North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Dempsey Benton, Secretary

September 4, 2008

The Honorable Beverly M. Earle, Chairman
Appropriations Subcommittee on Health and Human Services
North Carolina General Assembly
Room 634, Legislative Office Building
Raleigh, NC 27603

Dear Representative Earle:

Section 10.40F of S.L. 2007-323 (House Bill 1473), "Pilot Program/Medicaid Dual Eligible Special Needs Plan," required DMA to evaluate and establish a pilot program to offer dual eligible Medicaid recipients skilled nursing facility services through a "Special Needs Plan" working directly with Community Care of North Carolina in at least two, but not more than four, regions of the state and to submit a report to the General Assembly on the evaluation, selection, implementation, associated cost savings, and the feasibility of expansion of the pilot programs. It is my pleasure to submit the report at this time.

Please direct all questions concerning this report to Jeffrey Simms, Assistant Director for Managed Care at the Division of Medical Assistance. He can be reached at 647-8170 or via e-mail at Jeffrey.Simms@ncmail.net.

Sincerely,

Dempsey Benton

DB:dl

Attachment

cc: Dan Stewart
William W. Lawrence, Jr., M.D.
John Price
Sharnese Ransome
Jennifer Hoffmann
Legislative Library (2)

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2001 Mail Service Center • Raleigh, North Carolina 27699-2001
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Michael F. Easley, Governor

Dempsey Benton, Secretary

September 4, 2008

The Honorable Bob England, M.D., Chairman
Appropriations Subcommittee on Health and Human Services
North Carolina General Assembly
Room 2219, Legislative Building
Raleigh, NC 27601

Dear Representative England:

Section 10.40F of S.L. 2007-323 (House Bill 1473), "Pilot Program/Medicaid Dual Eligible Special Needs Plan," required DMA to evaluate and establish a pilot program to offer dual eligible Medicaid recipients skilled nursing facility services through a "Special Needs Plan" working directly with Community Care of North Carolina in at least two, but not more than four, regions of the state and to submit a report to the General Assembly on the evaluation, selection, implementation, associated cost savings, and the feasibility of expansion of the pilot programs. It is my pleasure to submit the report at this time.

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Michael F. Easley, Governor

Dempsey Benton, Secretary

September 4, 2008

The Honorable Verla Insko, Chairman
Appropriations Subcommittee on Health and Human Services
North Carolina General Assembly
Room 307-B1, Legislative Office Building
Raleigh, NC 27603

Dear Representative Insko:

Section 10.40F of S.L. 2007-323 (House Bill 1473), "Pilot Program/Medicaid Dual Eligible Special Needs Plan," required DMA to evaluate and establish a pilot program to offer dual eligible Medicaid recipients skilled nursing facility services through a "Special Needs Plan" working directly with Community Care of North Carolina in at least two, but not more than four, regions of the state and to submit a report to the General Assembly on the evaluation, selection, implementation, associated cost savings, and the feasibility of expansion of the pilot programs. It is my pleasure to submit the report at this time.

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Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Dempsey Benton, Secretary

September 4, 2008

The Honorable William Purcell, Co-Chair
Appropriations on Health and Human Services
North Carolina General Assembly
Room 625, Legislative Office Building
Raleigh, NC 27603

Dear Senator Purcell:

Section 10.40F of S.L. 2007-323 (House Bill 1473), "Pilot Program/Medicaid Dual Eligible Special Needs Plan," required DMA to evaluate and establish a pilot program to offer dual eligible Medicaid recipients skilled nursing facility services through a "Special Needs Plan" working directly with Community Care of North Carolina in at least two, but not more than four, regions of the state and to submit a report to the General Assembly on the evaluation, selection, implementation, associated cost savings, and the feasibility of expansion of the pilot programs. It is my pleasure to submit the report at this time.

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2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Dempsey Benton, Secretary

September 4, 2008

The Honorable Doug Berger, Co-Chair
Appropriations on Health and Human Services
North Carolina General Assembly
Room 622, Legislative Office Building
Raleigh, NC 27603

Dear Senator Berger:

Section 10.40F of S.L. 2007-323 (House Bill 1473), "Pilot Program/Medicaid Dual Eligible Special Needs Plan," required DMA to evaluate and establish a pilot program to offer dual eligible Medicaid recipients skilled nursing facility services through a "Special Needs Plan" working directly with Community Care of North Carolina in at least two, but not more than four, regions of the state and to submit a report to the General Assembly on the evaluation, selection, implementation, associated cost savings, and the feasibility of expansion of the pilot programs. It is my pleasure to submit the report at this time.

