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Division of Health Benefits

Tailored Plan Update

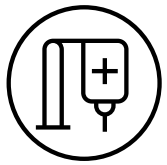
Melanie Bush
Deputy Medicaid Director

In this presentation...

Learn more about Behavioral Health and Intellectual/Developmental Disabilities Tailored Plans, a new kind of NC Medicaid Managed Care health plan. **They start July 1.**

Your NC Medicaid Direct plan will move to a Tailored Plan

If you are covered by NC Medicaid and receive services for severe mental illness, severe substance use or have a traumatic brain injury or intellectual/developmental disability, more details were mailed in mid-April.



Some people may get new services

If you are moving from a Standard Plan (Healthy Blue, AmeriHealth Caritas, Carolina Complete Health, UnitedHealthcare or WellCare) to a Tailored Plan, new services may be available to you.

Fixed if your providers are in-network

Your providers (doctors and specialists) will need to be in your Tailored Plan's network by January 31, 2025.

Moving to a Tailored Plan? Here's what you need to know

Tailored Plans cover the same services that you get from NC Medicaid Direct and offer additional benefits.

Tailored Plans are designed to put you first

That means looking at you as a whole person, all of you!

All your health needs met in one plan

With a Tailored Plan, your physical, mental, severe substance use, intellectual/developmental disability or traumatic brain injury needs are **all in one plan.**

Support from Tailored Care Managers

Tailored Care Managers help you get the medical or specialized care you need. They can help schedule your medical appointments, arrange transportation, and more.

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Tailored Plans Launch

What to Expect and Key Dates

What is a Tailored Plan?

Tailored Plans are a new kind of NC Medicaid Managed Care health plan. They cover your mental health, severe substance use, I/DD, TBI and prescriptions in one plan.

If you get NC Medicaid Direct services for these needs, your NC Medicaid plan may be moved to a Tailored Plan. The name is changing, but the services are not.

Tailored Plans include services for people with more intense needs, including people with:

Serious Mental Illness (SMI)

Severe Substance Use Disorders (SUD)

Intellectual/ Developmental Disabilities (I/DD)

Traumatic Brain Injuries (TBI)

Learn more at: Medicaid.NC.gov/Tailored-Plans

Who runs Tailored Plans?

1. Tailored Plans in North Carolina are managed by four companies called **Local Management Entities (LME)**.
2. Your LME will cover your behavioral health, physical health, and prescriptions.
3. If your NC Medicaid is moving to a Tailored Plan, it will be managed by one of these four companies:

Alliance Health

Partners Health Management

Trillium Health Resources

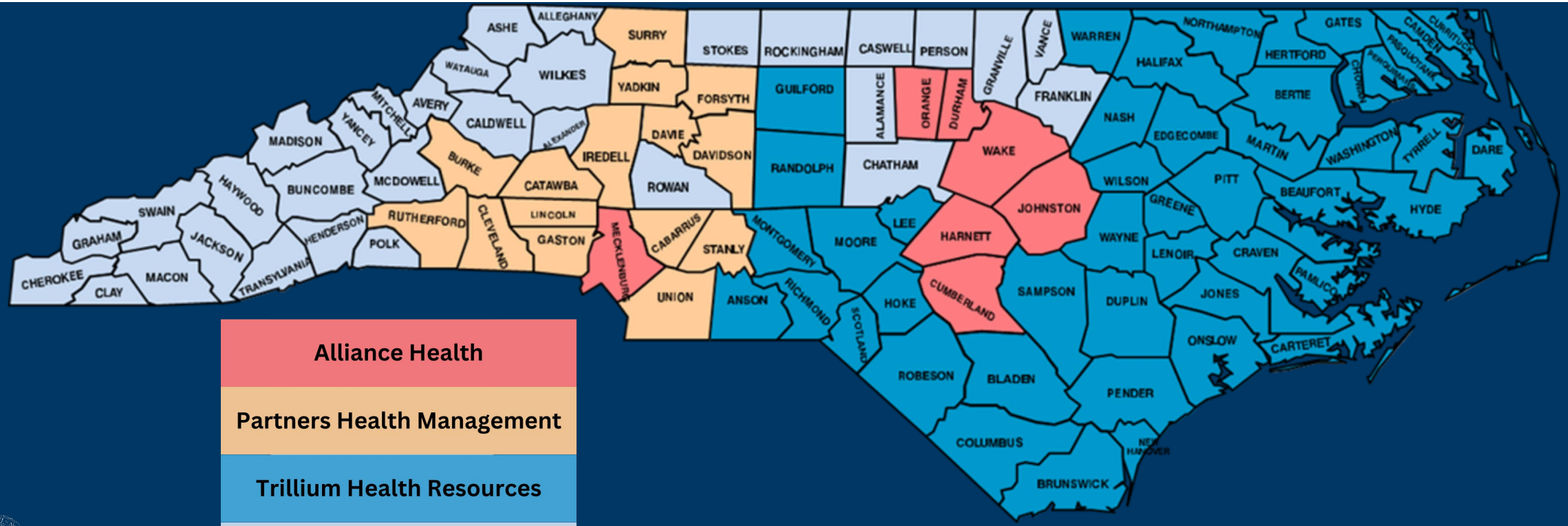
Vaya Total Care

How will I know which Tailored Plan I am in?

A letter was mailed in mid-April. That letter has information about which Tailored Plan you are in. Your plan is assigned based on the county where you get your Medicaid benefits.

