

DHHS Webinar: Integration of Behavioral and Physical Healthcare in Tailored Plans

Debra Farrington

(Slide 2) Thank you, Suzanne. Good morning, everyone. We'd like to thank you for joining the webinar today. And just to put it in context a little bit, you know that the Department has been, initiated our design for the type of plans that will be implemented in 2021. And as a part of that design process, we have developed a series of webinars that we will have every couple of months, where we will have an opportunity to share with our stakeholders some of our initial thinking about the design of Tailored Plans, provide you an opportunity to submit questions that we will address during this webinar, and in future webinars.

But it demonstrates our commitment to making sure that stakeholders are well-informed about the design process, and that you have multiple venues to be able to provide input. We have a number of Department staff available here today to address questions. And I'll start by introducing our medial leadership and then letting you know who are some other folks who are in the room.

I want to start by introducing Dr. Nancy Henley, who is the Chief Medical Officer for the North Carolina Medicaid Program. Welcome, Dr. Henley. We also have Dr. Brown with us. She is the Chief Medical Officer for the Division of Mental Health, CD and Substance Abuse Services. Dr. McCoy is the senior advisor to our Chief Medical Officer for DMH, DD SAS. We also have in the room today, Jay Ludlum, who is the Assistant Secretary for Medicaid Transformation. And we have other staff who are key in various areas and who are also part of our design team. Julia Lerche is here. She is out Chief Actuary. Deb _____ is here. She's the lead for our Behavioral Health IPD team. Kelsey Knick serves in multiple capacities, but she's our CD for Care Management on the Tailored Plan design. And then we have Danny Schreiber, who's with the Division of Mental Health, DD and SAS, as well.

So I think I got everyone in terms of introductions. We'll go ahead and start our presentation this morning. The focus of our conversation is on the integration of behavioral and physical healthcare and tailored plans.

(Slide 3) And I'll turn it over to Dr. McCoy to talk a little bit about what we're looking for with integrated care.

Dr. McCoy

All right, thank you everyone for dialing in. Your feedback and guidance to us through this design process is essential. We will be going over some fairly straightforward aspects of integrated care. Some of this work is still to be done, and we're wanting to bring you in earlier than later, so we can get your feedback as we proceed with the design process.

Just as introduction, I wanted to go over a little bit about what integrated care is, from the State's perspective, as well as from best practice perspective. It ensures that enrollees and providers have a seamless experience under one plan. And specifically, for the Tailored Plan population, that would include behavioral health, intellectual developmental disability, TBI, Innovations Waiver, and physical health services.

Some of the principals of integrated care include the place that places the person at the center of care and treats them as a whole person; care provided recognized with interactions between physical and behavioral health, TBI and IDB needs, and is based on evidence and based in best practices. The State would maintain a single point of accountability across all service types for the enrollee. Comprehensive care management serves as the glue to ensure integration, and integration promotes improved health outcomes, and the State will reward plans based on performance to further incentivize integration.

(Slide 4) Tailored Plans based on legislation are required to have a contractual relationship with an insurance company that provides Standard Plan services. But, that does not mean that the Standard Plan will manage the physical health services and the Tailored Plan will manage the behavioral health services. Rather, it needs to be an integrated product that provides physical and behavioral health services in a region. The Department will be establishing requirements that ensure these contracts are consistent with principles of integrated care that we discussed on the previous slide. And we'll discuss some of the ways that we will ensure that in the following slides.

Every aspect of Tailored Plan design will aim to promote integrated care in line with these principles, and stakeholders will have opportunities to engage with the Department on these design topics to ensure integration remains central to the planning effort. Some of the areas that we'll be discussing today will include benefits, enrollment, member services, utilization management, care management, Advanced Medical Homes, claims payment, and financial accountability. And I will now hand it over to Dr. Carrie Brown.

