TRANSCRIPT OF
BEHAVIORAL HEALTH SERVICES STANDARD PLANS
AND TRANSITION PERIOD WEBINAR
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Robby Buchanan — Welcome everyone. Thank you for joining today's webinar. My name is Robby Buchanan with WebEx, and I will be your organizer for today's webinar presentation on North Carolina Medicaid Behavioral Health Services in Standard Plans and During the Transition Period. Today's presentation is the sixth in a series of nine provider education modules that are planned on Medicaid transformation. Notification on additional provider education modules will be forthcoming and posted to the Medicaid Transformation website. There are a few housekeeping rules before we get started. If you experience technical difficulties joining the WebEx session, please dial 1-866-779-3239, or you can message a WebEx producer using the Q&A panel. During the presentation, all participants will remain in listen-only mode and as a reminder, this event is being recorded for rebroadcast. We will be holding a Q&A session at the conclusion of today's presentation. We encourage you to submit written questions at any time during the presentation using the Q&A panel at the bottom right of your screen. Please type your questions into the text field and hit Send, and please keep the dropdown as All Panelists. With that, we invite you to sit back, relax and enjoy today's presentation. I will now turn it over to Mindy Lipson, Senior Manager at Manatt Health Strategies, to make opening remarks. Mindy, you have the floor.

Mindy Lipson — Today's webinar is intended to help providers understand the approach to meeting the behavioral health needs of Medicaid beneficiaries, including topics such as the differences between Standard Plans and Behavioral Health and Intellectual Developmental Disability Tailored Plans, Medicaid Managed Care and Tailored Plan eligibility and enrollment, and Behavioral Health Net Benefits and Networks in Medicaid Managed Care. We have several team members from the North Carolina Department of Health and Human Services that will be on hand to present today's webinar and to help answer questions that we receive throughout the presentation. These team members include Julia Lerche, Chief Actuary and Policy Advisor of North Carolina Medicaid, Deb Goda, Behavioral Health Unit Manager from North Carolina Medicaid, and Lynn Tessa, Senior Program Analyst from North Carolina Medicaid. I would now like to introduce Julia Lerche, who will provide the content overview for the presentation and then briefly

cover North Carolina Medicaid transformation.

Julia Lerch

Good afternoon, this is Julia Lerche with North Carolina Medicaid. Thank you all for joining us today for this webinar. During this webinar, we'll be reviewing several topics. We'll provide you with an overview of the Medicaid managed care transition, including a timeline with major milestones as part of the transition. We will also review the eligibility and enrollment for Medicaid managed care, including who will be enrolled in the standard plans, and who will be eligible and be enrolled in the future Behavioral Health and Intellectual and Developmental Disabilities Tailored Plan. I will then hand it off to my colleague, Deb Goda, who will review the behavioral health benefits and networks in the various managed care products, and also review the care management approach under managed care, and then we'll close out with instructions for where providers can get more information. Okay, next slide, please. Go to the next slide.

So, for those of you that have participated in these webinars before with North Carolina Medicaid, you may be familiar with our vision statement for Medicaid Transformation. Our vision for Medicaid Transformation is to improve the health of North Carolinians through an innovative, whole-person-centered and well-coordinated system of care, which addresses both medical and non-medical drivers of health. This is really the core of what we're trying to accomplish through our managed care transition here at Medicaid, and we hope that that comes through in information that we'll share with you today. The next slide.

Just in terms of background for how we've gotten to where we are today on the Medicaid Transformation. And back in 2015, the General Assembly passed Session Law 2015-245, and that directed the Department to transition our Medicaid and North Carolina Health Choice programs from what's currently a predominantly fee-for-service program, which includes our managed care partners' local management entity managed care organizations that cover behavioral health for most of our populations today to one that's predominantly managed care, working with health insurance companies and other organizations to provide comprehensive managed care to our beneficiaries. Since the statute passed in 2015, we have been working collaboratively with many stakeholders, hopefully many of you all that are participating in this webinar have participated in other activities and provided feedback throughout the process. We've worked with clinicians, hospitals, beneficiaries and their caregivers, counties, health plans, elected officials, advocates and other stakeholders in shaping this program, and we know everyone is committed to ensuring that Medicaid is a

successful program and that managed care runs smoothly.

