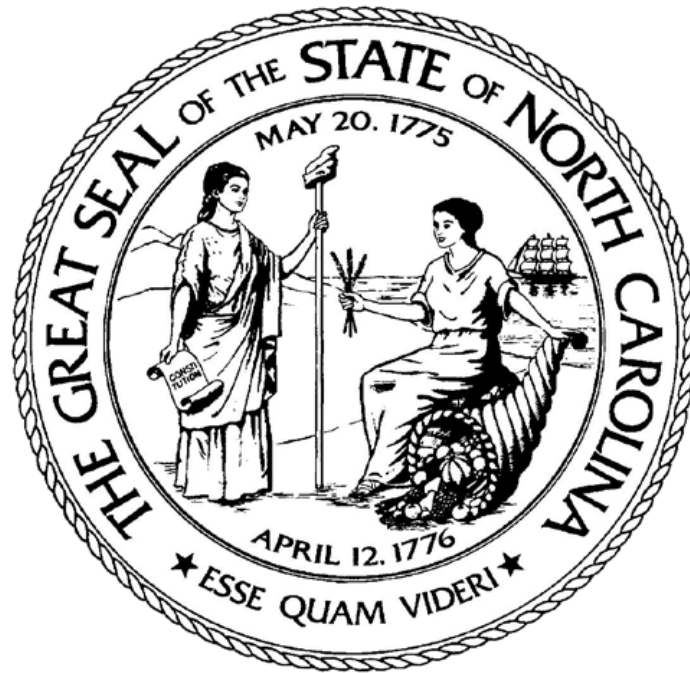


**Report to  
The Joint Legislative Oversight Committee on Medicaid and NC Health Choice  
on  
The Managed Care Strategy for North Carolina Medicare-Medicaid Dual  
Eligible Beneficiaries**

**Session Law 2015-245**



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



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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 Medicaid-Medicare dual-eligible beneficiaries through capitated contracts. The Department of Health and Human Services (DHHS) Division of Health Benefits, in partnership with the Dual Eligibles Advisory Committee, has worked during 2016 to shape this strategy.

This report represents the culmination of this effort and satisfies the obligations of the provision of S.L. 2015-245. However, this report is not the conclusion of the Division's work. It is better described as the beginning. This report sets forth numerous options and potential design features that will serve as a guide for the State in the execution of a thoughtful and comprehensive strategy for implementing a capitated program for dual-eligible beneficiaries in North Carolina.

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

- (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, DHHS and the Dual Eligibles Advisory Committee have identified a number of 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 Medicare Advantage plans overseen by the federal Centers for Medicare and Medicaid Services (CMS) to reduce deeply entrenched financial and programmatic misalignments that exist between the Medicaid and Medicare programs.

DHHS and the Dual Eligibles Advisory Committee concluded that it is wisest to allow two years of operations of the North Carolina Medicaid Prepaid Health Plan (PHP)

program before activating the capitated program for dual-eligible beneficiaries. The PHPs for non-dual-eligibles are anticipated to begin serving enrollees on or about July 1, 2019, following receipt of necessary federal approvals plus efforts to engage and start up PHP contracts. Hence, the dual-eligible beneficiaries' capitated program is proposed to start in at least one region no later than July 1, 2021, with full implementation state-wide no completed later than July 1, 2023.

Based on experiences of other states that have led the way in the use of capitated plans for dual-eligible beneficiaries, the final program will use two companion approaches. The first is a voluntary-enrollment capitated contracting strategy that aligns capitated Medicaid benefits with a 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 possible only when one entity is responsible for managing both the Medicare and Medicaid benefits. The second will entail a mandatory-enrollment capitated contracting strategy for Medicaid benefits only. (Federal law prohibits limiting Medicare beneficiaries' freedom of choice, and this prohibition cannot be waived.) This report discusses a range of options within this broad framework.

In addition, the strategy for a capitated program serving dual-eligible beneficiaries will involve the development of additional Medicaid benefits specific to the optional integrated Medicare-Medicaid capitated program to improve the take-up and cost-effectiveness of the program. The strategy will also create 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.

Dual-eligible beneficiaries will be further protected and served by new beneficiary counseling and advocacy resources. These resources will help beneficiaries to navigate the new capitated plan enrollment landscape and ensure that capitated plans are accountable to beneficiaries after enrollment. As discussed below, these could build upon the existing North Carolina Long-Term Care Ombudsman and 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 final strategy proposes to offer training and technical assistance for providers covering at least care coordination, network contract negotiation, claim billing, and compliance.