Dr. Carrie Brown

(Slide 5) Thank you, Dr. McCoy. Benefits are being designed to promote integration. And so, by design, the Tailored Plans will permit enrollees to obtain all of their Medicaid covered and State-funded services from the same managed care plan. Some of the Tailored Plan benefits include physical health services, pharmacy services, State plan long-term services and support, the full range of behavioral health services. So, ranging all the way from outpatient therapy to residential and inpatient therapy. Intermediate care facilities for individuals with intellectual disabilities. The 1915(b)(3) waiver services.

And for those of you that may not be familiar with that terminology, an example would be supported employment. Innovation waiver services. TBI or traumatic brain injury waiver services, State-funded behavioral health, I/DD and TBI services for the uninsured and underinsured. The only caveat is that dental services and children's developmental service

agency services are carved out by statute, and so will be offered during Medicaid fee-for-service instead of directly through the Tailored Plan.

(Slide 6) Enrollment is also being designed to promote integration. Meaning that Tailored Plan-eligible beneficiaries will be enrolled in a single managed care plan, so a single plan for physical, behavioral health, I/DD, TBI, and Innovations Waiver services. And individuals will thereby go through one enrollment process. They'll receive notices from one plan. They'll use one insurance card. And enrollees will have one member handbook, provider directory and coverage policies, all to help streamline the process.

In addition, enrollees are interfacing with one enrollment broker, and the enrollment broker is trained to meet specific needs of the Tailored Plan population. The enrollment broker will also support outreach and education to Tailored Plan enrollees to help ensure a smooth transition. And the enrollment broker is separate from the Standard Plan or the Tailored Plan and is directly contracted with DHHS

(Slide 7) In regards to member services, there are additional features to promote integration. Tailored Plan member service representatives will serve as the single point of contact for enrollees when they have questions about their plan or their care. Enrollees will be able to call one toll-free number to ask questions about both physical health and behavioral health, I/DD, TBI and Innovations Waiver services. Also call one single member to get clarification on plan policies and procedures, or to request auxiliary aids and services. Member services representatives will assist members with navigating any issues that they can have with their care or providers and regardless of service type.

So, examples of assistance might include help filing a complaint or appeal or facilitating a connection to the NC Ombudsman Program. Just a couple of details about the Ombudsman Program. It provides four core functions to beneficiaries receiving Medicaid services, including information education, issue resolution, referral, and plan monitoring and oversight. And it operates separate from DHHS and is selected through a competitive bid process.

(Slide 8) And this is just again saying that one number that everyone calls – just a pictorial sense – so there's basically one number that's managed through the Tailored Plan where an individual will call for authorization, denials, appeals. And so a single point of contact, which we felt was important. And I'm now going to hand the presentation over to Debra.

Debra Farrington

(Slide 9) Thank you, Dr. Brown. So we are on slide nine. We wanted to provide some information on key components of integrated care as it relates to the provision of care management services. Some of you may have heard that we intend to implement a new model of care management when we launch Tailored Plans, and that care management model will be focused on addressing not just the behavioral health needs of individuals in the Tailored Plan, but also making sure that the services that are coordinated address behavioral health, I/DD,

pharmacy, and primary care needs. Additionally, the care management will, care managers will coordinate services that are focused on an individual's unmet social needs.

So, to identify the key components of integrated care management, I want to first just highlight that we started with the basic requirements that were included in the Standard Plan, as our starting point for designing care management for the Tailored Plan. And then we looked at what additional requirements were necessary for care management to meet the unique needs of individuals who are going to be served through the Tailored Plan. One of the key components of our care management model is that there will be a single care manager for every enrollee who is in the Tailored Plan. You will note that this requirement differs from care management requirements in the Standard Plan. In the Standard Plan, individuals will be screened into care management. However, in the Tailored Plan, every individual will have an opportunity to have a care manager. It will be the individual's choice to be assigned to a care manager. Care managers will receive training that equips them to be able to coordinate care for individuals in a comprehensive manner for all individuals who are enrolled in care management.

Care management is going to be person-centered and holistic. It will not be episodic, but designed to support the individual throughout their entire enrollment in the behavioral health I/DD Tailored Plan. Care managers will complete assessments on individuals and that assessment is going to drive our care plan, and the care plan obviously is going to include goals and strategies for individuals to achieve those goals.

