MCAC Behavioral Health/IDD Subcommittee

Tailored Plan Eligibility

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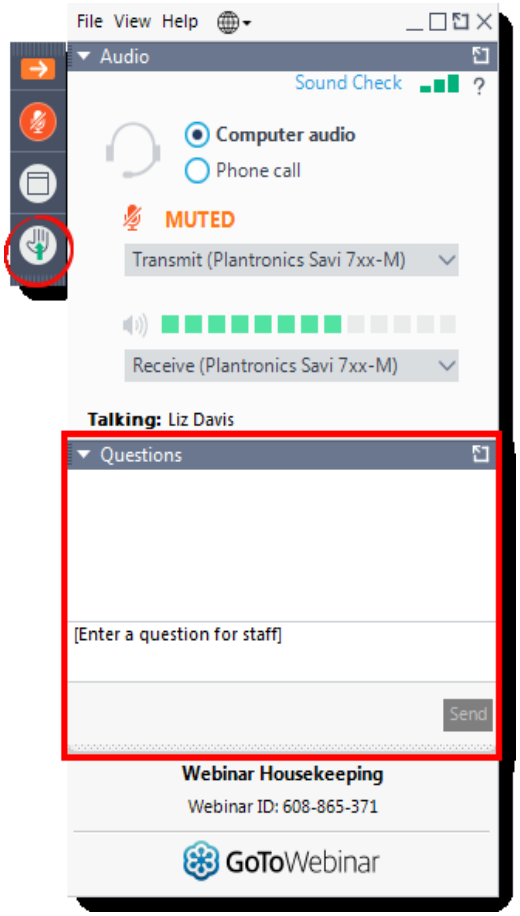

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Overview

Purpose:

- Provide overview of DHHS' approach to identifying populations expected to remain in FFS / LME-MCOs when Standard Plans are launched.

Agenda

- Managed Care Populations (Standard Plan)
  - Timeline
- BH I/DD Tailored Plan / enrollment overview
- BH I/DD Tailored Plan Criteria
- Review of Process to Validate Members with LME-MCOs

For more information on Medicaid Transformation, please visit:
https://www.ncdhhs.gov/assistance/medicaid-transformation

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

- 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.

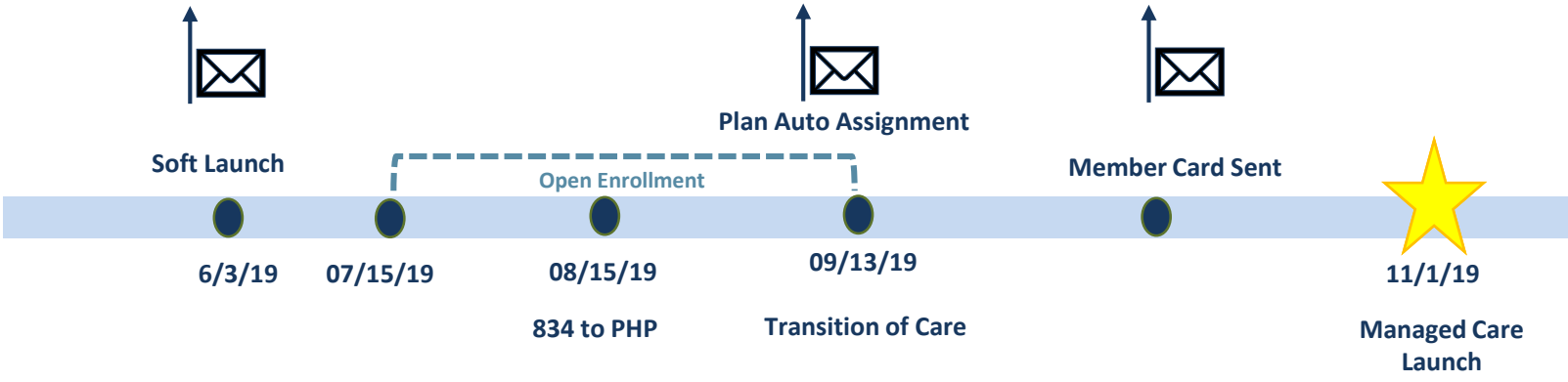
Delayed Managed Care Populations	Identification
Foster Children	HSFCY, HSFMN, HSFNN, IASCN, IASCY, MFCNN – Expanded identification under review
BH I/DD Tailored Plan - Eligible *Includes both non-dual and dual eligible*	Clinical criteria applied to historical fee-for-service and LME-MCO encounter data 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