This report gives background on dual-eligible beneficiaries in general and North Carolina in specific, as well as the existing delivery system. It also provides a summary of capitated strategies other states have already implemented to serve this complex population. The largest portion of the report presents a detailed discussion of the options DHHS will consider in the implementation of a capitated program for dual eligible beneficiaries. Finally, the report outlines the next steps for DHHS and the Dual Eligibles Advisory Committee.

## 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 Medicaid and Medicare. 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 work of the Dual Eligibles Advisory Committee and presents a proposed long-term strategy to cover dual eligibles through capitated PHP contracts.

### b. Work of the Dual Eligibles Advisory Committee

The Division of Health Benefits (DHB) established the Dual Eligibles Advisory Committee early in 2016. The committee's 31 members were selected to ensure that DHB 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 Exhibit 1 for the composition of the Dual Eligibles Advisory Committee. Persons identified with an asterisk (\*) participate on a 12-member steering committee that the larger group agreed should meet in between meetings of the full body to promote rapid progress toward fulfilling the committee's mission.

[Placeholder for Exhibit 1: Members of Dual Eligibles Advisory Committee]

The full committee has met in public forum on several occasions to discuss the myriad issues surrounding the dual eligible population: their health and functional challenges, the significance of social determinants of health, the 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 prepaid health plans, 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 high-level consensus recommendations emanating from the Dual Eligibles Advisory Committee to this point are as follows:

- Capitated plan enrollment for dual eligibles should be implemented only after managed care has been made to function smoothly for the Medicaid-only population.
- Integration of dual eligibles into managed care should be conducted in carefully planned phases based on services and other considerations.
- Dual eligibles 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 these further considerations that ought to be factored into planning for dual eligibles' entry into capitated health plans:

- Ensure adequate funding is available to the various programs and services that support our duals population.
- Examination of the PACE model will be helpful when designing a program for our duals population.
- Ensure that all services that dual eligibles require are adequately addressed in the roll-out plan along with the contracts and readiness reviews that support those services.

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

The committee further established three topical subgroups – Care Coordination, Behavioral Health, and Readiness – and produced a series of recommendations on those subject areas. See Exhibit 2 for those recommendations.

**[Placeholder for Exhibit 2: Recommendations on Beneficiary-Centered Care]**

DHB intends for the Dual Eligibles Advisory Committee to continue to function over the long term to assist in framing and eventually in implementing the capitated program for dual eligible beneficiaries. Having the ability to interact with stakeholders 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**

The Medicare and Medicaid programs cover different but overlapping populations. Seniors and individuals 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 only people who are eligible for full Medicare benefits but a broad range of groups with 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 long-term services and supports (LTSS). However, as discussed further in this report, the two programs also create numerous programmatic and financial misalignments including barriers to coordinated care that 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 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 by Medicaid. However, as discussed below, there are programmatic misalignments between Medicare and Medicaid that frequently lead to disruptions in access to care for wrap-around benefits. Partial duals 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 (co-pays and co-insurance). Providers are prohibited from billing for 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 (FFS) payment for that service and then only pay cost sharing up to the Medicaid FFS 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 C.F.R. § 413.89.<sup>1</sup>

ii. Misalignments Related to Full-Dual Eligible Beneficiaries

There are four sub-categories of full-dual eligible beneficiaries in North Carolina.<sup>2</sup> The interplay between the Medicare and Medicaid programs for full-dual eligible beneficiaries creates many administrative and financial conflicts that adversely impact Medicare and Medicaid beneficiaries.<sup>3</sup> These include inconsistent authorization procedures and medical necessity rules for overlapping benefits such as behavioral health, skilled nursing facility care, skilled therapies (occupational,

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<sup>1</sup> 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. Medicare bad debt payment reductions for dual eligible was implemented in phases: 88% in FY 2013 (Starting in Oct 1 2012); 76% in FY 2014 (October 1 2013); and 65% in FY 2015 (October 1 2014) and beyond.

<sup>2</sup> These are: (1) Categorically needy (Supplemental Security Income (“SSI”) beneficiaries), (2) Categorically needy no money payment (individuals with income below 100% of the federal poverty line 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).

<sup>3</sup> The Federal Coordinated Health Care Office at the Centers for Medicare and 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>.



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 a showing that the beneficiary is “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 and/or provider must first seek coverage through Medicare and have the claim denied before submitting the claim to Medicaid.<sup>4</sup> In a few other states, beneficiaries or providers must also 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 procedures for adverse coverage determination. The rules differ as to coverage pending appeal, timelines, and agencies tasked with administration.