The new model of care management has an emphasis on local care management. And what we mean by that is that care management will be delivered in community-based settings by community-based care management agencies or Tier 3 Advanced Medical Homes. And both the care management agencies and the Advanced Medical Homes will have behavioral health or I/DD certification, and they will be required to have frequent face-to-face contacts with enrollees.

(Slide 10) Going to go to slide 10 to talk about some additional components of the care management model. One additional feature is that care managers will work with multidisciplinary care teams. The care manager will be coordinating with a multiple -- a variety of professionals, including service providers and clinicians who will deliver primary care. Obviously behavioral health and I/DD providers will be a part of that team, as well as pharmacists or nutritionists, health workers, peer support are all members of a multidisciplinary team that will be focused on addressing the needs of individuals who are in the Tailored Plan.

Care managers will have access to clinical consultants across primary care as well as psychiatry. And one of the things we are really excited about is the opportunity that the 11/15 waiver provides us to both coordinate unmet resource needs and also be able to pay for those unmet resource needs to be addressed. So, care managers will have an essential role in coordinating those unmet service needs and referring individuals to programs to address their unmet, health-related resource needs. That includes housing, food, transportation, employment and

interpersonal safety. The unmet resource needs that care managers refer individuals to can be through the Healthy Opportunities Pilot, or it could be through other resource agencies that are available in the community.

And finally the last component that I want to address in care management is our data strategy. The behavioral health I/DD Tailored Plans will include data strategy to the state and key Tailored Plan stakeholders. And what I mean by that is that the Tailored Plans will be expected to bridge data silos, facilitate timely and secure exchange of information that's necessary to support individuals' care and to inform a whole integrated care management approach.

(Slide 11) We're going to go to slide 11, and Dr. Brown is going to address that.

Dr. Brown

So, one of the locations that care management can occur is through Advanced Medical Homes, which will be available to both Standard Plan and Tailored Plan Members. Just to clearly define it, an Advanced Medical Home is a DHHs-certified primary care practice that offers population health management at the local, in the community level, and includes enhanced care management.

AMH is billed on a strong history of primary care providers and local care management in North Carolina Medicaid. And North Carolina Medicaid has developed clinical and financial design details for Advanced Medical Homes. There are webinars that are available, and we've actually posted also a website where individuals can get additional information. North Carolina Medicaid's presently enrolling practices for the Standard Plans' Advanced Medical Homes. So, design work on how Advanced Medical Homes will work within the Tailored Plan context is just beginning, which is why we wanted to include it today. The foundation will be based on Advanced Medical Homes as they've been designed for Standard Plans but will obviously need to be adapted. And we're interested in feedback on any key features for Tailored Plan Advanced Medical Homes that listeners may have. And now I'm going to turn it over to Julia.

Julia Lerche

Good morning, everyone.

(Slide 12) We also wanted to share with you our thoughts around how the claims payment and the financial requirement for the Tailored Plans will support integrated care across physical and behavioral health services. Under the integrated model, all claims for a beneficiary that's enrolled in a Tailored Plan including those for physical health, behavioral health and I/DD services, as well as pharmacy, will run through a single entity. As noted earlier by Dr. Brown, there is a limited set of services that are carved out by legislation, and those will be covered through fee for service. Those include dental services provided by children's developmental service agencies, services provided through local education agencies, as well as eye glass fabrication and fitting. So, those will all be covered through fee for service. But otherwise, all other services will be covered by the single entity for the Tailored Plan that the beneficiary is

enrolled in. That entity will also be available for all of the functions related to claims payment, as well as claims issues and grievances around claims payment. There will also be a single set of timing around how quickly those entities must review and pay claims for those beneficiaries.

