

BH I/DD Tailored Plan RFA Questions and Answers Meeting

All questions and answers within this document or previous documents are for informational purposes only. While the responses reflect the Department's current thinking with respect to the questions as they relate to the Tailored Plan Request for Application (RFA), they are subject to change. The requirements and responsibilities defined within the RFA will govern subsequent Tailored Plan contracts. It is the responsibility of LME/MCOs to carefully read the RFA and respond to the items therein.

Medicaid Transformation Questions:

1. Q: Per SB808, Standard Plans must go live by July 1, 2021. Does the Department anticipate a two-phased rollout as originally intended for November 2019 and February 2020? If so, will it be the same phases, and what are the anticipated dates? A: *No, the Department is not planning on a phased in approach. On July 1, 2021 all 6 regions will go live.*

BH I/DD Tailored Plan General Questions:

1. Q: Will the Department please share the details about the current implementation schedule, to include plans to phase in Tailored Plans by region, or if all will go-live at the same time. A: *At this time the Department is not planning a phased in implantation approach and all BH I/DD Tailored Plans will go live at the same time.*
2. Q: Will the Department please confirm the timing of the RFA Release, Anticipated Award Window, and Implementation Timeline for Go-live of Tailored Plans. A: *The Department anticipates the release of the BH I/DD Tailored Plan RFA by November 2, 2020. Responses will be due/opened January 19, 2021 with awards announced the end of May/beginning of June 2021.*
3. Q: What is the process DHHS intends to utilize for LME/MCOs to submit questions/request clarification and obtain timely responses from the Department? A: *Between the issuance date (November 2, 2020) of the BH I/DD Tailored Plan RFA and the due date of responses (January 19, 2021), the Department will reserve the initial two-week period for LME/MCOs to submit questions for the Department's response and clarification. The Department will issue an addendum to the RFA with responses approximately two to three weeks later depending on the number of questions.*
4. Q: Based on the key personnel positions required in the SP RFP, can DHHS provide details regarding the similarities/differences between the key personnel positions that will be required for TPs? A: *Primarily the key personnel position will be the same for the BH I/DD Tailored Plan as what is written in the Standard Plan PHP contract; however, there are a few differences based on the needs of the members that will be served in the BH I/DD Tailored Plan. The main differences are as follows: In the SP PHP contract they are required to have a Chief Medical Officer and a Behavioral Health Director of the NC Medicaid Managed Care Program. In the BH I/DD Tailored Plan they are required to have a Chief Medical Officer, an Associate Medical Director, and an I/DD TBI Clinical Director of the NC Medicaid Managed Care Program and State funded services.*

In positions where a LCSW or RN was the only acceptable licensure in the SP PHP has generally been expanded in the BH I/DD Tailored Plan recognizing that LCMHC and LMFT regularly work with the population being served by the BH I/DD Tailored Plan and can offer their expertise.

5. Q: Regarding the relationship between the Standard and Tailored Plans, could it be addressed as to whether there are functions DHHS would like to see consistently performed by the Tailored Plan or Standard Plan A: *At this time, DHHS has no new guidance.*
6. Q: How do you plan to incorporate DMHDDSAS funding requirements into the RFA? For example, will those requirements and the Medicaid requirements be co-mingled in sections. In discussions about QM and discreet in others, since things like EPSDT and NEMT are not applicable to state funds? Or will there be more separation between the two funding sources/requirements such as a separate state funded A: *There will be clear delineation in the RFA between Medicaid and State funded service where appropriate.*
7. Q: Would you please discuss what requirements we, as TPs will have for monitoring PH providers, and the redundancy that will exist between TPs & SPs licensing boards and others? Understand the importance generally but thinking these providers will not be really pleased. A: *Like the SP PHP contract, BH IDD Tailored Plans will have network adequacy standards for hospitals, physicians, advanced practice nurses, SUD and mental health providers, emergent and non-emergent transportation services, safety net hospitals and all other services necessary to support capacity and make services sufficiently available. The BH I/DD Tailored Plan will also have additional network adequacy standards for I/DD and TBI providers. The BH I/DD Tailored Plan also has some enhanced services that the SP PHP contract does not offer so there will be additional standards for those services. There are time and distance standards broken down into urban and rural. These network adequacy standards are further broken down into Medicaid and state funded services. It is the responsibility of each managed care plan to provide oversight and monitoring of their individual provider network.*
8. Q: If I remember correctly there was some general guidance in way of a draft communication that provided information on the “requirements” for the relationship we would be required to have with a SP. Is this still the guidance we should be referring to? Can you say anything more about that? A: *No new guidance has been published. Refer to the BH I/DD Tailored Plan policy papers.*

