



BH I/DD Tailored Plan Care Management Webinar Transcript

Janie Shiver

Good morning everyone. This is Janie Shiver with the Division of Mental Health Developmental Disabilities and Substance Abuse Services. Welcome and thanks to all of you for joining us today for our most recent Tailored Plan webinar. Our webinar presentation today will be guided by Kelsi from North Carolina Medicaid. We have several other department colleagues that are joining us today, who will serve as panelists for the Question and Answer portion of today's presentation. They are Dr. Keith McCoy, Deb Goda, Debra Farrington, as one of our colleagues from Manatt, Toni Fiori, in the room with us today. We're also extremely glad to have both our Deputy Secretaries from the Department joining us today, Dave Richard and Kody Kinsley, and Deputy Secretary Kinsley is going to say a few remarks before we turn the presentation over to Kelsi.

Kody Kinsley

Hi, good morning everyone. This is Kody Kinsley. I am the Deputy Secretary for Behavioral Health and I/DD of the North Carolina Department of Health and Human Services. We're incredibly happy to have all of you on the call this morning. Thank you for joining this webinar. The Department has six core values that we hold at the center of all our work, and two of them are People Focused and Transparency, and we believe that our commitment to these webinars and our partnership with all of you is core to those goals as we make sure the work that we are doing is emblematic of your feedback. We know intimately that you all experience day in and day out the impact of the choices that we make, and we want to design this work in concert with what you know to be best. So, we really appreciate your active engagement. We're happy to have nearly a thousand people participating today. We hope that number will continue to grow as we move towards transformation and roll out of standard plans, and as we continue to design our Tailored Plan work. So, please continue to spread the word, encourage others to engage with us. Your feedback is critical. We hope everyone will speak up today. And we'll go through that soon enough.

The Department's goal for the transition of managed care is to improve the health of North Carolinians. We believe core to that is Care Management, and we've spent a lot of time working with our partners to design a strategy around Care Management that will provide excellent outcomes for the people that we serve. Today, we'll be going

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through the presentation on this topic, and we hope that all of you have received the white paper or will have found your way to the white paper that we released just yesterday. Again, I'd like to thank the team. There's a lot of work that's gone into this, and the team is both the focus of the Department, our partners at the LME-MCOs, our state and, State Consumer and Family Advocates, as well as our local CFACs, and then, of course, providers across the state have engaged us in this process. So, we look forward to a robust conversation today, and I'm happy to turn over to Kelsi Knick, who will walk us through. Thank you.

Kelsi Knick

Great. Thank you, Kody. So, today, we are going to cover Background and Guiding Principles, Tailored Care Management Models, and Key Takeaways from the Presentation.

So, as Kody mentioned, we released our policy paper entitled North Carolina's Care Management Strategy for Behavioral Health, Intellectual Developmental Disability Tailored Plans yesterday. This policy paper is, we want public comments. It's not a firm policy guidance. So, we do, appreciate any comments that you send to the Department. The paper outlines the key components of the Tailored Care Management model and provides a roadmap for our work ahead. Again, we welcome feedback from beneficiaries, families, other stakeholders, as we continue to refine this model. Today's webinar will review key concepts and takeaways from this paper.

Background and Guiding Principles. So, this slide just takes the timeline of real high-level timeline for managed care transition. As a reminder, in 2015, the North Carolina General Assembly enacted session law directing North Carolina Medicaid and Health Choice programs to move from a predominantly fee-for-service model to a managed care model.

Standard Plans will launch in two regions in November of 2019, and the remaining four regions will launch in February of 2020. In around the same time in 2020, we will be releasing, tentatively, our Tailored Plan Request for Applications will be published. Legislation requires that only the LME-MCOs will be able to bid to become a Tailored Plan, we we're expecting there to be one Tailored Plan per region. And the Tailored Plans are tentatively scheduled to launch in July of 2021. Next slide.

Standard Plans and Tailored Plans. So, both Standard Plans and Tailored Plans will be fully integrated managed care products, and they'll both deliver whole person care through coordinated physical health, behavioral health, I/DD and pharmacy products. They'll both address the full factors that impact health, such as addressing unmet health resource needs for such determinants of health, and they'll both perform localized Care Management at the site of care in the home or in the community. The Standard Plan will serve the vast majority of our

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Medicaid beneficiaries moving into managed care, which is approximately 1.6 million. And then the Tailored Plans will serve approximately 115,000 individuals, with more serious behavioral health disorders, serious emotional disturbances, severe substance use disorders, intellectual developmental disabilities, and traumatic brain injuries. And Tailored Plans will also be the only plans that will offer our 1915(b)(3) services, our State-funded services, and our Innovations and TBI Waiver services. Next slide.

