

DHHS Webinar Transcript:
State-funded Services Design Under BH I/DD Tailored Plans
January 24, 2020

Janie Shivar

Welcome everyone to our most recent webinar for Tailored Plans in Medicaid Transformation. We really appreciate everyone making time today to join us for this important presentation. We — as Tim indicated, this webinar is being recorded. It will be posted to the Department Medicaid Transformation website with other previous webinars within ten to twelve business days after the webinar is completed today. We do have a great team of panelists here today to answer questions. And you are able to submit your questions through the chat box only. We do have all of your lines muted. Our panelists today include LaToya Chancey, the I/DD team lead at DMH/DD/SAS. Kelsi Knick, Senior Policy Advisor at North Carolina Medicaid. Dr. Keith McCoy, Senior Policy Advisor in the Chief Medical Office for DMH/DD/SAS and DSOHF, as well as Stacey Smith, our AMH team lead here at DMH/DD/SAS. With that, I'm going to turn it over to our Deputy Secretary of Behavioral Health, Kody Kinsley, who is with us today, and he will provide some opening remarks, and then introduce our speaker for the main presentation.

Kody Kinsley

Thanks so much Janie, and thank you to everyone on the line who has joined us today for this important webinar. As Janie indicated, this webinar is part of our stakeholder engagement efforts centered around Tailored Plan design. While we recognize webinars are not ideal for every stakeholder, it does allow us an opportunity to share information, receive feedback, and field questions. And we want to thank you for your participation. Work on the tailor plans continue, and despite Medicaid Transformation being suspended, which is of course prompted due to the budget impasse, we are continuing our work. I wanna reiterate that point, that Medicaid Transformation is not a matter of if, but when we will be implementing Medicaid managed care. But we need the resources to do that. And so, we thank all of you for continuing your engagement, and staying focused on being ready, so that we can manage change effectively for all of North Carolina and provide this important transformation. The Department will move forward when we have the right budget necessary to do this implementation. This webinar is an example of how our work continues. And the focus today is State-funded Services. As many of you know, State-funded Services are the safety net services that provide the base minimum of services for individuals with mental health, IDD, TBI, substance use disorder, and other indications of needs. We recognize that the dollars in this fund are not the necessary resources that we need of the department to provide services for the

million individuals in North Carolina without insurance. But it is our best effort to try to provide those services. And today's webinar is focused on an array of efforts to prioritize those resources and to make good use of them, in aligning them with best practices.

So today some of the topics that we'll cover will be looking at how we intend to promote consistency and equity and access of state-funded services. And make sure we're prioritizing those to those with the greatest needs. Recognizing that we have limited resources available. How we're focusing the state-funded services on effective treatments that are proven or evidence-based, and consistent with the Department's priorities. How we'll make our efforts to maximize the impact of the limited state and federal funding. How we're work to further integrate our transition to community living principles and functions. And I want to double down on that. The Transition to Community Living Initiative is not an offset project, but a transformative effort to change our entire system and is core to our work. How we're to ensure the appropriate quality and oversight of state-funded services to make sure that our dollars are being used effectively and at targeted at the people who need them.

So, with that, we hope that you are looking forward to joining us. We'll have a very good in-depth conversation today. We look forward to your questions. And it's now my privilege to turn over this conversation to Renee Rader. Renee Rader is our Acting Assistant Director for Policies and Programs at the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Renee has taken the position formerly occupied by Kathy Nichols. Kathy moved on to another role, and we wish her the best of luck. And we're very excited to have Renee in this new position. Please welcome Renee.

Renee Rader

Thank you Deputy Secretary Kinsley. Today we're gonna talk about State-funded Services Design under BH I/DD Tailored Plans. An overview of what we will discuss today are the background and guiding principles; the provision of State-funded Services; community integration, including in-reach, transition and diversion; local health functions; accountability; and what to do next.

