North Carolina Medicaid Managed Care

BH I/DD Tailored Plan Care Management

Kelsi Knick

Senior Program Manager of Population Health

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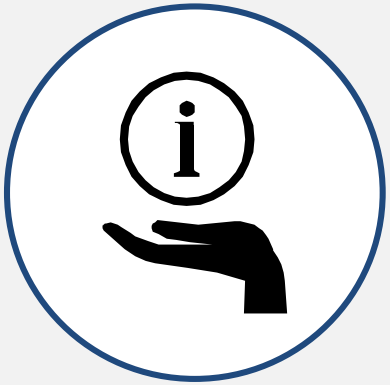
Agenda

- Care Management Under Managed Care
- Overview of BH I/DD TP Care Management Model
- Discussion of Current LME-MCO Practices and Future State Capabilities
- Next Steps

Key Principles for Medicaid Transformation

- Deliver **integrated, whole-person care** through coordinated physical health, behavioral health, intellectual/developmental disability and pharmacy services and care models
- Address the **full set of factors** that impact health, uniting communities and health care systems
- Perform **localized care management** at the site of care, in the home or community
- Maintain broad **provider participation** by mitigating provider administrative burden



Overview of Managed Care Transition

Under managed care, approximately 8 out of 10 Medicaid/NC Health Choice* beneficiaries will receive health coverage through integrated managed care products

- There will be two types of integrated managed care products available to Medicaid beneficiaries under managed care:
  1. Standard Plans (SPs) for most beneficiaries (approx. 1.6 million)
  2. Behavioral Health and Intellectual/Developmental Disability Tailored Plans (BH I/DD TPs) for populations with significant behavioral health, I/DD and TBI needs (approx. 115,000)
- Both products will offer robust services across the continuum of care, including physical health, behavioral health, pharmacy, and long-term services and supports (LTSS)
- *Only* BH I/DD TPs will provide more intensive behavioral health services, I/DD and TBI services (including Innovations and TBI waiver services), 1915(b)(3) services, and State-funded services

** Note: References to "Medicaid" hereafter are intended to encompass both Medicaid and NC Health Choice.*

Care Management Under Managed Care

Both managed care products will offer robust care management. BH I/DD TP care management will build on SP care management design to provide services customized to individuals with behavioral health, I/DD, and TBI needs.

SP care management will be available to certain "priority populations." Primary care practices certified as Tier 3 Advanced Medical Homes (AMHs) will take the lead on care management for their patients in SPs

BH I/DD TP care management will be available to all BH I/DD TP enrollees and will be provided through:

1. Tier 3 AMHs certified by DHHS to provide care management to the BH I/DD TP population
2. Care management agencies (CMAs)–community-based organizations (e.g., behavioral health or I/DD providers) certified by DHHS to provide care management to the BH I/DD TP population
3. BH I/DD TPs

Introduction to the AMH Program

The AMH program is a key vehicle for achieving integrated, whole-person care and local care management in North Carolina.

Vision for AMH in Managed Care

*Build on the Carolina ACCESS program to **preserve broad access to primary care services** for Medicaid enrollees and **strengthen the role of primary care in care management, care coordination, and quality improvement** as the state transitions to managed care*

Today's Carolina ACCESS primary care practices* have options:

- Current primary care practices in Carolina ACCESS program may **continue into AMH with few changes ("Tier 1" and "Tier 2")**
- Practices ready to take on more advanced care management functions may **attest into AMH "Tier 3"****
  - Tier 3 practices may rely on **in-house care management** capacity or **contract with a Clinically Integrated Network (CIN) or other partner of their choice**
  - Unlike in Carolina ACCESS, **practices ARE NOT be required to contract with Community Care of North Carolina (CCNC) to participate in AMH**

*Eligibility for AMH mirrors the legacy Carolina ACCESS program and includes general practice, family practice, internal medicine, pediatrics, OB/GYN, psychiatry and neurology

AMH Tiers Compared

Tiers 1 and 2

- SP **retains** primary responsibility for care management
- Practice requirements are the same as for Carolina ACCESS
- **Providers will need to coordinate across multiple plans:** practices will need to interface with multiple SPs, which will retain primary care management responsibility; PHPs may employ different approaches to care management