Tailored Plan Care Management. The Care Management design as described as we will go into detail on this slide is built on the principle that provider and community-based Care Management is crucial to the success of our fully integrated managed care product. Tailored Care Management will build on the Standard Plan Care Management model, but will be more intensive and customized, reflecting the specific needs of this population.

So, I'm going to walk through the core principles and just elaborate slightly on each one of those.

The Broad Access to Care Management. With limited exceptions, Tailored Care Management will be available to all Tailored Plan beneficiaries continuously throughout their enrollment, unless beneficiaries are already receiving intensive care coordination or case management services through other programs. Each Tailored Plan beneficiary will receive integrated, whole-person management, Care Management, from a single care manager with expertise and training in addressing behavioral health, I/DD and our ITVI needs. In addition to our physical health and unmet health-related resource needs of the beneficiary.

Person and Family Centered Planning. Care planning for Tailored Plan beneficiaries will be person-centered and will continue the unique needs of the beneficiary. Family members and other informal care givers and support can also participate as members of the beneficiary's care team, with the beneficiary's consent.

Provider-Based Care Management. To the maximum extent possible, care managers for Tailored Plan beneficiaries will be embedded within the provider organization's primary care practices for behavioral health or I/DD providers to support collaboration among providers and beneficiaries and to place Care Management as close to the site of care as possible.

Community-Based Care Management. Care managers should live near and be actively engaged in the communities of the beneficiaries that they serve. They should have frequent interaction with the

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beneficiaries, and be deeply familiar with the local resources, which include social services and support.

Community Inclusion. Tailored Plan care managers will support beneficiaries in living meaningful, productive lives in the community of their choice, to the greatest extent possible.

Choice of Care Managers. Tailored Plan beneficiaries may choose a care manager and may change care managers without cost. Consistency across the state, regardless of geography or the type of organization providing Care Management. All Tailored Plan beneficiaries will have access to consistent, high-quality Care Management.

And, lastly, Harnessing Our Existing Resources. Tailored Care Management would build upon our existing Care Management infrastructure in the state, particularly our LME-MCOs and our Advanced Medical Home structure that we've designed in the Standard Plan. Care management activities will align with overall statewide priorities for achieving quality and value.

Transition to Whole-Person Care. Tailored Plan Care Management models reflect the Department's broader goals for integrative whole-person care in our managed care environment. So, in our current environment, we have Community Care of North Carolina responsible for coordinating the physical healthcare services, while our LME-MCOs are responsible for the coordination of our mental health, substance use, I/DD and TBI services. So, in our future Tailored Plan environment, the Tailored Plan will be responsible as previously mentioned for providing whole-person care, which includes both the physical, behavioral health, TBI, I/DD, LTSS and pharmacy purposes.

Our Rationale for the Tailored Plan Care Management Model. So, Care Management, as Kody mentioned, is a major priority within Medicaid transformation across both Standard and Tailored Plans, and the State is really making new levels of investment in Care Management in both of the managed care products. Again, I can't stress enough that all Tailored Plan beneficiaries need and will receive integrated whole-person Care Management. Integrated Care Management places a person at the center of a multi-disciplinary care team and recognizes interactions across all their needs. The Department is committed to giving Tailored Plan beneficiaries choice in how they receive their Care Management and provide them access to provider-based Care Management that's performed at the site of care in the home or in the community for face-to-face interaction, if possible. And the Care Management standards will be consistent across the state to help

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ensure beneficiaries receive quality Care Management services regardless of where they live.

Overview of the Tailored Plan Care Management Approach. There are three approaches that the Department has developed. Tailored Plans, the Department Advanced Medical Home Plus, or referred to as AMH Plus practices, or Certified Care Management Agencies, referred to as CMA's, will all play a vital role in the success of the management care transition to Tailored Plan Care Management. The Department's vision is that Tailored Care Management will be provided primarily by care managers embedded within an AMH Plus practice that have demonstrated the capacity to provide integrated Care Management for the behavioral health and I/DD Tailored Plan population.

