Improving Member Health Through Managed Care Program Enhancements: North Carolina's Approach to Standard Plan Re-Procurement

North Carolina Department of Health and Human Services

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Executive Summary

The North Carolina Department of Health and Human Services is seeking input on priorities for the State's Medicaid managed care program in anticipation of the upcoming re-procurement of Standard Plans. Since the launch of the Standard Plan program, NCDHHS has gathered valuable insights from Medicaid members, providers, health systems, health plans and other partners, and has learned meaningful lessons in administering a Medicaid program under managed care. This paper describes key policy priorities that will build on progress achieved over the last several years while strengthening areas offering opportunities for advancement or requiring additional attention and support. NCDHHS invites comment from Medicaid members, providers, community-based organizations, health plans, state and local officials, and other partners to ensure that these priorities reflect the needs and values of the people served by Medicaid. Sustaining the current Medicaid program and making certain changes will require statutory authority and budget support from the North Carolina General Assembly, and NCDHHS is committed to collaborating with lawmakers.

Background: In 2021, the first Prepaid Health Plans (PHPs) enrolled Medicaid members in North Carolina, transitioning the delivery system from predominantly fee-for-service to managed care. In the coming months, NCDHHS will begin the process to re-procure the Standard Plan contracts for a new contract cycle starting in December 2027. Through re-procurement, NCDHHS has an opportunity to refine policy priorities and revise Standard Plan contractual requirements to align with Department and legislative priorities. Input from the field will be critical to informing the improvements and innovations that NCDHHS advances in the re-procurement.

NC Medicaid's vision is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care, which addresses both medical and non-medical drivers of health. A key area of focus in this procurement cycle will be that NCDHHS expects health plans and managed care partners will bring innovation to help NCDHHS slow cost growth of the program – not by restricting access or through greater administrative burdens but by decreasing avoidable and potentially avoidable care. Therefore, as Medicaid managed care continues to mature in North Carolina, NCDHHS seeks to leverage Standard Plans in more innovative, effective, and efficient ways to improve health guided by the following key objectives:

- ***Provide members timely access*** to care, a positive and respectful experience, and improved health outcomes
- ***Advance high-value and efficient care*** through collaborative care delivery that addresses the full spectrum of member needs and improves population health
- ***Engage and support providers*** and the healthcare workforce while reducing provider administrative burden
- ***Support cost effectiveness and predictability*** for long-term program sustainability

To advance these initiatives, NCDHHS will focus on the following program changes:

Simplify member choice and provider experience: An accessible Medicaid managed care program that is easy for members to navigate improves member agency in their care and ultimately member health. Simplifying choosing a Standard Plan can make it easier for members to evaluate

their options and select the Standard Plan that best meets their needs. Fewer Standard Plans also reduces the time providers spend navigating varying Standard Plan policies and procedures, freeing more time to focus on delivering high-quality care. By awarding up to three statewide Standard Plan contracts in the re-procurement, NCDHHS can continue providing members with a meaningful number of Standard Plan options, while simplifying member choice, and improving provider experience.

Expand access to managed care: NCDHHS is committed to ensuring that all Medicaid beneficiaries receive coordinated, cohesive care that is tailored to their unique needs. Today, certain vulnerable populations with higher needs – including individuals dually eligible for Medicare and Medicaid, Medically Needy beneficiaries, and Medicaid beneficiaries receiving long-stay nursing home services – receive their Medicaid coverage through NC Medicaid Direct.[1] NCDHHS is evaluating transitioning these populations into managed care, considering an integrated care strategy for individuals who are dually eligible for Medicaid and Medicare services and the feasibility of the transition during the next Standard Plan contract term. Under integrated care, a single entity has accountability for whole-person care and coordinates services across both Medicare and Medicaid. This model can help identify member needs, connect members to medical and non-medical care, allow them to remain at home or in community-based settings, and ultimately improve member health.

Ensure timely access to care: Reducing avoidable and potentially avoidable care is a priority of NCDHHS in order to reduce cost growth in the program. Network adequacy standards are an important tool to ensure members have timely access to the providers and care they need. NCDHHS is exploring standards that accurately capture meaningful access – where members have a choice of multiple providers, can easily identify providers that meet their needs, and can readily access care from their preferred providers. NCDHHS is also exploring how to enhance existing measures in critical areas with persistent challenges and emphasize the use of standards to reduce health disparities. Beyond network adequacy requirements, NCDHHS also plans to use the re-procurement to formalize the Standard Plan's role in addressing long-standing healthcare workforce shortages in rural and underserved communities through additional contractual requirements.

Improve Standard Plan accountability: NCDHHS is examining potential changes to Standard Plan operational and administrative processes that have the greatest impact on member access to coordinated, timely care, including care that addresses non-medical drivers of health. Processes include prior authorization, reimbursement edits, standards for timely access, and grievances and appeals. NCDHHS is also exploring opportunities to continually improve the member experience, the ability of individuals to understand what benefits are available, how to access those benefits in a timely manner, and how to advocate if Standard Plans deny them access. NCDHHS is examining potential changes to hold Standard Plans accountable for ensuring positive member experience

[1]North Carolina has four 1915(c) waiver programs, which allow the State to offer home- and community-based services not otherwise covered by Medicaid to eligible beneficiaries. The State's waiver programs include the Innovations waiver, the Traumatic Brain Injury (TBI) waiver, the Community Alternative Program for Children (CAP/C) waiver, and the Community Alternative Program for Adults (CAP/D) waiver. Individuals who are dually eligible for Medicaid and Medicare services in the Innovations and TBI waivers are enrolled in Tailored Plans, while individuals in the CAP/C and CAP/DA waivers are enrolled in NC Medicaid Direct.

through increased training for their staff, improved member education and materials, and other changes to help members easily navigate their Standard Plan's processes. With clearer and more specific contractual requirements in these areas, Standard Plans will have greater clarity of expectations and accountability for ensuring members have positive and efficient experiences accessing high-quality care when they need it.

Strengthen person-centered, coordinated care: Managed care was designed to support a well-coordinated system of care. Continued investment in and work to improve primary care attribution and assignment, coordinated discharge planning, and investment in timely clinical data through the health information exchange (HIE) will improve system of care coordination. NCDHHS also plans to enhance North Carolina's person-centered care management program by streamlining care management offerings, coordinating Standard Plan-level oversight, increasing accountability to outcomes, and improving data collection efforts to improve members' health and well-being.

Increase member engagement in primary care: A strong primary care system can improve members' health. Advanced Medical Homes (AMHs) serve as North Carolina's principal primary care providers, responsible for most members' health needs. NCDHHS intends to review and revise the requirements to become an AMH practice, to ensure that the program continues to adapt to member needs. NCDHHS is also considering placing more responsibility on Standard Plans to engage members in their assigned AMH or to identify an appropriate alternative medical home for them.

Incentivize quality care: NCDHHS will continue to use evidence-based quality measures that are meaningful to members to evaluate Standard Plan performance. NCDHHS is considering simplifying the number of measures that it tracks related to Standard Plan performance. Prioritizing standard measurement areas, potentially across all NC Medicaid programs, to reflect North Carolinians' greatest health needs, will encourage value-based arrangements that increase accountability for improvements in health outcomes. Strengthening transparency and data sharing will further contribute to Standard Plan performance expectations to improving member health.

Overview of Managed Care Transformation and Upcoming Procurement

History: In 2015, the North Carolina General Assembly directed NCDHHS to transition the Medicaid program from fee-for-service to managed care. In response, NCDHHS published the Proposed Program Design for Medicaid Managed Care in 2017,[2] outlining the overall vision, program objectives, and policy priorities for the launch of Medicaid Managed Care in North Carolina. At that time, NCDHHS established a vision to: "*...implement Medicaid managed care in a way that advances high-value care, improves population health, and establishes a sustainable program with predictable costs*.

