Enrolling Community Alternatives Program for Disabled Adults (CAP/DA) Participants in BH I/DD Tailored Plans

Session Law 2023-134, Section 9E.16.(c)

Report to

Joint Legislative Oversight Committee on Medicaid

By

North Carolina Department of Health and Human Services

June 17, 2024

Contents

Introduction

North Carolina is in the midst of a large-scale Medicaid transformation. Core to this effort has been the State's transition from a predominantly fee-for-service delivery system to integrated Medicaid managed care, where Medicaid enrollees obtain nearly all of their Medicaid benefits—including physical health, behavioral health, and pharmacy—from a single managed care plan. The Department of Health and Human Services (DHHS) first began transitioning most Medicaid enrollees into managed care in 2021 with the launch of Standard Plans, which serve the majority of the Medicaid population. Recognizing that certain populations with significant needs will benefit from specialized managed care plans, North Carolina plans to launch two additional types of managed care plans within the next year:

- Behavioral Health and Intellectual/Developmental Disability Tailored Plans (BH I/DD Tailored Plans) slated to launch in July 2024, which will serve individuals with a serious mental illness (SMI), serious emotional disturbance (SED), a severe substance use disorder (SUD), a traumatic brain injury (TBI), or intellectual or developmental disability (I/DD)
- The Children and Families Specialty Plan (CFSP), which is required by legislation to launch in December 2024, will provide coverage for children, youth, and families served by the child welfare system.

Several populations were excluded by the General Assembly from Medicaid managed care altogether (meaning they are not eligible to be enrolled in Standard Plans, BH I/DD Tailored Plans, or the CFSP).[1] These excluded populations include:

- Individuals who are dually eligible for both Medicare and Medicaid, unless they are enrolled in the Innovations or TBI 1915(c) Home and Community Based Services (HCBS) waivers;[2]
- Medically needy Medicaid beneficiaries, except for beneficiaries enrolled in the Innovations or TBI 1915(c) HCBS waivers;
- Community Alternatives Program for Children (CAP/C) 1915(c) HCBS waiver participants; and
- Community Alternatives Program for Disabled Adults (CAP/DA) 1915(c) HCBS waiver participants.

However, in its most recent biennium budget legislation, the General Assembly required DHHS to "develop and submit a proposal to the Joint Legislative Oversight Committee on Medicaid to transition the administration of the Community Alternatives Program for Disabled Adults (CAP/DA) to the BH I/DD Tailored Plans by January 1, 2025." This report contains this proposal, which reviews the criteria that DHHS and the BH I/DD Tailored Plans will need to address to ensure a successful transition of the CAP/DA population into managed care.

Overview of the CAP/DA 1915(c) HCBS Waiver and BH I/DD Tailored Plans

Community Alternatives Program for Disabled Adults (CAP/DA)

CAP/DA is a Medicaid 1915(c) HCBS waiver program that provides services and supports to Medicaid members 18 years of age or older with a physical disability, or who are 65 years of age and older with functional deficiencies due to age. CAP/DA participants must meet a nursing facility level of care,

[1] N.C. Gen. Stat. § 108D-40(a)

[2] Specifically, dually eligible individuals for whom Medicaid coverage is limited to the coverage of Medicare premiums and cost sharing.

meaning that without access to CAP/DA services and supports, those individuals will be at risk for institutionalization. Individuals must apply to enroll in the CAP/DA waiver; as of April 2024, 11,172 North Carolinians are enrolled, with an additional 755 on the waitlist.[3, 4] The purpose of CAP/DA is to provide a safe and supportive network of services, promote community integration, and autonomy of choice for participants. CAP/DA participants often rely on services that are only covered through the waiver program (see full list of services below) to assist them with activities such as bathing, eating, toileting, dressing, and transfer or walking. They may also require care from a registered nurse or nursing assistant to administer drugs, infuse fluids (to prevent dehydration), or administer gastronomy feedings. Other CAP/DA participants require dialysis or respiratory therapy.

CAP/DA provides an alternative to institutionalization for participants and supports self-determination by enabling participants to live and work in their communities and homes, among their families, friends, and close networks. The North Carolinians enrolled in CAP/DA have complex care needs that require intensive care management. In addition to having a physical disability, CAP/DA participants have high rates of hypertension, high cholesterol, diabetes, chronic obstructive pulmonary disease, and other chronic health conditions.

