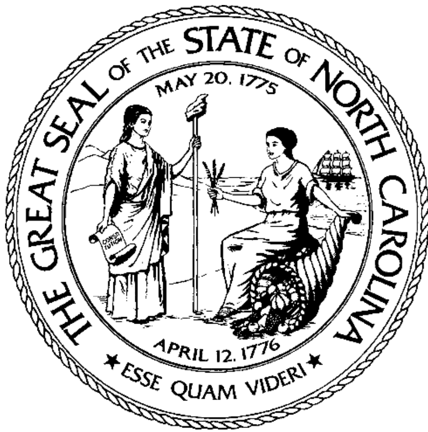
NC Managed Medicaid Fireside Chat



Behavioral Health in Managed Care: Standard Plans and Tailored Plans

January 7, 2021

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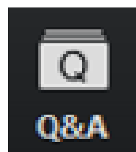
Logistics for today's COVID-19 Forum

Question during the live webinar



Technical assistance

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https://www.communitycarenc.org/newsroom/coronavirus-covid-19-information

Agenda

- **Behavioral Health Services: Standard Plans and Tailored Plan Differences**
- **Standard Plan Network Adequacy**
- **Transitions Between Standard and Tailored Plans**

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 the majority of Medicaid beneficiaries, as well as programs and services that address other unmet health related resource needs. Standard Plans 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. The Department released the BH I/DD Tailored Plan Request for Applications (RFA) on November 13, 2020 and expects these plans to 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 cover a will provide integrated physical health, behavioral health, pharmacy, and long-term services and supports.

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.

Behavioral Health Benefits in Managed Care

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 the majority 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 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

Standard & Tailored Plans Side by Side

- Many similarities exist between Standard and Tailored Plans
- Providers who deliver outpatient services are encouraged to contract with both SP and TP managed care entities

Similarities	Key Differences
• Fully Integrated Care • Operate under 1115 waiver • Consistent Departmental Oversight • Provider Contracting and Rates Negotiation • Community Based Care Management • Network Adequacy Requirements	• Regions • Entry into Open Network (open vs. closed) • State Funded, Block Grant, current (b)(3) services • Procurement method RFP vs. RFA

Transformation Seeks to Integrate Physical and 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

- In addition to physical health and pharmacy services, both Standard Plans and BH I/DD Tailored Plans will offer a robust set of behavioral health benefits, including outpatient and inpatient behavioral health services, crisis services, and withdrawal management services.
- Certain higher-intensity behavioral health, I/DD, and TBI benefits—including Innovations, TBI, and 1915(b)(3) waiver services, will only be offered under BH I/DD Tailored Plans (or LME-MCOs prior to BH IDD Tailored Plan launch).

Rationale for Integration

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**.

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.

Behavioral Health Benefits

- The Standard Plans will offer a set of low intensity behavioral health and Substance Use services, including outpatient behavioral health services, psychological services, peer supports, diagnostic assessments, etc.
- The Standard Plan will offer a set emergent behavioral health and substance use services to support members with emergent needs, including both mobile and facility-based crisis services, inpatient behavioral services, partial hospitalization, etc.
- The Standard Plan will offer a set substance use services, including outpatient opioid treatment, ambulatory detox, non-hospital medical detox, etc.

Rationale for 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.

Common Provider Questions

Medicaid Managed Care and BH I/DD Tailored Plan Networks

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 *(found in the appendix)* 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)