There is only one Tailored Plan per county

Your assigned Tailored Plan is based on the county that manages your Medicaid benefits. You cannot choose a different Tailored Plan.



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What's new for you?

Providers must be in-network

Your providers (doctors and specialists) must be in the Tailored Plan's network (also called "in-network") to be covered.

You must choose a new PCP if yours is not in-network

If you don't choose a PCP that's in your Tailored Plan's network, one was assigned to you. **You can change it until January 31, 2025.**

More covered services

If you choose to move from a Standard Plan (Healthy Blue, AmeriHealth Caritas, Carolina Complete, UnitedHealthcare or WellCare), you will get more services covered than you do now.

What's staying the same?

Your plan covers the same services as before

This includes I/DD, TBI, mental health, severe substance use, and care management services.

Innovations/TBI Waiver members

If you're on the Innovations Waiver or TBI Waiver, you keep your spot. If you're on the waitlist, you keep your place in line.

Same Tailored Care Manager as the one you have now

You have access to a Tailored Care Manager who can help you get the health services you need. If you have one now, they won't change.

If you will be moved to a Tailored Plan (LME)

May – June, 2024

A new member health plan ID card and welcome packet is being mailed from your Tailored Plan.

Your primary care provider (PCP)'s information is on these documents.

May 2024

You can begin scheduling rides to medical appointments.

Non-emergency medical transportation (NEMT) services are available for appointments on or after July 1, 2024.

July 1, 2024

Tailored Plans begin!

You can start seeing your medical providers (doctors and specialists) in your Tailored Plan's network.

January 31, 2025

Last day to see out-of-network providers.

If you would like to continue to see an out-of-network provider after this date, talk to your Tailored Plan.

Do I have to move to a Tailored Plan?

Possibly, if the letter you received from your NC Medicaid Enrollment Broker says you are moving to a Tailored Plan, and also describes your options.

If you received a letter saying you must move to a Tailored Plan, these are the next steps:

- **Moving to a Tailored Plan lets you keep your current coverage of services.** Tailored Plans cover the same services you get now through NC Medicaid Direct and your LME.
- **You may refuse to enroll in a Tailored Plan, but you could lose coverage for services.** If you choose a different health plan, certain services may not be covered.

Learn more about the transition to Tailored Plans:
medicaid.ncdhhs.gov/tailored-plans/moving-to-a-tailored-plan

Call your Tailored Plan to make sure your doctors and specialists are in your network

Check to see if your providers (doctors and specialists) accept your Tailored Plan - not just Medicaid.

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Call your Tailored Plan

- **Alliance Health 1-800-510-9132**
- **Partners Health 1-888-235-4673**
- **Trillium Health 1-877-685-2415**
- **Vaya Total Care 1-800-962-9003**

Search the directory

Look for your providers on the directory:
ncmedicaidplans.gov

You can keep seeing an out-of-network provider after **January 31, 2025.**
Talk to your Tailored Plan.

If your specialist or doctor is not in your network:

Your providers (doctors or specialists) need to accept your Tailored Plan to provide services to you. Providers who do not will be considered out-of-network. **During your move to Tailored Plans:**

✓ You may keep seeing current Medicaid providers

Even if they're not listed on your health plan ID card, you may keep seeing the doctors you see now until January 31, 2025.

✓ Your prescriptions stay the same

Coverage for your prescriptions stays the same until at least January 31, 2025.

✓ Your dental coverage will not change.

You can keep seeing the **dental** providers you see now.

✓ You may change your primary care provider (PCP)

This is the doctor you see when you feel sick, need a check-up, or need help with chronic conditions like diabetes. You can change your PCP for any reason until January 31, 2025 and twice a year after that.

What is in the Welcome Packet?

In late May through mid-June, Tailored Plans will mail Welcome Packets to you. These included:

- Your new Tailored Plan ID card
- Your Member Handbook
- Your Primary Care Physician (PCP) is listed on your member ID card

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Services Offered by Tailored Plans

Assistance Offered by Tailored Care Managers

Tailored Care Managers offer support to help you get the care you need.
Tailored Care Managers can help:

- Arrange medical appointments
- Find prevention programs
- Find resources for home maintenance and repairs
- Secure prescriptions and medical supplies
- Find housing options and financial help
- Support transitions out of hospital or nursing facilities
- Provide support with chronic health issues
- Locate after school care or childcare
- Arrange transportation

Services offered by Tailored Plans

If you opt out of Tailored Plans, these services are not paid for by other NC Medicaid Managed Care health plans.

Here are some examples:

- ✓ Child and adolescent day treatment services
- ✓ Intensive in-home services
- ✓ Multi-systemic therapy services
- ✓ Psychosocial rehabilitation
- ✓ Residential treatment facility services
- ✓ Community living and supports (specific to I/DD & TBI)
- ✓ Supported employment (available to I/DD, TBI, and behavioral health)
- ✓ Respite (specific to I/DD, TBI, serious emotional disturbance and severe SUD)
- ✓ State-funded behavioral health, I/DD, and TBI services

Non-Emergency Medical Transportation (NEMT)

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NC Medicaid's Tailored Plans Covers Free Rides to Medical and Mental Health Appointments

WHO IS ELIGIBLE?

People on NC Medicaid, including Tailored Plans, who need transportation assistance to travel to their medical appointments qualify to receive NEMT services. Accessible rides are available for members with mobility disabilities.