Individuals enrolled in the CAP/DA waiver can receive the following HCBS:

- Adult day health
- In-home aide
- Equipment, modification, and technology
- Meal preparation and delivery
- Respite
- Personal emergency response services
- Specialized medical supplies
- Participant goods and services (e.g., chore services, pest eradication, non-medical transportation)
- Community transition and integration services
- Training, education, and consultative services
- Case management
- Coordinated caregiving

CAP/DA participants are currently enrolled in NC Medicaid Direct, through which populations excluded, delayed, or exempt from managed care receive physical health, pharmacy, and certain State Plan long-term services and supports (LTSS) (e.g., nursing facility care, home health) through fee-for-service, and behavioral health, I/DD, and TBI services through limited benefit managed care plans—Prepaid Inpatient Health Plans (PIHPs)—offered by the local management entity/managed care organizations (LME/MCOs). Four LME/MCOs offer PIHPs, covering distinct geographic regions within North Carolina. The majority of CAP/DA participants—79%—are also dually eligible for both Medicare and

[3] DHHS data

[4] While the CAP/DA waiver can serve up to 11,648 individuals, a number of these slots are reserved for specific CAP/DA populations (e.g., individuals transitioning back to the community from a facility, individuals with Alzheimer's Disease, CAP/DA participants moving from one county to another). As a result, there may be a waitlist for entry into the waiver even when there are open waiver slots. Additionally, because waiver slots are allocated on a county-by-county basis (see the "Waiver Slot Management" section below for more detail), individuals may be placed on a waitlist if their county has no available slots, though there may be waiver capacity in other counties.

Medicaid due to their age, income, and/or disability statuses.[5] These individuals receive their acute and post-acute care (e.g., hospital services, primary care some home health) via Medicare but most other services, such as LTSS, are provided through Medicaid. Medicaid may also help with the cost of Medicare premiums and cost-sharing. This structure means that dually eligible North Carolinians must coordinate their care across NC Medicaid Direct, Medicare, and LME/MCOs.

BH I/DD Tailored Plans

BH I/DD Tailored Plans will go live on July 1, 2024, and will be administered by the LME/MCOs. BH I/DD Tailored Plans will be one of North Carolina's prepaid health plan (PHP) Medicaid managed care products, along with Standard Plans and the CFSP, that coordinate a comprehensive set of integrated physical health, behavioral health, and pharmacy services for enrollees. As directed by the North Carolina General Assembly,[6] BH I/DD Tailored Plans will enroll high-need populations with a serious mental illness, serious emotional disturbance, severe SUD, I/DD, or traumatic brain injury. Populations that will enroll in BH I/DD Tailored Plans at launch include participants in the Innovations 1915(c) HCBS waiver for individuals with I/DD and the TBI 1915(c) HCBS waiver, including waiver participants who are dually eligible for Medicare and Medicaid.[7] Other dually eligible members not enrolled in these waivers will remain excluded from managed care. (For more on dual eligibles in Medicaid managed care, see the section below titled "Implications on the State's Longer-Term Strategy for Dual Eligible Populations.") At their launch, BH I/DD Tailored Plans will provide fully integrated physical health, behavioral health, pharmacy services, State Plan LTSS, 1915(i) HCBS,[8] and HCBS provided under the Innovations and TBI 1915(c) waivers.[9] Individuals slated to enroll in BH I/DD Tailored Plans in July 2024 will be eligible to receive Tailored Care Management, an integrated, whole-person care management model that assigns enrollees a single designated care manager supported by a multidisciplinary care team.[10]

Notably, only 24% of CAP/DA participants meet the clinical BH I/DD Tailored Plan criteria, although as noted above, the majority of these individuals would be ineligible for BH I/DD Tailored Plans regardless of their CAP/DA participation because they are dually eligible for Medicare and Medicaid. Additionally, according to federal law, federally recognized tribal members and others eligible for health services through the Indian Health Services cannot be mandated to enroll in the BH I/DD Tailored Plans.[11] DHHS

[5] DHHS data
[6] North Carolina Session Law 2018-48
[7] The TBI 1915(c) waiver was approved in 2021 and is administered by one LME/MCO. Enrollment in the TBI 1915(c) waiver is limited to eligible individuals living Cumberland, Durham, Johnston, Orange, Mecklenburg, and Wake counties.
[8] 1915(i) is another option for offering HCBS in Medicaid. North Carolina offers 1915(i) HCBS to individuals with an SMI, SED, severe SUD, I/DD, and TBI; individuals do not need to meet an institutional level of care but must meet other needs-based eligibility criteria. Services offered in North Carolina are: community living and supports, community transition, individual transitions and support, respite, and supported employment services.
[9] These HCBS support an individual's activities of daily living through personal care services, environmental modifications, and meal services. There is an additional emphasis on crisis stabilization services and services that improve community integration through vocational trainings, which are absent from the CAP/DA service array due to the differing needs of the populations.
[10] Tailored Care Management launched on December 1, 2022. Nearly all individuals who will be enrolled in the BH I/DD Tailored Plans are eligible to receive Tailored Care Management, with exceptions for members using services that DHHS has determined are duplicative (e.g., Assertive Community Treatment, High-Fidelity Wraparound, Care Management for At-Risk Children, long-stay Skilled Nursing Facility services or Intermediate Care Facilities for Individuals with Intellectual Disability services).
[11] Social Security Act §1932(a)(2)(C)

would need to ensure these individuals can continue to access all services through NC Medicaid Direct if they choose not to enroll in the BH I/DD Tailored Plans.