Tier 3

- PHP **delegates** primary responsibility for delivering care management to the practice level (see next slide)
- **Single, consistent care management approach:** Practices will have the option to provide care management in-house or through a single CIN/other partner across all Tier 3 SP contracts
- **Initial attestation process closed 1/31:** based on attestation data, majority of SP beneficiaries are expected to be attributed to Tier 3 practices

Tier 4: To launch at a later date

Deep Dive on Tier 3 AMHs

Tier 3 AMHs are responsible for delivering care management at the practice level, including:

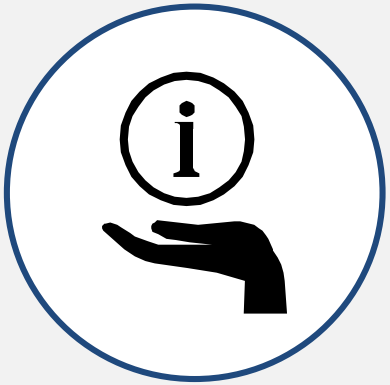
Tier 3 Responsibilities

- **Risk stratify** all empaneled patients
- Provide **care management to high-need patients,** which includes (but is not limited to):
  - Conducting a **comprehensive assessment** of enrollees' needs
  - Establishing a **multi-disciplinary care team** for each enrollee
  - Developing a **care plan** for each enrollee
  - **Coordinating all needed services** (physical health, behavioral health, social services, etc.)
  - Providing **in-person assistance securing unmet resource needs** (e.g. nutrition services, income supports, etc.)
  - Conducting medication management, including regular medication reconciliation and support of medication adherence
  - Providing **transitional care management** as enrollees change clinical settings
- **Receive claims data feeds** (directly or via a CIN/other partner) and meet state-designated **security standards** for their storage and use

Guiding Principles for BH I/DD TP Care Management

In alignment with the broader goals for Medicaid transformation, the Department is using following guiding principles in the design of the BH I/DD TP care management model.

- **All enrollees will be eligible for care management.** BH I/DD TP care management will be available to all BH I/DD TP enrollees continuously throughout an individual's enrollment.
- **An integrated, whole-person approach.** BH I/DD TP enrollees will receive integrated, whole-person care management from care managers with expertise and training in addressing BH, I/DD, and/or TBI needs *in addition* to physical health needs.
- **Community-based care management.** Care management will be provided at the site of care, in the home or community, to enable frequent face-to-face interaction between care managers, providers, and enrollees.
- **Choice of care management providers.** BH I/DD TP enrollees may choose among care management providers and may change care managers at any time.
- **Community inclusion.** BH I/DD TP care managers will support enrollees in living meaningful, productive lives in the community.
- **Consistency across the state.** Regardless of geography or type of entity providing care management, all BH I/DD TP enrollees will have access to consistent, high-quality care management.
- **Leverage existing resources.** BH I/DD TP care management will build on existing, high-functioning care management infrastructure in the state to the extent it aligns with DHHS's vision for care management.



Overview of BH I/DD TP Care Management Approach

NC DHHS

Establishes care management standards for BH I/DD TPs aligning with federal Health Home requirements

The BH I/DD TP will act as the Health Home and will be responsible for meeting federal Health Home requirements

BH I/DD TP Health Home

All approaches will be subject to one set of requirements and will provide care management across physical health, behavioral health, I/DD, and other services and the enrollee's unmet health-related resource needs.

Care Management Approaches

BH I/DD TPs have flexibility in how they provide care management, as long as the approach meets DHHS standards and care management is provided in the community to the maximum extent possible.

Approach 1: Tier 3 AMH with BH and/or I/DD Certification*

DHHS will create specialized BH and I/DD certifications for Tier 3 AMHs that serve a substantial number of BH I/DD TP enrollees and have experience serving these populations

Approach 2: Care Management Agencies (CMAs)*

BH I/DD TPs contract with agencies such as those that provide BH or I/DD services (e.g., mental health or substance use agencies, home care agencies, etc.) that obtain CMA certification

Approach 3: BH I/DD TP-Employed Care Managers

BH I/DD TPs may provide care management in certain circumstances that will be outlined in more detail by DHHS.