(Slide 13) Next slide. Also to support integration, the Tailored Plan entities will be required to manage Medicaid services under a single pool of payments from the State. The State will make per-member, per-month payments -- those are referred to as Capitation Payments -- to the Tailored Plans based on the projected average cost for the populations enrolled and those payments will account for the full scope of Medicaid services, which include Physical Health and Behavioral Health and I/DD Services, as well as the care management and administrative support activities for which the Tailored Plan is accountable to the State. The Tailored Plans will not be allowed to split those Capitation Payments in two separate pools that do not support integrated care. So, for example, the Tailored Plans will not be able to allocate one pool of funds for Behavioral Health Services and then another pool of funds for Physical Health Services. They are expected to manage costs in an integrated fashion to support our vision and goals around integrated care, and to ensure that resources are used to support the needs of the whole person. I am now going to turn it over to Debra.

Debra Farrington

(Slide 14) Thank you, Julia. That concludes the main content of the information we wanted to share. As Dr. McCoy mentioned earlier, we recognize that some of the information we are sharing is familiar to some of you. We're sharing the basic information about where we're starting in our integrated care designs, because we want you to hear what our initial thoughts are and have an opportunity to comment on that, as well as provide input into areas that you want the Department to consider as we move forward with design. You'll notice on Slide 14 that we have outlined a number of ways for you as stakeholders, family members and consumers to participate with our design process. We will continue to have webinars and various meetings. You may know that we have established a behavioral health I/DD Tailored Plan subcommittee of the MCAC that will be starting to meet soon. Those meetings will be open to the public, and you can participate in those as well. We will be publishing a number of white papers that provide great more details about our design recommendations, and we hope that you will provide comments and questions in response to those white papers.

We will also put regular information up on our website. The PowerPoint from today's presentation will be available, as well as the written script and recording of this webinar will be available to you. We will continue to engage with all individuals from the behavioral health I/DD community, including consumers, family members, care givers, advocacy organizations, providers, and folks who are involved at the county level in DHHS, local health, and our county managers and county commissioners. So, we appreciate your participating. We have received a number of questions, and what we're going to do is take some time to read those questions and ask different members of our panelists to respond. I'm going to start with questions for Dr. McCoy. The first question we have is, Can consumers keep their doctor?

Dr. McCoy

So, we anticipate that, the behavioral health system has been a closed network thus far through the LME-MCOs, and through legislation that will continue. On the Physical Health side, that is intended to be an open network and will be both on the Standard Plan and the Tailored Plan side. So, if you have a provider, a doctor who qualifies to be a Medicaid provider and agrees to the rates, then they would be included in the service array.

Debra Farrington

Thank you. The next question asks, The town (?) and consumer will want to have the last word on approval. Is this integration team capable of overriding family or consumers' wishes?

Dr. McCoy

The intent, especially on the care management side that has, the care manager will be sort of the locus of coordination for a team that may include a wide variety of clinicians. And the intention is for care managers to be thoroughly trained on being person-centered, which means that what gets asked for or requested by the provider to the plan will need to be something that that consumer or beneficiary wants. When it comes to approval of the services, there will continue to be specific medical necessity criteria that the plans will compare the request against. And if the request is denied, the consumer enrollee will continue to have appeals rights to be able, if they feel like the decision was incorrect.

Debra Farrington

Thank you. Let's see. We have another question. We're going to direct this to Kelsey. This question asks, Will there be more than one health plan available to the consumer, or only one?

Kelsey Knick

So, for a Tailored Plan design, it will be set up similarly to how we are today with the LME-MCOs. The structure of the LME-MCOs may or may not stay the same but, depending on where you live, that will be the plan that you're assigned to.

Debra Farrington

Thank you. And then, we had a question where someone asked, How do care managers compare to care coordination as it is delivered today.

Kelsey Knick

I think that's a great question, and a question we get asked a lot. And Debra covered some of those differences earlier, but I certainly will reiterate them, 'cause I think that, in the community, people don't quite understand the difference between the terminology that we use as care manager, case manager, and care coordination, and kind of what the differences

are with that. When we're talking about the Tailored Plan, we really are focusing on designing a program that builds not only building off the Standard Plan care management design, but also building off of the federal requirements for a behavioral health home.