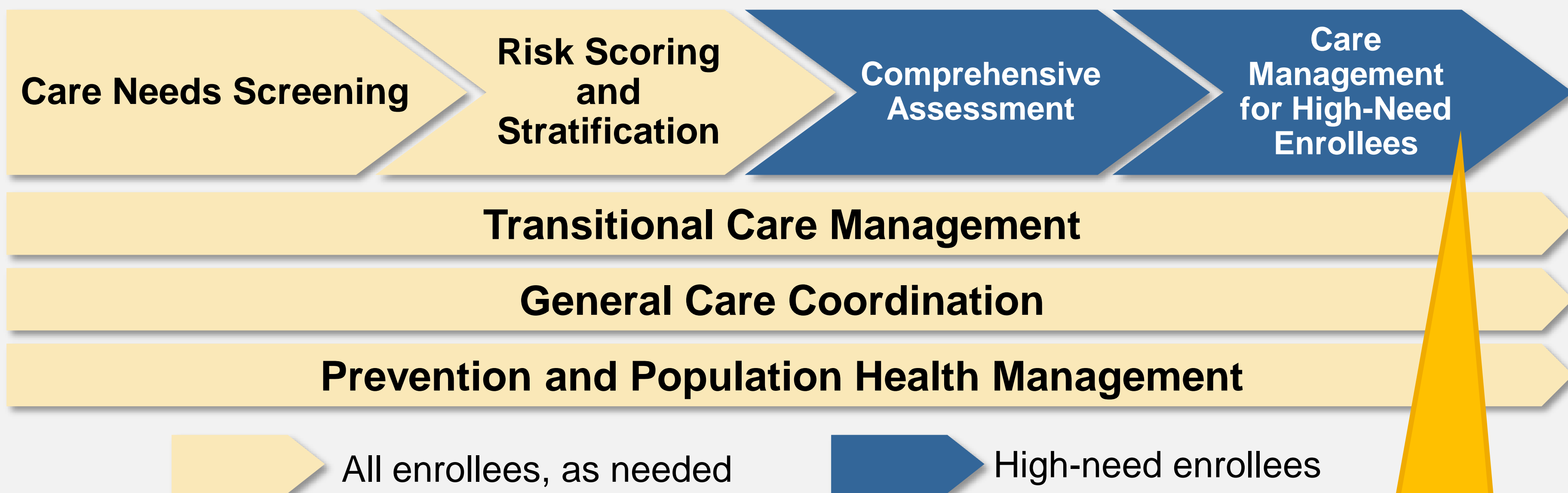
- DHHS will use network analysis:
  - To assist in decisions around auto-enrollment and managed care launch
  - To determine when/whether to require a Standard Plan to submit a mitigation strategy submissions or a Corrective Action Plan (CAP)
  - To determine when to take other steps to mitigate deficiencies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

Common Provider Questions

Standard Plan Care Management

Standard Plan Care Management Approach Address BH

Standard Plan members with behavioral health needs are a priority population for care management.



- **Standard Plans must also implement processes to identify priority populations, including:**
  - Children and adults with co-occurring physical and behavioral health conditions*
  - Individuals in need of long term services and supports (LTSS)
  - Enrollees with rising risk
  - Individuals with high unmet resource needs

Care management performed in Standard Plans must uniquely account for mental health/substance needs, or other needs the beneficiaries may have

*Including behavioral health, substance use, increased risk for chronic conditions, and foster care populations

Common Provider Questions

Process to Transition between Standard and Tailored Plans

Notices Regarding Managed Care Transition

In March 2021, DHHS will send notices to individuals regarding July 2021 managed care enrollment.

There will be different notices for beneficiaries who will be required to enroll in a Standard Plans v. 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 in 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:

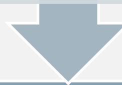
- Beneficiary's continued enrollment in FFS/LME-MCO
- Option to enroll in a Standard Plan with explanation that Standard Plans will offer a more limited set of benefits for developmental disability, mental illness, TBI, or substance use disorder
- Contact information for enrollment broker for choice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