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Michael F. Easley, Governor

Dempsey Benton, Secretary

September 4, 2008

Susan Morgan, Interim Director
Fiscal Research Division
Room 619, Legislative Office Building
Raleigh, NC 27601

Dear Ms. Morgan:

Section 10.40F of S.L. 2007-323 (House Bill 1473), "Pilot Program/Medicaid Dual Eligible Special Needs Plan," required DMA to evaluate and establish a pilot program to offer dual eligible Medicaid recipients skilled nursing facility services through a "Special Needs Plan" working directly with Community Care of North Carolina in at least two, but not more than four, regions of the state and to submit a report to the General Assembly on the evaluation, selection, implementation, associated cost savings, and the feasibility of expansion of the pilot programs. It is my pleasure to submit the report at this time.

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REPORT ON PILOTING INTEGRATED CARE VIA DUAL ELIGIBLE SPECIAL NEEDS PLANS: RESPONSE TO SESSION LAW 2007-323, SECTION 10.40F

May 1, 2008

Background

With the graying of our population, North Carolina faces a growing population of vulnerable low-income elderly with long-term care needs. During calendar year 2006, dual eligibles (individuals qualifying for both Medicare and Medicaid) made up 21% of the NC Medicaid eligible population. Dual eligibles are a vulnerable group, one-third of whom need assistance with three to six activities of daily living (eating, dressing, bathing, etc.)[1] And though a large portion of their health care bills are paid through Medicare, in fiscal year 2007 the average dual eligible in NC had Medicaid expenditures that were 70% higher than those of a non-dual eligible.

One of the most challenging groups to care for within the dual eligible population are people who have functional, medical, or cognitive impairments that would qualify them for admission to a skilled nursing facility or an intermediate care facility. This group, the Nursing Facility Certifiable (NFC) population, is made up of those who reside in Nursing Homes (NHs), participate in the Community Alternatives Program for Disabled Adults (CAP DA) program, as well as functionally dependent individuals who receive care from family, assisted living arrangements, or other community resources. The number of functionally dependent seniors living in the community is estimated to be at least twice that of the number living in NHs.[2]

While data is not available on the entire NFC population, state fiscal year 2006-2007 data from the NC Division of Medical Assistance shows that the NH population and CAP DA population together make up about 5% of the Medicaid population and represent about 19% of all Medicaid expenditures (See Figures 1 and 2).[3]

Figure 1: Proportion of Medicaid Population made up of NH and CAP DA population (SFY07)

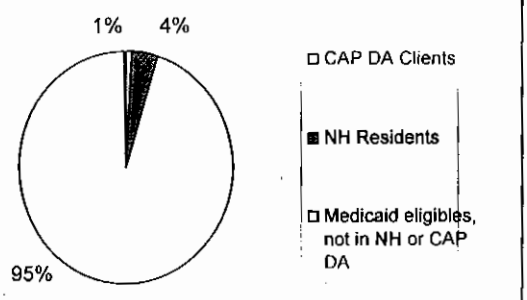
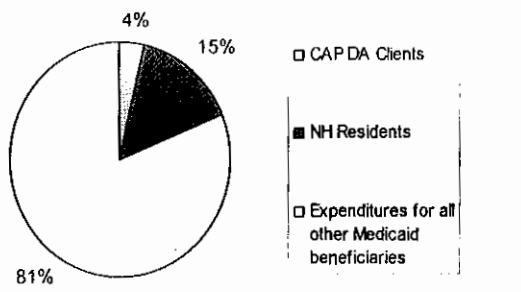


Figure 2: Proportion of Medicaid Budget spent on NH and CAP DA population (SFY07)



There is wide recognition that the array of services needed to care for the NFC population can be difficult to integrate, coordinate, and monitor. The CAP DA program was implemented to serve in this capacity, but with federal and county limits on numbers of participants many counties have long waitlists, some with eligible frail adults waiting for appropriate services for a year or more.