And so we are designing a behavioral health home care management model for the Tailored Plan. And, one of the differences between care coordination that's provided today and care management that will be provided in the Tailored Plan is that, right now, if you need physical care management, most people get that through CPMC. If you need to address your behavioral health concerns, that would come through the LME-MCOs. In the future, you'll have one care manager, ideally, assigned to you. There may be some circumstances where you may have two, such as if somebody's pregnant and they need a pregnancy medical home care manager. But, ideally, you'll have one that will cover your physical health care, your behavioral health care, your pharmacy needs, long-term services and support. Everything that that individual needs to provide whole-person, integrated care.

So, that's one big difference. Another difference is that everybody that is in a Tailored Plan is automatically eligible for care management, whereas now, for care coordination, people can be risk stratified or screened in based on the conditions that they present. Care coordination currently is generally episodic, and it's not long-term through the course of the individual's treatment. Care management, as we are designing it, will follow that individual through the course of their treatment, and it won't be episodic.

There'll also be more focus on a multidisciplinary team, with individuals' clinical consultation with specialists, as well. The staffing patterns may look a little bit different than we see today with your coordination. We may have the community health workers, the peer support, individuals that are on the team to help provide that care management that currently the way the structural and the LME-MCO is set up, we don't have.

Another difference is that we are really pushing for local care management, boots on the ground, individuals that know their community and that are providing a lot of face-to-face contact with the individuals that they are assigned to.

And, lastly, I'll note that addressing unmet health resource needs, or social determinants of health, which may be more of a familiar term to people, that's also going to be an issue that both Standard Plan and Tailored Plan care managers will be required to address, as well.

Debra Farrington

Thank you, Kelsey. We have a number of care questions about care management. One of the things that I wanted to highlight is what Dr. McCoy said, is that some of what you're hearing today are our initial thoughts. But certainly a lot more time and attention and discussions with external stakeholders need to happen before we are final on some of the recommendations. So, what you're hearing from us today about care management are our initial thoughts. And there are some questions that have not yet been answered. So, I say that because we have one question that talks about the qualifications of professionals and care managers. And I just

wanted to highlight that that's one of the things that hasn't yet been determined. But we definitely welcome your input on it, and you can submit your thoughts about that to our Medicaid Transformation website, and you can find that, a place there where you can submit your questions. But we have not yet finalized some of our recommendations around qualifications.

We also have a question, Kelsey, about enrollees. This may be another area that we haven't completely finalized. But this question asks, For children and adolescents, will enrollees have to switch back and forth between Tailored and Standard Plans as they move to lower levels of services or as their symptoms fluctuate?

Kelsey Knick

That's a great question, too. I mean, ideally, we want an individual to have at least amount of disruption as possible. And we want them to be assigned to the plan that best suits their needs and their family's needs. There are certain services that will only be available in a Tailored Plan, and so, if the individual or the child, the parents of the child choose those services, they will stay in the Tailored Plan. There are services that are offered in both the Standard Plan and Tailored Plan. However, if they need more comprehensive care management that is only offered in the Tailored Plan, they'll most likely end up staying in a Tailored Plan and won't be bouncing back and forth from plan to plan. But I do want to reiterate, or iterate, I guess, is that individuals have a choice, if they are assigned to a Tailored Plan, if they would like to go to a Standard Plan, they do have that choice, with the exception of Innovation, NTBI.

Debra Farrington

Thank you. I appreciate that. We're going to change directions just a little bit. I have a few questions that we want Jay to address. And our first set of questions, Jay, deals with the role of the enrollment broker. So, this question asks, Is the enrollment broker the same for Tailored Plans and Standard Plans?

Jay Ludlum

Yes. The intent is to keep the enrollment broker for both of those _____.

Debra Farrington

Okay. And, the next question asks how the enrollment broker will be expected to collaborate with the Tailored Plans.

Jay Ludlum

Yes, so the enrollment broker will work with the State to receive requests for individuals who want to move -- who have not been identified but want to move to a tailored plan. And then that material will be sent to the State for review.

Debra Farrington

Okay. Thank you. This question is similar, but is about how -- support to the members. This person asks whether members services representatives will be employed by a managed care plan.

Jay Ludlum

That's a good question. Each health plan will have its own member services team and will be expected to come to -- come up with a stakeholder engagement plan. So, each of the Tailored Plans will have a member service team.