Finance:

1. Q: Should the LME/MCOS expect to have requirements for value added services as part of our response and if so, will the Department include the cost for those in our PMPM? A: *Per 42 CFR 438.3(e)(1)(i), value added services cannot be included when determining capitation rates. Yes, ILOS and value-added services will be part of the response to the BH I/DD Tailored Plan RFA.*
2. Q: The Pre-RFA White Paper included a provision regarding rate floors for in-network providers. As such, please provide detail regarding how the rate floors, coupled with the payments to out-of-network providers will be incorporated into the capitation payments. A: *Capitation rates will*

include cost considerations for all provider reimbursement requirements in the contract, including rate floors.

3. Q: How will the administrative cost for the TP be calculated-as an overall percentage of the PMPM or based on projected actual cost? A: *DHHS intends for the administrative component of the Tailored Plan capitation rates to be developed on a PMPM basis using a similar methodology as that used for Standard Plans. While the methodology will be similar, the resulting amounts will reflect differences in contract requirements and scale.*
4. Q: How will the varying contracted services from the SP factor into the administrative revenue? A: *DHHS intends to use a common methodology to develop the administrative component of the initial Tailored Plan capitation rates across the seven regions. This will not account for variation in subcontracting arrangements with other vendors.*
5. Q: The Pre-RFA White Paper included a provision regarding the provider networks of Tailored Plans being closed, but inclusive of all Essential Providers in the regions. At least right now, essential providers include, among others, FQHCs. N.C. S.L. 2015-245 §5(13). FQHC's have different payment structures than other providers. Under some managed care networks in other states, the State Medicaid Agency will make supplemental payments to supplement the MCO's rates to ensure the minimum payment thresholds are met; in others, MCOs receive moneys in their capitation to account for the supplemental payments and are responsible for making all the payments. While there are different underlying requirements, conceptually this is similar to supplemental payments with hospital systems. Please describe the Department's intent regarding FQHC payments. A: *Please refer to the Standard Plan contract. The requirements will be the same for the BH I/DD Tailored Plan.*

IT/System Interoperability Requirements:

1. Q: Although not specifically tied to Medicaid Transformation, is the Dept able to provide any updates on the timeline and plan to have LME/MCOs/future TPs connected to HIE? A: *All the LMEs/MCOs are now NC HIEA full participants. Many have signed up for the NC*Notify service and are already monitoring the Medicaid beneficiaries assigned to them. The HIEA has been working to develop an onboarding packet with requirements to receive claims.*
2. Q: Is the Department planning to default to the CMS Interoperability standards? A: *From a Division standpoint, the current draft of the CSR for Fee for Service change is asking that GDIT follow the standards as outlined in the CMS Final Rule. The Department indicated, yes, they'll default to the CMS interoperability standards.*
3. Q: Will the LME/MCOs be required to have an IT Certification like HiTrust or SOC 2, either in the initial TP RFA response or as a future requirement? A: *Yes, the preference is for a SOC2 type 2 or HiTrust as a requirement for TP RFA. If planning to pursue SOC2 type 2 you need to take guidance from AICPA. Contracts with vendors providing offsite hosting or cloud services must require the vendor to provide the State with an annual third-party risk assessment report (e.g.*

Service Organization Control (SOC) 2 Type II, International Organization for Standardization (ISO) 27001, Federal Risk and Authorization Management Program (FedRAMP) Moderate), to establish compliance with state statutes. Here is the link https://files.nc.gov/ncdit/documents/Statewide_Policies/SCIO_System_and_Service_Acquisition.pdf (SA-9 – External Information System Services). We would like to have the assessment performed by go live.

