Plan for Implementation of Behavioral Health and Intellectual/Developmental Disability Tailored Plans

Session Law 2015-245, As Amended by House Bill 403

Report to the
Joint Legislative Oversight Committee on
Medicaid and NC Health Choice

Prepared by
North Carolina Department of Health and Human Services

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Contents

Introduction **1**

1. Operational Date of BH IDD Tailored Plans **3**

2. Proposed Parameters for Contracts Between LME/MCOs and Partnering Entities to Operate BH IDD Tailored Plans **3**

2.1. General Contract Parameters 3

2.2. Parameters to Incent Integrated Care and Achieving Measurable Outcomes 4

2.3. Parameters to Minimize Cost-Shifting 5

3. Legislative Changes to Implement BH IDD Tailored Plans **5**

4. Proposed Process for Recipients Transitioning between a BH IDD Tailored Plan and a Standard Benefit Plan **6**

4.1. Overview of Qualifying Events 6

4.2. Assessment Form Review and DHHS Timelines 7

4.3. Training for Standard Benefit Plan Care Managers 8

4.4. Quarterly Claims/Encounter Data Review Process 8

4.5. Process and Criteria for Assessing BH IDD Tailored Plan Eligibility When an Individual Visits the ED for the Second Time Within 18 Months for a Psychiatric Visit or Has Their Second Episode Using Behavioral Health Crisis Services Within 18 Months 9

4.6. Access to Care During Transitions Between BH IDD Tailored Plans and Standard Benefit Plans 10

4.7. Process for Periodic Evaluation of BH IDD Tailored Plan Enrollment 10

5. An Estimate of State Spending Under the 1115 Waiver if BH IDD Tailored Plans Are Implemented Compared to if BH IDD Tailored Plans Are Not Implemented **12**

6. Measurable Outcomes to Include in BH IDD Tailored Plan Contracts **13**

7. Solvency Standards for LME/MCOs Operating BH IDD Tailored Plans **14**

8. Anticipated Barriers to the Ability of BH IDD Tailored Plans to Meet Standardized Contract Terms **14**

8.1. Risk-Adjusted Cost Growth 15

8.2. PHP Formularies 15

8.3. MLR 15
8.4. Provider Networks 16
8.5. Election of PCPs 16
8.6. Other Standardized Contract Terms 16

9. BH IDD Tailored Plans' Closed Provider Networks 18
9.1. Background 18
9.2. State Standards for Access 19
9.2.1. Closed Provider Networks 19
9.2.2. Network Adequacy Standards 19
9.2.3. Assurances of Adequate Capacity and Services 21
9.3. PHP Access Plan 22

10. CAP/C Waiver Enrollees to the Populations Covered by BH IDD Tailored Plans 23

11. Children Aged Zero to Three Years Old With, or at Risk for, Developmental Delay or Disability 24
11.1. Transition to BH IDD Tailored Plans for Children Aged Zero to Three with, or at Risk for, Developmental Delay or Disability 25
11.2. Transition to BH IDD Tailored Plans for Children Turning Age Three with, or at Risk for, Developmental Delay or Disability 25

12. Children in Foster Care 26

Introduction

Pursuant to Section 4(10)b. of Session Law (S.L.) 2015-245, as amended,[1] the North Carolina Department of Health and Human Services (DHHS) is submitting this Plan for Implementation of Behavioral Health and Intellectual/Developmental Disability (BH IDD) Tailored Plans to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, North Carolina General Assembly.

On June 15, 2018, the North Carolina General Assembly passed House Bill (HB) 403, amending S.L. 2015-245 "An Act to Transform and Reorganize North Carolina's Medicaid and NC Health Choice Programs." This new law authorizes 1) the carve in, or inclusion, of behavioral health services into Standard Benefit Plans, and 2) the creation of BH IDD Tailored Plans—specialized managed care products targeted toward individuals with significant behavioral health needs (including mental health and substance use disorders), intellectual/developmental disabilities (I/DDs), and traumatic brain injuries (TBIs). With the passage of this transformative legislation, the majority of the North Carolina Medicaid[2] population is slated to transition to **integrated** managed care products over the next several years.

Under Section 4(10)b. of S.L. 2015-245, as amended by HB 403, DHHS is required to submit to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice of the North Carolina General Assembly a "detailed plan for implementation of BH IDD Tailored Plans under the 1115 Waiver" by June 22, 2018. This report must contain 12 components:

1. The date when BH IDD Tailored Plans are planned to be operational.
2. The proposed parameters for contracts between LME/MCOs and partnering entities to operate a BH IDD Tailored Plan, including, but not limited to, incentive arrangements for providing integrated care and for achieving measurable outcomes, and strategies to minimize cost-shifting between the LME/MCO and the partnering entity.
3. Proposed language for any legislative changes needed to implement the plan.
4. A detailed description of the process by which recipients will be able to transition between BH IDD Tailored Plans and Standard Benefit Plans. At a minimum, this process must include the following:

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[1] References to S.L. 2015-245 include subsequent amendments by S.L. 2016-121; Section 11H17.(a). of S.L. 2017-57; Part IV of S.L. 2017-186; Section 11H.10.(c) of S.L. 2018-5; Sections 4 - 6 of HB 403; and HB 156. This document is in response to reporting requirements defined in HB 403.

[2] "Medicaid" for purposes of this document refers to the North Carolina Medicaid and NC Health Choice programs, unless noted otherwise.

I. The proposed definition for a qualifying event, after which a Standard Benefit Plan enrollee would be eligible to enroll with a BH IDD Tailored Plan, and the proposed process for rapid enrollment in a BH IDD Tailored Plan after a qualifying event.

II. A process for the periodic evaluation of BH IDD Tailored Plan enrollees with criteria to determine whether enrollees continue to require the comprehensive services managed by the BH IDD Tailored Plans or whether their needs can be adequately met through coverage by a Standard Benefit Plan.

III. A detailed description of the process and criteria to be used for the assessments that are required under sub-subdivision l. of subdivision (5) of this section of individuals after their second visit to an emergency department for a psychiatric problem within the prior 18 months or after their second episode using behavioral health crisis services within the prior 18 months.

IV. The manner by which a recipient's continuation of care shall be ensured when the recipient transitions between BH IDD Tailored Plans and Standard Benefit Plans or between Standard Benefit Plans and BH IDD Tailored Plans. This process should include a consideration of the maintenance of the recipient's care providers as well as any prior authorization approvals existing prior to the recipient transitioning between these two plans.

5. An estimate of State spending under the 1115 Waiver if BH IDD Tailored Plans are implemented compared to an estimate of State spending under the 1115 Waiver if BH IDD Tailored Plans are not implemented.

6. Specific measurable outcomes, along with a time frame for the achievement of each measurable outcome, to be included in the capitated PHP contracts for BH IDD Tailored Plans.

7. A description of the solvency requirements for LME/MCOs operating BH IDD Tailored Plans describing how the solvency requirements relate to the solvency standards for PHPs set by the Department of Insurance under Section 6 of this act and how they relate to the solvency standards for LME/MCOs.

8. Any anticipated barriers to the ability of BH IDD Tailored Plans to meet the standardized contract terms described in subdivision (6) of Section 5 of this act.

9. Justification and proposed guidelines for the management of the closed provider networks utilized by the BH IDD Tailored Plans as required by sub-sub-subdivision 6. of sub-subdivision a. of this subdivision.

10. A plan for adding recipients who are being served through the CAP/C program to the populations covered by BH IDD Tailored Plans.