Transitioning CAP/DA Participants Into Managed Care Via BH/IDD Tailored Plans

To ensure a smooth transition to managed care, DHHS has strategically considered the timing of the managed care transition for all populations, including CAP/DA participants. LME/MCOs, which will launch BH I/DD Tailored Plans in July 2024, have experience managing certain 1915(c) populations—specifically waiver populations with I/DD and/or TBI —but the CAP/DA population and some of the CAP/DA services will be new for BH I/DD Tailored Plans. A collaborative process of intensive planning and preparation between DHHS and the BH I/DD Tailored Plans is needed to ensure a successful transition and mitigate any risk of service disruption during the transition of CAP/DA participants from NC Medicaid Direct to managed care. Participants, advocates, and providers will also need to be thoughtfully engaged in transition planning as well, which is described in more detail in later sections of the report.

To support this process, DHHS has identified a set of criteria that will need to be addressed prior to transitioning CAP/DA participants into managed care. The criteria, explored in detail below, reflect lessons learned in peer states that have previously transitioned similar populations into managed care and North Carolina's experience with its Medicaid transformation, as well as a review of CAP/DA program requirements and current BH I/DD Tailored Plan functions. The criteria include:

- **Federal Authorities and Contracting.** DHHS obtains approval for the appropriate federal authorities to transition the CAP/DA population to BH I/DD Tailored Plans and updates the BH I/DD Tailored Plan contract to reflect the inclusion of this population.
- **Level of Care Evaluation**. DHHS defines whether BH I/DD Tailored Plans have a role in determining CAP/DA eligibility.
- **Waiver Slot Management.** The role of BH I/DD Tailored Plans—if any—in managing CAP/DA waiver slots is defined.
- **CAP/DA Benefits and Utilization Management.** BH I/DD Tailored Plans cover the full service array provided in the CAP/DA waiver, including consumer-directed services.
- **Network Adequacy.** BH I/DD Tailored Plans have adequate provider networks to ensure CAP/DA participants have undisrupted access to their HCBS providers, primary care providers, and specialists.
- **Whole-Person Care Management.** CAP/DA participants transition from their current waiver case management to whole-person care management, while ensuring that participants continue to benefit from their relationships with and the expertise of current case management entities.
- **Transitions of Care.** DHHS has in place processes and oversight mechanisms to minimize service disruptions during the transition of CAP/DA participants to managed care.
- **Quality and Monitoring.** BH I/DD Tailored Plans are in compliance with federal HCBS quality monitoring and reporting requirements for the CAP/DA population and integrate the CAP/DA population and providers into their quality measurement activities.
- **Stakeholder Engagement**. DHHS and BH I/DD Tailored Plans conduct outreach to CAP/DA participants, providers, advocates, and other stakeholder communities to build awareness about and prepare for the transition to managed care.

The sections below explore the key considerations for meeting these imperatives in further detail.

Federal Authorities and Contracting

Imperatives for CAP/DA Transition
DHHS will have to ensure that it has the federal Medicaid authorities necessary to effectuate the CAP/DA transition to BH I/DD Tailored Plans. Specifically, DHHS will need to:

- Amend its 1115 demonstration to authorize the enrollment of the CAP/DA population in BH I/DD Tailored Plans;
- Amend the CAP/DA 1915(c) waiver to reflect that BH I/DD Tailored Plans will be the delivery system for CAP/DA benefits; and
- Remove the CAP/DA population from the 1915(b) waiver to reflect that the CAP/DA population will no longer be enrolled in the LME/MCO PIHP product for their behavioral health benefits (with the exception of members of a federally recognized tribe and individuals eligible for Indian Health Services who cannot be mandatorily enrolled in BH I/DD Tailored Plans).

Additionally, DHHS will need to determine whether any new Medicaid authority (e.g., new State Plan service) is needed to implement its preferred care management model. And finally, DHHS will need to amend the BH I/DD Tailored Plan contract to reflect the new requirements and policy decisions outlined in this report.

Key Considerations to Achieve Imperatives
Each of the required changes to federal authorities will require state resources to amend the waivers as well as time for Centers for Medicare & Medicaid Services (CMS) review and, in some instances, public comment. For example, any changes to the State's 1115 demonstration requires a 30-day state public comment period prior to submitting the amendment to CMS. After that, the changes are subject to a separate federal 30-day public comment period. The public comment period is followed by a process of negotiations between DHHS and CMS to come to an agreement on the final contents of the amendment. Overall, the timeline for federal approval of 1115 waiver amendments can take more than one year; amendments to 1915(b) and 1915(c) waivers are typically quicker, but still take many months. The state would not be able to begin enrollment of the CAP/DA population into BH I/DD Tailored Plans until there is an approved 1115 demonstration because changes to 1115 demonstrations must be prospective; CMS does not permit retroactive changes. To give a sense of the potential timeline, DHHS initiated a state public comment period in November 2021 on a relatively straightforward 1115 demonstration amendment to define which populations would be covered under the BH I/DD Tailored Plans. CMS approved that amendment in July 2023 (20 months later).

