Medicaid Managed Care
Proposed Concept Paper

Managed Care Benefits and Clinical Coverage Policies

North Carolina Department of
Health and Human Services

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Contents

This document is part of a series of concept papers that the Department of Health and Human Services scheduled for release from late 2017 through early 2018 to provide additional details to stakeholders regarding the transition of North Carolina Medicaid and NC Health Choice programs to a managed care service delivery model. This is a technical paper primarily for providers and health plans that will participate directly in Medicaid managed care. Some topics mentioned in this document may be covered in more detail in other concept papers in the series. For more information on the Department's proposal, stakeholders are encouraged to review the Amended North Carolina Section 1115 Demonstration Waiver Application and previously released concept papers available at ncdhhs.gov/nc-medicaid-transformation.

Input is welcome and appreciated. Send comments to Medicaid.Transformation@dhhs.nc.gov.

I. Introduction

The North Carolina Department of Health and Human Services (the Department) is committed to providing accessible, comprehensive, whole person care and health services to North Carolinians covered by Medicaid. The Department will contract with two types of prepaid health plans (PHPs): commercial plans and provider-led entities. PHPs will be required to meet minimum standards set by the Department, but will also be given sufficient flexibility to innovate to promote the quality and efficiency of care, and to improve health. The Department will hold both types of PHPs to the same standards of care, expectations of quality and service delivery.

The Department is committed to ensuring that people who are covered by Medicaid will have access to services and a comprehensive set of benefits, while also permitting prepaid health plans flexibility when appropriate. PHPs must cover all services in the current Medicaid fee-for-service State Plan, use the State definition of "medical necessity" in making coverage determinations, and use the State's Preferred Drug List (PDL). PHPs also may not set benefit limits that are more stringent than the State's existing fee-for-service program. For a limited number of services, the Department will require PHPs to use existing clinical coverage policies, clinical programs and/or billing guidelines established and updated by the Department. For most other services, PHPs will be permitted flexibility to establish their own clinical policies as long as the amount, scope and duration of a service are no more restrictive than the State's existing fee-for-service policy.

The Department is also committed to supporting whole person care, and seeks to integrate physical and behavioral health. Consistent with clinical evidence and best practices, the Department will work with the North Carolina General Assembly (NCGA) to create integrated managed care products that cover a full complement of physical, behavioral and pharmacy services for all enrollees. The Department seeks changes to statute to permit PHPs to develop and offer two types of products: standard plans, and behavioral health and intellectual and developmental disability tailored plans (BH I/DD TPs). The majority of Medicaid and NC Health Choice enrollees, including adults and children with lower intensity behavioral health needs, will receive integrated physical, behavioral and pharmacy services through standard plans when managed care launches. The Department also proposes, contingent on legislative authority from the NCGA, to allow select populations with unique needs (e.g., the Community Alternatives Programs for Children (CAP/C) and for Disabled Adults (CAP/DA)) to be phased into managed care over time.

Under this vision, individuals with higher intensity behavioral health needs, I/DD and traumatic brain injuries will be enrolled into behavioral health and I/DD tailored plans, which will include specialized managed care products targeted toward the needs of these populations, at some point after managed care launches. More information on the Department's approach for BH I/DD TPs is available at ncdhhs.gov/nc-medicaid-transformation. This "Managed Care Benefits and Clinical Coverage Policies" concept paper will focus on the benefit package for standard plans, consistent with those plans providing integrated behavioral services to the population they serve.

II. Benefits Covered under Standard Plans

Standard plans will be required to cover the same physical health, behavioral health and pharmacy services as Medicaid fee-for-service, except for a small number of services excluded from Medicaid managed care by statute and, pending authorization from the NCGA, a subset of behavioral health services that will be only available through BH I/DD TPs (see *Section III: Behavioral Health Integration into Standard Plans*).

Benefits covered under standard plans will continue to include federal mandatory and optional benefits currently provided in the Medicaid fee-for-service program, as outlined in North Carolina's Medicaid State Plan.