[2] North Carolina's Proposed Program Design for Medicaid Managed Care. August 2017. https://www.ncdhhs.gov/documents/files/medicaid-managed-care-proposed-program-design/download

In July 2021, the first Standard Plans enrolled North Carolina Medicaid beneficiaries as members under their coverage. Since 2021, the Standard Plan program has performed well given the dynamic environment in which it has operated. The program launched at the height of the COVID-19 Public Health Emergency, took on an expected increase of enrollment during the pandemic without severe shock to provider networks, rapidly implemented telehealth programs and absorbed both the beginnings of the Continuous Coverage Unwinding of eligible members and Medicaid expansion. NCDHHS implemented additional changes, updates, and improvements to the Standard Plan program – evaluating outcomes and amending contract terms to ensure that members and providers have more impactful health and administrative experiences within the managed care environment.

The Standard Plans now collaborate with Local Management Entities (LMEs) in their capacity as Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans (Tailored Plans), developed to meet the needs of individuals living with Serious mental illness (SMI), Severe substance use disorders (SUD), I/DDs, and/or TBIs. Additionally, Standard Plans administer the Healthy Opportunities Pilots, NCDHHS' innovative approach to deliver evidence-based, non-medical interventions (e.g., housing, food, safety) to eligible members. Since its launch in 2022, participation in the Healthy Opportunities Pilots has been found to be associated[3] with decreased emergency room visits and lowered total cost of care.

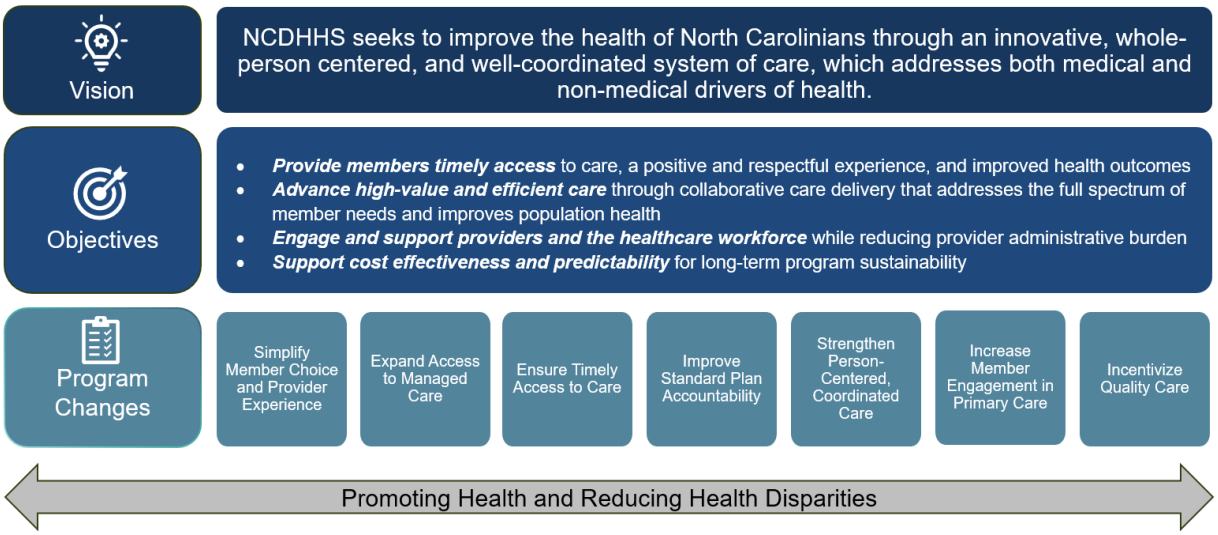
Moving forward: NCDHHS will build on this strong foundation to continue to improve the health of North Carolinians through the State's Medicaid program. As Medicaid managed care matures in North Carolina, NCDHHS will leverage Standard Plans in more innovative, effective, and efficient ways to improve member health. The program is guided by the following key objectives:

- ***Provide members timely access*** to care, a positive and respectful experience, and improved health outcomes
- ***Advance high-value and efficient care*** through collaborative care delivery that addresses the full spectrum of member needs and improves population health
- ***Engage and support providers*** and the health care workforce while reducing provider administrative burden
- ***Support cost effectiveness and predictability*** for long-term program sustainability

In early 2026, NCDHHS will release a Request for Proposals (RFP) for new Standard Plan contracts to begin in December 2027. NCDHHS maintains its focus on improving member health through innovative care and a delegated community care approach. NCDHHS also remains committed to reducing the provider administrative burden and improving timely claims payment, allowing providers to focus on treating patients and delivering quality care.

[3] Healthy Opportunities Pilot Interim Evaluation Report Summary. April 4, 2024. https://www.ncdhhs.gov/documents/healthy-opportunities-pilots-interim-evaluation-report-summary/open

Medicaid Managed Care and Standard Plan Re-Procurement: Vision, Objectives, and Program Changes



Improving Member Health through Managed Care Program Enhancements

Simplify Member Choice and Provider Experience

A key tenet of Medicaid managed care is member choice. In 2019, NCDHHS selected four statewide Standard Plans and one regional Standard Plan to cover beneficiaries across six regions (see Figure 1). Medicaid beneficiaries who are required to enroll in Standard Plans have a choice of at least four Standard Plans, and in some regions members can choose among all five Standard Plans operating in the State.[4] Federally recognized Tribal members and other individuals eligible to receive Indian Health Services who are residing in certain counties in western North Carolina can also choose the Eastern Band of Cherokee Indians (EBCI) Tribal Option. Most beneficiaries who meet criteria for Tailored Plans[5] can choose to enroll in either a Tailored Plan or a Standard Plan.

[4] Statewide Standard Plans: WellCare, UHC Community Plan, Healthy Blue, AmeriHealth Caritas
Regional Standard Plans: Carolina Complete Health

[5] Tailored Plans offer physical health, pharmacy (prescriptions), care management and behavioral health services for members with serious mental illness, severe substance use disorders, I/DD or TBIs.

Standard Plan Regions

It is critical that members can select a managed care plan that best meets their needs. Too many managed care plan options can cause decision paralysis, potentially leading fewer members to actively select a managed care plan. Additionally, multiple managed care plans require Medicaid providers to navigate different systems, processes, and policies for each managed care plan. It is projected that by Jan. 1, 2026, North Carolina will have five Standard Plans, four Tailored Plans, four Prepaid Inpatient Health Plans, one Children and Families Specialty Plan and two Primary Care Management organizations. Providers devote considerable time and financial resources to contracting with managed care plans, complying with disparate administrative requirements, navigating different networks for patient referrals, and managing revenue cycle challenges with multiple payers, taking time away from focusing on patient care. North Carolina boasts high rates of provider participation in Medicaid; NCDHHS wants to ensure the continuation of this trend and reduce provider administrative burden where possible.

Focus on Three Standard Plans Available Statewide that Meet Consistent Requirements and Standards: Among the five Standard Plans that participate today, four plans operate statewide and one plan operates regionally as a Provider-Led Entity (PLE) model. Through the upcoming Standard Plan procurement, NCDHHS recommends the competitive selection of no more than three, statewide Standard Plans – including any plans that operate as PLE models – to ensure program sustainability, reduce administrative costs for NCDHHS, and most importantly, to improve the member and provider experience in ways that lead to better clinical outcomes. In a competitive model, plans are selected not only for meeting baseline qualifications, but for demonstrating clear capacity to improve health outcomes, reduce potentially avoidable costs, integrate behavioral and physical health, support value-based care models, and invest in North Carolina communities.

Competitive Procurement

NCDHHS acknowledges that some stakeholders have expressed interest in an "Any Willing Plan" model, which would allow any health plan meeting minimal qualifications to participate in NC

Medicaid's Standard Plan program. This perspective reflects a genuine interest in promoting openness, consumer choice, and potential market competition. However, NCDHHS respectfully believes that a competitive procurement-based model more effectively delivers on those goals. Competitive procurement drives meaningful competition by selecting only those plans best equipped to deliver quality care, lower costs, and advance North Carolina's Medicaid goals.

The North Carolina Medicaid program is known nationally for its innovation, the speed at which it works and its dedication to engaging communities, the NC General Assembly, members and providers throughout its work. For that reason, the health plans that participate in the NC Medicaid managed care program must be sophisticated organizations that have clinical, administrative and operational flexibility to match the demands of a rapidly evolving healthcare environment in North Carolina. NCDHHS does not recommend lowering the requirements for any health plan including those bidding pursuant to the PLE models, how they qualify for procurement, how they are scored, or how they are expected to perform after go-live. It is the recommendation of NCDHHS that regardless of a health plan's status as a PLE, North Carolina providers and members should have confidence in the health plan and the high expectations of plan performance should be the same regardless of the plan's governance model.