Over the past several years, the Centers for Medicare and Medicaid Services (CMS) has provided new programs to help states integrate Medicare and Medicaid services for these vulnerable individuals. However, even functionally independent and highly educated low-income seniors can be confused by trying to navigate a healthcare system that involves multiple separate insurers for inpatient care, home health care, durable medical equipment (Palmetto- Medicare Part A and Medicaid), outpatient care, personal care assistance and some vaccines (more than 50 plans are offered by 20 companies[4]). Since the Medicare Modernization Act of 2003, there has been an increased focus on integrating care and funding for care via Medicare Advantage Special Needs Plans.

Special Needs Plans were created by the Medicare Modernization Act of 2003 (Section 231) as either a new Medicare Advantage or Medicare Health Plan that would coordinate care (inpatient, outpatient, long-term care, and as of 2006, prescription medication) under one plan for individuals who were identified as:

1) institutionalized,
2) dually eligible for Medicare and Medicaid (DE SNPs), or
3) individuals with severe or disabling chronic conditions.[5]

CMS partnered with the Robert Wood Johnson Foundation and the Centers for Health Care Strategies (CHCS) in December 2005 to form an "Integrated Care" workgroup to help generate states' awareness of DE SNP products and remove administrative barriers to integrate Medicare and Medicaid services through these products. The workgroup was formed out of concern by patients, providers, and insurers that the current fee for service environment is fragmented and encourages increased volume of care and cost shifting instead of quality care management. There is a high level of interest among those involved in the workgroup toward having healthcare managed and delivered by one managed care organization that would have more focused accountability. There is also agreement that, if contracts and waivers are well planned, beneficiaries would have a much simpler system to navigate. This workgroup, along with foundations and health care policy organizations like CHCS, have now funded research and demonstration grants to encourage and assist states to coordinate with DE SNPs to better integrate care for the vulnerable dual eligible population.[6-8] Several states are coordinating with DE SNPs at this time and though it is too early to show evidence of improved quality of care for the participants, the states of Arizona, Minnesota and Wisconsin felt positive about their programs, and Florida was eager to get started. (Note: Florida is in the end of their design phase and their planned implementation is December 2008. Their report to their legislature dated January 2008 is attached in Appendix A).

In Session Law 2007-323, the North Carolina General Assembly directed the N.C. Department of Health and Human Services to "evaluate and establish a pilot program in at least two but not more than four regions of the State to offer nursing facility certifiable dual eligible Medicaid recipients services through a Special Needs Plan (SNP). ..." with

the hope that these plans could align incentives to meet long term care needs, ensure access, and provide quality and efficient services to this challenging population.

Potential Benefits of SNPs

Special Needs Plans are attractive in that they offer the *potential* for:

- Improved integration and coordination of inpatient, outpatient, and long term care services.
- Aligned financial and care goals — if all care is paid for by one source there is less incentive to hospitalize or do unnecessary tests or procedures and more incentive to care for the patient "in place" and keep them healthy.
- Simplifying materials given to beneficiaries about where to go with questions, problems — one source, one plan.
- Improved administrative efficiency if providers are able to bill just one plan.
- Predictable costs for the state for this population as a result of capitation.
- Potential access to claims data for inpatient, outpatient, and prescription drugs (information that has been lost to the state for duals as of January 2006) for these individuals. (Note: This must be part of the initial state-DE SNP contract.)

Potential Disadvantages of SNPs

Special Needs Plans are daunting in that they offer:

- Unknown quality of care and unknown effect on outcomes — thus far there is no evidence that these plans improve care. (Note: This evidence is being sought by CMS; data should be available in early 2009.)
- No savings guaranteed to state or federal governments, although there is a cost neutrality requirement. SNPs are "full risk" operations that work within the capitated amount, whether that means profit or loss. To ensure savings, the state would have to pay a capitated rate that is more favorable than current costs.
- This arrangement could shift more costs from Medicare to Medicaid. Over time, savings would accrue to the Medicare program due to shifting of care to outpatient services (e.g. treating ill nursing home patients on site instead of in a hospital). Many states have worked with plans to prevent this from happening, and believe that it results in improved care. (Note: Contracts for such arrangements need protective language to account for cost differentials.).
- Not all states have been able to simplify or coordinate enrollment materials and dates, giving beneficiaries the impression that they have two plans at some times and one plan at others, which can be confusing. Grievance procedures for Medicare and Medicaid remain separate in all states.
- Confusion when seniors move across county lines or go outside of their network of SNP providers for care.