11. A plan for transitioning children aged zero to three years old with, or at risk for, developmental delay or disability.
12. A plan for adding coverage, under BH IDD Tailored Plans or another specialty plan, of all recipients who are enrolled in the foster care system, who are enrolled in Medicaid under the former foster care eligibility category, who receive Title IV-E Adoption Assistance, or who are under the age of 26 and formerly received Title IV-E Adoption Assistance. This plan shall include assurances that these recipients will be supported in instances when they have a change in residence.

This report addresses each item required by legislation. In the coming months, DHHS intends to work with stakeholders, including families and consumers, providers, advocates, local management entities/managed care organizations (LME/MCOs), and health plans, to further define the details of BH IDD Tailored Plan implementation and ensure a successful transition to BH IDD Tailored Plans.

1. Operational Date of BH IDD Tailored Plans

DHHS intends for BH IDD Tailored Plans to be operational at the start of the first fiscal year that is one year after the implementation of the first contracts for Standard Benefit Plans. DHHS must develop qualifications and implement a procurement process for the BH IDD Tailored Plans, and then conduct readiness reviews to ensure selected BH IDD Tailored Plans meet all applicable standards. Further, DHHS intends to align with the start of a state fiscal year to promote administrative simplification and minimize costs to the State. In addition, such alignment will simplify state budget processes and capitation rate setting for BH IDD Tailored Plans, Standard Benefit Plans, and LME/MCOs.

2. Proposed Parameters for Contracts Between LME/MCOs and Partnering Entities to Operate BH IDD Tailored Plans

As required in Section 4(10)a.5. of S.L. 2015-245, as amended by HB 403, LME/MCOs operating BH IDD Tailored Plans will contract with an entity that holds a prepaid health plan (PHP) license, and that covers the services required under a Standard Benefit Plan contract. Section 4(10)b.2. of S.L. 2015-245, as amended by HB 403, also requires DHHS to report "the proposed parameters for contracts between LME/MCOs and partnering entities to operate a BH IDD Tailored Plan." DHHS proposes that, at a minimum, these contracts include the following parameters.

2.1. General Contract Parameters

Consistent with legislative requirements, during the first four years of BH IDD Tailored Plans, LME/MCOs will be the only type of entity to hold a BH IDD Tailored Plan contract with DHHS.

LME/MCOs operating BH IDD Tailored Plans will have accountability for ensuring that their BH IDD Tailored Plans meets DHHS's requirements. As noted earlier, Section 4(10)a.5. of S.L. 2015-245, as amended by HB 403, requires that LME/MCOs operating a BH IDD Tailored Plan must "contract with an entity that holds a PHP license and that covers the services required…under a Standard Benefit Plan contract." In addition to holding a PHP license, DHHS recommends that the partnering entity covering Standard Benefit Plan services also be required to hold a contract with DHHS to serve as a Standard Benefit Plan.

2.2. Parameters to Incent Integrated Care and Achieving Measurable Outcomes

DHHS believes that the creation of BH IDD Tailored Plans—integrated managed care products providing physical health, behavioral health (including mental health and substance use), I/DD, TBI, long-term services and supports (LTSS), and pharmacy services—is crucial to delivering whole-person care for populations with significant behavioral health, I/DD, and TBI needs. To maximize the success of BH IDD Tailored Plans, DHHS recommends implementing the contract parameters described below to incent integrated care and achieve improved, measurable outcomes.

Per federal requirements, DHHS will update North Carolina's Medicaid Managed Care Quality Strategy draft to reflect BH IDD Tailored Plans. BH IDD Tailored Plans will be contractually obligated to adhere to the Quality Strategy. DHHS envisions that BH IDD Tailored Plans will be subject to many of the provisions as Standard Benefit Plans. For example, BH IDD Tailored Plans will have the same requirement as Standard Benefit Plans to report on the Healthcare Effectiveness Data and Information Set (HEDIS) measures for follow-up after hospitalization for mental illness and comprehensive diabetes care: HbA1c poor control.[3]

To customize the Quality Strategy to reflect the specific needs of the BH IDD Tailored Plan population, DHHS will define quality objectives for BH IDD Tailored Plans that will incent integrated care for individuals with serious behavioral health, I/DD, and TBI diagnoses. The objectives will also reflect issues related to quality of life, community integration, and social determinants of health. The objectives will reflect emerging best practices from leaders on quality measurement, including the National Quality Forum, the Institute for Healthcare Improvement, the Agency for Healthcare Research and Quality (AHRQ), and the Substance Abuse and Mental Health Services Administration (SAMHSA), among others. Each objective will be tied to select quality standards required of BH IDD Tailored Plans.

In addition, the contract between DHHS and LME/MCOs operating BH IDD Tailored Plans will include parameters for the LME/MCOs and its partnering entities to work together to ensure that

[3] North Carolina's Medicaid Managed Care Quality Strategy draft, https://files.nc.gov/ncdhhs/documents/DRAFT_QualityStrategy_20180320.pdf

enrollees receive integrated care planning and treatment that take a whole-person approach to addressing enrollees' physical health, behavioral health, I/DD, TBI, LTSS, and social needs. The contract will also specify that BH IDD Tailored Plans and their partnering entities must ensure efficient coordination of physical health, behavioral health, I/DD, TBI, LTSS, pharmacy, and other services.

2.3. Parameters to Minimize Cost-Shifting

DHHS recommends implementing the parameters described below to minimize cost-shifting between LME/MCOs and partnering entities:

- **Monitoring and Oversight.** LME/MCOs operating BH IDD Tailored Plans will be required to monitor utilization and expenditures of behavioral health, I/DD, and TBI services, and report this information to DHHS quarterly. DHHS will review these reports to ensure that as North Carolina transitions from the current fee-for-service and LME/MCO delivery system to BH IDD Tailored Plans, the spend on behavioral health, I/DD, and TBI services does not decline. If DHHS determines that a BH IDD Tailored Plan is not spending adequately on behavioral health, I/DD, and TBI services, it may take corrective action.
- **Medical Loss Ratio (MLR).** DHHS will require LME/MCOs operating BH IDD Tailored Plans to annually report their MLR and issue rebates if a BH IDD Tailored Plan does not meet North Carolina's minimum MLR standard, consistent with DHHS's approach to Standard Benefit Plans.
- **Actuarially Sound Rates.** Per federal requirements, DHHS will set actuarially sound rates that are adequate to cover physical health, behavioral health, I/DD, TBI, LTSS, and pharmacy services. These premiums will be set to ensure plans are adequately funded to provide the necessary behavioral health, I/DD, and TBI services, among others, and meet the care coordination, care management, and other standards required in the BH IDD Tailored Plan contract with DHHS.

3. Legislative Changes to Implement BH IDD Tailored Plans

The creation of BH IDD Tailored Plans operated by LME/MCOs will require changes to General Statutes Chapter 122C, Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985. Chapter 122C provides structure and direction for the system in North Carolina that provides services and care to individuals experiencing issues related to behavioral health, I/DD, and substance use disorder. Potential revisions to Chapter 122C to reflect the creation of BH IDD Tailored Plans include:

- Ensuring that the LME/MCO boards and the Consumer and Family Advisory Committees have adequate representation across different catchment areas and both physical and behavioral health;
- Outlining expected responsibilities of LME/MCOs in their performance as PHPs; and
- Including coverage of integrated physical health, behavioral health, I/DD, TBI, LTSS, and pharmacy services as part of LME/MCO responsibilities.

By November 2018, DHHS will identify and draft the changes to Chapter 122C required to implement S.L. 2015-245, as amended by HB 403.

