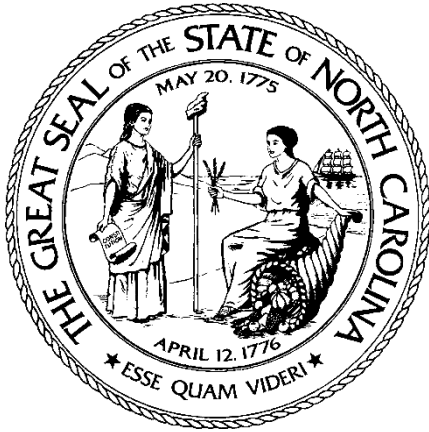


Overview of Behavioral Health I/DD Tailored Plan RFA Pre-Release Policy Paper

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Overview of Behavioral Health I/DD Tailored Plan RFA Pre-Release Policy Paper

February 10, 2020

Agenda

- **RFA Process and Timeline**
- **RFA Pre-Release Paper Content Areas**
 - **Administration**
 - **Quality**
 - **Select Programmatic Features**
 - **Provider Participation/Contracting**
 - **Financial Management & Monitoring**
- **Next Steps**
- **Q&A**

Background

Overview of NC's Medicaid Managed Care Transition

Under Medicaid Managed Care, Standard Plans and Behavioral Health I/DD Tailored Plans will provide a robust set of physical health, behavioral health, long-term services and supports, and pharmacy benefits to Medicaid and NC Health Choice beneficiaries.

Standard Plans

- Will serve the majority of Medicaid beneficiaries, including those with mild to moderate behavioral conditions —including mental health and substance use disorders

Behavioral Health I/DD Tailored Plans

- Will serve populations with more serious behavioral health conditions, I/DD, and TBI
- Will offer additional behavioral health and I/DD services, including
 - State-funded behavioral health, I/DD, and TBI services
 - 1915(c) Innovations and TBI services
 - Additional high-intensity Medicaid behavioral health services

For now, North Carolina's move to Medicaid Managed Care has been suspended but planning for the launch of Behavioral Health I/DD Tailored Plans is continuing. Until the new plans go live, individuals who currently access behavioral health, I/DD, and TBI services through LME/MCOs will continue to access those services as they do today.*

Tentative RFA Release & Contract Award Timeline

The Department is preparing to issue the Behavioral Health I/DD Tailored Plan Request for Applications (RFA) to seek LME/MCOs to serve as Behavioral Health I/DD Tailored Plans and support the goals of Medicaid managed care.

2020

2021

Spring:
Behavioral Health I/DD Tailored Plan RFA Released

Summer:
Offerors submit responses

Late Fall:
Department awards Behavioral Health I/DD Tailored Plan contracts

Summer:
Behavioral Health I/DD Tailored Plans Launch

A more detailed schedule of events will be outlined in the RFA

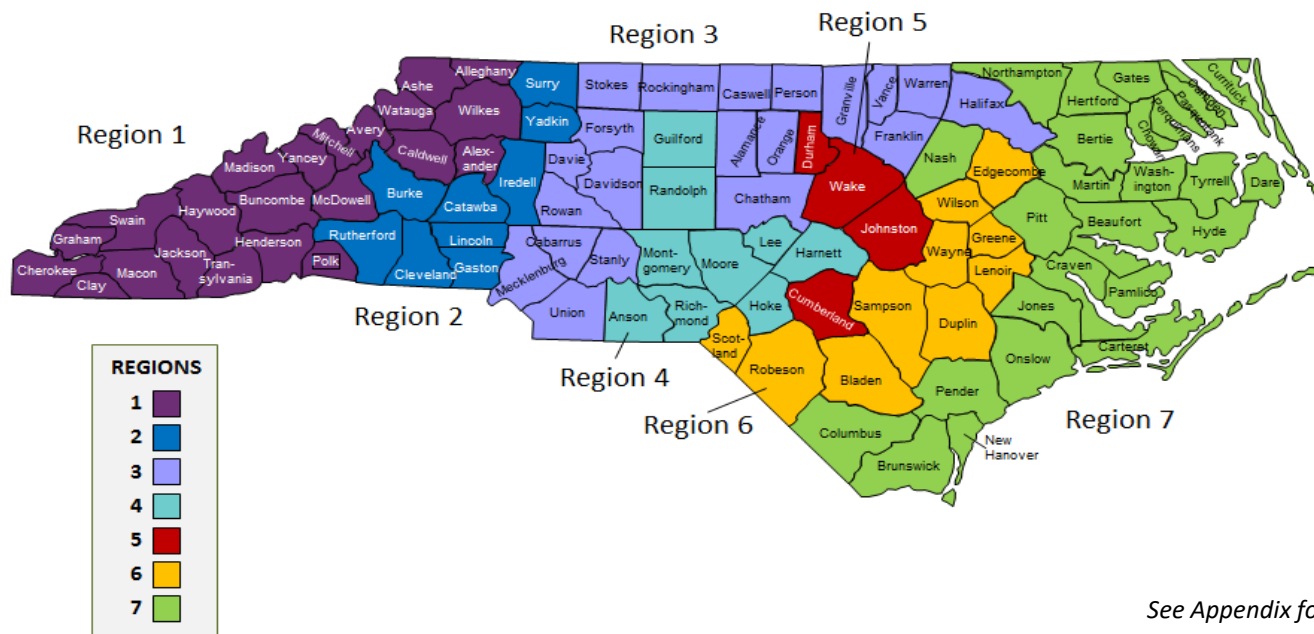
Overview of the Behavioral Health I/DD Tailored Plan Procurement Process

