Report to
The Joint Legislative Oversight Committee on
Medicaid and NC Health Choice
on
The Managed Care Strategy for North Carolina Medicare-Medicaid Dual Eligible Beneficiaries

Session Law 2015-245, Section 5(11)

State of North Carolina
Department of Health and Human Services
Division of Health Benefits

Health Benefits
HEALTH AND HUMAN SERVICES

January 31, 2017

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I. Executive Summary

At the end of the 2015 session, the General Assembly passed, and the Governor signed, Session Law (S.L.) 2015-245, also known as the Medicaid reform bill. One provision of the law called for the development of a long-term strategy for serving Medicare-Medicaid dual-eligible beneficiaries through capitated contracts.[1] The Department of Health and Human Services Division of Health Benefits (DHB), in partnership with the Dual Eligibles Advisory Committee comprised of an array of stakeholders, has worked during 2016 to shape this strategy.

This report represents the culmination of the Advisory Committee's deliberations and satisfies the obligations of the provision of S.L. 2015-245.[2] However, this report is not the conclusion of the Department's work. It is better described as the end of the beginning. This report sets forth numerous options and potential design features that will serve as a guide for the Department to execute a thoughtful and comprehensive capitated program for dual-eligible beneficiaries in North Carolina.

The Department and the Advisory Committee have identified three key principles that will guide the implementation of a capitated program for dual-eligible beneficiaries. These principles will apply regardless of the specific policy design features reflected in the final program:

(1) Proceed cautiously and ensure that capitated plans have the capacity to serve the dual-eligible population

(2) Ensure that person-centered care planning and delivery are central to the entire program

(3) Provide a robust suite of care coordination services to beneficiaries in partnership with the local management entities/managed care organizations (LME-MCOs).

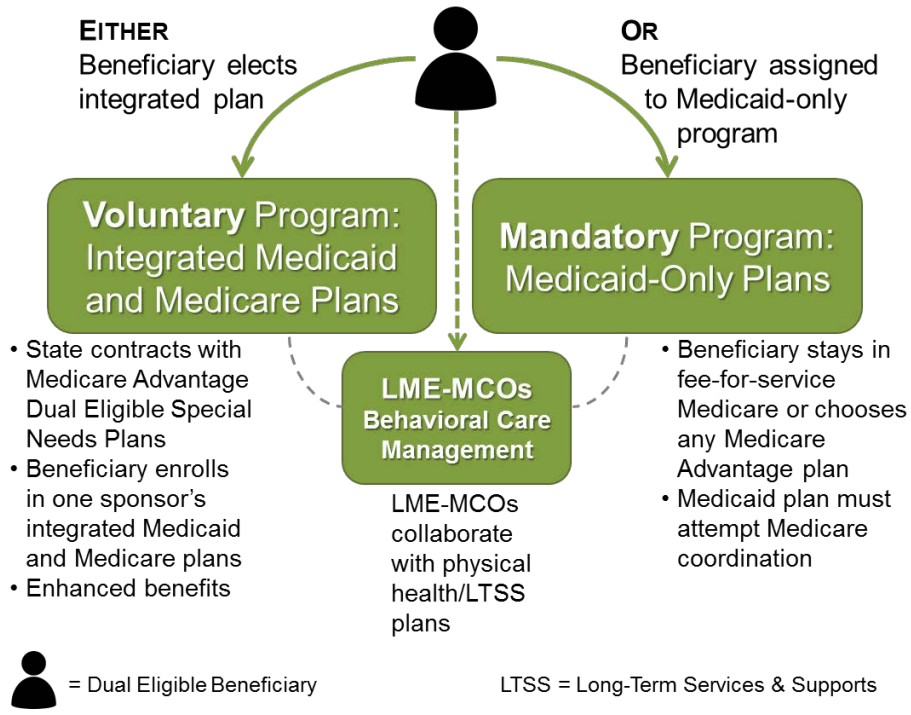
In addition, although this report discusses many different specific policy options, the Department and the Advisory Committee have identified important design features that ought to be reflected in any capitated program for dual-eligible beneficiaries in North Carolina.

The strategy for covering dual-eligible beneficiaries will leverage capitated contracts to deliver the most integrated, highest quality and most cost-effective care possible. This will call for the integration of Medicaid capitated contracts with

[1] Section 4.4(c) of NC Senate bill 838 provided that the Programs of All-inclusive Care for the Elderly (PACE) were to be independent from the Medicaid reform process. Thus, while recognized herein, PACE is not a focus of this report.

[2] This report was prepared between November 2016 and January 2017. The Department and the Advisory Committee recognize that the U.S. Congress is currently considering changes to the federal laws governing Medicaid and Medicare. Although some potential changes could impact the recommendations in this report, considering that the substance and timing of any changes to federal legislation remain purely speculative, this report relies upon current federal law.

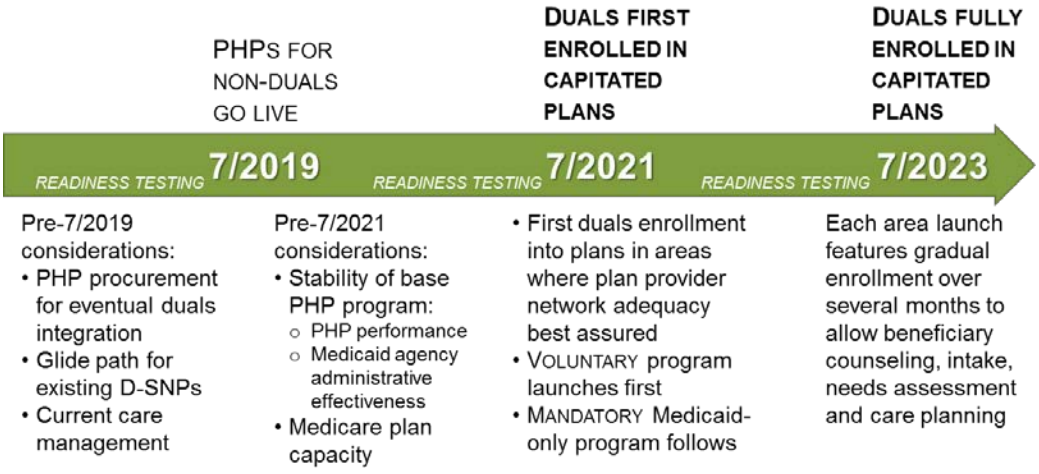
special-purpose Medicare Advantage plans overseen by the federal Centers for Medicare & Medicaid Services (CMS) to reduce deeply entrenched financial and programmatic misalignments that exist between Medicaid and Medicare.



The Department and the Advisory Committee concluded that North Carolina should allow approximately two years of operations of the North Carolina Medicaid Prepaid Health Plan (PHP) program—the program for non-dual eligible beneficiaries—before launching the capitated program for dual-eligible beneficiaries. This transition will allow time for the Department, beneficiaries, health plans and providers to adjust to the capitated delivery system prior to expanding to full-dual eligible beneficiaries. The PHPs for non-dual eligible beneficiaries are anticipated to begin serving enrollees on or about July 1, 2019, following receipt of necessary federal approvals and the procurement of PHP contracts. Hence, the capitated program for dual-eligible beneficiaries is proposed to start in at least one region no later than July 1, 2021, with full implementation statewide no later than July 1, 2023. The Department will continue to work with the Advisory Committee and other stakeholders to develop a firmer timeline as implementation steps begin. Any timeline will be subject to the readiness of participating plans to accept enrollment based on a thorough readiness review.

The Department recommends that the enrollment be phased in starting with densely populated areas of the state where health plans are more likely to be able to meet network adequacy requirements and then roll out to the more rural areas using a model of care and approach suited to those communities. Further, the

Department recommends staging enrollment within these phases to allow the plans enough time to meaningfully engage with new beneficiaries, perform needs assessments and complete personalized care plans.



Having explored the experiences of other states that have led the way in the use of capitated plans for dual-eligible beneficiaries, the Department is proposing a program that will use two companion approaches:

> The first is a voluntary-enrollment capitated contracting strategy that aligns capitated Medicaid benefits with a dual-eligibles focused Medicare Advantage plan operated by the same parent company. This will ensure that beneficiaries enrolled in an integrated product will gain full advantage from the financial and programmatic alignment that is only possible when one entity is responsible for managing both the Medicare and Medicaid benefits.
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> The second will entail a mandatory enrollment capitated contracting strategy for Medicaid benefits only. This second arm of the program is needed because federal law prohibits limiting Medicare beneficiaries' freedom of choice, and this prohibition cannot be waived. The mandatory program thus ensures that all affected dual-eligible beneficiaries will become enrolled in capitated plans for at least their Medicaid benefits. The mandatory program also provides a smooth enrollment pathway for beneficiaries into the voluntary enrollment program.

This report discusses a range of options that can be deployed within this broad framework.

In addition, this strategy calls for the development of selected additional Medicaid benefits specific to the voluntary integrated Medicare-Medicaid capitated program to improve the take-up and cost-effectiveness of the program.

The strategy also will incorporate a quality measurement and incentive program for the capitated plans that includes validated long-term care measures and mechanisms to reward health plans that deliver higher quality care. This quality measurement system also will be used in the ongoing evaluation of the impact and cost effectiveness of the program and will inform further implementation. The quality measurement system also will integrate with the quality improvement and evaluation process outlined in the North Carolina Medicaid and NC Health Choice Section 1115 waiver application.

Dual-eligible beneficiaries will be further protected and served by new beneficiary counseling and advocacy resources called for under federal Medicaid managed care regulations. These resources will help beneficiaries navigate the new capitated plan enrollment landscape and ensure that plans are accountable to beneficiaries. These supports should build upon and supplement the resources of the existing advocacy services from the North Carolina Long-Term Care Ombudsman and counseling delivered by the Seniors' Health Insurance Information Program.

Finally, any capitated program for dual-eligible beneficiaries will present new opportunities and challenges for North Carolina's Medicare and Medicaid providers. The program will therefore offer training and technical assistance for medical and non-medical providers covering at least care coordination, network contract negotiation, claim billing, quality reporting and compliance.

In the months to come, the Department, working with the Advisory Committee and other stakeholders, will further specify the dual eligibles program design and its component parts. It will be especially important to conduct actuarial and fiscal analyses to ensure program viability, and to partner with North Carolina's health care, long-term services and supports (LTSS) and social services community, plus beneficiary advocates and health plan sponsors, to prepare for the transition.

Section III of this report gives background on dual-eligible beneficiaries in general and North Carolina in specific, and the existing delivery system. Section IV summarizes capitated approaches other states have used to serve this complex population. Sections V through X present a detailed discussion of the options the Department will consider in the implementation of a capitated program for dual-eligible beneficiaries. Finally, Section XI outlines the next steps for the Department and the Advisory Committee.

Finally, please consult Appendix A for definitions of the technical terms, abbreviations and acronyms included in this report.

II. Introduction

A. Purpose of This Report

North Carolina's Medicaid reform law, S.L.2015-245, called for the transformation of the Medicaid program, in large part by enrolling beneficiaries into prepaid health plans (PHPs) that will be at risk for costs and accountable for quality of care under capitated contracts. However, the law gave separate instructions for persons covered by both Medicare and Medicaid. Section 4(5) stated:

> "Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except recipients who are dually eligible for Medicaid and Medicare. … The Division of Health Benefits shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts, as required by subdivision (11) of Section 5 of this act."

To frame the long-term strategy for serving dual eligibles, the legislation, in section 5(11), directed the agency as follows:

> "Develop a Dual Eligibles Advisory Committee, which must include at least a reasonably representative sample of the populations receiving long-term services and supports covered by Medicaid. The Division of Health Benefits, upon the advice of the Dual Eligibles Advisory Committee, shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts and report the strategy to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by January 31, 2017."

This report fulfills the requirement set forth in the law. It describes the Department's work with the Advisory Committee and presents the long-term strategy to cover dual eligibles through contracts with capitated (prepaid) health plans.

B. Work of the Dual Eligibles Advisory Committee

The Department established the Advisory Committee in June 2016. The committee's 31 members were selected to ensure that the Department would gain the considered input of a diverse group of stakeholders—providers of health care, long-term services and supports and social services; consumer advocates, health plans and more. See Appendix B for the composition of the Advisory Committee.

The full committee met in public forum on eight occasions to discuss the myriad of issues surrounding the dual eligible population: their health and functional challenges, significance of social determinants of health, fragmentation of care and problems of care coordination, constraints on the supply of resources needed to

meet dual eligibles' needs, and options and mechanisms for launching a program to enroll dual eligibles into PHPs—among others. One meeting included presenters from other states that have preceded North Carolina along the path of enrolling dual eligibles into managed care arrangements.

The Advisory Committee also considered the goals outlined in North Carolina's Section 1115 waiver application from June 2016 that pertained to the delivery of long-term services and supports. Notable among those goals were the following:

- Support and build a system that promotes consumer choice.
- Build upon the current system by ensuring continued access to facility-based services when necessary; and by expanding the continuum of services and variety of settings in which to receive them, including expanded access to home- and community-based services (HCBS).
- Promote use of enabling technology to further the waiver's LTSS-related goals; promote health and quality outcomes such as hospitalization prevention; and improve communication among supporting providers.
- Invest in service strategies that prevent, delay or avert need for Medicaid-funded LTSS through appropriate upstream interventions, including increased engagement between LTSS and primary care providers.
- Recognize and bolster family caregivers and other natural supports that play a key role in supporting beneficiaries with long-term care needs.
- Ensure that LTSS beneficiaries have access as needed, to hands-on streamlined service. Coordination that is responsive to their clinical and social needs, and fosters a holistic/whole person approach to care.
- Focus on care transitions and opportunities for early interventions related to transition planning.