Standard Plan Open Enrollment Timeline: Phase 1 Regions

- Medicaid Eligible + Managed Care Enrolled Beneficiaries in Regions 2 and 4 will:
- Receive Welcome Packet + Letter
- Select Provider / Plan through Application or Enrollment Broker

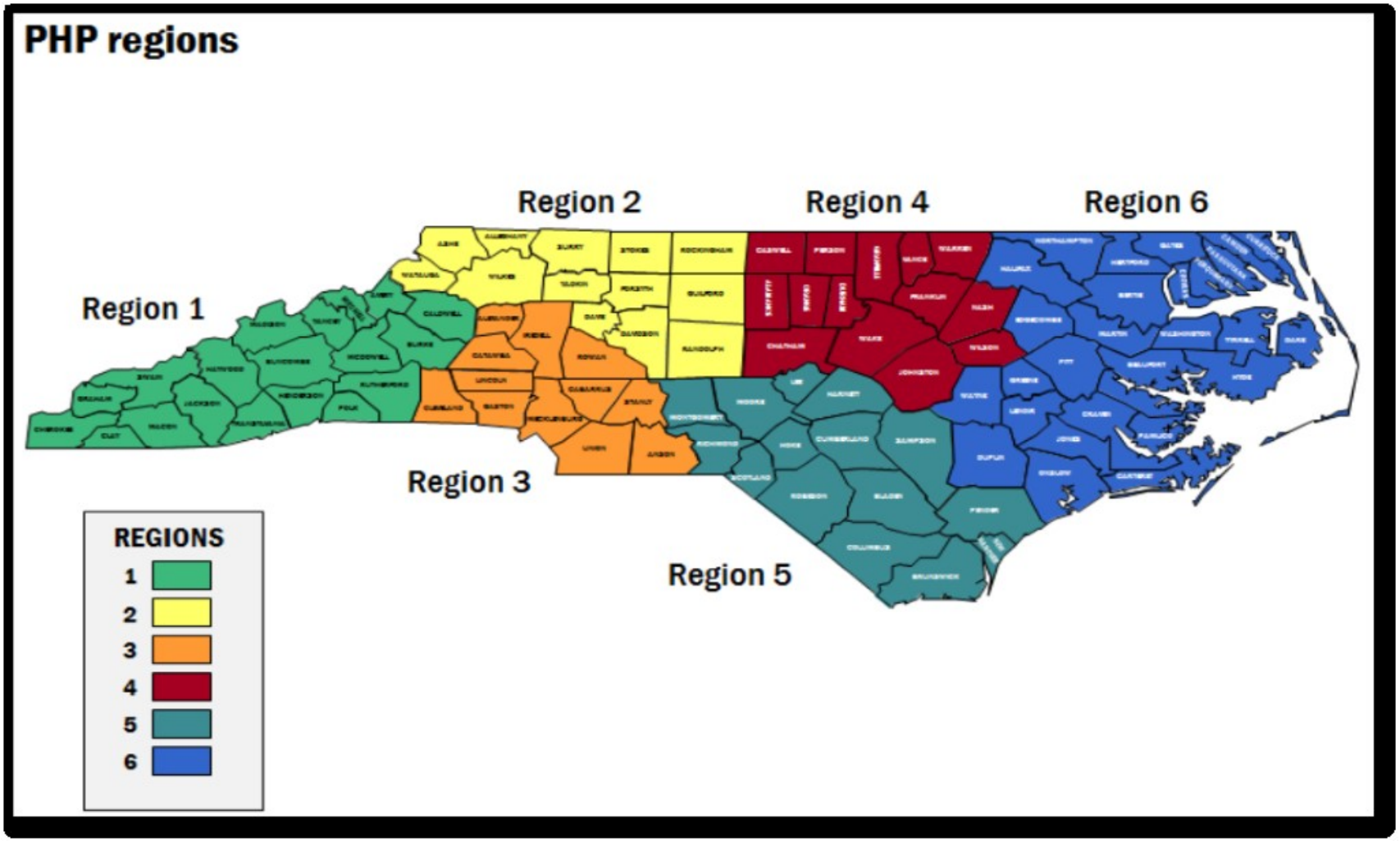
- Medicaid Eligible + Managed Care Enrolled Beneficiaries that do NOT select a plan will be auto-enrolled into a plan.
- Member will receive notice of Plan Assignment.