Background and Guiding Principles: What are State-funded Services? State-funded Services refer to non-Medicaid behavioral health, Intellectual and Development Disability and Traumatic Brain Injury services provided to uninsured individuals and underinsured individuals (which would be someone who has Medicaid or other insurance, but does not have coverage for the service needed). State-funded Services are supported through a limited pool of funding authorized by the

General Assembly and a variety of federal grants. State-funded Services are not Medicaid and are not considered entitlements. Local Management Entities-Managed Care Organizations (LME-MCOs) manage state-funded, as well as Medicaid, behavioral health, I/DD and TBI services today. On December 30th, North Carolina's Department of Health and Human Services released the North Carolina's Design for State-funded Services Under Behavioral Health and Intellectual/Developmental Disability Tailored Plans Policy Paper for public comments. The paper details the Department's vision for State-funded Behavioral Health, I/DD and TBI services under Tailored Plan and covers: eligibility, services, and care management for State-funded Services; the continuation of the Transitions to Community Living Initiative principles; what we're calling "Local health functions," which are community-wide prevention and promotion activities in the context of Medicaid Transformation; and Tailored Plan accountability for all of the above. The paper is still available online, for public comments, and we will be accepting public comments until January 29th, 2020.

Both standard plans and 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. The Standard Plans will serve the majority of Medicaid beneficiaries, including those with mild to moderate behavioral conditions — including mental health and substance use disorders. The Tailored Plans will serve populations with more serious behavioral health conditions, I/DD and TBI. The Tailored Plans will offer additional behavioral health and I/DD services, including state-funded behavioral health, I/DD and TBI services - which we'll be talking about today - 1915(c) Innovations and TBI waiver services, and additional high intensity Medicaid behavioral health services. To reiterate what Deputy Secretary Kinsley said earlier, for now, North Carolina's move to Medicaid Managed Care has been suspended. Individuals will continue to access Medicaid and State-funded behavioral health, I/DD and TBI services through the LME-MCOs as they do today.

The Department used the following guiding principles to inform the design and improve the delivery of State-funded Services under Tailored Plans: (1) promote consistency in access to State-funded Services among the highest need individuals; (2) focus the service array on best or promising practices; (3) maximize impact of limited state and federal funding; (4) extend the principles of the Transitions to Community Living Initiative; and (5) ensure appropriate oversight of services.

As an aside, for those of you who are not familiar with the Transitions to Community Living Initiative or TCLI, the Department established TCLI

following a settlement agreement with the U.S. Department of Justice in 2012 to ensure that adults living with serious mental illness can choose where they would like to live, and have the support and service they need to successfully live in the community.

Moving on to the provision of State-funded Services - eligibility. Tailored Plans will be required to use standardized eligibility criteria as an initial screening of eligibility for State-funded Services. The criteria for Behavioral Health Services are that the individual is at 300% or less of the federal poverty level, which amounts to \$37,470 for one person per year, and the individual is either uninsured or they have either private insurance or Medicaid but it doesn't cover the service and there is no other clinically appropriate alternative available or they have insurance that would cover the service, but the cost sharing requirements for that makes the service unaffordable. For I/DD and TBI Services, the criteria does not include an income limit, but the individual would either be uninsured, or have insurance, such as a private insurance or Medicaid, that doesn't cover the service and another clinically appropriate alternative is not available. In all instances, eligibility for State-funded Services includes an application for Medicaid coverage. The Department will work with stakeholders on the implementation of eligibility criteria to ensure that they are as streamlined and as simplified as possible for consumers and providers.

Tailored Plans will be required to offer a standard set of State-funded Services targeted to each disability group. The Department will work with stakeholders to determine which of the services listed below will be required across all Tailored Plans and which will be optional. The Department will review and update its service definitions for current services and develop service definitions for new services. Current recipients will be able to maintain access to their current or equivalent services if they meet medical necessity.

So, State-Funded Services that will be offered for all disability groups would include: behavioral health urgent care; diagnostic assessment; facility based crisis for adults; facility based crisis for children and adults; inpatient behavioral health services including three-way bed contracts; mobile crisis management; and outpatient service. Adult mental health services will include: assertive community treatment; assertive engagement; community support team; partial hospitalization; psychosocial rehab; mental health recovery services, which incorporate current service definitions; individual placement and support; transition management service; and two new services, case management and peer supports. Child mental health services will include: intensive in-home

