Tailored Plans:
The Next Step in a Long Evolution

Rob Robinson, Pam Silberman, Cynthia Binanay

Medicaid transformation in North Carolina marks the next step in a lengthy history of caring for individuals with behavioral health challenges. "Tailored" health plans will cover people with severe mental illness, substance use disorders, intellectual/developmental disabilities, and traumatic brain injury, a vulnerable population that North Carolina's LME/MCOs are uniquely qualified to serve.

Until the 1940s in North Carolina, public hospitals cared for most institutionalized patients with mental health problems and most physician members of the American Psychiatric Association practiced in public institutions. During and after World War II, the paradigm started to shift when activists began to promote a new mental health policy that moved away from the care and treatment of those with complex needs in state institutional settings and toward community-based alternative settings.

In the early 1970s, in response to national community mental health centers legislation [1], all 100 North Carolina counties were clustered into "area authorities" responsible for providing publicly funded behavioral health and intellectual/developmental disability services to the people of our state. The community-based movement gained further strength in 1990 with the passage of the Americans with Disabilities Act, aimed at eliminating discrimination against those with disabilities [2]. The 1999 Olmstead decision by the U.S. Supreme Court went further to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs [3].

In 2001 the North Carolina General Assembly enacted significant mental health reform legislation with the primary intent of deinstitutionalization and privatization of clinical services [4]. Over the ensuing decade the area authorities transitioned to local management entities (LMEs) and shifted from their role as providers of behavioral health and disability services to become managers of networks of private health care providers in respective portions of the state. Initially, the state paid for these services on a fee-for-service basis.

By 2013 the state fully transitioned LMEs to full-risk-bearing managed care organizations (MCOs) receiving a per-member-per-month payment from the state to cover the mental health, substance use disorder, and intellectual and developmental disability (IDD) needs of Medicaid enrollees and the uninsured. This was the state's first foray into a statewide, fully capitated managed care system. However, the system remained fragmented, with physical health needs managed on a fee-for-service basis through Community Care of North Carolina (CCNC), and behavioral health/IDD needs managed through a capitated arrangement with the LME/MCOs.

Today, Medicaid transformation represents the most significant change in the public health care landscape in our state's history—namely, transitioning the delivery of physical health care to a managed care environment with the goal of integrating care across the behavioral health-physical health continuum. With years of experience in a capitated system already, North Carolina's LME/MCOs are playing a critical role in this transformation, and a new way of approaching care for a significantly more complex population is foundational.

Enhancing Care for Persons with SMI, SUD, and IDD

Currently, seven LME/MCOs deliver behavioral health care coordination to North Carolina's Medicaid population as well as to individuals who are uninsured or underinsured. The LME/MCO system has been successful in meeting the General Assembly's mandates to achieve budget predictability and generate savings to reinvest in our communities, while increasing the number of people served and supporting the development and adoption of innovative, evidence-based programming to meet real-world needs (Carolinas Center for Medical Excellence External Quality Review, prepared on behalf of NC DHHS, unpublished data, 2018).

However, the fragmented system was not designed to optimize and integrate the physical health needs of people with complex mental health (MH), substance use disorder (SUD), and IDD challenges. We know that adults in the United States living with serious mental illness (SMI) die on average 25 years earlier than others, largely due to treatable medical conditions [5].

The current siloed system makes it challenging to coordinate care for individuals with comorbid psychiatric and serious medical conditions. Often providers are not aware of

Electronically published September 2, 2019.

Address correspondence to Rob Robinson, 5200 W. Paramount Parkway, Morrisville, NC 27560 (rrobinson@alliancehealthplan.org).

N C Med J. 2019;80(5):317-319.
0029-2559/2019/80516

the full array of services, supports, medications, and treatment providers comprising an individual's overall care. This can result in one provider ordering medications that may be contraindicated based on other medical conditions or medications prescribed by others. Coordination of care becomes even more challenging when individuals are transitioning from higher levels of care back to the community.

Behavioral health clinicians and the LME/MCOs are not uniformly aware when a member is hospitalized for a medical condition and as a result the member may be discharged without proper linkage to behavioral health care. Conversely, a member hospitalized related to their psychiatric condition may not be appropriately linked back to primary care. When people can get all the care and support they need in one location, and in a coordinated manner, the result is improved overall health and wellness.