Three Statewide Plans

Limiting participation to no more than a total of three, statewide Standard Plans, including PLE model plans, which offers a consistent set of plan options across all geographic regions, maintains meaningful member choice, and enhances the simplicity of the enrollment experience. Having no more than three Standard Plans will reduce administrative burden for providers, while maintaining choice and competition and reinforcing plan viability, and market stability. Finally, having no more than three statewide Standard Plans would also allow NCDHHS to better balance the administrative, financial, operational and oversight work with the other managed care programs which it operates, including Tailored Plans (4 plans), Prepaid Inpatient Health Plans (4 plans), Children and Families Specialty Plan (1 plan) and the Eastern Band of Cherokee Indian (EBCI) Tribal Option (1 plan).

NCDHHS recommends moving forward with statewide plans only and no longer using the regional entity model for Standard Plans. For a regional entity, completing readiness activities, managing contract amendments, and overseeing and monitoring quality outcomes require the same NCDHHS resources of a statewide plan. The Department's actuarial estimate of the annual fixed administrative cost component for each health plan entity is approximately $13 million in total funds and approximately $3.25M in State Funds per Standard Plan.

If NCDHHS were to move forward with no more than three statewide Standard Plans, NCDHHS could better ensure a smooth transition at go-live by measuring readiness as the state reduces the number of existing plans and from an on-going perspective, by monitoring provider participation rates, member satisfaction surveys, and service accessibility trends. NCDHHS will also track grievance and appeal patterns to identify and address potential disruptions in care delivery.

While an Any Willing Plan model may appear to expand plan participation, experience in other states suggests that it does not ensure better health outcomes, lower costs, or stronger accountability. A statewide, competitive procurement process best equips the state to deliver on

the Medicaid program's promise—driving better outcomes, strengthening accountability, and ensuring access to high-quality, coordinated care.

Feedback Requested. NCDHHS is interested in hearing from members, providers, community-based organizations, health plans, state and local officials, and other partners about streamlining the number of Standard Plans available across the State:

- Overall, will the proposed approach of contracting with up to three Standard Plans statewide improve member care and the provider experience?
- Assuming the PLE model moves forward, should the PLE be held to the same criteria as the Standard Plans? If not, what other approaches should NCDHHS consider to ensure high quality care and performance from the PLE?
- What challenges do members and providers anticipate if fewer Standard Plans are available?
- What benefits will members and providers experience if fewer Standard Plans are available?
- What parts of the Medicaid program and Standard Plan enrollment processes are working well for members? What aspects can be improved from a member perspective?
    - NCDHHS will also continue to contract with an Enrollment Broker to support choice counseling for managed care plan and primary care provider selection. How can this support be improved?

Expand Access to Managed Care

When NCDHHS launched managed care, most Medicaid and NC Health Choice populations were mandatorily enrolled in Standard Plans. However, NCDHHS delayed the transition of certain vulnerable populations into managed care to ensure that provider relationships and care regimens were not disrupted. One such vulnerable population is individuals who are dually eligible for full Medicaid and Medicare benefits, consisting of adults over age 65 as well as children and adults under 65 who have disabilities.

Individuals who are Dually Eligible for Medicare and Medicaid Services

Today, most dually eligible individuals receive their coverage through NC Medicaid Direct, including those who are long-term nursing home residents and those who receive Medicaid coverage through the Medically Needy program (further described below). A small percentage of individuals who are dually eligible for Medicaid and Medicare services– those with I/DD or TBI who are enrolled in the Innovations or TBI waiver programs[6] – are enrolled in Tailored Plans rather than NC Medicaid Direct.

[6]North Carolina has four 1915(c) waiver programs, which allow the State to offer home- and community-based services not otherwise covered by Medicaid to eligible beneficiaries. The State's waiver programs include the Innovations waiver, the TBI waiver (which is only available in the Alliance service area), the CAP/C waiver, and the CAP/D waiver. Individuals in the Innovations and TBI waivers are enrolled in Tailored Plans, while individuals in the CAP/C and CAP/DA waivers are enrolled in NC Medicaid Direct.

NCDHHS is required by statute[7] to transition most of the population dually eligible for full Medicaid and Medicare benefits into managed care (carved out populations are listed on page 15), while maintaining individuals partially eligible for Medicaid and Medicare services (those with Medicaid coverage for Medicare premiums and cost sharing only) in NC Medicaid Direct. NCDHHS is evaluating the transition of the population dually eligible for Medicaid and Medicare services into managed care, how to leverage the transition to initiate an integrated care strategy for individuals who are dually eligible for Medicaid and Medicare services, and the feasibility of the transition during the next Standard Plan contract term.

Individuals who are Dually Eligible in North Carolina: As of January 2025, over 364,000 individuals were dually eligible for Medicaid and Medicare services in North Carolina, of which 76% were individuals eligible for full Medicaid and Medicare services and 24% were individuals partially eligible for Medicaid and Medicaid services. Among individuals dually eligible for full Medicaid and Medicare services, 55% were adults aged 65 and older and 45% were adults and children younger than 65 with disabilities. This population has significant needs – most have six or more chronic conditions – and high rates of morbidity and mortality.[8] Today, these individuals experience a siloed approach to health care, with their Medicaid and Medicare benefits provided through two separate programs (Medicare serves as the primary payer). This results in a range of barriers to care for individuals who are dually eligible for Medicaid and Medicare services, including underutilization of and uneven access to care, limited and confusing information, complex, uncoordinated and fragmented benefits, and a lack of adequate health system-level supports.[9]

Integrated Care: The transition of these individuals into Medicaid managed care provides an opportunity to improve the current beneficiary experience by moving towards greater integration where individuals receive Medicaid and Medicare coverage from one entity responsible for care across both programs. A growing body of evidence points to the positive effects of integrated care on outcomes for this population, with studies noting reductions in hospitalizations, readmissions (which reduce Medicare expenditures), and nursing facility entries among those enrolled in integrated care models.[10]

As individuals who are dually eligible for Medicaid and Medicare services are integrated into managed care, NCDHHS is considering how Standard Plans could operate or partner with organizations that operate special Medicare Advantage (MA) products called dual-eligible special needs plans (D-SNPs). Unlike other MA plans, D-SNPs only serve individuals who are dually eligible for Medicaid and Medicare services, and they have contracts with both the Centers for Medicare & Medicaid Services (CMS) for Medicare and the State for Medicaid. D-SNPs are designed to better coordinate care between Medicaid and Medicare through federal regulatory requirements, including:

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[7] N.C. Gen. Stat. § 108D-40

[8] Higgins A, Kaufman B, Sorenson C, Smith M, Repka S, Japinga M (2022). North Carolina Medicare-Medicaid Integration: Advancing Whole-Person Care. Washington, DC: Duke-Margolis Center for Health Policy.

[9] ibid

[10] JEN Associates, Inc. 2013. Massachusetts Senior Care Option 2005–2010 impact on enrollees: Nursing home entry utilization. Cambridge, MA: JEN Associates, Inc. and Johnson MB, McCarthy D. The Visiting Nurse Service of New York's choice health plans: continuous care management for dually eligible Medicare and Medicaid beneficiaries.

- Tailoring benefits specifically for the needs of individuals dually eligible for Medicaid and Medicare services
- A Model of Care (MOC) describing how the plan will meet the needs of individuals who are dually eligible for Medicaid and Medicare services
- A health risk assessment process that collects information about non-medical needs, including transportation, housing, and food security
- Member advisory committees that provides input on the quality and accessibility of D-SNP services

NCDHHS is considering whether to require all Standard Plans selected in the next procurement to directly operate a D-SNP or partner with an existing D-SNP, so Medicaid services for these individuals are closely coordinated and integrated with their Medicare services. Better integration supports high-value and whole-person care.