Table 1: North Carolina Fee-for-Service State Plan Services

Mandatory Federal Benefits	Additional North Carolina Benefits
• Inpatient hospital services • Outpatient hospital services • Early and periodic screening, diagnostic and treatment services (EPSDT) • Nursing facility services • Home health services • Physician services • Rural health clinic services • Federally qualified health center services • Laboratory and X-ray services • Family planning services • Nurse midwife services • Certified pediatric and family nurse practitioner services • Freestanding birth center services (when licensed or otherwise recognized by the State) • Transportation to medical care • Tobacco cessation counseling for pregnant women	• Prescription drugs • Clinic services • Physical therapy • Occupational therapy • Speech, hearing and language disorder services • Respiratory care services • Other diagnostic, screening, preventive and rehabilitative services • Podiatry services • Optometry services • Prosthetics • Chiropractic services • Other practitioner services as outlined in the Medicaid State Plan • Eyeglasses • Private duty nursing services • Personal care • Hospice • Case management • Durable medical equipment • Prosthetics, orthotics and supplies • Home infusion therapy • Services for individuals age 65 or older in an institution for mental disease (IMD) (only to the extent covered by standard plans) • Inpatient psychiatric services (only to the extent covered by standard plans) • Health homes for enrollees with chronic conditions

Services Carved Out of Managed Care

When a covered service is not provided through managed care, it is considered "carved out." Carved out services will continue to be delivered through Medicaid fee-for-service. The Department will continue to administer and manage prior authorization and providers will continue to submit their claims through fee-for-service platforms.

North Carolina Session Law 2015-245, as amended by Session Law 2016-121, carves out the following services from the managed care program:

1. Dental services;
2. Services provided through the Program of All-Inclusive Care for the Elderly (PACE);
3. Audiology, speech therapy, occupational therapy, physical therapy, nursing and psychological services documented in an individualized education program (IEP) and provided or billed by local education agencies;
4. Services provided and billed by a children's developmental services agency (CDSA) that are included in the child's individualized family service plan; and
5. Services for Medicaid applicants provided prior to eligibility determination in cases where retroactive eligibility is approved.

Additionally, North Carolina Session Law 2017-186 excludes the fabrication of eyeglasses from PHP contracts. To align with the eyeglass fabrication exclusion, the Department also recommends the eyeglass provider's visual aid fitting and dispensing fee be carved out of managed care.

In Lieu of Services

The Department will also encourage PHPs to use "in-lieu-of services" (ILOS), which are services or settings not covered under the North Carolina Medicaid State Plan, but that are medically appropriate, cost-effective alternatives to services that are covered.[1] A relatively standard feature of managed care, PHPs must submit proposed ILOS to the State for prior approval. Once approved, ILOS must be offered to members as an optional service to replace traditional State plan services.[2] The Department seeks to partner with PHPs that will bring innovative ideas on how to leverage ILOS to address public health needs, social determinants of health, and behavioral health and substance use treatment not otherwise covered by Medicaid.

III. Behavioral Health Integration into Standard Plans

The Department proposes that certain benefits be covered under both the standard plans and BH I/DD TPs, while more intensive services are covered only by BH I/DD TPs. This builds on the approach detailed in the "North Carolina's Proposed Program Design for Medicaid Managed Care" and is based on stakeholder feedback that there should be a meaningful distinction between standard plan and BH I/DD TP benefit packages to best support enrollees' needs, and to promote BH I/DD TP enrollment among the highest-need

[1] Since they are a direct substitute for a Medicaid-covered service, ILOS is included in the Medicaid capitation rate and in the Medical Loss Ratio calculation.

[2] ILOS is distinct from "value-added services," which are services not covered by a state's Medicaid program that a PHP wants to provide. Value-added services could include over-the-counter prescription medications, eye glasses, dental care, etc. Unlike ILOS, value-added services are not considered when setting Medicaid capitation rates.

populations. All standard plan and BH I/DD TP plans will cover a comprehensive set of behavioral health services, including inpatient, outpatient, crisis and substance use disorder treatment services.