services; high fidelity wraparound; mental health day treatment; multi-systemic therapy; and respite. For I/DD and TBI Services, they will include: meaningful day and prevocational services, which also incorporate existing current service definitions; TBI long-term residential rehabilitation services; residential services; respite; and supported employment. Substance use disorder services are based on the American Society of Addiction Medicine (or ASAM) levels and will include: ambulatory detox services; assertive engagement; alcohol or drug abuse treatment centers, which is the ADATC its detoxification; outpatient opioid treatment; non-hospital medical detoxification; substance use residential supports; social setting detoxification; substance abuse halfway house; substance abuse comprehensive outpatient treatment; and intensive outpatient program; substance abuse medically monitored community residential treatment; and non-medical community residential treatments; and clinically managed population specific high intensity residential services. And then there'll be new services that'll include case management; peer supports; and supported employment.

Tailored Plans will be required to provide care management to certain high-needs populations obtaining State-funded Services. The Department will develop case management service definitions; define the role of Tailored Plan care management staff; and conduct oversight of the Tailored Plans. The Tailored Plans will offer care management under two different models. For recipients who have I/DD or TBI Needs, care management will be plan-based at the Tailored Plan, and will provide time-limited intervention for recipients with high needs. For those with Behavioral Health Needs, provider-based case management service definitions will be developed that incorporate evidence-based practices. This will be time-limited for high needs individuals. And the Tailored Plans will be expected to employ a care management coordinator that oversees the service and assists with complex situations.

Additional details on the I/DD and TBI care management: The Tailored Plan will employ care managers to provide short-term care management to select uninsured, high needs adult recipients with I/DD and TBI diagnoses. The I/DD and TBI care manager's responsibilities include: conducting care management comprehensive assessments and developing individual support plans; coordinating State-funded Services; connecting recipients to programs and resources that can assist in securing pre-vocational and vocational opportunities; providing in-person assistance for securing Medicaid coverage; and providing referral, information, and assistance in obtaining and maintaining available medical services (for example, Federally Qualified Health Centers and

Rural Health Centers), community-based resources and social support services.

For those with behavioral health needs, the Department is also developing new case management service definitions for uninsured adult and child recipients with significant behavioral health needs. These service definitions will specify: which individuals are eligible for the service; what providers are qualified to offer the services; what the staffing and training requirements will be; what the utilization management requirements will be; fidelity monitoring requirements; and billing requirements. The expectation is also that the Tailored Plans will employ a state-funded behavioral health care management coordinator to oversee the new case management services.

Provider Networks: Tailored Plans will be required to develop and deepen provider capacity for priority, evidence-based or best practice services. Provider network requirements include: meeting time, distance and appointment wait time standards for covered services; submitting a network access plan that details approach for meeting standards; developing an approach for delivering culturally competent care to targeted groups, including: blind or visually impaired individuals; deaf or hard of hearing individuals; veterans and their families; and pregnant women with substance use disorders. Tailored Plans will also be required to establish a complaints and appeals system to support recipients of State-funded Services. The appeals process will include: plan-level appeals process for utilization review decisions to deny, reduce, suspend or terminate State-funded Services; and access to Non-Medicaid State Appeals Hearing Process. To support recipients, Tailored Plans will use strategies to resolve complaints and appeals at the lowest level that meets the recipients' needs; and will provide recipients with reasonable assistance throughout the complaint and appeals process, such as providing interpreter services.

In-Reach, Transition and Diversion: Tailored Plans will connect individuals who are residing in or at risk of entry into institutional settings or adult care homes to community-based services and supports to promote community integration. This applies to individuals with I/DD, TBI, SMI, or SED residing in institutional settings or Adult Care Homes. In-reach staff will work with the individuals to explore options for transitioning to the community and will evaluate whether an uninsured individual is likely Medicaid eligible. Those who choose to transition into the community will work with transition staff on an effective and timely transition, including identifying and providing linkages to services and supports. Those individuals who are at risk of entry into an institutional setting or

adult care home will work with diversion staff to support them to remain in the community, including screening for eligibility and providing linkages to community-based services.