The high-level consensus recommendations emanating from the Advisory Committee to this point are:

- Capitated plan enrollment for dual eligible beneficiaries should be implemented only after managed care has been made to function smoothly for the Medicaid-only population.
- Integration of dual-eligible beneficiaries into managed care should be conducted in carefully planned phases based on services and other considerations.

- Dual-eligible beneficiaries who do not receive full Medicaid benefits ("partial duals") should not be included in the initial implementation of managed care for dual eligibles.

The committee also articulated further considerations that ought to be factored into planning for dual eligibles' entry into capitated health plans:

- Ensure adequate capitation payments and reimbursement rates are available to the various programs and services that support the dual-eligibles population.

- Examination of the PACE model will be helpful when designing a program for the dual-eligibles population.

- Ensure that the readiness review process and rollout plan are tailored to reflect the services that dual eligibles require.

Ultimately, the Advisory Committee concluded that the first capitated contracts with health plans for dual-eligible beneficiaries should begin approximately two years following the start of PHP capitation contracts for Medicaid-only beneficiaries, and that such contracts should be implemented first in areas of North Carolina that have sufficient provider capacity and concentrations of beneficiaries to enable a smooth rollout.

The committee further convened three topical subgroups—Care Coordination, Behavioral Health, and Readiness—and produced a series of recommendations on those subject areas. See Appendix C for those recommendations.

The Department intends for the Advisory Committee to continue to assist in framing and eventually implementing the capitated program for dual-eligible beneficiaries. Having the ability to interact with stakeholders as the program is designed, implemented and operational will make the ultimate program that much more effective.

III. Background on Medicare-Medicaid Dual Eligible Beneficiaries

A. Definition of Dual-Eligible Beneficiaries, Summary of Services Under Each Program, Summary of Benefit and Financial Misalignments

Medicare and Medicaid cover different but overlapping populations. Seniors and people with disabilities are eligible for Medicare, while low-income seniors, people with disabilities, and other low-income adults, families and children are eligible for Medicaid benefits. "Medicare-Medicaid dual-eligible beneficiaries" include people who are eligible for full Medicare benefits, but may be eligible for different levels of benefits from state Medicaid programs. Medicare is the primary payer for all

services covered by both programs, with Medicaid helping cover Medicare premiums and cost-sharing, and filling in the gaps in the Medicare benefit package.

This results in a complementary benefit package in many ways. For example, Medicare is the primary payer for doctors, hospitals, post-hospitalization skilled nursing, home health care and prescription drug costs, while Medicaid covers additional behavioral health services and LTSS. However, as discussed further in this report, the two programs feature numerous programmatic and financial misalignments, including barriers to coordinated care, which ultimately harm dual-eligible beneficiaries and cost both payers more money.

The two major categories of Medicare-Medicaid dual-eligible beneficiaries are referred to commonly as "full-dual" and "partial-dual" beneficiaries. Full-dual eligible beneficiaries are eligible for full Medicaid benefits, including medically necessary LTSS, Medicaid behavioral health benefits, transportation and "wrap-around" benefits. Wrap-around benefits are Medicaid benefits for services that are also covered by Medicare. Medicaid will cover services beyond the quantitative or non-quantitative limits imposed by Medicare such that the beneficiary may continue to receive services once Medicare no longer covers the service—assuming it is covered under Medicaid rules. However, as discussed below, there are programmatic and financial misalignments between Medicare and Medicaid that frequently lead to disruptions in access to care for wrap-around benefits. Partial-dual eligible beneficiaries are not entitled to full Medicaid benefits and generally only receive help with Medicare premiums and, in some cases, cost sharing.

i. Medicaid Coverage of Medicare Cost Sharing

Full-dual eligible beneficiaries and some types of partial-dual eligible beneficiaries are entitled to help from the state Medicaid agency in paying their Medicare premiums (Part B and, if needed, Part A), and cost sharing (copays and coinsurance). Providers are prohibited from billing for Medicare cost sharing for most types of dual-eligible beneficiaries and all categories of full-dual beneficiaries.

However, many states, including North Carolina, only pay cost sharing for dual-eligible beneficiaries when the Medicare portion of the provider reimbursement (80% of the allowed amount) is *lower* than the Medicaid fee-for-service rate of payment for that service and then only pay cost sharing up to the Medicaid fee-for-service rate. In most cases, the Medicare payment exceeds the Medicaid payment and, as such, no cost sharing is paid. This is referred to as "lesser-of" cost sharing coverage.

The provider is still prohibited from balance-billing the beneficiary. Once the Medicare provider has billed Medicaid for the cost sharing and been denied, the

provider may submit a bad-debt claim to the federal government for some but not complete relief pursuant to 42 CFR § 413.89.[3]

ii. Misalignments Related to Full-Dual Eligible Beneficiaries

There are four subcategories of full-dual eligible beneficiaries in North Carolina.[4] Each category is eligible for Medicaid benefits under a different pathway and full-dual eligible beneficiaries are, therefore, a heterogeneous and continuously changing population. The interplay between the Medicare and Medicaid programs for full-dual eligible beneficiaries creates many administrative and financial conflicts that adversely impact beneficiaries. [5] These include inconsistent authorization procedures and medical necessity rules for overlapping benefits such as behavioral health, skilled nursing facility care, skilled therapies (occupational, physical, speech), home health and durable medical equipment. These inconsistent rules create barriers and delays in access to care that beneficiaries in only one of the programs are less likely to encounter. For example, Medicare home health services require beneficiaries to show that they are "home bound," while Medicaid home health benefits generally have a more relaxed medical necessity standard. Yet because Medicare is the primary payer, in North Carolina a beneficiary or provider must first seek coverage through Medicare and have the claim denied before submitting the claim to Medicaid.[6] In a few other states, beneficiaries or providers also must appeal the Medicare determination prior to submitting a claim for coverage under Medicaid.

In addition to coverage determination procedure misalignments, the programs also use different appeals procedures, exposing beneficiaries to three or more appeals systems for adverse coverage determinations. The rules differ as to coverage pending appeal, timelines, evidence submission guidelines, rules on authorized representatives, and agencies tasked with administration. The 2016 federal Medicaid managed care rule took steps to align the notice and timeline

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[3] Prior to the passage of the Middle Class Tax Relief and Job Creation Act of 2012, providers were reimbursed 100 percent of bad debts for dual-eligible beneficiaries. Reductions in Medicare bad debt payments for dual eligible beneficiaries have been implemented in phases: 88% in FY 2013 (starting Oct. 1, 2012); 76% in FY 2014 (Oct. 1, 2013); and 65% in FY 2015 (Oct. 1, 2014) and beyond.

[4] These are (1) Categorically needy (SSI) beneficiaries), (2) Categorically needy no money payment (individuals with income below 100% of the federal poverty line (FPL) and limited assets of $2,000 for an individual or $3,000 for a couple),(3) Medically needy (disabled individuals who do not receive SSI and whose income or assets exceed the categorically needy limits, but who cannot afford their medical care, also known as "spend-down"), and (4) Unearned income limit (Individuals with unearned income at or below 200% of FPL with varying degrees of cost-sharing responsibilities).

[5] The Federal Coordinated Health Care Office at the Centers for Medicare & Medicaid Services published an extensive list of misalignments between the Medicare and Medicaid programs in the Federal Register: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FederalRegisterNoticeforComment052011.pdf.

[6] *Provider Adjustment, Time limit & Medicare Override Job Aid*, NCTracks, *available at*: https://www.nctracks.nc.gov/content/dam/jcr:27044934-435a-4643-a9cc-c14a1c5ac1fb/Provider_Adjustment_TimeLimit_Medicare_Override_Job_Aidv1.2.pdf.

requirements for Medicaid managed care appeals with those that apply to Medicare Advantage, but the procedures continue to differ and to be administered by different organizations.[7]

The programs' financial misalignments also contribute to cost-shifting between Medicare and Medicaid. For instance, Medicaid programs have an incentive to maximize Medicare coverage for full-dual eligible beneficiaries and Medicare providers subject to prospective or bundled payment or participants in shared savings programs have an incentive to shift costs to Medicaid.

Finally, there are administrative barriers and conflicting financial incentives for the payers themselves, resulting in a lack of investment in effective care coordination for full-dual eligible beneficiaries.[8] In particular, states can gain CMS's permission to run mandatory programs for Medicaid beneficiaries, allowing for full participation in care coordination models such as patient-centered medical homes or managed care programs. Medicare, in contrast, does not allow mandatory beneficiary enrollment into care coordination programs, such as those of Medicare Advantage plans. Thus, neither CMS nor states can require participation in integrated programs or programs having enhanced care coordination for Medicare benefits.

In addition, Medicare's role as the primary payer for acute care benefits and Medicaid's role as the primary payer for LTSS creates financial disincentives for states to invest in care coordination for full-dual eligible beneficiaries. That is because some portion or all of the return on investment will be captured by the federal government through reduced Medicare expenditures.

In summary, the Medicare and Medicaid program rules impose numerous impediments for full-dual eligible beneficiaries that any integrated program must address carefully.

iii. Misalignments Related to Partial-Dual Eligible Beneficiaries

Partial-dual eligible beneficiaries experience different barriers and misalignments than full-dual eligible beneficiaries. Partial-dual eligible beneficiaries are not eligible for full Medicaid benefits, meaning they are not eligible for LTSS or wrap-around benefits, but do get help in paying some or all of Medicare premiums and some or all cost sharing, depending on the individual's eligibility. There are four subcategories of partial-duals in North Carolina.[9]

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[7] 81 *Fed. Reg.* 27498-27901 (May 6, 2016), available at https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

[8] *See for example*: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=70.

[9] These are: (1) Comprehensive Medicare-Aid program (MQB-Q) (Medicaid pays Medicare premiums and cost-sharing), (2) Limited Medicare-Aid (MQB-B) (Medicaid only pays Part B premiums), (3) Medicaid-Working Disabled (MWD) (Medicaid only pays Part A premiums), and (4) Limited

Partial-dual eligible beneficiaries receive coverage for all their services from Medicare, but still experience access barriers and administrative challenges related to their status as dual-eligible beneficiaries. Of note, as described above, many partial-dual eligible beneficiaries face balance billing from providers for the Medicare cost-sharing responsibility, many end up paying these cost sharing obligations even though such balance billing is illegal, and the limited cost sharing coverage results in more restrictive access to care because fewer providers are willing to serve them.

In conclusion, although partial-dual eligible beneficiaries experience fewer program misalignments than full-dual eligible beneficiaries, they also have access to fewer benefits and continue to face greater barriers to care than Medicare-only beneficiaries. In addition, most full-dual eligible beneficiaries start as partial-dual eligible beneficiaries who become impoverished or more disabled due to medical conditions. As such, partial-dual eligible beneficiaries present an important responsibility and opportunity for state interventions.

B. High-level Demographic and Expenditure Data on Dual Eligible Beneficiaries in North Carolina and Nationally

During December 2015 (the most recent snapshot of data available) there were 319,720 dual-eligible beneficiaries of any age in North Carolina.[10] Of these, 235,947 had some type of full-dual eligibility status. Based on the data from 2011, the last year with published results on state-level full-year dual eligibility with diagnostic and utilization data, there were 334,277 dual-eligible beneficiaries in North Carolina out of 1.629 million Medicare beneficiaries and 1.956 million Medicaid beneficiaries.[11]

Although dual-eligible beneficiaries composed only 21% of the Medicare population in North Carolina, they accounted for 37% of total Medicare expenditures. Similarly, dual-eligible beneficiaries were only 17% of Medicaid enrollees, but their services consumed 31% of Medicaid expenditures. Medicare expenditures were higher for full-dual eligible beneficiaries in all categories of service than any class of partial-dual eligible beneficiary and higher than for Medicare-only beneficiaries. There

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Medicare-Aid Capped Enrollment (MQB-E) (Medicaid pays Part B premiums, but fully federally funded without state cost-sharing).

[10] Monthly snapshots will inherently be lower than the rates of beneficiaries with a dual-eligible status at any time during the year. Medicare-Medicaid Enrollee State and County Enrollment Snapshots, Updated Quarterly, Medicare-Medicaid Coordination Office, Centers for Medicare & Medicaid Services (December 2015) *available at*: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeStateandCountyEnrollmentSnapshotsQuarterly.zip.

[11] North Carolina State Profile, Medicare-Medicaid Coordination Office, Centers for Medicare & Medicaid Services *available at*: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2011StateProfilesNC.pdf.

were especially large differences for inpatient hospital, skilled nursing facility and psychiatric hospital services.

Full-dual eligible beneficiaries in North Carolina had far higher rates of chronic conditions than Medicare-only beneficiaries or Medicaid-only beneficiaries with a disability. Only 12% of the full-dual eligible beneficiaries had no chronic conditions and 52% had three or more chronic conditions. The most common chronic conditions among full-dual eligible beneficiaries were diabetes/end-stage renal disease (ESRD)/other endocrine; heart disease/failure and other cardiovascular; and psychiatric/mental health.

Most of the full-dual eligible beneficiaries in North Carolina use some form of LTSS. Institutional care (nursing facility, etc.) was used by 61%, state plan HCBS by 14%, and waiver HCBS by 7%. Only 18% used none.

C. Summary of Existing Medicaid Capitated Plans: LME-MCOs

North Carolina already operates capitated programs that serve full-dual eligible beneficiaries. The first is PACE (described below) and the second is LME-MCOs, which deliver mental health, intellectual or developmental disability (I/DD), and substance use disorder services to all Medicaid beneficiaries over age three, including full-dual eligible beneficiaries.

