BH I/DD TAILORED PLAN ELIGIBILITY AND ENROLLMENT WEBINAR

Gerald

(Slide 1) Ladies and gentlemen, hello, and welcome to Tailored Plan Eligibility and Enrollment Webinar. My name is Gerald, and I will be in the background answering any WebEx technical questions, but if you do experience technical difficulties during or joining this WebEx session, you can call WebEx technical support at 1-866-779-3239. Please note that as an attendee, you are part of a larger audience. However, due to privacy rights we have chosen not to display the number or list of attendees to everyone on the call today. And as a reminder, today's call is being recorded. There will be a Q&A session at the conclusion of the formal presentation. However, you can submit a question at any time during the presentation by simply typing your question into the Q&A panel located on the right-hand side of your screen. Just type your question into the text field and click the Send button. Please be sure to keep the "Send To" defaulted to "ALL PANELISTS". Also during today's presentation, you do have the opportunity to use closed captioning if you desire. I have placed the link into the closed captioning into the chat panel. I will do it periodically throughout the event. Just take that link, open it up in a Web browser and put it off to the side of your screen. With that, we invite you to sit back, relax and enjoy today's presentation. I would now like to turn the call over to your very first speaker and moderator for today's event. He is the Deputy Secretary for North Carolina Medicaid, Mr. Dave Richards. Mr. Richards, you have the floor.

David Richards

Thank you so much, and welcome everybody. We really appreciate you joining the call today. This is another one of our series of calls aimed at helping the field understand our direction for the I/DD and Behavioral Health Tailored Plans. Today, we're going to talk about the plan eligibility enrollment, which is a very specific topic, to help all of us understand who will be in both the Tailored and the Standard Plans as we go live.

(Title slide) To start the call today, and the presentation today, will be Julia Lerche, who is Medicaid's Chief Actuary and Policy Advisor. So, I'll turn it over to Julia to start.

Julia Lerche

Thank you, Dave, and thank you, everyone, for taking the time to participate in this Webinar today. As Dave mentioned, this is one in a series of Webinars in which the department is sharing our vision and information about our approach to serving beneficiaries with significant mental health and substance abuse needs, as well as beneficiaries with intellectual and developmental disabilities or traumatic brain injuries, as we transit from the Medicaid program's managed care as required by the legislature.

(Slide 3) During today's Webinar, we will focus on the process the Department intends to use to identify beneficiaries who meet the eligibility criteria for these Tailored Plans, which are being

developed by HHS to serve beneficiaries with pre-existing behavioral health needs, which includes both mental illness, as well as substance abuse disorders, in addition to beneficiaries with intellectual or developmental disabilities or traumatic brain injuries. The criteria that we will walk through today and that will be used for purposes of determining the Managed Care and coverage options that are available to beneficiaries enrolled in both the Medicaid and North Carolina Health Choice programs. During the Webinar, we'll talk about the principles that guided our approach, the criteria we'll use to identify beneficiaries that meet the criteria, the process for enrollment, and the differences in benefits between the Standard Plan Managed Care program and the Behavioral Health and Intellectual and Developmental Disabilities Tailored Plan. We'll then wrap up the Webinar with some key takeaways, and we will take your questions at the end of the Webinar.

(Slide 4) On March 18th, the Department released a paper on this very topic that we'll be covering on the Webinar today. The paper provides an overview of the Behavioral Health and I/DD Tailored Plan Eligibility and Enrollment processes that we have developed to date. And we'll be reviewing many of the key concepts in the paper during this Webinar. The paper includes additional details for others who are still interested in learning more. And on the slide here, you can find a link to the paper, if you would like to access it.

(Slide 5) Okay, we're going to go into the next slide.

(Slide 6) So, here we talk about the timeline for transitioning the Medicaid program to managed care. Right now, we're in the middle of a very large scale transformation of the Medicaid program from one that is predominantly fee-for-service to one that is primarily managed care. We'll be launching in the next several years two different types of managed care products – Standard Plans and Behavioral Health and I/DD Tailored Plans. The Standard Plan launch will begin this November, in two of six regions defined in the state. And the remaining four regions will go live and folks will begin getting their coverage in February of 2020. The Behavioral Health and I/DD Tailored Plan, which we'll talk about in more detail through this Webinar, are tentatively scheduled to begin in July of 2021. In the period between the Standard Plan launch and the Tailored Plan launch, for those beneficiaries that are identified and determined to be eligible for the Tailored Plan due to their medical and behavioral health needs, they will all continue to be enrolled in their current system, which is primarily fee-for-service, with Behavioral Health Coverage through LME-MCOs for many of our beneficiaries, although there are some populations like young children and children enrolled in the North Carolina Health Choice program that do receive their behavioral health services through the fee-for-service program, and if they meet the criteria for the Behavioral Health and I/DD Tailored Plans, they will remain in their current systems, until the launch of the Tailored Plan. And we'll go into more detail around that in the following slides.