WHAT TRIPS ARE COVERED?

- ✓ Visits to your Medicaid doctor or specialist
- ✓ Trips to the pharmacy or for prescription pick-up
- ✓ Mental health appointments
- ✓ Substance abuse treatment

Continued...

Non-Emergency Medical Transportation (NEMT)

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NC Medicaid's Tailored Plans Covers Free Rides to Medical and Mental Health Appointments

HOW TO SCHEDULE NEMT RIDES?

Call your Tailored Plan to schedule NEMT rides.

- Alliance Health 1-800-510-9132
- Partners Health 1-888-235-4673
- Trillium Health 1-877-685-2415
- Vaya Total Care 1-800-962-9003

Request your ride at least 2 days before your appointment for best availability. This 2-day requirement does not apply in urgent pickups, like hospital discharges.

Continued...

Non-Emergency Medical Transportation (NEMT)

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TRAVEL-RELATED REIMBURSEMENTS

If you drive yourself to an appointment, or if a family member or friend gives you a ride, you might get money back for travel costs such as:

- ✓ Gas vouchers
- ✓ Food
- ✓ Overnight or long-term lodging
- ✓ Parking fees and tolls during transportation to health appointments
- ✓ Transportation vouchers for taxi payments, ride-sharing services, or public transportation
- ✓ Mileage reimbursements

Contact your Tailored Plan (Alliance, Trillium, Vaya Total Care, or Partners Health Management) to ensure your trip is covered and get more details.

Learn more at: Medicaid.NC.gov/NEMT

1915(i) Medicaid Home and Community-Based Services

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NC Medicaid's New 1915(i) Free Services Help You Live More Independently At Home

Tailored Plans include 1915(i) home and community-based services to help members and caregivers get the support they need.

WHO IS ELIGIBLE?

NC Medicaid members with:

- serious mental illness,
- severe substance use disorders,
- traumatic brain injuries,
- or intellectual/developmental disabilities.

1915(i) Medicaid Home and Community-Based Services

Continuation...

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WHAT SERVICES ARE COVERED?

- ✓ **Respite Care:** Breaks for caregivers, including overnight or weekend care
- ✓ **Supported Employment:** Helps you find a job that's right for you
- ✓ **Individual Placement and Support Services:** Job help for those with severe mental illness or substance use disorders
- ✓ **Individual and Transitional Support:** Helps with housing, finances, etc.
- ✓ **Community Living and Support:** Learn to perform daily activities, like bathing and dressing, and community aspect activities like grocery shopping and making friends
- ✓ **Community Transition:** Helps you move from an institutional setting back to your community

Call your health plan or call your Tailored Care Manager or care coordinator (if you have one) to find the services you need.

Learn more at: Medicaid.NC.gov/1915i

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What should I do?

Moving to Tailored Plans?
Here are 5 things you can do:

1. Update your address if needed.

2. Know who runs your Tailored Plan.

3. Change your assigned primary care provider (PCP), if desired

4. Check if your doctors and specialists are in your Tailored Plan.

5. Ask about your Tailored Care Manager.

NC MEDICAID MEDICAL CARE ADVISORY COMMITTEE (MCAC) MEETING

Medicaid Enrollment & Finance Update

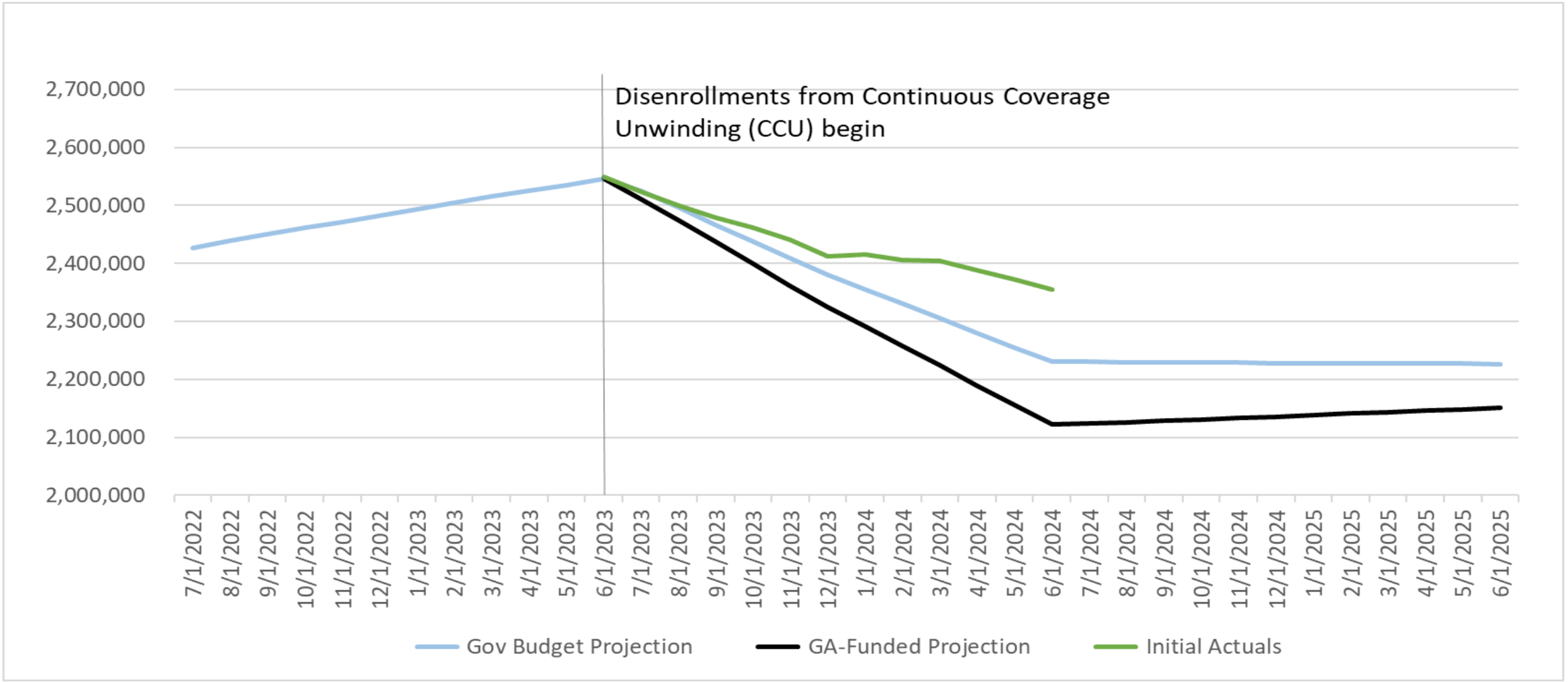
Adam Levinson
Chief Financial Officer

June 21, 2024

Overview

- Enrollment
  - Year-to-Date (YTD) Actuals v Biennium Forecast
  - Continuous Coverage Unwinding (CCU)
- Financial Position
  - State Fiscal Year (SFY) 2024 YTD Actuals v Budget and Prior Year
  - Governor's Recommended Budget Adjustment for SFY 2025

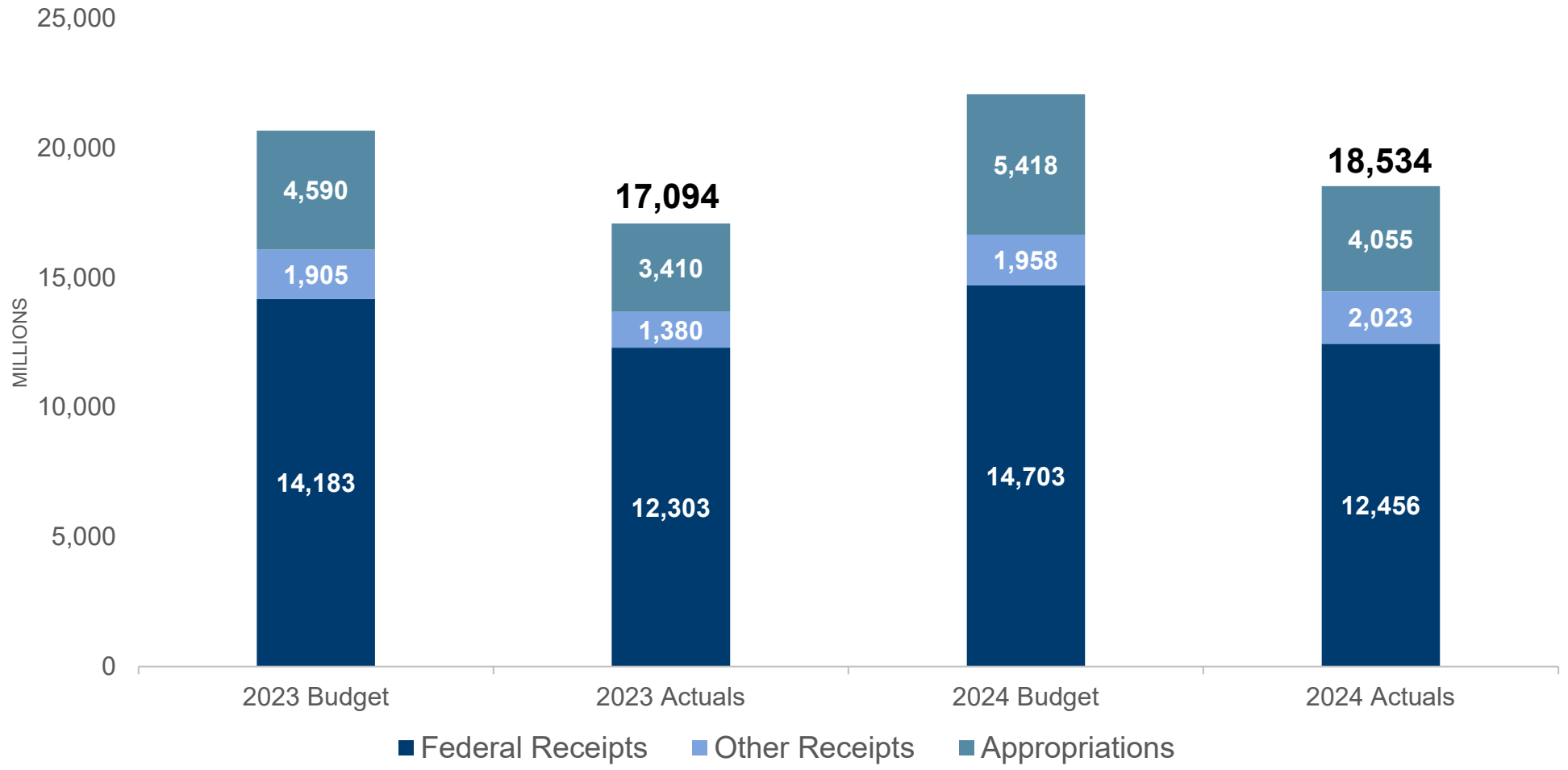
SFY 2024 Non-expansion Actual v Forecasted Medicaid Enrollment (Excludes Family Planning)