Or, Approach 2, performed by certified Care Management agencies. The certified Care Management agency, again, or a CMA, is a new designation and will be unique to providers serving the I/DD and behavioral health Tailored Plan population. Organizations that may be certified as CMAs by the Department will include behavioral health and/or I/DD providers with the experience and capacity to provide Care Management to behavioral health and I/DD Tailored Plan populations.

And the third approach is, Care Management may be provided by the Tailored Plan themselves. The Tailored Plan may employ their own care managers.

An Advanced Medical Home or a certified community agency, Care Management agency, may work with a clinically integrated network or CIN or another partner. A CIN or other partner is a concept that the Department has already defined for Standard Plans. It means an entity that assists practices and providers to meet Care Management requirements who share staff, IT analytic functions and our administrative support. The term is really broad, and it encompasses hospital systems, health systems, independent practice associations, and third-party data vendors. Next slide.

Glide Path to Provider-Based Care Management. So, recognizing that the population eligible for Care Management services will increase, this model will require a multi-year effort to enhance the workforce at the AMH Plus practice and certified Care Management agency level. The Department will establish a glide path for the provision of provider-based Care Management. Through this Glide Path, the Department will establish targets for the proportion of Tailored Care Management occurring at the level of the certified CMAs and AMH Plus practices, which will ramp up over the first four years of the Tailored Plan

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implementation, which aligns with the initial period in which the LME-MCOs have exclusive rights to operate a Tailored Plan.

The Glide Path aims to create a plan approach for most Tailored Plan Care Management to move to primarily provider-based over the first four years of the Tailored Plan contract, while creating a smooth transition for beneficiaries and client care coordinators.

Care Management design aligns with Standard Plan requirements to the greatest extent possible, but in several areas, the Department is building special guardrails to meet the unique needs of the behavioral health and I/DD Tailored Plan population. This slide depicts a high-level overview of a beneficiary's experience from enrollment to receiving ongoing Care Management. So, unlike Standard Plans, Care Management, where a beneficiary has to screen into Care Management, an eligible Tailored Plan beneficiary is auto enrolled into Tailored Care Management. They do have the option to opt out if they're not interested in receiving Care Management services, with some exceptions.

Care Management Assignment. Once they're enrolled, they go to Care Management Assignment. And the Tailored Plan is responsible, with input of choice from the beneficiary, for assigning the beneficiary to an AMH Plus practice, a certified CMA, or the Tailored Plan themselves for Care Management services. The assigned entity is responsible for assigning the care manager to that beneficiary. The Tailored Plan will be required to share with each AMH Plus practice and certified CMA a roster of assigned beneficiaries and current demographic information to help facilitate outreach. The AMH Plus practice certified CMA or Tailored Plan assigned care manager will reach out to that beneficiary to engage them in services.

Next is a Comprehensive Assessment and Person-Centered Planning. The Care Management Comprehensive Assessment, it informs the care plan and Individual Support plan. It's a comprehensive assessment that is required to be completed in person, and it's an evaluation of the beneficiary's whole-person needs. Behavioral health, I/DD, long-term services and support, TBI, pharmacy, physical health, as well as unmet health-related resource needs. This is performed by a multi-disciplinary team. And I just want to add that the start of Care Management services is not dependent upon the completion of this care plan.

And Ongoing Care Management. Again, with limited exceptions, Tailored Plan beneficiaries are eligible for Care Management for the life of the enrollment in the Tailored Plan.

Acuity Tiering and Contract Requirements. So, given the importance of trusted, high-quality relationships in Care Management, the Department

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will establish minimum levels of contacts between care managers and beneficiaries engaged in the model. This includes contacts that are provided face-to-face within the practice setting, the home, or other community settings. The Department plans to establish a standardized methodology based on claims history for determining the acuity of each beneficiary, which will be used to guide these minimum contact requirements and minimum dollar amounts for Care Management fees. In recognition of the complex needs of the Tailored Plan population, the Department will require that care managers serving this population possess a set of minimum qualifications and completion of required training components. The Department is aiming to balance that the care managers engaged in this model are highly qualified while ensuring that we have an adequate and growing work force available in North Carolina.

Payments for Care Management. The Department is developing requirements governing Care Management payments to Tailored Plans, as well as down street payments for Tailored Plans to AMH Plus practices and certified CMAs. The Department is ultimately responsible for all aspects of Medicaid programs. One of those functions is payments to the Tailored Plans. The Department will pay Tailored Plans at capitated Managed Care rate a separate per-member per-month Care Management payment for each beneficiary that is under active Tailored Care Management and an Engagement Plan payment. The Tailored Plan will issue monthly claims to the Department for the PMPM Care Management and Engagement payment and be responsible for making payments to the certified CMA and AMH Plus practices who are providing Care Management. The AMH Plus practice and certified CMA will then submit claims to the Tailored Plan for Care Management payments.