- PHP begins sending Members Insurance Cards



Transition of Care sent to PHPs to support continuity of care

Standard Plan PHP Regions



Guiding Principles for Development of Criteria

DHHS convened a multi-disciplinary team of clinicians to develop the clinical criteria (qualifying diagnoses and relevant service utilization) to identify populations most likely to need the services and level of care expected from the BH IDD Tailored Plans.

Considerations

- Enrollment in the product that best meets a beneficiary's needs
- Minimal barriers to access
- Compliance with legislation
- Responsible stewardship of public funds
- Data availability

Populations Groups

Enrollment after Standard Plan PHP Launch and prior to BH I/DD Tailored Plan Launch

LME-MCO Populations[1]	Service Delivery System
BH I/DD Tailored Plan Eligible – Innovations and TBI Waivers *Includes Foster Children enrolled in the waivers*	Remain with LME-MCO
Foster Children[2] *Not enrolled in Innovations or TBI waivers*	Remain with LME-MCO
Standard Plan *Beneficiaries eligible for the Standard Plan AND* *Beneficiaries not meeting BH I/DD Tailored Plan Criteria*	Phase-out of LME-MCOs; will continue for members prior to PHP enrollment
BH I/DD Tailored Plan Eligible – Non-Waiver *Excludes Foster Children*	Remain with LME-MCO with option to enroll in Standard Plan
Other populations excluded or delayed from managed care that meet BH I/DD Tailored Plan criteria *Excludes Foster Children*	Remain with LME-MCO
Other populations excluded or delayed from managed care that do not meet BH I/DD Tailored Plan criteria *Excludes Foster Children*	Remain with LME-MCO

[1]Hierarchy for categorizing individuals into groups is as follows: Innovations, TBI, Foster Children, Excluded and Delayed population criteria, BH I/DD Tailored Plan eligible criteria, and Standard Plan eligible criteria.

[2]Foster Children identification for rate setting will be revised beginning in November 2019 to include Special Needs and Living Arrangement codes, in addition to current eligibility code criteria.

BH I/DD Tailored Plan Eligibility Criteria

DHHS will collect and review the following data to identify beneficiaries meeting BH I/DD Tailored Plan criteria.

Data Source	BH I/DD Tailored Plan Eligibility Criteria	Notes
LME-MCOs	• Innovations Waiver • TBI Waiver • TCLI • Innovations Waiver Waitlist • TBI Waiver Waitlist • Children with complex needs	• DHHS will rely on current process for Innovations / TBI waiver beneficiary identification and monthly updates of lists from LME-MCOs for other beneficiaries
Analysis of historical claims / encounters	• Use of Medicaid service only available in BH I/DD Tailored Plan • Use of BH, IDD, or TBI services funded with non-Medicaid funds • Qualifying IDD diagnosis (any position) • Qualifying SI/SED (primary position) & enhanced BH service use • Qualifying SUD (primary position) & enhanced BH service use • Two or more psychiatric hospitalizations/readmissions within prior 18 months • Two or more visits to the ED for psychiatric problem within prior 18 months *(prior to SP launch only)* • Two or more episodes using BH crisis services (regardless of diagnosis) within prior 18 months *(prior to SP launch only)*	• See upcoming policy paper for qualifying diagnoses and relevant services • Initial eligibility determination will be based on claims / encounters with dates of service since January 1, 2018 • Weekly data checks proposed initially
DSOHF	• Admissions to state psychiatric hospital or ADATC (includes IVCs)	• Date of discharge/active stay since Jan. 1, 2018
DHHS	• Beneficiary requested review for BH I/DD Tailored Plan eligibility • Utilization triggered review for BH I/DD Tailored Plan eligibility *(applies post-SP launch):* two ED visits for psychiatric problem or two episodes using BH crisis services	• DHHS to review request for Standard Plan exemption and make determinations • SPs to notify DHHS of utilization triggers post SP launch