The LME/MCOs have historically been responsible for supporting individuals with the most complex needs, who often have multiple diagnoses and are further challenged by lack of transportation, unstable housing, and economic insecurity. To successfully support these people the LME/MCOs have effectively developed provider networks that offer enhanced Medicaid services such as Assertive Community Treatment Teams, Community Support Teams, and Intensive In-Home Services, which provide comprehensive supports to individuals in their homes and communities to allow them to live successfully. These types of enhanced Medicaid services will not be available in the Standard Plans, the new plans whose members will include North Carolinians with no more than mild-to-moderate behavioral health care needs.

In addition, LME-MCOs have created supported housing options using capital investments, landlord incentives, and other strategies to increase housing capacity and move people with complex needs from homelessness to safe, stable housing. They also provide supported employment programs to help individuals with disabilities find and maintain competitive jobs of their choice that provide the same work settings and same pay rates enjoyed by persons without disabilities. They become more independent, self-supporting, and more thoroughly integrated into their communities [6]. Data analysis confirms for us that a relatively small group of Medicaid beneficiaries with MH/SUD/IDD service needs account for a disproportionately large amount of Medicaid spending. The health care costs of these particular Medicaid beneficiaries are exponentially higher than other Medicaid beneficiaries (North Carolina Department of Health and Human Services, unpublished data, 2016). Based on these dynamics, North Carolina's policymakers collectively determined that individuals with SMI, SUD, IDD, and traumatic brain injury would be best served by care management entities meeting their complex service and support needs.

During the 2018 legislative session the General Assembly added provisions to the Medicaid managed care program to create Behavioral Health IDD Tailored Plans to serve these individuals, who would receive all of their care—physical, behavioral, and pharmaceutical—from these plans [7]. While Standard Plans will take the lead in caring for people with mild-to-moderate MH/SUD issues, Tailored Plans will focus on care for people with much more significant and complex issues within the MH/SUD/IDD populations.

LME/MCOs are uniquely qualified to meet these needs because of our historical experience serving this population, which has included the creation of specialized networks of services and supports. Building upon a well-established infrastructure and a long history of caring for this complex population and leveraging productive relationships in our communities, LME/MCOs have the initial opportunity to serve as the Tailored Plan contractors. This will occur through an application process beginning in 2020. LME/MCOs will need to demonstrate the ability to meet the North Carolina Department of Health and Human Services (NC DHHS) contractor requirements, as well as additional requirements the department establishes specifically for the Tailored Plans.

Preparing to Thrive as Tailored Plan Operators

North Carolina's LME/MCOs are energized by the opportunity to deliver whole-person care coordination to Medicaid-covered persons with SMI and IDD residing in our communities. Collectively, we have been appreciative of the willingness of NC DHHS to include LME/MCOs as active participants in policymaking efforts to design a Tailored Plan model, as we believe this creates the best mechanism to facilitate access to needed services for these complex subgroups, measure and monitor quality, avoid costly crisis-point care, and elevate health status and quality of life.

Benefitting from lessons learned from Medicaid policy in other states and the start-up experience of North Carolina's Standard Plans over the coming months, Alliance, the LME/MCO serving over 470,000 individuals in a four-county region in Central North Carolina who are Medicaid-eligible or uninsured/underinsured, is designing its operations to meet the broader goals of Medicaid transformation. This work is reflective of efforts underway statewide across our public behavioral health managed care system.

Social Determinants of Health (SDOH)

Identifying the SDOH needs of our members and helping link them to appropriate available community resources is critical. Our care management model, called Complete Care, and its associated data analytics tools are built on the principles of population health, with priority placed on reducing health inequities or disparities among different population groups due to, among other things, the SDOH.

Pharmacy Management

Medication regimens are central to effective treatment for physical and behavioral health conditions. We engaged an expert to assist in our selection of an optimal pharmacy benefits manager and we plan to implement a multi-pronged set of programs to identify each Tailored Plan member's medication needs, facilitate access to those medications,

track and support adherence, and support prompt appropriate review of medication regimens when needed.

Physical Health Care Coordination Partner

The legislation establishing Tailored Plans requires LME/MCOs to contract with entities that hold a prepaid health plan (PHP) license and that cover the services required under a Standard Plan contract. We are in the process of identifying which of those entities is best suited to support us, as well as which care coordination activities are most appropriate to contract out versus self-perform. Moreover, we are exploring opportunities to serve as a subcontractor to the Standard Plans to help deliver optimal service to their enrollees with low to moderate behavioral health needs.