Today, 52% of individuals who are dually eligible for Medicaid and Medicare services in North Carolina are already enrolled in a D-SNP for their Medicare coverage.[11] Across North Carolina, 21[12] D-SNPs are currently offered – one D-SNP is available statewide and the others are offered in certain areas of the state. In addition to D-SNPs, the Program of All-Inclusive Care for the Elderly (PACE) serves 1,956 individuals who are dually eligible for Medicaid and Medicare services who also qualify for nursing home level of care by providing medically necessary care and other services in communities to support independent living. Over time, NCDHHS aims to increase the number of individuals dually eligible for Medicaid and Medicare services in North Carolina who receive integrated care through aligned Standard Plans and D-SNPs, or through PACE programs.

NCDHHS Vision for Integrated Care for Individuals who are Dually Eligible for Medicaid and Medicare Services

An integrated system of high-value, community-centered, and whole-person care that prioritizes the preferences and needs of dually eligible beneficiaries and their families, resulting in better health, reduced disparities, and improved experiences.

To achieve its vision of an integrated system of high-value, community-centered, and whole-person care, NCDHHS is considering using the re-procurement to transition this population into managed care during the next Standard Plan contract cycle and initiate an integrated care strategy for individuals who are dually eligible for Medicaid and Medicare services. Specifically, NCDHHS is considering whether to require respondents to the Standard Plan solicitation to demonstrate they have the requisite experience and ability to serve individuals who are dually eligible for Medicaid and Medicare Services through an integrated model by describing their approach to:

- **Customized Supports that Help Members Remain in their Homes and Communities** and avoid institutional settings, including establishing a statewide provider network capable

[11] Higgins, A, Smith M, Sorenson C, Kaufman B, Jones K, Seaman A, Qu R. (2024). Update to the Report, North Carolina Medicare-Medicaid Integration: Advancing Whole-Person Care. Washington, DC: Duke-Margolis Center for Health Policy.
[12] Includes all Coordination-Only D-SNPs with any enrollees operating in North Carolina as of 2023

of delivering integrated physical, behavioral, social, and long-term services and supports (LTSS)

- **Model of Care for Individuals who are Dually Eligible for Medicaid and Medicare Services** that provides person-centered service coordination across both Medicaid and Medicare benefits
- **Identifying and Addressing Non-Medical Drivers of Health** by leveraging Medicare Supplemental Benefits, Medicaid In-Lieu-of Services and Medicaid Value-Added Services
- **Incorporating Member Input** to improve access, quality and member experience

NCDHHS is also considering whether to require that Standard Plans operate a D-SNP or partner with a D-SNP that has statewide coverage as a condition of contract award. Once individuals who are dually eligible for Medicaid and Medicare services are carved into Medicaid managed care, NCDHHS would be able to move towards exclusively aligned enrollment for D-SNPs, whereby the State would execute a State Medicaid Agency Contract (SMAC) only with D-SNPs that have a companion Standard Plan contract or partnership with a PHP that has a Standard Plan contract.

Case Study: Arizona's Contracting Approach to Integrated Care for Individuals Dually Eligible for Medicaid and Medicare Services

Arizona – Arizona requires its Medicaid Accountable Care Organizations (ACOs) or their affiliated organization to provide Medicare benefits to dually eligible members through a CMS- and State-contracted Medicare Advantage D-SNP for all counties in the ACO's geographic service areas. Further, Arizona only executes State Medicaid Agency Contracts with D-SNPs when the Medicare Advantage organization holds a companion Medicaid program contract that covers the requested counties and populations.

Finally, NCDHHS is considering whether to enhance existing care management requirements for Standard Plans to support a transition process for their members that is comparable to Money Follows the Person (MFP). MFP is a federally funded grant program that helps Medicaid-eligible North Carolinians living in institutional settings move into their own homes and communities. The program provides assistance from transition coordinators and coverage for one-time expenses needed to transition from an institution to the community, including security deposits, utility start-up expenses, furniture, accessibility modifications or other one-time items and services that may be required to transition. Based on the success of this existing program, Standard Plans may be encouraged to adapt their care management models for individuals transitioning out of institutional care to a model that is comparable to MFP, including support from transition coordinators. Standard Plans could also be encouraged to offer Value-Added Services[13] comparable to those offered under MFP, including security deposits, utility startup expenses, furniture, accessibility modifications and other one-time items and services to help facilitate transitions, to the extent they

[13] Value-Added Services are additional services outside of the Medicaid benefit package (i.e., State Plan and/or Medicaid managed care contract) that are delivered at managed care plans' discretion and are not included in capitation rate calculations.

are not already available to members through the 1915(i) Medicaid Home and Community-Based Services benefit, In-Lieu-of Services[14], or Healthy Opportunities Pilots services.

North Carolina's Success with Money Follows the Person

A study of North Carolina's MFP program found that it was effective in improving participants' quality of life while providing LTSS services in a community-based setting at a lower cost than facility-based care. In North Carolina, five out of the seven measured categories noted improvements. A measure of "Satisfaction with Living Arrangement" increased by 45% over the pre-transition baseline. **The study recommended that the MFP transition program become part of the permanent LTSS landscape**.

Implementation Considerations: NCDHHS faces significant implementation considerations in transitioning individuals who are dually eligible for Medicaid and Medicare services into managed care. Identifying and resolving these issues are critical to ensuring a smooth transition of these members and to achieving integrated care.

- *Operational Considerations of Transition*. NCDHHS must plan for and execute a series of programmatic, financial, and technical changes to prepare for the transition of individuals who are dually eligible for Medicaid and Medicare services into managed care, including financial analyses to determine capitation rate impacts, design of plan requirements, including how to best meet the needs of individuals who are dually eligible for Medicaid and Medicare services who meet Tailored Plan clinical eligibility criteria,[15] and engagement with the CMS to obtain necessary federal approvals, among others. Engagement with external partners will be critical to inform program design.
- *Financial Considerations of Transition*. Transitioning individuals who are dually eligible for Medicaid and Medicare services into managed care will increase Medicaid expenditures for administrative and care management costs paid to managed care plans. Because Medicare is the primary payer of most acute care services for individuals who are dually eligible for Medicaid and Medicare services, the benefits of care management and coordination activities often accrue to the Medicare program, not Medicaid. One way to realize Medicaid cost savings for individuals who are dually eligible for Medicaid and Medicare services is through an integrated care model that helps divert these individuals from facility-based settings by keeping members in their homes and communities. In addition to administrative and care management costs paid to managed care plans, NCDHHS will require additional funding for the Department's operational and administrative activities to support the transition of individuals who are dually eligible for Medicaid and Medicare services into managed care. The transition is expected to require significant staff and contractor resources to implement given the complexity and level of effort needed.
- *Timing of Transition*. NCDHHS is committed to uninterrupted member access to care. This will require that both the Department and Standard Plans have enough time to make

[14] In-Lieu of Services (ILOS) are medically appropriate and cost effective substitutes for a covered service or setting under the Medicaid State plan. ILOS are delivered at managed care plans' discretion and members cannot be required to utilize ILOS. ILOS are included in capitation rate calculations.
[15] This includes individuals with SMI, severe SUDs, Intellectual and developmental disabilities or TBI.

operational and financial changes ahead of the transition. Additionally, an integrated care strategy that helps align members' Medicaid and Medicare benefits will require alignment between three different types of contracts that operate under different contractual timelines:

1. *State Medicaid Managed Care Contracts* between the State and Standard Plans/Tailored Plans, which include requirements for **Medicaid benefits** provided to individuals who are dually eligible for Medicaid and Medicare Services
2. *Medicare Advantage Contracts* between the Federal government and D-SNPs, which include requirements for **Medicare benefits** provided to individuals who are dually eligible for Medicaid and Medicare Services
3. *State Medicaid Agency Contracts* between the State and D-SNPs, which include requirements for D-SNPs to **coordinate Medicaid and Medicare benefits** for individuals who are dually eligible for Medicaid and Medicare Services

To implement an integrated care strategy for duals, NCDHHS will need to make changes to *State Medicaid Managed Care Contracts* and *State Medicaid Agency Contracts*, while providing managed care plans with enough time to adjust their *Medicare Advantage Contracts* and, if applicable, applications for new D-SNP products.

For all of these reasons, NCDHHS does not anticipate that individuals who are dually eligible for Medicaid and Medicare services will transition into managed care immediately at the start of the next Standard Plan contract cycle; instead, this population is expected to transition at a later date within the next contract cycle.