Level of Care Evaluation

Imperatives for CAP/DA Transition
To be eligible for the CAP/DA waiver, individuals must meet a nursing facility level of care. Today, DHHS contracts with an independent assessment entity to collect information required to complete the level of care evaluation. DHHS needs to determine whether it will make any changes to this process with

the transition to BH I/DD Tailored Plans; any changes must comply with federal regulations for 1915(c) waiver evaluations of need.[12]

Key Considerations to Achieve Imperatives
DHHS currently uses a different process to determine level of care for the CAP/DA waiver as compared to the Innovations or TBI waivers. For the Innovations and TBI waivers, the LME/MCOs—today in their role as PIHPs, and in the future, in their role as BH I/DD Tailored Plans—evaluate level of care, with oversight from DHHS. With the CAP/DA transition to BH I/DD Tailored Plans, DHHS will need to decide whether to continue using the independent assessment entity to support level of care evaluations, or whether the BH I/DD Tailored Plan should assume this responsibility.

Waiver Slot Management

Imperatives for CAP/DA Transition
The General Assembly has capped the number of people that can be enrolled in the CAP/DA waiver at any given time to 11,648 people. Currently, DHHS assigns each county in North Carolina a maximum number of available CAP/DA waiver slots to enroll participants, manages a statewide CAP/DA waitlist, and reallocates slots between counties when a county is not utilizing their slots to its maximum allotment. DHHS seeks approval from the General Assembly to add at least 1,000 additional waiver slots as part of its CAP/DA 1915(c) waiver renewal application to CMS later this year to help address the waiting list in some counties. After the transition to BH I/DD Tailored Plans, the number of people who can enroll in the CAP/DA waiver will remain capped. A process for how—if at all—BH I/DD Tailored Plans will coordinate with DHHS and counties to manage waiver slots and the waitlist will need to be defined.

Key Considerations to Achieve Imperatives
In defining whether BH I/DD Tailored Plans will have a role in managing CAP/DA waiver slots after the transition to managed care, A key decision point will be if waiver slots will continue to be assigned to counties or if they will instead be assigned to BH I/DD Tailored Plans, similar to the approach used for the Innovations waiver.[13] If BH I/DD Tailored Plans were to become responsible for managing waiver slots, a formalized process for how BH I/DD Tailored Plans allocate waiver slots among counties within a plan's region would need to be established. It would also need to be determined if DHHS would continue to maintain a statewide waitlist for the CAP/DA waiver, or if BH I/DD Tailored Plans and/or counties would manage their own waitlists.

CAP/DA Benefits and Utilization Management

Imperatives for CAP/DA Transition
BH I/DD Tailored Plans will be required to cover the entire CAP/DA service array authorized under the 1915(c) waiver to ensure participants can continue to access the services that support their ability to remain in their homes and communities.

[12] 42 CFR 441.302(c)
[13] As with the CAP/DA waiver, the General Assembly caps the total number of Innovations waiver slots, which is 14,736 for this waiver cycle. Those waiver slots are then distributed among the BH I/DD Tailored Plans based on their relative population size and the BH I/DD Tailored Plans then allocate waiver slots among counties within their catchment area. An individual enrolled in the Innovations waiver retains their slot if they move between BH I/DD Tailored Plans.

Key Considerations to Achieve Imperatives
While BH I/DD Tailored Plans currently cover HCBS authorized under the Medicaid State Plan, the Innovations 1915(c) waiver, and the TBI 1915(c) waiver, they only cover some of the CAP/DA 1915(c) waiver services. Nine of the eleven CAP/DA service categories are also included in the Innovations and TBI waivers, but the benefits may not be identical across the waiver programs. For example, which professionals can deliver the service, in what manner, and for what duration may vary across the waivers. BH I/DD Tailored Plans will need to expand their service offerings to include the full scope of CAP/DA services and also ensure that they have the infrastructure and processes to support and facilitate robust consumer direction for CAP/DA participants, given that nearly one-third of CAP/DA participants self-direct their waiver services.[14] Further, DHHS needs to determine if BH I/DD Tailored Plans will be required to follow existing CAP/DA clinical coverage policies.

Lastly, DHHS will need to develop a BH I/DD Tailored Plan utilization management policy for CAP/DA services to ensure there are clear standards for waiver participants to obtain CAP/DA services. The policy should, at a minimum, address:

- Level of care evaluation process;
- Process for requesting a grievance or appeal of the level of care evaluation;
- Process for waiver participants to request services (i.e., through the Service Request Form or Continued Need Review); and
- Process for BH I/DD Tailored Plan to authorize services, including prior authorization requirements.