(Slide 7) On the next slide, we just wanted to give a high-level overview of the difference between the Standard Plans and the Tailored Plans. I'm going to use the shorthand Tailored Plans for the Behavioral Health and I/DD Tailored Plans. There will be some similarities between the plans. Both the Standard Plans and the Tailored Plans will be integrated managed care products that cover a broad array of services, physical health, behavioral health, long-term services and supports, and pharmacy benefits. The Standard Plans will serve the majority of the Medicaid population that is not also enrolled in Medicare. When we refer to non-dual eligible

throughout the presentation, we mean those that are not enrolled in both Medicare and Medicaid. It's those populations that are only enrolled in the Medicaid program. The Behavioral Health and I/DD Tailored Plans will serve, as we mentioned before, our populations that have significant behavioral health conditions, which include serious mental illness, serious emotional disturbance and substance use disorders, as well as those beneficiaries with an intellectual and developmental disability or traumatic brain injury. The Tailored Plans will cover some behavioral health and I/DD/benefits that are not, that will not be covered through the Standard Plans. And we will go through the list of the services that are only available in Tailored Plans later in the Webinar. In addition to that, any of the current (b)(3) waiver services, as well as our Innovations and TBI waiver services, and services that the LME-MCOs currently cover that are only State funded and not Medicaid funded will only be available through the new Tailored Plans. They will not be available through the Standard Plan PHPs, with certain exceptions if they need to be covered through the ETSBT program for children.

(Slide 8) Moving on to the next slide . . .

(Slide 9) So, here on slide 9, this slide walks through how all of the various Medicaid populations will be covered as we move into the managed care environment. As I mentioned before, most of our Medicaid beneficiaries will be enrolled in a Standard Plan. Where we have in the, the first grouping here are folks that are included in Managed Care. There are the populations that will be mandatorily enrolled in Standard Plans. Unless they are, they meet one of the categories that are listed below that are either exempt, excluded or delayed. So, included in the Standard Plans will be most of our Medicaid and Health Choice enrolled children, unless they meet the Tailored Plan eligibility or again meet one of the exceptions listed below, are parents and caretakers, as well as people who have disabilities and they're not dually eligible for Medicare and Medicaid and they don't meet, again, one of the criteria listed below. Members of federally recognized tribes will be exempt from mandatory enrollment in managed care, which means that they will have a choice to stay in the fee-for-service program. We're also working with the Eastern Band of Cherokee Indians on a tribal option that will be a coverage option for members of federally recognized tribes, as well as some of their dependents in certain cases. So, folks that are federally – members of federally recognized tribes will typically be enrolled either in the fee-for-service program or the tribal option, but they will have the option to enroll in a Standard Plan, and should they meet the criteria for Tailored Plan enrollment in their eligibility, they'll also have a Tailored Plan option. The populations that are listed as excluded – this is based on what's in current legislation, and the excluded populations do not have the option to enroll in a managed care product. This includes our medically needy beneficiaries. Those are the beneficiaries that have a spend-down or deductibles that they have to meet before their benefits kick in in Medicaid. Beneficiaries that are enrolled in our Health Insurance Premium Payment program that pays premiums for other coverage arrangements and then Medicaid wraps around that, that type of insurance. Folks that are enrolled in our CAP/C and CAP/DA waivers will be excluded from managed care in the initial years. And then beneficiaries that are enrolled in programs with very limited Medicaid benefits, so, for example, family planning programs, partial dual, which is where we pay Medicare premiums and co-pays only, folks that are only eligible for emergency services, inmates that have very limited coverage. Beneficiaries that are enrolled in our PACE program will also not be enrolled in managed care. PACE is a marginal managed care program already. The box down at the bottom lists out the populations that are delayed. And we'll go through each of these. So, as mentioned before, we're proposing to

launch the behavioral health and I/DD tailored plans in July of 2021. Prior to that launch, the beneficiaries that we identify or who are identified as Tailored Plan eligible will be enrolled in the current system, which is predominantly fee-for-service, with an LME-MCO for their behavioral health benefits. They will have a choice to opt into a Standard Plan, should they want to do that, whether they are Medicaid only and do not have Medicare. For our dual eligible beneficiaries that meet Tailored Plan enrollment, they will not have the option of a managed care product until Tailored Plans launch in 2021, at which point, if they meet the eligibility criteria, they will be enrolled in a Behavioral Health and I/DD plan.