In addition, language related to the populations that will be served by LME/MCOs prior to the launch of BH IDD Tailored Plans must be updated following the passage of HB 156, "An Act to Require Medicaid Prepaid Health Plans to Obtain a License from the Department of Insurance and to Make Other Changes Pertaining to Medicaid Transformation and the Department of Insurance," in June 2018. Specifically, in the period between Standard Benefit Plan launch and BH IDD Tailored Plan launch, LME/MCOs will also need to continue to serve the following populations that were temporarily carved out of managed care, for a period not to exceed five years after the launch of Standard Benefit Plans:

- Recipients who reside in a nursing facility and have so resided, or are likely to reside, for a period of 90 days or longer and who are not being served through the Community Alternatives Program for Disabled Adults (CAP/DA) waiver; and
- Recipients who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing.

4. Proposed Process for Recipients Transitioning between a BH IDD Tailored Plan and a Standard Benefit Plan

4.1. Overview of Qualifying Events

An individual initially enrolled in a Standard Benefit Plan may be subsequently found eligible for a BH IDD Tailored Plan. DHHS will allow Standard Benefit Plan enrollees who meet one of the following qualifying events to enroll in a BH IDD Tailored Plan at any time during the coverage year. To meet a qualifying event, enrollees must:

- Have submitted a completed BH IDD Tailored Plan Assessment Form (described in Section 4.2), and be found by DHHS to meet the BH IDD Tailored Plan level of need;
- Be identified through quarterly claims/encounter data review as having a diagnosis or using a service that would qualify them for a BH IDD Tailored Plan, including, but not limited to:

    - Having two or more psychiatric hospitalizations or readmissions within the prior 18 months;
    - Meeting DHHS's definition of a child aged zero to three years old with, or at risk for, developmental delay or disability;
    - Being diagnosed with a condition that meets the definition of complex needs as defined in the 2016 settlement agreement between DHHS and Disability Rights of North Carolina; and
    - Having one or more involuntary treatment episodes within the prior 18 months.

- Have two visits to the emergency department (ED) for a psychiatric problem within the prior 18 months, and are assessed as meeting the BH IDD Tailored Plan level of need;
- Have two episodes using behavioral health crisis services within the prior 18 months, and are assessed as meeting the BH IDD Tailored Plan level of need;
- Subsequent to having two visits to the ED for a psychiatric problem or two episodes using behavioral health crisis services within 18 months, have a third ED visit for a psychiatric problem or a third use of behavioral health crisis services within the following 12 months;
- Become involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs, and meet criteria established by DHHS;
- Require a service that is available only through a BH IDD Tailored Plan;[4]
- Be covered under the Innovations or TBI waivers; or
- Join the Innovations or TBI waiver waiting lists.[5]

4.2. Assessment Form Review and DHHS Timelines

The BH IDD Tailored Plan Assessment Form will be a short clinical assessment completed by a Medicaid-enrolled provider who meets DHHS-established qualifications to assess whether the applicant's health care needs meet the BH IDD Tailored Plan eligibility criteria. DHHS will work with stakeholders to develop a set of qualifications for the providers who will be permitted to complete this form. These qualifications will include, but will not be limited to:

- Meet Medicaid or NC Health Choice qualifications for participation;

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[4] Includes a Medicaid State Plan; a 1915(b)(3) waiver; or a state-funded behavioral health, I/DD, or TBI service.

[5] Individuals excluded from managed care at launch for being enrolled in the Community Alternatives Program for Children (CAP/C) or the Community Alternatives Program for Disabled Adults (CAP/DA) waiver programs will remain excluded even if they join the Innovations or TBI waiver waiting lists.

- Have a current and signed DHHS Provider Administrative Participation Agreement; and
- Be acting within the scope of their clinical practice, as defined by the appropriate licensing entity.

DHHS will review, and approve or deny mid-coverage year transfer and disenrollment requests for a qualifying event on a standard timeline of three to five calendar days within receipt of the request, consistent with DHHS's timeline for other "with cause" events in Standard Benefit Plans.[6] However, DHHS will conduct an expedited review for enrollment into a BH IDD Tailored Plan if an individual experiencing a qualifying event has an urgent medical need. DHHS will consider a situation an urgent medical need if continued enrollment in the Standard Benefit Plan could jeopardize the enrollee's life; physical or mental health; or ability to attain, maintain, or regain maximum function. DHHS will review and will approve or deny expedited requests on a timeline of up to 48 hours within receipt of the request.

4.3. Training for Standard Benefit Plan Care Managers

DHHS will require that Standard Benefit Plans train care managers in services available only through BH IDD Tailored Plans; BH IDD Tailored Plan eligibility criteria; and the process for an enrollee who needs a service that is available only through BH IDD Tailored Plans to transfer to a BH IDD Tailored Plan. As a result of this training, Standard Benefit Plan care managers will be well equipped to support enrollees transitioning across plans.

4.4. Quarterly Claims/Encounter Data Review Process

DHHS will conduct a quarterly claims/encounter data analysis of Standard Benefit Plan enrollees to evaluate whether utilization of services indicates they meet the eligibility criteria for a BH IDD Tailored Plan. Individuals who appear to be eligible for a BH IDD Tailored Plan will be sent a notice advising them to contact the enrollment broker to obtain choice counseling and to determine whether a transition to a Standard Benefit Plan may be more appropriate to meet their health care needs. DHHS will also notify a Standard Benefit Plan when one of its enrollees appears to be eligible for a BH IDD Tailored Plan based on quarterly claims/encounter data

[6] Individuals may disenroll from their plan and enroll in a new plan "with cause." Definitions of "with cause" include when an enrollee moves out of the plan's service area; when a plan does not cover a service the enrollee seeks because of the plan's moral or religious objection; when an enrollee needs concurrent, related services that are not all available within the PHP's network, and the provider determines receiving services separately would subject the enrollee to unnecessary risk; when an LTSS enrollee must change a residential, institutional, or employment supports provider based on a change in status from in-network to out-of-network; when an enrollee's complex medical conditions would be better served under a different PHP; when a family member becomes newly eligible and is enrolled in a different PHP; when a PHP exhibits poor performance, upon launch of evaluations of PHP performance; and "other reasons," including poor quality of care, lack of access to covered services, and lack of access to providers experienced with meeting specific need, to be determined on a case-by-case basis.

review. DHHS will require the Standard Benefit Plan to notify the enrollee's care manager of the enrollee's eligibility to transition to a BH IDD Tailored Plan and require the care manager to provide the enrollee with guidance on how to effectuate the transition. Individuals will not transition to a BH IDD Tailored Plan unless they actively elect to make the change in PHP enrollment.

4.5. Process and Criteria for Assessing BH IDD Tailored Plan Eligibility When an Individual Visits the ED for the Second Time Within 18 Months for a Psychiatric Visit or Has Their Second Episode Using Behavioral Health Crisis Services Within 18 Months

DHHS anticipates that most individuals with two ED visits for a psychiatric problem or two episodes requiring use of behavioral health crisis services within 18 months who are determined to meet BH IDD Tailored Plan level of need will be identified through the quarterly claims/encounter data review described above *prior* to their second ED visit or use of a crisis service. These individuals will have the opportunity to move to a BH IDD Tailored Plan at any point during the year.

However, if an individual in a Standard Benefit Plan has two ED visits or two uses of crisis services within 18 months, the Standard Benefit Plan will be responsible for contacting DHHS within 72 hours of being notified of an enrollee's second ED visit or use of crisis services. Within 72 hours of notification, DHHS will conduct a claims/encounter data review to determine whether an individual has a diagnosis or has utilized a service that would qualify them for a BH IDD Tailored Plan.