Network Adequacy Standards

Imperatives for CAP/DA Transition
BH I/DD Tailored Plans must newly build a network of CAP/DA waiver providers. In line with Medicaid managed care rules,[15] BH I/DD Tailored Plans must have adequate networks to serve the CAP/DA population across all services that they need, including waiver services, physical health services, and behavioral health services. In modifying the BH I/DD Tailored Plan network requirements to reflect the enrollment of the CAP/DA population, it is critical that DHHS seek to minimize disruptions in the provider-participant relationship.

Key Considerations to Achieve Imperatives
The transition of CAP/DA services to BH I/DD Tailored Plans creates a substantial risk of disruption in care. With the inclusion of CAP/DA services in the BH I/DD Tailored Plan benefit package, DHHS will need to establish new network adequacy standards, and specifically, quantitative network adequacy standards for CAP/DA services to ensure that each BH I/DD Tailored Plan provides sufficient access to CAP/DA waiver services.[16] BH I/DD Tailored Plans will be required to contract with "any willing provider" of CAP/DA services that meets objective quality standards and accepts network rates. CAP/DA participants typically have strong relationships with their waiver providers, and maintaining existing

[14] DHHS data
[15] 42 CFR 438.68
[16] 42 CFR 438.68(b)(2)

provider relationships is vital to helping waiver participants live successfully in the community. However, contracting with managed care plans may be new for some of the CAP/DA providers. DHHS must consider how it can support and facilitate an efficient contracting process between BH I/DD Tailored Plans and CAP/DA providers. At the same time, BH I/DD Tailored Plans will need to consider how they can build relationships with CAP/DA providers in their geographic regions.

BH I/DD Tailored Plans will also need to assess the experience and expertise of their existing physical and behavioral health network in treating individuals with physical disabilities and recruit new providers to fill in gaps, including any specialized providers in different regions of the state that have expertise in serving the CAP/DA population. BH I/DD Tailored Plans must also provide training and ongoing technical assistance to its provider network on meeting the needs of this unique population.

Whole-Person Care Management

Imperatives for CAP/DA Transition
North Carolina has established a priority to offer whole-person, integrated care management to all Medicaid managed care enrollees. DHHS will need to determine which care management model—Tailored Care Management or another model—will achieve that goal for the CAP/DA population. The whole-person care management model should incorporate 1915(c) case management requirements and should leverage the expertise and experience of the existing CAP/DA case management entities.[17]

Key Considerations to Achieve Imperatives
The current care management approach for the CAP/DA population is bifurcated, with no one entity responsible for addressing all of a person's needs. CAP/DA participants currently receive required 1915(c) case management services (e.g., assessment, care planning, referrals or linkages and monitoring, and follow-ups) from a county-based CAP/DA case management entity. Waiver case management primarily focuses on an individual's waiver-related needs; it is not whole-person care management. CAP/DA participants may also obtain care management through their local Community Care of North Carolina (CCNC) network for physical health needs and/or care coordination from their LME/MCO if they have behavioral health needs.

BH I/DD Tailored Plans will offer Tailored Care Management—a whole-person care management model targeted toward individuals who meet the current BH I/DD Tailored Plan eligibility criteria. Tailored Care Management is authorized under the federal Health Home State Plan option. It can be delivered by BH I/DD Tailored Plans or providers that have obtained certification to offer Tailored Care Management: either primary care providers certified as advanced medical home plus practices or behavioral health or I/DD providers certified as care management agencies. Tailored Care Management is not currently offered to individuals in the CAP/DA waiver, even if they have significant behavioral health needs, an I/DD, or a TBI.

DHHS will need to determine the approach for providing whole-person care management to CAP/DA waiver participants, recognizing that it is critical to retain the expertise and experience of the existing CAP/DA case management entities in any future system. The approach may be a modified version of Tailored Care Management or another option. In identifying the approach, DHHS will consider the

[17] 42 CFR 441.301(c)(1); 42 CFR 441.301(c)(2); 42 CFR 441.301(c)(3)

unique needs of the CAP/DA population and how these needs align with current Tailored Care Management requirements.

If DHHS determines that developing a modified version of Tailored Care Management for the CAP/DA population would be the preferred approach for delivering whole-person care management, the program will require a number of modifications to meet the needs of CAP/DA participants. These include but are not limited to: identifying new care management requirements to reflect the unique health needs of the CAP/DA waiver population; assessing requirements for coordination with Medicare for dual eligibles; establishing new care manager training requirements; and conducting an actuarial analysis to determine rate implications.