Medically Needy Beneficiaries (individuals who are dually eligible for Medicare and Medicaid and others)

Medically Needy Medicaid beneficiaries include aged, blind, and disabled individuals who have too much income/resources to receive supplemental security income (SSI), but not enough to pay for medical care, as well as individuals who qualify for Medicaid under a Modified Adjusted Gross Income (MAGI) group. As of January 2025, North Carolina has approximately 27,000 Medically Needy Medicaid beneficiaries (excluding those on a 1915(c) waiver or enrolled in PACE), of which 23,000 are dually eligible for Medicare and Medicaid.[16] As most of this population is dually eligible, NCDHHS is considering whether to transition this population into managed care under the same timeline as other dually eligible populations. Transitioning this population could ensure these individuals benefit from more integrated, community-centered, and whole-person care under an integrated care model. Including this population in Medicaid managed care would require legislative changes.

Medicaid Beneficiaries Receiving Long-Stay Nursing Home Services (individuals who are dually eligible for Medicare and Medicaid and others)

Nursing home services for "short stays" (less than 90 days) are currently covered under Medicaid managed care, while individuals with "long stays" (more than 90 days) receive services through NC Medicaid Direct. As of January 2025, approximately 14,400 Medicaid beneficiaries are in long stay nursing homes in North Carolina, of which 11,800 are dually eligible for Medicare and Medicaid

[16] Excludes individuals enrolled in a 1915(c) waiver program.

services and 2,600 are eligible for Medicaid only. NCDHHS is considering whether to transition this population into Medicaid managed care at the same time as other dually eligible beneficiaries. Through enhanced transition support processes, managed care could help members who are ready and able to transition from nursing homes back into the community.

Populations to Remain Carved Out of Managed Care

When NCDHHS launched managed care, most Medicaid and NC Health Choice populations were mandatorily enrolled in Standard Plans. However, certain populations were excluded or exempt and remained in NC Medicaid Direct. The populations outlined below will remain in NC Medicaid Direct, receiving their Medicaid services through a fee-for-service model rather than managed care:

- Individuals partially eligible for Medicaid and Medicare services[17]
- Individuals who qualify for emergency services[18]
- Beneficiaries who meet the definition of Indian[19] who choose to not enroll in managed care
- Presumptively eligible beneficiaries, during the period of presumptive eligibility
- Beneficiaries who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program
- Beneficiaries enrolled under the Medicaid Family Planning program
- Beneficiaries residing in carceral settings, including state prisons, county and tribal jails, and juvenile justice facilities, whose Medicaid eligibility has been suspended while they are incarcerated and during the first year after they have been released.
- Beneficiaries being served through CAP/C
- Beneficiaries being served through CAP/DA.

[17] Beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is limited to the coverage of Medicare premiums and cost sharing

[18] Includes qualified aliens subject to the five-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611 and undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611.

[19] Definition under 42 C.F.R. § 438.14(a)

Feedback Requested. NCDHHS is interested in hearing from members, providers, community-based organizations, health plans, state and local officials, and other partners about the following questions related to transitions of individuals dually eligible for Medicaid and Medicare services, long-term nursing stay residents, and the Medically Needy population to Medicaid managed care:

- Overall, will the transition of individuals dually eligible for Medicaid and Medicare services, long-term nursing stay residents, and the Medically Needy populations into Medicaid managed care improve member care and experience?
- What challenges do providers anticipate with the transition of individuals dually eligible for Medicaid and Medicare services, long-term nursing stay residents, and the Medically Needy population into Medicaid managed care? What implications do these provider challenges have for the timing of when these populations transition into managed care?
- Are there other approaches, including best practices from other states or community-led initiatives, that NCDHHS should consider to improve health outcomes and member experience for individuals dually eligible for Medicaid and Medicare services, long-term nursing stay residents, and the Medically Needy population?
- As the State develops an integrated care strategy for individuals dually eligible for Medicaid and Medicare services, how can NCDHHS best meet the needs of dually eligible individuals who meet Tailored Plan clinical eligibility criteria, including SMI, severe SUDs, I/DDs or TBIs?
- If the state moves towards exclusively aligned enrollment for D-SNPs, which would reduce the total number of D-SNPs in the state, how will this impact member and provider experience and member care?

Ensure Timely Access to Care

When NCDHHS developed the Medicaid managed care program in 2017, promoting access to care was a top priority for the transition. During the first four years of Standard Plan operations, the State made progress in increasing access through Medicaid expansion, supporting telehealth initiatives, and increasing access to treatment for opioid use disorder. However, challenges persist in other areas. Meaningful member access to care requires that members have a choice of multiple providers, can easily identify providers that meet their needs, and can readily access care from their preferred providers. Changes to prior authorization, network adequacy standards and workforce development all provide significant opportunity for innovation.

From 2021-Today: Key Achievements in Promoting Access to Care

Increased Access to Medicaid through Medicaid expansion, enrolling more than 620,000 North Carolinians (as of February 2025) and extending postpartum Medicaid coverage for 12 months after delivery.

Combined Medicaid and CHIP programs for Children by transitioning children who were receiving NC Health Choice coverage to NC Medicaid. This change expanded benefits for children, eliminated enrollment fees and copays for medical visits and prescriptions, and promoted simplification for members, providers, Standard Plans and the State.

Expanded Use of Telehealth by permanently implementing more than 50% of the telehealth flexibilities adopted during the COVID-19 Public Health Emergency, ensuring members have access to on-demand care when they need it

Combatting the Opioid Epidemic by removing financial barriers for opioid treatments (e.g., copay requirements and expanding Standard Plans' SUD service array to include Substance Abuse Intensive Outpatient Program (SAIOP) Substance Abuse Comprehensive Outpatient Treatment (SACOT) and social setting detox services.

Revise Network Adequacy Standards: Network adequacy standards are an important tool to ensure members have access to providers and care. Current standards outlined in Standard Plan contracts, including time and distance and appointment wait times, do not always provide NCDHHS with the full insight needed to determine whether members have meaningful access to needed care. NCDHHS is exploring new measures that could more accurately capture meaningful access - including measures that address critical areas with persistent challenges such as behavioral health, measures that can help reduce disparities, and measures for services to address non-medical drivers of health. Revised or new requirements will draw from best practices in other states and the latest research on how to analyze meaningful member access to care. Changes are expected to include new measures beyond time and distance, including provider-member ratios or other measures that reflect meaningful and timely access to care. At least 13 states have adopted provider/member ratios or another standard to determine the minimum number of providers available, and at least five states[20] have specific provider/member ratios or minimum numbers of providers for mental health and substance use disorder care.

Enhance Standard Plans Role in Workforce Development: Since launching Standard Plans, North Carolina continues its focus on reducing long-standing healthcare workforce shortages in rural and underserved communities and ensuring the availability of the team-based workforce required to transform health care delivery and reimbursement. Since 2021, the State has expanded community-based residency programs that promote essential workforce training and continued existing loan repayment, community grant, and Area Health Education Center (AHEC) residency programs. Additionally, the State is working with legislative leaders to review the recently approved1115 waiver option to further boost the behavioral health workforce.

[20] Colorado, Delaware, Illinois, Maryland and New York

While Standard Plans supported these and other workforce initiatives, their involvement and support has been voluntary rather than mandatory. NCDHHS will use the upcoming re-procurement to formalize the Standard Plan's role in addressing healthcare workforce shortages in rural and underserved communities through additional contractual requirements related to workforce. The State will leverage best practices from other states to inform these requirements. As part of the re-procurement process, NCDHHS will require Standard Plans to take an active role in provider recruitment and retention efforts. This includes participating in initiatives that address provider shortages in rural and underserved areas.

Feedback Requested. NCDHHS is interested in hearing members, providers, community-based organizations, health plans, state and local officials, and other partners about the following questions related to network adequacy requirements:

- Overall, will the proposed approaches improve access to care? Are there other approaches, including best practices from other states or community-led initiatives, that NCDHHS should consider?
- What are the most important indicators of meaningful access to care for members?
- What are key barriers to access that could be addressed through new or revised standards?
- How are Standard Plans currently supporting workforce initiatives through community reinvestment? What has been most successful? Are there best practices that NCDHHS should consider based on current initiatives?
- What are the most important and viable opportunities for Standard Plans to support workforce initiatives?