LME-MCOs are quasi-governmental entities that contract with the Department and receive capitated payments for covered services. Importantly, any savings or profit is required to be used to provide additional services to beneficiaries. LME-MCOs have primarily reinvested these savings to support the integration of behavioral health and physical health care. For instance, some are supporting primary care delivery within behavioral health settings and other LME-MCOs are offering behavioral health provider training on how to coordinate with primary care providers. Other examples include adding interactive technologies and improving accessibility of facilities.

The LME-MCO program uses entities with exclusive designated contiguous geographic areas of the state operating under a Medicaid combination 1915(b)/(c) waiver. Enrollment into LME-MCOs is mandatory for any Medicaid beneficiaries in need of mental health, developmental disability, psychiatric residential treatment facility (PRTF), inpatient psychiatric care, intermediate care facility for individuals with I/DD (ICF/IDD), substance use disorder services or self-directed personal care services. The LME-MCO is responsible for prior authorization for claims, managing a network of providers for all services covered under the LME-MCO including performing provider credentialing and delivering care coordination services. Many full-benefit dual eligible individuals in North Carolina depend on the services delivered by LME-MCOs to manage their behavioral health conditions or I/DD services.

LME-MCOs do not cover all Medicaid services that are important for full-dual eligible beneficiaries. Services that are carved out from LME-MCO benefits and currently delivered exclusively in the fee-for-service environment include the Community Alternatives Program for Children (CAP/C), Community Alternatives Program for Disabled Adults (CAP/DA), Medicaid State Plan Personal Care Services and dental; and medical services (wrap around services as described above) offered under the Medicaid State Plan such as physician, hospital, nursing home, home health, private duty nursing, physical therapy, occupational therapy, speech therapy and durable medical equipment.[12] These services are delivered today with limited access to care coordination, network management or utilization management for all Medicaid beneficiaries, including full-dual eligible beneficiaries.

When North Carolina introduces PHPs for physical health services, the PHPs will coordinate all Medicaid benefits other than those delivered by LME-MCOs, for nearly all Medicaid beneficiaries other than full-dual eligible beneficiaries. This will include nursing facility care and other LTSS for the Medicaid-only population. Per S.L. 2015-245 as amended by S.L. 2016-121, services covered under LME-MCOs will continue to be delivered under the current system for four years after the date capitated PHP contracts begin. During this time, North Carolina will continue to ensure that LME-MCOs promote access to effective behavioral health services, including ongoing efforts to increase access to community-based services such as outpatient therapy.

D. Summary of Medicare Capitation Programs in North Carolina

There are two programs currently operating in North Carolina that deliver Medicare Part A and B benefits to full-dual eligible beneficiaries through capitated managed care products. These are the range of Medicare Advantage products and PACE.

i. Medicare Advantage Plans in North Carolina

The Medicare Advantage program, officially called Medicare Part C, allows Medicare beneficiaries to enroll voluntarily in a privately run health plan responsible for delivering all Part A and B covered services plus, for some plans, extra benefits of the plan's choosing, in return for a monthly capitation payment paid mostly by the federal government.

Nationally, 33.3% of Medicare beneficiaries were enrolled into some sort of Medicare Advantage plan as of January 2017. The penetration rate is slightly lower in North Carolina where 31.9% (589,814) of the Medicare beneficiaries in the state

[12] An additional waiver that would be delivered through the LME-MCOs is currently under consideration. The waiver would provide array of community-based services and community alternatives for individuals with traumatic brain injuries (TBI) who are currently in nursing facilities or specialty rehabilitation hospitals, or who are in the community and at risk for placement in nursing facilities or specialized rehabilitation hospitals. The TBI waiver services provide a community-based alternative to institutional care for persons who continue to require neuro-behavioral or skilled nursing facility level of care.

were enrolled in Medicare Advantage plans. Enrollment varies considerably by county, from 10% in Bertie County to 60% in Stokes County. Full- and partial-dual eligible beneficiaries are eligible to enroll into Medicare Advantage, but the enrollment rates for dual-eligible beneficiaries are lower than for the Medicare population overall, with only 13% of the 2011 enrollment months for Medicare Advantage in North Carolina coming from dual-eligible beneficiaries.

Importantly, in addition to the general protection allowing Medicare beneficiaries to voluntarily enroll or disenroll from Medicare Advantage and Part D plan coverage annually, all dual-eligible beneficiaries are entitled to a permanent special enrollment period whereby they can enroll, disenroll or switch Medicare Advantage and/or Part D plans monthly. This protection is known as the "lock-in prohibition."

Within the Medicare Advantage program, there is a range of specialized programs for sub-populations of Medicare beneficiaries known as Special Needs Plans (SNPs). There are three subcategories of SNPs, all of which operate in North Carolina:

- Chronic Condition SNPs (C-SNPs), which restrict enrollment to Medicare beneficiaries having specific severe or disabling chronic conditions.

- Institutional SNPs (I-SNPs), which restrict enrollment to beneficiaries who, for 90 days or longer, have had or are expected to need the level of services provided in a skilled nursing facility, a nursing facility, an ICF/IDD or an inpatient psychiatric facility.

- Dual-Eligible SNPs (D-SNPs), which limit enrollment to dual-eligible beneficiaries.[13]

SNPs differ from traditional Medicare Advantage plans in important ways. First, while regular Medicare Advantage plans are not required to also offer a companion outpatient prescription drug benefit under Medicare Part D, SNPs are required to do so. Second, CMS expects SNPs to implement a strategy to tailor services for the specialty population eligible for the plan, referred to as a model of care (MOC), and to structure their plan benefit package (PBP) to address the specialized needs of the targeted enrollees. All SNPs are required to have specially designed PBPs that go beyond the provision of basic Medicare Parts A and B services and deliver care coordination services.

[13] D-SNPs are currently authorized through December 2018, but based on past reauthorizations with broad bipartisan support, are likely to be reauthorized again. SNP-related advocacy and policy organizations, including health plans, associations, states, and consumer advocates have pushed for a range of incremental adjustments to the SNP models, including adjustments to the rate setting and risk-adjustment model to better account for the risk profile of SNP members, and have sought longer term or permanent authorization. *See* Association for Community Affiliated Plans, Testimony to the http://www.finance.senate.gov/download/association-for-community-affiliated-plans_comments-to-sfc-ccwg_1-21-16.

CMS allows coverage of supplemental benefits, including "specialized provider networks (e.g., physicians, home health, hospitals, etc.) specific to the unique SNP population..., longer benefit coverage periods for inpatient services; Longer benefit coverage periods for specialty medical services;…Additional preventive health benefits (e.g., dental screening, vision screening, hearing screening, age-appropriate cancer screening, risk-based cardiac screening); Social services (e.g., connection to community resources for economic assistance); transportation services; and wellness programs to prevent the progression of chronic conditions." [14]

Further, D-SNPs also differ from other categories of SNPs. Of significance, section 164(c)(2) of Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), as amended by section 1853(a)(1)(B)(iv) of the Social Security Act, requires that all D-SNPs have an executed contract with applicable state Medicaid agencies. This agreement must set forth how the D-SNP will coordinate access to the Medicaid services to which the beneficiary is entitled.

In 2016, 27,896 Medicare beneficiaries in North Carolina were enrolled into some sort of SNP, reflecting only 4.9% of Medicare Advantage participants. Most of those SNP enrollees (21,219) were enrolled into one of the seven D-SNP plans operating in North Carolina.[15]

ii. PACE in North Carolina

The other category of Medicare capitated program serving dual-eligible beneficiaries in North Carolina is the Program of All-inclusive Care for the Elderly (PACE). PACE provides fully integrated Medicare and Medicaid benefits for seniors who are clinically eligible for nursing facility placement.

PACE is intended to offer a community-based alternative to nursing facility care and allows participants to remain at home and receive intensive medical care and social supports at a designated PACE Center during the day. The PACE Center is frequently structured around an adult social day care provider with additional capacity for primary care, skilled therapies, transportation and pharmacy. PACE services, provided by an interdisciplinary care team with authority for all service authorizations and care coordination, include all Medicare and Medicaid covered services. The PACE interdisciplinary team has authority to approve additional services as needed.

PACE providers serve as both the plan and provider with responsibility for managing and coordinating benefits, programs and services for both Medicare and Medicaid. PACE coverage is all-inclusive, including nursing home stays, behavioral

[14] Medicare Managed Care Manual, Chapter 16-B: Special Needs Plans *at* Section 70.2. *Available at*: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c16b.pdf.
[15] The seven plans are operated by Humana, United Healthcare, Gateway Health and Cigna-Healthspring. The United Healthcare D-SNP has the most members with 13,222 beneficiaries.

health, dental and all other services under the discretion of the interdisciplinary team. PACE plans are at full risk for all care pursuant to a single three-way federal and state contract. PACE can produce cost savings for Medicare and Medicaid compared to the fee-for-service system by delivering high quality person-centered medical services, intensive care coordination, and comprehensive and flexible home- and community-based services.

Eligibility for PACE is limited to individuals age 55 or older who are nursing facility clinically eligible, are able to live safely in the community, and are living in an area served by a PACE facility. Beneficiaries do not actually need to be full-dual eligible beneficiaries to enroll into PACE, but most PACE participants are full-dual eligible beneficiaries.[16]

There are currently 11 PACE entities (12 sites) in North Carolina serving approximately 1,900 beneficiaries.

IV. Summary of Other States' Managed Care Approaches for Medicare-Medicaid Dual Eligible Beneficiaries

Many states have recently taken steps to partner with Medicare Advantage D-SNPs to deliver more integrated and coordinated care for dual-eligible beneficiaries under capitated programs. This section presents a concise overview of the programs being implemented in a sample of states: Virginia, Florida, Texas, Minnesota, Tennessee and Arizona. States have approached capitated programs for dual eligibles in three principal ways: (1) Medicare-Medicaid Dual-Eligible Plans as a part of the Financial Alignment Initiative, (a demonstration program operated by the Medicare-Medicaid Coordination Office that CMS does not plan on allowing any more states to take up); (2) PACE (described above); and (3) through capitated Medicare and Medicaid contracts integrated by contract. **Due to the practical and administrative limitations on the use or growth of the other options, the third of these options is the principal focus of this report and the work of the Department and the Advisory Committee.**

A. Virginia

Virginia's new program to deliver integrated care for full-dual eligible beneficiaries is called Commonwealth Coordinated Care Plus (CCC Plus). It builds upon the existing voluntary Commonwealth Coordinated Care (CCC) program that Virginia operates in partnership with CMS as a part of the Financial Alignment Initiative, a demonstration project. The CCC program is due to sunset Dec. 31, 2017, and Virginia is implementing CCC Plus to replace it and to implement mandatory Medicaid managed long-term care in the state simultaneously.

[16] If the PACE enrollee is not a full-dual eligible beneficiary, the beneficiary will be responsible for the Medicaid portion of the capitation payment as a premium.

CCC Plus will be a statewide Medicaid managed LTSS program that will serve approximately 213,000 individuals with complex care needs, through an integrated Medicare-Medicaid model, across the full continuum of care. CCC Plus will operate as a mandatory Medicaid managed care program. Nearly all adult Medicaid beneficiaries will be enrolled into the CCC Plus program, including populations not in need of LTSS, those in need of LTSS and those with I/DD. Individuals enrolled in the state's three HCBS waivers that specifically serve individuals with I/DD will be enrolled in CCC Plus for their non-waiver services (i.e., medical, behavioral health, pharmacy and transportation services), while each individual's I/DD waiver services will continue to be delivered through fee-for-service.

In addition, the adult dental benefit, school health services, community intellectual disability case management and institutional preadmission screening also will be available through fee-for-service. Finally, individuals participating in the state's existing Medicaid managed care programs (Medallion 3.0 and FAMIS), residing within an ICF-IDD facility, a psychiatric residential treatment facility or an Alzheimer specialty assisted living facility; or participating in hospice, Money Follows the Person program or PACE will not be eligible for CCC Plus.

The Medicare portion of the benefit will be optional and will be incorporated through D-SNPs operated by the same managed care companies holding managed LTSS (MLTSS) contracts with the state. All full-dual eligible beneficiaries are eligible to voluntarily enroll, but partial-dual eligible beneficiaries are excluded, as are individuals participating in PACE. Securing a Medicare contract to operate a D-SNP is a condition of the MLTSS contract, and the contract between the D-SNP entity and the state Medicaid agency is comprehensive and requires aligning service areas, coordinating care with the MLTSS contracted services, limiting allowable marketing activities, and limiting eligibility to the target population.[17]

Importantly, the CCC Plus program envisions the possibility of misaligned enrollees between the Medicare and Medicaid participating entities. In specific, because beneficiaries are enrolled mandatorily into the Medicaid portion of the program and allowed to enroll into any Medicare D-SNP voluntarily, some D-SNP beneficiaries will be enrolled into Medicaid CCC Plus plans operated by a competing company. The contract between the D-SNP and the Medicaid agency defines the terms for how the D-SNP will collaborate with the MLTSS plan serving the same beneficiary in this circumstance, such as in notifying the MLTSS plan of care transitions and coordinating the payment of cost sharing.

[17] http://dmasva.dmas.virginia.gov/Content_atchs/mltss/Template_Contract%20and%20App%20A%20(v2).pdf.

B. Florida

Florida illustrates a different approach to serving dual-eligible beneficiaries than the one being pursued in Virginia. Florida operates two Medicaid capitated programs in conjunction with multiple D-SNPs that exhibit differing degrees of integration.