Alternatively, if DHHS determines that modifying Tailored Care Management for the CAP/DA population is not the preferred approach, the Department will need to conduct an intensive design process to develop a new whole-person, integrated care management model for the CAP/DA population. The model would need to establish detailed requirements, including, but not limited, to:

- Components and intensity of care management and care coordination, including those related to care transitions, unmet health-related social needs, and individual and family supports;
- Staffing and training;
- Health information technology, including data sharing between NC Medicaid Direct and BH I/DD Tailored Plans, BH I/DD Tailored Plans and case management entities, and across providers;
- Payment methodology; and
- Quality.

For either model, DHHS will need to determine how to integrate CAP/DA waiver case management into the broader care management model. For example, federal rules require that 1915(c) waiver case management must:

- Incorporate an annual assessment of a participant's functional needs;[18]
- Include development of a person-centered service plan that documents the 1915(c) services and natural supports that will enable a participant to reach their goals and verifies that the participant's living arrangement aligns with federal home and community-based settings rules;[19] and
- Meet federal requirements for conflict-free case management.[20]

Further, DHHS will need to determine how to align the completion of the Service Request Form and Continued Need Review (CNR) assessment with other care management assessments to minimize burden on the waiver participant. In addition, DHHS must ensure that care plans address the totality of a person's physical health, behavioral health, LTSS, pharmacy, and unmet health-related resources in addition to functioning as the person-centered service plan for CAP/DA waiver benefits. Finally, DHHS and BH I/DD Tailored Plans will need to ensure that care managers are trained in the new care management model.

[18] 42 CFR 441.301(c)(3)
[19] 42 CFR 441.301(c)(2)
[20] 42 CFR 441.301(c)(1)(vi)

Transitions of Care

Imperatives for CAP/DA Transition
As noted above, for CAP/DA waiver participants, the transition to BH I/DD Tailored Plans will carry a significant risk of service disruption. DHHS and BH I/DD Tailored Plans will need to have processes and safeguards in place to ensure continuity of services and providers for CAP/DA participants during this transition and establish oversight mechanisms to ensure that these processes and safeguards work as intended.

Key Considerations to Achieve Imperatives
With the inclusion of the CAP/DA population and services in managed care, BH I/DD Tailored Plans—instead of NC Medicaid Direct—will be responsible for reviewing and authorizing waiver service requests in an individual's person-centered service plan. This transition carries inherent risks. Failure to re-authorize existing services could jeopardize waiver participants' ability to live successfully in the community. Additionally, service disruptions could create cash flow issues for waiver service providers.

To minimize these disruptions, DHHS and BH I/DD Tailored Plans will need to modify the BH I/DD Tailored Plan transitions of care policy to ensure continuity of care for the CAP/DA population during the transitional period. The transitions of care policy already requires BH I/DD Tailored Plans to have policies, processes, and procedures in place to support members transitioning to and from different delivery systems in the state, as well as between Medicaid managed care plan types (e.g., Standard Plans to BH I/DD Tailored Plans), and to assist a member transitioning from a provider when that provider is terminated from the BH I/DD Tailored Plan's network. These requirements, which will apply to CAP/DA participants, address pre-transition planning, the transfer and receipt of relevant and time-sensitive member information that could impact continuity of care, treatment records for behavioral and physical health, care management records, and existing service authorizations. Additionally, DHHS will need to establish new transition of care policies regarding the CAP/DA transition, such as how long an out-of-network provider can bill the BH I/DD Tailored Plans for CAP/DA services.

Importantly, DHHS will need to establish a monitoring and oversight approach so that it can swiftly identify and address any disruptions in care. As part of this approach, it will need to identify metrics against which to monitor the BH I/DD Tailored Plan transition (e.g., increases in service denials, continuity of provider/participant relationships), define scenarios that would trigger corrective action, and determine penalties for any BH I/DD Tailored Plans that are not sufficiently providing smooth transitions of care.

Quality and Monitoring

Imperatives for CAP/DA Transition
In addition to ensuring uninterrupted access during and after the transition to managed care, DHHS and the BH I/DD Tailored Plans will need to collaborate to ensure continued high quality of CAP/DA services is maintained, given that participants rely on CAP/DA services to live safely and independently in the community. Federal rules reinforce the importance of ensuring the quality of HCBS, establishing requirements for quality monitoring and reporting standards for LTSS delivered under managed care and

for HCBS delivered through 1915(c) waivers.[21] With the enrollment of the CAP/DA population into managed care, BH I/DD Tailored Plans will also need to include CAP/DA participants and providers in their broader quality measurement activities.