- The Department will establish criteria for a comprehensive and thorough application process to award Behavioral Health I/DD Tailored Plan contracts.
- The RFA will include requirements for both Medicaid and State-funded Services that Behavioral Health I/DD Tailored Plans must meet.
- The RFA will include evaluation questions that Offerors must complete and submit to the State to be considered for a Behavioral Health I/DD Tailored Plan contract award.
- Evaluation of applications will be based primarily on the Offerors' qualifications and ability to meet the expectations and requirements of both Medicaid managed care and State-funded Services operations, as outlined in the RFA.
- Offerors will not submit price bids as part of their RFA responses; the Department will set actuarially sound capitation rates which plans must accept if awarded a contract.

Behavioral Health I/DD Tailored Regions

The Department will award a regional contract in each of seven Regions

- The Department has defined seven Behavioral Health I/DD Tailored Plan Regions within North Carolina, which are consistent with the current LME/MCO catchment areas.
- Regions were defined through a facilitated process led by the North Carolina Association of County Commissioners (NCACC), which coordinated with its county representatives and consulted with LME/MCOs
- Offerors may only apply for the Region(s) in which they are currently operating as an LME-MCO



See Appendix for list of counties by Region

Empty Regions Process

The Department will use an optional, supplemental questions request to award an “empty” Region if no contract is awarded to the entity currently serving that Region.

Offerors that would like to be considered for an expanded service area in an empty Region will be asked to respond to additional questions in this supplemental questions request.

Supplemental questions will assess an Offeror’s:

- Experience in and approach to developing provider networks and managing community health functions in Regions in which they currently do not operate; and
- Administrative and operational capacity to manage an expanded service area.

The Department also will assess projected enrollment in empty Regions; the Department retains the right to divide a Region and award each sub-region to two or more qualified Offerors if an award of an empty Region would result in a substantial number of new enrollees being added to any one Offeror.

Behavioral Health I/DD Tailored Plan Administration

Behavioral Health I/DD Tailored Plan Administration

In concert with 122C, Session Law 2015-245, and Session Law 2018-48, the Department has outlined provisions regarding the administration and management of Behavioral Health I/DD Tailored Plans.

Entity Status

- Behavioral Health I/DD Tailored Plans must be operated by only LME/MCOs for the first contract period of four years. As such, only LME/MCOs can apply to be Behavioral Health I/DD Tailored Plans under the initial RFA.
- LME/MCOs can initiate mergers through currently accepted processes requiring Department approval.

Entity Governance

- Tailored Plans will be subject to the same governance requirements that currently apply to LME/MCOs, as outlined in N.C. Gen. Stat. § 122C, which include a single governing board and other advisory boards, as follows:
 - Governing Board:** Comprised of 11-21 voting members, representing consumers and families and clinical, financial, and insurance industry experts
 - Consumer and Family Advisory Committee (CFAC):** Must include all local CFAC committees within the Plan's Region
 - Other Advisory Boards:** A non-binding, advisory-only board of county commissioners
- Plans must comply with all applicable provisions of N.C. Gen. Stat. § 122C, Article 4 regarding the composition, meeting schedule, training, compensation, and maintenance of each of these governing and advisory boards.