Local Health Functions: Tailored Plans will be required to work with Standard Plans and other stakeholders to support the delivery of “local health functions,” which focus on health prevention and promotion for the Medicaid and State-funded populations. For Crisis and Involuntary Commitment, Tailored Plans will continue to implement and update their community crisis plans, and will work to increase access to behavioral health crisis options. For Disaster Emergency Response, Tailored Plans will develop region specific response plans, comply with specific network adequacy and prescription requirements to reduce barriers to care, and provide behavioral health services to members residing in shelters. The Tailored Plans will also be required to support local collaboratives tailored to address the unique populations including crisis and children’s System of Care collaboratives. And Tailored Plans will also be required to connect recipients to housing, supported employment, free and low-cost prescriptions (for State-funded populations only), and other social services that promote community inclusion principles and are funded through other sources.

Accountability: The Department will oversee the Tailored Plan’s management of State-funded Services to ensure the health, safety and welfare of recipients and stewardship of state and federal funds. Tailored Plans will be required to report on quality measures complementary to Medicaid as well as distinct to State-funded Services. They’ll be required to report on eligibility data on State-funded Services recipients to ensure stewardship of funds and connection to available coverage. And they’ll be required to report on service utilization and spending data to ensure appropriate allocation of funds and provide progress towards federal and state programmatic goals.

So, what to do next? This is a reminder that the Department values input and feedback from stakeholders and will make sure that stakeholders have the opportunity to connect through a number of venues and activities. The ways to participate include regular webinars such as this one, conference calls, meetings, conferences, comments on periodic white papers, such as the State-funded Service White Paper, FAQs, and other publications. And you can find regular updates on our website at www.ncdhhs.gov.

The Department of Health and Human Services will engage Consumers, Families, Caregivers, and Consumer Representatives, Providers, Health Plans, and LME/MCOs, Counties, and the General Public.

This concludes the presentation portion of today's webinar, and we will move into questions and answers.

Suzanne Thompson: Thank you Renee. So, we have several questions. The first one is: as a provider, how do we best serve those who walk in our door for services when we're out of state funds.

Jane Shivar: So, we'll open that question on to one of our other experts whose gone. We have another question that they're asking on the Tailored Plans' network adequacy requirements for state funded purposes. How are these programs from the requirements that LME/MCOs face today?

Renee Rader: So, we are still working on these requirements. We are working to align them with the requirements for the Standard Plans so that there's consistency. There will be, there will be clarity between the current network adequacy requirements and the requirements in the Tailored Plan, with a focus on access availability and also wait time.

Jane Shivar: Okay, and then, so, they're asking on the Tailored Plans, how will they be held accountable for meeting network Adequacy standards for their state-funded services? Does the Department have enforcement and accountability mechanisms like they do for Standard Plans?

Suzanne Thompson: That question might be appropriate for Dr. McCoy. Dr. McCoy, are you able to respond?

Keith McCoy: Sure. Can you hear me?

Suzanne Thompson: Yes. Thank you.

Keith McCoy: Great. So, we do have a process of ensuring network adequacy, that does come with accountability measures, both for the Medicaid side as well as the State-funded side. I think the key difference when it comes to network adequacy on the State-funded side is that these are not entitlement funds. Once funds are exhausted, there's not a requirement to continue that. We do rely on the LME/MCOs and featured Tailored Plans to work collaboratively with Providers to effectively manage those funds to minimize disruptions in care to recipients.

Suzanne Thompson: Okay, Dr. McCoy, I think this is another question for you. It says for enhanced behavioral health Medicaid covered services under Tailored Plans, must TPs meet quantitative access and network adequacy

requirements? Will DHHS use similar enforcement mechanisms for TPs as they use for STs, such as liquidated damages for violations?