The Statewide Medicaid Managed Care program consists of two Medicaid components: the Managed Medical Assistance (MMA) program and the Long-Term Care (LTC) program. The MMA program provides medical, dental and behavioral health services to infants, children and adults with Medicaid benefits. The LTC program provides LTSS to the elderly and adults with disabilities with Medicaid benefits who are nursing facility clinically eligible.

Full-dual eligible beneficiaries are required to enroll into an MMA plan unless they are enrolled into a Medicare Advantage plan having a companion contract with the Medicaid agency that covers all Medicaid services, in which case they are excluded. Similarly, full-dual eligible beneficiaries in need of LTSS are required to enroll into an LTC plan unless they are enrolled into a Medicare Advantage plan that has a companion LTC contract.

The D-SNPs operating in Florida are required to offer the MMA benefit package pursuant to the MIPPA contract with the state and can offer the LTC benefit package, but are not required to. Further, the plans participating in the LTC program are not required to hold D-SNP contracts. Florida makes capitated payments to D-SNPs for Medicaid wraparound primary and acute care services covered by the MMA program if the D-SNP does not have a companion Medicaid MLTSS plan.

Florida has had to implement various rules to determine which plan has responsibility for primary care coordination. The MMA plan requires the beneficiary to select a primary care provider unless the beneficiary is enrolled into a Medicare Advantage plan. These rules seek to reduce any disruptions in access to acute care services for full-dual eligible beneficiaries, but also ensure the provision of care coordination if none is being provided.

Partial-dual eligible beneficiaries are excluded from enrollment in either Medicaid capitated program.

C. Texas

Texas operates a comprehensive Medicare-Medicaid integrated program that can serve as a helpful example for North Carolina, called the STAR+PLUS program. For full-dual eligible beneficiaries, the STAR+PLUS program is an optional program building upon a mandatory Medicaid MLTSS program. In addition, the same STAR+PLUS Medicaid program is mandatory for adults ages 21 and older who either have a disability and get Supplemental Security Income (SSI) benefits, or do not get SSI but qualify for STAR+PLUS HCBS waiver services.

Texas requires the MLTSS plans operating in the densely populated areas of the state to also operate companion D-SNP contracts in the same service area. Texas also allows D-SNPs to operate without offering MLTSS plans. For those D-SNPs lacking companion STAR+PLUS MLTSS contracts, the State only pays for Medicare cost sharing through the MIPPA agreement. The MLTSS program covers all Medicaid benefits for full-dual eligible beneficiaries except for some densely populated counties where behavioral health services are delivered through NorthSTAR Behavioral Health managed care program. Nursing facility services were originally carved out and delivered fee-for-service, but were carved into the MLTSS program starting March 1, 2015.

Under the State's contract with the D-SNP entity, contractors are required to make "reasonable efforts" to coordinate benefits provided by the D-SNP with the Medicaid services covered under the STAR+PLUS MLTSS contracts, including identifying LTSS providers, helping beneficiaries access LTSS, coordinating the delivery of Medicaid LTSS and Medicare benefits and services and training D-SNP network providers about LTSS. These provisions are necessary because the D-SNPs (including those operating STAR+PLUS MLTSS plans) serve beneficiaries enrolled in STAR+PLUS MLTSS plans operated by other companies.

D. Minnesota

For full-dual eligible beneficiaries age 65 and over, Minnesota offers a voluntary fully integrated D-SNP and Medicaid MLTSS product through the Minnesota Senior Health Options (MSHO) program. This voluntary program operates in parallel with a pair of mandatory programs called Minnesota Senior Care (MSC) and Minnesota Senior Care Plus (MSC+). MSC and MSC+ are available in different parts of the state and differ regarding the coverage of LTSS. MSC+ differs in that it includes LTSS within the contract. In MSC counties, LTSS continues to be available fee-for-service. MSC+ currently provides acute care and LTSS to full-dual eligible beneficiaries and Medicaid-only beneficiaries. Dual eligible beneficiaries receive any Medicare-covered services on a fee-for-service basis or through a separate Medicare Advantage plan or prescription drug plan.

Full-dual eligible beneficiaries age 65 and older can opt out of the MSC and MSC+ system if they enroll into MSHO. All MSHO plans are Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNP), responsible for delivering both Medicare and Medicaid benefits as one plan with the same care coordination requirements applying to all benefits. For example, the D-SNP Model of Care requirements include requirements specific to Medicaid MLTSS. Minnesota only contracts with D-SNPs that have a companion MSHO plan and embeds all the state-specific D-SNP requirements directly into the Medicaid MLTSS contracts.

In addition, Minnesota requires Medicaid MLTSS contractors participating in Minnesota Senior Health Options (MSHO) program to offer a D-SNP, and limits

enrollment in MSHO to beneficiaries who choose to receive all their Medicare and Medicaid services from the MSHO plan. This ensures that all MSHO enrollees receive both their Medicare and Medicaid coverage through the same entity.

Minnesota operates a different voluntary program for full-dual eligible beneficiaries ages 18-64 that also provides an option for beneficiaries to receive coverage through aligned Medicare and Medicaid plans. The program, called Special Needs BasicCare (SNBC), is available to individuals with qualifying physical, developmental, mental health or brain injury-related disabilities. SNBC plans are not required to hold companion D-SNP contracts, but some do. For full-dual eligible beneficiaries, SNBC plans are required either to coordinate Medicare benefits delivered fee-for-service or by a Medicare Advantage plan or to coordinate services through their own linked D-SNP product. Currently, PrimeWest Health and South Country Health Alliance offer the option to combine Medicare and Medicaid into a single package of coverage; another plan (Ucare Connect + Medicare) was due to launch Jan. 1, 2017.

E. Tennessee

Tennessee has covered LTSS for older adults and individuals with physical disabilities via the TennCare CHOICES program since 2010. Services had previously been paid for on a fee-for-service basis. Tennessee requires Medicaid MCOs covering LTSS in the TennCare CHOICES program to offer a companion D-SNP, although D-SNPs operating prior to January 2014 are currently exempt from this requirement. Likewise, the State requires TennCare CHOICES MLTSS contractors to hold D-SNP contracts.

Tennessee has additional requirements for D-SNP contractors, including notifying the member's Medicaid MCO of any planned or unplanned inpatient admissions and coordinating with the Medicaid MCO regarding discharge planning, including ensuring that LTSS services are "provided in the most appropriate, cost effective and integrated setting." The requirements also include following up with enrollees and their Medicaid MCO to provide needs assessments or develop person-centered plans of care for MLTSS members; coordinating nursing facility services across programs; and training staff on coordinating benefits for dual-eligible beneficiaries.

There are three population groups within the CHOICES program, organized by level of care need. Group 1 is for people of any age who receive nursing home care. Group 2 is for adults age 21 and over with a disability, and seniors who are nursing facility clinically eligible, but choose to reside at home. Group 3 is for adults age 21 and over with a disability, and seniors who are not nursing facility clinically eligible, but need some home care services to delay or prevent the need for nursing home care in the future. For Group 2, the home care services must be less expensive than nursing home care and for Group 3, the slimmed-down home care services cannot be more than $15,000 per year. Home care services include personal care, attendant care, home-delivered meals, personal emergency response systems, adult day care, in-

home respite, inpatient respite, assistive technologies, minor home modifications, pest control and community-based residential alternatives. Self-direction is available for many of these services.

For TennCare and TennCare CHOICES, Tennessee contracts with two national, for-profit plans—AmeriGroup Community Care and UnitedHealthcare Community Plan—and one local, for-profit plan—Volunteer State Health Plan, also called BlueCare.

In addition, on July 1, 2016, Tennessee launched Employment and Community First CHOICES, which is an integrated MLTSS program specifically focused on fostering integrated, competitive employment and independent, integrated community living for individuals with I/DD. The program will grow slowly, focusing only on beneficiaries newly eligible for I/DD HCBS services.

F. Arizona

The Arizona Long-Term Care System (ALTCS) is a MLTSS program that provides integrated Medicare and Medicaid services for seniors and disabled individuals who need long-term care, including the I/DD population. ALTCS covers both institutional care and home- and community-based services to beneficiaries at risk of institutionalization. Arizona requires contractors in plans participating in ALTCS to also have companion D-SNPs to cover Medicare services and to coordinate all aspects of members' health, including disease management and care management.

Enrollment in an ALTCS Medicaid plan is mandatory and enrollment for full-dual eligible beneficiaries into the companion D-SNP is encouraged. More than one-third (60,000) of the full-dual eligible beneficiaries in need of LTSS are enrolled in an aligned and integrated product. The others are either enrolled in Medicare fee-for-service or a different Medicare Advantage plan.

V. Options for Capitated Contracting for Full-Dual Eligible Beneficiaries in North Carolina

Within the framework of federal rules and available waivers, states have numerous options to develop capitated contracting strategies for full-dual eligible beneficiaries. However, considering the General Assembly's intent through S.L.2015-245 to implement capitated programs for the full array of Medicaid benefits for full-dual eligible beneficiaries, and to coordinate those services with Medicare to the extent possible, the options narrow considerably.

PACE presents a ready and tested option to effectuate S.L.2015-245. As discussed above, PACE is an effective and efficient option for some full-dual eligible beneficiaries and ongoing growth of PACE should be supported. However, programmatic and operational factors limit the viability of PACE as an option to provide integrated services for the entire full-dual eligible population in North

Carolina. Therefore, although PACE should continue to be supported as a solution for some beneficiaries, the strategy in this report focuses on the use of other capitated Medicaid and Medicare plans.

The principal program structure decisions are to determine (1) which Medicaid benefits to include within capitation contracts, (2) the timeline for implementation by region/benefit/population, and (3) the type of relationship the Department wants to establish between the Medicare and Medicaid capitated plans. There also are numerous other options and policy decisions described below to enable the successful implementation of a capitated program for full-dual eligible beneficiaries.

The options explored in this report for full-dual eligible beneficiaries hinge on the assumption that North Carolina will implement an optional program with fully linked Medicare and Medicaid capitated products and a companion, but separately branded and operated, mandatory Medicaid-only capitated program. Furthermore, it is anticipated that the latest date upon which dual eligible beneficiaries would begin to enroll into such a program or programs is July 1, 2021.[18]

Although it is possible to make the Medicaid portion of a linked program mandatory—as planned in Virginia, for example—because beneficiaries cannot be mandated to enroll into any plan for Medicare benefits, some will refuse to enroll into the Medicare portion of a linked mandatory product and may even enroll into the Medicare portion of a competitor's product. This creates significant operational challenges for the plans and the state, and confusion for providers and beneficiaries.

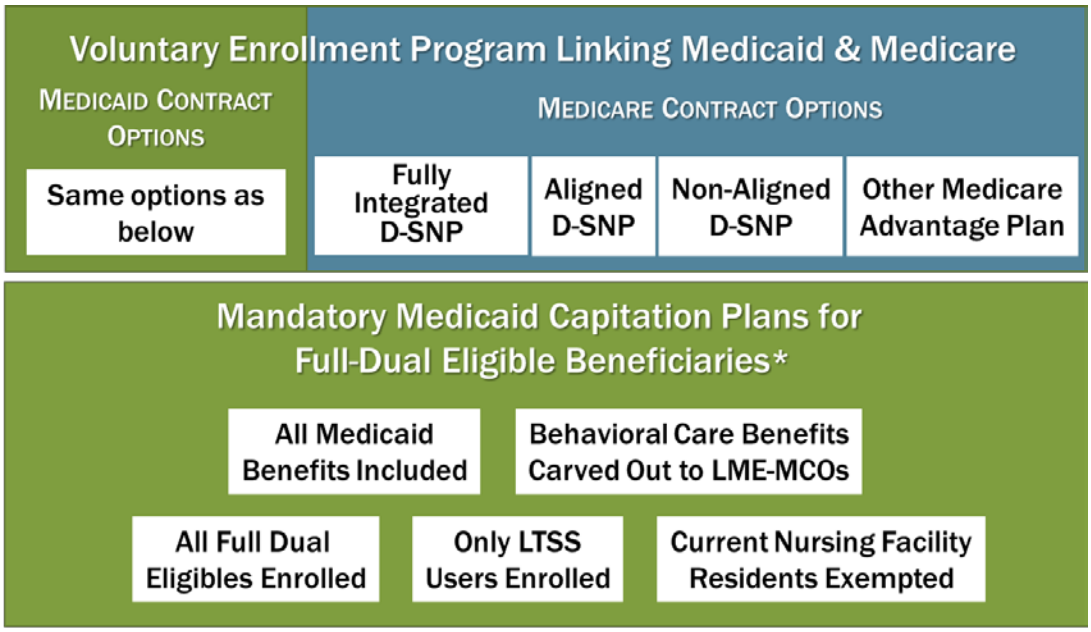
As demonstrated in the contract addendum that Virginia is requiring for D-SNPs participating in its program, such potential misalignments require careful planning and complex tracking obligations by plans and state enrollment operations staff. Misalignment can only be avoided by standing up a linked, voluntary program where enrollment into the Medicaid managed care program is tied to voluntary enrollment into a Medicare product, ensuring that each plan will serve only beneficiaries who are fully aligned. This allows participating plans to focus all their efforts on delivering excellent care to their own enrollees rather than struggling to coordinate with competing plans to deliver services to shared enrollees.

Further, the benefits of a mandatory program can still be achieved by *also establishing* a separate mandatory Medicaid program not linked to a Medicare program, but where participating plans also *must* participate in the voluntary linked program with aligned service areas and aligned administrative requirements for

[18] The reform law calls for enrollment of Medicaid-only beneficiaries into PHPs within 18 months following North Carolina's receipt of necessary federal waivers/approvals. Allowing an estimated 18 months for such approvals after the June 1, 2016, submission of the 1115 waiver application, PHP operations are likely to begin July 1, 2019. Then, approximately two years of PHP operations would be allowed before activating plans for dual-eligible beneficiaries.