In the "Behavioral Health and Intellectual/Developmental Disability Tailored Plan" concept paper, the Department recommended, consistent with the State Plan, that the following behavioral health services be covered under standard plans:[3]

1. Inpatient behavioral health services
2. Emergency department behavioral health services
3. Outpatient behavioral health services provided by direct-enrolled providers
4. Partial hospitalization
5. Mobile crisis management
6. Substance abuse intensive outpatient program (SAIOP)
7. Facility-based crisis services for children and adolescents
8. Professional treatment services in facility-based crisis program
9. Psychosocial rehabilitation
10. Outpatient opioid treatment
11. Ambulatory detoxification
12. Non-hospital medical detoxification
13. Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization
14. Substance abuse comprehensive outpatient treatment program (SACOT)
15. Research-based intensive behavioral health treatment
16. Diagnostic assessment
17. Early and periodic screening diagnostic treatment (EPSDT)[4]

IV. Clinical Coverage Policies

Consistent with federal regulations and strategies in other states, North Carolina will develop an approach to PHP clinical coverage policies and utilization management that safeguards beneficiary access to services, while encouraging PHP innovation.

Physical Health Benefits

As is the strategy in other states, North Carolina's PHPs will be required to use the Department's definition of "medical necessity" when making coverage determinations for physical health benefits.[5] Consistent with

[3] The final list of behavioral health services covered in standard plans may be determined in future legislation.

[4] A child under age 21 who requires a State Plan behavioral health or I/DD service that is offered only by BH I/DD TPs will be required to enroll in a BH I/DD TP to receive the service.

[5] As outlined in 10A NCAC 25A .0201 (1990), "All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants."

federal regulations, PHPs will also be prohibited from setting benefit limits that are more stringent than the Department's fee-for-service program. For example, if the fee-for-service program covers 10 visits for a specific service, PHPs could cover 12 visits, but could not limit a beneficiary to only six visits.

To promote consistency across PHPs, the Department is considering requiring a standard decision support methodology to validate utilization management. In areas where the decision support methodology is not specified, PHPs will be permitted flexibility to develop their own clinical, prior authorization and utilization management policies, as long as the amount, scope and duration are no more restrictive than the State's existing fee-for-service policy for that service. PHPs will be required to submit these policies to the Department for approval, post the policies on their publicly available website, and track and report benefit determinations related to those policies (e.g., number of appeals, complaints) to the Department at a frequency to be determined.

For a limited number of services, the Department will require PHPs to use existing Medicaid clinical coverage policies to maintain services for specific vulnerable populations, maximize federal funding and comply with State mandates. The proposed required policies are outlined in Table 2. All new clinical coverage policies developed by the Department after the implementation of managed care will be reviewed and documented as applying or not applying to PHPs based on criteria defined above.

Table 2: Required Physical Health Clinical Coverage Policies

Coverage Policy Name[6]
1A-23: Physician Fluoride Varnish Service
1E-7: Family Planning Service
1A-4: Cochlear and Auditory Brainstem Implants
1A-36: Implantable Bone Conduction Hearing Aids (BAHA)
13A: Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair
13B: Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair
1A-39: Routine Costs in Clinical Trial Services for Life Threatening Conditions
1A-5: Case Conference for Sexually Abused Children

Outpatient Pharmacy Benefits

Current pharmacy management uses careful selection of medications on the prescription drug list (PDL), and maximizes PDL compliance, generic utilization and drug rebates to provide access to therapeutically needed medications at the lowest possible cost. To support providers during transition to managed care and maintain consistency in the administration of the pharmacy benefit, the State will oversee and manage the program through current management strategies. Standard plans will also include all covered outpatient drugs for which the manufacturer has a Centers for Medicare & Medicaid Services rebate agreement, and for which the Department provides coverage. Additionally, North Carolina Session Law 2016-121 Section 5(6)(b) mandates that PHPs will be required to use the same drug formulary established by the Department. The "North Carolina Medicaid and Health Choice Preferred Drug List" is available at dma.ncdhhs.gov/documents/preferred-drug-list.

[6] Detailed clinical coverage policies are available at dma.ncdhhs.gov/providers/clinical-coverage-policies.