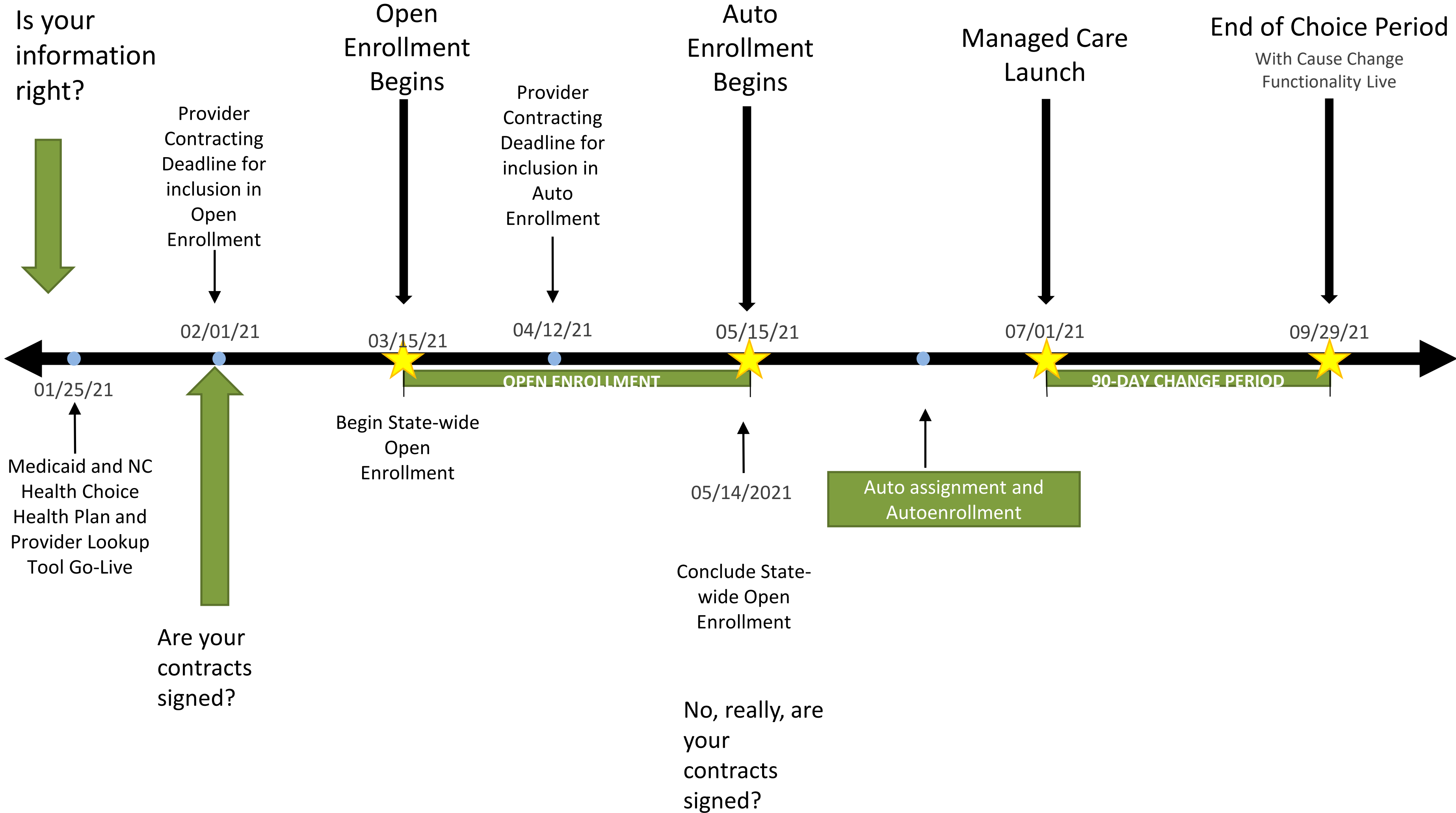
NC Medicaid Reviews the Request and Transfers Member

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

Common Provider Questions

Provider Next Steps

NCMT Provider Timeline



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 provide 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).
- BH I/DD Tailored Plans will not launch until July 2022. Providers should stay tuned for additional information regarding their launch.