Improve Standard Plan Accountability

NCDHHS is committed to improving health outcomes, enhancing timely access to care, and improving member and provider satisfaction by simplifying and standardizing the Medicaid managed care experience. For members, simplification begins with fewer Standard Plans that are available no matter where they live. No more than three Standard Plans operating statewide can help members discern the meaningful differences across options and make the best choice for them. Once members are enrolled in a Standard Plan, their experience and ability to access care depends on how easily they can navigate their Standard Plan's processes, the type of assistance they receive from Standard Plan staff, and the accessibility of information and resources provided to them. NCDHHS is exploring opportunities to continually improve the member experience by standardizing policies, procedures and practices and holding Standard Plans accountable for ensuring positive member experience.

The standardization of policies, procedures and practices will focus on areas that are important to members receiving well-coordinated, needed care quickly and ultimately improving health.[21] Policies related to prior authorization, standards on timely access to care, training for call center staff and Standard Plan care managers, grievances and appeals processes, and member education

[21] CAHPS Summary Report. 2022. https://medicaid.ncdhhs.gov/nc-cahps-2022-survey-report-two-page-summary/download?attachment

and materials, among others, will be explored through re-procurement. NCDHHS plans to incorporate indicators of meaningful access and positive member experience that are measured through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey into standardized policies that will help improve member experience across all Standard Plans.

For providers, a streamlined managed care program will reduce administrative burden, enabling them to focus on delivering timely and high-quality patient care. Currently, Medicaid has high rates of provider participation, but provider satisfaction has decreased since the State transitioned to Medicaid managed care. Medicaid providers report[22] significant challenges navigating multiple managed care plans' requirements and processes given a lack of standardization across managed care plans. These challenges related to the delivery of and reimbursement for care – ranging from varying utilization management requirements, claims adjudication processes, required forms and assessments, and grievance and appeals processes – mean that providers allocate significant time and resources to administrative management. Addressing provider administrative burden on key processes like prior authorization will help prevent decreases in provider participation, promote a positive member experience, and ensure members' access to high-quality and timely care.

Through Standard Plan re-procurement, NCDHHS will explore opportunities to align prior authorization requirements across Standard Plans and consider refinements to the current process that aim to improve timely member access to care while maintaining necessary oversight.

Building a More Simplified and Standardized Managed Care Program

Members – Improving the member experience by standardizing member-facing processes that help members navigate the healthcare system more easily and access needed care quickly.

Providers – Supporting providers' ability to focus on delivering the best patient care by minimizing administrative burden, standardizing processes, and ensuring challenges are addressed quickly and efficiently.

Standard Plans – Promoting effective and efficient stewardship of State resources by standardizing processes and practices across all Standard Plans through clear and specific contractual requirements.

NCDHHS plans to use the upcoming re-procurement to simplify the member and provider experience by streamlining and standardizing contractual requirements for Standard Plans, including:

Enhance Clarity and Specificity of Contractual Requirements: NCDHHS plans to further standardize required forms, assessments, and processes related to utilization management, claims adjudication, member complaints, grievances and appeals, and provider training and education. NCDHHS also plans to review managed care policies for prior authorization from other states – including examples highlighted below - to inform its contractual requirements. While the

[22] 2023 Medicaid Provider Experience Survey. Feb. 2, 2024. https://medicaid.ncdhhs.gov/documents/reports/providerexperiencesurveywave3report/download?attachment

prior authorization process is an important tool that allows managed care plans to assess an appropriate level of need and manage provider resources, prior authorization can impede a member's timely access to care. Standardized requirements will ensure that Standard Plans are administering the Medicaid program consistently. The combination of no more than three Standard Plans and standardized requirements across all Standard Plans will make the Medicaid program more attractive and easier to navigate for both members and providers.

Case Study: Prior Authorization Approaches in Ohio and Illinois

Ohio – The state's Medicaid managed care contract requires Managed Care Organizations (MCOs) to implement state expectations to standardize and streamline prior authorization (PA) requirements to reduce administrative burden for providers. This includes standardizing:

- Certain aspects of approved lengths of stay for certain services requiring PA
- MCO notification of providers for submission of PA requests
- Types of clinical documentation required for prior authorization decision-making

The contract also requires MCOs to waive PA requirements for providers who consistently demonstrate excellence in PA performance and to offer a peer-to-peer consultation to providers whenever the MCO denies a PA request.

Illinois – The state has a multi-pronged approach that includes the following:

- Transparency through a public list of all services that require PA
- Use of data-driven methods to determine which services require PA
- Focus on high-cost and long-term services rather than routine care

Select Single Vendors: NCDHHS is exploring opportunities to require Standard Plans to contract with a single vendor for services, rather than having each Standard Plan contract with a different vendor or implement oversight independently. For certain functions, including auditing delegated care management, streamlined contracting could minimize the number of additional entities with which providers interact. NCDHHS is seeking partner input on this approach, including whether there are other areas where single vendor contracting could help improve the member or provider experience.

Enhance Provider Credentialing: Today, NCDHHS has centralized a key process for providers in contracting with managed care plans: credentialing. Standard Plans, as well as Prepaid Inpatient Health Plans and Tailored Plans, must accept the NCTracks enrollment approval and contract with the provider or facility without requesting additional credentialing information. NCDHHS also plans to add features – a statewide Credentialing Committee and Delegated Enrollment/Credentialing to allow major hospitals and health care systems to perform credentialing for their practitioners – to further align North Carolina's provider enrollment and credentialing standards with the National Committee for Quality Assurance (NCQA). NCDHHS will also be re-procuring a Provider Data Management/Credentialing Verification Organization (PDM/CVO) to further reduce provider administrative burden, eliminate redundant data entry across multiple managed care plans,

improve multi-payer services, enhanced security protocols, and addresses Medicaid program needs.

Feedback Requested. NCDHHS is interested in hearing from members, providers, community-based organizations, health plans, state and local officials, and other partners about the following questions related to the simplification and standardization of Standard Plan processes:

- If required forms, assessments, and processes related to prior authorization, claims adjudication, member complaints, grievances and appeals, and provider training and education are further standardized across Standard Plans, will member care and provider experience improve? What specific processes (e.g., prior authorization, claims submission, grievance and appeals) should be improved and how?
- Are there specific approaches, including best practices from other states or community-led initiatives, that NCDHHS should consider to standardize Standard Plan processes?
- How can the member experience be improved when members interact with Standard Plans?
    - What types of training for Standard Plan-level staff (e.g., call center staff, care managers) would better assist members with navigating Standard Plan policies?
- Are there other approaches NCDHHS should consider to simplify member access to care?
- What additional opportunities should NCDHHS explore in the next Standard Plan procurement to make the program more efficient for members or providers?

Strengthen Person-Centered, Coordinated Care

NCDHHS launched managed care on a foundation of long-standing investment in local, practice-embedded care management, shown to improve health outcomes in many settings.[23] Care management services were delivered through a wide range of programs, including Community Care of North Carolina's locally-delivered care management, and through programs focused on specific subpopulations such as members with high-risk pregnancies or children with special health care needs. In the transition to managed care, NCDHHS' foundational principles emphasized broad access to services with a focus on:

- Access to appropriate care coordination and care management support across multiple settings of care;
- Developing person-centered care plans and goals for members with complex social or medical needs;

[23] https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/hcbs/medicaidmgmt/mm8.html

- Providing transitional care management for members transitioning between care settings and episodic care management support for members needing connection to non-medical social supports
- Delivering care management and coordination through primary care practices and at the local level to the fullest extent possible.

Since managed care launch, the proportion of members receiving care management services increased more than five-fold, demonstrating the important progress made to date. Under managed care, a component of Standard Plans' capitation payment is intended to reflect the cost of providing care management services for their assigned members. Most Standard Plan members must be assigned to primary care practices in their community, which have attested to their ability to provide delegated care management, either directly or via a partner entity. These practices are called Advanced Medical Home Tier 3 (AMH Tier 3) practices.[24] For these members, the Standard Plan delegates care management responsibility to the AMH Tier 3 practice and negotiates a per-member-per-month fee for the services. Some members also qualify for programs such as the Care Management for At Risk Children (CMARC) and Care Management for High Risk Pregnancies (CMHRP) programs, which build on pre-managed care efforts led by Local Health Departments (LHDs). An additional care management program, the NC Integrated Care for Kids pilot program, a national CMS innovation center model, emerged after managed care launch and is active in five counties. As NCDHHS moves into the next Standard Plan procurement, it intends to:

Reiterate its Commitment to Local Care Management: As North Carolina's care management programs evolve, NCDHHS will continue to prioritize delivery of care management embedded in local communities and will continue to promote provision of care management through AMH Tier 3 practices.