Entity Licensure

- LME/MCOs are currently exempt from PHP licensing set forth by the NC Department of Insurance
- Behavioral Health I/DD Tailored Plans will not be required to have a PHP license as a condition of initial contract award, but must become licensed as a PHP at least 90 days before the end of their third contract year.*

* Contingent upon legislative authority authorizing this conversion.

Behavioral Health I/DD Tailored Plan Subcontracting

Offerors bidding to become a Behavioral Health I/DD Tailored Plan may form strategic partnerships with subcontracting entities.

Required Contracting with PHPs

- LME/MCOs operating as Behavioral Health I/DD Tailored Plans must subcontract with a Prepaid Health Plan (PHP) “that covers the services required to be covered under a Standard Benefit Plan contract.”
- The Department does not require plans that meet these statutory requirements to hold a Standard Plan contract or a license in the same region as the Behavioral Health I/DD Tailored Plan.
- The Department must review and approve contracts between Behavioral Health I/DD Tailored Plans and PHPs.

Oversight and Monitoring of Subcontracts

- The Behavioral Health I/DD Tailored Plan must ensure oversight and monitoring of subcontractors.
- The Behavioral Health I/DD Tailored Plan must provide the Department with copies of executed contracts with any subcontractors.

Guidelines on Subcontracting Relationships

- The RFA outlines parameters governing the contractual relationship between Behavioral Health I/DD Tailored Plans and their subcontractors. These parameters focus on promoting:
 - Financial and operational integration across all service types;
 - A unified member experience; and
 - A unified provider experience.

Quality

Quality

The Department seeks to improve outcomes for enrollees by focusing on rigorous and innovative outcomes measurement, promoting equity through reduction or elimination of health disparities, and rewarding Behavioral Health I/DD Tailored Plans and, providers, for advancing quality goals.

Behavioral Health I/DD Tailored Plans must:

- Meet all standards relevant to the Standard Plans, as well as meet additional standards related to unique aspects of their population;
- Develop Quality Management and Improvement Programs, Quality Assessment and Performance Improvement Plans, and at least three Performance Improvement Projects
- Achieve NCQA Health Plan Accreditation with LTSS Distinction for Health Plans by the end of Contract Year 3; and
- Report a wide range of quality metrics, including outcome metrics, with variations depending on whether the enrollee is receiving Medicaid or State-funded Services.*

The Department intends to measure outcomes beyond HEDIS (e.g., AHRQ).

The Department will report Plans' performance on measures, and in Contract Year 2, implement a withhold program for a small subset of priority measures to reflect Medicaid performance.

*The measure set may change based on modifications to the underlying measure sets (e.g., HEDIS) or changes in state policy priorities

Select Programmatic Features

In-Reach & Transition

Behavioral Health I/DD Tailored Plans must identify members who are receiving care in an institutional setting and help transition them to the community, if their needs can be met safely in the community

Eligible populations for in-reach and transition services include:

- Members with SMI residing in an adult care home (ACH) or state psychiatric hospital; and
- Members residing in an ICF-IID or state developmental center.

Required in-reach activities include:

- Ensuring members' know about available community-based options;
- Identifying and addressing barriers to transition;
- Addressing concerns of members/their family who decline or are ambivalent about transitioning;
- Providing opportunities to meet with peers who are living, working, and receiving services in integrated settings; and
- Supporting facility staff to ensure smooth transitions.

Required transition activities include:

- Assisting members prior to discharge;
- Identifying training needed by receiving providers/agency;
- Addressing barriers to transition (e.g., network adequacy; transportation)
- Addressing potential funding options and needs (e.g., spend down)

For adults, these functions will be completed by Plan-based staff; the Department will release further guidance on how this will work for children.