In terms of some of our focus areas for the managed care transition, we are focused on delivering whole-person care through coordinated physical health, behavioral health, IDD and pharmacy products, and care models, and that's where we'll focus our time today, but we're also working towards addressing the full set of factors that impact health, which includes both the medical and non-medical drivers of health, working with communities and healthcare systems to achieve the vision for our future Medicaid. We're also striving for localized care management to the extent possible at the site of care in the home or the community, and maintaining what we currently have broad provider participation in the program, and we're doing that by trying to mitigate any provider administrative burden as we transition into the new world of managed care here in Medicaid. The next slide.

In the process of trying to achieve our vision for Medicaid, we are really focused on integrated, coordinated systems of care. And what that means is that when beneficiaries are enrolled in managed care plans, that managed care plan will cover the full scope of their healthcare needs, excluding dental, which is carved out. But that covers medical, behavioral health, IDD, traumatic brain injury, and pharmacy benefits, and all – basically, benefits that are covered under Medicaid.

As we move into managed care, rather than being reimbursed directly by the State, Medicaid providers will need to contract with the managed care entities, and they'll be reimbursed by those managed care entities that we refer to as prepaid health plans, for services that are provided to beneficiaries that are enrolled in those managed care plans. There will be certain populations in the Medicaid program that will continue to receive coverage as they do today through the fee-for-service program. Those we refer to and we'll go through them in detail later in the slide as Excluded Populations. They're excluded from enrollment in the managed care plans, and we'll walk through those. In a managed care space, there are two types of products that will be offered. The first that will launch are standard plans. And the standard plans are where many, most of our Medicaid and North Carolina Health Choice beneficiaries will be enrolled. They're scheduled to launch later this year, in November of 2019 in two of our six regions. We'll review that later. And in February of 2020 for the remaining regions. We're expecting about 1.5 million of our 2 million beneficiaries to be enrolling in the standard plans, just to give you some idea of how the populations will split out.

The second type of product is the Behavioral Health and Intellectual and Developmental Disability Tailored Plan. Those plans are really geared and focused toward qualifying high-need populations with serious mental illness, serious emotional disturbance, severe substance use disorders, intellectual and developmental disabilities or traumatic brain injury. They're tentatively scheduled to launch in July of 2021, and for those populations that meet that criteria, prior to launch of the Tailored Plans, they will generally be enrolled in our current system, so they'll stay in the fee-for-service system and to the extent they're currently enrolled in an LME-MCO, which are behavioral health managed care entities today, they'll remain where they are. Some will have the option to enroll in a standard plan if they wish to take action to do so. We estimate a little over 100,000 of our beneficiaries will meet the qualifications for enrolling in these Tailored Plans in 2021. And those, again, those beneficiaries will, for the most part, be staying in the current system, until that time. The remaining 400,000 or so beneficiaries, as I said, will stay in the current system, at least for the next several years, and we'll review those populations later in the slide.

Just to make sure it's clear, beneficiaries will not be enrolled in both a pre-paid health plan and an LME-MCO. So, beneficiaries that are enrolling in a Standard Plan will not also have an LME-MCO. They will receive their behavioral health benefits through the Standard Plans, if that's where they're enrolled. The Standard Plans, both the Standard Plans and the Tailored Plans will have a robust set of behavioral health benefits. However, there are certain more intensive behavioral health benefits that will only be available through the behavioral health and IDD Tailored Plans, and prior to the launch of those plans will continue to be available through the LME-MCOs. And Deb will review those services later in the presentation.

Both products will have a focus on high-quality, localized care management to align with our vision for Medicaid, as we went through earlier in the slides. Okay, moving on to the next slide.

This slide walks through or Medicaid Transformation timeline with the major milestones that we have achieved thus far and are looking ahead to achieve. In October of 2018, we had our 1115 demonstration waiver approved by CMS. That's the waiver that gives us federal authority to move forward with our managed care program. In February 2019, we awarded standard plan contracts to five pre-paid health plans. Starting in June, later in June, and into July, our enrollment broker, who is a contractor of the Department that we're working with to help assist beneficiaries with the plan enrollment process, they will begin to send

enrollment packages to beneficiaries in the first two regions where we'll be doing our managed care rollout. And that's when beneficiaries will have the opportunity to elect the health plan that works best for their needs.

Through the summer of 2019, we expect that the standard plans will be reaching out and contracting with providers. There are network adequacy requirements that the health plans need to meet as part of their contractual obligations and to meet the needs of the beneficiaries, and those will be tested prior to launch by the Department.