Value-based Contracting

Paying for value is integral to the movement toward achieving greater quality and accountability. We are seeking to move beyond paying providers entirely on a traditional fee-for-service basis. Instead, we are developing innovative mechanisms to align provider compensation with the access, quality, and cost-effectiveness outcomes we share with NC DHHS. We plan to introduce value-based payment mechanisms into our provider contracts along with the necessary resources to support our providers at the outset of Tailored Plan operations, and to build out our value-based contracting portfolio with each passing year.

The Challenges Ahead

While the long-term goals are laudable, LME/MCOs face specific challenges in preparing to operate Tailored Plans. Currently, we are reimbursed on a per-member-per-month basis for members with both higher- and lower-acuity needs. Much of the current member base of the LME/MCOs, with lower acuity, will move to the Standard Plans. It is therefore essential to ensure that new capitation rates reflect the higher-acuity needs of the members we will serve, and also provide funds to help pay for the administrative costs needed to enhance our provider networks.

Moreover, historical and potential future cuts to state single-stream funding—the state appropriation for the MH/SUD/IDD service needs of uninsured and underinsured North Carolinians—will jeopardize the ability of the LME/MCOs to effectively stand up the Tailored Plans and to manage appropriate care for this vulnerable population. Single-stream funding is separate from Medicaid funding, and is essential to providing the LME/MCOs the resources required to address the needs of uninsured individuals. In our work we see that without critical services these individuals are much more likely to end up in jails and emergency rooms, and homeless [8]. The rate of visits to US emergency departments continues to rise, and emergency departments increasingly treat medically underserved patients. Approximately 50% of frequent emergency department users have a mental health diagnosis [9].

Single-stream funding has been cut in state budgets for four consecutive years, contradicting the original intent in creating the public behavioral health managed care system in North Carolina—for LME/MCOs to use savings derived from effective management of the system to build infrastructure to address unmet community needs. Continued reductions jeopardize not only the sustainability of longstanding behavioral health services, but the financial stability of Alliance and the other LME/MCOs as we prepare to take on operations of the Tailored Plans.

Nonetheless, we are excited to play a lead role in this important next step in the evolution of public health care in North Carolina, aimed at reaching the goal of NC DHHS to achieve whole-person care for the specialized populations we have served for many years. Our proven experience and established community relationships are essential for effectively integrating care for these individuals. Furthermore, this important health policy development for our state preserves the role of the public behavioral health care system in Medicaid transformation and ensures continued stability and continuity of care for people who desperately need it. NCMJ

Rob Robinson, MS chief executive officer, Alliance Health, Morrisville, North Carolina.
Pam Silberman, JD, DrPH professor and director of the Executive Doctoral Program in Health Leadership in the Department of Health Policy and Management, Gillings School of Global Public Health, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina; member, Board of Directors, Alliance Health, Morrisville, North Carolina.
Cynthia Binanay, MA, BSN senior project leader, Duke Clinical Research Institute, Durham, North Carolina; director of operations, Hubert-Yeargan Center for Global Health, Durham, North Carolina; chair, Board of Directors, Alliance Health, Morrisville, North Carolina.

Acknowledgments

Potential conflicts of interest. Alliance Health expects to operate tailored plans under Medicaid transformation in North Carolina. The authors have no relevant conflicts of interest.

References

1. National Council for Behavioral Health. Community Mental Health Act. NCBH website. https://www.thenationalcouncil.org/about/national-mental-health-association/overview/community-mental-health-act/. Accessed June 24, 2019.
2. Americans with Disabilities Act, 42 USC § 12101 (1990).
3. Olmstead v. L.C., 527 US 581 (1999).
4. 2001-437 NC Sess Laws, HB 381.
5. Parks J, Svendsen D, Singer P, Foti ME. Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA: National Association of State Mental Health Program Directors Council; 2006. https://nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf. Accessed June 6, 2019.
6. Nord D, Luecking R., Mank D, Kiernan W, Wray C. The state of the science of employment and economic self-sufficiency for people with intellectual and developmental disabilities. Intellect Dev Disabil. 2013;51(5):376-384.
7. 2015-245 NC Sess Laws. HB 372, as amended by 2018-4840 NC Sess Laws.
8. National Council for Community Behavioral Healthcare. The Uninsured: The Impact of Covering Mental Illness and Addiction Disorders. Washington, DC: NCBH; 2007. https://www.thenationalcouncil.org/wp-content/uploads/2012/12/CoveringTheUninsured.pdf. Published June 2007. Accessed June 20, 2019.
9. Niedzwiecki MJ, Sharma PJ, Kanzaria HK, McConville S, Hsia R. Factors associated with emergency department use by patients with and without mental health diagnoses. JAMA Netw Open. 2018;1(6):e183528.