In-Reach & Transition for Children & Youth in BH Settings

Behavioral Health I/DD Tailored Plans also must conduct in-reach and transition for children and youth members in state psychiatric hospitals, psychiatric residential treatment facilities (PRTFs) and certain residential treatment levels

In-reach and transition protocols for children and youth include:

- Identification and engagement for transition services;
- Collaboration with facilities, community providers, and other youth-specific entities or systems;
- Development of individualized, person-centered transition plans;
- Identification and addressing transition barriers; and
- Warm handoffs and linkages to community providers and care managers, where appropriate.

Children and youth members residing in state developmental centers or other ICF-IIDs will receive in-reach and transition services as described on prior slide.

Diversion

Behavioral Health I/DD Tailored Plans must identify members at risk of institutional care and help them remain in their community.

- Behavioral Health I/DD Tailored Plans must provide diversion services to all members who have transitioned from an institutional or correctional setting within the previous six months or are seeking entry into an institutional setting.
- Other members (e.g., members with an I/DD or TBI with an aging caregiver and children/youth with I/DD and complex behavioral health needs) are also eligible for diversion services.
- Diversion activities are the responsibility of the assigned organization providing Tailored Care Management (i.e., the Behavioral Health I/DD Tailored Plan, AMH+ practice, or care management agency (CMA)); the Behavioral Health I/DD Tailored Plan must provide diversion activities to members not already engaged in Tailored Care Management.

Care Management for Innovations & TBI Waiver Populations

The Department has designed the Tailored Care Management model to meet the unique needs of the Innovations and TBI waiver populations and ensure that members enrolled in the Innovations or TBI waiver have the same access to whole-person care management as all other members.

For the Innovations and TBI waiver populations, Tailored Care Management will:

- Provide waiver care coordination services as are required under the Innovations or TBI waiver today;
- Coordinate across physical health, behavioral health, LTSS, pharmacy, I/DD, and TBI-related services;
- Provide transitional care management; and
- Address members' unmet health-related resource needs.

Behavioral Health I/DD Tailored Plans must auto-enroll these waiver populations in Tailored Care Management at launch and give them the option of obtaining Tailored Care Management through an AMH+ practice, CMA, or the Behavioral Health I/DD Tailored Plan.

Behavioral Health I/DD Tailored Plans must institute processes to minimize disruption for members with the transition to Tailored Care Management.

Waiver members may keep their previous care coordinator as the care manager for Tailored Care Management, if that care coordinator meets certain qualifications

These members may opt out of Tailored Care Management in which case they will receive care coordination services under the waiver. Tailored Care Management and care coordination for the waiver populations must comply with federal conflict-free rules.

Stakeholder Engagement

Community engagement is a core component of the delivery and administration of Medicaid and State-funded Services.

Behavioral Health I/DD Tailored Plans must:

- Engage with county agencies and community based organizations (CBOs) to help guide and support the delivery of services to Medicaid members and families in their regions;
- Develop and implement a Local Community Collaboration and Engagement Strategy that supports continued engagement with county agencies, CFACs, and CBOs and build partnerships at the local level to improve the health of their members;
- Collaborate with other Department partners (e.g., Department of Instruction, the Division of Vocational Rehabilitation Services) to ensure that members' unique needs are met; and
- Collaborate with the North Carolina Housing Financing Agency, the Department and with other public agencies to support the expansion of supported housing opportunities available to members with mental illness, I/DD, TBI and/or SUDs.

Provider Participation/Contracting

Provider Networks

- In accordance Statute, Behavioral Health I/DD Tailored Plans must include any willing provider in their physical health networks; they will maintain closed networks for behavioral health, I/DD, and TBI providers but must include all essential providers in their regions unless an alternative arrangement has been approved by the Department.
- Plans must meet network adequacy standards for physical health, behavioral health, I/DD, and TBI services, including standards for time, distance, and appointment wait times as well as accessibility and cultural competency provisions
- Behavioral Health I/DD Tailored Plans will also be required to provide and protect access to out-of-network providers for their members as required under federal law.

Network Oversight

- Plans must submit a network access plan (after contract award and annually thereafter) that describes their approach to meeting network adequacy standards and demonstrates compliance with network adequacy requirements
- The Department is committed to promoting access to high-priority evidence-based interventions and providers that can best meet the needs of members; priority areas include access to Electroconvulsive therapy (ECT) for indicated conditions and Clozapine utilization for the treatment of chronic psychotic disorders, among other areas.
- As part of the network access plan, Behavioral Health I/DD Tailored Plans will be required to develop and effectuate strategies for developing access and capacity; Tailored Plans will be reviewed on these strategies prior to go-live and must report on their progress at least annually.