Source: Forecast from May 2023 Governor's Recommended Budget Medicaid Rebase (as updated in October 2023); GA-funded Projection from Medicaid Rebase funded in S.L. 2023-134; Actuals from Medicaid Monthly Enrollment Reports

Non-expansion Actual YTD Service Expenditures v. Budget

Through April 2024 NC Medicaid spent approximately 75% of the appropriations budget for services for SFY 2024.



Source: BD701 actuals as of April 2024 and April 2023

Governor's Recommended Budget Adjustments for SFY 2025

Important Investments in Medicaid (State Appropriations):

- Medicaid Rebase ($458 m)
- Physician, Specialty Provider, Dental Rate Increases ($265 m)
- Home & Community-Based Services (HCBS) Direct Care Workers ($180 m)
- 1,000 Innovations Waiver Slots ($35 m annualized)
- Healthy Opportunities Statewide Expansion ($21 m)

Source: Governor's Recommended Budget Adjustments FY 2024-25

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Medicaid & Beneficiary Advisory Committees: Final Rules

Kathy Batton
Communications Manager, Communications & Engagement

June 23, 2024

CMS Final Rule: Ensuring Access and Eligibility in Medicaid

Finalized on April 22, 2024

For more than 40 years, CMS has required every state to convene a Medicaid Care Advisory Committee (MCAC) in which various Medicaid stakeholders, including beneficiaries, can provide recommendations to the state agency.

However, beneficiaries have had mixed involvement with the MCAC across the country.

CMS has designed this new rule to center the lived experience of beneficiaries, their families, and caregivers in Medicaid programs and policies.

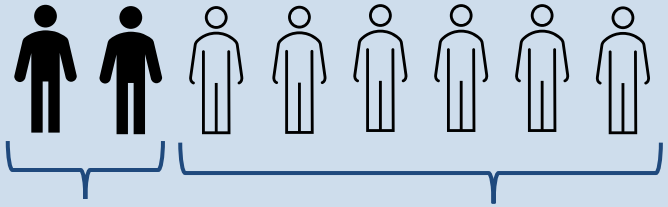
"I think they [beneficiaries] need to be an integral part of the policy making. I think that's how we go farther, maybe not faster, but that's how we go farther… So I think that they deserve a seat at the table as far upstream as possible."

Medicaid beneficiary
CHER beneficiary focus group,
April 2023

MAC/BAC Changes in Proposed Federal Rules

- CMS proposed rules require states to replace existing Medical Care Advisory Committees with two new groups:
  - Medicaid Advisory Committee
  - Beneficiary Advisory Council
- The MAC/BAC will broadly advise state Medicaid agencies on health and medical services, policy development, and program administration
- MAC and BAC must meet:
  - Once per quarter
  - Two MAC meetings must be open to the public
  - BAC members meet separately and prior to MAC meetings.
- States must allow for virtual participation, as well as financial support to address barriers for beneficiary participation (e.g., childcare)
- Applicable as of July 9, 2025

MAC Membership



At least 25% from the BAC:

- Current or past Medicaid beneficiaries
- Individuals who support Medicaid beneficiaries

Other MAC Members:

- State or local consumer advocacy groups or CBOs
- Health plan representations
- Other state agencies

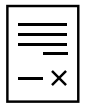
MAC Membership and Composition

Using a phased approach, beneficiaries will make up **25 percent** of the MAC membership.

July 9, 2025	July 10, 2026	July 11, 2027
10 percent of the MAC will be composed of beneficiaries	**20 percent** of the MAC will be composed of beneficiaries	**25 percent** of the MAC will be composed of beneficiaries

In addition to a required percentage of beneficiaries, the MAC **must** include representation of **at least one person** from the following categories:

State or local consumer advocacy groups or community-based organizations that represent the interest of, or provide direct services, to Medicaid beneficiaries



Participating Medicaid MCOs, PIHPs, PAHPs, PCCM entities or PCCMs or a health plan association representation such plans

Other state agencies that serve Medicaid beneficiaries as ex-officio, non-voting members

To be eligible for the **BAC**, one must be either

a current or past Medicaid beneficiaries, or

an individual with direct experience supporting a Medicaid beneficiary, such as family members and caregivers - both paid and unpaid

Other Final Rules

Length and Terms of Members

- States will determine the length of terms for committee and council members.
- An individual's term may not be followed immediately by a consecutive term.

Reimbursement for Participation

- States will have the ability to reimburse beneficiaries, which can include reimbursement for travel, lodging, meals, and childcare, however other compensation such as daily stipends will be counted as income.
- The State could submit a SPA to CMS to disregard such stipends or other countable income.

Annual Report

- The MAC with support from the state must submit an annual report describing its activities, topics discussed, and recommendations. The state must review the report and include their response to the recommendations from MAC members.
- The first report will need to be finalized by July 9, 2026, and must be published online within 30 days.