Medicaid covered services. This reduces the complexity of operating the linked program and achieves the benefits of implementing a mandatory program. It also allows state public education efforts to differentiate the more controversial mandatory product from the optional one.

The array of choices to be made is depicted in very general fashion in the image below. The remaining text of this section presents full discussion of the options.



A. Options for Linking Medicare Advantage with Voluntary Enrollment into Capitated Medicaid Plans

i. Medicaid Capitated Plan Options

Any capitated program for full-dual eligible beneficiaries that aligns Medicare and Medicaid coverage will entail the use of capitated contracts for the Medicaid benefits to which these beneficiaries are entitled. However, there is a range of options for the treatment of aligned Medicaid benefits.

If North Carolina elects a D-SNP model, as discussed below, it can choose to include all the Medicaid benefits within the addendum to the D-SNP agreement or as a separate, free-standing agreement. North Carolina can choose whether to restrict eligibility to specific sub-populations of the full-dual eligible population.

In addition, North Carolina can decide either to include all Medicaid benefits within the capitated Medicaid contracts or to leave some in their current delivery systems. As discussed above, the Medicaid reform plan envisions that the services covered

under LME-MCOs will continue to be delivered through the LME-MCOs until four years after the date capitated PHP contracts begin. During this time, North Carolina will continue to ensure that LME-MCOs promote access to effective behavioral health services, including ongoing efforts to increase access to community-based services, such as outpatient therapy by independent licensed individual practitioners. As such, the Department recommends continuing to rely upon the LME-MCOs for the management of behavioral health services for full-dual eligible beneficiaries. The pros and cons of this approach and alternatives are discussed below.

a. Coverage of all LTSS (except those under LME-MCOs), Medicaid drugs, Medicare premiums and cost sharing (retaining LME-MCOs as carve-out for behavioral health services)

This approach would entail the procurement of a capitated contract inclusive of all Medicaid benefits except for those currently managed by LME-MCOs. It would allow for continuity in the access to those services and reduce disruption for those providers. This continuity is very important for the populations served by LME-MCOs, especially individuals with I/DD. This approach would wrap in all other Medicaid benefits and allow the entire full-dual eligible beneficiary population access to a fully integrated program.

However, this approach will retain some of the fragmentation that arises when some benefits are delivered by different entities. This could raise added barriers for the effective coordination of substance use disorder services in a manner compliant with the consent requirements at 42 CFR Part 2, because the integrated plan would have more difficulty securing sufficient consent from the Part 2 substance use disorder treatment providers. However, the Department intends to preserve the LME-MCO system for full-dual eligible beneficiaries at the outset of the program.

b. Coverage of all LTSS, behavioral health (including all benefits currently covered by LME-MCOs), Medicaid drugs, Medicare premiums and Medicare cost sharing

A more integrated option would entail the inclusion of all Medicaid covered benefits for full-dual eligible beneficiaries into the benefit package offered under the Medicaid capitated contract. This approach would allow the plan to control and coordinate all of a beneficiary's services.

For behavioral health benefits in particular, this would allow for easier exchange of information related to substance use disorder treatment under 42 CFR Part 2. The integrated plan would be the payer for the substance use disorder service and be in a good position to require providers subject to Part 2 to collect adequate patient consent to share the diagnostic and treatment information with other providers for care coordination purposes. This is more challenging, though, if the LME-MCOs continue to provide those services.

Given North Carolina's current situation, implementing a fully capitated approach within one plan would be more disruptive to the system and would require providers and beneficiaries served in the LME-MCO system to adapt to a new system for accessing their mental health, substance use disorder or I/DD services.

ii. Medicare Capitated Plan Options

Any capitated program for full-dual eligible beneficiaries that aligns Medicare and Medicaid coverage must use Medicare Advantage plans for the Medicare benefits to which these beneficiaries are entitled. CMS is accustomed to such arrangements, and there is a range of options that will give North Carolina substantial authority over the Medicare Advantage plans. This section discusses the options, the level of integration possible within each option, and pros and cons. The options are (1) fully integrated dual eligibles special needs plans (FIDE-SNPs), (2) aligned D-SNPs, (3) non-aligned D-SNPs, and (4) other Medicare Advantage products.

a. FIDE-SNPs

A FIDE-SNP is a sub-type of D-SNP that is a fully integrated Medicare and Medicaid product. D-SNPs classified as FIDE are described in section 1853(a)(1)(B)(iv) of the Social Security Act and in regulations at 42 CFR 422.2. FIDE-SNPs include a number of characteristics that make them more flexible than traditional D-SNPs and add incentives for plans to participate.

In return for implementing coordinated Medicare and Medicaid assessments and a health risk assessment for all participants, increased care coordination steps and an obligation to take risk for Medicaid benefits, FIDE-SNPs may receive an add-on to the Medicare portion of their capitation payment to reflect the portion of their beneficiary population who are nursing facility clinically eligible. This is referred to as a "frailty adjustment."

In addition, states are required to design FIDE-SNPs to include LTSS and most Medicaid benefits, to employ an integrated enrollment process, to include incentives for plans to provide care in the least restrictive setting, and to implement an integrated model of care. States have flexibility as to the inclusion of behavioral health benefits under the Medicaid portion of the plan and to align the Performance Improvement and Quality Improvement Program requirements under Medicaid managed care regulations with those required under Medicare Advantage.

In determining whether a given D-SNP is a FIDE-SNP, CMS will consider a range of substantive factors. CMS defines FIDE-SNPs to be CMS-approved D-SNPs that:

- Provide dual-eligible enrollees access to Medicare and Medicaid benefits under a single managed care organization;

- Have a CMS-approved, MIPPA-compliant contract with a state Medicaid agency that includes coverage of specified primary, acute, and long-term care benefits and services, consistent with state policy, under risk-based payment;

- Coordinate the delivery of covered Medicare and Medicaid health and long-term care services, using aligned care management and specialty care network methods for high-risk enrollees;

- Employ policies and procedures approved by CMS and the state to coordinate or integrate member materials, enrollment, communications, grievance and appeals, and quality improvement; and

- CMS will allow long-term care benefit carve-outs or exclusions only if the plan can demonstrate that it meets the following criteria:

    - The plan is at risk for substantially all services under the capitated rate

    - The plan is at risk for nursing facility services for at least six months (180 days) of the plan year.[19]

These criteria would allow enough flexibility for North Carolina to retain the LME-MCO program as currently operated in conjunction with a FIDE-SNP program, because behavioral health services are permitted to be carved out and the I/DD services would likely fall within the LTSS carve-out exception.

In general, the FIDE-SNP model is designed to allow plans to successfully serve the frailest and highest risk dual-eligible population. FIDE-SNP requirements are potentially more burdensome for plans than alternative D-SNP options in some ways, including greater expectations for assessments of health, functional and social challenges. However, the model also gives additional flexibility for the state and plans to offer additional optional benefits not covered by Medicare or Medicaid and to reduce duplication of requirements.

The frailty factor described above is designed to compensate for the inadequacy of the legacy risk adjustment methodology at predicting the costs of high-need full-dual eligible beneficiaries. However, the updates CMS has made to the risk adjustment model for CY 2017 and beyond may reduce the likelihood that CMS will continue to offer the frailty adjustment for long. Nevertheless, an improved risk model with less focus on a frailty factor based on nursing facility clinical eligibility will likely increase the appeal of a FIDE-SNP program that seeks to cover both LTSS and non-LTSS full-dual eligible beneficiaries.

[19] Medicare Managed Care Manual, Chapter 16-B: Special Needs Plans *at* Section 20.2.5.1.

b. Aligned D-SNP

An alternative to the FIDE-SNP is a traditional Medicare Advantage D-SNP, but with an agreement with the Medicaid agency providing for Medicaid covered services, referred to as an "aligned D-SNP." This would resemble the FIDE-SNP in many ways, but would allow the state more flexibility to carve out some portions of the Medicaid benefit until the provider system is better prepared for managed care.

For instance, North Carolina could launch an aligned D-SNP program where the nursing home benefit is retained in fee-for-service, while the rest of the LTSS—other than the LME-MCO services, presumed to remain with LME-MCOs—are covered within the capitation package.

D-SNPs are required to perform many of the enhanced care coordination services required of a FIDE-SNP, but North Carolina would not have to adopt integrated enrollment forms or meld plan payments to providers. However, the state would have the flexibility to require these integrated enrollment forms and integration of plan payments to providers under the standard MIPPA agreement.

Using a D-SNP but not a FIDE-SNP means plans would be ineligible for the Medicare frailty factor rate adjustment for the population nursing facility clinically eligible.

c. Non-Aligned D-SNP

A third alternative would be to simply continue to leverage the Medicare D-SNPs already operating in North Carolina. North Carolina could amend the D-SNPs' contracts with the Department to require the plans also to participate in a capitated program for Medicaid benefits without actively linking the plan enrollments.

Although this would reduce North Carolina's administrative burden somewhat in standing up the program, it would substantially reduce the benefits of implementing a D-SNP model for full-dual eligible beneficiaries. The plans would face misaligned enrollment such that many of their members could be enrolled into Medicaid plans operated by competitors. Such an outcome would undermine the effectiveness of care coordination mechanisms and increase administrative complexity.

d. Other Medicare Advantage products

North Carolina could forgo the use of D-SNPs entirely and seek to contract with conventional Medicare Advantage plans. Although this would save the state from having to navigate the D-SNP contract approval process, it would make it much harder to negotiate any agreements with the Medicare Advantage plans and would not allow the Department to access encounter data from the Medicare Advantage plans for services delivered to dual-eligible beneficiaries. One of the principal benefits of the D-SNP models is the power it grants to states to require the Medicare Advantage plans to serve specific populations and to meet other state demands. Any

effort to deliver capitated Medicaid services in conjunction with traditional Medicare Advantage requirements would raise significant challenges.

iii. Key Factors to Consider for Linking Medicare Advantage with Voluntary Enrollment into Capitated Medicaid Plans

As described above, there are pros and cons related to each option for structuring a linked Medicare-Medicaid voluntary product. Additional considerations include state operational capacity, the availability of qualified staff for the effective delivery of care coordination services, how beneficiaries will experience and navigate each option, provider engagement and support, how to transition beneficiaries currently enrolled in D-SNPs, plan readiness and capacity, and how service authorizations for HCBS services, including self-direction, will transition to managed care.

a. Department Operational Considerations

There will be state government operational challenges associated with each option for developing an integrated capitated Medicare-Medicaid program. The obligations differ from those associated with implementing a traditional MLTSS program. An integrated FIDE-SNP/Medicaid program requires a state to gain deep knowledge of the operations of Medicare Advantage, including contracting, enrollment, appeals, beneficiary notices, marketing materials, quality and financial reporting, star ratings, quality improvement programs, bid submissions, rate setting, audits and compliance.

The FIDE-SNP model, and to a lesser extent the traditional D-SNP, comes with a commitment from CMS to work with and support states in tailoring many of these Medicare Advantage design elements to the needs of the state's specific program. However, many of the elements are still inflexible, requiring careful planning by state agencies to ensure that systems and programs align as seamlessly as possible.

b. Care Manager Capacity

Many programs serving individuals having chronic conditions, through capitated programs or otherwise, rely upon experienced and dedicated care management professionals and effective health information technology. This is particularly true for full-dual eligible beneficiaries, owing to the high degree of administrative complexity in the health insurance programs themselves, to say nothing of the challenges associated with managing clinical and social needs of the population.

Decision-makers will carefully consider the approach to developing an integrated program for full-dual eligible beneficiaries to ensure that the health plans will have proper numbers of care management professionals with the credentials and skills for the target population. This may inform the decision of when to carve in the benefits currently delivered through the LME-MCOs.

c. Health Plan Capacity

Another crucial consideration that should inform the program design and rollout schedule is the capacity and preparedness of plans willing to participate. Depending on the design chosen, plans likely will need to be able to meet all Medicare Advantage D-SNP participation requirements, including proof of an adequate provider network, while also meeting participation requirements for both the linked Medicaid contract and the companion mandatory Medicaid capitated contract. This will require establishing successful relationships with Medicaid providers that may have never participated in managed care. It also will require delivery of services to a population that has generally not participated in managed care.

Plans also may need to find ways to partner with the accountable care organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP) in North Carolina. Some ACOs have made investments in serving full-dual eligible beneficiaries through the Medicare fee-for-service value-based purchasing system.

As such, the new program will present a challenge for most potential entrants and the Department should set up the procurement and readiness review process to rigorously assess the capacity and quality of applicants.

d. Partnership with Existing Provider-led Care Coordination

Many care coordination programs, including many models of care for D-SNPs, rely upon the cooperation and engagement of primary care providers and specialists managing chronic conditions. Any increases in unfunded clinical coordination activities will need to be carefully considered and coordinated with representatives of providers and other stakeholders.

North Carolina has a long and celebrated history of provider-led care coordination in the fee-for-service system. Any capitated program for full-dual eligible beneficiaries should leverage that experience. This could include requiring plans to operate patient-centered medical homes.

e. Future of Existing D-SNP Market

As mentioned above, there are seven D-SNPs currently operating in North Carolina, serving 21,219 beneficiaries. The Department intends to allow these D-SNPs to continue to operate until the rollout of a program with capitated Medicaid benefits. Then, the Department will plan for transitioning these beneficiaries into the new program.

It is possible to allow unintegrated D-SNPs to continue to operate; some states run multiple competing D-SNP-based programs simultaneously. However, this leads to increased administrative complexity for the Department, and for the plans,

providers and beneficiaries, while diluting the participation and impact of the integrated program.