Debra Farrington

Okay. Excellent. Thank you. This question is about network adequacy.

Jay Ludlum

Um-hum.

Debra Farrington

What is the process for assuring network adequacy at the consumer level? And I think that folks are concerned about individuals being able to get access to appropriate appointments in a timely way.

Jay Ludlum

Yeah. That's a, that's a great topic all by itself, is network adequacy. So, network adequacy is, is really part of the quality continuum. So there are different ways of measuring adequacy. One is a paper network. Do the health plans have -- have they contracted with sufficient number of providers that can serve their beneficiary needs in the regions in which those beneficiaries live? I think that that's, that's your first gate. Then what we're talking about also is realized access. So, realized access is about whether or not an individual who wants to get an appointment is able to get an appointment. Whether or not they want to get into the office, whether they're able to physically get into the office, because of the way that the office is laid out, or whether it has appropriate physical footprint. And then there are the quality evaluations. So, the -- based on quality indicators that the health plans will be expected to submit to us -- we'll evaluate them and make sure that the access, simply getting access to a provider may not positively impact care. And therefore we'll be also evaluating quality. So, we are -- we have a multi-tiered approach at looking at the impact of provider networks on the care that's provided by each of the health plans. And we also have very stringent oversight mechanisms in the standard plan model that we intend to bring to the tailored plan model, as well, around, you know, the potential for liquidated damages. If we find a repeated pattern of inaccessibility or low-quality care. We may even be able to -- well, we'll just stop there. There

are a number of different mechanisms that we have for oversight, and it's something that we'll be watching very closely.

Debra Farrington

Thank you, Jay. This is a general question, and, just want to acknowledge that the Department is in a silent period because of our procurement efforts, but, to the extent possible, can you address the question that we have from the audience about when will the assignments be announced? And I'm assuming that this is a question about the Standard Plan announcement.

Jay Ludlum

So, and the -- well, just to familiarize people if they're not familiar -- the Department has committed to awarding the Standard Plan contracts during the week of February 4th, and we continue to appear to be on target for that. The assignment of individuals to health plans -- there is, it's kind of a multilayered question -- but, effectively, individuals will be permitted to enroll in standard plans in two regions, two out of four -- or, two out of six regions, starting on or about July 15th of 2019. There's a 60-day open enrollment period. And then, and then we'll auto-assign individuals. So, truthfully, this really, the assignment of individuals to health plans will start this summer, and then, of course, be effective in November. And then, for the other four regions, the process will start in October, to be effective in February.

Debra Farrington

So, Dr. McCoy, we found a question. This question relates to area programs' LME-MCOs structure, and it asks whether the LME-MCOs will be required to consolidate.

Dr. McCoy

So, the Department will follow the current legislation requiring there to be five to seven contracts per Tailored Plans.

Debra Farrington

Thank you. Let's see. We have a few other questions here that I want to address. Kelsey, we had a question about the Tailored Plan as it relates to accreditation. Do we have enough information at this point to address that?

Kelsey Knick

We don't. We're still working on that aspect of the design.

Debra Farrington

Okay. Let's see. We have a question around base support, Deb. If you feel comfortable. This question says, Currently, I/DD's _____ support provider services authorized by the LME-MCOs before a provider can serve the individual and bill. How will this change?

Debra Farrington

The Innovations waiver and the TBI waiver services will continue to require prior approval before the service is provided.

Debra Farrington

Okay. Thank you. And the questions aren't necessarily organized anyway, so I appreciate your patience as we go through this. This is a question about care management, and it asks about what kind of training will be provided for care managers.

Kelsey Knick

That's a good question, as well. As mentioned before, we're building off of the Standard Plan requirement as much as possible for the care managers, especially because we may have some AMH Tier 3 practices providing care management for individuals that are both in the Standard Plan and the Tailored Plan. That being said, we recognized that individuals that are in the Standard Plan may have some specialized needs that individuals in the Tailored Plan don't have, and so we are currently working on, the State is working on what we feel would be the best training topic for the care managers to be trained on. But we have not finalized that decision, and so certainly if there are suggestions, feel free to send them to us.