In November of 2019 is when the Standard Plans will begin providing coverage and benefits to beneficiaries in the initial two regions of our phase in. And then in February 2020, is when we anticipate that the Standard Plans will cover beneficiaries in the remaining four regions. Also in February 2020 is when we're targeting to send out a request for applications for the Behavioral Health and Intellectual and Developmental Disability Tailored Plan, which is where the Department would be procuring the contractors for those plans, with an award date targeted for May of 2020. Following that award, those Tailored Plans will then be working to build out their provider networks to meet the network adequacy standards for the Tailored Plan. So you all can expect to be hearing from them during that time period for contracting. And then the targeted launch date for the Tailored Plans is July of 2021. Okay?

The next slide provides a map where folks can see the regions. The legislation from 2015 that authorized and directed the Department to launch managed care required that the Department develop six regions in the state for purposes of managed care contracting. We are, as mentioned before, doing a regional phase in where in November of 2019, that's when the first two regions, which are Region 2 and Region 4 on the map here up in the central, northern part of the state, will begin covering beneficiaries that reside in those regions. The other four regions, as we mentioned before, will begin covering beneficiaries in February of 2020. Okay?

Moving on. So now we're going to get into more detail around the eligibility criteria and the enrollment processes for beneficiaries between the Standard Plans and the Behavioral Health IDD Tailored Plans. On Slide 10 – Slide 10 here provides background on the various, we call them population cohorts at the Department – but population groups, and where they will be enrolled as we begin to roll out managed care. Most of our Medicaid beneficiaries, as we mentioned earlier, will

be enrolling in Medicaid managed care, either in the Standard Plans or the Behavioral Health IDD Tailored Plans. We know that the Tailored Plans will not cover all beneficiaries that have behavioral health needs. Beneficiaries that are eligible for the Tailored Plans will generally also have a choice to enroll in the Standard Plans, so the Standard Plans also have significant requirements around meeting the needs of those beneficiaries, although there are some differences in the covered benefits, which we'll review later in the presentation.

So, in terms of who is enrolled in managed care, the populations that will be included in managed care initially are our Medicaid and North Carolina Health Choice enrolled children, parents and caretaker adults and our beneficiaries with disabilities who are not enrolled in both Medicaid and Medicare. And there are exceptions, which are, if a beneficiary is in one of the many bullets down below, they fall into one of those categories. But generally, our children, parents and non-dual disabled will be enrolled in Standard Plans at launch. Members of federally recognized tribes are exempt from managed care, and what that means is they will basically be staying in the current system, but they will have the option to enroll in the Standard Plan or Tailored Plan, if they meet the Tailored Plan eligibility criteria. The Department has also been working very closely with the Eastern Band of Cherokee Indians. They are our one federally recognized tribe in the state, and we are working with them to roll out a Tribal managed care entity, which is scheduled for later in 2020. In terms of the populations that will be excluded, so these are beneficiaries that will remain in the current system, with fee for service coverage. They will not have the option to enroll in a Standard Plan. They are completely excluded from managed care based on legislation, so those populations include what we refer to as the Medically Needy Population. Those are our beneficiaries that have a spend-down or a deductible that they need to meet before their benefits begin. So, they will not be enrolled in a managed care plan, unless they are on the Innovations waiver or the TBI waiver, in which case they would be enrolled in the Tailored Plan.

Similarly, for the health insurance premium payment program, this is a program where we cover the premium for private insurance, and then Medicaid wraps around that. Beneficiaries in that program will also be excluded, again, unless they are on the Innovations or TBI waiver. Our Community Alternative Program waiver enrollees will also be excluded from managed care. They'll continue to be covered through the current fee-for-service system. And then beneficiaries that have limited Medicaid benefits, which include our populations that only receive family planning benefits, partial duals who are those who have Medicare

and Medicaid covers only their premiums and co-payments and deductibles. Those populations will not be enrolled in Managed care. Additionally, other beneficiaries that are only eligible for emergency services will not be included, and inmates will not be included in managed care. Additionally, our Pace, populations of beneficiaries in the Pace program – there are about, under 2,000 of them – they will be excluded from managed care enrollment.