Harmonize Care Management Models to Ensure Members Receive High-Value Services Appropriate to Their Needs: NCDHHS intends to simplify its approach to care management programs, aligning programs that address overlapping member needs to minimize fragmentation of services within the managed care environment. This will include incorporating high-risk pregnancy and at-risk children care management services into requirements for Standard Plan and AMH Tier 3 care management.

Coordinate Standard Plan Oversight of High-Value Care Management Interventions: NCDHHS will further align its core care management delivery requirements to external standards to augment the structure and consistency of oversight across programs. Beneficiaries receiving care management from AMH Tier 3 practices are excluded from the sampling analyses conducted for members served by Standard Plans to assess oversight of delegated care management for Standard Plan-level accreditation by NCQA. Given the proportion of members served in AMH Tier 3 practices, extending this oversight process to include all Standard Plan care managed members will ensure that North Carolina's investment in primary care-based care management yields the broadest improvements

[24] AMH Tier 3 practices are part of the larger AMH program for providers of primary care services who meet requirements for serving as a Medicaid member's medical home. These providers must offer a minimum set of care coordination services and may elect to be delegated for broader care management services that strengthen the medical home in meeting quality improvement goals. Further information about the AMH program can be found at https://medicaid.ncdhhs.gov/documents/providers/advanced-medical-home-provider-manual/open

for members' health and that all members' care management is held to the same standard, regardless of how they are served. However, AMH Tier 3 practices will not be required to obtain an external credential to continue providing delegated care management services; the expectation for providers would be to deliver services according to updated NCDHHS-defined standards and to participate in required monitoring activities. NCDHHS is also exploring requiring Standard Plans to select a single vendor to monitor AMH Tier 3 delegates to reduce the care management monitoring burden on practices.

Hold Standard Plans Accountable for Timely, Effective Care Management: Standard Plans will be held accountable to specific metrics related to the proportion of their eligible members who complete key steps in the care management process and ultimately the outcomes they attain. In support of these goals, Standard Plans will oversee the effectiveness of care management across all settings. This also may include improving timeliness of Standard Plan- and AMH-conducted risk assessment and reassessment to match members with services.

Collect Data to Inform Actionable Care Management Policies and Improved Outcomes: In its re-procurement, NCDHHS seeks data to assess care management effectiveness to ensure efforts translate to better health outcomes. NCDHHS may assess how Standard Plans and AMH Tier 3 practices track and report data on care management effectiveness, including care transitions, chronic disease management, and avoidable hospitalizations. Evaluation will help refine care management efforts and ensure alignment with member needs. Data will also help NCDHHS effectively track the delivery of services, to recognize and reward effective engagement. In addition, NCDHHS will pursue augmented data sharing to support robust understanding of member needs and service delivery. NCDHHS is exploring strategies that facilitate rapid member outreach during public health emergency/disaster planning and response. To build on North Carolina's history of innovation in care management, NCDHHS seeks Standard Plans that will align processes and generate data that demonstrate value.

Feedback Requested. NCDHHS is interested in hearing from members, providers, community-based organizations, health plans, state and local officials, and other partners about the following questions related to care management:

- What aspects of the existing Medicaid care management model are the most impactful on improving patient care, outcomes, and experience? How is that impact understood or measured?
- How would increased alignment between an external standard for care management and the care management standards required of the AMH Tier 3 practices affect the delivery of care management services? How would it affect members' health outcomes?
- What care management services and overall infrastructure are most important for high-risk pregnant members?
- What innovative supports from health plans have had the highest impact in identifying and addressing members' non-medical needs? How can health plans do more to help maximize member enrollment in other federal and state programs that help connect them to non-medical benefits and services?

Increase Member Engagement in Primary Care

NCDHHS developed the AMH program to build upon the strong foundational population health management workforce and capabilities required for Carolina Access, strengthened and adapted to integrate into the promise of managed care. In its re-procurement, NCDHHS seeks to review and evolve AMH program design, improving assignment of members to primary care providers where they seek care, and exploring strategies to increase primary care, preventive care and utilization of care to address non-medical drivers of health for members currently not utilizing those services. The re-procurement will consider:

Re-assess AMH Program Requirements: While AMH providers continue to provide the same high level of care offered under the Carolina Access model, the AMH model has not been updated since managed care launch and re-procurement offers an opportunity to do so. NCDHHS will reassess AMH model requirements[25] to ensure access, simplify primary care requirements to focus on those that add the most value for members, and reduce burdens on providers.

Improve PCP Assignment to Better Support the Medical Home Relationship: All Standard Plans are currently required to assign members who do not actively select a primary care provider to a medical home using similar criteria, but NCDHHS continues to receive feedback from providers about the appropriateness of assignments and disruptions to continuous assignment.

NCDHHS maintains its commitment that all members, even historically unassigned members, should have a designated medical home. After conducting extensive research to further characterize the issues identified by providers and Standard Plans, as well as outreach to address data challenges that may have contributed to them, NCDHHS is considering changes to its assignment algorithm to better reflect where a member seeks care, by prioritizing recent visit history reflected in claims rather than past assignment. NCDHHS is also considering additional opportunities to improve assignment stability, increase transparency to providers on reasons for member assignment or reassignment, and reduce provider burden in updating member assignments while maintaining member choice.

Require Standard Plans to Take on Expanded Roles in Identifying and Engaging "Unengaged" Members: For members who are not engaged[26] with a primary care provider, NCDHHS is considering requiring Standard Plans to take on additional accountability in engaging these members. While these members would continue to be assigned to medical homes, Standard Plans could be required to make additional efforts to engage them in care, either directly or through a designated partner, and members would continue to be included in Standard Plan-level quality performance measurements. In addition, NCDHHS is considering requiring Standard Plans to provide further direct support to providers to augment their engagement efforts. An updated approach to engaging members may also involve changes to how providers' performance is measured in value-based payment initiatives to balance provider incentives for engaging members to balance incentivizing providers to open their panels to new patients while minimizing the quality

[25] See p. 7 of the Advanced Medical Home Provider Manual, available at https://medicaid.ncdhhs.gov/documents/providers/advanced-medical-home-provider-manual/open

[26] NCDHHS is considering definitions of engagement that would include visiting a primary care provider in the previous 12 or 18 months.

measurement impacts of members who are difficult to engage. The approach would give Standard Plans an additional incentive to engage members with their assigned primary care providers. (Further information about value-based payment programs can be found below.) Finally, NCDHHS is considering additional accountability related to requirements to maximize member enrollment in federal and state programs to address non-medical drivers of health.

Feedback Requested. NCDHHS is interested in hearing from members, providers, community-based organizations, health plans, state and local officials, and other partners about the following questions related to evolution of the AMH program and member assignment to medical homes:

- Are there changes to the AMH program expectations that would improve delivery of services to members, increase quality of care for members, or reduce provider burden? How is that impact understood or measured?
- Are there innovative ways NC Medicaid and Plans can support members in selecting medical home practices that will best meet their needs?
- Are there innovative models for linking unengaged members to primary care? How is success assessed for these programs?
- What role should Plans play in identifying and engaging with unengaged members directly? What can they do to support providers in identifying and engaging with unengaged members?

Incentivize Quality Care

NCDHHS is dedicated to improving the health of Medicaid members across the state. To measure and track health-related outcomes, NCDHHS holds Standard Plans accountable for specific metrics that indicate their ability to manage and improve member health (e.g., Standard Plans document the percentage of women ages 21-64 who receive cervical cancer screenings) and reflect public health priorities. These metrics are also used to compare Standard Plans' performance against their peers within the State and nationally. Some of these measures are tied to financial incentives through Standard Plan-level withholds for Standard Plans that meet and exceed quality standards.