The programs create misaligned financial incentives for providers and health plans serving full-dual eligible beneficiaries. For example, skilled nursing facilities in most states receive a higher reimbursement rate for the Medicare-covered post-acute rehabilitation stay than they do during the Medicaid-covered stay that may follow the exhaustion of a beneficiary’s Medicare Part A benefit. However, if the beneficiary returns to the hospital for a three-day inpatient stay, the Part A benefit period re-starts, allowing the nursing facility to again receive the higher Medicare rate for another benefit period. Most nursing facilities nonetheless seek to deliver high-quality nursing care to long-stay full-dual eligible beneficiaries, but the financial misalignment has been found to contribute to disproportionate rates of potentially avoidable hospitalizations among full-dual eligible beneficiaries.<sup>5</sup>

Finally, the programs create administrative barriers and misaligned financial incentives for the payers themselves, resulting in the oft-cited vacuum in effective care coordination investment for full-dual eligible beneficiaries.<sup>6</sup> In particular, states have the authority to implement mandatory programs for Medicaid beneficiaries, allowing for far greater rates of participation in care coordination models such as patient-centered medical homes or managed care programs. Medicare, to the contrary, does not allow mandatory participation in care coordination programs, like those offered by Medicare Advantage plans, such that neither CMS nor states can require participation in integrated programs or programs having enhanced care coordination for Medicare benefits.

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<sup>4</sup> *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](https://www.nctracks.nc.gov/content/dam/jcr:27044934-435a-4643-a9cc-c14a1c5ac1fb/Provider_Adjustment_TimeLimit_Medicare_Override_Job_Aidv1.2.pdf).

<sup>5</sup> *Medicare-Medicaid Eligible Beneficiaries and Potentially Avoidable Hospitalizations*, Misha Segal, et. al. Medicare and Medicaid Research Review, Centers for Medicare and Medicaid Services, Office of Information Products and Data Analytics (2014).

<sup>6</sup> See for example: [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=70](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=70).

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 make major investments in care coordination for full-dual eligibles because some portion 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 sub-categories of partial-duals in North Carolina.<sup>7</sup>

Partial-dual eligible beneficiaries receive all their care pursuant to Medicare benefits 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.

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.

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<sup>7</sup> 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 Medicare-Aid Capped Enrollment ("MQB-E") (Medicaid pays Part B premiums, but fully federally funded without state cost-sharing).

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

During the month of December 2015 (the most recent snapshot of data available) there were 319,720 dual eligible beneficiaries in North Carolina.<sup>8</sup> 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.<sup>9</sup>

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 than Medicare-only beneficiaries. There were large differences for inpatient hospital, skilled nursing facility, and psychiatric hospital services.

Medicaid expenditures for full duals were lower than for Medicaid-only beneficiaries with disabilities for most services where Medicare is the primary payer, but significantly higher (\$730 compared to \$144 per member per month on average) for Medicaid nursing facility care, reflecting Medicaid's crucial role in financing long-term nursing facility services for full-dual eligible beneficiaries.

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. The most common chronic conditions among full-dual eligible beneficiaries were diabetes/ESRD/other endocrine, heart disease/failure and other cardiovascular, and psychiatric/mental health.

Most of the full-dual eligible beneficiaries in North Carolina utilize some form of LTSS with only 18% not receiving some sort of institutional (61%), state plan (14%), or waiver (7%) home- and community-based LTSS.

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<sup>8</sup> Monthly snap-shots 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 and Medicaid Services (December 2015) available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeStateandCountyEnrollmentSnapshotsQuarterly.zip>.

<sup>9</sup> North Carolina State Profile, Medicare-Medicaid Coordination Office, Centers for Medicare and Medicaid Services available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2011StateProfilesNC.pdf>

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

North Carolina already operates capitated programs that serve full-dual eligible beneficiaries. These are the Local Management Entities-Managed Care Organizations (LME-MCOs), which deliver mental health, intellectual and developmental disability, and substance use services to all Medicaid beneficiaries including full-dual eligible beneficiaries.

LME-MCOs are quasi-governmental entities that contract with the State and receive capitated payments for covered services. Importantly, any savings or profit is required to be used to provide additional services to beneficiaries. These additional services are known as “B3 services,” in reference to Section 1915(b)(3) of the Social Security Act. LME-MCOs have primarily reinvested managed care 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.

The LME-MCO program uses four 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 mental retardation (ICF-MR), substance abuse services, or self-directed personal care services (“Innovations”). The LME-MCO is responsible for prior authorization for Innovations and ICF-MR 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 intellectual or developmental disabilities.