In addition to those populations, we also have several populations that we refer to as Delayed Populations, and these fit into several different categories. So the first is where we're going to focus some time on the next few slides, which is our Behavioral Health and IDD Tailored Plan eligible beneficiaries. So, those beneficiaries, as we mentioned before, are the population that are targeted for our Tailored Plans that are scheduled to roll out in the middle of 2021. In the meantime, anyone that meets that eligibility criteria, unless they're on the Innovations or TBI waiver, can opt into a Standard Plan. If we at the Department identify them as meeting Tailored Plan eligibility in this period leading up to launch of Standard Plans, they will be remaining in the current system with the option to move into the Standard Plan should they wish to do so.

The dual eligibles, so those with Medicare and full Medicaid benefits, they will receive – if they meet the Tailored Plan eligibility, they will receive their behavioral health and IDD services through the Tailored Plan in 2021, but their other Medicaid-covered services will remain in fee-for-service until 2023, which is when the whole dual population is scheduled to come into managed care.

Beneficiaries who are in the foster care system, those who are former foster care youth and those in adoptive placement will actually be excluded from managed care until 2021. So they will not have the option to enroll in the Standard Plan in this initial period of managed care rollout. And then in 2023 is when we plan to bring in our long-stay nursing home population, so beneficiaries who are in a nursing facility for more than 90 days will not, will be excluded from Standard Plan and Tailored Plan enrollment in these initial years, and then they'll come in in 2023 when we have, and, we don't have all of the details right now for how the plans will be established, but that's our legislative, statutory requirement to bring them into managed care in 2023. And in addition, those who are eligible to have Medicare and full Medicaid benefits will—who are not Tailored Plan eligible will be coming into managed care in 2023. And all that to say these are how we figure out where beneficiaries move in terms of the delivery system once they are in

Medicaid. None of this impacts actual eligibility for Medicaid. So the eligibility for Medicaid does not change as we move into Medicaid managed care, we're talking about where beneficiaries receive their benefits. Whether it's their managed care plan, Tailored Plans or through the fee for service system. So that's the designations that we're making through this slide.

Okay, moving on to slide 11. So as mentioned before the Tailored Plans are targeted to beneficiaries with more intensive behavioral health needs, including mental health and substance use disorders. IDD and traumatic brain injuries. Beneficiaries with those conditions will be eligible to enroll in the Tailored Plans as well. We are doing data reviews to try to identify beneficiaries that meet the criteria for Tailored Plans so we can make sure they are staying in the current system. We also will have a process and we'll walk through that later in the slides, for how beneficiaries can ask to be considered for Tailored Plan eligibility so they can also remain in the current system. But slide 11 here lays out the major criteria for eligibility for Tailored Plans and what we'll be looking for in our data reviews. So any beneficiaries that are enrolled in the Innovations or TBI Waiver or on a waiting list for one of those waivers, will be identified as part of the Tailored Plan eligibility group and they will stay in the current system. As I mentioned before, anyone who is on an Innovation or TBI waiver will be staying in fee for service. They will not have the option to enroll in the standard plan unless they first disenroll from their waiver. Beneficiaries on the waiting list, as I mentioned, will also be flagged to remain in the current system and in Tailored Plans when Tailored Plans roll out. Enrollees who are in the transition to community living initiative will also meet the Tailored Plan eligibility criteria. Additionally, those that have used the Medicaid service in the past and our lookback period is from January of 2018. So anyone that's used a Medicaid service that will not be available through the standard plans but will be available through the LME-MCOs in it's initial period. And in the future in the Tailored Plans will also be flagged for Tailored Plan eligibility. Those that have used the behavioral health IDD or TBI service funded with state, local, federal or other non-Medicaid funds will also be flagged for Tailored Plan eligibility. As will children with complex needs as defined in the 2016 settlement agreement.

Beneficiaries that have a qualifying IDD diagnosis code will also be part of the Tailored Plan eligibility group. Those that have a qualifying SMI, SED or substance use disorder diagnosis code and also have used a Medicaid covered enhanced behavioral health service since January of 2018 will be part of the Tailored Plan population. Beneficiaries that

have had an admission to a state psychiatric hospital or alcohol and drug abuse treatment center will also be included. So that includes those with one or more involuntary treatment episodes in a state-owned facility. And then, finally, beneficiaries that have two or more visits to the emergency department for psychiatric problems or psychiatric hospitalization or readmission or two or more episodes of using a behavioral health crisis service since January of 2018 will be included in the Tailored Plan eligible population.