Quality. The Department will establish a common set of quality measures as key mechanisms to ensure Tailored Plan accountability to the Department. All quality measures for Tailored Plans will align with and build on the Department's quality strategy, which will be updated to include Tailored Plans, and which primarily emphasizes outcomes for beneficiaries over process measures. In addition to the quality measures developed by the Department, Tailored Plans will be responsible and required to report to the Department all federal health and quality measures as seen on this slide. Stay tuned for – there'll be more to come on our Tailored Plan quality measure work.

Data and Health Information Technology. The efficient exchange of timely and actionable beneficiary health information is crucial to Tailored Plan Care Management. Tailored Plans, AMH Plus practices, and certified CMAs, as well as physical health, behavioral health and

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I/DD providers, will be expected to regularly collect, use and share data in support of integrated and coordinated approach to patient care, using the data to manage population health, respond to individual beneficiaries' needs, track referrals and follow up, monitor medication adherence, and respond to unmet health-related resource needs. To support care managers' data use, Tailored Plans will be expected to share information with AMH Plus practices and CMAs, included but not limited to Care Management assignment rosters, beneficiary summary information, risk stratification results, and historical claim and encounter data. In accordance with federal health and requirements, Tailored Plans will be expected to ensure that AMH Plus practices and certified CMAs maintain system step processes that allow for interdisciplinary care team communications and coordination of care. The Department will work with Tailored Plans, AMH Plus practices, and certified CMAs after contracts are awarded to develop consensus around specific data formats, content, triggers, and transition methods for these critical data exchanges.

And lastly, our Key Takeaways from this presentation are that Tailored Plans, Tailored Care Management, is built upon the Standard Plan model with added customization to meet the specialized needs of its population. With limited exceptions, Tailored Care Management is available to those eligible for Tailored Plans, and available throughout the duration of the beneficiary's enrollment. Provider and Community Based Care Management is at the heart of Tailored Care Management design and is critical to the success of a fully integrated, whole person system of care within Managed Care. A multi-year Glide Path will be established to enhance the work force at the AMH Plus practice and certified CMA level. And a minimum set of contact requirements and minimum qualifications to serve as a care manager will be required by the Department in recognition of the complex needs of the Tailored Plan population.

And, lastly, as we continue to refine our Tailored Care Management design, the Department welcomes feedback to promote a smooth transition and to manage care and rollout of Tailored Plan Care Management. I think we'd now like to turn it over to Debra, and we welcome your questions and comments.

Debra Farrington

Thank you, Kelsi. So, we have a couple of general questions that I'm going to direct today. The first question is, will there, will there be MCOs anymore, or will each agency have their own care manager or care coordinator?

Dave Richard

So, Debra, I think your question is, will MCOs continue to provide care management? I think as Kelsi described it, that we have a Glide Path to

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reach the, the Tailored Plan Care Management that are provider-based, the one with AMH Plus. The goal is that we transition people in a way that there is no one that winds up losing service or not having the correct service. So, there will be LME-MCO, Care Management will take place during the transition period and if a family or a consumer member chooses to continue to have their Care Management provided by the LME-MCO at some point.

Debra Farrington

Thank you. This next general question asks about how provider payments will happen as we transition to Managed Care, and the specific question is, do you anticipate there are going to be gaps in payment times to providers during this transition.

Dave Richard

One of the things that we are clear about in our transition to Medicaid Managed Care is that there, there are really two key principles. Number One, that beneficiaries do not lose any service during a transition to Managed Care. The example we're using with Standard Plans is that if you have an appointment scheduled for November 2nd in fee-for-service, that you will get that appointment met with Managed Care regardless of whether there's a mistake by the State or a health plan that people will receive that service. For providers, it's the second key principal we have, is that we know that if beneficiaries are going to be seen and receive the service they need, providers need to be paid. So, a strong commitment in our Standard Plan transition is that providers will not receive gaps in payment during that process, and as we move to Tailored Plans, the same commitment will be available for, by as we go there. The most important thing that happens in any of our transition is that beneficiaries receive the services that they are entitled to receive, and that do not have any transition problems as we move to managed care.