If DHHS finds that the enrollee is eligible for a BH IDD Tailored Plan based on the claims/encounter data review, DHHS will send a notice informing the individual of eligibility and of the option to transition from a Standard Benefit Plan to a BH IDD Tailored Plan. Enrollees will be instructed to contact the enrollment broker to receive choice counseling, which will include information about the benefits that are unique to BH IDD Tailored Plans and how to transfer to a BH IDD Tailored Plan. At least two attempts will be made to contact individuals to actively provide choice counseling. The choice counseling will include information about the benefits that are unique to BH IDD Tailored Plans and how to transfer to a BH IDD Tailored Plan. In addition, DHHS will notify a Standard Benefit Plan when one of its enrollees appears to be eligible for a BH IDD Tailored Plan based on the claims/encounter data review. DHHS will require the Standard Benefit Plan to notify the enrollee's care manager of the enrollee's eligibility to transition to a BH IDD Tailored Plan, and require the care manager to provide the enrollee with guidance on how to effectuate the transition. Identified enrollees will be flagged in DHHS's eligibility system as eligible for a BH IDD Tailored Plan and will be able to transition at any point during the coverage year or at renewal without needing to submit additional information.

It is possible, but likely rare, that in conducting the claims/encounter review after a second ED visit or use of crisis service, DHHS will find no evidence that an individual should be in a BH IDD Tailored Plan. In these cases, DHHS will send a notice to these enrollees informing them that they may be eligible to enroll in a BH IDD Tailored Plan based on a clinical assessment, will transmit a copy of the BH IDD Tailored Plan Assessment Form, and will instruct them to contact the enrollment broker for choice counseling. At least two attempts will be made to contact individuals to actively provide choice counseling. If the enrollees or his/her authorized representative believes that enrollment in a BH IDD Tailored Plan would be beneficial, they will work with a provider to complete the BH IDD Tailored Plan Assessment Form and return it to the enrollment broker, which will facilitate DHHS's review and approval.

Finally, DHHS will require that training for Standard Benefit Plan care managers address that enrollees who have had, within the past 18 months, two ED visits for treatment of a psychiatric problem or two episodes requiring use of behavioral health crisis services may be eligible to transition to a BH IDD Tailored Plan, and will give care managers guidance on how to advise their assigned enrollees in this scenario.

4.6. Access to Care During Transitions Between BH IDD Tailored Plans and Standard Benefit Plans

During transitions of care across Standard Benefit Plans and BH IDD Tailored Plans, the receiving PHP (either a Standard Benefit Plan or BH IDD Tailored Plan) will be subject to the following access to care requirements:

- DHHS will notify the receiving PHP of enrollees transitioning from other PHPs or fee-for-service into its plan and will require the prior PHP to provide transition-of-care information;
- The receiving PHP will allow enrollees in an ongoing course of treatment approved by their previous PHP, LME/MCO, or Medicaid fee-for-service **or** with an ongoing special condition where switching providers may disrupt the enrollees' care to continue seeing a provider (even if the provider is out-of-network) for up to 90 days;
- The receiving PHP will assist enrollees with out-of-network providers to transition to an in-network provider by the end of the transition period; and
- Enrollees who are pregnant and in their second or third trimester may continue seeing their providers throughout their pregnancy and through 60 days after delivery.

4.7. Process for Periodic Evaluation of BH IDD Tailored Plan Enrollment

In general, all Medicaid enrollees will be re-enrolled in their current plan by default and given an opportunity to change plans at their annual redetermination.

As part of the quarterly claims/encounter data review process, DHHS intends to monitor BH IDD Tailored Plan enrollees' behavioral health service utilization to identify whether they are accessing services to meet their needs. DHHS will notify the BH IDD Tailored Plan if, in the prior year, an enrollee did not use a service offered only by BH IDD Tailored Plans, including a state-funded service, or any other behavioral health service. In these cases, DHHS will require the BH IDD Tailored Plan to task the enrollee's care manager with reaching out to the enrollee to ensure they have sufficient access to care.

Using claims/encounter data, DHHS will identify BH IDD Tailored Plan enrollees who have not used a service offered only by BH IDD Tailored Plans, including a state-funded service, within the past two years. DHHS will send these individuals a customized notice at renewal, informing them that they may no longer need the unique services offered only by BH IDD Tailored Plans and can contact the enrollment broker to obtain choice counseling to help them consider whether to transition to a Standard Benefit Plan.[7] BH IDD Tailored Plan care managers will also be tasked with engaging enrollees to ensure they are accessing services to meet their health care needs.

BH IDD Tailored Plan capitation rates will reflect any expected enrollment of enrollees who may no longer need the level of services offered through a BH IDD Tailored Plan but who choose to remain enrolled in a BH IDD Tailored Plan. The enrollment broker will be required to have detailed processes, approved by DHHS, on the choice counseling it will provide to enrollees considering leaving a BH IDD Tailored Plan. Enrollees who want to change from a BH IDD Tailored Plan to a Standard Benefit Plan may submit a request for a "with cause" enrollment change at any time by contacting the enrollment broker and attesting to "cause" without additional documentation required.

DHHS will also use claims/encounter data to identify BH IDD Tailored Plan enrollees who have not used **any** behavioral health service, including a state-funded service, within the past two years. At renewal, DHHS will transfer these individuals to a Standard Benefit Plan and provide notice of a change in PHP enrollment.[8] Such individuals will be given 90 days to change PHPs without cause.

[7] DHHS will not send these notices to individuals eligible for a BH IDD Tailored Plan on the basis of I/DD- or TBI-related eligibility criteria.

[8] This provision will not apply to individuals eligible for a BH IDD Tailored Plan on the basis of I/DD- or TBI-related eligibility criteria.

5. An Estimate of State Spending Under the 1115 Waiver if BH IDD Tailored Plans Are Implemented Compared to if BH IDD Tailored Plans Are Not Implemented

By implementing BH IDD Tailored Plans, the total (federal and state) spending under the 1115 waiver is expected to ultimately be between $85 million and $115 million less per year than if BH IDD Tailored Plans were not implemented. This translates into $28 million to $38 million in annual savings for the State.

Savings are driven by:

- **Reducing overlapping or redundant care coordination resulting from a non-integrated system.** For example, an enrollee with co-occurring behavioral and physical health conditions may have two separate care plans and two entities trying to connect with the same set of providers.
- **Averting unnecessary utilization, or shifting utilization to lower-cost sites of care through integrated care management**. For example, ensuring enrollees have access to providers and outpatient services when needed can reduce avoidable emergency department or inpatient hospital utilization.
- **Providing integrated care management of enrollees with co-occurring conditions.** General medical costs for treating people with co-occurring chronic medical and behavioral conditions are two to three times higher than costs for treating individuals with a chronic medical condition alone.

The assumptions behind these estimates are:

- Ultimate savings due to behavioral and physical health integration are achieved in the third year of BH IDD Tailored Plan implementation.
    - Integration savings for the proposed Standard Benefit Plan populations are $30 million to $45 million per year by Year 3 of Standard Benefit Plan implementation.
    - Integration savings for the proposed BH IDD Tailored Plan and foster children and adopted children populations are $55 million to $70 million per year by Year 3 of BH IDD Tailored Plan implementation.
- If BH IDD Tailored Plans are not implemented, physical health benefits would be provided by PHPs, and behavioral health and I/DD benefits would continue to be provided by LME/MCOs.
- The following populations are excluded from the analysis, but could generate additional savings for the State under an integrated system:

- Enrollees enrolled in both Medicare and Medicaid (dual eligibles)
- CAP/C and CAP/DA waiver enrollees
- Other enrollees in a nursing facility for more than 90 days

6. Measurable Outcomes to Include in BH IDD Tailored Plan Contracts

As outlined in North Carolina's Medicaid Managed Care Quality Strategy draft, DHHS seeks to develop a data-driven, outcomes-based continuous quality improvement process that rewards PHPs—including Standard Benefit Plans and BH IDD Tailored Plans—for advancing quality outcomes in targeted areas. Quality Strategy goals include:

- Ensure appropriate access to care;
- Drive person-centered, whole-person care;
- Promote wellness, prevention, and improved quality of life;
- Improve chronic condition management;
- Actively engage communities to improve population health; and
- Pay for value.