Common Provider Questions

Questions

Appendix

Comparing Plan Benefits

Behavioral Health, I/DD, and TBI Services Covered by Both Standard Plans and BH I/DD Tailored Plans	Behavioral Health, I/DD and TBI Services Covered Exclusively by BH I/DD Tailored Plans (or LME-MCOs Prior To Launch)
Enhanced behavioral health services are italicized	
State Plan Behavioral Health and I/DD 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 • *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* • Research-based intensive BH treatment for Autism Spectrum Disorder • Diagnostic assessment • *Non-hospital medical detoxification* • *Medically supervised or ADATC detoxification crisis stabilization* **EPSDT**	**State Plan Behavioral Health 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)* • *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)* • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) **Waiver Services** • Innovations waiver services • TBI waiver services • 1915(b)(3) services **State-Funded behavioral health and I/DD Services** **State-Funded TBI Services**

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 PHP region	
4	Inpatient Behavioral Health Services	1 provider of each inpatient BH crisis service within each PHP 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

Readiness Resources: Provider Playbooks Available Now

As of Jan. 4, 2021, four new resources in the NC Medicaid Provider Playbook have been published to provide additional information on North Carolina's transition to Medicaid Managed Care. These playbooks include:

- Introduction to Medicaid Transformation: Part 1 - Overview
- Introduction to Medicaid Transformation: Part 2 - Enrollment and Timelines
- Contracting with Health Plans
- Medicaid and NC Health Choice Provider and Health Plan Lookup Tool

This also serves as a reminder that Medicaid bulletins continue to be published and are collected on the **NC Division of Health Benefits website**.

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

Common Provider Questions

Common Provider Questions on Behavioral Benefits in Managed Care

Question: Today in Medicaid Direct, pediatricians can take care of depression, anxiety in their patients but if they have a therapist in their office, that therapist has to bill the LME-MCO. Does that still happen July 1?

Answer: Both Standard Plans and BH I/DD Tailored Plans cover Outpatient Behavioral Health Services Provided by Directed Enrolled Providers. The therapist will need to bill the plan the individual is enrolled in, the Standard Plan or the LME-MCO.

Question: What counts as mild/moderate behavioral health?

Answer: Mild/moderate behavioral health means an individual does not meet the criteria for a BH I/DD Tailored Plan or LME-MCO only services. See the appendix for a full list of BH I/DD Tailored Plan only services.

Common Provider Questions on Medicaid Managed Care and BH I/DD Tailored Plan Networks

Question: What if I am unable to finalize a contract with a Standard Plan by the deadlines, must contracting efforts cease on the deadline?

Answer: The deadline for contracts to be signed and returned to the Standard Plans is to ensure a provider is included in the Open Enrollment and Auto-enrollment information and are not intended to terminate any provider contracting efforts. Providers should continue to work with Standard Plans to finalize contracts, including through and beyond managed care launch, as necessary.

Question: What happens if a Standard Plan's network is not adequate? How does a beneficiary obtain covered services?

Answer: A Standard Plan shall adequately and timely cover services out-of-network for a beneficiary, if the Standard Plan's network is unable to provide the covered services on a timely basis.

Common Provider Questions on Medicaid Managed Care and BH I/DD Tailored Plan Networks (cont.)

Question: Will waivered MAT physicians be given first option to continue services for patients in their panel or forced to relinquish care due to not contracting?

Answer: For members enrolled in a Standard Plan, the Physician or provider must be enrolled with or have a contract with the Standard Plan.

Common Provider Questions on Standard Plan Care Management

Question: How does the Standard Plan design support population management and quality for those with behavioral health conditions?