(Slide 10) Now, additionally, beneficiaries in foster care, children in adoptive placement, and beneficiaries who are former foster care youths up to ae 26 will be delayed in managed care. They will not be enrolled in Standard Plans nor have the option to enroll in a managed care product until July of 2021. And then, finally, there are some populations where legislation defines that they would come into managed care in 2023. That includes the majority of our dual-eligible population that are enrolled in dual Medicare and Medicaid benefits who do not meet Tailored Plan eligibility, as well as Medicaid-only beneficiaries that are in a nursing facility for more than 90 days. Last summer, the legislature, working with the Department, defined eligibility criteria for the new Behavioral Health and I/DD Tailored Plan. The criteria is documented in legislation as we noted that was passed last summer. To operationalize what is in legislation, we here at the Department had a multi-disciplinary team of clinicians, which included psychiatrist, licensed clinical social workers and pediatricians, all with deep expertise and experience working with populations with Behavioral Health, I/DD and CDI, all worked on developing the criteria and process for identifying beneficiaries that meet the Tailored Plan as laid out in legislation. In developing the specifications, we use the guiding principles that are listed on the slide here. Number 1 was to ensure that we are getting beneficiaries into the managed care product that best meets their needs. We want to minimize any barriers to access of needed services or coverage arrangements. Complying with the legislation was one of the goals. And then on ensuring that or processes and approach results in responsible stewardship of public funds. The Tailored Plans will generally cost more to the State than the Standard Plans due to the more robust care management and additional benefits that would be offered to those plans. And we want to make sure that we get beneficiaries to the right place in a responsible way to the State.

(Slide 11) On the next slide, this walks through the criteria that we will use for identifying beneficiaries eligible for the Tailored Plan. There are really two ways that the Department will identify beneficiaries who meet eligibility. The first is on this slide here, which is, we will review the data that is available for the Department to identify those that meet the criteria, and we'll walk through that in a minute. And then on the next slide, we'll talk about secondary process, which will be a process for beneficiary to reflect or review eligibility, again, to ensure that we're minimizing barriers. So in terms of the data review that the Department will do, we have a process in place to review encounter data from our LME-MCOs, claims data from fee-for-service programs, and other data that we collect from various sources, including our State facilities and LME-MCOs who keep track of various criteria for our beneficiaries. I'm not going to walk through all of these, but I'll just speak to a couple. If there is anyone that's enrolled in Innovations or TBI Waiver or is on one of the waiting lists for a waiver will be identified as Tailored Plan eligibility. Anyone that's enrolled in the TCLI initiative will be flagged for Tailored Plan eligibility. Anyone that has used the Medicaid service or State-Funded service,

that will only be available through the Tailored Plans and will not be available through the Standard Plans, other than through ETSCT, will be identified as Tailored Plan eligible. Anyone with a qualifying I/DD diagnosis code will be Tailored Plan eligible, and you can read the rest of the criteria that are listed here. We're currently estimating that about 30,000 of our dual-eligible beneficiaries and about 85,000 of our Medicaid-only beneficiaries or non-dual beneficiaries that will meet the Tailored Plan eligibility criteria based on our data reviews done so far.

(Slide 12) On the next slide, this walks through our Eligibility Request process. We know that data is not perfect, and we can't identify everyone necessarily through data. We will have beneficiaries that are new to the Medicaid program, new to the state, for whom we do not have any data on which to assess their Tailored Plan eligibility. There are also these folks that are – those folks will be – there may also be folks that are enrolled in Standard Plans and would like to assess because they have things that were not identified through data reviews. And so this slide walks through that process, so the beneficiary or the provider who believes that the beneficiary has a need to be in a Behavioral Health and I/DD Tailored Plan, there will be a request form that's available through the enrollment broker and also on DHS's website that can be submitted to the Department for review. It will be submitted through our enrollment broker. They'll be managing the work load to make sure that the forms are processed – the forms are taken in and they're routed to the Department for review. The enrollment broker will translate the request to the Department, and the Department will review that request and make the appropriate – take the appropriate action. And should the request be approved, the beneficiary would then be moved either to the Tailored Plan or prior to the Tailored Plan launch into the current fee-for-service system and LME-MCOs. There will be notification back to the beneficiary of the approval or the denial on and, as I mentioned before, we would then transfer the person's enrollment from their Standard Plan to the, either the current system or the Tailored Plan in the future state.

(Slide 13) Moving forward on slide 14 . . .