Other Requirements

- States must offer a rotating variety of meeting attendance options (in-person, virtual, hybrid) and always offer a telephone dial-in option.
- States must post publicly the MAC/BAC annual report (including state responses to recommendations), along with bylaws, membership lists, meeting minutes, and the member recruitment and selection process.
- CMS requires states to provide staffing, financial, and other administrative support. States may claim FFP at the standard administrative match rate of 50%.

Questions & Feedback

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NC MEDICAID MEDICAL CARE ADVISORY COMMITTEE (MCAC) MEETING

1115 Annual Post-award Forum

Kristen Dubay
Chief of Population Health

June 21, 2024

Background - Section 1115 Demonstrations

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are likely to further the goals and objectives of the Medicaid program.

- Section 1115 demonstrations provide states additional flexibility to waive certain components of federal Medicaid law and make changes to the way they operate their Medicaid programs
- States have used 1115 waivers to implement a wide range of programmatic changes, including changes to eligibility, benefits, delivery systems, and cost sharing
- Waivers can encompass the entirety of a state's Medicaid program or be tailored to specific sub-populations
- Demonstrations generally must be budget neutral to the federal government, meaning that Medicaid expenditures under the demonstration cannot exceed what expenditures would have been without the demonstration.
- Demonstrations are generally approved for an initial five-year period and can be extended for up to an additional three to five years.

Link to North Carolina's Approved Waiver

medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf

Background - North Carolina 1115 Waiver

The current demonstration is approved from Nov. 1, 2019, through Oct. 31, 2024, and includes the following key components:

Mandatory Managed Care Program

North Carolina has begun transitioning its Medicaid delivery system to managed care and will offer three different plans, including:

- Standard Plans - targeted to most of the Medicaid population. Standard Plans launched on July 1, 2021, and currently enroll approximately 1.8 million individuals.
- Behavioral Health Intellectual/Developmental Disability Tailored Plans (Tailored Plans) - targeted to individuals with behavioral health needs, an I/DD, or traumatic brain injury (TBI). The Tailored Plans will provide enhanced benefits and care management and are scheduled to launch July 1, 2024.
- The Specialized Plan for Children in Foster Care and Formerly in Foster Care - targeted to children and youth in foster care and former foster youth. The plan will provide enhanced benefits and specialized care management tailored to individuals involved with the child welfare system.

Healthy Opportunities Pilots

The State is testing the impact of providing select evidence-based, non-medical interventions related to housing, food, transportation and interpersonal safety to high-need Medicaid enrollees. The Pilots launched in early 2022.

OUD/SUD Program

North Carolina received approval to provide a broader range of substance use disorder (SUD) treatment services with the goal of expanding access to the full continuum of SUD care. North Carolina began implementing this component of the demonstration in 2019.

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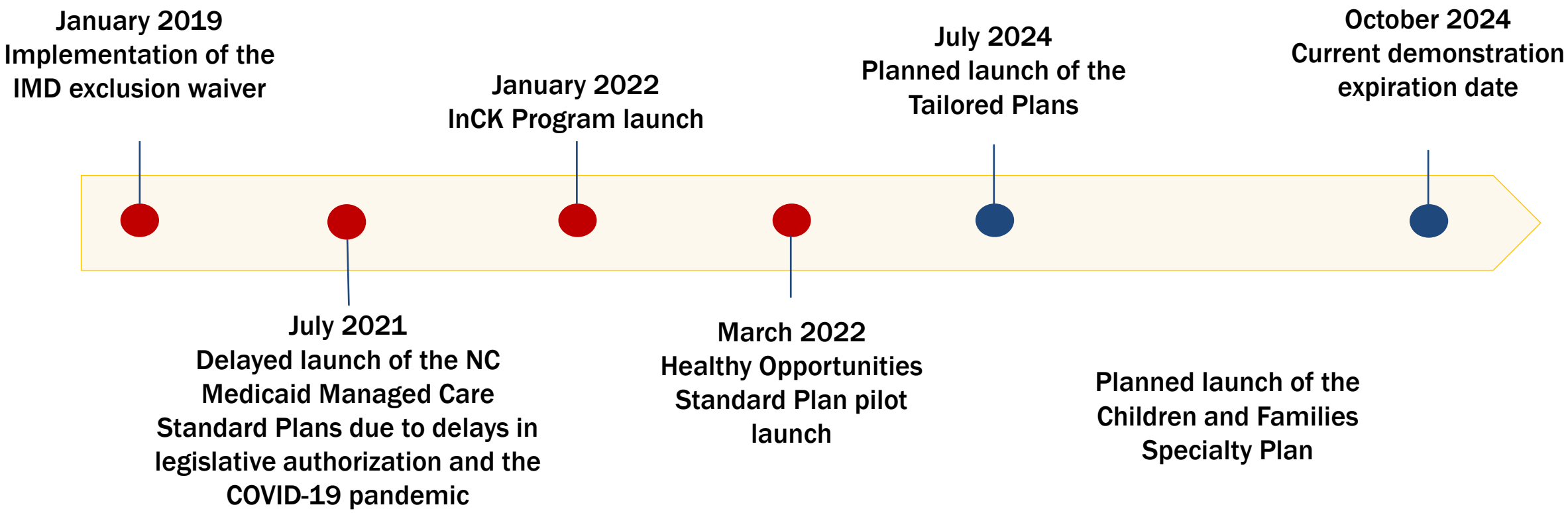
North Carolina 1115 Waiver Timeline

Most of North Carolina's 1115 demonstration was effective as of November 2019; however, implementation of managed care is just beginning as a result of state budget issues and the COVID-19 pandemic.