Answer:

- 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 are required to prioritize individuals with co-occurring BH and physical health conditions for care management.
  - Standard Plans area accountable for a set of measures that address standard of care for individuals with BH conditions (i.e., Follow-up after MH hospitalization; Depression screening for Adolescents; Proper Opioid Prescribing).
  - Providers can more easily offer integrated (co-located services) in their offices since both physical and BH providers in their offices can enroll and bill with 1 entity (Standard Plan) instead of splitting admin oversight between PHP and an LME-MCO. PHPs are encouraged to develop and support more best practice integrated care work.
  - The Standard Plans will offer a set of low intensity behavioral health and substance use services, including outpatient behavioral health services, psychological services, peer supports, diagnostic assessments, etc.
  - The Standard Plans will offer a set emergent behavioral health and substance use services to support members with emergent needs, including both mobile and facility-based crisis services, inpatient behavioral services, partial hospitalization, etc.
  - The Standard Plans will offer a set of substance use services, including outpatient opioid treatment, ambulatory detox, non-hospital medical detox, etc.

Common Provider Questions on Process to Transition between Standard and Tailored Plans

Question: As a primary care office can I only see individuals enrolled in the Standard Plan if they do not have BH or I/DD needs, or do I specifically have to contract with a BH I/DD Tailored plan?

Answer: As a primary care practice you can see members who are enrolled in both the Standard Plan and BH I/DD Tailored Plan and are encouraged to contract with both types of plans.

Remember, Standard Plans cover behavioral health services now. So, integrated behavioral health services (embedded in Primary care offices) are covered by Standard Plan for members enrolled in Standard Plans.

Question: Will PCP's be required to relinquish behavioral health services to a subcontracted entity?

Answer: PCPs will not be required to relinquish behavioral health services to a subcontracted entity, if they employee behavioral health providers and are contracted with the plan.

Common Provider Questions on Process to Transition between Standard and Tailored Plans (cont.)

Question: How do transitions between Standard Plan and the LME-MCO (future BH I/DD Tailored Plans) work?

Answer: When a member has a need for an LME-MCO only, or future BH I/DD Tailored Plan only, service they may make a request to transition through the Enrollment Broker (Medicaid Direct Transition Process).

Standard Plans and BH I/DD Tailored Plans will be required to facilitate warm hand-offs between plans so individuals are supported, and pertinent clinical information is exchanged between the plans.

Common Provider Questions on Provider Next Steps

Question: What if I am part of big health system, is all this contracting happening in the background?

Answer: You need to talk with your health system.

Question: What is the plan B if patients can't get into their regular behavioral health provider after July 1 (i.e., if current behavioral health providers drop Medicaid)?

Answer: The Standard Plan is responsible for ensuring that members have access to all necessary services, including behavioral health services. The member should be able to call the plan for referral and connection to an in-network behavioral health provider. In addition, if the member has a Care Manager, that person can assist them in finding a new behavioral health provider.

Common Provider Questions on Provider Next Steps (cont.)

Question: I don’t think most of my behavioral health providers I refer to are signed up with Standard Plans. Does the State have a list we can check?

Answer: Providers can use the Enrollment Broker’s Provider Directory tool that contains all active Medicaid and NC Health Choice providers, including primary care providers, specialists, hospitals, and facilities. Once the tool is live at the end of January, this tool can be used to search to search for behavioral health providers, as well as the health plans to which they are contracted. In addition to this, the Department is publishing a weekly report starting this month where providers can view this information before the directory is live. More information will be sent out at the end of this week in a Medicaid Bulletin.

Common Provider Questions on Provider Next Steps (cont.)

Question: What is the payment rate the Standard Plans will use for behavioral health, is that going to be less than the current LME-MCO payment? We still can't get fee schedules for behavioral health from the plans.

Answer: There is no rate floor for behavioral health services (other than for psychiatrists who fall under the physician rate floor). Each Standard Plan will develop their own fee schedule for behavioral health. Providers should work with the Standard Plans during contracting to negotiate their behavioral health rates.

Question: How do I know what Standard Plan a member is enrolled with?

Answer: This will be on the member's Medicaid ID and in NC Tracks.

Common Provider Questions on Provider Next Steps (cont.)

Question: Will Standard Plans offer telehealth for behavioral health and I/DD services?

Answer: Yes, Standard Plans may offer telehealth services for certain behavioral health and I/DD services.

Questions?