

January 7 NCMT Behavioral Health Fireside Chat

Questions

Q. What is the difference between open and closed networks?

A. An open network means that "any willing, qualified provider" is able to participate and the plan can only refuse to add a provider to a network if the provider does not accept the network rates. A closed network is where the plan has the ability to refuse participation of a provider due to whatever criteria the plan uses, such as not needing additional providers because the plan has a sufficient network.

Q. If you provide OBOT services for OUD, do you need to do anything different if patient is in tailored plan?

A. You would need to be sure to contract with the BH/IDD Tailored Plan to provide OBOT to a Tailored Plan member. But the service itself will be in both types of plans.

Q. How is this different for FQHCs since the BH benefit is carved out currently (specific for folks in tailored plans)?

A. FQHCs will be in both Standard and BH/IDD Tailored Plans and will no longer be carved out of managed care as they are today with the LME/MCOs.

Q. Are the PHPs going to be different for the tailored plan so a provider will need to enroll potentially more than the 5 plans? - already going to be an administrative burden with 5 plans.

A. Correct, the Tailored Plans will be different entities than the Standard Plans and will have separate contacting. Some Tailored Plans may work with a Standard Plan to access their network, but they are not required to.

Q. Are you ready to indicate what a reasonable timeline is for appointment wait time for psych testing? With a paucity of doctoral-level psychologists who test children and adolescents in the state already, what might be the expectation for standard or tailored-plan recipients?

A. Routine BH access to care standards are 14 days for both Standard and Tailored Plans.

Q. Are there specifically defined behavioral health quality measures that we will be accountable for in the same manner that we have the physical health quality measures?

A. Yes! Standard Plans are accountable for a variety of BH/SUD measures including Timely Follow-up After MH Hospitalization, Depression Screening & Follow-Up, Firstline Psychosocial Care for Children on Antipsychotics, and several Opioid Prescribing/Treatment Measures.

Q. The PHP does the comprehensive assessment or the provider/Care manager if they are tier 3 AMH?

A. It can be either. Members who are assigned to an AMH Tier 3 will have the care management (including assessment) provided by the Tier 3. Other members will receive care management from the PHP if they are not assigned to a Tier 3 AMH.

Q. Will there be a standard care needs screening?

A. DHHS has defined a set of core domains that must be included in the Standard Plans Care Needs Screening (CNS). We have also required the Standard Plan use 11 specific screening questions to assess SDOH/Healthy Opportunities.

Q. Is formal psych testing considered "routine", like therapy?

A. Routine BH needs are defined by the acuity of the member's need, rather than the specific service. But generally, the need for psych testing would be seen as routine.