Other Key Enrollment Concepts

- Prior to BH I/DD Tailored Plan launch, beneficiaries identified as eligible to remain in the legacy system (generally FFS / LME-MCO) will continue in the legacy system until the launch of the BH I/DD Tailored Plans, unless they opt to enroll in a Standard Plan
  - Number of beneficiaries eligible for legacy system will grow over time as new beneficiaries meet criteria
- Beneficiary eligibility will be reassessed prior to BH I/DD Tailored Plan launch (e.g., updated lookback period)
- Following BH I/DD Tailored Plan launch, DHHS will monitor for eligible enrollees (excluding those with IDD or TBI needs) who have not utilized a BH service other than basic outpatient and medication management in the past 24 months; these beneficiaries will be moved to Standard Plan (when eligible)
- BH I/DD Tailored Plans will cover new populations that are not currently covered by the LME-MCOs
  - Beneficiaries aged 0 – 3 meeting eligibility criteria
  - NC Health Choice beneficiaries meeting eligibility criteria
  - Legal aliens meeting eligibility criteria

Summary of Enrollment Approach

The following summarizes enrollment defaults and options for beneficiaries based on various criteria related to managed care status and tailored plan eligibility. Members of federally recognized tribes may have different options.

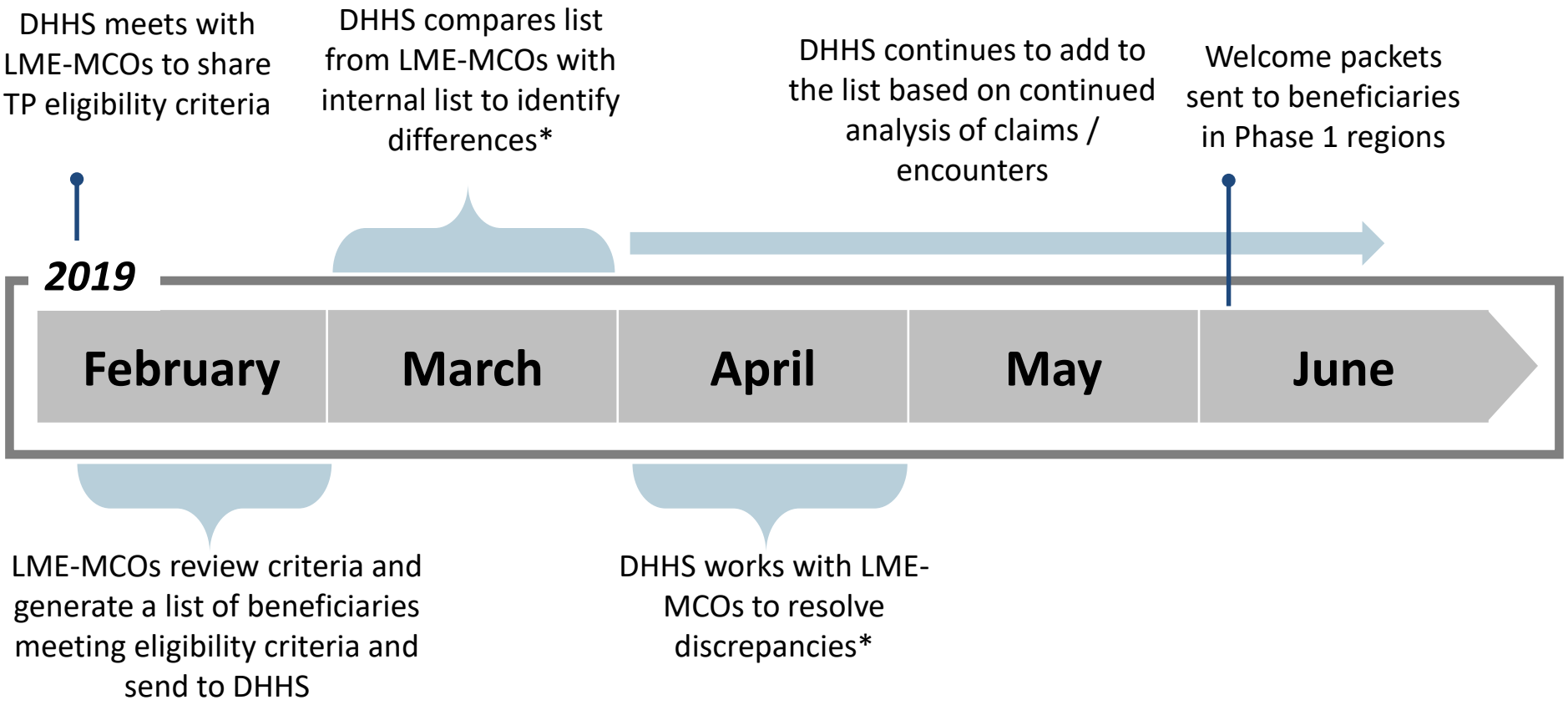
Beneficiary Categories			Enrollment Prior to TP Launch	Enrollment at and after TP Launch
Innovations/TBI Waiver Beneficiary			*Default:* Legacy FFS/LME-MCO *Option* to enroll in SP; would need to disenroll from waiver	*Default:* TP *Option* to enroll in SP; would need to disenroll from waiver
Non- INN/TBI Waiver Beneficiary	Not Excluded from Managed Care	Flagged TP Eligible Prior to SP Launch	*Default:* Legacy FFS/LME-MCO[1] *Option* to enroll in SP[2]	*Default:* • At launch: TP with eligibility recheck • Ongoing at redetermination: Continue in TP unless no relevant service use in 24 months *Option* to enroll in SP
		Flagged TP Eligible between SP and TP launch	*Default:* SP *Option* to enroll in legacy FFS/LME-MCO when TP eligible (those meeting certain criteria will be auto-enrolled in legacy system[3])	*Default:* • At launch: legacy system beneficiaries move to TP with eligibility recheck (SP beneficiaries stay with SP with option to move to TP) • Ongoing at redetermination: Continue in TP unless no relevant service use in 24 months *Option* to enroll in SP
		Not Flagged TP Eligible Prior to TP Launch	*Default:* SP	*Default:* SP *Option* to enroll in TP if found TP eligible (may default to TP in some cases)
	Excluded from Managed Care (e.g., CAP/C, CAP/DA, duals, HIPP, medically needy)		Legacy delivery system	TP-Eligible Duals: TP wrap for behavioral health and I/DD services; FFS wrap for other Medicaid-covered services Other Excluded: FFS