Key Considerations to Achieve Imperatives
States' federally required Medicaid managed care quality strategy must include quality measures for LTSS populations, measures on appropriateness of care and community integration, and mechanisms for how the State identifies members in need of LTSS.[22] As required for all managed LTSS (i.e., LTSS delivered through a managed care delivery system), DHHS will need to ensure that the CAP/DA population is reflected in the State's managed care quality strategy and that BH I/DD Tailored Plans are able to report on necessary data and other measures for the CAP/DA population under managed care. For example, DHHS will need to ensure there are mechanisms in place to assess quality and appropriateness of care furnished to CAP/DA participants under BH I/DD Tailored Plans, including during care transitions and as measured against those services in their care plans. CAP/DA will also need to be incorporated into BH I/DD Tailored Plans' Quality Assessment & Performance Improvement (QAPI) Program (also federally required for managed LTSS). BH I/DD Tailored Plans will also need to participate in DHHS' efforts to prevent, detect, and remediate critical incidents—events or occurrences that cause harm to members or serve as indicators of risk to a member's health or welfare—for CAP/DA participants.

DHHS will also need to determine how existing CAP/DA performance measures aligning with 1915(c) waiver requirements should be modified to reflect the transition of the CAP/DA waiver to BH I/DD Tailored Plans while also remaining in compliance with federal HCBS quality reporting requirements.[23] BH I/DD Tailored Plans will be required to report on these measures in the future. Lastly, DHHS will need to work with BH I/DD Tailored Plans on reporting on the new HCBS Quality Measure Set for CAP/DA participants (as well as for all members using HCBS, such as Innovations waiver participants and individuals using 1915(i) services). Reporting on these measures is voluntary at this time but states will be required to begin reporting on the required measures every two years, beginning in the first managed care plan contract rating period that begins on or after July 10, 2028, for HCBS provided under managed care.[24]

Stakeholder Engagement

Imperatives for CAP/DA Transition
DHHS will need to engage stakeholders on the proposal to transition CAP/DA into the BH I/DD Tailored Plans to build consensus, support, and lay the groundwork for a successful transition grounded in lived experiences and person-centeredness. After the transition to BH I/DD Tailored Plans, DHHS will need to determine the most appropriate forum for engaging CAP/DA participants and their families.

---

[21] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability Final Rule, 2016
[22] 42 CFR 438.330(b)(5)
[23] 42 CFR 441.311(c), 441.311(f)(2), 441.312, 441.474(c), 441.580(i), 441.585(d), 441.745(b)(1)(v)).
[24] CMS will periodically identify new measures to include or existing measures to remove from the HCBS Quality Measure Set.

Key Considerations to Achieve Imperatives

DHHS and the BH I/DD Tailored Plans will need to coordinate on extensive, sustained outreach to CAP/DA participants and their advocates, providers, and other stakeholders to make them aware of the transition to managed care and the key steps and benchmarks along the way (with timelines). Multiple stakeholder groups, including but not limited to CAP/DA participants and their families and advocates, providers and provider representatives, counties, and case management entities will need to be engaged. The substance of the engagement should be informational (e.g., how the transition will impact them, what steps they need to take), but DHHS could also use the process to collect input on key considerations from the stakeholders' perspectives on the risks of transition and how to mitigate those risks (e.g., how to facilitate building BH I/DD Tailored Plan provider networks).

DHHS and the BH I/DD Tailored Plans should consider venues for gathering feedback from CAP/DA participants, providers, and their advocates during the transition planning period, particularly around how to maintain existing provider/participant relationships, care management, and ensure that there are no disruptions in care. It will be important for both DHHS and BH I/DD Tailored Plans to understand stakeholders' concerns so that they can proactively address them when planning for the transition. Targeted communication strategies may be needed for different stakeholder populations, such as non-English speaking populations, individuals residing in rural areas, and Tribal communities. The BH I/DD Tailored Plans will also be required to develop and maintain stakeholder groups representing CAP/DA participants and their families, advocates, and providers. DHHS will need to determine the most appropriate forum for BH I/DD Tailored Plans' ongoing engagement with CAP/DA participants and their families, which would need to be outlined in the BH I/DD Tailored Plan contract. DHHS currently requires BH I/DD Tailored Plans to coordinate with local and statewide Consumer and Family Advisory Committees (CFACs) which are set up to represent the voices and perspectives of people who receive services for mental health, substance use disorders, I/DD, or TBI (including Innovations and TBI waiver participants).[25] DHHS should determining if CFACs, or another forum, are most appropriate for gathering feedback from CAP/DA participants and their experiences under managed care. Additionally, BH I/DD Tailored Plans are required to develop and implement an engagement strategy for members utilizing LTSS. DHHS will need to determine whether any new components of this strategy are needed to reflect the enrollment of CAP/DA participants into BH I/DD Tailored Plans.

Due to the short turnaround time to meet the reporting deadlines, DHHS was unable to get formal stakeholder feedback but based on informal feedback, some stakeholders expressed concerns. If this proposal moves forward, there may be substantial opposition and we reiterate the need to socialize the proposal with stakeholders for their input before plans are finalized.