(Slide 14) This just walks through the timeline. As noted earlier, there will be two processes. We'll have a Data Review process and also a process for beneficiaries to request a review of their Tailored Plan eligibility. The process – we have a process that's going forward now, prior to the launch of the Standard Plan to identify those beneficiaries that meet one of the Tailored Plan criteria. We're doing those data review now. We're looking back at claims and encounters going back to services from January 1 of 2018, looking for qualifying diagnoses, as well as qualifying service codes that would identify someone as meeting Tailored Plan eligibility. We will continue to do those reviews against our data throughout the process, and really throughout the – from now into the future, so that we pick up those that have new claims or if they are new to the system. As folks are identified meet the Tailored Plan eligibility, as we mentioned before, they'll stay in the current system, if they are flagged prior to the launch of the Standard Plans. We will also be continuing to identify folks, and we'll walk through that on the next slide. As we move into, as we get closer to the launch of the Tailored Plans, we will do a reassessment of Tailored Plan eligibility. So, as I mentioned before, for the initial launch of the Standard Plans will be back at claims through January 1 of 2018. As we move closer to Tailored Plan launch, we'll be assessing folks based on a more recent lookback period to identify who still look like they meet the level of need for the Tailored Plan. For those that are reassessed as meeting the Tailored Plan eligibility leading up to the launch of the Tailored Plan, they would then be

defaulted into the Tailored Plan with the continuation of option for Standard Plan enrollment as well. Moving to the next slide.

(Slide 15) So an ongoing basis, the Department will review data that's available to us for beneficiaries that meet the Tailored Plan eligibility criteria. For those that meet one of the criteria – and this is again after we begin the Standard Plans – we will be either sending a notice that the beneficiaries have the new option to move back to the current system, or, in some cases, we will automatically move them to the current system or the future state that will be the Tailored Plan. So the box here on the left is the criteria by which if a beneficiary, for example, is enrolled in the Innovations or TBI Waiver, they will automatically be moved into the Tailored Plans once they launch, and prior to launch of Tailored Plans, they'll be moved to the current LME-MCO system, because that is the only place where the benefits will be available. Similarly, for beneficiaries that enrolled in and we enrolled in the TCLI program, or as identified as using a Medicaid service or a State-Funded service that's only available in either the Tailored Plan or identified as the Tailored Plan, the LME-MCO system, they will automatically be moved. For those that are identified as meeting other criteria, such as having a qualified I/DD diagnosis, having another qualifying SMI or SED or SUD diagnosis and using an enhanced service, those that have had two or more emergency department visits for a psychiatric problem, or a psychiatric hospitalization or two or more crisis episodes, they will get a notification that they have the option to move out of their Standard Plan into either the current LME-MCO system or the Tailored Plan, and then they'll have the option to move, if they notify the enrollment broker.

(Slide 16) On the next slide, this just, again, talks about we will continue and have an ongoing review process for identifying folks that meet the Tailored Plan eligibility. There will be – prior to the launch of the Tailored Plan, once a beneficiary is determined eligible, that they meet the Tailored Plan eligibility, they will remain in the current system until the Tailored Plans are launched. After the launch of the Tailored Plans in 2021, there will be process for identifying beneficiaries that are enrolled in the Tailored Plan who may no longer need the level of services that are offered through the Tailored Plan. Beneficiaries that have an I/DD diagnosis or traumatic brain injury needs will remain in the Tailored Plan once they're enrolled in the Tailored Plan. We do not intend to move them back to a Standard Plan. Beneficiaries that don't have an I/DD or TBI needs but are in because of an SMI, mental illness, emotional disturbance or substance use disorder, if they have not utilized behavioral health service other than outpatient therapy or medication management in the last 24 months, the Department does plan to move them out of the Tailored Plan and back into the Standard Plan because through that review, we have assessed that they are no longer in need of the Tailored Plan benefits. If they again meet the Tailored Plan eligibility they would again have the option to move, but we will be doing those reviews to make sure that the Tailored Plan is really serving the beneficiaries that really need the Tailored Plan services.

(Slide 17) On the next slide, this talks about the transition between plans. The Department is really dedicated to ensuring that beneficiaries have a smooth transition process when they are moved from one plan to another. We have transition of care requirements in our managed care contracts to ensure that those handoffs are done smoothly. For the review process for those that, those beneficiaries that are not identified through data reviews and request a review of their eligibility, we do plan to review those review – excuse me, review those requests in a timely

way. Our goal is for standard reviews, or those that are not urgent, that those requests will be reviewed in five to seven days, and then beneficiaries would be moved to the plan if their request is approved. We're also working through an expedited review process. For example, if a beneficiary has an urgent need for a service, and they're enrolled in a Standard Plan, and the service is not offered to a Standard Plan but is offered through the Tailored Plan, that we would have an expedited office for getting them moved into the Tailored Plan so they can receive the service that they need.

(Slide 18) Now we're going to move into the …

(Slide 19) … the benefits that are available through Tailored Plans and Standard Plans, and I am going to pass this off to Kathy Nichols.