Featured centrally in these goals are measurement of consumer engagement; timely access to services, supports, and care management; improvements in quality of life; and improvement in health outcomes. Health outcome measures will be stratified to measure health disparities across populations based on geography, race/ethnicity, gender, and diagnosis.

Because the initial quality goals and measures were developed for Standard Benefit Plans, DHHS plans to update the Quality Strategy prior to the launch of BH IDD Tailored Plans to incorporate the measures most meaningful to individuals with behavioral health needs, I/DDs, and TBIs. DHHS will seek community input, identify best practices in quality measurement for these populations, and build on current LME/MCO requirements for performance measurement. DHHS will ensure that the new measures reflect both medical and social models of care.

DHHS will use a variety of tools to ensure PHPs move toward plan-level accountability for quality outcomes. DHHS will set standards for PHP quality assessment and improvement plans related to priority measures. PHPs will be required to monitor, report, and take action to improve performance against measure benchmarks and targets set by DHHS. Based on Quality Strategy goals, PHPs will have direct financial accountability for a subset of overall quality measures, and reduction or elimination of disparities.

DHHS will require PHPs to establish and maintain working relationships with providers and other community stakeholders to support plan-level financial accountability for quality measures,

including select outcomes in the first year of the BH IDD Tailored Plan launch. As mentioned earlier, BH IDD Tailored Plans will be required to report on the HEDIS measures for follow-up after hospitalization for mental illness and comprehensive diabetes care: HbA1c poor control. Later years will build on these baselines to attain increasingly ambitious quality performance targets focused on priority outcomes specified by DHHS. PHPs will be expected to increase the proportion of providers in advanced payment models that may require alternative approaches to contracting, data sharing, and provider and enrollee engagement. These contracts will drive accountability and improved regional and state-level performance across consumer outcomes.

7. Solvency Standards for LME/MCOs Operating BH IDD Tailored Plans

Considering recent changes in North Carolina statutes regarding solvency standards for LME/MCOs,[9] additional work is necessary to develop solvency standards applicable to entities that transition to becoming BH IDD Tailored Plans and to compare those proposed standards to current, recently modified standards. DHHS will apply the following principles:

- To the greatest extent possible, to facilitate consistency and fairness and to acknowledge the increased risk associated with BH IDD Tailored Plans, LME/MCOs operating BH IDD Tailored Plans and their Standard Benefit Plan partners should be treated consistently with the proposed oversight standards applicable to PHPs operating Standard Benefit Plans, including solvency standards similar to those expected to be applied to PHPs.
- DHHS will work with the Department of Insurance and other stakeholders to explore the legal implications, administrative issues, and feasibility of applying the PHP solvency standards to the LME/MCOs operating BH IDD Tailored Plans (and their Standard Benefit Plan partners).
- DHHS will consider the use of other financial-related tools, such as reinsurance requirements (to the extent possible), performance bonds, or other acceptable alternative arrangements, to assist in the financial oversight of the LME/MCOs operating BH IDD Tailored Plans.

8. Anticipated Barriers to the Ability of BH IDD Tailored Plans to Meet Standardized Contract Terms

Section 5(6) of S.L. 2015-245, as amended by S.L. 2016-121, requires that DHHS's contracts with PHPs must include standardized terms related to risk-adjusted cost growth, formularies, a minimum MLR, provider networks, and assignment of PCPs. Section 4(10)b.8. of S.L. 2015-245, as amended by HB 403, requires DHHS to identify "any anticipated barriers to the ability of

[9] Section 11F.10.(a) and (b) of S.L. 2018-5.

BH IDD Tailored Plans" to meet these standardized conditions. An assessment of BH IDD Tailored Plans' ability to meet each of these contract terms is described in 8.1 Risk-Adjusted Cost Growth.

8.1. Risk-Adjusted Cost Growth

Per Section 5(6)a. of S.L. 2015-245, PHPs will be contractually obligated to ensure that "[r]isk-adjusted cost growth for its enrollees [is] at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states." DHHS intends to track annual growth in the expenditures of each BH IDD Tailored Plan by region and population cohort to most closely align with the populations included in the annual report of the Office of the Actuary. (DHHS may exclude BH IDD Tailored Plan populations that do not align with those in the annual report.) DHHS does not anticipate that BH IDD Tailored Plans will encounter any unique barriers to meeting this contract term.

8.2. PHP Formularies

Pursuant to Section 5(6)b. of S.L. 2015-245, DHHS must contractually require that "PHP spending for prescribed drugs, net of rebates, ensures the State realizes a net savings for the spending on prescription drugs. All PHPs shall be required to use the same drug formulary, which shall be established by DHHS." Plans may see an increase in their pharmacy costs compared to fee-for-service costs if enrollee compliance with drug regimens improves under the BH IDD Tailored Plans. Other than this, DHHS does not anticipate that BH IDD Tailored Plans will encounter unique barriers to meeting this contract term, beyond the typical challenges to achieving net savings encountered by all PHPs. All else being equal, to achieve net savings, BH IDD Tailored Plans must ensure that DHHS maintains similar levels of pharmacy rebates achieved under the current Medicaid fee-for-service program. Therefore, DHHS will monitor BH IDD Tailored Plan compliance with the North Carolina Preferred Drug List and with pharmacy claims encounter reporting as a proxy for net savings. BH IDD Tailored Plans that fail to meet these standards will be subject to sanctions and damages.

8.3. MLR

Section 5(6)c. of S.L. 2015-245, as amended by S.L. 2016-121 and HB 403, requires that PHPS must meet "a minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by DHHS. The minimum medical loss ratio shall be neither higher nor lower than eighty-eight percent (88%)." DHHS does not anticipate that BH IDD Tailored Plans will encounter any unique barriers to meeting this contract term, beyond the typical challenges faced by all PHPs associated with meeting a minimum MLR.

8.4. Provider Networks

Per Section 5(6)d. of S.L. 2015-245, DHHS must contractually require that "PHPs develop and maintain provider networks that meet access to care requirements for their enrollees. PHPs may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. Notwithstanding the previous sentence, PHPs must include all providers in their geographical coverage area that are designated essential providers by DHHS…unless DHHS approves an alternative arrangement for securing the types of services offered by the essential providers." DHHS does not anticipate that BH IDD Tailored Plans will encounter any unique barriers to meeting access to care requirements, as LME/ MCOs will be able to leverage their existing behavioral health, I/DD, and TBI networks, and will also be able to leverage their partnering Standard Benefit Plans' physical health, LTSS, and pharmacy networks.

DHHS recognizes that the "any willing provider" requirement specified in Section 5(6)d. applies only to physical health networks for BH IDD Tailored Plans, and that Section 4(10)a.6. of S.L. 2015-245, as amended by HB 403, requires that entities operating BH IDD Tailored Plans provide for the use of closed provider networks for the provision of behavioral health, I/DD, and TBI services. To ensure adequate access to care considering the closed network requirements, DHHS intends to set more stringent behavioral health, I/DD, and TBI network adequacy requirements for BH IDD Tailored Plans than for Standard Benefit Plans. For instance, DHHS may require that BH IDD Tailored Plan networks include a greater number of providers offering certain benefits or may modify time and distance standards to ensure that BH IDD Tailored Plan enrollees have sufficient access to behavioral health, I/DD, and TBI benefits.

