REQUEST FOR BOARD ACTION

HENDERSON COUNTY BOARD OF COMMISSIONERS

MEETING DATE: September 4, 2018

SUBJECT: Medicaid Transformation Update

PRESENTER: Brian Ingraham, CEO Vaya Health

ATTACHMENTS: Yes

1. Power-point Presentation

SUMMARY OF REQUEST:

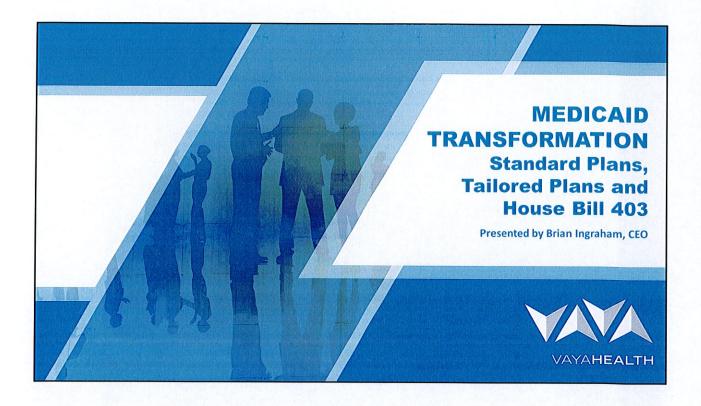
Brian Ingraham, CEO of Vaya Health, will present information on Medicaid Transformation, including the standard and tailored plan designations and options.

BOARD ACTION REQUESTED:

No Board action is required. This item is for informational purposes only.

Suggested Motion(s):

No motion suggested.



Standard Plans and Tailored Plans: What are they?

Standard Plans address the majority of the Medicaid population, both physical health and behavioral health for those individuals with mild to moderate challenges

 Standard Plans can be up to four statewide commercial plans and up to 10 Provider Led Entities (PLEs) serving the 6 regions of the state Tailored Plans are for those individuals who have more complex behavioral health needs, individuals with IDD and other individuals identified in House Bill 403

- Tailored Plans will also manage the physical health needs of the person with behavioral health/IDD
- Current legislation stipulates there will be no fewer than 5 and no more than 7 Tailored Plans

House Bill 403

- Added Secretary's concept of BH/IDD Tailored Plans that will cover integrated physical health, pharmacy, BH and IDD services for complex, high-risk population
- Added mild to moderate BH population to scope of Standard Plans

 list of services includes inpatient, OPT, crisis and some SUD –
 overlap with enhanced services
- Established assessment and transition process for members moving between plans
- Excluded CAP-C and CAP-DA from Standard Plans
- Went from three to four statewide PHP contracts
- Directed DHHS to submit a report to JLOC Medicaid and NCHC with TP implementation plan by 6/22/18

HB 403 – Tailored Plan Overview

- LME/MCOs can be only entities that operate BH/ IDD TPs for the initial 4-year contract term
- · No fewer than five and no more than seven
- Must maintain some components of 1915(b)/(c) Waiver:
 - B3 and HCBS services
 - Care Coordination
 - Closed provider networks
 - Manage rates
 - · Local Business Plans
 - CFAC input
- Requires LME/MCOs to partner with Standard Plan PHP
- Covered population shrinks but covered services expand to include physical health and pharmacy

HB 403 - Tailored Plan Rollout

- TP application process cannot start until 31 Aug 2018
- TPs go live one year after implementation of first SP contracts (potentially as early as November 2020)
- LME/MCOs must go through RFA process: "Comprehensive readiness review"
- Constituent counties may change depending on TP regions
- After initial 4-year term, contracts awarded through competitive RFP process open to nonprofits

HB 403 – TP Covered Population

- Individuals with SED or a diagnosis of "severe" SUD or TBI
- Individuals with a developmental disability as defined by Chapter 122C
- Individuals with mental illness who:
 - Meet TCLI criteria
 - Had 2 or more psychiatric hospitalizations or admissions within prior 18 months
 - Known to have had one or more IVC within prior 18 months
 - Had 2 or more visits to the ED for a psychiatrictric problem within prior 18 months
- Individuals with any diagnosis who have had 2 or more episodes using BH crisis services within prior 18 months
- Individuals receiving any of the services currently covered by LME/MCOs that are NOT covered by SPs
- Children with Complex Needs
- Children aged 0-3 with or at risk of developmental delay or disability
- Children involved with DJJ/ DDP "who meet criteria established by DHHS"

Standard Plan RFP

- Must identify subcontractors by name
- Deadline for RFP response: 2 pm 12 Oct 2018
- Contracts awarded to PHPs: February 2019
- Anticipates a two-phase PHP rollout:
 - November 2019: Medicaid managed care program will launch in Phase 1 regions (central).
 - February 2020: Medicaid managed care program will launch in Phase 2 regions (east & west).