We estimate, as I mentioned before, a little over a hundred thousand beneficiaries meeting this criteria for Tailored Plan eligibility. That breaks out about 30,000 of them are dual eligible. Again those are those beneficiaries that have Medicare and full Medicaid benefits and roughly 85,000 are non-dual so they don't have Medicare, they only have Medicaid. Okay?

Moving on to slide 12. As mentioned before, in late June and into early July, beneficiaries will begin to receive notices from the Department. That provides information on enrolling in managed care, and those notices in June will be sent to our beneficiaries in Regions 2 and 4. Those are our initial regions. And then for the other four regions, they'll begin to get their notices in September. There are different notices for beneficiaries, depending on whether or not they meet the Tailored Plan eligibility criteria. For those that are – that don't meet the Tailored Plan eligibility criteria, we refer to them as Standard Plan Mandatory.

And they'll receive a notice that gives them information about the timeline for enrolling in managed care, how they can go about selecting a primary care provider in a health plan, what they need to do if they believe they need, they basically may meet a Tailored Plan eligibility criteria, so if they believe they need certain services to address IDD, mental illness, TDI or substance use disorder, there's a process and information there for how they can get more information about their other choices should they want to stay in the current system. And then there will be contact information for the enrollment broker, who will be available to help them through this process of plan selection.

There will also be notices going out to those beneficiaries that are identified as Tailored Plan eligible, except those that are in the Innovations or TDI waiver. They will not be getting one of these managed care notices, because they will not have the option to be in a managed care program unless they want to dis-enroll from their waiver, and we do not suspect that will be likely to happen. So, beneficiaries eligible for the Tailored Plan, as we mentioned before, they will remain

in the current system, with the option to enroll in the Standard Plan. And their notice will give them information that makes it clear to them that they will continue to be in the current program if they don't take any action, that they do have new options, new Standard Plan options, and there will be explanations of those Standard Plan benefits, including information that the Standard Plans offer a more limited benefit set than they may be getting today in the fee-for-service program and through the LME-MCOs. And then, again, there will be information for the enrollment broker contact, should they need more assistance in making their selection. So, I'm going to pass this off to my colleague, Deb Goda, who's our Behavioral Health Unit Manager here in North Carolina Medicaid. Take it away, Deb.

Deb Goda

Thank you so much, Julia. So, talking about the transition between Standard Plans and Tailored Plans or between Standard Plans and the current fee-for-service environment with the LME-MCO of the behavioral health managed care organization. Beneficiaries who aren't identified by our running of the data prior to Tailored Plan – or, sorry, Standard Plan launch, we want a process whereby the individuals with assistance from their providers can say, we feel that you missed us in this process. So, while we think we've gotten it just about right from data, we don't want to not have a process whereby people can indicate that they've been missed or feel that they need to have services that are available in the LME-MCO arena or the Tailored Plan arena. So, beneficiaries not identified by us as the Behavioral Health IDD Tailored Plan eligible can request a review of their eligibility for the Tailored Plan at any. So, prior to the Tailored Plan, individuals who are found to be eligible for the Tailored Plan will be able to move back into fee-for-service and receive their behavioral health services through the LME-MCO. After Tailored Plan launch, those beneficiaries would be transitioned from the Standard Plan directly into the Tailored Plan.

So, right now, we are in the process of developing approval _____ that contains all of the necessary information needed to determine whether or not the beneficiary's needs meet the Behavioral Health IDD Tailored Plan eligibility criteria. Beneficiaries will work closely with their providers in completing this form and in providing documentation for this process. So, if an individual feels that their needs are for a tailored plan, then they would reach out to our enrollment broker, Maximus, as part of the process, and they can indicate that they are interested in being reviewed for Tailored Plan eligibility. The beneficiary will be sent a form, or they can download that form from the enrollment broker's site. They can complete it with the assistance of their provider, and it would be submitted back to the enrollment broker. The enrollment

broker will then take that request and will notify DHHS or its designated vendor that this individual has requested to be assessed to be in the fee-for-service/LME-MCO system or in the Tailored Plan after Tailored Plan launch. DHHS or its designated vendor will review that request. If it is a regular request it will be reviewed and acted upon within seven days. If it is an expedited request where a Tailored Plan only service is necessary within 72 hours to ensure health safety and well-being, then that request will be processed and the transition will occur within 72 hours to back to fee-for-service or to the Tailored Plan and the LME-MCO will be given that authorization request to act upon. So DHHS and their designated vendor will work with the enrollment broker to notify the beneficiary of approval or non-approval. If they are approved the beneficiary will be transferred from the Standard Plan to the Tailored Plan or back to fee-for-service and the LME-MCO system and we will ensure that the LME-MCO receives and acts upon the request for that service that is needed by the beneficiary.