Kathy Nichols

So, good afternoon. The slide that you see here is laid out for the way we sort of split up our Behavioral Health policies in the State plan and the (b)(3)s and in our waiver services. One of our key underlying principles as we kind of work through this determination was that there should be no difficulty for somebody to access a crisis service. So that is the majority of the enhanced services that are available in both plans. So, on the left side are the services that are going to be covered by both Standard and Tailored Plans, so, which are your basic in-patient/out-patient mental health crisis and substance abuse detox services, including non-medical detox and our State facility detoxification center. So, and the think behind that is that you shouldn't have to worry about what plan you're in in order to access these services. For the ones that are longer term services and somebody's journey to recovery, they should have time after accessing the crisis service and stabilizing to transition to a tailored plan and get the care management and the services specifically targeted to this population, and that process would be basically what Julia had just walked through, was determining standard and expedited transitions for different plans. And then, services that will be in Tailored Plans only will be the residential treatment for children and adults that enhance behavioral health services for children and adults and the Innovations in TBI services. The 1915(b)(3) services and the in lieu of services we are looking at the State-Funded alternative service definitions as well, will all be going into the Tailored Plans, but with more – with a baseline for them at least to begin with so that we don't have multiple definitions as we transition into a new environment. And I think the most important thing for folks for this slide, especially on the left-hand side, is that there will be some changes and some impact immediately for the behavioral health system in November, because folks that meet access to these crisis services and have a mild to moderate behavioral health condition will be looking at providers and plans and network information very soon. The enrollment broker should help walk them through this process, but as early as November, that we will start to see a shift in the behavioral health services and systems.

(Slide 20)

Julia Lerche

(Slide 21) All right. In terms of key takeaways, again, as we mentioned before, both the Standard Plans and the Tailored Plans will be integrated managed care products that will provide

physical health, behavioral health, long-term services and supports, and pharmacy benefits. As Kathy mentioned and just went through, the Tailored Plans will cover some additional services that are not, will not be available through the Standard Plans. The Department will conduct regular reviews of available data and identify beneficiaries who are eligible for the Behavioral Health and I/DD Tailored Plans. For those that are not identified through that data process, there will be a process whereby beneficiaries with the support of their providers can submit a request to review their eligibility for Tailored Plans. Beneficiaries may be identified as eligible for Behavioral Health I/DD Tailored Plans either before or after Standard Plan launch will continue to look for beneficiaries that meet the criteria for the data review process and the request process will continue. Prior to Standard Plan launch, beneficiaries who are identified as meeting the Tailored Plan's criteria will remain in the current system, which is generally fee-for-service LME-MCO's covering behavioral health, until the launch of Tailored Plans. After Standard Plan launch, we will continue to review the available data for folks that meet the Tailored Plan eligibility, and they will either be automatically moved or they will have the choice to move, depending on their circumstances, as we reviewed in an earlier slide. And then, finally, we will establish processes to ensure that beneficiaries who are enrolled in the Standard Plan who meet the Tailored Plan criteria can transition as quickly and smoothly as possible to the Tailored Plan or the Plan system.

(Slide 22) I'm going to pass this off to Janie Shivar, who's going to finish this off before questions.

Janie Shivar

Julia, thank you. And thanks to Kathy, as well. At this time, we're going to be taking a few questions from all of you. You can see in the final slide that's on your screen, it directs you to our Medicaid transformation website. This presentation as well as past presentations are posted there. This presentation will be posted in a couple of weeks. Also, you can see the e-mail address for directing any questions that you may have, Medicaid.Transformation@dhhs.nc.gov. So, at this time, Debra Farrington will read some of the questions that you all have sent in via the chat feature today.

Debra Farrington

Thank you, Janie. So the first set of questions I have are for Dave. The first question is, "Will the transition to managed care still remain on schedule for November 1st for the first phase?

David Richard

We are – Friday, November 1st, and nothing has changed in our commitment to that date for the first day as the managed care.

Debra Farrington

And folks also want to know whether the enrollment broker is a part of North Carolina DHHS or separate.

David Richard

They are a contractor for North Carolina DHHS. It's looking up a little bit. They're a contractor to North Carolina DHHS, so they report directly to the Department in terms of their responsibilities as an enrollment broker.

Debra Farrington

Thank you. The next set of questions we have are for Deb. We have a few questions about the Innovations wait list. Will those who are currently on a registry of unmet needs, for instance, the Innovations waiver, be served in the Tailored Plan immediately, or is there anticipated that a wait list will remain?