The LME-MCOs do not cover all of Medicaid services that are important for full-benefit 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”), the Community Alternatives Program for Disabled Adults (“CAP Choice”), Medicaid State Plan Personal Care Services, dental, and medical services (“wrap around” services as described above) offered under the Medicaid State Plan such as hospital, nursing home, private duty nursing, PT, OT, ST, and durable medical equipment. These services are currently delivered without 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 all Medicaid beneficiaries other than full-dual eligible beneficiaries. This will include nursing facility care and other LTSS for the Medicaid-only population. The services covered under LME-MCOs will continue to be delivered under the current system until four years after the date capitated PHP contracts begin, at minimum.

#### 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 the PACE program.

##### i. Medicare Advantage Plans in North Carolina

The Medicare Advantage program, officially called Medicare Part C, allows Medicare beneficiaries to enroll voluntarily into a privately-run health plan that is 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 per-member capitation payment.

Nationally, 31% of Medicare beneficiaries were enrolled into some sort of Medicare Advantage plan in 2016. The penetration rate is slightly lower in North Carolina where 26.14% (564,221) of the Medicare beneficiaries in the state were enrolled in Medicare Advantage plans in 2016. Enrollment varies considerably by county from 9.92% in Craven and Camden counties to 58.59% 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 on an annual basis, 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 sub-categories 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.

SNPs differ from traditional Medicare Advantage plans in some 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.

CMS provides that possible supplemental benefits include: “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.”<sup>10</sup>

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 3205(d) of the Affordable Care 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.

Finally, there are additional sub-categories of D-SNPs with differing eligibility rules and different requirements as to the plan’s coordination with a state Medicaid agency. These are discussed more fully below.

In 2016, 27,896 Medicare beneficiaries in North Carolina were enrolled into some sort of SNP, reflecting only 4.9% of Medicare Advantage beneficiaries. Most of those SNP enrollees (21,219) were enrolled into one of the seven D-SNP plans operating in North Carolina.<sup>11</sup>

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<sup>10</sup> 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>.

<sup>11</sup> 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.

## ii. PACE in North Carolina

The other category of Medicare capitated program serving dual-eligible beneficiaries in North Carolina is the Program for All Inclusive Care for the Elderly (PACE). PACE provides fully integrated Medicare and Medicaid benefits for seniors who are qualified for nursing home placement. The PACE program is intended to offer a community-based alternative to nursing home 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, includes all Medicare and Medicaid covered services and have authority to approve additional services as needed.

Eligibility for PACE is limited to individuals 55 years of age or older who are qualified for nursing home level of care, 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-benefit dual eligible beneficiaries to enroll into a PACE program but if they are not, the beneficiary will be responsible for the Medicaid portion of the capitation payment as a premium. Due to the coverage of comprehensive LTSS, this premium can be extremely expensive and as such, most PACE participants are full-dual eligible beneficiaries.

As of 2016, there are eleven North Carolina PACE sites in operation serving approximately 700 people and an additional site is under development in Smithfield, NC.

## **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, and Illinois.

### 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 operated in partnership with CMS as a part of the Financial Alignment Initiative, a demonstration project. The CCC program is due to sunset December 31, 2017 and Virginia is implementing CCC Plus to replace it and to implement mandatory Medicaid managed long-term care in the state simultaneously.

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 the populations not in need of LTSS, those in need of LTSS, and those with I/DD. Individuals enrolled in the 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 will also be available through FFS. Finally, individuals participating in the state's existing Medicaid managed care programs (Medallion 3.0 and FAMIS), residing within an ICF-ID facility, a psychiatric residential treatment facility, an Alzheimer specialty assisted living facility, participating in hospice, participating in the Money Follows the Person program, or participating in 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.<sup>12</sup>

Importantly, the CCC Plus program envisions the possibility of misaligned enrollees between the Medicare and Medicaid participating entities. In specific, because beneficiaries are enrolled passively/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.

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<sup>12</sup>[http://dmasva.dmas.virginia.gov/Content\\_atchs/mltss/Template\\_Contract%20and%20App%20A%20\(v2\).pdf](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 meet nursing home level of care.