PHPs will be required to follow the same clinical coverage policies and prior authorization criteria as those used in the fee-for-service PDL/Prior Approval (PDL/PA) program (for preferred and nonpreferred classes) as outlined in Table 3. Drugs and/or drug classes requiring prior approval are available at nctracks.nc.gov/content/public/providers/pharmacy/forms.html.

Approximately one year after the initial effective date of the PHP contract, PHPs will be allowed to propose plan specific PDL/PA clinical coverage policies for review and approval by the Department for the following year. For those drugs/classes not listed in the Department's PDL, PHPs will be allowed to develop and propose their own clinical coverage policies for review and approval by the Department.

Table 3: Required Outpatient Pharmacy Clinical Coverage Policies

Coverage Policy Name[7]
9: Outpatient Pharmacy Program
9A: Over-the-counter products
9B: Hemophilia Specialty Pharmacy Program
9D: Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17
9E: Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older

As new drugs are approved to the market, the PHP will be allowed to require PA for those drugs based on the drug's FDA-approved indications and uses until the Department establishes its own criteria.

Behavioral Health Benefits

The Department proposes that in the initial years after standard plans launch, PHPs will be required to retain the provisions currently in the LME/MCO contract for utilization management and clinical coverage policies, and follow the Department's existing behavioral health clinical coverage policies, as outlined in Table 4.

Under this vision, after BH I/DD TPs launch, the Department will maintain the interim approach for both standard plans and BH I/DD TPs for at least one year. During that period, the Department will seek feedback from beneficiaries, providers and PHPs to determine if additional flexibility should be allowed.

This phased approach will create consistency across delivery systems during transition of populations from fee-for-service to managed care, and will allow for additional oversight of the PHPs by the Department to ensure services are delivered consistently across plans and regions.

[7] Detailed clinical coverage policies are available at dma.ncdhhs.gov/providers/clinical-coverage-policies.

Table 4: Required Behavioral Health Clinical Coverage Policies

Coverage Policy Name[8]	
8A:	Enhanced Mental Health and Substance Abuse Services[9]
8A-1:	Assertive Community Treatment (ACT) Program
8A-2:	Facility-Based Crisis Service for Children and Adolescents
8B:	Inpatient Behavioral Health Services
8C:	Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
8D-1:	Psychiatric Residential Treatment Facilities for Children under the Age of 21
8D-2:	Residential Treatment Services
8E:	Intermediate Care Facilities for Individuals with Intellectual Disabilities
8I:	Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population
8L:	Mental Health/Substance Abuse Targeted Case Management
8N:	NC Health Choice – Intellectual and Developmental Disabilities Targeted Case Management

V. Prior Authorization

To lower the administrative burden on providers, the Department will develop a common prior authorization request form with standard data elements for all PHPs to follow. Additionally, the PHPs will be required to follow the same adverse benefit determination appeal process previously defined in "North Carolina's Proposed Program Design for Medicaid the Managed Care Program Design."

During the initial transition to managed care, the Department intends to require all PHPs to honor existing and active prior authorizations on file with the NC Medicaid program for 90 days to ensure continuity of care for beneficiaries.

[8] Detailed clinical coverage policies are available at dma.ncdhhs.gov/providers/clinical-coverage-policies.

[9] 8A: Enhanced Mental Health and Substance Abuse Services policy includes Mobile Crisis Management (MHDDSA); Diagnostic Assessment (MHDDSA); Intensive In-Home Services; Multi-systemic Therapy (MST); Community Support Team (CST); Psychosocial Rehabilitation; Child and Adolescent Day Treatment (MHSA); Partial Hospitalization; Professional Treatment Services in Facility-Based Crisis Program; Substance Abuse Intensive Outpatient Program; Substance Abuse Comprehensive Outpatient Treatment Program; Substance Abuse Non-Medical Community Residential Treatment; Substance Abuse Medically Monitored Community Residential Treatment; Detoxification Services; Ambulatory Detoxification; Non-Hospital Medical Detoxification; Medically Supervised or ADATC Detoxification Crisis Stabilization; and Outpatient Opioid Treatment