Debra Farrington

Thank you. This question is from a provider asking whether a provider will be able to contract with more than one MCO, LME-MCO, or PHC.

Dave Richard

As currently exists, providers contract with multiple LME-MCOs. They'll continue to be able to do that. And with our Standard Plans, we really hope that providers will contract with the four Statewide Plans, and if they're in a region of the Regional Plan as it rolls out, that they'll contract with them. But, of course, those are provider and plan decisions, as they walk through it, but we are hopeful that providers will contract with all the plans.

Debra Farrington

Thank you. Let me get into some care management-specific questions at this time. And one of the questions deals with why the Department is placing so much emphasis on Care Management being delivered by provider organizations. And, Dr. McCoy, would you answer that?

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- Dr. Keith McCoy Sure. So, there's evidence across the country that Care Management approaches serving complex patients like those who will be in the Tailored Plans is that these approaches that are as close to the patient as possible and as integrated with their face-to-face provider experience as possible, are more effective when you have all that integration going on. So many states are taking this into account, as they design their Care Management approaches, and we are doing the same.
- Debra Farrington Thank you. I have another question for you. So, this question is, are MCOs only providing Care Management during the transition, or after year 4, would we – in this case, the LME-MCO – person asks, would we still be providing ongoing care management at the MCO?
- Dr. Keith McCoy I think there are a couple of important points here. As you saw in the Glide Path, that target would still be having 20% of Care Management likely to be provided in the plan, for various reasons. As, you know, it does take some time to build provider capacity, and so that's part of why we have the Glide Path over time. Some individuals will also opt out of Care Management, and I want to emphasize that there likely will still be roles for care coordination activities for those who have opted out of Care Management. And then, you know, there, there also may be individuals who elect or are most appropriately served by the Tailored Plan and the voice care manager. So, there would be opportunities for plan-based care management ongoing.
- Debra Farrington Thank you. Kelsi, we have some more questions about Care Management. This question asks, could you provide a brief description or differentiation between Care Management and Case Management?
- Dr. Keith McCoy I think the main thing that the explanations that we have are on page 3 of the white paper, so I would refer you to page 3 of the white paper to read more about the differences between those three things.
- Debra Farrington Okay. Thank you for that. This question deals with AMHs, and how providers are identified as Advanced Medical Home Practices. Kelsi, could you address that? Advanced Medical Home Health Providers are identified as Advanced Medical Homes.
- Kelsi Knick So, in our Standard Plan, we have three levels of Advanced Medical Home Practices. And the third level, which we're calling Tier 3, is a practice level where that they've attested to that basically says that they can provide all the services of a Medical Health Home, as well as provide the Care Management function. And they may provide that Care Management function in house, meaning that a care manager may be embedded with the, the clinic, the physical health clinic. Or they may be utilizing a CIN, which I mentioned previously in the presentation, which is an entity that is assisting them in providing that Care Management

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service, or, assisting them with risk stratification of data needed to provide the care management services. So, building off the Standard Plan model for Advanced Medical Homes are, we are, we anticipate using the Advanced Medical Home Tier 3 practices, and we're calling them AMH Plus practices, to be the entities that will provide or will be available to provide Care Management for the Tailored Plan population. It will be a certification process, not an attestation process. And the Department is in the process now of developing what that process will look like. But we'll want to ensure that those AMH Plus practices have the capabilities and capacity to treat the specialized needs of the behavioral health and I/DD population.

Debra Farrington Okay. And Kelsi, just as one quick follow-up, we have a question about, sort of drawing the distinction between the PCP AMH and the traditional I/DD behavioral health provider.

Kelsi Knick So, we'll still have those. We'll still have your I/DD and behavioral health providers, and you won't, the AMH or Health Home, or your primary care physician, number of physicians can be an AMH, but we're not asking an individual, a beneficiary, to change from their current provider to an AMH, or vice versa, in order to get care management. We really don't want to disrupt any, any care at all, and we're hoping that individual can stay consistent with the services that they're currently getting through the transition, and when we transition.

Debra Farrington Okay. Thank you. Will care managers still be under State benefits? Will individuals receiving State benefits be able to receive Care Management?

Dr. Keith McCoy You mean – so, there are two different types of, of individuals who might be receiving State benefits, State-funded services. One would be individuals who are in Medicaid, who need a service that is not provided through Medicaid. Another would be the uninsured population who need a service that might be provided in Medicaid, but since they don't have Medicaid, they can't receive it. The, the Care Management model we're outlining today is specific to those with Medicaid.