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 covering 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.

a. 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 MTLSS 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 Home and Community Based Services (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 costs-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, help beneficiaries access LTSS, coordinate the delivery of Medicaid LTSS and Medicare benefits and services, and train 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.

b. 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 and in MSC counties, LTSS continues to be available fee-for-service. MSC+ currently provides acute care and LTSS to full-dual eligible beneficiaries as well as 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 FIDE SNPs 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 January 1, 2017.

c. 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 a number of 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 dually 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 meet nursing home level of care but choose to reside at home. Group 3 is for adults age 21 and over with a disability and seniors who do not meet nursing home level of care 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 that is specifically focused on fostering integrated, competitive employment and independent, integrated community living for individuals with intellectual and developmental disabilities (I/DD). The program will grow slowly, focusing only on beneficiaries newly eligible for I/DD HCBS services.

d. 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 Partial-Benefit Dual Eligible Beneficiaries**

As was described earlier in Section III, there are four types of partial-dual eligible beneficiaries in North Carolina.<sup>13</sup> MQB-Q is the only category that includes coverage

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<sup>13</sup> (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).

for cost sharing while the other three only cover 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 enter contracts 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.

## **VI. Options for Capitated Contracting for Full-Dual Eligible Beneficiaries**

There are numerous ways a state could develop capitated contracting strategies for full-dual eligible beneficiaries. However, considering the legislature’s decision through S.L.2015-245, to implement capitated programs for the full continuum of Medicaid benefits for full-dual eligible beneficiaries and to coordinate those services with Medicare to the extent possible, the options narrow considerably.

The principal program structure decisions are: (1) determining which Medicaid benefits to include within the capitation contract, (2) determining the timeline for implementation by region/benefit/population, and (3) determining the type of relationship the State wants to establish between the Medicare and Medicaid capitated plans. However, there are numerous other options and policy decisions discussed below related to supporting the successful implementation of a capitated program for full-dual eligible beneficiaries.

As a threshold matter, a key lesson from the states described above is that any capitated program for full-dual eligible beneficiaries should involve an optional capitated Medicaid program with close linkages to Medicare Advantage plans *and* a separate companion mandatory program including only Medicaid benefits. The options presented below focus on different ways North Carolina could pursue an optional Medicare-Medicaid linked program and a separate section on different ways North Carolina could pursue a companion mandatory Medicaid-only program.

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 members will refuse to enroll into the Medicare portion of a linked mandatory product and may even enroll into the Medicare portion of a competitor 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 their 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 beneficiaries who are fully aligned. This allows all 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 that is not linked to a Medicare program but where participating plans must also participate in the linked program with aligned service areas and aligned provider administrative requirements for Medicaid covered services. This reduces the administrative 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 options explored in this report for full-dual eligible beneficiaries start from 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 earliest date upon which dual eligible beneficiaries would be enrolled into such a program or programs is July 1, 2021.<sup>14</sup>**

- a. Options for a Voluntary Enrollment Capitated Medicaid Plans for Full-Benefit Dual Eligible Beneficiaries, Linked with Medicare Advantage
  - i. Medicare Capitated Plan Options
    - 1. Fully Integrated Dual Eligibles Special Needs Plans (FIDE-SNP)

A FIDE-SNP is a sub-type of 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 Social Security Act and in regulations at 42 CFR 422.2. FIDE-SNPs were authorized by the Affordable Care Act and include a number of characteristics that make them more flexible than traditional D-SNPs and add incentives for plans to participate.

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<sup>14</sup> 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 date of the 1115 waiver application, PHP operations are likely to begin July 1, 2019. Then, two years of PHP operations would be allowed before activating plans for dual eligibles.

In return for implementing coordinated Medicare and Medicaid assessments and a health risk assessment for all participants, increased care coordination requirements 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 meeting nursing home level of care. 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.

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 serve the most frail and highest risk dual eligible population successfully. FIDE-SNP requirements are potentially more burdensome for plans than alternative D-SNP options in some ways, including greater requirements 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 reflect 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 after 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 home level of care will likely increase the appeal of a FIDE-SNP program that seeks to cover both LTSS and non-LTSS full-dual eligibles.

## 2. Aligned D-SNP

An alternative to the FIDE-SNP that should be considered is a traditional Medicare 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 implement 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, are carved into the capitation.

D-SNPs are required to implement many of the enhanced care coordination services required of a FIDE-SNP but the state 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.

However, using a D-SNP but not a FIDE-SNP would prevent the plans from being eligible for the Medicare frailty factor capitation rate adjustment for the population meeting the nursing home level of care.

## 3. Non-Aligned D-SNP

A third alternative would be simply to continue to leverage the D-SNP program currently operating in North Carolina. North Carolina could amend the D-SNPs’ contracts with the state and require the plans also to participate in a MLTSS program without actively linking the plan enrollments.