- Keith McCoy: Yes, we have specific network adequacy standards and penalties, you know, for, for that process, that will be standard throughout Medicaid Transformation Managed Care.
- Suzanne Thompson: Okay. I think, Stacy, this one might be for you. We have had several questions about mental health residential services, such as supervised living and group living, and will they continue in the Tailored Plans?
- Stacy Smith: Well, I'm not sure if that question's for me, but I will try to answer it. My understanding is that the services that Tailored Plans are expected to cover have been identified in the RFA, and that would be the best place to check for that information. Kelsi, is there anything else that you might want to add?
- Kelsi Knick: Hey, Stacy. I can't comment on the State-funded Services. I'm sorry to pass the buck. I don't know if Dr. McCoy can speak to that.
- Keith McCoy: Yes, so I think the question here is given that we are condensing the service definition, Stacy, when it comes to adult residential, like for group living high, group living low, for those sorts of things, will each of those levels, how will we account for those in the future service definition that's more of a catch-all service definition that's proposed in this. So, Stacy, are you able to talk about the Adult Mental Health Team's vision for how the current service definitions might roll up into the future residential service definitions for mental health?
- Stacy Smith: Sure, so our plan will be to look at what's existing and also look at some best practices that are being used in other states regarding residential services for adults with mental illness, and the also getting feedback from Stakeholder work groups in our Tailored Plan Partners and revising that policy or service definition to best fit the needs and also best fit the network.
- Suzanne Thompson: Thanks, Stacy. LaToya, I'm not sure if these are questions that you can answer, but we've had a couple questions about why I/DD case management is left out of the I/DD portion, and can you give a brief explanation for the difference between care management and case management?
- LaToya Chancey: So, care management will be included within the Tailored Plan's responsibilities. This is something that is outlined in the white paper, and then I believe the question may have come in right before Renee had an

opportunity to delve into care management for the Behavioral Health I/DD Plan, Tailored Plan. So, it will be offered. care management is going to be looking at linking people to available resources in their community or linking them to available services that are available where there's State funds, and supporting them with the Medicaid eligibility process with doing that application, and it's going to be really looking at supporting those individuals with those higher level and higher needs of care. I know there was another question about what's the last part of the question that you just said about the difference with that is that care – with care management, unlike case management, it's going to be really focusing in on referring them and linking them and following through with the actual linkage to available resources that are available in their community.

Suzanne Thompson: Okay, and then the part about why is case management omitted for the I/DD population?

LaToya Chancey: It's not. It's going to be the Behavioral Health I/DD Tailored Plan's care management will be available for the I/DD population.

Suzanne Thompson: Okay. All right, there's several questions about the waiting list for State-funded services and the question is, is it going to be a statewide list, and how is it going to be operation-wise? Janie, who do you think's the best person?

Janie Shivar: So, with that, we are currently looking at building an I/DD and TPI statewide registry of unmet needs, where we will be looking at compiling all of the data that we currently have across all of the LME/MCOs, as well as pulling in those who may be waiting for state-funded services, as well. That is a process that is going through where internal approval processes. We're really close to – getting closer to a finished product. But it is something that we are in the process of doing.

Suzanne Thompson: So, the next question is, they don't see developmental therapy or personal assistance on the array for I/DD services. Will there be an alternative service for individuals current receiving these?

LaToya Chancey: In accordance to what we have listed in the white paper, development day services and personal assistance will be being reviewed on a meaningful day and pre-vocational services, where we will be looking to establish new or updated service definitions that incorporate our current definitions, as long as there's some promising practices in the field.

Suzanne Thompson: Okay, for I/DD care management, will that be a provider function, or an NCO function?

LaToya Chancey: That would be a Tailored Plan function. So that will be something that is done out of the Tailored Plans. And the reason why we decided to go that route is we really wanted to capitalize on the existing Tailored Plans function that they have with care management so yes, they will at the Tailored Plans level.

Suzanne Thompson: So, the next question, do we have an updated list on the website anywhere on the Tailored Plan diagnosis?

Keith McCoy: So, we do have lists that have to do with Medicaid eligibility and diagnoses when combined with either service utilization or for some based on diagnose alone that indicate tailored plan eligibility. For State-funded Services, generally the reference point for eligibility is in the service definition itself. Others who are in the room, please feel free to add to that when it comes to diagnostic criteria on the state-funded side.

Suzanne Thompson: Stacey, this one is probably for both you and Renee. Are peer support services going to be with the MTO as part of the Tailored Plan?

Stacey Smith: So, peer support services are part of both the Tailored Plan and Standard Plan.

Suzanne Thompson: So, any provider can then provide the services? Correct?

Stacey Smith: They would need to contact the Standard Plan and/or Tailored Plan to develop a contract with them and then if the Standard or Tailored Plan contract with them, then yes, they can provide the service.

Suzanne Thompson: Ok, it says where currently state funded support that are non UCR money such as first in family and NC start how will they fit into this?