Debra Farrington Thank you. This question deals with the credentials of a staff who perform Care Management. Why does DHHS continue to stress licensed staff for supervision for MHSA versus senior qualified professional staff?

Kelsi Knick I think that that's a fair question, and we have done a lot of internal dialogue on what the appropriate qualifications and credentials should be with serving this very specialized and memorable population, and appreciate the question, and we would appreciate comments and thoughts on how to best address this issue.

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- Janie Shiver This is Janie. I'm just going to go ahead and go to our next, our last slide, since Kelsi made that remark, because, if you'll look at the bottom right-hand corner of that slide, you'll see our Medicaid transformation mailbox. And that's the perfect place for you all to send in comments and recommendations and thoughts to us, as well as your questions. So, be sure to bookmark that.
- Debra Farrington This is another question – this is Debra – that I think we probably need to give some more thoughts to, but I just wanted to raise it for the team. And this question asks, will there be any legal restrictions on the ownership or governance of a care management agency?
- Dave Richards So, Dave, I'll jump in. I think Debra's correct, we want to make sure that we consider all of those. And just a reminder, is the reason why we're publishing this paper, is to get those kinds of comments, so it's, the questions are important. But, I think currently, we certainly aren't looking for only non-profits to do this work, or – so, so, we, we don't have that broad base legal concern. But there might be some other issues about conflicts that will have to be addressed.
- Debra Farrington Thank you for that. This general question is, when do Innovations Only providers need to submit applications to the Standard Plan insurance companies?
- Kelsi Knick Innovations Waiver beneficiaries will be in the Tailored Plan. If an individual under the Innovations Waiver would like to receive services through a Standard Plan, they will need to dis-enroll from the Waiver first. So, any Innovations Waiver providers who are going to continue to only provide services to Innovations Waiver beneficiaries will not be submitting applications to contractor with the standard plan.
- Dave Richards Okay. Just to add something, I think, I think it's really important to, to note this, is that we don't anticipate anyone who is currently receiving Innovations Waiver services would want to dis-enroll to be served in the Standard Plan because, again, as Deb mentioned is that the lack, there will not be Innovations Waiver services there in the, in the service array in the Standard Plans, but people with I/DD would never match what it available inside the Innovations Waiver.
- Kelsi Knick Correct.
- Debra Farrington That's a perfect segue to the next question that we received, and it relates to individuals receiving notices. So, providers have been told that current behavioral health I/DD beneficiaries will receive letters concerning choosing a Standard Plan when the letters go out this year, and that selecting a Standard Plan will cause them to lose their Innovations Waiver slot. Is this accurate?

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- Dave Richards So, I, I – we have heard this comment from people and have, we appreciate people raising that question, because we have spent quite a bit of time making sure that our systems are in place so that we don't do that. So, if somebody is on Innovations Waiver, they should not receive a letter suggesting that they have an option to enroll on the Standard Plan. There are people on, on the wait list that we would, we believe also that won't receive that letter, but we're working through the process and making sure that we are notifying everyone about what their options are. So, someone is, is on, currently on the Innovations wait list, the way the legislation reads, is that they would be inside a Tailored Plan. So, if somebody receives that letter, then we want them to raise their hand. But, again, we will, we have heard this loud and clear and are working very, very hard to make sure that we avoid sending letters to people that should not receive it.
- Debra Farrington Thank you, Dave. And the thing that I would add is that we will be distributing copies of those letters in the coming days to weeks, so that providers LME-MCOs and other interested stakeholders will have access to that language, will be able to see what the letters look like, and will have some clear designations about who will receive each type of letter. We have a question about Care Management agency certification. Will there be certification requirements for an agency that wants to provide Care Management?
- Deb Goda Yes, there will be. And the Department is working on those criteria right now, so if you have suggestions on what that certification process or actual certification itself should look like, please submit them to the Medicaid Transformation mailbox.
- Debra Farrington Thank you. Will persons on the wait list for Innovation Services who do not have Medicaid still be eligible to receive these free services?
- Deb Goda Individuals who are not on Medicaid are not currently eligible to receive these free services. You must be enrolled in Medicaid to receive these free services.
- Debra Farrington Thank you, Deb. Do Medicaid members who are diagnosed with a severe substance abuse disorder qualify for a Tailored Plan, Dr. McCoy?
- Dr. Keith McCoy They do. Um, we have a database process for that, based on service utilization to detect those, as well as we'll be sharing for feedback a process that people can ask to be made eligible based on their history, if their service history doesn't tell us that they likely have that level of need.
- Debra Farrington Thank you. We have Innovations and ICF providers who are receiving contract applications from the Standard Plans PHPs. Should they be completing those contracts now?