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So the key takeaway for this portion of the presentation is that most of beneficiaries, including those who have mild to moderate behavioral health needs are going to be enrolled in the Standard Plan. Beneficiaries may request through the enrollment broker a form which they can complete with the assistance of their provider to move from the Standard Plan to the Tailored Plan. Providers will assist beneficiaries in understanding the difference between the two plans based on the service need and the diagnostic needs of the individual. Providers are key in helping beneficiaries who they feel may benefit from Tailored Plan services or services that are only offered within the Tailored Plan. Providers can refer beneficiaries to the enrollment broker if there are additional questions on how to request the transition from the Standard Plan to the Tailored Plan. This is not going to happen until 2021, so please stay tuned for additional information on Tailored Plan launch. But in the meantime, those beneficiaries who need services that are only offered through the LME-MCOs may request to move back to fee-for-service and receive their services through the LME-MCO.

Next slide.

Now we're going to talk about behavioral health and network for managed care.

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So under managed care transformation both Standard Plans and

Tailored Plans will have physical health, behavioral health and pharmacy services. So, the Standard Plans will be responsible for taking care of all of the needs for those individuals with the exception of dental, and those that are in the Tailored Plan will continue on with their fee-for-service and LME-MCO services until Tailored Plan launch, at which time the Tailored Plan will be responsible for all of their physical health, behavioral health and pharmacy services. This applies to most Medicaid and North Carolina Health Choice enrollees, except for those that have been excluded or exempted as Julia mentioned earlier. So, in addition to physical health and pharmacy services, both the Standard Plans and the Tailored Plans have behavior health services. The Tailored Plans will have a more extensive set of services for individuals who have a higher level of need. It will also include all of the Innovations waiver services, TBI waiver services and the 1915(b)(3) waiver services and the State-funded services. So currently if an individual is receiving services through DMHDDSAS dollars, also known as IPRS dollars, those individuals could only access those services through the Tailored Plan or through the LME-MCO system. So integrating behavioral health and physical healthcare benefits enable plans, care managers and providers to deliver whole-person, coordinated care. So we are expecting this from both of our plan products.

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So if a beneficiary needs a service that's only offered under the Tailored Plan or under the MCO beforehand, he or she will need to transition to the behavioral heath I/DD Tailored Plan to receive that service. I won't read all of the services, but you can see that there is an extensive array of behavioral health I/DD and TBI services that are offered under the Standard Plan. These will meet the needs of most people who have mild to moderate behavioral health needs. The services offered under the behavioral health I/DD TBI Tailored Plan include all of the services offered under the Standard Plan, plus the additional services in that column. Those are things such as your residential treatment facilities for children, your ICF facilities for individuals with intellectual disabilities, substance abuse residential treatment facilities, sort of community treatment or ACT team, and others. So, individuals who need a service that is not offered under the Standard Plan can request to be assessed for Tailored Plan eligibility and prior to launch can be assessed to move back in the fee-for-service LME-MCO system. Now, peer support is not current a service that is a State plan service, but we are pursuing it as a State plan services. Once it is approved by CMS it will be available in the Standard Plan. And then we also have a clinically-managed low intensity substances abuse service that will be offered

underneath the behavioral health Tailored Plan, but the spa has not yet been approved for that service, but once it has it will be offered under the Tailored Plan only.

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So, Behavioral Health Network Requirements. Both the Standard Plans and the Tailored Plans will need to have network adequacy for all of their providers, be they physical health providers or behavioral health providers. So this slide is showing the urban and rural standards for their behavioral health network – Standard and Tailored. Please note the Standard Plans has an open network, so they must contract with any Medicaid provider that wishes to contract with them and is willing to accept their rate. The Tailored Plan will continue to be a closed network, just as they are with the LME-MCO system. Both plans need to have an adequate network of behavioral health providers. So you can see, for outpatient behavioral health services, in urban areas there must be two providers for each outpatient behavioral health service within 30 minutes or 30 miles of the residents for at least 95% of the members. In rural areas, that is two providers within 45 minutes or 45 miles for at least 95% of the members. For location-based services, for behavioral health there must be two providers of each service within 30 minutes or 30 miles for at least 95% of members. In rural areas, again, two providers within 45 minutes or 45 miles. Behavioral health crises services, there must be one provider in each PHP region. There must be one inpatient behavioral health provider within each PHP region and for partial hospitalization there needs to be a provider within 30 minutes or 30 miles for at least 95% of the members for both urban and rural areas. The full Standard Plan network adequacy requirements can be found at the link at the bottom of the slide [https://files.nc.gov/ncdhhs/30-19029-DHB-2.pdf] if you want to see the other services and what those requirements are.