NC Medicaid Managed Care – Standard Plans

Standard Plans are comprehensive managed care plans that launched in July and enroll the majority of NC Medicaid beneficiaries

Standard Plans provide comprehensive physical and behavioral health benefits and whole-person care management for enrollees who are not excluded or exempted from managed care.*

- After a competitive procurement, North Carolina awarded Standard Plan contracts to the following health plans in early 2019:
  - AmeriHealth Caritas North Carolina, Inc.
  - Blue Cross and Blue Shield of North Carolina
  - Carolina Complete Health
  - UnitedHealthcare of North Carolina, Inc.
  - WellCare of North Carolina, Inc.
- Standard Plans were initially scheduled to launch on November 1, 2019. Implementation was moved to July 1, 2021, due to delays in the State budget and the COVID-19 pandemic.
- In early 2022, eligible individuals in Pilot regions enrolled in Standard Plans were able to access Healthy Opportunities Pilot services.

NC Medicaid Enrollment, Nov. 2021

Standard Plans 1.67 M

Total 2.67 M

* Includes individuals who will become eligible for Tailored Plans or the Specialized Plan for Children in Foster Care

InCK Program

The North Carolina Integrated Care for Kids Program is funded by a 7-year, $16 million grant from CMS to NCDHHS, Duke University and the University of North Carolina at Chapel Hill.

- Funds are being used to provide SDOH based risk-factor analysis and enhanced care management/care coordination services for children participating in the program.
- The InCK pilot currently operates in five counties (Alamance, Orange, Durham, Granville & Vance) and serves ~100,000 young people.
- InCK services are available to all Medicaid and NC Health Choice beneficiaries, within the five-county pilot area, from birth to age 20, regardless of where they receive care.
- Key players:
  - Health Plans are responsible for providing InCK care management services to beneficiaries and outbound reporting to NC Medicaid on these efforts
  - Clinically Integrated Networks (CINs) assist in care coordination for beneficiaries
  - InCK Integration Consultants support care managers in resource navigation and create Shared Action Plans for select InCK participants
  - Care managers coordinate services for InCK beneficiaries

InCK Program – Progress To-date

The InCK pilot program has successfully launched in five counties and is providing services to ~100,000 young people across the state

- The InCK Program officially launched in January 2022, with InCK Integration consultants providing initial outreach and coordination for program participants.
- In February 2022, the Virtual Health platform for InCK successfully went live. This web-based platform allows care managers to coordinate across participants' care teams and to view key SDOH data relevant to providing enhanced services for beneficiaries.
  - The Virtual Health platform houses specific "child profile" data sets that can be accessed by select members of a child's care team and used to inform their navigation of public services.
- InCK risk scoring and child profile data (housed on the platform) are currently updated on a monthly basis via integration between the Government Data Analytics Center (GDAC), NCDHHS, NCDPS and NCDPI.
  - InCK beneficiaries are divided into three risk tiers, or "Service Integration Levels" based upon the combined data from these agencies.
- In January 2023, the InCK Alternative Payment Model (APM) launched.
  - The InCK APM provides technical specifications & metric-based incentives for the Standard Plans participating in the program's pilot launch.

NC Medicaid Managed Care - Tailored Plans and Children and Families Specialty Plan

NC will launch two specialized managed care products: Tailored Plans and the Children and Families Specialty Plan

Tailored Plans

- Launch date: July 2024
- Population: Individuals with behavioral health needs, I/DD or TBI
- Benefits: Comprehensive physical, behavioral health, I/DD, and TBI benefits; includes 1915(c) HCBS waiver services and additional behavioral health benefits not available through Standard Plans
- Care Management: Tailored Care Management – intensive, community-based care management authorized under Medicaid Health Home authority and tailored to the unique needs of the population

Children and Families Specialty Plan

- Population: Children in foster care and adoptive placements and former foster youth
- Benefits: Comprehensive physical and behavioral health services
- Care Management Model: Specialized care management model targeted to the unique needs of the foster care/adoptive placement/former foster youth population, including close coordination between the Plan and the NC Department of Social Services

Healthy Opportunities Pilots

The federal government authorized up to $650 million in state and federal Medicaid funding to provide select, non-medical interventions to high-needs Medicaid enrollees

- Pilot funds are used to cover the cost of delivering federally-approved Pilot services which include housing, food, transportation and interpersonal safety
- The Pilots operate in three regions and serve 33 counties (*more information on next slide*)
- A Medicaid enrollee must meet at least one State-defined health risk factor and at least one State-defined social risk factor to receive Pilot services
- Key players:
  - Health plans are responsible for approving which enrollees qualify for Pilot services and coordinating with care managers
  - Network Leads (NLs) connect health plans with HSOs and manage a network of HSOs that provide Pilot services
  - Human Services Organizations (HSOs) deliver Pilot services to enrollees
  - Care managers identify enrollees and coordinate services

Health Risk Factors
(examples by population)

- Adults – e.g., two or more chronic conditions
- Pregnant women – e.g., multifetal gestation
- Children, age 0-3 (e.g., admitted to neonatal intensive care unit)
- Children, age 0-20 (e.g., experiencing three or more adverse childhood experiences)