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- Deb Goda If the services, if they are only providing ICF, IID services and Innovations Waiver services, they should not be contracting with the Standard Plan.
- Dave Richards This is Dave. I'll just add to that. As, again, we know so many of our providers are, provide multiple service array. So, some providers might be ICF, Waiver Services plus mental health services, and we encourage providers to do this, is that if you are, look at our, our position papers and our policy papers, look at the distinctions between what services will be available in Standard Plans, what will be available in Tailored Plans, and if you're providing a service that is available in both, and you're receiving requests or you're contacted by or discussing with Standard Plans, then you should consider entering contracts with those, since those will be available inside the Standard Plans. So, Deb, is absolutely correct. If you only do an ICF in Waiver, you probably shouldn't have to bother, but if you're doing multiple services, especially those that are going to be in Standard Plan and Tailored Plan, you should consider it.
- Debra Farrington Yes. And this relates to that. A provider asks, as an Innovation provider, when would they be applying to be a part of the Tailored Plan?
- Deb Goda The Tailored Plans are not set to launch until 2021, June, July.
- Debra Farrington July.
- Deb Goda And in advance of that, you would be working with your designated Tailored Plan entity that you wish to contract with.
- Dr. Keith McCoy The Tailored Plans won't be designated probably until the latter half of 2020, because the RFA is scheduled to go out in February of next year, so, it's a way away before supervisors will need to be thinking about specific Tailored Plans contracting.
- Dave Richards Just to add, although it's not part of this paper, I think any comments about, from providers about how ease of transition, if you would think about, would be helpful for us. I mean, we all assume that if a current LME-MCO becomes the Tailored Plan provider, and they already have relationships with a provider network, then they should be able to make that an easy transition as that goes forward.
- Debra Farrington Speaking of transitions, we have two questions related to that. One of them talks about how we intend to sort of support the Glide Path for providers. When do we anticipate providers will be applying to be designated as Care Management agencies? And then the next question talks about or asks about how we will support the LME-MCOs in their provision of Care Management as that provider capacity is increased. Do you want to first address the Glide Path for providers, and how we envision that occurring?

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- Dr. Keith McCoy Right, so, we anticipate that, especially within the behavioral health and I/DD provider world, but also within the ANH world, that capacity will need to be built over time through staffing, through IT infrastructures, through relationships with CINs, if that's how they choose. We do anticipate having some investment into that from the state level as far as encouraging that capacity building.
- Debra Farrington Thank you. And then, how do you envision as Tailored Plans are launched, is the need for increased care management supporting the LME – the Tailored Plans, excuse me – during that period until the provider capacity is built.
- Dr. Keith McCoy All right, well, the, the LME-MCOs have significant staffing currently that are care coordinators. To become a care manager, there would be some additional training requirements, and obviously they would need to meet the specific qualifications to be a care manager. But we anticipate that that would be necessarily straightforward upfit in the since with that training, because the staff are already well acquainted with a lot of the roles that care management performs. So, we anticipate that that would be a place where some initial investment would go, and then over time, as provider capacity is filled, some of those roles will shift into the provider system. But as we said before, there will also still be needs for plan-based care management, as well as care coordination in the future in a Tailored Plan environment.
- Debra Farrington Thank you, Dr. McCoy. We have a couple of questions that are related that address whether an agency can provide Care Management and other kind of service supports for the individual at the same time. The specific reference to ACT and some other sources that have Care Management kind of built into the surface. Can you address that?
- Dr. Keith McCoy Sure. So, we are looking through the service array currently as to, are there some services that have significant, sort of Case Management aspects to the service that, if someone had both that, especially if it were a standard evidence-based practice that has a fidelity model to it, to where if they had both that service and Health Home level, you know, Tailored Care Management, that there would be such overlap, that it wouldn't make sense to do both of those at the same time. ACT is one of those services that we're looking at having – making sure that we fully understand what the fidelity model requires from a case management standpoint and how that cross-walks with what the Tailored Care Management requirements are. So, we're still looking at those services at this point, and future iterations of the policy paper will delve further into those. If there are comments or perspectives on that for specific services, we would welcome those.