Provider Payment

Behavioral Health I/DD Tailored Plans will be subject to requirements for provider payments consistent with Standard Plan practices, including:

- Rate floors for in-network physicians, physician extenders, pharmacies (dispensing fees), hospitals and nursing facilities;
- Additional payments based on utilization of specific services; and
- PMPM payments for Tailored Care Management and medical home fees for Advanced Medical Homes.

Out-of-Network Providers

- **Physical Health:** The plan will be required to reimburse at no more than 90% of the NC Medicaid Direct rate for physical health services provided by an OON provider that refused a contract after the Behavioral Health I/DD Tailored Plan made a good faith effort to contract or was excluded for failure to meet objective quality standards. If the Tailored Plan has not made a good faith effort to contract with a OON provider, OON provider will be reimbursed at 100% of the NC Medicaid Direct rate.
- **Behavioral Health:** The plan will reimburse at 100% of the NC Medicaid Direct rate for behavioral health services provided by OON providers
- **Emergency/Post Stabilization:** The plan will reimburse up to 100% of the NC Medicaid Direct rate for emergent or post-stabilization services provided by OON providers
- **Transitions of Care:** The plan will reimburse at 100% of the NC Medicaid Direct rate for services delivered by OON providers delivered during transitions of care

Financial Management & Monitoring

Financial Management and Monitoring

The Department developed financial management requirements to monitor and promote program integrity and sustainability. The Department expects the Behavioral Health I/DD Tailored Plan to be a responsible steward of federal, state and local resources.

Capitation Rate Setting for Medicaid

- The Department will set capitation rates for Behavioral Health I/DD Tailored Plans that include monthly PMPM payments, maternity event payments, and payments for additional directed payments to certain providers as required.
- Plans also will receive and be responsible for making separate care management payments.
- The capitation rate-setting methodology aligns with the capitation rate-setting process for Standard Plans and will be detailed in the draft Rate Book.
- The Department is considering including a time-limited risk mitigation provision in the Behavioral Health I/DD Tailored Plan contract.

Medical Loss Ratio

- The Medical Loss Ratio (MLR) standard is set to a minimum of 88% for health care services as defined in statute.
- If a Plan's MLR is less than the minimum MLR threshold, the Plan must either (1) remit a rebate to the Department; (2) contribute to health-related resources targeted towards high-impact initiatives, or (3) a combination of the two.

Financial Management and Monitoring, cont.

Solvency

- Plans must have and maintain adequate financial resources to guard against the risk of insolvency.
- The Department has identified a set of financial viability standards for Tailored Plans to help ensure solvency including:
 - Fully fund risk reserves at 12.5% of total expected annual Medicaid capitation by Day 1 of launch
 - Purchase reinsurance to protect against the financial risk of high-cost individuals or propose an alternative mechanism for managing financial risk
 - Meet solvency standards for PHPs set forth by the DOI before the end of Contract Year 3
 - Maintain ratios of assets to liabilities in line with industry standards and consistent with the current LME-MCO contract and SP contract

Withholds

- The Department will utilize a premium withhold program to incentivize Tailored Plan performance in a range of possible areas including, but not limited to:
 - Quality improvement;
 - Value-based payments;
 - Care management;
 - Healthy Opportunities; and
 - Operational effectiveness

Financial Management and Monitoring, cont.

Managing Program Costs

- Risk-adjusted cost growth must be at least two percentage (2%) points below national Medicaid spending growth
- Plans must use the same drug formulary, as established by the Department, and ensure the State realizes a net savings for the spending on prescription drugs
- The Department will monitor the annual cost growth of Plan expenditures by Region and population and will review cost growth reports provided by Behavioral Health I/DD Plans