Deb Goda

That's a two-part question. For folks who are on the Innovations wait list, the fee waiver will continue to have a waiting list, and, until we have additional slots available. But the individual will be Tailored Plan eligible and will receive their other physical and medical care through the Tailored Plan. They do have the option of moving to the Standard Plan while they are on the waiting list, but if they receive an Innovations waiver or TBI waiver slot, then they will be required to transition to the Tailored Plan at that time.

Debra Farrington

And so, in terms of the second part of that question, will we still have a waiting list? A registration –

Deb Goda

Yes.

Debra Farrington

The next question is whether individuals who are on CAP/C and CAP/DA remain in fee-for-service, or will they be in managed care?

Deb Goda

Those individuals at this point in time who are in CAP/C and CAP/DA will remain in fee-for-service.

Debra Farrington

Thank you, Deb. The next question asks, if an Innovations recipient chooses to opt out of Tailored Plan, will they be informed that they will lose their Innovations service?

Deb Goda

Yes. They will be informed that they will lose their Innovations waiver services, and I believe they would have to – we would ask them to withdraw from the Innovations waiver in writing as they moved.

Julia Lerche

Yeah, this is Julia. The enrollment broker – as Deb said – a beneficiary will have to dis-enroll from the waiver before they can move to a Standard Plan. So, it will be challenging for them to move to a Standard Plan until they dis-enroll from the waiver.

Debra Farrington

Thank you. If a person on the Innovations wait list decides to use Standard Plan benefits while waiting, will they lose their place on the wait list?

Julia Lerche

No. Once you are on the waiting list, you are on the waiting list for the waiver until you withdraw your name.

Debra Farrington

This next question is, Will existing authorizations for patients transition with the patient when the switch occurs? So, when managed care goes live, will authorizations follow the patient?

Julia Lerche

There is a requirement in the managed care contract or around transitions of care that include that managed care companies having to honor authorizations – I don't remember if it's 60 or 90 days – we are working on the transition of care policy paper, so be on the lookout for that. We can try to follow up.

Deb Goda

It's the authorization, and if the Standard Plan chooses to end the authorization prior to the end of the authorization expiring on its own, then due process will be afforded.

Debra Farrington

We have a set of questions for Kathy Nichols. These are about the submission process for a person who wants to change. Will all requests for Tailored Plans have to be manually submitted by a provider or a consumer?

Kathy Nichols

So, if the request is outside of the categories, as Julia had outlined earlier, the service utilization lookback, the involuntary commitment lookback, somebody that thinks that a new problem has

emerged doesn't make them eligible for a Tailored Plan or that they didn't get picked up in the data points that we were looking at, then yes, it would be a manual submission by either the provider or the – just like you can do now for a service request – you would be able, either entity would be able to start the process, and then there would be a review for the medical necessity and appropriateness of the person needing to switch plans.

Debra Farrington

Okay. This next question is, Will foster care be included in both the Standard and Tailored Plan, or just in the Tailored Plan?

Kathy Nichols

So, to go back to the slide of the Standard Plan and the Tailored Plans when you – because this will be made available – but if you look through it, all of the residential services would be to the, 1 through 4 would be enhanced services at the moment, so it would be under Tailored Plans, as it is not a crisis or emergency service would pay for health.

Debra Farrington

Okay. Thank you. Who is responsible for triggering a review of a beneficiary's plan?

Kathy Nichols

Well, I'm assuming that if the plan needs to be, if they need to change – what Julia had explained is the base setting for how we are parceling out Tailored and Standard Plans to begin with in terms of diagnoses and service lookbacks and some of the other criteria. If somebody comes to Medicaid new, they will be able to document any behavioral health concerns they might have had if they're coming from a previous state. The advanced medical home in the Standard Plan may find somebody as having emergent needs that need to be addressed to fill in and send up that clinical information. So, there are several ways where identification of an appropriate plan would take place. And there will be a rolling, ongoing submission of claims information with the points that Julia had noted as the ongoing data collection process by the State.

Debra Farrington

Thanks, Kathy. Julia, I have a set of questions for you. Under the Tailored Plan eligibility, it states, in quotes, Have use of medical service that will only be available through the Tailored Plan. Does that mean if they have ever used such a service, or is there a timeframe that will be looked at?

Julia Lerche

So for, for now, for identifying who will not enroll in a Standard Plan, we're looking at services going back to January 1st of 2018. If they used a Tailor – if a beneficiary utilized a Tailored Plan only service in the middle of 2017, that would not get picked up, but if they've used one since January 1 of 2018, they would be identified as Tailored Plan eligible.

Debra Farrington

Thanks, Julia. Do those youths that will qualify for a Standard Plan have to have a provider or a consumer submit a request?