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So to review, a subset of highly intense behavioral health IBD/CBI benefits will only be offered in the tailored plans. It's important for providers to understand which benefits are offered in which plan so that they can provide guidance to the individuals that they're supporting. Providers will need to contract with both the standard plan and the LME/MCOs and then tailored plans after tailored plan launch. And once managed care launches providers bill the appropriate payor via Medicaid Direct fee for service, the LME/MCO or standard plans.

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And a brief overview of care management.

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So the standard plan/care management approach... Our individuals who have behavioral health needs are a priority population for care management. Care management has to encompass those physical, behavioral health and non-health drivers. We expect that all individuals will be screened to determine whether or not they have a need for the care management. And then there must be a way for the standard plan to identify priority populations including children; adults with special healthcare needs, including behavioral health; individuals who are at risk for chronic conditions; individuals in need of long-term services and support; enrollees who have risk factors affecting their health; and individuals with high unmet resource needs. They must also provide transitional care management; general care coordination functions for services and social determinants of health; and they also must provide prevention and population health management. These services will be provided by AMHs -- Advanced Medical Homes -- in standard plans, generally.

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I'm going to turn it over to Lynne Hesta.

Lynne Hesta Thanks Deb. For everyone participating on today's call please know that the department remains committed to ensuring that providers receive education support during and beyond the transition to Medicaid Managed Care. We will look now at provider opportunities for further engagement.

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Providers should know that we value their input and feedback and are making every effort to provide opportunities to connect through a multitude of activities. We are in the midst of a series of topic-based webinars that offer education to providers on key topics to effectively serve Medicaid and North Carolina Health Choice beneficiaries in the transition to managed care. And also offer fact sheets and FAQs to assist in the understanding of Medicaid changes. The North Carolina website serves as a central hub for providers to access resources about the transition to managed care. In addition to the Medicaid transformation link provided on this slide, the main Medicaid webpage

(www.medicaid.ncdhhs.gov) offers links to additional engagement opportunities. From the main Medicaid webpage choose providers, then providers transitioning to Medicaid managed care. In addition to the presentations and recordings for this series of webinar training courses, there is information for PHP meet & greets currently being held across the state. PHP meet & greets offer providers and practice staff the opportunity to meet health plan representatives to ask questions about joining their networks. The department is also hosting virtual office hours, which is an opportunity for providers to ask questions regarding the transition to Medicaid Managed Care in a real-time format. Please review these websites frequently to stay abreast of new information and opportunities for engagement. And because we value your feedback we encourage you to continue submitting questions or concerns to the Medicaid Transformation email address provided on this slide.

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Here is a snapshot of the upcoming provider education opportunities. Three additional webinars are scheduled in the coming weeks that will cover topics on AMH contracting with health plans, clinical policies and healthy opportunities in Medicaid Managed Care. In addition there is a link to the PHP meet & greets and virtual office hours schedule on the right side of this slide. Providers are encouraged to visit the Medicaid websites often and to look for upcoming events and webinars, advertise through special bulletins and _____ tracks provider announcements.

We thank you for joining us today. I will now transition to Mindy to open up for questions and answers.

Mindy Lipson — Thanks Lynne. The first question is for Julia and it is: ***how will beneficiaries learn if they're eligible for a behavioral health and intellectual & developmental disability-tailored plan?***

Julia Lerch — So beneficiaries, as their region rolls out for managed care, will be getting a notification of their coverage options. Beneficiaries that meet the tailored plan eligibility criteria will receive a notice that indicates that they will stay in the current system, but they have the option to enroll in standard plans. There will be information there that alerts the beneficiaries that if they do choose to move to a standard plan they may have limited benefits compared to what they have in the current system.

Mindy Lipson — Thanks Julia. The next question is for Deb and it's: ***what will happen if a person is in a standard plan and needs a service that's only offered in***

a behavioral health and intellectual & developmental disability-tailored plan?