Accordingly, the Department may seek to modify eligibility for the current D-SNPs to preclude their serving full-dual eligible beneficiaries simultaneously with the launch of a new integrated program. The existing D-SNPs can be allowed to continue to serve partial-dual eligible beneficiaries. This transition can be effectuated by transferring full-dual eligible beneficiaries into the new FIDE-SNP (or D-SNP) program, while simultaneously passively—not mandatorily—enrolling each beneficiary into the Medicaid portion of the benefit.

The most important step in effecting this transition without disrupting beneficiaries' care is to ensure that existing D-SNPs successfully qualify for all parts of the integrated program in all counties where they currently operate, and that they do so under the same contract number and model of care. This will allow them to transition D-SNP beneficiaries into the new program, while remaining compliant with Medicare enrollment rules.

Further, Medicaid authority must include the option for passive enrollment into the Medicaid portion of the benefit. This will reduce disruption to full-dual eligible beneficiaries currently served within the D-SNP program and create an incentive for existing plans to participate in the new program.

f. Alignment with the PHP Program

The Department also will work to align the PHP program for non-dual eligible beneficiaries and the capitated program for full-dual eligible beneficiaries. If the capitated plan is already a PHP serving the Medicaid-only population, this also allows for a more seamless transition for any member who becomes dually eligible.

CMS has offered an enrollment option called "seamless enrollment" for newly eligible Medicare beneficiaries where they are passively enrolled into the Medicare Advantage product operated by the parent company of the Medicaid plan they were enrolled in prior to aging into Medicare. CMS has issued a moratorium on seamless enrollment of this type, but may lift it by the time this program launches. As such, North Carolina should carefully consider options for aligning the PHP plan entities and service areas with the program for dual-eligible beneficiaries.

g. HCBS Service Authorization System

The service authorization process for HCBS services, including self-direction, will need to be adapted to managed care. There are many models for this process including, on the one hand, fully transitioning authorization authority to the plan's utilization management department or, on the other hand, retaining the authority of a county or Department-contracted authorization system that exists today in the fee-for-service system. Different approaches for different benefits also must be

considered, such as retaining LME-MCO authorization system, while integrating the other LTSS into the plan's utilization management system.

The Department will carefully consider the way beneficiaries currently access HCBS services, and ensure that any transition to managed care retains a person-centered planning approach and complies with applicable federal HCBS regulations.

h. Eligible Population

An important question is whether a linked product should be targeted only to full-dual eligible beneficiaries who need LTSS, as opposed to the entire population of full-dual eligible beneficiaries.

The Department could limit program eligibility to the population in need of LTSS. "Community-well" full-dual eligible beneficiaries could stay in fee-for-service for some Medicaid services, though those beneficiaries would continue to have access to care coordination services through LME-MCOs (assuming LME-MCOs continue to operate). That may suffice since most of the Medicaid-covered services used by the community-well population are for behavioral needs.

Alternatively, full-dual eligible beneficiaries who do not need LTSS could be placed into the same PHPs into which non-dual eligible beneficiaries will be enrolled.

Focusing on the LTSS population also would target resources on those beneficiaries with the highest Medicaid expenditures and those meeting the nursing facility clinical eligibility necessary for the FIDE-SNP plan (if any) to qualify for frailty adjustment. As such, it is definitely an option to consider carefully.

B. Mandatory Enrollment into Capitated Medicaid Plans for Full-Dual Eligible Beneficiaries, Not Linked to Medicare Advantage

As explained above, a linked Medicare-Medicaid plan arrangement must be voluntary for beneficiaries, because there is no authority for mandatory enrollment under Medicare and extremely limited authority for passive enrollment (automatic enrollment, but with an option for the beneficiary to refuse enrollment).

Further, although the Medicaid portion of a linked program could be made mandatory, the misaligned membership that could result will undermine the effectiveness of the program. Therefore, the plan to deliver integrated Medicare-Medicaid benefits for full-dual eligible beneficiaries should include a mandatory enrollment capitated program for Medicaid benefits only operated in parallel with the optional program. Otherwise, a significant fraction of the population could be left out of capitated programs, in contravention of S.L.2015-245 requirements.

i. Alignment with the Linked Medicare-Medicaid Program

Any companion program should mirror, to the extent possible, the geographic region, provider contracting requirements, and rate setting methodologies employed in the linked optional program. This will reduce inadvertent incentives for plans or providers to steer beneficiaries to the Medicaid-only program and will ease implementation for all parties.

ii. Phase-in Considerations

Another set of complex variables relates to phasing in of the mandatory program. The Department will explore whether to implement statewide or regionally, all at once or in regional phases. Enrollment could be phased in starting with more densely populated regions where it is more likely that plans will be able to meet provider network adequacy requirements and where it will be easier to gain meaningful participation, and then rolling out to the more rural regions. This would need to be balanced with the need for controlled enrollment growth to provide plans with adequate time to perform needs assessments and to develop care plans for newly enrolled beneficiaries.

Similarly, the program could be phased in for the long-stay nursing facility population by excluding individuals currently receiving institutional LTSS from enrolling into the program. This would carve out beneficiaries currently served in nursing facilities or other institutional placement; they would continue to be served in fee-for-service. However, if beneficiaries newly transitioned into an institutional placement, they could remain enrolled and the plan would manage those services. This would allow for an even more gradual transition to managed care for those service providers.

Finally, there are three options as to the order of implementation between mandatory and optional components of a program for full-dual eligible beneficiaries. One approach would be to launch the mandatory enrollment program first and the voluntary program linked with D-SNPs or other Medicare Advantage plans later. Alternatively, the programs can be activated simultaneously or the mandatory program can be implemented after the voluntary one.

In general, the mandatory program will likely be perceived by providers and beneficiaries as more disruptive. As such, it can be more effective to begin with the voluntary program. The disadvantage of this approach is that it will lengthen the time before Medicaid spending is brought substantially under capitation.

However, initiating the voluntary program first can allow the Medicaid LTSS system three incremental steps toward full capitation. The system would have its first experience with managed care through the rollout of the PHP program two years earlier, which will include capitated LTSS for the non-dual eligible population. The voluntary program also will allow plans, providers, beneficiaries and beneficiary

advocates additional time to work out any issues in the system before full-dual eligible beneficiaries are finally enrolled into a mandatory program.

iii. Enrollment and Marketing Rules

In addition to the factors raised above related to the linked voluntary Medicare-Medicaid program, the Department also must consider enrollment and marketing rules to incentivize enrollment into the integrated program; whether to include a robust care coordination benefit in the mandatory Medicaid capitated program; mechanisms to reduce plan incentives to enroll beneficiaries into the Medicaid-only product; and options for aligning the program with the PHP program.

The mandatory program is a backup system to the voluntary integrated program, so the enrollment and marketing rules should be designed to make it more likely that full-dual eligible beneficiaries will choose the integrated program. This could include allowing greater flexibility in marketing for FIDE-SNP or D-SNP plans to communicate to beneficiaries enrolled in the Medicaid plan operated by the parent company. It also could entail an enrollment lock-in for beneficiaries in the Medicaid capitated program outside an annual open enrollment period, but with an exception for beneficiaries choosing to enroll into the integrated program. Finally, this could include beneficiary materials and education requirements in the Medicaid capitated program that explain integrated program advantages and even assist with enrollment. Achieving some of these design elements will require a coordinated approach to framing the contracts for the integrated and Medicaid-only products.

iv. Care Coordination Services

Full-dual eligible beneficiaries enrolled in the mandatory Medicaid-only program will continue to receive all Medicare benefits either through fee-for-service or through a Medicare Advantage plan not affiliated with the Medicaid plan sponsor. Therefore, it may be worthwhile to demand robust care coordination in the mandatory Medicaid-only program to help beneficiaries access the care they need. This will include coordination with and leveraging the work of various programs in Medicare fee-for-service, such as ACOs participating in the MSSP. In addition, care coordinators serving the full-dual eligible population can be a valuable source of information for beneficiaries about the integrated program—provided marketing rules for the integrated program will allow them to talk about it.

If a care coordination benefit is included under the Medicaid-only program, the Department ought to consider whether to allow, require or prohibit plans from using the same care managers for both integrated and Medicaid-only products. Although it can be advantageous to have the care coordinator serve a beneficiary across the mandatory and optional programs, it can also be more successful to have specialized care coordination teams working on the integrated product. .

v. Financial Alignment

Across all program design elements, it is important to consider how to reduce incentives for plans and providers to steer full-dual eligible beneficiaries into less integrated programs. For instance, if the plans or providers can profit more per member from the Medicaid-only program, they may be less likely to take necessary steps to make the integrated program succeed. Given this backdrop, the Medicaid-only program should have rate methodologies, risk-adjustment systems, provider credentialing and network adequacy requirements that mirror the integrated program.

A final consideration is how to align the Medicaid-only and integrated programs with the PHP program. Of most significance, the Medicaid-only and integrated programs should align MLTSS rate setting, risk-adjustment, provider credentialing and network adequacy with LTSS coverage under the PHP program.

VI. Options for Capitated Contracting for Partial-Dual Eligible Beneficiaries in North Carolina

As described in Section III, there are four types of partial-dual eligible beneficiaries in North Carolina.[20] MQB-Q is the only category that includes coverage for cost sharing, while the other three cover only Medicare Part B or A premiums. In addition, as also noted earlier, North Carolina is a "lesser-of" cost-sharing state such that Medicaid only makes limited cost-sharing payments for MQB-Q beneficiaries.

Given these attributes of Medicaid coverage for partial duals, there is little to gain from North Carolina Medicaid implementing a capitated program to manage benefits for partial-dual eligible beneficiaries.

However, in some states, Medicaid agencies contract with all Medicare Advantage plans operating in the state to pay premiums in a more efficient manner and to pay cost sharing on a capitated basis. Further analysis is needed to determine if enough partial-dual eligible beneficiaries have enrolled into Medicare Advantage plans to warrant seeking such agreements.

VII. Options for Adding Medicaid LTSS Benefits Specific to the Managed Care Programs

In addition to the program design elements described earlier, North Carolina must consider options for adding LTSS benefits to the integrated program. Selected

[20] (1) Comprehensive Medicare-Aid program (MQB-Q) (Medicaid pays Medicare premiums and cost-sharing), (2) Limited Medicare-Aid (MQB-B) (Medicaid only pays Part B premiums), (3) Medicaid-Working Disabled (MWD) (Medicaid only pays Part A premiums), and (4) Limited Medicare-Aid Capped Enrollment (MQB-E) (Medicaid pays Part B premiums, but fully federally funded without state cost-sharing).

additional LTSS benefits can more than pay for the added cost. They greatly improve enrollment take-up of voluntary programs and increase cost-effectiveness of managed care transition. Additional HCBS benefits can give participating plans flexibility to support beneficiaries in the community to keep them healthy and out of more costly hospitals and nursing facilities.

Potential supplementary benefits that are not currently covered for the full-dual eligible adult population in North Carolina are home modifications, caregiver counseling and respite, home meal delivery, adult dental, flexibilities in location for adult social day services, skill building services for institutional residents to facilitate safe discharge, and additional behavioral health diversionary services such as community crisis stabilization, residential treatment for substance use disorders and community support program services for individuals with serious mental illness (SMI).

If no new benefits were to be added, the only way to influence beneficiary choice would be to emphasize the value of integration and care coordination. As important as these programs are, they may not seem compelling to beneficiaries.

Additional benefits can be authorized through an 1115 waiver concurrently with the request for managed care authority where the added benefits may be financed out of demonstration savings. Focusing additional benefits on the full-dual eligible population participating in the integrated capitated program with the purpose of reducing long-term institutional placement and hospitalization, and promoting community reentry can reduce or eliminate any net budget impact for the State.

In coming months, actuarial analyses will need to be performed to project costs of added benefits and offsets expected.

VIII. Options for Quality Measurement and Incentive Program

Any capitated program will need to measure quality. As a starting point, all Medicare Advantage plans, including FIDE-SNPs and D-SNPs, are subject to the same Part C and D reporting requirements as any other Medicare Advantage plans plus an additional set of measures specific to the SNP program.[21] Plan performance on these measures is made public annually and North Carolina also can require dual submission into the CMS system and a state system such that the Department will have access to the data as well. Any reporting strategy for the integrated program should avoid duplication with measures already collected.

Other measures should seek to integrate with the quality improvement process outlined in the Section 1115 waiver application. Additional measures should focus on key process and outcome goals program-wide. Though there will be a need for

[21] Part C Reporting Requirements Technical Specifications (2016) *available at*: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html.

some process measures to responsibly oversee the program (e.g., completion of needs assessments and care plans), most measures should focus on quality outcomes that are goals of the program. These could include additional chronic disease modules to the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, measures addressing diversion from institutional placement, rebalancing, utilization of self-direction among the population receiving personal care services, and engagement in substance use disorder treatment among individuals with a screening risk identified or substance use-related hospitalization, or many other possibilities.

There are numerous resources available for selecting measures for the Medicaid portion of an integrated program and, as LTSS measures are being developed nationally and in other states to support existing MLTSS programs, many more will undoubtedly be available when program planning begins in earnest.

The Department also plans to institute a financial incentive to promote quality within the integrated program. For example, the Department could withhold a portion (2-3%) of the capitation payments to all plans, then distribute it to the plans in proportion to their performance on quality measures.

Finally, the quality measurement strategy should feed into a program evaluation and assessment process at the state level. This will allow state leadership to determine whether the program should be expanded, altered, continued or terminated. This evaluation effort also should integrate with the evaluation process outlined in the Section 1115 waiver application.

