JOINT LEGISLATIVE COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Medicaid Transformation

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Nov. 14, 2017

Recap: Where We Are in the Transformation

- **Aug. 2017**: Published detailed Proposed Program Design
- **Nov. 2017**:
  - Released two Requests for Information (RFI)
  - Released a proposed PHP capitation rate setting methodology
  - Released concept paper with further detail on Behavioral Health I/DD Tailored Plans
  - Will soon submit amended 1115 waiver to CMS
- **Next 3-4 months**: Will publish several short, technical concept papers with more detail on specific topics
- **Feb. 2018**: Anticipated CMS approval of revised waiver
- **Spring 2018*:** Release Request for Proposal (RFP)
- **July 2019*:** Phase 1 of managed care goes live

* Assuming timely CMS approval and other activities

Pre-Paid Health Plan Procurement

- Releasing RFIs was the first step in PHP procurement process
  - Requested non-binding Letters of Interest

- In spring 2018, intend to release a Request for Proposal (RFP)
  - RFP will articulate standards PHPs are expected to meet across wide variety of program areas; e.g. plan administration, quality improvement, presence in NC
  - Potential plans will respond with detailed information on how they will meet these standards
  - DHHS will score results based on rubric established in RFP
  - DHHS will establish capitation rates that plans will be paid; all plans who win a bid will be paid using same formula

Behavioral Health Integration

- Consistent with principle of learning from best practices from other states while building on what is working in NC today
- Single point of accountability for care and outcomes; gives beneficiaries one insurance card
- Once managed care is fully implemented, Medicaid beneficiaries would receive coordinated physical and behavioral health services
- Most Medicaid beneficiaries would be enrolled in **Standard Plans;** a smaller number with significant BH or I/DD needs would be enrolled in **Tailored Plans**
- Time sensitive for NCGA action given timing of procurement process

Standard Plans

- Standard Plans would cover most beneficiaries in Medicaid managed care, including adults and children
- Most Medicaid beneficiaries would ultimately be in Standard Plans
- Integrated plan providing both physical health and behavioral services
- Would be expected to ensure that beneficiaries can access a network of providers for routine and some crisis BH services in addition to physical health services
- Would include statewide commercial plans and regional PLEs
- Would be selected through a competitive process
- Anticipated for Phase 1 of managed care in July 2019

Behavioral Health and I/DD Tailored Plans

- Specialized plans targeting ~120,000 beneficiaries with significant BH and I/DD needs; would have access to expanded service array
- Integrated plan providing both physical health and behavioral services
- Would be expected to ensure that beneficiaries can access a network of providers for the full, expanded array of BH and I/DD services (and physical health)
- Anticipate a phased rollout after launch of standard plans
  - Tailored plan population would temporarily remain in current arrangement (physical services in state administered fee-for-service, behavioral services authorized through LME/MCOs)
- Tailored Plans would be selected through a competitive process to ensure entities could meet requirements for both behavioral and physical health delivery
- Capitation rate setting formula will reflect enhanced risk of this population

Concept Paper on Behavioral Health and I/DD Tailored Plans

- Overview of covered populations in Standard Plans and Tailored Plans
- Detailed lists of ICD-9 and ICD-10 diagnosis codes associated with each population that would be in Tailored Plans:
  - Intellectual/Developmental Disability (I/DD)
  - Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED)
  - Substance Use Disorder (SUD)
- Detailed list of BH and I/DD services covered only by Tailored Plans and list of services covered by both Standard Plans and Tailored Plans
- Enrollment processes for Tailored Plans include:
  - Processes for both legacy FFS beneficiaries and for new Medicaid applicants
  - Processes both before and after the launch of Tailored Plans
  - Mid-coverage year transitions and renewals

Behavioral Health and I/DD Services Available in Standard Plans and Tailored Plans

Covered by Both Standard and Tailored Plans

State Plan BH and I/DD Services

- Inpatient behavioral health services
- Outpatient behavioral health emergency room services
- Outpatient behavioral health services provided by direct-enrolled providers
- Partial hospitalization
- Mobile crisis management
- Substance abuse intensive outpatient program (SAIOP)
- 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 (ADATC) detoxification crisis stabilization
- Substance abuse comprehensive outpatient treatment program (SACOT)
- Research-Based Behavioral Health Treatment of Autism Spectrum Disorder (*pending CMS approval)*
- Diagnostic assessments

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Covered Exclusively by Tailored Plans

State Plan BH and I/DD Services

- 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 use non-medical community residential treatment
- Substance abuse medically monitored residential treatment
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)
- Diagnostic assessments

Waiver Services

- TBI waiver services
- Innovations waiver services
- 1915(b)(3) services

All State-Funded BH and I/DD Services
State-Funded TBI Services

EPSDT

Further Work to Develop BH and I/DD Tailored Plans

DHHS intends to work closely with the NCGA to further develop additional components of Tailored Plans:

- Governance structure for BH and I/DD Tailored Plans
  - Non-Medicaid federal grant dollars will be managed by Tailored Plans; thus only non-profit or governmental (122C) entities will be able to offer them
  - Anticipate that some LME/MCOs would submit bids in partnership with a physical health plan to serve as a Tailored Plan
- Number of regions
- Whether or not to procure a statewide Tailored Plan

Supplemental Payments: Context and Approach

- Federal rules prohibit DHHS from making supplemental payments (other than DSH and GME) directly to providers for services covered under managed care
- DHHS is working closely with NC Hospital Association to design a payment structure within Medicaid managed care with the following goals:
  - Achieve cost-neutrality to the State
  - Result in similar reimbursement for hospitals
  - Continue direct DSH and GME payments
- Proposal uses hospital-specific rate floors to prevent disruption
- May need statutory authority from NCGA to implement
- Same rates will apply under managed care and remaining fee-for-service populations
- DHHS will release a white paper with technical details in next few weeks