8.5. Election of PCPs

Per Section 5(6)e. of S.L. 2015-245, PHPs must "assure that enrollees who do not elect a primary care provider will be assigned to one." DHHS does not anticipate that BH IDD Tailored Plans will encounter unique barriers to meeting this contract term, beyond the challenges encountered by all PHPs.

8.6. Other Standardized Contract Terms

On June 15, 2018, North Carolina's General Assembly passed HB 156, which establishes additional contract terms for PHPs. Given the recent passage of this legislation, DHHS is in the process of evaluating whether there are any anticipated barriers to the ability of BH IDD Tailored Plans to meet the terms specified in Sections 5(6)f. and 5(6)g. of S.L. 2015-245 as amended by HB 403:

> f. Terms that, to the extent not inconsistent with federal law or regulations, or state law or rule, ensure PHPs will be subject to certain requirements of Chapter 58 of the General Statutes in accordance with this sub-subdivision. Compliance with these

requirements shall be overseen and enforced by DHHS. The requirements to be incorporated in the terms of the capitated PHP contracts are in the following sections of Chapter 58, and the requirements in these sections shall be applicable to PHPs in the manner in which these sections are applicable to insurers and health benefits plans, as the context requires:

1. G.S. 58-3-190, Coverage required for emergency care, excluding subdivisions (3) and (4) of subsection (g).
2. G.S. 58-3-191, Managed care reporting and disclosure requirements.
3. G.S. 58-3-200(c), Miscellaneous insurance and managed care coverage and network provisions.
4. G.S. 58-3-221, Access to nonformulary and restricted access prescription drugs.
5. G.S. 58-3-225, Prompt claim payments under health benefit plans.
6. G.S. 58-3-227, Health plans fee schedules.
7. G.S. 58-3-231, Payment under locum tenens arrangements.
8. G.S. 58-50-26, Physician services provided by physician assistants.
9. G.S. 58-50-30, Right to choose services of certain providers.
10. G.S. 58-50-270, Definitions.
11. G.S. 58-50-275, Notice contact provision.
12. G.S. 58-50-280, Contract amendments.
13. G.S. 58-50-285, Policies and procedures.
14. G.S. 58-50-295, Prohibited contract provisions related to reimbursement rates.
15. G.S. 58-51-37, Pharmacy of choice. The requirements of this statute to be incorporated into capitated PHP contracts shall apply to all PHPs regardless of whether a PHP has its own facility, employs or contracts with physicians, pharmacists, nurses, or other health care personnel, and dispenses prescription drugs from its own pharmacy to enrollees.
16. G.S. 58-51-38, Direct access to obstetrician-gynecologists.
17. G.S. 58-67-88, Continuity of care.

This sub-subdivision shall not be construed to require DHHS to utilize contract terms that would require PHPs to cover services that are not covered by the Medicaid program.

g. A requirement that all participation agreements between a PHP and a health care

provider incorporate specific terms implementing sub-sub-subdivisions 3, 5, 6, 10, 11, 12, and 13 of sub-subdivision f. of this subdivision.

9. BH IDD Tailored Plans' Closed Provider Networks

9.1. Background

At the national level, access to care within Medicaid managed care historically has been measured by provider network adequacy, or by whether managed care plans contract with enough providers to serve enrollees. Increasingly, however, access to care is thought of in a more multifaceted way, with multiple provisions in place beyond ensuring enough providers. DHHS proposes that LME/MCOs operating BH IDD Tailored Plans be subject to similar network adequacy standards as those that DHHS has proposed for PHPs operating Standard Benefit Plans. That approach is based primarily on the standards reflected in the final federal Medicaid managed care rule,[10] which includes the following features:[11]

- **Availability** addresses whether provider networks are sufficient to meet the needs of enrollees. Availability is a function of the number of providers, their willingness to participate in the program, and their ability to offer timely appointments.
- **Accessibility**[12] involves the proximity of providers to enrollees, based on geographic time and distance. At the point of care, accessibility is determined by physical access, such as ramps, and by providers' ability to communicate in non-English languages or sign language.
- **Accommodation** is the extent to which a provider's operating hours, appointment policies, language and cultural competencies, awareness, and communications meet enrollees' constraints and preferences.
- **Realized access** addresses managed care enrollees' actual use of services.

DHHS has developed network adequacy and provider accessibility standards consistent with federal and state laws, and has developed a monitoring system to ensure compliance by PHPs with all applicable standards.

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[10] Published in the Federal Register May 6, 2016 (81 FR 27498).

[11] "Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability." https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/adequacy-and-access-toolkit.pdf

[12] For LTSS provided in a home or community setting, accessibility can be expressed as the time and distance for caregivers to travel to enrollees' residences.

9.2. State Standards for Access

North Carolina's PHP contracts will include requirements to ensure that PHPs meet and, in some cases, exceed federal standards. These include requirements related to enrollee access to care, such as network adequacy, availability of services, and assurances of adequate capacity and services. During the initial transition to managed care, DHHS 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. These requirements are vital in verifying that member services are adequately provided and that there is a smooth transition to managed care. DHHS will closely monitor these areas and respond as necessary to ensure requirements are successfully met. BH IDD Tailored Plans will be expected to meet nearly all the network adequacy standards required for Standard Benefit Plans, with the modifications described in this section to reflect the characteristics of the BH IDD Tailored Plans. In the coming months, DHHS will finalize the network adequacy standards for BH IDD Tailored Plans.

9.2.1. Closed Provider Networks

Section 4(10)a.6. of S.L. 2015-245, as amended by HB 403, requires that "[e]ntities operating BH IDD Tailored Plans shall maintain closed provider networks for behavioral health, intellectual and developmental disability, and traumatic brain injury services and shall ensure network adequacy." Advantages to a BH IDD Tailored Plan of a closed network of providers include increased control over the quality of the providers in its network; limiting networks to providers committed to aligning with the BH IDD Tailored Plan's quality improvement goals and its approach to delivery of care and care management; and simplified transitions from LME/MCOs to BH IDD Tailored Plans, as the current LME/MCO networks can be leveraged fully in the BH IDD Tailored Plans.

DHHS's oversight of LME/MCOs operating BH IDD Tailored Plans will include safeguards to ensure that the closed networks do not limit access to care. In developing comprehensive network adequacy standards for BH IDD Tailored Plans, DHHS will consider enrollees' needs relating to access to behavioral health, I/DD, and TBI services and will ensure that the spectrum of covered behavioral health, I/DD, and TBI services is available and accessible to all enrollees.

9.2.2. Network Adequacy Standards

PHPs—including Standard Benefit Plans and BH IDD Tailored Plans—will be expected to maintain and monitor a network of contracted providers supported by mutually agreed-on PHP/provider contracts. The network should be sufficient to provide adequate access to services covered under the Medicaid and NC Health Choice programs for all enrollees[13] based on

[13] This includes enrollees with limited English proficiency or with physical or mental disabilities.

standards developed by DHHS. DHHS's network adequacy standards will vary by urban versus rural areas, and will include time and distance standards for providers who serve adult and pediatric enrollee needs. To recognize the special accessibility needs surrounding behavioral health, I/DD, and TBI services, the standards will include specific measurements for those services. PHPs will also be expected to meet standards for appointment wait times for primary care and specialist care. The network adequacy standards for the Standard Benefit Plans are in Prepaid Health Plan Network Adequacy and Accessibility Standards.