Julia Lerche

So, if they, if they want to request a review for Tailored Plan eligibility, they will need to work with a provider – the beneficiary will need to sign that they want to be reviewed, and that they understand that they'll be moved, if their review is approved. There will be some documentation that's required as part of that process. So if anyone else wants to add anything in the room here?

Deb Goda

That's concise. Good job.

Julia Lerche

Thanks.

Debra Farrington

This question reads, There isn't a way to grandfather the youth into the Tailored Plan based off of the services they received during the lookback period?

Julia Lerche

So, if they meet a criteria, and they're flagged based on a review of claims from the lookback period, they will be identified as Tailor Plan eligible.

Debra Farrington

Okay. How would someone move from a Tailored Plan to a Standard Plan?

Julia Lerche

So, unless the person is enrolled in an Innovations or TBI waiver, that we had said earlier, if they're in one of those waivers, they would need to dis-enroll from the waiver before they move. Otherwise, beneficiaries will have the option to move to a Standard Plan, and they can do that by contacting the enrollment broker. So, they will receive notices upon launch of Standard Plans and when they're enrolled in the Standard Plans, or the Tailored Plans, of their other options and how they can change.

Debra Farrington

Thanks, Julia. This is also a quote from the slide deck. What are those Medicaid services that are only available in the Tailored Plan? You have reference to a slide.

Kathy Nichols

Sure. The Medicaid-only services that are only going to be eligible in the Standard Plans are the – I'm sorry, thank you, the Tailored Plans – are the Enhanced Services under Policy 8A, so Community Support Team and hints of in-home, multi-systemic therapy, psychosocial rehab. What am I missing? I'm looking at Dr. McCoy. Everything under the Innovations and any, any waiver service would be under Tailored Plans only.

(Slide 19) The child residential services, including psychiatric residential treatment facilities. And then any of your long-term substance abuse services. So, the residential substance abuse services for longer periods of time. I said, yeah, the waiver of services, and then, yes, the, the, a finalized list of (b)(3)s, and in lieu of services, would be in, and all State-Funded services, after Medicaid. But all State funded services will be in Tailored plans.

Debra Farrington

Thank you, Kathy. We have a couple questions about younger children, for the zero to three population. Where does that population go if he or she does not meet the CDSA criteria? Will they be served in a Standard Plan?

Kathy Nichols

I think that's a great question for Dr. McCoy.

Keith McCoy

So, we have two different time periods. We have the time period when Standard Plans have launched, and then when the Tailored Plans will also launch. So, if that zero to three population is determined to be one that would be appropriate for a Tailored Plan, and we've determined that based on a list of diagnoses, then they would stay in the fee-for-service world, and anything that they need behavioral health would also stay fee-for-service, because the LME-MCO's do not currently serve the zero to three population. After Tailored Plans launch, they would – those who have, meet those diagnostic criteria would be served in the Tailored Plan. Otherwise, they would get their needs met starting in November and forward through the Standard Plan process, if they have the type of Medicaid – if they're not in an excluded or an advanced population.

Debra Farrington

Okay. Dr. McCoy, while you're at it, we have another question. For individuals who are Tailor Plan eligible, will they be covered on the Standard Plan for physical health needs before 2021?

Keith McCoy

No, they will not. They will remain fee-for-service for their physical health needs, and then once Tailored Plans launch, the Tailored Plan will be responsible as their integrated insurance plan, their integrated health plan. The one caveat for that, as we said, are for those individuals who are dual-eligible Medicaid/Medicare. The physical health benefit is not part of what the Tailored Plan will manage.

Debra Farrington

Okay. And we did get a follow-up question, about the zero to three population. Can you just clarify again where that population will be served? If they are at risk, but not meet the CDSA criteria?

Keith McCoy

So, the CD – we don't have a specific CDSA criteria. I think that may be referenced from an older policy paper. So now we have a diagnostic list that we have that's in the current eligibility and enrollment paper that we would go off of, as that process. There is the ability to, you know, sort of do the raise your hand as we talk about it. If you feel like that there's a need that's appropriate to be served in another setting, you can certainly let the State know that. Yeah, and CDSA services are carved out of Medicaid transformations. So those are going to be eligible to individuals who qualify for them no matter what.

Debra Farrington

Okay. This question is, Do basic substance abuse services fall under the Standard Plan or the Tailored Plan?

Keith McCoy

They would be in both.

Unidentified Female

If by basic, you mean outpatient and detox.

Keith McCoy

Yeah, a lot of people's basic services would be for a typical outpatient, community-based, you know, services that occur in an office setting. And both Tailored Plans and Standard Plans would have those services available to their beneficiaries.

Unidentified Female

Okay. Excellent.

Debra Farrington

We have a question about self-direction. And this question is, Will anything change for families who are self-directing services using the employer of record?