Deb Goda — So that individual will request, with the assistance of their provider, to be reviewed for eligibility for the tailored plan. That service request, depending on whether or not there's an urgent need, will be processed from three days to seven days and the LME/MCO would receive that request for that service to process.

Mindy Lipson — Thanks Deb. The next question is also for you. And it is: ***how will a provider know if his or her patient is eligible to move to a behavioral health and intellectual & developmental disability-tailored plan?***

Deb Goda — So the provider should be aware of the services that are offered under each plan. And if the individual requires the service that's only offered under the tailored plan or the LME/MCO system, then a request would need to be made for the individual to be reviewed to move to that plan.

Mindy Lipson — Thank you. So the next question is for Julia. And it's: ***after July 2021 will the LME/MCOs no longer be handling services for beneficiaries that are eligible for a tailored plan?***

Julia Lerch — So the legislation requires that for the first four years after launch of the tailored plan, that the department contract only with the entities that are LME/MCOs. So the LME/MCOs in essence, through a request for a procurement process/request for application, the LME/MCOs can apply to become and operate the tailored plan. And LME/MCOs are the only entities, as I said, that are eligible to apply to operate tailored plans. The LME/MCOs as they exist today only covering behavioral health services will terminate -- that will end when the tailored plans launch because they'll be operating tailored plans at that point.

Mindy Lipson — Great. Thank you Julia. The next question is also for Julia: ***so if a person is dual eligible for Medicare and Medicaid, will their enrollment be delayed?***

Julia Lerch — So there will be basically two different populations within the dual-eligible. So if a dual-eligible meets the criteria for tailored plan eligibility, that dual-eligible will receive their behavioral health and IBD/TBI services through the tailored plan when tailored plans launch in 2021 and they'll continue to receive their other medical benefits through the current fee-for-service program. In 2023 that's when all dual-eligible -- so those with Medicare and Medicaid -- will be enrolling in a managed care product for all of their services.

Mindy Lipson — Thanks Julia. Another question for you: ***will NC Health Choice enrolled children also be enrolling in managed care?***

Julia Lerch — The answer is yes they will. They also will -- if they meet tailored plan eligibility criteria -- be treated like children in Medicaid who meet tailored plan eligibility criteria. There are some small differences in the covered benefits between Medicaid and Health Choice and those will continue under the future systems, but the delivery systems for the Health Choice children will mirror that of Medicaid children.

Mindy Lipson — Thanks Julia. Another question for you is: ***what is the enrollment broker?***

Julia Lerch — So the enrollment broker is an entity that the department has contracted with to support beneficiaries through this transition to managed care. The department has contracted with an entity called Maximus. And what they'll be doing is providing Choice counseling for beneficiaries -- so helping them through the process of selecting the prepaid health plan or health plan and PCP that works best for them. They'll be providing enrollment assistance in education beneficiaries. They'll be doing outreach to beneficiaries to help educate them about the transformation. And they'll assist members over the phone through a contact center online and through a user-friendly website.

Mindy Lipson — Thanks Julia. I think this one is also for you and the question is: ***is there a list of diagnoses that fit the standard plan versus tailored plan eligibility criteria?***

Julia Lerch — Yes there is. It is posted on the website that's in the last slide of the presentation. It's (www.ncdhhs.gov/assistance/medicaidtransformation) and if you look at the banner it says 'latest news' / 'final policy guidance for behavioral health IDT tailored-plans eligibility and enrollment' has all of the details about the criteria for tailored plan eligibility including the list of diagnoses. I saw there was ***one other question asking if autism was one of the qualifying diagnoses*** and it is.

Mindy Lipson — I think we have time for one final question and this I think is a question for Deb. And the question is: ***do you think a provider should or can a provider contract as both standard and tailored plans?***

Deb Goda — I would hope that the providers would contract with both the standard and tailored plans so that they can provide services to the individuals that need the services, but also if they have an individual who moves from a lower intensity need to a higher intensity need they can continue

that relationship with the beneficiary as they move from the standard to the tailored plan.

Mindy Lipson — Thanks Deb. So I think that that takes us to our time today. And we want to thank everyone for participating in today's webinar. The presentation, recording, and Q&A summary will be posted shortly. Thank you so much to all of you.

Robby Buchanan — Ladies and gentlemen thank you for attending today's webinar. This concludes today's event. You may now disconnect your lines and have a great day.

End of webinar.