Caveats for Proceeding with a Pilot

Neither quality improvement nor cost-effectiveness of SNPs has been proven in general. In fact, the measures by which to evaluate them are currently being finalized. "Since January of 2007, the Geriatric Measurement Panel (GMAP) of the National Committee for Quality Assurance (NCQA), funded by the Centers for Medicare & Medicaid Services (CMS), has been developing recommendations for evaluating SNPs. In March of 2007, NCQA proposed a potential list of evaluation measures for SNPs, which were approved by the GMAP in November 2007...to be finalized April 2008."[5] These recommended measures include thirteen HEDIS measures, and five Structure and Process measures (see boxes below). A report of the performance of SNPs based on these measures is expected in 2009 to CMS.

Proposed Measures upon which to Evaluate SNPs

HEDIS Measures

CMS is requiring SNPs to submit a subset of HEDIS measures for each SNP benefit package. All HEDIS submissions must undergo a HEDIS Compliance Audit™. Medicare Advantage (MA) contracts with multiple plans will report HEDIS on their entire book of business, in addition to the SNP submissions. Based on input from a subset of the GMAP, CMS is requiring each SNP to report the following HEDIS measures in 2008 to NCQA:

- Colorectal Cancer Screening*
- Glaucoma Screening in Older Adults
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy of COPD Exacerbation
- Controlling High Blood Pressure*
- Persistence of Beta Blocker Treatment After a Heart Attack
- Osteoporosis Management in Older Women
- Antidepressant Medication Management
- Follow-Up After Hospitalization for Mental Illness
- Annual Monitoring for Patients on Persistent Medications
- Potentially Harmful Drug-Disease Interactions
- Use of High Risk Medication in the Elderly
- Board Certification

*Measures that can be collected using the hybrid method which requires review of a systematic sample of medical records

Structure and Process measures

- Integration of benefits and services
- Case management
- Care transitions
- Member experience
- Clinical quality improvement

(Public comment ended 1/18/2008.) http://web.ncqa.org/tabid/625/Default.aspx

The experience of SNPs in general in North Carolina has been short and geographically limited. In 2007 there were 30 counties with access to either one, two, three, or four SNPs offered by two companies.[9, 10] Of the 4 SNPs in NC in 2007, 3 were for institutionalized Medicare beneficiaries and one for dual eligibles (DE SNP).[9] The

enrollment numbers of each plan were fairly small in their first year and both the cost and quality information are proprietary.

There one DE SNP product offered in NC last year was a SecureHorizons/Evercare product called Evercare Plan DH.[9] Two DE SNP products are offered in NC in 2008 — the previously offered Evercare Plan DH (now owned by parent company UnitedHealthcare) and a new DE SNP offered by Southeast Community Care (parent company Arcadian Health Inc). Only three counties have both DE SNPs available (Chatham, Orange, and Wake) and 31 other counties have access to one DE SNP or the other (see Appendix B and C for list and map). That leaves 66 NC counties with no access to a DE SNP product at this time.

Due to the higher cost of SNPs (CMS contracted an enhanced reimbursement of 110% to 112% of expected costs to all Medicare Advantage plans as part of the MMA) and the current lack of evidence of benefit from them, CMS has placed a moratorium on the creation of any new SNPs in 2008. Thus, creating a pilot now would require contracting with one of the existing organizations offering SNPs in our state at this time. Also, given the geographic specificity of the DE SNPs, the counties which could participate in any pilot starting in 2008 would be limited.

Supporting Reasons to Proceed with the Pilot

- The DE SNP products already exist in our state and are proceeding to enroll participants without state oversight, data sharing, or the integration of services that would make them advantageous to participants in the first place.
- This vulnerable population stands to gain a much easier-to-understand and navigate system of care that could offer care management as well.
- Our state could learn a great deal about the care management of a challenging population from large corporations who do this for profit. The data sharing agreements that could be a part of our contract would allow us to see Medicare claims and prescription drug data that are currently not available to us.