Mandatory Network Providers. Federal and state statutes and regulations require PHPs to contract with certain types of providers. For example, federal regulations require PHP networks to include at least one federally qualified health center (FQHC), at least one rural health clinic (RHC), and at least one freestanding birth center (FBC), where available, for the PHP's contracted service area. North Carolina law[14] requires PHPs to contract with *all* "essential providers"[15] in their geographic area, unless DHHS approves an alternative arrangement for securing the types of services offered by the essential providers.

Exceptions to Network Adequacy Standards. PHPs that are unable to meet DHHS's network adequacy standards may request an exception for a specific access-to-care gap in a specific region. To determine whether an exception is granted, DHHS may consider, but is not limited to, such factors as:

- Utilization patterns in the specific service area;
- Number of Medicaid providers in that provider type/specialty practicing in the service area;
- History of enrollee complaints regarding access;
- Specific geographic considerations;
- Proposed long-term plan by the PHP to address the access-to-care gap in its network; and
- Comprehensiveness of the PHP's plan for addressing enrollee needs in the short run, including the PHP's process to help find services through out-of-network providers, or to coordinate the use of telemedicine and other telecommunications technology, as applicable.

[14] Section 5(6)d. of S.L. 2015-245, as amended by S.L. 2016-121.

[15] "Essential providers" are FQHCs, RHCs, rural health centers overseen by DHHS, free/charitable clinics, state veterans' homes, and local health departments. Section 5(13) of S.L. 2015-245, as amended by S.L. 2016-121.

Where exception requests are approved, DHHS will monitor enrollee access to the relevant provider types in the relevant regions on an ongoing basis and will report the findings annually to CMS, as required.

Out-of-Network Services. If a PHP's provider network is unable to provide necessary covered services to an enrollee, the PHP must cover these services out-of-network for the enrollee in an adequate and timely manner, for as long as the PHP's network is unable to provide them. PHPs are responsible for communicating administrative requirements (e.g., prior authorization requirements, to the degree prior authorization is not prohibited under federal regulation) and for coordinating payment with the out-of-network providers and ensuring the cost to the enrollee is no greater than it would have been if the services were furnished within the network.[16] In certain cases where there may be a longer-term need, the PHP and the out-of-network provider may be encouraged to engage in single-case agreements to ensure both parties understand what is administratively and financially expected and to minimize potential disputes that may disrupt the enrollee's care. Additionally, enrollees may switch plans under certain conditions at any point in the year to obtain medically necessary services that are not available within the PHP's network.

Telemedicine. As discussed previously, when an enrollee requires a medically necessary service that is not available within DHHS's expected driving distance, the PHP will be expected to ensure the enrollee has access to that service and either could utilize an out-of-network provider *or* could access the service through telemedicine, if applicable and medically appropriate. The enrollee must have a choice between an out-of-network provider and telemedicine, and cannot be forced to receive services through telemedicine.

PHPs must also ensure the availability and delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and literacy, and with diverse cultural and ethnic backgrounds, disabilities, gender, sexual orientation, or gender identity.

9.2.3. Assurances of Adequate Capacity and Services

DHHS will develop and maintain a monitoring and oversight system to ensure that PHPs have adequate capacity to provide care to all enrollees in their service areas.[17] For BH IDD Tailored Plans, the monitoring and oversight system will pay particular attention to behavioral health, I/DD, and TBI services to ensure that enrollees have adequate access to services subject to closed networks. Key components of this system include, but are not limited to:

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[16] DHHS will publish the process that enrollees must follow to access services from an out-of-network provider, and PHPs will be expected to adhere to that process. Enrollees will have the right to appeal any adverse benefit determination related to a request for services in accordance with 42 C.F.R. § 438.402.

[17] In accordance with 42 C.F.R. § 438.207.

- Requiring PHPs to submit regular documentation, including provider network data and reports that summarize findings from the PHP's own network data analysis, to demonstrate network adequacy;
- Requiring PHPs to submit updated, machine-readable provider directories in a standardized format;
- Monitoring enrollee complaints related to access to care and provider networks;
- Reviewing the "Consumer Assessment of Healthcare Providers and Systems" (CAHPS) survey findings related to availability and access to services, and acting as needed; and
- When necessary, issuing corrective action plans when PHPs are identified as noncompliant with network adequacy standards and access requirements.

In addition, DHHS intends to contract with a qualified external quality review organization (EQRO) to perform an annual external quality review of each PHP. This review will determine, in part, PHP compliance with network adequacy and access requirements; confirm the adequacy of PHP networks; and validate PHP data. The EQRO must issue a report on these findings, which will be posted on DHHS's website. DHHS also will monitor enrollee access to care issues, including using geographic mapping and other techniques.

9.3. PHP Access Plan

PHPs, including BH IDD Tailored Plans, will be required to submit to DHHS an access plan, which will be reviewed and monitored by DHHS staff. As part of the access plan, BH IDD Tailored Plans will be expected to explain how their closed networks will not limit access to providers and services necessary for this population. An access plan must achieve the following:

- Describe a PHP's policies and procedures for maintaining and ensuring that its network is sufficient and consistent with state and federal requirements.
- Be filed with DHHS with the response to the request for proposals, periodically through readiness reviews, annually after managed care launches, and within 30 business days after a material change occurs.
- Demonstrate that a PHP has:
    - An adequate network that it is actively maintaining (or a plan for establishing such); and
    - Procedures to address referrals, disclosures, and notices to enrollees of the PHP's services and features; documented processes for coordination; and continuity of care and transition of care policies that comply with DHHS's requirements.
- Demonstrate the PHP's efforts to address the needs of all enrollees, including those with limited English proficiency or literacy.

- Demonstrate the PHP's efforts to ensure its network providers make available physical access, reasonable accommodations, culturally competent communications, and accessible equipment for enrollees with physical or intellectual disabilities.
- Establish that a PHP's network has an adequate number of providers and facilities within a reasonable distance.
- Document a PHP's quantifiable and measurable process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of the Medicaid population enrolled.
- Include the factors used to build a provider network, including a description of the network and the criteria used to select providers.
- Demonstrate a PHP's quality assurance standards, consistent with DHHS's Quality Strategy and requirements, which must be adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care.

DHHS will review each PHP's access plan to ensure it meets network adequacy expectations and requirements and provides a reasonable approach to the PHP's oversight and management of its providers and networks.

10. CAP/C Waiver Enrollees to the Populations Covered by BH IDD Tailored Plans

North Carolina's CAP/C waiver provides home- and community-based services to medically fragile children who have specialized and complex medical needs. Based on experiences from other states and feedback received from families, providers, and other stakeholders, DHHS proposes to delay the enrollment of CAP/C waiver enrollees into Medicaid managed care until four years after the managed care transition. This delay ensures that enrollees maintain access to existing service providers and case management support while DHHS and stakeholders design a Medicaid managed care program equipped to meet their specialized needs and provide the unique services used by this population. Prior to the transition of CAP/C waiver enrollees to managed care, DHHS plans to conduct a robust stakeholder engagement process to solicit feedback on the managed care delivery system that will be best equipped to serve the CAP/C population, specific design features that should be incorporated into the managed care delivery system, and strategies to ensure a smooth transition to managed care. When CAP/C enrollees are transitioned into managed care, DHHS envisions that they will be served by a PHP program that specializes in serving CAP/C enrollees. Key features of this PHP will include specialized staffing and care management requirements.