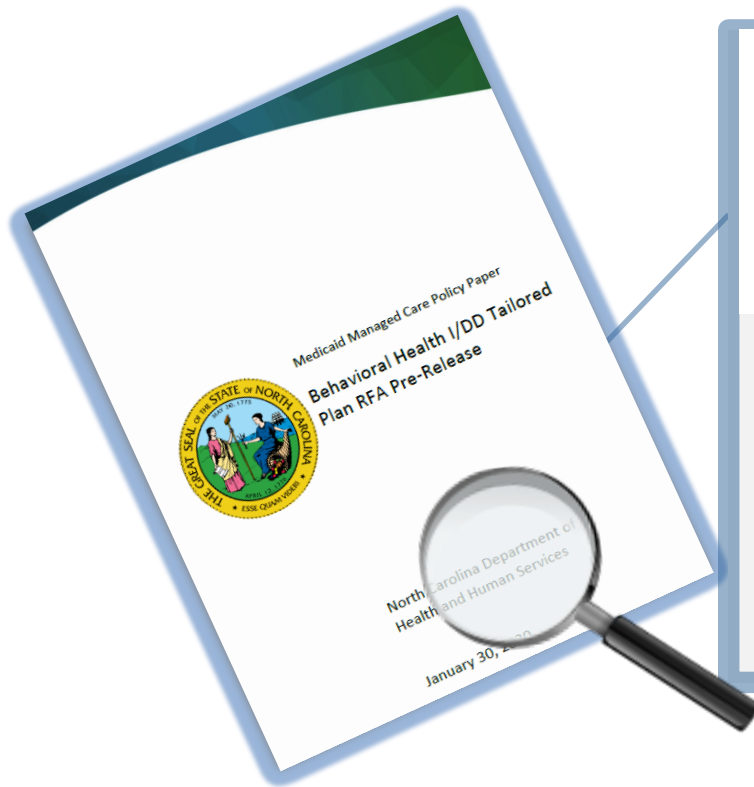
Value-Based Payment (VBP)

- VBP models ensure that provider payments incentivize population health, appropriateness of care, improved quality and outcomes, and other measures of value
- The Department will develop a menu of state-approved VBP model options to assist Behavioral Health I/DD Tailored Plans and providers in identifying and entering into innovative arrangements that fit this unique landscape and go beyond the Tailored Care Management model
- The Department will require Behavioral Health I/DD Tailored Plans to report on their VBP strategies and progress, which will be compared to Department-defined VBP targets starting in Contract Year 2.
- Tailored Plans and providers will have the flexibility to propose alternative models for approval.
- The Department will build VBP into the payment model for Tailored Care Management.

Next Steps

Submit Comments on RFA Pre-Release Policy Paper

The Department is accepting comments on the policy paper until February 14th.



The paper is available at <https://files.nc.gov/ncdhhs/TP-RFA-Pre-Release-Policy-Paper-Final-01.30.2020.pdf>.

Comments should be submitted to Medicaid.Transformation@dhhs.nc.gov

Reminder: Other Opportunities to Engage

DHHS values input and feedback from stakeholders and will make sure stakeholders have the opportunity to connect through a number of venues and activities.

Ways to Participate

- Regular webinars, conference calls, meetings, and conferences
- Comments on periodic white papers, FAQs, and other publications
- Regular updates to website:
<https://www.ncdhhs.gov/assistance/medicaid-transformation>



DHHS Engages

- Consumers, Families, Caregivers, and Consumer Representatives
- Providers
- Health Plans and LME-MCOs
- Counties
- General Public

Comments? Questions? Let's hear from you!

Comments, questions, and feedback are all very welcome at
Medicaid.Transformation@dhhs.nc.gov

Questions?

Appendix

List of Counties by Region

Table 1: List of Counties by Behavioral Health I/DD Tailored Plan Region

Behavioral Health I/DD Tailored Plan Regions	Counties
Region 1	Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Swain, Transylvania, Watauga, Wilkes, Yancey
Region 2	Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Rutherford, Surry, Yadkin
Region 3	Alamance, Cabarrus, Caswell, Chatham, Davidson, Davie, Forsyth, Franklin, Granville, Halifax, Mecklenburg, Orange, Rockingham, Person, Rowan, Stanly, Stokes, Union, Vance, Warren
Region 4	Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond
Region 5	Cumberland, Durham, Johnston, Wake
Region 6	Bladen, Duplin, Edgecombe, Greene, Lenoir, Robeson, Sampson, Scotland, Wayne, Wilson
Region 7	Brunswick, Carteret, Columbus, Nash, New Hanover, Onslow, Pender, Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington