the network adequacy standard, the plan must submit a request for approval of an exception
  - Exception requests must be approved by DHHS and must demonstrate how the plan will ensure members are able to obtain the services covered under the exception.

Standard Plan Behavioral Health Network Adequacy

DHHS has developed robust behavioral health network adequacy standards to ensure Standard Plan beneficiaries' access to behavioral health services. Standard Plans will maintain an open network for all services, including behavioral health services.*

#	Service Type	Urban Standard	Rural Standard
1	Outpatient Behavioral Health Services	2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of Members	2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of Members
2	Location-Based Services (Behavioral Health)	2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of Members	2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members
3	Crisis Services (Behavioral Health)	1 provider of each crisis service within each health plan region	
4	Inpatient Behavioral Health Services	1 provider of each inpatient BH crisis service within each health plan region	
5	Partial Hospitalization (Behavioral Health)	1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of Members	1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of Members

***Open Provider Network:** Any willing provider that meets specific quality standards and accepts the rates offered by the plan

Full SP network adequacy requirements can be found at https://medicaid.ncdhhs.gov/transformation/health-plans

Standard Plan BH Appointment Wait Time Standards

DHHS has developed robust behavioral health appointment wait time standards to ensure Standard Plan members' access to behavioral health services.

Behavioral Health Appointment Wait Time Standards

#	Service Type	Appointment Wait Time Standard
1	Mobile Crisis Management Services	Within 2 hours
2	Urgent Care Services for Mental Health	Within 24 hours
3	Urgent Care Services for SUDs	Within 24 hours
4	Routine Services for Mental Health	Within 14 calendar days
5	Routine Services for SUDs	Within 14 calendar days
6	Emergency Services for Mental Health	Immediately (available 24 hours a day, 365 days a year)
7	Emergency Services for SUDs	Immediately (available 24 hours a day, 365 days a year)

Full SP network adequacy requirements can be found at https://files.nc.gov/ncdhhs/30-19029-DHB-2.pdf

Network Adequacy What Ifs

For licensed independent practitioners (LPCs, LCSWs), there is no rate floor. What happens if there is not enough contracted licensed practitioners to provide services such as individual psychotherapy to children and adults?

How will health plans find a provider (therapist) for beneficiaries, if no one is taking new patients?

Quality What Ifs

Are there metrics that the State is tracking around integrated care that providers need to know about?

Does the AMH model support collaborative care teams that include psychiatrists and mental health professionals?

Do we have the behavioral health metrics that primary care providers will need to follow in Standard Plan? What are the metrics and how will they be tracked?

Will current peer support authorizations cross over at managed care launch?

Notices Regarding Managed Care Transition

DHHS sent notices in March 2021 to individuals regarding July 2021 managed care enrollment.

There were different notices for beneficiaries who will be required to enroll in a Standard Plans vs. those eligible for a BH I/DD Tailored Plan who will by default remain in Medicaid FFS/LME-MCOs. DHHS anticipates that beneficiaries may reach out to providers with questions about these notices.

Notices for beneficiaries slated to enroll into Standard Plans will include information about:

- Timeline that the beneficiary will enroll in managed care
- Process for selecting a primary care provider and a health plan
- Steps to take for beneficiaries who believe they need certain services to address needs related to developmental disability, mental illness, TBI, or substance use disorder
- Contact information for enrollment broker for choice counseling

Notices for beneficiaries who are eligible for a BH I/DD Tailored Plan and will remain in FFS/LME-MCOs will include information about:

- Beneficiary's continued enrollment in FFS/LME-MCO
- Option to enroll in a Standard Plan with explanation that Standard Plans will offer a more limited set of benefits for developmental disability, mental illness, TBI, or substance use disorder
- Contact information for enrollment broker for choice counseling

What if a Member Needs a Service That is not Covered by Standard Plans?

A provider can request a transfer to NC Medicaid Direct and LME-MCO if a member needs a behavioral health or I/DD service that is *not* covered by Standard Plans.

Provider Works with Member to Complete the Request

Member and provider discuss which services member needs that are not available in current plan.

Member or Legal Guardian Signs the Request

Member or guardian confirm the member wants to immediately un-enroll from the Standard Plan.

Provider Submits the Request

Provider submits the provider form and a service authorization form to the Enrollment Broker, which will send to appropriate Vendor within 24 hours.

NC Medicaid Reviews the Request and Transfers Member

NC Medicaid reviews the request and, if approved, transfers member to new plan within 1 business day.

Enrollment What Ifs

Are plans going to be required to reinstate or expedite coverage for people in the prison system?

Is there a safety net for beneficiaries to get services while they figure out the plan/PCP they want or have been assigned to?

General What Ifs

Are the number of visits providers currently have per year under Medicaid going to stay the same under the different health plans?

Are documentation standards different between Tailored Plans vs Standard Plans?

How are commercial insurance companies different than Medicaid? What is the difference between their Medicaid product/services and their commercial services?

Providers like the current system of Medicaid and the ability to talk to someone who will listen to you. What if there is a problem, how do we escalate to a higher power after we attempt to work through the issue with the plan and they cannot help?

Hot Topics Worth a Mention

Payments

- AMH Tier 3 Glidepath Timeline
- HOSAR Screening
- Equity Payments
- Emergency/Crisis Rate Floor
- Good Faith Contracting and Payments

COVID

- Public Health Emergency
- Vaccine Updates:
  - Will the age go to 12?
- New Flexibilities:
  - Time on shelf
  - Unused doses
  - Type of vaccine


QUESTIONS?

APPENDIX

Implementation of Rate Floors for Facility-Based Crisis and Mobile Crisis Services

Effective July 1, 2021, NC Medicaid will increase fee-for-service rates and establish rate floors for facility-based crisis and mobile crisis management services that will mandate minimum reimbursement rates to aid in contracting between providers and health plans, including Local Management Entitles/Managed Care Organizations (LME-MCOs) and Prepaid Health Plans (health plans).

Updating the rates and imposing a rate floor on LME-MCOs and health plans will help to:

- Stabilize the behavioral health crisis system during the transition to NC Medicaid Managed Care; and
- Support behavioral health crisis providers in the contracting process with health plans.

The following changes will be effective July 1, 2021:

- Fee schedules for procedure code S9484 will be set at $30 per unit;
- Fee schedules for procedure code H2011 will be set at $90 per unit; and
- LME-MCO and health plan contracts will be updated to include the rate floor.

These new rate floors may create additional capacity and opportunities for enhanced performance by behavioral health crisis service providers, especially those serving geographies that allow for higher utilization of staffing resources. In light of the Department's commitment to sustainable rates for facility-based crisis and mobile crisis management services, the Department encourages health plans and providers to be innovative in effectively meeting the behavioral health crisis response and de-escalation needs of the communities they serve.

No other changes to the behavioral health fee schedule or managed care reimbursement requirements are anticipated for an effective date of July 1, 2021, other than COVID-19 actions. NC Medicaid will continue to evaluate how to support rates for walk-in clinic crisis services.

For more information, please see Implementation of Rate Floors for Facility-Based Crisis and Mobile Crisis Services.

NCTracks Changes to Provider Verification Process

Currently, NCTracks sends notifications for expiring credentials (licenses, certifications and accreditations) to all enrolled providers required to be licensed, certified and/or accredited. These notices are sent to the Provider Message Center Inbox beginning 60 days in advance of the expiration date of the credential.

Effective May 9, 2021, NC Medicaid is taking additional steps to ensure providers meet their contractual obligation and responsibility to keep credentials current on their NCTracks enrollment record by making system modifications to begin a process of 45- and 60-day notifications of suspension if a provider fails to update their credential prior to the expiration date on file with NCTracks. Providers were first informed of this forthcoming system modification in March of 2018.

Choosing from providers with complete and up-to-date licensure, certification and accreditation information allows NC Medicaid beneficiaries to make informed choices to achieve the best health outcomes. System modifications alerting providers to update expiring credentials will assist providers in meeting federal and State enrollment and credentialing requirements and will assist NC Medicaid in removing unlicensed providers and expired credentials from provider records. With updated provider information, NC Medicaid will be able to transmit accurate provider data to health plans and other departmental partners who serve Medicaid beneficiaries.

Please see NCTracks Changes to Provider Verification Process for additional information on the timeline for notifications, suspension and termination as well as what happens when credentials expire.

Provider Data Updates

Providing the most accurate and complete provider information is a top priority so Medicaid and NC Health Choice beneficiaries can make the most informed choice for their health plan and primary care provider. NCTracks is the “system of record” for provider enrollment data, which is then shared with health plans to inform contracting and provider directories.

In our review, the primary challenge with accurate data has been encouraging providers to keep their information accurate and current on all applicable enrollment records. If provider information is not current, then the data that flows forward to the health plans and the enrollment broker will not be accurate.

It is critical that all providers take the time now to review their provider records in NCTracks and submit changes as needed using the Manage Change Request (MCR) process.

Please see Provider Data Updates for additional information and resources.

Managed Care Populations

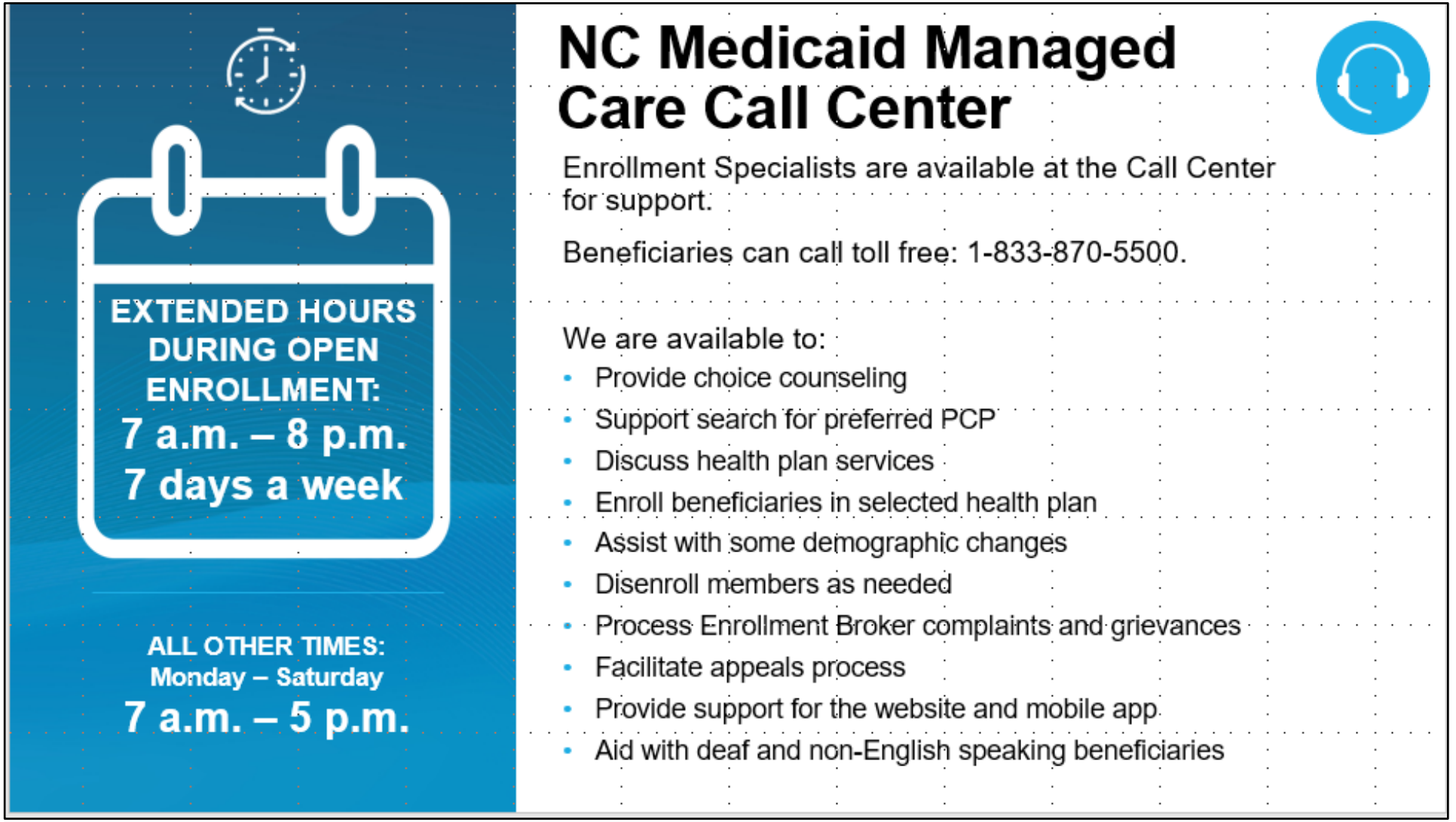
While most Medicaid beneficiaries will enroll in NC Medicaid Managed Care, some people will not. The table below outlines who must enroll, who may enroll, and who cannot enroll.

MANDATORY	EXEMPT	EXCLUDED[1,2]
Must enroll in a health plan	**May enroll** in a health plan or stay in NC Medicaid Direct	**Cannot enroll** in a health plan; stay in NC Medicaid Direct
Most Family & Children's Medicaid, NC Health Choice, Pregnant Women, Non-Medicare Aged, Blind, Disabled	Federally recognized tribal members/IHS eligible beneficiaries, beneficiaries eligible for behavioral health Tailored Plans	Family Planning Program, Medically Needy, Health Insurance Premium Payment (HIPP), Program of All-Inclusive Care for the Elderly (PACE), Refugee Medicaid

[1]Some individuals are temporarily excluded and become mandatory later. This includes dually-eligible Medicaid/Medicare, Foster Care/Adoption, Community Alternatives Program for Children (CAP-C), and Community Alternatives Program for Disabled Adults (CAP-DA).

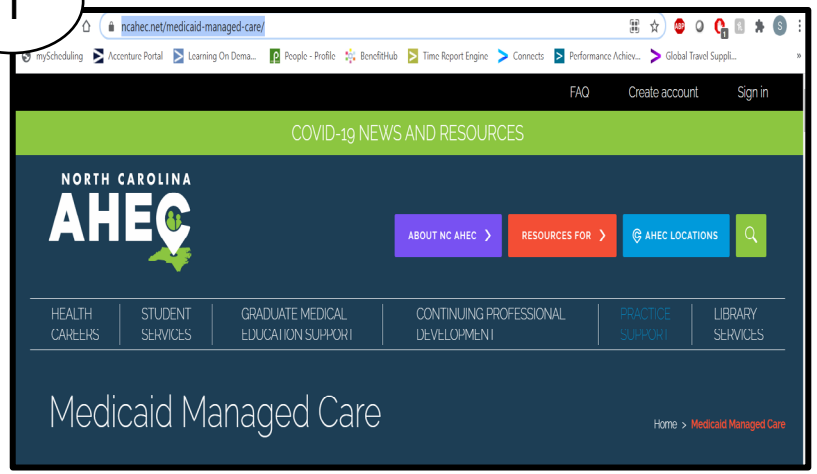
[2]Some federally recognized tribal members/IHS eligible beneficiaries are excluded and may enroll in the EBCI Tribal Option.

Medicaid Managed Care Call Center is LIVE!



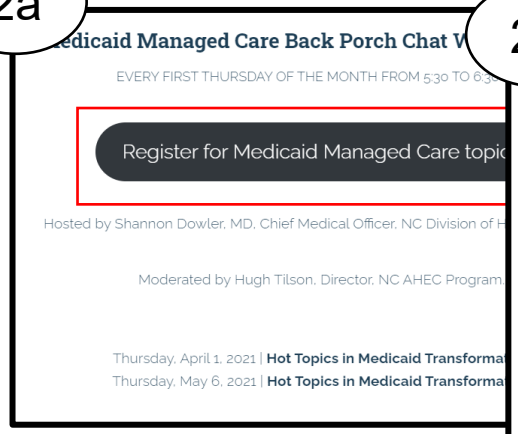
How To Sign up for the Back Porch Chat Webinar Series