*Tier 3 AMHs or CMAs may contract with a clinically integrated network (CIN) for certain care management and data sharing functions

Integrated, Community-Based Care Management

At its core, the BH I/DD TP care management model aims to promote integrated, community-based care management.

- **Integrated care management** places the person at the center of a multidisciplinary care team and recognizes interactions across all of their needs—ranging across physical health, behavioral health, I/DD, and TBI—developing a holistic approach to serve the whole person

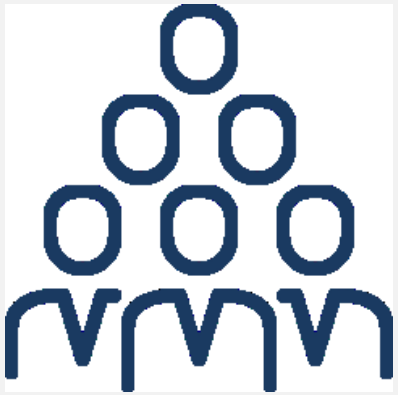
- **Community-based care management** ensures that care managers are physically located in settings that enable frequent face-to-face interaction between care managers, providers, and enrollees

Integrated Care Management Means that Care Managers…

- **Coordinate a comprehensive set of services** addressing all of the enrollee's needs; enrollees will not have separate care managers to address physical health, behavioral health, TBI, and I/DD-related needs
- **Provide holistic, person-centered planning.** Enrollees receive a care management assessment that evaluates all of their needs—from physical health, behavioral health, I/DD, and TBI services to employment and housing—and drive the development of a care plan that identifies the goals and strategies to achieve them
- Connect enrollees to programs and services that **address unmet health-related resource needs** (e.g. housing, food, transportation, interpersonal safety, employment, etc.), including through healthy opportunity pilots in regions where available
- **Are part of multidisciplinary care teams** made up of clinicians and service providers (e.g. primary care providers, behavioral health and I/DD or TBI providers, pharmacists, nutritionists, community health workers, peer supports, etc.) that communicate and collaborate closely to efficiently address all of the enrollee's needs
- **Have access to technology that bridges data silos across providers and plans**, and facilitate the timely and secure exchange of information to support and inform integrated care management

Community-Based Care Management Means that Care Managers…

- **Primarily use face-to-face meetings,** supplemented by telephone, text message, and email, to engage and support the client whether in the home or a treatment setting. They speak the client's language or have easy access to interpreters
- **Are local,** and live in and/or have experience working in the geographic region where their panel lives. They:
  - Understand local culture and how it impacts the physical and behavioral health of clients
  - Conduct regular assessments of community health assets and needs and use the results to plan/implement services that respond to cultural and linguistic diversity
- **Are embedded within or assigned to a designated group of primary care practices or behavioral health or I/DD providers**
- **Have professional working relationships in the community** with residential and outpatient treatment facilities, home health and housing agencies, community-based social service agencies, schools, police, correctional facilities, and other service providers that their clients may come in contact with on a regular basis
- **Leverage their community-based connections** to facilitate/fast track services needed to stabilize clients in community settings or transition to other settings to gain most favorable outcome for the client
- **Build effective relationships with family and other caregivers** to guide them in supporting the client through transitions and ongoing treatment



Appendix

Definitions

*__Adults with Special Health Care Needs__ is defined as those who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes, but is not limited to individuals: with HIV/AIDS; an SMI, SED, I/DD or SUD diagnosis; or receiving 1915(b)(3), Innovations or TBI Waiver services.

Children with Special Health Care Needs is defined as those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age. This includes, but is not limited to, children: in foster care; receiving Early Intervention; with an SMI, SED, I/DD or SUD diagnosis, and/or receiving 1915(b)(3), Innovations or TBI Waiver Services.

****High Unmet Resource Needs** is defined as enrollees who are homeless; witnessing domestic violence or lack of personal safety; or showing unmet needs in three or more social determinants of health domains (i.e., housing, food, transportation, and interpersonal violence/toxic stress) on the care needs screening.