<u>Other Required Activities and Considerations</u>

There are additional activities that will need to be complete prior to a January 1, 2025, transition to managed care. For example, DHHS will need to work with its actuary to update BH I/DD Tailored Plan capitation rates to reflect the CAP/DA population and services. Representatives for CAP/DA participants will need to be incorporated into the state's support system for Medicaid enrollees obtaining LTSS. The federally required managed care member support system helps assist members in understanding their

[25] The statewide and local CFACs inform DHHS and the General Assembly on the management of the state's LME/MCO system for organizing Medicaid behavioral health, I/DD, and TBI services.

managed care benefits and service navigation, provides education on the grievances and appeals processes, and hears concerns on accessing HBCS through their managed care plan.

DHHS will also need to determine what, if any, new staffing requirements will apply to BH I/DD Tailored Plans with the integration of CAP/DA. For example, BH I/DD Tailored Plans are currently required to have a Clinical Director who oversees and is responsible for all I/DD and TBI clinical activities, including but not limited to the proper provision of Innovations and TBI waiver services, developing clinical practice standards, quality management of I/DD and TBI benefits, and integration of I/DD and TBI benefits with physical health and behavioral health benefits. DHHS could consider a similar role with a focus and expertise on supporting people with physical disabilities, including but not limited to the CAP/DA population.

DHHS will also need to assess how the BH I/DD Tailored Plan transition will impact the Department's budget and ensure there is proper funding for any transition. DHHS anticipates that this transition will create additional costs associated with plan administration, underwriting gain, and premium tax; it is unclear whether these will be offset by potential cost savings associated with enhanced care management under BH I/DD Tailored Plans and the transition of physical health services to managed care for the CAP/DA population. Any cost savings will not be evident for several years after the transition.

Implications on the State's Longer-Term Strategy for Dual Eligible Populations

As noted above, almost four out of five CAP/DA participants are dually eligible for both Medicare and Medicaid. The dual eligible population has particularly complex medical, behavioral, and social support needs, which are compounded for CAP/DA participants who also have service and support needs related to their physical disability and who meet an institutional level of care. Dual eligible individuals, including those in North Carolina, have historically received care from two non-integrated programs: Medicaid and Medicare. This fragmented structure is antithetical to North Carolina's goal of providing whole-person, coordinated, integrated care across the care continuum and equitable care due to lack of integration between Medicare and Medicaid programs. In recognition of this, DHHS is developing a long-term strategy for integrating dual eligible populations into managed care to provide those populations with access to integrated, whole-person, coordinated care.[26] That strategy will be informed by a report from the Duke-Margolis Center for Health Policy, which recommended establishing and enrolling dual eligibles in "Dual Eligible Special Needs Plans" (D-SNPs) (Medicare) that are "aligned" with PHPs (Medicaid).[27, 28] This approach would provide significant, meaningful integration of an individual's Medicare and Medicaid benefits. All dual eligible populations (except for those excluded by statute) would have the option to enroll in these aligned D-SNPs and PHPs, and all services (again, except for those excluded by statute) would be available through the aligned D-SNPs and PHPs. This approach would support more integrated care management, benefit coordination, and quality improvement strategies for dually eligible members, who often have difficulties navigating two distinct health insurance programs. The Duke-Margolis report notes that implementing this approach will be administratively complex, requiring a

[26] DHHS is also statutorily required to transition North Carolina residents with full Medicaid benefits who are also enrolled in Medicare into Medicaid managed care by 2026.
[27] "North Carolina Medicare-Medicaid Integration: Advancing Whole-Person Care," Duke-Margolis Center for Health Policy. Oct 2022.
[28] "Alignment" refers to when a dual-eligible beneficiary is enrolled in a D-SNP and an affiliated Medicaid managed care plan offered by the same parent entity.

significant amount of state capacity and investment. The report cites developing new data sharing infrastructure and processes and engaging with stakeholders as just some of the activities required. If DHHS ultimately opts for implementing aligned D-SNPs and PHPs, the overall timeline for implementing this strategy could span several years.

The current BH I/DD Tailored Plan contract includes several provisions for dual eligibles enrolled in the Innovations or TBI waivers. Those provisions will need to be evaluated for whether they adequately address the needs of CAP/DA waiver participants who are dual eligibles. Moreover, if CAP/DA participants are enrolled into managed care via BH I/DD Tailored Plans separate and apart from the State's execution of a broader dual eligibles integration strategy, CAP/DA participants could be subject to multiple managed care transitions within the course of a few years. Each managed care transition brings with it the risk of service disruption.

Appendix A: North Carolina General Assembly Session Law 2023-124 Section 9E.16(.c)

SECTION 9E.16.(c) No later than June 1, 2024, DHHS shall develop and submit a proposal to the Joint Legislative Oversight Committee on Medicaid to transition the administration of the Community Alternatives Program for Disabled Adults (CAP/DA) to the BH I/DD Tailored Plans by January 1, 2025, notwithstanding G.S. 108D-40(a)(11)