IX. Options for Enhanced Beneficiary Enrollment Counseling and Advocacy Resources

The PHP program will include an enrollment broker that will operate a call center, develop and distribute beneficiary enrollment notices, and provide basic enrollment counseling. This enrollment broker should serve the identical function for the programs for full-dual eligible beneficiaries using tailored call center scripts and notices. For the voluntary linked program, CMS will assist in the development of notices that satisfy both Medicare and Medicaid requirements and will facilitate coordinated operations with the Medicare enrollment systems.

In addition to the enrollment broker, full-dual eligible beneficiaries need access to additional, more intensive beneficiary enrollment counseling support to help understand their options and choose the integrated coverage option that makes the most sense for their needs. Full-dual eligible beneficiaries currently have access to a good but limited array of beneficiary counseling. This includes the federally supported, state administered Seniors' Health Insurance Information Program (SHIIP). SHIIP helps Medicare beneficiaries understand and access their benefits through unbiased support and counseling. In addition, the 2016 Medicaid managed care final rule calls for additional Medicaid enrollment choice counseling, assistance

in understanding capitated benefit programs, assistance to beneficiaries who need LTSS, and expanded assistance to beneficiaries receiving LTSS for filing grievances and appeals of adverse benefit determinations.[22]

The Department will consider increasing the capacity of these programs to perform outreach, education and counseling for full-dual eligible beneficiaries. SHIIP serves all Medicare beneficiaries and has limited experience or spare capacity to assist full-dual eligible beneficiaries in navigating Medicaid benefits, much less the complexities that will be associated with the multiple interlocking capitated programs proposed herein. This will increase take-up in the voluntary program and reduce beneficiary and caregiver confusion and concern.

In addition to enrollment options counseling, full-dual eligible beneficiaries need advocacy support to ensure participating plans and providers are held accountable to the beneficiaries. The North Carolina Long-Term Care (LTC) Ombudsman program currently provides advocacy and support for any resident of a long-term care facility. This includes investigations of complaints and assistance with formal grievances. These programs are crucial and provide exceptional service to the beneficiaries who use them. However, to ensure the success of a program of integrated care for full-dual eligible beneficiaries, this program needs to be expanded.

Of note, the LTC Ombudsman program only assists residents of long-term care facilities and focuses on core issues of safety and rights. These services are crucial and must be maintained. However, ombudsman services are not available for general concerns about managed care or HCBS or other Medicaid benefits. The rollout of capitated plans for full-dual eligible beneficiaries may expose fragile beneficiaries and their families to disruptions. A well-functioning ombudsman program will help the Department and the plans to address any issues in a timely manner.

The Department will engage with CMS and the Administration for Community Living (ACL, the federal agency overseeing the LTC Ombudsman program) early in the process to try to secure additional support for expanded SHIIP and ombudsman programs.

X. Options for Provider Training and Technical Assistance

The Advisory Committee repeatedly highlighted the potential challenges of an integrated capitated program for full-dual eligible beneficiaries arising from provider capacity and willingness to participate in managed care. Many of the key provider groups for services for full-dual eligible beneficiaries may prefer Medicare

[22] 42 CFR 438; 81 *Fed. Reg.* 27498-27901 (May 6, 2016), *available at* https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

fee-for-service or have limited, if any, experience with plan contract negotiations, billing or compliance. Further, many of these programs have limited experience participating in coordination of care across the entire continuum of services. In the same manner that some primary care doctors may have limited experience discussing the home life and safety of a patient, a personal care aide or adult day care provider may be unaccustomed to contributing to a comprehensive plan of care with physicians and other clinicians.

Behavioral health and I/DD providers who have participated with LME-MCOs may have more experience, but the process of participating in a regional, exclusive program is very different from participating in commercial plan networks in a competitive market with multiple plans serving the same area and covering the full continuum of Medicare and Medicaid benefits. In addition, many physicians may oppose managed care and resist increased care coordination obligations.

Accordingly, the Department will consider options for offering training and technical assistance for providers. The program would aim to introduce the concept of the integrated, capitated program to providers well before the plans begin the process of executing or modifying contracts. There might be two tracks: One of outreach and education focusing on Medicare fee-for-service providers emphasizing program benefits to them and their patients, and the second focusing on Medicaid LTSS and behavioral health providers imparting skills and resources for the managed care contracting and participation process. This effort will help providers engage, improve the quality of Medicaid services delivered under the program and lower risks for providers associated with billing compliance.

XI. Next Steps for Implementation

Beyond this report, the Department will continue to work with stakeholders to implement S.L.2015-245 provisions that pertain to dual eligible beneficiaries. These efforts will include continued meetings of the Advisory Committee, and engagement with the General Assembly and CMS.

The Advisory Committee will continue to meet to discuss concepts raised in this report, including potential Medicare and Medicaid contracting options and schedule for rolling out different elements of the program. The Advisory Committee also will discuss Medicaid contract procurement and readiness review criteria and process. The Advisory Committee also will continue to discuss the potential for additional Medicaid benefits based on evidence for service efficacy, provider capacity and needs of the full-dual eligible population. The Advisory Committee also will meet with the existing North Carolina SHIIP and Ombudsman programs to discuss options for potentially expanding the beneficiary counseling and advocacy resources for full-dual eligible beneficiaries of a capitated program.

The Department also will meet with provider associations and others in the provider community to plan for provider training and technical assistance

associated with serving full-dual eligible beneficiaries and participating in a capitated program.

The Department also will begin the process of engaging with the CMS Center for Medicaid and CHIP Services, and the CMS Consortium for Medicaid and Children's Health Operations to discuss what approach North Carolina should take to secure Medicaid authority for benefit and delivery system changes contemplated in this report. This would include the potential options for the LME-MCO program; contracting options; additional benefits; marketing rules; use of mandatory, optional, and passive enrollment authorities; regional rollout options; network adequacy standards; care coordination services; overlaps with existing services; and other policy issues.

Similarly, the Department will begin to engage with the CMS Center for Medicare and the CMS Consortium for Medicare Health Plan Operations, the federal agencies responsible for overseeing the Medicare Advantage program, to discuss the options for FIDE-SNP and D-SNP contracting, and any state plans to contract with traditional Medicare Advantage organizations. This discussion will include the options for meeting MIPPA requirements in the contract between the SNP entity and the Department. The discussion also will cover the eligibility limitations for the optional FIDE-SNP (or D-SNP) program and the timeline for contract submission and approval by CMS.

Early discussions also will address North Carolina-specific marketing policies and any initiatives to integrated beneficiary notices and plan-level coverage determination grievance and appeal procedures. Conversations with CMS also will cover any plans to alter eligibility criteria for existing D-SNP plans and how beneficiaries of those plans will be transitioned to other coverage.

The Department also will follow this report with ongoing engagement and communication with the legislature. This will include discussion of the new managed care authority and any additional statutory authority necessary for supplemental benefits, enrollment counseling, and/or beneficiary ombudsman services.

APPENDIX A: DEFINITIONS

Accountable Care Organization (ACO): Groups of doctors and other health care providers who voluntarily work together with Medicare to give high quality service to Medicare fee-for-service beneficiaries as a part of the Medicare Shared Savings Program (MSSP). An ACO is not a Medicare Advantage plan or an HMO. ACOs also may work with payers other than Medicare.

Centers for Medicare & Medicaid Services (CMS): The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey: A patient experience survey system that asks consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The acronym "CAHPS" is a registered trademark of the federal Agency for Healthcare Research and Quality (AHRQ).

Division of Health Benefits (DHB): The division of the North Carolina Department of Health and Human Services created by S.L. 2015-245 to administer the transformed Medicaid program, moving Medicaid to an outcome-driven, capitated model.

End Stage Renal Disease (ESRD): The last stage (stage five) of chronic kidney disease (CKD). When CKD or other kidney diseases develop into ESRD, dialysis or a kidney transplant is necessary to live. Qualified individuals with ESRD are eligible for Medicare regardless of age.

Fee-For-Service: The method of paying providers for each encounter or service rendered.

Full-Dual Eligible Beneficiaries: Individuals who are entitled to benefits under Medicare Part A, enrolled in Medicare Part B, eligible to enroll in Medicare Part D, and eligible for full Medicaid benefits.

Home- and Community-Based Services (HCBS) Waivers: Medicaid waivers under Section 1915(c) of the Social Security Act that allow a state to cover home- and community-based services, and provide programs designed to meet the unique needs of individuals with disabilities who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities.

Intellectual and Developmental Disabilities (I/DD): A severe, chronic disability attributed to a mental/cognitive or physical impairment or combination of mental

and physical impairments diagnosed or that become obvious before age 22. The condition is likely to continue indefinitely and limits the individual in three or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

Local Management Entities-Managed Care Organizations (LME-MCOs): Quasi-governmental entities that contract with the NC Department of Health and Human Services and receive capitated payments for covered services. LME-MCOs are managed care entities with exclusive designated contiguous geographic areas of the state operating under a Medicaid combination 1915(b)/(c) waiver. Enrollment into LME-MCOs is mandatory for any Medicaid beneficiaries in need of mental health, developmental disability, psychiatric residential treatment facility (PRTF), inpatient psychiatric care, intermediate care facilities for individuals with I/DD, substance use disorder services, or self-directed personal care services.

Long-Term Care Ombudsman Program: A program that assists residents of North Carolina long-term care facilities in exercising their rights and attempting to resolve grievances between residents, families and facilities. The Long-Term Care Ombudsman Program consists of an Office of the State Long-Term Care Ombudsman and 16 Offices of the Regional Long-Term Care Ombudsman that are housed in Area Agencies on Aging across North Carolina.

Long-Term Services and Supports (LTSS): The range of medical, habilitation, rehabilitation, home care or social services a person needs over months or years to improve or maintain function or health that are provided in the person's home, other community-based setting or long-term care facility, such as a nursing facility.

Managed Care and **Managed Care Organizations (MCOs):** Managed care is a general term describing programs that enroll individuals into organized health plans—or MCOs—that receive fixed prepaid sums, called capitations, in return for delivering a defined package of health care and related services to their enrollees.

Managed Long-Term Services and Supports (MLTSS): A capitated program in which a state contracts with Medicaid plans to deliver some or all of the LTSS covered under the state's Medicaid program to eligible beneficiaries.

Medicaid: The program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations, and the State Plan and waivers approved by CMS.

Medicaid Waiver: Generally, a waiver of existing law authorized under Section 1115(a), 1115A, or 1915 of the Social Security Act. A Section 1115(a) waiver also is referred to as a demonstration.

Medicare: Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS). Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D is a voluntary option that covers outpatient prescription drugs.

Medicare Advantage: The Medicare managed care options that are authorized under Title XVIII as specified at Part C and 42 CFR § 422. Medicare Advantage plans are private health plans that contract with CMS and receive prepaid capitation payments from CMS and also may collect premiums from enrolled beneficiaries. Capitation rates and premium amounts vary depending upon factors, including local area cost benchmarks, the plan's benefit package, the plan's bid to CMS to provide the Part A, Part B and Part D services, and the plan's costs of furnishing supplemental services.

Medicare Advantage Special Needs Plan (SNP): The Medicare Modernization Act of 2003 (MMA) established new types of Medicare Advantage plans specifically designed to provide targeted care to individuals with special needs. In the MMA, Congress identified "special needs individuals" as (1) institutionalized individuals; (2) dual eligibles; and/or (3) individuals having severe or disabling chronic conditions, as specified by CMS. SNPs established to provide services to these special needs individuals are called "Specialized MA plans for Special Needs Individuals," or SNPs. The three types are chronic condition SNP (C-SNP), dual eligible SNP (D-SNP), and institutional SNP (I-SNP). Most recently, section 206 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the SNP program through December 31, 2018. SNPs are expected to follow existing Medicare Advantage program rules, including regulations at 42 CFR 422, as interpreted by guidance, with regard to Medicare-covered services and Prescription Drug Benefit program rules. All SNPs must provide Part D prescription drug coverage because special needs individuals must have access to prescription drugs to manage and control their special health care needs (see 42 CFR 422.2).

- **C-SNP:** C-SNPs are SNPs that restrict enrollment to special needs individuals having specific severe or disabling chronic conditions, defined in 42 CFR 422.2.

- **I-SNP:** I-SNPs are SNPs that restrict enrollment to individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a

SNF/NF, an intermediate care facility for individuals with I/DD (ICF/IDD), or an inpatient psychiatric facility.

- **D-SNP:** D-SNPs enroll individuals who are entitled to both Medicare (Title XVIII) and medical assistance from a state plan under Medicaid (Title XIX). As provided under section 164(c)(2) of MIPPA, and as amended by section 3205(d) of the ACA, as of Jan. 1, 2013, all D-SNPs are required to have an executed contract with applicable state Medicaid agencies.

    - **Fully Integrated Dual Eligible SNP (FIDE-SNP):** A FIDE-SNP is a D-SNP that is a Medicare and Medicaid fully integrated product. D-SNPs classified as FIDE are described in section 1853(a)(1)(B)(iv) of the Act and at 42 CFR 422.2. FIDE-SNPs are CMS-approved D-SNPs that enroll special needs individuals entitled to medical assistance under a Medicaid State Plan; provide dual-eligible enrollees access to Medicare and Medicaid benefits under a single managed care organization; have a CMS-approved, MIPPA-compliant contract with a state Medicaid agency that includes coverage of specified primary, acute, and long-term care benefits and services; consistent with state policy; under risk-based financing; coordinate the delivery of covered Medicare and Medicaid health and long-term care services; using aligned care management and specialty care network methods for high-risk enrollees; and employ policies and procedures approved by CMS and the state to coordinate or integrate member materials, enrollment, communications, grievance and appeals, and quality improvement.