Keith McCoy: I will defer - LaToya is able to address NC start.

LaToya Chancey: Yes NC Start will be a part of the state Standard Plan as well as the Tailored Plan and so those allocations will continue to come out of our divisions as they have in the past with first in families that is also something that is going to be available to any participants that are eligible for it because it's not an actual state-funded service so allocation will be separate from the items that we're actually talking about today in terms of actual state funded services.

Suzanne Thompson: Dr. McCoy, I think this one might be another one for you. It says will individuals with third party insurance and under insured for behavioral health services be guaranteed to receive state funded services. All MCOs currently do not offer state funded services for the under insured.

Keith McCoy: So, I think we are continuing to have conversations about where the line should be for that, there is currently some flexibility and I think that from the state prospective we desire some consistency across the state both from a provider prospective as well a regulator prospective as well as from a recipient prospective. But because state funded services are not entitled services I certainly can't say there will be a guarantee for coverage. That would depend on part funding availability. But I think we intend to have some additional conversations around some of the eligibility criteria that we've outlined today and welcome comments and prospective from providers, consumers, recipients and groups as well as other MCO and other stakeholders on that.

Suzanne Thompson: Here's another one Dr. McCoy, will the MCOs have the authority to deviate from the eligibility criteria?

Keith McCoy: And again, our prospective is that consistency is really important in this, but we intend to continue to have some additional conversation in part or in light of the fact we get from this policy paper so we welcome comments and feedback accordingly.

Suzanne Thompson: Stacey, I think this one will be for you. Will peer support operate under the same rules and same rates for both the Standard Plan and the Tailored Plan.

Stacey Smith: So, the policy and the service definition will be the same the Tailored Plans and the Standard Plans will maintain their authority to set their rate that they see is needed to support their providers. So just as there is now there's probably different rates being paid out because DMH does not set rates any longer we make rate recommendations and the LME/MCOs maintain the authority to flex the rate to meet the needs of their provider networks. So, there will be consistency across the service provided, the rate that its paid could vary based on what the Standard Plans and Tailored Plans feel their network needs to sustain.

Suzanne Thompson: Thanks Stacey. Dr. McCoy this one says the paper states the co-payments cannot be charged for State-funded Services and is on page 9 of the presentation. Is there a reason for this change? I thought there was a rule in place about sliding fee scale being required.

Keith McCoy: I would have to defer to others on fee scales that's not an area where I have expertise.

Suzanne Thompson: Ok, we will take that one back then. I think Renee or Dr. McCoy either one of you can answer this. It says will the current state PHP be

overseeing Tailored Plans or will there be new PHP accrued for Tailored Plans?

Dr. McCoy: The PHP language is a little confusing in North Carolina. There's a formal definition when it comes to licensure with the department of insurance in North Carolina. So, there's sort of a technical licensure for PHP and there's a broader concept of what a PHP is and technically today, the LME/MCO are PIHP whereas the standard plans are PHPs. From that standpoint, the LME/MCOs for the first round for Tailored Plans so it's currently written in legislation from launch until 2024. The LME/MCOs' will be the only entity eligible to apply. It won't be the standard plans that take over the Tailored Plans system that we designed. It can only be the LME/MCOs that do that. Whereas the Standard Plans are the one who have already been awarded contracts for the remainder of the Medicaid population.

Suzanne Thompson: I think that will conclude our time for today. I know that there are probably a few other questions we haven't answered and we will take these questions and get answers to them so that we can respond accordingly.

Janie Shivar: And folks always please do feel free to submit your questions or comments to the mailbox you'll see it on your lower right-hand corner of your screen: Medicaid.Transformation@dhhs.nc.gov. Also, Renee can you remind folks about the white paper that we're accepting comments on through January 29.

Renee Rader: The state funded services policy paper is posted online and we're going to continue accepting comments through January 29.

Suzanne Thompson: We want to thank everybody that concludes our session for today. As Janie said in about 10 to 12 days the recording as well as the slide presentation will be posted on the department website.

Janie Shivar: Yes, so if you will just keep a check on the department web page under Medicaid transformation it will get posted fairly soon and, in the meantime, do send your questions to the transformation mailbox. Thank you all for your time today.

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