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Debra Farrington

Thank you. We're going to get one more question. And I think we're going to select a question that deals with the letters. What kind of letters will go out? There was a question as to whether those letters were vetting with consumers and stakeholders, and so, I'll address that question. So, we have over the last several months been working with our enrollment broker, Maximus, and some Department staff to develop a series of letters, what we're calling notices, that go out to individuals who are required to participate in the standard plan. There are other letters that are designed to go to individuals who are exempt, who have a choice, whether they participate in Managed Care or not. And we did send a series of those letters out to beneficiaries, consumers and stakeholders. We got some feedback on those letters. Some of those – that feedback, we've been able to incorporate, and we've generated a final version of the notices that our records earlier will be sent out. I do want to make the point though, that, the process will allow for us to revise the letters as we go through implementation of Managed Care. We weren't able to integrate all of the comments, focused on the ones that were priority. We looked at the reading level of the information that was in the notices. But we'll continue to receive feedback on those notices, and we'll continue to modify and improve them as we go throughout Managed Care. And be on the lookout for getting those notices in the coming weeks, so that you can see what they look like and be able to respond to questions that come up. Are there any other things we need to address before we turn it back over to Janie? We appreciate it. We did have one question as to whether the recording will be available online, and it will be, so that folks can check the Medicaid Transformation website to get access to this recording, and the materials from today's webinar.

Janie Shiver

Thank you, Debra, and thank you, Kelsi, and all of our panelists that were here today, available to answer questions. And for the very informative presentation. As Debra said, this presentation will be posted. It usually gets posted to the Medicaid Transformation website within about 10 to 12 business days. So, you will see on the last slide the Medicaid Transformation website is posted. Keep that bookmarked. And keep checking back there for access to today's presentation, as well as all of the previous presentations that have been provided. Again, the email address in your lower right-hand screen is available so that you all can send questions in there. Really important that, for the white paper, to that exact same email address, medicaid.transformation@DHHS.NC.gov. Comments are to be received by June 28, 2019, so please be mindful of that. And for our closing remarks, I'm going to turn it over to our Deputy Secretary of Medicaid, Dave Richards, to wrap everything up for us today.

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Debra Farrington And Dave, before you go, I just want to acknowledge that we do have some questions that we've not been able to answer today, and folks have asked whether we will post a FAQ. We don't anticipate posting a response to the questions, but we will use the questions that we've received today to help inform our future policy design and any revisions we make to the Care Management approach. And so, I just wanted to acknowledge that we didn't get to all the questions.

Dave Richards Thank you, Debra. That's a really important point. And, let me begin finishing by where Kody started is that, we want to thank all of you for taking the time to join this webinar. We value the input that you bring. It does influence how, what our policies are. We also know that this is, you've only had a few hours to look at the papers, so we weren't expecting you to be experts in everything that was in there. We encourage you to read the paper. It's not a hard read. It's not that long. But it lays out the Department's view of how we should make this move to Tailored Care Management. We believe it is a cornerstone of how successful we will build – be with moving two Tailored Plans in integration of behavioral health, developmental disabilities, and brain injury into physical health, as a key component of that. We also want to be clear is that this is a, a process that is consistent with our standard plan design. I think that we'd want to do in our state work is that we don't want to have inconsistencies between how we do managed care. It recognizes the unique needs of this population but is really designed to make sure that as the Tailored Plans and the Standard Plans work together to support behavioral health, that we have a consistent model on how we're doing the Care Management, the key component of that. Also acknowledge that we think this is consistent with what we've heard from stakeholders as we went across the state, as we began the process of designing Standard Plans and Tailored Plans and believe that we have hit the mark to make sure that we're responsive to that. I also want to say on behalf of the entire team that we appreciate the work that LME-MCO Care Coordination is doing and continues to do. We believe that this is the next evolution and the proper evolution of a really robust and important community-based system will support the needs of people with severe mental health and substance use needs, along with those of I/DD. And then, finally, just want to reiterate our commitment to hearing what you say, and your response to this, speaking to groups as folks have more questions about that, about this paper, and other thing about our Tailored Plan design, and working with you as we make this transition. This is critical for the citizens of North Carolina that we have a working relationship with all our stakeholders across the state to make sure that we get this right. Okay, and on behalf of the entire team,

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thank you so much for joining us and look forward – we all look forward to the continued dialogue with our stakeholders.

End of webinar.