Debra Farrington

Okay. Thank you very much. This is a question about -- I guess who qualifies for a Tailored Plan, and it says, So once your child turns 18 and can get Medicaid, can they be enrolled in a Tailored Plan? So, one of the things we've been making a point of in some of the presentations that we've done is that the eligibility rules for Medicaid do not change as a result of us going into managed care. So, if a person currently qualifies under Medicaid rules, they will still qualify. But our implementation of Tailored Plans, Standard Plans, are not going to change the eligibility rules and categories.

Kelsey Knick

Correct. And Tailored Plans are for children and adults, so it's just not for adults.

Debra Farrington

Okay. We do have a question, it's a general question. I think Dr. McCoy, you can take this one. This says, Please discuss the timeline for the development of Tailored Plans, sort of what

happens between the implementation of Standard Plans and when we go live with Tailored Plans.

Dr. McCoy

Right. So, LME-MCOs will continue to exist after the launch of Standard Plans, so this will occur between November and February, later this year and early next year. Tailored Plans are anticipated to launch part of the way through 2021, which is when the LME-MCOs that are awarded a Tailored Plan contract will begin to cover the services that they have been covering for their population, but also add the physical health and pharmacy and other services that we've been talking about. So, we do anticipate the LME-MCOs to cover a smaller population during the period between when the Standard Plans launch and the Tailored Plans launch.

Debra Farrington

Thank you. We have a question about a current waiver. We have a 1915(b) waiver and a 1915(c) waiver, and folks are curious, Deb, about whether -- how our existing waivers will be impacted by this change.

Debra Farrington

Our (b) waiver, which is the managed care waiver for the mental health I/DD SUD services, will be absorbed into the 11/15, when Tailored Plans launch. The (c) waivers, for innovations, as well as TBI, will continue to be (c) waiver authorities, and will remain the same, just under the management of the 11/15 instead of a base.

Debra Farrington

Okay. And I do want to acknowledge that we've received a number of questions about case load sizes. We've received a number of questions around the credentials of care managers. And I just want to reassure you that we are thinking about those things. We are gathering research from multiple states. We're looking at our existing care management structure. But we have not yet formulated specific recommendations around case load sizes, around contacts, or around credentials of the care managers. Those things will be addressed. We will formulate a set of recommendations around each of those areas and distribute that out to the community. And certainly, again, we welcome your feedback on any of those areas, if you have specific recommendations that you would like for the Department to consider. And, just, Kelsey, if you could just reiterate, we've had a number of questions about who will employ care managers. If you could talk about care management agencies, as well as Advanced Medical Homes, how that fits into our current proposal for our care management model.

Kelsey Knick

Sure. And I just want to tag onto one thing that Debra said before about staffing patterns and training, and all these great questions that everybody's had. We anticipate in March, in the March timeframe, we will have a care management white paper that we will publish, and our

hopes are that some of these questions will be worked out by then, but some of it will still be what we put in a white paper to elicit your feedback to help us formalize and finalize the design. Advanced Medical Homes Tier 3, with a behavioral health certification or a sur-management agency, which I think we kind of made up that name here in North Carolina, so if people aren't familiar with a CMA, I think we just, the kind of terminology that we're using is an agency in the community that will be providing the care management. We have not solidified what the, whether they have to be accredited, who is a care management agency, what criteria do they have to meet in order to become that? Those entities, though, will be employing your care managers that will be providing the local community-based face-to-face care management for the individuals that are in the Tailored Plans.

Debra Farrington

Thank you. And another thing that we will make sure to address as well is any recommendations around firewalls. We have a question about whether those care management agencies and Advanced Medical Homes can provide other services. I know that in the Standard Plan model, the Advanced Medical Homes will be providing primary care services, as well as care management. And I think we'll be clarifying some of those requirements for care management agencies, as well.