11. Children Aged Zero to Three Years Old With, or at Risk for, Developmental Delay or Disability

Section 4(5)*l*.4.V. of S.L. 2015-245, as amended by HB 403, requires that children aged zero to three years old with, or at risk for, developmental delay or disability enroll in a BH IDD Tailored Plan. Today, this population is excluded from LME/MCO enrollment and receives behavioral health and I/DD services through Medicaid fee-for-service. Most, if not all, of these children also receive early intervention services through the North Carolina Infant-Toddler Program (N.C. ITP). The N.C. ITP is a federal entitlement program for infants and toddlers aged birth to three with developmental delays and/or disabilities and their families who enroll with Children's Developmental Services Agencies (CDSAs). CDSAs are the local lead agencies for N.C. ITP. They are responsible for determining eligibility for the N.C. ITP and providing supports and services to eligible families based on family-identified concerns and child and family strengths within the context of natural environments and everyday routines.

For the purposes of BH IDD Tailored Plan eligibility, DHHS will define children as having, or at risk for, a developmental delay or disability as follows:

- All children with an I/DD diagnosis, including autism spectrum disorder, atypical autism spectrum disorder, and global developmental delay, regardless of service utilization
- Children who have used a CDSA service other than multidisciplinary evaluation/assessment services or case management **and** have one of the following diagnoses:
    - Disruptive mood dysregulation disorder
    - Other persistent mood disorder
    - Obsessive compulsive disorder
    - Post-traumatic stress disorder (meeting the diagnostic criteria for children six years old and under)
    - Reactive attachment disorder
    - Disinhibited social engagement disorder

DHHS will require that BH IDD Tailored Plans have adequate networks to serve enrollees who are aged zero to three with, or at risk for, developmental delay, and will require BH IDD Tailored Plans to provide training to ensure that their provider networks are equipped to serve the needs of this population. DHHS recognizes a need for increased coordination between CDSAs and LME/MCOs today and between CDSAs and Standard Benefit Plans and BH IDD Tailored Plans in the future, both while the child is under age three and is receiving services through a CDSA and after the child turns age three and is transitioning to Part B/619 Preschool Services or other appropriate services for toddlers who might not qualify for Part B/619 services

or preschool services. As a result, DHHS has developed a plan to ensure that children aged zero to three years old with, or at risk for, developmental delay or disability make a smooth transition to managed care and benefit from improved coordination between BH IDD Tailored Plans, including their medical providers, and the CDSAs.

11.1. Transition to BH IDD Tailored Plans for Children Aged Zero to Three with, or at Risk for, Developmental Delay or Disability

Children aged zero to three years old with, or at risk for, developmental delay or disability will continue to receive many of their Medicaid-covered services through CDSAs after they enroll in a BH IDD Tailored Plan. They will receive other services not provided by the CDSAs through their BH IDD Tailored Plan provider network. During and after the transition to managed care, these children will retain their current CDSA service coordinator, who will continue to be responsible for the child's Individualized Family Service Plan (IFSP). DHHS will provide training to CDSA service coordinators to ensure that they are equipped to support families during this transition to BH IDD Tailored Plans. There will be centralized coordination of the services provided and billed by CDSAs and the services authorized by the BH IDD Tailored Plans.

11.2. Transition to BH IDD Tailored Plans for Children Turning Age Three with, or at Risk for, Developmental Delay or Disability

DHHS recognizes that children turning age three with, or at risk for, developmental delay or disability receiving early intervention services from the N.C. ITP have certain needs when transitioning to BH IDD Tailored Plans. All children receiving early intervention services from the N.C. ITP must leave the program by age three. The N.C. ITP strives to provide appropriate support and assistance to families in planning for the transition from early intervention services, including connecting them with other providers of services for young children. With the creation of BH IDD Tailored Plans, DHHS will establish new requirements to ensure that the transition to BH IDD Tailored Plans is incorporated into this planning:

- As noted above, the service coordinator will continue to be responsible for developing the IFSP Transition Plan. The Transition Plan will be required to include steps and strategies for the transition to BH IDD Tailored Plans, in addition to information about educational Part B-619 preschool or other related services.
- The service coordinator will facilitate the transition planning conference. The conference must include the future BH IDD Tailored Plan care manager, the local education agency, and other participants, as indicated.
- The service coordinator will be required to discuss with the family the option of providing consent to transfer designated information (i.e., the most recent IFSP and updated progress monitoring) to the future BH IDD Tailored Plan care manager.

12. Children in Foster Care

Children in foster care, former foster care children under age 26, and children in adoptive placements (collectively referred to as "children in foster care") are vulnerable, high-need populations that typically have specialized physical and behavioral health care needs. The Medicaid delivery system for these children must provide a high level of coordination among the many individuals and entities involved in providing for their physical, behavioral, developmental, social, and educational needs. It is essential that Medicaid facilitate seamless coverage across geographic areas, as children may be placed with relatives or other care providers and may frequently move long distances. Managing the needs of children in foster care is further complicated by several factors, including frequent changes in placement and caregivers, high risk of overuse of psychotropic medications, and multisystem involvement that requires cross-agency coordination.

To ensure a smooth transition for children in foster care, DHHS intends to design a PHP program that specializes in serving children in foster care. DHHS has identified the following key attributes for a successful PHP serving children in foster care:[18]

- **Key Personnel Requirements.** A PHP serving children in foster care will need to employ personnel with expertise in serving this population. This may include a foster care medical director and a behavioral health clinical director with minimum experience and licensure requirements, who will be accountable for the delivery of medical and behavioral health services, respectively, provided to children in foster care. In addition, foster care liaisons could serve as a single point of contact between the PHP, county Department of Social Services office, and other involved state and local agencies, and could be available to respond to urgent, emergent, or routine needs.
- **Care Management.** Children in foster care require enhanced care management. Optimally, the model would incorporate the American Academy of Pediatric standards for care management for the complex needs of children in foster care. These standards are trauma-informed and promote coordination and communication across medical providers, county Department of Social Services staff, other government agencies, and foster and birth parents.
- **Continuity of Care During Transitions of Coverage.** Given the complexity of this population and the potential changes in placement, DHHS will consider establishing more stringent continuity of care policies for PHP(s) serving foster care children than for other PHPs, and could require additional contracting requirements for out-of-network providers during transitions in coverage.

[18] North Carolina Medicaid does not track individuals who formerly received adoption assistance as an eligibility category.

- **Comprehensive Medication Management Services.** PHP(s) serving children in foster care will need to establish protocols to monitor the use of psychotropic medications in a manner consistent with the North Carolina-developed "Best Practices for Medication Management for Children and Adolescents in Foster Care."[19] These protocols could include guidelines to help the PHP's providers determine whether the enrollee's medication regimen is appropriate and accurate, and help ensure that the enrollee has access to required medications during transitions in care.
- **Information Management and Data Sharing.** Sharing electronic medical, child welfare, educational, and other relevant records is essential for managing care across the different systems involved in a child's foster care. DHHS will need to create interagency agreements, if not already in place, to authorize data sharing for children in foster care. To complement DHHS efforts, PHP(s) serving children in foster care will need to support efforts to facilitate sharing of relevant information across these different entities, including ensuring coordination and sharing of health information among providers and other agencies.
- **System of Care Approach.** A PHP serving children in foster care must use a strengths-based system of care approach that emphasizes an individualized, community-based, and strengths-focused perspective. Care delivered from a system of care perspective encompasses interagency collaboration, child and family partnerships, cultural competency, and community-based services and supports. A PHP must support child and family teams, including families, youth, and child-serving agencies, as the vehicles for developing person-centered plans of care for children in foster care.

[19] Developed by Community Care of North Carolina in consultation with the Medication Management Sub-Group of the Fostering Health NC Initiative.