HOUSE BILL 403:
Medicaid and Behavioral Health Modifications.

2017-2018 General Assembly

Committee:		**Date:**	June 27, 2018
Introduced by:		**Prepared by:**	Jennifer Hillman
Analysis of:	S.L. 2018-48		Staff Attorney

OVERVIEW: S.L. 2018-48 modifies components of the 2015 Medicaid Transformation legislation as follows: (i) allows Prepaid Health Plans (PHPs) to cover certain behavioral health services when capitated PHP contracts begin; (ii) adds certain populations to the list of populations that will not be covered by PHP contracts; (iii) increases the number of statewide PHPs required from three to four; and (iv) directs a planning period for and the implementation of BH IDD Tailored Plans to serve individuals with severe behavioral health needs, to be initially operated by local management entities/managed care organizations (LME/MCOs), and to begin one year after the 1115 demonstration waiver begins.

This act became effective June 22, 2018.

CURRENT LAW: S.L. 2015-245, An Act to Transform and Reorganize North Carolina's Medicaid and NC Health Choice Programs, as amended by S.L. 2016-121, Sec. 11H.17 of S.L. 2017-57, Sec. 4 of S.L. 2017-186, Sec. 11H.10 of S.L. 2018-5, S.L. 2018-48, and Secs. 4-7 of S.L. 2018-49, with the stated purpose of providing a legislative framework for the transformation of North Carolina's Medicaid program to provide budget predictability for the taxpayers of the State while ensuring quality care to those in need. S.L. 2015-245 requires transition of the current Medicaid and NC Health Choice programs to capitated contracts with Prepaid Health Plans (PHPs) under an 1115 waiver to be approved by the Centers for Medicare and Medicaid Services (CMS). S.L. 2015-245 specifies the Medicaid services and populations to be covered by capitated PHP contracts, as well as the terms of those contracts.

BILL ANALYSIS: Section 1 of the act modifies components of the Medicaid Transformation legislation, S.L. 2015-245, as amended, as follows:

- Requires all Prepaid Health Plans (PHPs) to cover certain behavioral health services listed in the legislation. Prior to this change, the Medicaid Transformation legislation excluded all behavioral health services from PHP coverage for four years.
- Requires local management entities/managed care organizations (LME/MCOs) to cease serving Medicaid recipients who are not in certain populations that are excluded from being covered by PHPs, and requires an adjustment to the LME/MCOs capitation rate based on this change. Prior to this change, the Medicaid Transformation legislation required LME/MCOs to continue covering all the populations the LME/MCOs currently serve, for four years.
- Adds the following populations to the list of populations who are excluded from PHP coverage: recipients who qualify under the family planning category, inmates in prisons, CAP/C participants, and CAP/DA participants.
- Also adds to the list of populations who are excluded from PHP coverage recipients with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an

intellectual/developmental disability, or who have survived a traumatic brain injury, which are defined to include, at a minimum, recipients who meet any of the following criteria:

- Individuals with a serious emotional disturbance, a diagnosis of severe substance use disorder or traumatic brain injury, or with a developmental disability as defined in G.S. 122C-3(12a).
- Individuals with a mental illness diagnosis who also meet any of the following criteria: (i) have a serious mental illness or a serious and persistent mental illness as defined in the 2012 Settlement Agreement between DHHS and the US Department of Justice; (ii) have had two or more psychiatric hospitalizations or readmissions within the prior 18 months; (iii) have had two or more visits to the emergency department for a psychiatric problem within the prior 18 months, upon an assessment and determination by DHHS; or (iv) have had one or more involuntary treatment episodes within the prior 18 months.
- Individuals, regardless of diagnosis, who meet any of the following criteria: (i) have had two or more episodes using behavioral health crisis services within the prior 18 months, upon an assessment and determination by DHHS; (ii) are receiving a service that is currently covered by the LME/MCOs but that will not be covered by PHPs; (iii) are receiving or need to be receiving behavioral health, intellectual and developmental disability, or traumatic brain injury services paid for by a source of funding other than Medicaid; (iv) are children with complex needs, as defined in the 2016 settlement agreement between DHHS and Disability Rights of North Carolina; (v) are children, aged zero to three, with, or at risk for, developmental delay or disability; or (vi) are children or youth involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs who meet criteria established by DHHS.