Although this would reduce the state'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 the care coordination mechanisms and increase administrative complexity.

#### 4. Other Medicare Advantage products

North Carolina could forgo the use of D-SNPs entirely and seek to develop contracts 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. 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 comply with other specific state requirements. Any effort to deliver capitated Medicaid services in conjunction with traditional Medicare Advantage requirements would raise significant challenges.

##### ii. Medicaid Capitated Plan Options

Any capitated program for full-dual eligible beneficiaries must involve the implementation of a capitated contract for the Medicaid benefits to which these beneficiaries are entitled. However, even if North Carolina adopts a FIDE-SNP model, the D-SNP model requiring the highest degree of integrated management of Medicaid benefits by one contractor, there are a range of options for the treatment of aligned Medicaid benefits.

North Carolina can choose whether to include all Medicaid benefits within the capitated Medicaid contracts or whether to leave some in their current delivery systems. In addition, North Carolina can choose whether to restrict eligibility to specific sub-populations of the full-dual eligible population.

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

The first and most integrated option would entail the inclusion of all Medicaid covered benefits for full-dual eligible beneficiaries into the benefit package offered by the entity holding the FIDE-SNP (or traditional D-SNP) 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 C.F.R. 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.

However, implementing a fully capitated approach within one plan would be more disruptive and require providers and beneficiaries served in the LME-MCO system to adapt to a new delivery system.

*a. Sub-option: Only allow those receiving LTSS to enroll*

A sub-option of the fully integrated approach that should be considered is to limit enrollment to individuals who are eligible for LTSS. This would reduce the heterogeneity of the covered population and the challenges of rate setting that go with it. It would also make it more likely that the participating FIDE-SNP plans (if any) would be eligible for a frailty adjustment to the Medicare capitation payments. Finally, as utilization data have shown, most full-dual eligible beneficiaries in North Carolina use some sort of LTSS in any given year.

The disadvantage of this approach is that a capitated program that limits enrollment to those receiving LTSS would leave the population not currently in need of LTSS in unmanaged fee-for-service. This may make it more likely that this population will not have needs identified in a timely manner, resulting in more costs for Medicaid and Medicare. This may result in more individuals becoming eligible for LTSS. It would also create an incentive for providers and beneficiaries to seek LTSS earlier than necessary.

*b. Sub-option: Only allow those not currently receiving institutional LTSS to enroll*

Similarly, another option for consideration would be the inclusion of the full Medicaid benefit package but exclude 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 FFS. However, if a beneficiary transitioned to an institutional placement, he or she 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 and would also focus the program on those beneficiaries meeting the nursing home level of care necessary to qualify the FIDE-SNP plan (if any) for frailty adjustment.

The disadvantage of this approach is that it would leave the population currently served by institutional providers without access to a fully-integrated option.

2. Coverage of all LTSS (except those under LME-MCO contracts), Medicaid drugs, Medicare premiums, and cost sharing (retaining LME-MCOs as carve-out for BH services) (same eligibility sub-options apply here)

Another important alternative would be to include all Medicaid benefits except for those currently included in the LME-MCO program. This would allow for continuity in the access to those services and reduce disruption for those providers. Yet this approach would wrap in all other Medicaid benefits and allow the entire full-dual eligible beneficiary population access to a fully integrated program. In addition, as described above, the FIDE-SNP rules would permit this structure, provided all the other LTSS were carved into the Medicaid contract held by the FIDE-SNP plan.

However, this approach will retain the fragmentation that is inevitable when some benefits are delivered by a different entity. As discussed above, this would create additional barriers for the effective coordination of substance use disorder treatment services in a manner compliant with the consent requirements at 42 C.F.R. Part 2 because the integrated plan would have more difficulty securing sufficient consent from the Part 2 substance use disorder treatment providers.

This option could be further sub-divided into the population focus scenarios described above (focusing on the LTSS population only or excluding the current long-stay institutional placement population) and would have similar implications.

### iii. Key Factors to Consider for Each Option

As described above, there are pros and cons related to each possible option for structuring a linked Medicare-Medicaid voluntary product. In addition to the factors discussed above, considerations include state operational capacity, the availability of trained staff for the effective delivery of care coordination services, how beneficiaries will experience and navigate each option, 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.

Another variable in the implementation of the program is whether to implement state-wide or regionally, all at once or in regional phases.

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/MTLSS 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, come 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.

Many programs serving patients with 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 the clinical and social needs of the population.

Our decision-makers will need to consider carefully the approach to developing an integrated program for full-dual eligible beneficiaries to ensure that the health plans will have access to an adequate supply of experienced care management professionals who have 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.