Social Risk Factors

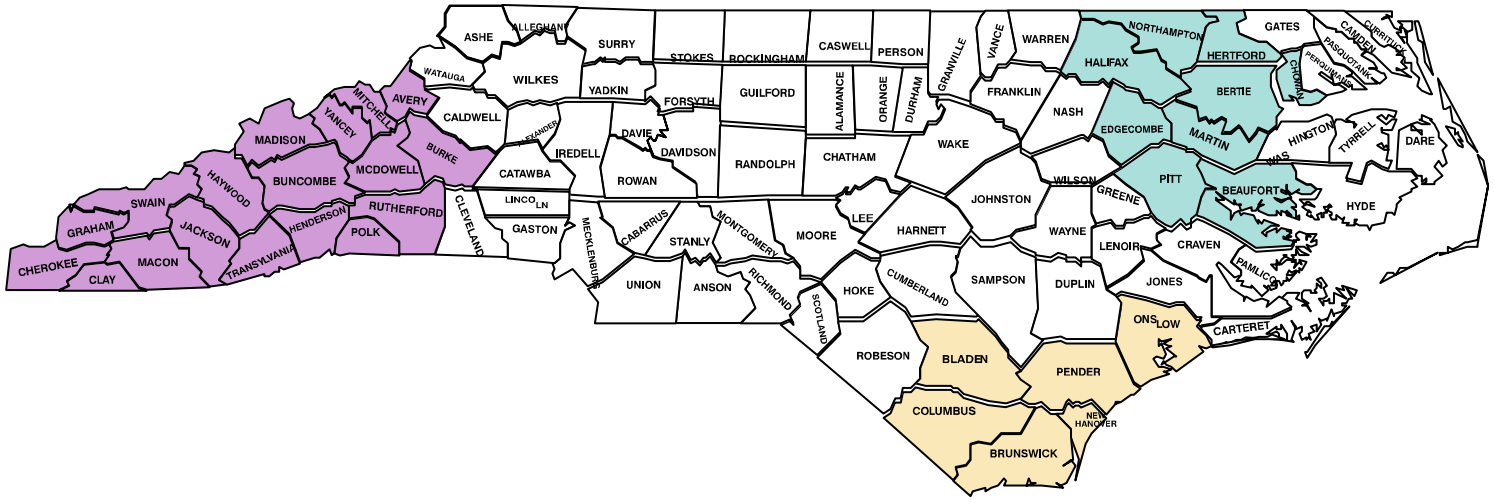
- Homeless and/or housing insecure
- Food insecure
- Lack of transportation
- At risk of, witnessing or experiencing interpersonal violence

Healthy Opportunities Pilots – Progress To-date

North Carolina implemented its Health Opportunities Pilots in early 2022

Progress To Date

- North Carolina awarded three NL contracts in May 2021
- NLs are working closely with their networks of HSOsto deliver Pilot services.
- Based on COVID-19 experience, North Carolina is working with NLs to ensure historically underutilized providers are adequately represented in their networks



Network Leads and Their Regions

Access East, Inc.

Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt

Community Care of the Lower Cape Fear (CCLCF)

Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender

Impact Health (Dogwood Health Trust)

Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

Early Successes in First Ten Months

NCDHHS developed and launched a roadmap to create an ecosystem model of addressing unmet resource needs.

- Delivered over 380,000 non-medical services to over 22,600 Medicaid members and growing
- Personal accounts of how Healthy Opportunities services have "changed lives"
- Generated partnerships and collaboration across health and human service sectors: 5 health plans, 5 clinically integrated networks (23 care management organizations), 3 Network Leads, 115+ HSOs
- Created non-medical service definitions, fee schedule, invoicing and claims processes, and encounters
- Established Network Leads to connect health and human service organizations and model contracts to govern relationships
- Built a technology system to link the medical and non-medical sectors
- Established additional, predictable funding source to local HSOs
- Capturing data to evaluate
- Setting a national model and precedent: CMS recently approved 1115 waivers for Arizona, Massachusetts, and Oregon with additional financing and flexibilities to address unmet resource needs

SUD Demonstration Waiver

North Carolina received a waiver of the so-called "IMD Exclusion;" this supports the state's efforts to expand access to the full continuum of OUD/SUD treatment services

Waiver Authority

- Under federal Medicaid law, states are generally prohibited from using federal Medicaid funds for care provided to most patients in mental health and SUD residential treatment facilities larger than 16 beds (known as IMDs)
- As part its 1115 waiver, North Carolina received authority beginning in 2019 to access federal matching funds for certain OUD/SUD treatment services delivered through short-term residential and inpatient settings that are considered IMDs.

Programmatic Changes

- Supported by the waiver the IMD exclusion, North Carolina will significantly expand access to the full continuum of ASAM levels of care (all benefits are authorized under the State Plan)
- New benefits include clinically managed low-intensity residential treatment services, clinically managed population-specific high-intensity residential programs, ambulatory withdrawal management with extended on-site monitoring, and clinically managed residential withdrawal management
  - The state also expanded coverage of existing services to adolescents including clinically managed high-intensity residential services and medically monitored intensive inpatient services
- The State's SUD Implementation Plan outlines strategies and timelines for ensuring access to critical levels of care, using evidence-based patient placement criteria, using nationally recognized provider qualifications for residential treatment facilities, and other key implementation milestones

Questions/comments?