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA): The statute that lifted a prior moratorium on SNP contracts and outlined the elements for agreements between Medicaid agencies and D-SNPs. MIPPA was amended by section 1853(a)(1)(B)(iv) of the Social Security Act to require all D-SNPs to have an executed contract with applicable state Medicaid agencies. This agreement, commonly referred to as "the MIPPA agreement," must set forth how the D-SNP will coordinate access to the Medicaid services to which the beneficiary is entitled.

Medicare-Medicaid Coordination Office: An office within CMS, formally named the Federal Coordinated Health Care Office, established to more effectively integrate benefits under the Medicare and Medicaid programs, and improve the coordination between the federal government and states for individuals eligible for benefits under both such programs to ensure that such individuals get full access to items and services to which they are entitled.

Medicare Shared Savings Program (MSSP): A program aiming to facilitate coordination and cooperation among providers to improve quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs.

Model of Care (MOC): A structure for care management processes and systems that will enable the health plan to provide coordinated care for special needs individuals. The MOC provides the foundation for promoting SNP quality, care management and care coordination processes. Every SNP must have MOC reviewed and approved by the National Committee for Quality Assurance (NCQA). NCQA is a private, not-for-profit organization that, among other functions, has contracted with CMS to develop a set of measures to evaluate the structure, processes and performance of SNPs.

Money Follows the Person program: Money Follows the Person Rebalancing Demonstration Grant is a federal grant program that helps states rebalance their Medicaid long-term care systems.

New to Service: Beneficiaries who are entering LTSS care for the first time.

North Carolina Department of Health and Human Services: The Department of Health and Human Services manages the delivery of health- and human-related services for all North Carolinians, especially the most vulnerable citizens—children, elderly, disabled and low-income families. The Department works with health care professionals, community leaders and advocacy groups; local, state and federal entities; and many other stakeholders to make this happen. The Department is divided into 30 divisions and offices. Divisions and offices fall under four broad service areas: health, human services, administrative and support functions. The Department also oversees 14 facilities: developmental centers, neuro-medical treatment centers, psychiatric hospitals, alcohol and drug abuse treatment centers, and two residential programs for children.

North Carolina Medicaid Prepaid Health Plan (PHP) Program: A capitated program initially for non-dual eligible Medicaid beneficiaries in North Carolina. The PHPs are anticipated to begin serving enrollees on or about July 1, 2019, following receipt of necessary federal approvals plus efforts to procure and contract with PHPs.

Nursing Facility Clinically Eligible: A standard of eligibility for care in a nursing facility based on an individual's care needs and functional, cognitive and medical status as set out in North Carolina Medicaid and Health Choice Clinical Coverage Policy 2B-1. Professional judgment and a thorough evaluation of the resident or beneficiary's medical condition and psychosocial needs are necessary, and an understanding of and the ability to differentiate between the need for nursing facility care and other health care alternatives.

Partial-Dual Eligible Beneficiaries: Individuals who are entitled to benefits under Medicare Part A, enrolled in Medicare Part B, eligible to enroll in Medicare Part D, and eligible for some form of assistance under the North Carolina Medicaid program but not full Medicaid benefits. The four categories of Partial-Dual Eligible Beneficiaries in North Carolina are (1) Comprehensive Medicare-Aid program (MQB-Q) (Medicaid pays Medicare premiums and cost-sharing), (2) Limited

Medicare-Aid (MQB-B) (Medicaid only pays Part B premiums), (3) Medicaid-Working Disabled (MWD) (Medicaid only pays Part A premiums), and (4) Limited Medicare-Aid Capped Enrollment (MQB-E) (Medicaid pays Part B premiums, but fully federally funded without state cost-sharing).

Personal Care: Services that provide some or total assistance with personal hygiene, dressing and feeding, and nutritional and environmental support functions. Such services must be essential to the maintenance of patients' health and safety in their own homes.

Pre-Admission Screening and Resident Review (PASRR): A federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care. PASRR requires that (1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability; (2) be offered the most appropriate setting for their needs (in the community, a nursing facility or acute care settings); and (3) receive the services they need in those settings.

Primary Care Provider (PCP): A provider, including a specialist serving as a PCP, who within the provider's scope of practice and according to state certification or licensure requirements, is responsible for providing all preventive and primary care services to his or her assigned patients in the capitated plan.

Prior Authorization: Review and approval by the capitated plan that must be obtained prior to a beneficiary receiving covered items and services for which prior authorization is required.

Program of All-inclusive Care for the Elderly (PACE): A Medicare and Medicaid program that helps people meet their health care needs in the community instead of a nursing home or other institutional care facility. Enrollment is limited to people age 55 or older who are qualified for nursing facility level of care.

Provider: A person or organization enrolled with CMS to provide Medicare covered items or services, or issued a provider identification number by the state to provide Medicaid covered items or services, to a participant. Capitated plans are not considered providers.

Readiness Review: A readiness review evaluates the capitated plans' ability to comply with federal and state requirements, including, but not limited to the ability to quickly and accurately process claims and enrollment information, accept and transition new participants, and provide adequate access to all Medicare and/or Medicaid-covered medically necessary items and services. CMS and the Department use the results to inform decisions about whether the capitated plan is ready to begin accepting enrollment. At a minimum, a readiness review includes a desk review and a site visit to the prospective plan's headquarters.

Seniors' Health Insurance Information Program (SHIIP): A program that counsels Medicare beneficiaries and caregivers in North Carolina about Medicare, Medicare supplements, Medicare Advantage, Medicare Part D and long-term care insurance.

Serious Mental Illness: A diagnosable mental disorder experienced by an adult that is sufficiently severe and enduring to cause functional impairment in one or more life areas and a recurrent need for mental health services.

Spend-down: The policy that allows individuals to qualify for the Medicaid program by incurring medical expenses at least equal to the amount by which their income or assets exceed eligibility limits. It operates similarly to deductibles in private insurance in that the spend-down amount represents medical expenses the individual is responsible to pay.

State: The North Carolina Department of Health and Human Services is the single-state Medicaid agency and as such, has ultimate authority for the program.

State Plan: The North Carolina State Plan for medical assistance (Medicaid) filed with CMS in compliance with Title XIX of the Social Security Act.

Utilization Management: A comprehensive approach and planned activities for evaluating appropriateness, need and efficiency of services, procedures and facilities according to established criteria or guidelines under program provisions. Utilization management typically includes new activities or decisions based upon the analysis of care, and describes proactive procedures, including discharge planning, concurrent planning, pre-certification and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, and appeals introduced by the provider or participant.

42 CFR Part 2: Federal regulations, promulgated pursuant to 42 U.S.C. § 290dd-2, governing the confidentiality of records related to federally supported substance use disorder treatments.

APPENDIX B: DUAL ELIGIBLES ADVISORY COMMITTEE MEMBERS

MEMBER	ORGANIZATION
Blair Barton-Percival	NC Association of Area Agencies on Aging
Mary Bethel	NC Coalition on Aging
Vickie Bradley	Eastern Band of Cherokee Indians
Conor Brockett	NC Medical Society
Sally Cameron	NC Psychological Association
Hugh Campbell	NC Association of Long Term Care Facilities
Rene Cummins	NC Statewide Independent Living Council
Corye Dunn	Disability Rights NC
Chris Egan	NC Council on Developmental Disabilities
Cindy Ehlers	NC Council of Community Programs
Abby Carter Emanuelson	National Multiple Sclerosis Society
Keith Greenarch	The Adaptables Center for Independent Living
Ken Jones	Brain Injury Association of NC
Genie Komives, MD	NC Academy of Family Physicians
Alan Kronhaus, MD	Doctors Making House Calls
William Lamb	Friends of Residents in Long-Term Care
Ken Lewis	NC Association of Health Plans
Frances Messer	NC Assisted Living Association
Carol Meyer	The Carolinas Center for Hospice and End of Life Care
Benjamin Money	NC Community Health Association
Carrie Palmer	NC Council of Nurse Practitioners
Jo Anne Powell	Roanoke Chowan Community Health Center
Sharnese Ransome	NC Association of County Departments of Social Services
Greg Richardson	NC Commission of Indian Affairs
Tim Rogers	Association for Home Health & Hospice Care of NC
Richard Scott	Governor's Advisory Council on Aging
Linda Shaw	NC PACE Association
Craig Souza	NC Health Care Facilities Association
Lynette Tolson	NC Association of Local Health Directors
Jeff Weegar	NC Hospital Association
Tom Wroth	NC Community Care Networks

APPENDIX C: DUAL ELIGIBLES ADVISORY COMMITTEE SUGGESTIONS ON CARE COORDINATION, BEHAVIORAL HEALTH AND READINESS

The Dual Eligibles Advisory Committee examined specific key design elements that should be closely considered and examined as the Department develops its strategy to effectively integrate dual-eligible beneficiaries into the reformed Medicaid program. The three beneficiary-related elements examined by the Advisory Committee were:

1. Care coordination
2. Integration of behavioral health
3. Evidence of readiness

1. Advisory Committee Care Coordination Recommendations

Both the Advisory Committee and the prior Department Whole Person Care workgroup identified the care coordination function as a crucial element in a managed system for ensuring quality, coordinated "whole person" care. The Whole Person Care workgroup identified several considerations for the design of care coordination within a managed system. Advisory Committee members reviewed these recommendations, supported them and supplemented with additional considerations. A synthesis of the Advisory Committee observations and earlier stakeholder recommendations are below.

Recommendation: *Care coordination scope should cover coordination across service delivery programs. The care coordinator function should have the capacity to work across multiple, separate service plans and programs.*

- Ability to coordinate both Medicare and Medicaid services
- Ability to coordinate across primary care, long-term care and behavioral health, including within LME-MCOs
- Ensure health plan payment structure incents and supports effective coordination with other plans

Recommendation: *The care coordination function should be designed to support the needs of the "whole person," including social support needs.*

- Social determinants of health: Care coordinator scope of responsibility should include identifying and coordinating social factors that may affect a person's health and quality of life, including:
  - Safe and adequate housing
  - Access to employment
  - Ensuring food security
  - Ensuring adequate transportation
  - Physical health

- Dual eligibles require emphasis on medication management oversight should be included in the care coordination function

- Coordinating oral health services should be within the scope of the care coordination services

Recommendation: *Care coordinators should work in all settings.*

- Care coordination function should include coordinating services of individuals residing in long-term care settings
- Medicaid reform initiative should be used as an opportunity to examine how to effectively coordinate services for individuals residing in facility settings

Recommendation: *The care coordination function and support level should be adjusted to meet the needs of individual beneficiaries.*

All beneficiaries should be assessed for care coordination needs, and care coordination services should be measured and adjusted to meet the specific support needs of the individual

Recommendation: *Each beneficiary receiving care coordination should have a single or lead care coordinator.*

- This recommendation is informed by stakeholders' current experience with beneficiaries having multiple coordinators due to participation in multiple programs, which results in confusion and duplication of effort and can compromise efforts to effectively integrate care

- The Whole Person Care workgroup also identified this as a mechanism to supported providers

Recommendation: *Care coordination should be provided at the local level.*

- Facilitates stronger relationship with beneficiary and beneficiary support and resources

- The Whole Person Care workgroup also identified this as a strategy that reduced burden on providers

Recommendation: *Care coordination should not be structured to conduct utilization management functions, and should not be limited to managing service utilization and service access.*

Care Coordinator Competencies

Recommendation: *Required care coordination training and competencies should include how to meet the specific needs of family caregivers, not just the beneficiary.*
Consider examining other studies to determine that care coordination model/services are aligned with identified needs of family caregivers.

Recommendation: *Ensure required care coordination training and competencies meet the specific needs of younger dually eligible beneficiaries.*
Care coordinators should be adept at navigating services and supports related to safe and adequate housing; and employment.

Considerations for System Design to Better Facilitate Effectively Coordinated Care

- An integrated health insurance exchange (HIE) system is crucial for effective care coordination
- Privacy-related firewalls impact effective coordination
- Learn from existing efforts related to LME-MCOs

2. Advisory Committee Behavioral Health Recommendations

Recommendation: *Minimize the administrative burden on providers to enroll and participate in Medicaid managed care program.*
Outpatient therapies are among the most highly utilized behavioral health service.

Recommendation: *Identify and analyze promising practices related to care integration underway within current LME-MCO network.*
Innovative efforts are underway in a number of LME-MCOs that the Department should consider when exploring how to ensure that dual eligibles who receive services through the PHP and LME-MCOs could experience the most integrated experience possible

Recommendation: *Examine current practices related to self-direction to inform Medicaid plan design.*

3. Advisory Committee Program Readiness Recommendations Ensuring Beneficiary Input and Feedback

Existing Department stakeholder outreach efforts, such as Medicaid reform public meetings and listening sessions, and the LTSS/Medicaid Reform webinar series were a "good start" to engage beneficiaries, but identified a number of options to

improve beneficiary knowledge about reform in general and to make informed decisions at the time of plan selection.

Recommendation: *Engage the provider network in stakeholder outreach.*

- Engage providers with whom the beneficiary already has a relationship to help solicit feedback and share information; but agencies should not be expected to do so without additional resources

- Ensure provider network is clear on contractors available to advise beneficiaries

Recommendation: *Examine SHIIP as model.*

- Consider using volunteer network to expand outreach opportunities

- Ensure volunteer-based networks are adequately funded and supported to perform role effectively

- Examine use of informal meeting locations, such as coffee-houses, etc.

- Information should also be centralized

- The Department must ensure its readiness for managing coordinated services for dual-eligible beneficiaries