Kelsey Knick

Right, Debra. I don't, I don't think that question is, is directed towards Advanced Medical Homes as much, because generally they're providing your physical health care, not both behavior pallets. So, yes, for the care management agencies, we have started that discussion about firewalls or if an entity can do, only do care management, or if they can do care management and other services and kind of, what that would look like, so we can ensure, to the best of our ability, that the beneficiary is getting all of their needs met. So, that is still a work in progress.

Debra Farrington

Okay. Thank you. Julia, we have a question about Tailored Plans, and who can enroll in the network. And the participant asks whether Tailored Plans will have closed networks.

Kelsey Knick

So, as Dr. McCoy mentioned earlier in his comments, the LME-MCOs currently have closed networks for behavioral health purposes, and under the legislation for Tailored Plans, that will continue for purposes of the Behavioral Health Services. For Physical Health Services, the rules for Tailored Plans will be similar to the rules for Standard Plans under statute, which is that any provider that is interested in contracting with that plan, as long as they're willing to accept the rates that the plan is offering them, and meet certain quality standards, the plan will contract with that provider.

Debra Farrington

Thank you. And we have a question, Julia or Jay, I'm not sure which of you guys would like to address this, but we have a question around how the credentialing process will work, and if Tailored Plan providers will participate in the centralized credentialing process.

Jay Ludlum

Yeah, this is Jay. Yes, they will participate in the centralized credentialing process. So, as much as possible -- and just, from a design perspective -- as much as possible, to reduce the risk on beneficiaries, providers in the State, we intend to use the Standard Plan model as our starting point and as our platform. And, of course, there are places where the Standard Plan model does not work or apply in a Tailored Plan context, but from an operation standpoint, most of the platform that we're building for Standard Plan, we will begin migrating components of that operating model, maybe even before Tailored Plans launch, so that we can ensure a smooth transition as much as possible, and also to -- so that providers aren't engaging the State in two or three different ways. They're just going through one provider enrollment process. One provider credentialing process. And not having to go through all of these various and disparate systems, or platforms.

Debra Farrington

Okay. Thank you. We have a group of questions that I'm going to read out and then ask Dr. McCoy to address them. There's three separate questions, and I'll read them individually. The first question, the _____ asks, The language around care management design and Tailored Plans seems to suggest that much of the care management responsibility will be moved out of the LME-MCOs. Is this understanding correct? Let me read the second two questions. So, care management will not be done by the TP? By the MCO? And will care managers eventually only be employed outside of the LME-MCOs? So, Dr. McCoy, I think if you could talk about plan responsibility, as it relates to these questions.

Dr. McCoy

And as we finalize the _____?

Debra Farrington

Yes.

Dr. McCoy

Right. Some of the elements of this we're still working on. You know, we anticipate that if there's network adequacy issues when it comes to care management, that there may be other locuses where care management may need to be done, which may include potential the Tailored Plan. But again, some of those design elements are still being worked out and will be in the white papers that Kelsey mentioned earlier. I think the important thing to discuss here is

that the responsibility for care management, for the Health Home model, that oversighted the responsibility of the Tailored Plan. So, the Tailored Plans will have a lot of work that they will be responsible for, to ensure that care management truly meets these Health Home standards, which are very high standards. And that it's truly integrated, comprehensive, and really meets the needs of the beneficiary. And so that is an extra layer of oversight that we have not had thus far that the Tailored Plans will be doing.

Debra Farrington

Thank you. I appreciate that. And, we just want to thank everyone for participating in today's webinar. We have received a number of questions. Some of them are duplicative, so we don't want to repeat the same thing over and over. But we will collect all the questions. We will compile responses to those questions and make those available in the community. We appreciate everyone's input. We appreciate your thoughtfulness and your willingness to engage with us in the design. The Department has made a great effort and is completely committed to transparency, and so we hope that our bringing this information to you at this point of our design is helpful, and that you'll take full advantage of the opportunity to provide your thoughts to us about our initial design work. Thank you. Is there anything closing that you guys would like to add? I do want to reiterate, as well, that these materials for today's webinar are available -- will be available shortly on the Medicaid transformation website, both the PowerPoint, as well as a recording will be made available within the next couple of days. Thank you again, and this concludes our webinar for today.