4. Q: What role does the Department plan to take in ensuring NC HealthConnex (or other sources of ADT data) is ready to widely support Medicaid Transformation (e.g., making a twice daily, reliable, detailed feed available to all PHPs, AMH+s and CMAs)? A: *The Department was communicating with HIEA (and NCHA/PatientPing) to understand the ADT landscape and gaps in NC when COVID hit. Their focus with HIEA has shifted more to surveillance, but still plans to pursue the ADT issue soon. Also, from the HIEA side - they are promoting and providing training on the ADT notification services – NC*Notify – to the Medicaid provider community. All the PHPs except for United have signed the participation agreement and several have enrolled in this service as well.*

5. Q: Has the Department established any standards for data exchange between the TP’s, SP’s, AMH+, CMA’s, etc., for example, FHIR, HL7, CSV? A: *Yes, we will follow the SP model. We may want to develop further data standards, but all the mandatory basics are here:*

<https://files.nc.gov/ncdhhs/medicaid/Tailored-CareMgmt-DataStrategy-PolicyPaper-FINAL-20190912.pdf> (published TP Care Management Data Strategy paper)

<https://medicaid.ncdhhs.gov/transformation/advanced-medical-home/advanced-medical-home-data-specification-guidance>

Published guidance on AMH data formats and frequencies. TPs will use the same.

CCP/Pharmacy:

1. Q: When clinical coverage policy references “year” without specifying (rolling, calendar, fiscal) what does is the default as the defined timeframe? For example, 1T-1 has a limit of 2 per year however, it is unclear when this benefit would be required to re-set. A: *This is a rolling year. When a claim comes in it looks at the date of service, then back 365 days and forward 365 days*
2. Q: Can an LME MCO be less restrictive to allow claims to pay without medical records required in CCP so long as the provider remains responsible for maintaining documentation in their medical record? For example: CCP 1E-2 – Therapeutic and Non-Therapeutic Abortions requires the provider to submit an Abortion Statement or claims will deny. Are we permitted to pay a claim without this statement, and have it been provided upon request such as when we complete audits? A: *No. The PHP/MCO/LME must receive the abortion statement, the sterilization statement, and the hysterectomy statements from the provider. These should be manually reviewed to determine that they are correct and meet the policy criteria.*

3. Q: Please provide feedback as to what NC Medicaid currently does with form DMA-3214 – Abortion Statement. A: *All three of the statements listed in the bullets above must be kept by the payer.*
4. Q: When will the Department make a resource available concerning the Clinical Coverage Policies? A: *Once BH I/DD Tailored Plans are awarded, the Department's clinical policy team will provide guidance and technical assistance to the BH I/DD Tailored Plans regarding physical health, behavioral health and I/DD clinical coverage policies.*
5. Q: Will NCDHHS determine the reimbursement to pharmacies for prescription drugs dispensed under the tailored plan or can the health plan leverage their PBM pharmacy network reimbursement rates? A: *Please refer to the Standard Plan contract. The requirements will be the similar for BH I/DD Tailored Plan. Session Law 2015-245, BH I/DD Tailored Plan will reimburse pharmacies a dispensing fee established by the Department.*
6. Q: If NCDHHS will determine the ingredient cost reimbursement, what is the pricing formula that will be required? A: *Please refer to the Standard Plan contract. The requirements will be the similar for the BH I/DD Tailored Plan. Ingredient cost reimbursement for pharmacies will be at the same rate as NC Medicaid and NCHC FFS service rate. After year two of the contract, subject to the Department's approval, the BH I/DD Tailored Plan may develop it's own pharmacy contracting for ingredient reimbursement if the BH I/DD Tailored Plan can demonstrate that the reimbursement results in overall savings to the DHHS and does not impact quality and access to care.*

TBI Waiver:

1. Q: Will the Department please share their intent around whether there are plans to roll out the TBI waiver to be statewide, coinciding with Tailored Plan go-live. If so, please share those details. If not, please share the rationale. A: *There is no intent to go statewide with the TBI waiver at BH I/DD Tailored Plan launch. The waiver is currently only serving 38 beneficiaries in year three which approximate 1/3 of the projected capacity in year three. There have been challenges with enrolling people including extremely high deductibles. We are looking to pilot changes to the waiver with renewal, such as increasing the percentage of poverty level and lowering the age of injury to 18, in the hopes of increasing waiver enrollment. The low amount of enrollment, the relatively low number of beneficiaries that can be served with the current funding levels, and the need to build provider capacity does not make statewide expansion a viable option at this time.*

Quality:

1. Q. We welcome the opportunity to help shape quality metrics that are meaningful, measurable, and maintain choice and control for our members Initial recommendations for consideration include: 1) Reporting beginning in year 2, once a baseline of membership is established..2) Aligning the timeline with the 3-year NCQA timeline. This will allow Plans to be working towards

accreditation goals and meeting the State's performance measure goals. *A: The Department is looking forward to engaging with BH I/DD Tailored Plans around quality measurement and understands that BH I/DD Tailored Plans have concerns around reporting requirements. This engagement is scheduled to begin this month.*

2. Q: Would the state consider the following: Year 1 – Beta Year – allow the Plans to understand the population & those measures which their population qualify based on HEDIS reporting rules. Year 2 – Test Year – allow Plans to develop and test initiatives; therefore, establishing baseline measures, effectiveness of interventions and barriers. Year 3 – First reporting year of priority measures established based on Year 2 measures. *A: The Department intends to reduce reporting burden by substantially decreasing the number of measures plans will be required to report, focusing on the highest-priority measures for which plans will eventually be held accountable. DHHS intends to track, and in some cases is expected by federal partners to report, some of the measures that have been removed from the BH I/DD Tailored Plan RFA but will use its own resources to calculate these measures in order to reduce BH I/DD Tailored Plan requirements.*
3. Q: How is the withhold factor into the rates and how are they being determined? Will the LME/MCO be able to earn it back in subsequent years for exceeding goals? *A: BH I/DD Tailored Plans will have no quality withhold obligations until 18 months after managed care launch; in the planned timeline, they would only be required to report measure results and incorporate them into quality improvement efforts in the first year, and would not be at any financial risk. DHHS believes this approach will allow BH I/DD Tailored Plans to build on their experiences reporting measures in the LME-MCO program and will ensure that BH I/DD Tailored Plan enrollees' care is assessed with the same rigor as their SP PHP counterparts, while avoiding premature financial accountability. In recognition that the first year will involve additional learning for both BH I/DD Tailored Plans and DHHS, DHHS has not yet designated which measures will be used in the eventual withhold program.*
4. Q: We would request the State to convene a sub-group to discuss the measures within the BH/TP contracts. *A: The Department expects to collaborate closely with BH I/DD Tailored Plan around measurements but recognizes that some aspects of the measure set are set in place for an additional period due to outside constraints. These include measures that have been negotiated with CMS as part of waiver programs and cannot be changed unilaterally by the state. DHHS has noted LME-MCO feedback on these measures shared in response to the white paper and looks forward to incorporating BH I/DD Tailored Plan feedback into the waiver renegotiation process. They also include measures, such as Child and Behavioral Core measures, that DHHS will be legally required to report as early as 2024. Given the impending reporting requirement, DHHS intends to begin reporting these measures now to ensure accurate data by 1/1/24; because the measure specifications are set by CMS and measure stewards, DHHS is unable to alter numerators, denominators or other aspects of these measures.*

Healthy Opportunities:

1. Q: What are the specific expectations and scope of work for LME/MCOs regarding work with regional awardees, SP PHPs, and others on Healthy Opportunities, prior to TP go live? *A: We are still finalizing the pilot timelines. A proposed timeline has the pilots going live approximately 6*

months before BH I/DD Tailored Plans go launch. Once the timeline is finalized, we can engage in more conversation around Healthy Opportunities and the pilots.