Kathy Nichols

The Innovations waiver will – the only thing that is changing about the Innovations waiver in this process is that when Tailored Plans go live, the authority will move from the fee waiver to

the 1115 waiver. For the other services, the fee waiver is going to remain the same, so I do not anticipate any changes in employer of record as an option.

Debra Farrington

Julia, we have a few more questions for you. So, consumers who qualify for the Tailored Plan will use the current fee-for-service plan, or have the opportunity to enroll in the Standard Plan. If they do not choose the Standard Plan, will they stay fee-for-service, until the launch of Tailored Plans?

Julia Lerche

Yes.

Debra Farrington

Thank you. When a person transfers between a plan, is the DHHS position final, or does the person have any appeals?

Julia Lerche

It's an action, so there will be an appeal process.

Debra Farrington

This person asks, Why is DHHS reviewing the beneficiaries' eligibility for continued enrollment, as opposed to the Tailored Plan facilitating that review?

Julia Lerche

This is Julia, again. The reason that the Department will be doing reviews is because the plans themselves have, have financial and other interests in terms of who they cover and do not cover. And that the department would like to be consistent with all of the populations. If we gave that to the plans, there may be lack of consistency in those situations.

Dave Richard

And is there, there – I think this is the case where it's important that the Department do this work because of one, the sensitivity that we have on where people are in terms of the plans being an appropriate plan, and also the assurance of making sure that we are providing the appropriate rates for those health plans based upon the people that are enrolled in them.

Debra Farrington

Thanks. We have a couple questions about provider notifications as it relates to individuals being enrolled in different plans. And this question is, Will providers be notified when their participants are placed in a different plan?

Dave Richard

We're having a lot of looks around the room, because I think we are at one trying to remember how that process will work and also making sure that we have, that we have that in place. I think it's a great question that we need to come back to that appealed about. Unless someone else has a –

Julia Lerche

There will be a portal, so providers can go into the portal like they do today to see where beneficiaries are covered. I can't answer the question about whether there will be any direct notification if someone changes. The information will be available.

Debra Farrington

We have another provider question. And this one is, whether providers are currently able to contract with Standard Plans for behavioral health services.

Julia Lerche

Yes, they should. We encourage providers to contract with Standard Plans.

Debra Farrington

And a follow-up question to that is, How will current behavioral health outpatient providers either be approved or disapproved to enroll with Standard Plans?

Unidentified Female

The legislation around managed care does require the managed care plan to accept any willing provider that will accept the applicable rate and that doesn't have any issues around quality. So, the onus is on the plan to come up with a reason why they shouldn't. But if a provider approaches a plan, the plan should be – must contract with that provider unless there are extenuating circumstances.

Debra Farrington

Okay. How will providers who are not the primary care provider but who provide Standard Plan services be reimbursed?

Julia Lerche

So, there are a number of requirements laid out in the contract with the managed care entities. There are some provider types, such as physicians and physician extenders, as well as hospitals, and I'm not going to remember the whole list but, nursing facilities, pharmacies who are dispensing fees where there are prescribed rate floors so the health plans cannot pay less than what will be in the fee-for-service fee schedule for those provider types unless the provider and the plan mutually agree to an alternative arrangement. There are also special reimbursement

arrangements with SUICs and local health departments, public ambulance providers, and other provider types, where it's not specified in the contract, providers will need to negotiate reimbursement with the health plan.

Debra Farrington

Thank you. One follow-up question to the portal question, Julia. Can a provider tell in the portal which PHC a patient's assigned to, and who the PCT is?

Julia Lerche

Yes. Yes, that information will be available in the provider portal.

Debra Farrington

And there's a question about whether the fee schedule is for Standard Plans. And I think that's a matter of where we publish our fee schedule now.

Julia Lerche

So, we do have fee schedules that are published on our website. I don't have the exact site. I don't know if anyone in the room does. We can follow up with that information.

Debra Farrington

Okay. Well, we're almost out of time, and so I would just like to turn it over to Kody, so that he can have some final words as we wrap up.

Kody Kinsley

Good afternoon, everyone. This is Kody Kinsley, the Deputy Secretary for Behavioral Health and I/DD. I just want to thank everyone for your continued participation on these calls. I hope it's been incredibly clear that the Department is really focused on ensuring that we have robust, thoughtful, and open dialogue across our state as we go through this transformative process, and I hope that you'll continue to send us your input and your thoughts along the way and look for future policy papers and Webinars that are coming out very often. So, again, thank you all so much. I know that we're all committed to making this as smooth and seamless of a transition as possible and that we keep in our minds that those that we serve are those that need to be taken care of the most here. So thank you all again, and I hope you have a great day.

End of Webinar