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

As such, the program will present a major challenge for most potential market entrants and the State should prepare the procurement and readiness review process accordingly to rigorously assess the capacity and quality of potential plans.

Another key barrier to the delivery of care for dual-eligible beneficiaries is the burden that multiple payers presents to providers for contracting and billing. Providers, especially of overlapping benefits, face significant administrative challenges in navigating their obligations under Medicare and Medicaid, submitting bills for full payment, and accessing information and support for care coordination and population health management. DHHS wants to make sure that any program for full-dual eligible beneficiaries takes into account how program design elements may impact providers.

In addition, 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 state medical societies and other stakeholders.

Integrated capitated programs for full-dual eligible beneficiaries are intended to ease, rather than complicate, the experience of beneficiaries and their caregivers in navigating the health care and supports systems. In considering the various options for implementing a capitated program, the state should consider how beneficiaries will learn about and navigate these programs. This includes identifying trusted sources of information as well as the linguistic (including cognitive) and cultural needs of the target population.

As mentioned above, there are seven D-SNP plans currently operating in North Carolina, serving 21,219 beneficiaries. Assuming these D-SNPs are allowed to continue to operate until the roll-out of a program with capitated Medicaid benefits, North Carolina will need a strategy for transitioning these beneficiaries into the new program. It is possible to allow the unintegrated D-SNPs to continue to operate; some states do run multiple competing D-SNP-based programs simultaneously. However, this leads to increased administrative complexity for the State and for the plans, providers, and beneficiaries, while diluting the participation and impact of the integrated program.

Accordingly, DHB may seek to modify the 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 the full-dual eligible beneficiaries into the new FIDE-SNP (or D-SNP) program while simultaneously passively (not mandatorily) enrolling the individual into the Medicaid portion of the benefit.

The most important step in implementing this transition without disruption to the beneficiaries is ensuring that the 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 the D-SNP beneficiaries into the new program while remaining compliant with Medicare enrollment rules.

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

An additional consideration is how the service authorization process for HCBS services, including self-direction, will transition to managed care. There are many

models for this process including, on the one hand, fully transitioning the authorization authority to the plan's utilization management department or, on the other hand, retaining the authority of a county or DHHS-contracted authorization system that existed in the fee-for-service system.

Different approaches for different benefits must also be considered, such as retaining the LME-MCO authorization system while integrating the other LTSS into the plan's utilization management system. DHB will carefully consider the way beneficiaries currently access the HCBS services and ensure that any transition to managed care retains a person-centered planning approach and complies with applicable federal HCBS regulations.

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

As explained earlier, a linked Medicaid-Medicare plan arrangement must be voluntary for beneficiaries, because there is no mandate available in Medicare. Further, although the Medicaid portion of that program could be made mandatory, the misaligned membership that would 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 companion mandatory enrollment capitated program for Medicaid benefits only. Otherwise, a significant fraction of the population could be left in an unmanaged fee-for-service program, in contravention of the requirements of S.L.2015-245.

Any companion program should mirror to the extent possible the geographic region, benefits, provider contracting requirements, and rate setting methodologies employed in the linked 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.

In addition to the implementation sub-options discussed above, with a mandatory program the State also has the option of applying the mandatory enrollment requirement to just a subset of the population. For example, the program could call for mandatory enrollment for the non-LTSS and HCBS full-dual eligible population but only apply mandatory enrollment to beneficiaries transitioning to institutional placement for the first time after the start of the program – known as “new to service” beneficiaries. This would allow the nursing home and other institutional provider community a longer transition timeline to mandatory managed care and prevent disruption to beneficiaries in current long-stay status. These beneficiaries could of course still enroll voluntarily into the integrated program.

Finally, there are three options as to the order of implementation between the mandatory and optional components of a program for full-dual eligible beneficiaries. One approach would be to implement 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, implementing 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 as fully under capitation as possible.

However, implementing the voluntary program first can allow the Medicaid LTSS system two 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 will produce an increment to the population served in managed care, allowing plans, providers, beneficiaries, and beneficiary advocates time to work out any issues in the system.

#### i. Additional Considerations

In addition to the factors raised above related to the linked voluntary Medicare-Medicaid program, DHB must also consider: enrollment and marketing rules to incentivize enrollment into the integrated program; whether to include a robust care coordination benefit in the mandatory Medicaid MLTSS program; mechanisms to reduce plan incentives to enroll beneficiaries into the Medicaid-only product; and the options for aligning the MLTSS 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 enroll into the integrated program. This could include allowing greater flexibility in marketing for FIDE-SNP or D-SNP plans to communicate to the beneficiaries enrolled in the Medicaid MLTSS plan operated by the parent company. It could also entail an enrollment lock-in for beneficiaries in the MLTSS 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 MLTSS program that explain the advantages of the integrated program 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.