NCDHHS stratifies measure performance to identify opportunities for reducing disparities and improving overall performance. For example, NCDHHS examines stratified Standard Plan-level performance on a measure of prenatal and postpartum care, a measure that records the percentage of postpartum members who had a timely prenatal visit early in their pregnancy and a timely postpartum visit after their delivery. Using this information, NCDHHS can target Standard Plan incentives to improve timeliness of care that can improve perinatal and postnatal health outcomes.

At the launch of managed care, NCDHHS planned a coordinated approach of measurement, performance improvement projects (PIPs) and withhold measures intended to advance a common

set of goals.[27] For key measures, such as blood pressure control and timeliness of prenatal care, performance showed improvement over time, although many measures remain at or below national medians.[28] NCDHHS is exploring approaches to improve Standard Plan performance and focus on additional measures that meaningfully improve member health.

In its re-procurement, NCDHHS seeks to advance quality measurement and value-based payment (VBP) program design and performance. Specifically, NCDHHS seeks to:

Increase Standard Plan Focus on Selected Measurement Topics: NCDHHS will emphasize quality improvement related to key health challenges facing North Carolinians (note that there is overlap between these areas):

- Pregnancy care and maternal health outcomes
- Chronic conditions
- Behavioral health
- Childhood-specific conditions
- Readmissions and other lower-value health care utilization

NCDHHS expects Standard Plans to coordinate efforts around these topics.

Enhance Standard Plan Accountability through the Withhold Program: The withhold program serves as a powerful incentive to influence Standard Plan-level performance and investments within Medicaid managed care programs. Under the CMS regulatory framework, NCDHHS retains, or withholds, a portion of Standard Plans' capitation payment (i.e., total Standard Plan payment for the care of their members), and the Standard Plans must meet or exceed certain quality measure performance targets to earn it. For state fiscal years 2025 and 2026 NCDHHS is withholding 1.5% of capitation, which is returned to Standard Plans based on their individual performance on a selected set of quality measures. In the future, operational requirements measures (e.g., a measure assessing electronic visit verification rates in home health) may be added. NCDHHS is considering how to modify the withhold program to best reflect State population health priorities, which could involve:

- *Updating the list of measures included in the withhold to capture emerging population health priorities*: NCDHHS will refine the withhold program to prioritize measures that emphasize Standard Plan-level support for timely access to care addressing the key health challenges listed above
- *Restructuring the program accountability approach*: While NCDHHS' initial approach to withhold design emphasized individual Standard Plan performance improvement over a Standard Plan's own baseline, NCDHHS is considering approaches that would reward collaborative efforts for statewide improvement

Strengthen Expectations for Standard Plans to Engage with the Health Information Exchange and Expand Clinical Data Sharing: In parallel with its transition to managed care, NCDHHS

[27] Implementation of the withhold was delayed to 2023 pursuant to NCGS 180D-65(5)a
[28] Quality Measure Performance and Targets for the AMH Measure Set. January 2025. HTTP://medicaid.ncdhhs.gov/nc-medicaid-quality-measure-performance-and-targets-amh-measure-set/download?attachment

continues to modernize its Medicaid data systems to support oversight of managed care plan performance and generate accurate, actionable information for program operations as well as performance measurement. As part of this process, NCDHHS secured funding from CMS to develop its data capabilities. Standard Plans should be active partners in these efforts, supporting contracted providers to improve their digital documentation capabilities and reporting digital quality measures and other data on topics such as care management and Health Related Social Needs (HRSN) screening to North Carolina. These efforts will include North Carolina's HIE, ensuring that complete data are available for all NC Medicaid beneficiaries. Standard Plans can use their engagement with providers to support improvements in the quality of clinical data shared through the HIE, as well as using other data shared through this program to augment care coordination efforts.

Increase Transparency and Public Reporting: As required in the Centers for Medicaid and Medicare Services' final rule on Medicaid and CHIP Managed Care Access, Finance and Quality[29], NCDHHS will expect Standard Plans to contribute to public reporting of Standard Plan-level quality data[30], as well as other relevant information, for the purpose of populating a website members can use to inform their selection of health plans.[31]

Update Standard Plans' Approach to Provider Performance Arrangements: To promote sustainable performance improvements, NCDHHS will pursue an updated approach to performance arrangements. Currently, Standard Plans' investment in value-based payment for providers has generated a fragmented landscape of incentive models that does not fully account for providers' differing capacities to engage in population health management and take on risk. Additionally, providers have noted that because Standard Plan-generated reports do not follow a single, consistent format, they are less likely to produce actionable insights to improve care and value. NCDHHS is considering standardizing and revising Standard Plan reporting requirements to facilitate improvements to incentivizing participation in value-based care.

NCDHHS will emphasize more streamlined lists of quality measures for standardized contracting requirements. NCDHHS has developed a standardized AMH performance incentive model, developed as a common option for AMHs across Standard Plans. This model concept, described in the AMH Standardized Performance Incentive Program Draft Policy Guide will serve as one key starting point for additional primary care payment reform over coming years, including potentially offering a Medicaid prospective payment methodology for primary care. NCDHHS expects its model to be one of a menu of incentive options Standard Plans will offer to primary care practices to ensure each practice can participate in a program that meets its population health management capabilities. NCDHHS will also require Standard Plans to offer performance incentive approaches that reach a wider range of provider types, particularly in areas of behavioral health and maternal health.

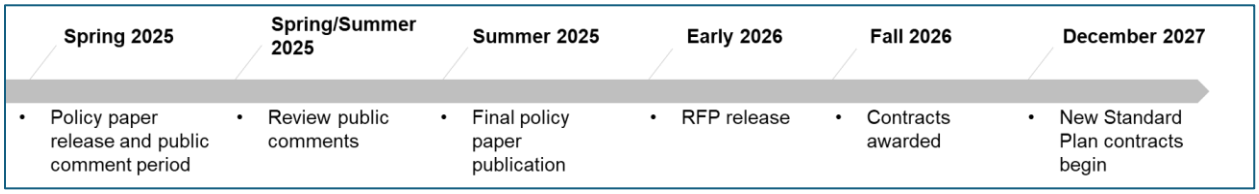
[29] 86 FR 41002, available at https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance
[30] 42 CFR 438.510
[31] 42 CFR 438.520

Feedback Requested. NCDHHS is interested in hearing from members, providers, community-based organizations, health plans, state and local officials, and other partners about the following questions related to leveraging quality measures and value-based payments to improve outcomes.

- What investments can plans make to support quality improvement in the specific areas of focus described above? What types of investments have had the greatest impact?
- How can Standard Plans support value-based payment models for providers of different sizes, level of resources and capacity for population health management? Which models are most appropriate for rural providers?
- Which value-based payment models, in North Carolina or elsewhere, are most effectively improving access and outcomes for specialty care? In what ways, specifically?
- Should NC Medicaid use value-based payment as a strategy to support better maternal health outcomes? If yes, how?

Key Dates and Opportunities for Feedback

NCDHHS will continue working with members, providers, community-based organizations, health plans, state and local officials, and other partners to refine this proposed program design. Feedback will be requested through public comment on this paper, and potentially other policy papers through the Spring of 2025 to inform the Department's Request for Proposals (RFP), to be released in early 2026. The new Standard Plan contracts will be effective in **December 2027**.



The program changes for North Carolina's Medicaid managed care plans were identified for their potential to improve the member and provider experience, enhance care management and ensure timely access to high-value care. NCDHHS is dedicated to improving the health of all North Carolinians.

Feedback on the Medicaid managed care proposed program design is welcome. Please send written input by May 7, 2025, to:

Email: Medicaid.NCEngagement@dhhs.nc.gov with the subject line of "Managed Care Program Enhancements Feedback"

U.S. Mail: Department of Health and Human Services, Division of Health Benefits, 1950 Mail Service Center, Raleigh NC 27699-1950

Drop-off: Department of Health and Human Services, Dorothea Dix Campus, Adams Building, 101 Blair Dr., Raleigh NC

Send questions about NC Medicaid transformation to Medicaid.NCEngagement@dhhs.nc.gov. For more information about transformation efforts, visit https://medicaid.ncdhhs.gov/transformation