- Increases the required number of statewide PHP contracts from three to four.
- Requires DHHS to create a plan for implementing a new type of capitated PHP contract called a "BH IDD Tailored Plan" that, except as specifically designated in the legislation, will be the same as other capitated PHP contracts, to be called "Standard Benefit Plans." The legislation prohibits DHHS from taking action to implement BH IDD Tailored Plans until the earlier of August 31, 2018, or authorization in a subsequent act of the General Assembly; however, after that date has passed, the legislation authorizes DHHS to implement the plan according to all existing and newly-enacted requirements of the Medicaid Transformation legislation.
- Establishes the following requirements for BH IDD Tailored Plans:
  - In the event of discontinuation of the 1915(b)/(c) waivers, specified essential components of those waivers shall be incorporated into the 1115 waiver.
  - BH IDD Tailored Plan contracts shall begin one year after Standard Benefit Plan contracts begin.
  - The initial BH IDD Tailored Plan contracts shall last four years.
  - LME/MCOs shall be the only entities that may operate the initial contracts for BH IDD Tailored Plans. After the initial contracts end, BH IDD Tailored Plan contracts shall be the result of requests for proposals issued by DHHS and the submission of competitive bids from nonprofit PHPs and entities operating the initial BH IDD Tailored Plan contracts.
  - An LME/MCO may only operate an initial contract for a BH IDD Tailored Plan after applying to DHHS, meeting criteria established by DHHS, and undergoing a comprehensive readiness review.
  - Prior to operating a BH IDD Tailored Plan, an LME/MCO's constituent counties may change, as allowed under Chapter 122C of the General Statutes.

- DHHS shall issue no more than seven and no fewer than five regional BH IDD Tailored Plans contracts and shall not issue any statewide BH IDD Tailored Plans.
- LME/MCOs operating BH IDD Tailored Plans shall contract with an entity that holds a PHP license and covers the services required to be covered under a Standard Benefit Plan contract.
- Entities operating BH IDD Tailored Plans shall utilize closed provider networks only for behavioral health, intellectual and developmental disabilities, and traumatic brain injury services.
- BH IDD Tailored Plans shall cover the behavioral health, intellectual and developmental disabilities, and traumatic brain injury services excluded from coverage by Standard Benefit Plans.
- BH IDD Tailored Plans shall cover Medicaid recipients with severe behavioral health needs that are otherwise excluded from PHP coverage, and this population shall be automatically enrolled with a BH IDD Tailored Plan.

- Amends the definition of "Prepaid Health Plan" to include LME/MCOs that operate or will operate a BH IDD Tailored Plan.
- Requires DHHS to submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by June 22, 2018 with a plan for implementing BH IDD Tailored Plans, containing at least the following information.
  - The date when BH IDD Tailored Plans are planned to be operational.
  - The proposed parameters for contracts between LME/MCOs and partnering entities, including strategies for integrating care and minimizing cost-shifting between the two entities.
  - Proposed language for any legislative changes needed to implement the plan.
  - A detailed description of the process for recipients to transition between BH IDD Tailored Plans and Standard Benefit Plans.
  - An estimate of State spending under the 1115 waiver if BH IDD Tailored Plans are implemented compared to estimated spending if BH IDD Tailored Plan are not implemented.
  - Measureable outcomes, and the timeframes for their achievement, to be included in the BH IDD Tailored Plan contracts.
  - A description of the solvency requirements that will apply to LME/MCOs operating BH IDD Tailored Plans.
  - Any anticipated barriers to the ability of BH IDD Tailored Plans to meet the standardized contract terms required for Standard Benefit Plans.
  - Plans for each of the following: (i) covering CAP/C recipients under BH IDD Tailored Plans; (ii) transitioning children aged zero to three with, or at risk for, developmental delay or disability to BH IDD Tailored Plans; and (iii) covering foster children, former foster children, and recipients and former recipients of adoption assistance under BH IDD Tailored Plans or another specialty plan.

EFFECTIVE DATE: This act became effective June 22, 2018.

BACKGROUND: DHHS submitted the report required by this legislation to the Medicaid Oversight Committee on June 22, 2018. A copy of the report is available at: http://www.ncleg.net/documentsites/committees/BCCI-6660/Reports%20to%20the%20LOC/

Reports%20Received%20in%202018/SL%202015-245%20amended%20by%20SL%202018-8%20BHIDDTP%20Implementation%20Plan%206.22.18.pdf.