Full-dual eligible beneficiaries enrolled in the mandatory 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. In addition, the care coordinators serving the full-dual eligible population can be a valuable source of

information for beneficiaries about the integrated program –provided the marketing rules for the integrated program will allow them to talk about it.

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

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 can profit more per member from the Medicaid-only program, they may be less likely to take the steps necessary to make the integrated program succeed. Given this backdrop, the Medicaid-only program should have aligned rates, risk-adjustment systems, provider credentialing, and network adequacy requirements, among other elements.

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 the LTSS rate setting, risk-adjustment, provider credentialing, and network adequacy with the LTSS coverage under the PHP program.

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

In addition to the program design elements described above, North Carolina must consider options for adding LTSS benefits to the integrated program. Additional targeted LTSS benefits can more than pay for the added cost. They greatly improve enrollment take-up of voluntary programs and increase the 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 the hospital and nursing home. In addition, absent new benefits specific to the integrated program, beneficiary communications promoting and explaining the program must focus on the value of integration and care coordination. Unfortunately, though these programs are unquestionably important, 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 the 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.



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, non-medical but medically necessary transportation, 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 SMI.

### **VIII. Options for Quality Measurement and Incentive Program**

Any capitated program for full-dual eligible beneficiaries 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 suite of measures specific to the SNP program.<sup>15</sup> Plan performance on these measures is made public on an annual basis and North Carolina can also require dual submission into the CMS system and a state system such that the State will have access to the data as well. Any reporting strategy for the integrated program should avoid duplication with the measures already collected.

Other measures should focus on key process and outcome goals program-wide. Though there will be a need for 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 the 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 by the time the program planning begins in earnest.

North Carolina should also consider instituting a financial incentive element to the quality measurement system for the integrated program. For example, DHB 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.

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<sup>15</sup> Part C Reporting Requirements Technical Specifications (2016) *available at:* <https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html>

## **IX. Options for Enhanced Beneficiary Counseling and Advocacy Resources**

Full-dual eligible beneficiaries currently have access to a high-quality but limited array of beneficiary counseling and advocacy programs. These include the federally supported, state administered State Health Insurance Assistance Program (SHIP) and Long-Term Care Ombudsman program. The SHIP helps Medicare beneficiaries understand and access their benefits through the provision of unbiased support and counseling. The Ombudsman program provides more interventionist 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.

North Carolina will need to consider increasing the capacity of these programs to perform outreach, education, and counseling for full-dual eligible beneficiaries. The SHIP 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, 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 regarding HCBS or other Medicaid benefits. The roll-out of a capitated program for full-dual eligible beneficiaries will potentially expose very fragile beneficiaries and their families to disruptions. A well-functioning ombudsman program will help the State and the plans address any issues in a timely manner.

DHB 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 SHIP and ombudsman programs.

## **X. Options for Provider Training and Technical Assistance**

The Dual Eligibles Advisory Committee has repeatedly highlighted the potential challenges for 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 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 the coordination of care across the entire continuum of services. In the same manner that primary care doctors may be unused to discussing the home life and safety of a patient, a personal care aid or adult day care provider is unused to contributing to a comprehensive plan of care with physicians.

The behavioral health and I/DD providers that 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, DHB will consider the options for offering training and technical assistance for providers. The program would aim to introduce the concept of the integrated, capitated program to providers before the plans begin the process of executing or modifying contracts. There might be two tracks: one of outreach and education focusing on the Medicare fee-for-service providers emphasizing the benefits of the program 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 to 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**

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

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

DHB will also 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.

DHB will also begin the process of engaging with the CMS Center for Medicaid and CHIP Services and Consortium for Medicaid and Children's Health Operations to discuss what approach North Carolina should take to securing Medicaid authority for the 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, the use of mandatory, optional, and passive

enrollment authorities, regional roll-out options, network adequacy standards, care coordination services, overlaps with existing services, and other policy issues.

Similarly, DHB will begin to engage with the CMS Center for Medicare and the 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 as well as 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 State. The discussion will also 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 will also 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 will also cover any plans to alter the eligibility criteria for the existing D-SNP plans and how beneficiaries of those plans will be transitioned to other coverage.

DHB will also 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.