[1] Certain populations, such as legal aliens, children under age three and children enrolled in NC Health Choice, are excluded from LME-MCOs. For these populations, the legacy delivery system is FFS.

[2] TP eligibles opting to stay in an SP or move to an SP would default to their SP at redetermination.

[3] Criteria for being auto-enrolled in a TP (or legacy system) for those enrolled in an SP include joining Innovations / TBI waiver or waitlist, TCLI, being added to the list of Children with Complex Needs, history of utilization of Medicaid or other funded service only available through the TPs or following a positive assessment.

Proposed Timeline for Reviewing TP Population with LME-MCOs



* Review of beneficiaries in Phase 1 regions will be prioritized; timeline may vary for Phase 2 regions

Discrepancy Resolution

	On DHHS Initial List	Off DHHS Initial List
On LME-MCO List	✓ Flagged as TP eligible	**LME-MCO must provide evidence that the beneficiary met the DHHS defined criteria to be added as TP eligible**
Off LME-MCO List	✓ Flagged as TP eligible	✗ Not flagged as TP eligible

Appendix: Benefit Packages

Only BH I/DD TPs will cover a subset of high-intensity State Plan BH services; TBI, Innovations and 1915(b)(3) waiver services; and State-funded BH, I/DD, and TBI services

BH, TBI and I/DD Services Covered by Both SPs and BH I/DD Tailored Plans	BH, 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 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* • *Facility-based crisis services for children and adolescents* • *Professional treatment services in facility-based crisis program* • Peer supports (move from(b)(3) to state plan)* • *Outpatient opioid treatment* • *Ambulatory detoxification* • *Substance abuse comprehensive outpatient treatment program (SACOT)* • *Substance abuse intensive outpatient program (SAIOP) pending legislative change* • *Clinically managed residential withdrawal (aka social setting detox)** • *Research-based intensive behavioral health treatment* • *Diagnostic assessment* • EPSDT • *Non-hospital medical detoxification* • *Medically supervised or ADATC detoxification crisis stabilization*	**State Plan BH and I/DD Services** • Residential treatment facility services for children and adolescents • *Child and adolescent day treatment services* • *Intensive in-home services* • *Multi-systemic therapy services* • *Psychiatric residential treatment facilities* • *Assertive community treatment* • *Community support team* • *Psychosocial rehabilitation* • *Substance abuse non-medical community residential treatment* • *Substance abuse medically monitored residential treatment* • *Clinically managed low-intensity residential treatment services** • *Clinically managed population-specific high-intensity residential programs** • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) **Waiver Services** • Innovations waiver services • TBI waiver services • 1915(b)(3) services (excluding peer supports if moved to state plan) **State-Funded BH and I/DD Services** **State-Funded TBI Services**

*DHHS will submit a State Plan Amendment to add this service to the State Plan