1



1. Navigate to the North Carolina AHEC Medicaid Managed Care page

2a



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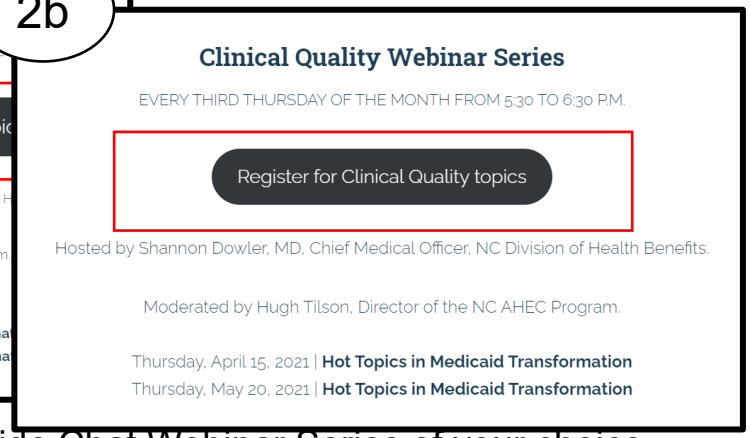
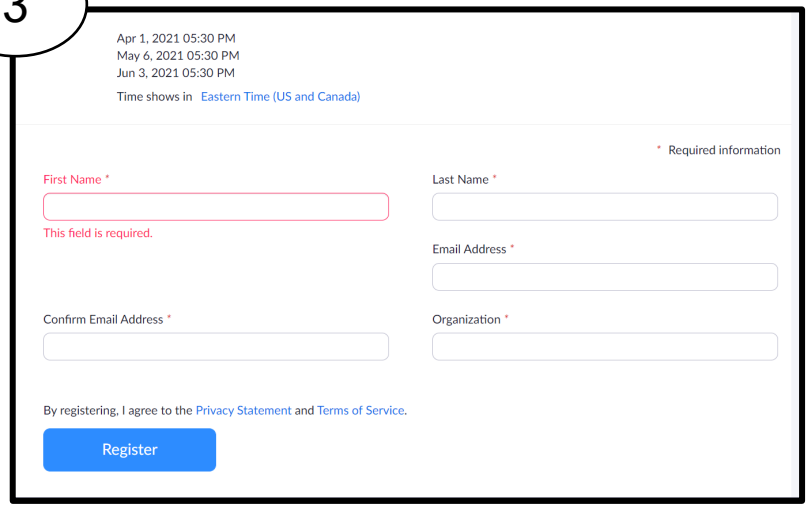


2. Scroll down to the Fireside Chat Webinar Series of your choice

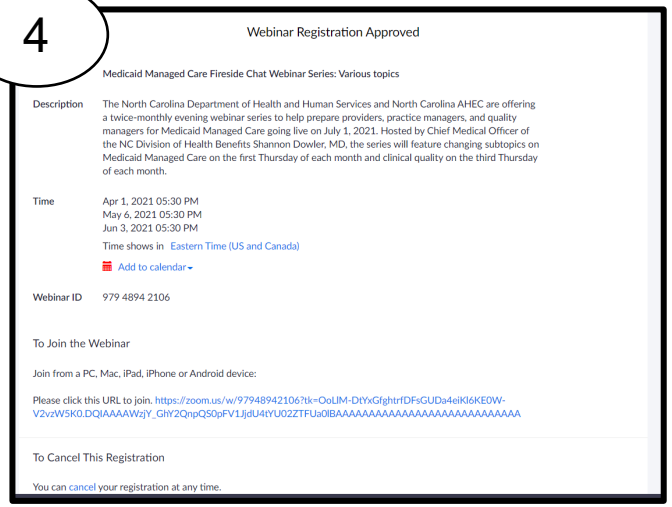
2b. Click on “Register for Medicaid Managed Care topics” or “Register for Clinical Quality topics”

3



3. Fill out all the required information and click register

4



4. When you see this page, your registration is successful.