Other Considerations

Current federal guidelines prohibit altering the current plans/products to further target or limit enrollment. This means the plans must be open to enrolling all dual eligibles, not just those who are nursing home certifiable. As such, the pilot program will need to be broader than as specified in Section 10.40F of SL 2007-323.

In addition, the timeline to implement such a pilot is lengthy. The requirement outlined in Session Law 2007-323 to "evaluate and establish a pilot program in at least two but not more than four regions of the State to offer nursing facility certifiable-dual eligible Medicaid recipients services through a Special Needs Plan (SNP)" is likely to take years, not months (see Appendix D for a projected timeline to implement an integrated care program; developed by CHCS).

Practical Planning

With these issues in mind, there are multiple organizations, resources, and people ready and willing to help with this effort. In preparing this report the Medicaid managed care organizations in Arizona, Minnesota, Florida, Wisconsin and New York were all helpful and forthcoming with information about their experience with DE SNPs and offered to allow our state to see or use any of their contract language we desired. CMS and the CHCS both have websites with toolkits and roadmaps for states undergoing this endeavor.

Geographically, the options for choosing two to four multi-county regions as specified in Session Law 2007-323 are limited given the availability of DE SNPs in our state. On a conference call with CMS Region IV on February 19, 2008, we were informed that the moratorium on the creation of new SNP products would continue until the end of 2009. This means that during 2008 and 2009 the two existing plans will continue to build their base of experience in their current locations. Competition during this time will be limited to the existing local market.

In light of these constraints, the Division of Medical Assistance proposes that the Department of Health and Human Services explore identifying two regions for a coordinated DE SNP pilot.

The process for selecting the counties to participate in the regions should include, but not be limited to:

- The availability of a DE SNP in the county,
- The number of dual eligibles resident in the county,
- Special consideration of contiguous counties, and
- The number of CAP DA slots/allocations and the extent of the CAP DA waitlist in the counties of interest as a means to approximate unmet need for the frail elderly duals.
- Additionally, if there is an ongoing Medicare demonstration project or a high likelihood that another demonstration will be implemented in the county, those counties should be excluded from this pilot.

Conclusion

In summary, DE SNPs offer a potential way of turning a fragmented and difficult-to-understand world of disconnected providers and payors into an integrated managed care system for a vulnerable population. These plans are new and therefore do not have a record of sufficient duration to demonstrate evidence of improved quality of care. They also do not guarantee savings to states, but rather offer cost neutrality. Given the fact that the quality and cost effectiveness of SNPs has not been proven, this pilot should be aligned with the efforts of Community Care of North Carolina (CCNC) to manage the aged, blind, and disabled populations, and to build upon the "early lessons" learned and the CCNC management approach. NC communities, through these initiatives, are learning what program components and processes are needed to best support these individuals with chronic illness(es). The expectation is that a NC model,

in collaboration with CCNC, has the greatest potential to improve quality and contain costs. Such a model requires thoughtful and strategic planning as well as sufficient time to implement and evaluate.

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A Report to the Florida Legislature

Merits and Challenges of Integrating Payments and Services for People Eligible for both Medicare and Medicaid

December 2007

AHCA

Executive Summary

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Sources

Executive Summary

The 2007 Legislature asked the Agency for Health Care Administration to analyze the merits and challenges of seeking a waiver to implement a voluntary program that integrates payments and services for dually enrolled Medicare and Medicaid recipients who are age 65 or older. (See s.409.912(5)(f), F.S.) Since the passage of the 2003 Medicare Modernization Act (MMA), the federal direction on Medicare and Medicaid integration has focused on integration through Medicare Advantage Special Needs Plans. At the same time, Congress has not authorized the continuation of existing Medicare demonstration waivers. As a result, for Florida and other states, there is no current ability to fully integrate Medicare and Medicaid payments and services for dual eligibles through waiver authorities.

People who are eligible for services under both Medicaid and Medicare are known as "dual eligibles." They are people with low incomes who are age 65 or over or disabled adults under age 65. Florida serves an average of 476,500 dual eligibles each month. Nationally, annual health expenditures for dual eligibles are more than double those of the non-dually eligible--$16,278 versus $7,396. Finding ways to better integrate the two programs for this population could reduce this cost differential.

The basic differences between Medicaid and Medicare create barriers to integration. They have different provider requirements, payment systems, quality assurance provisions, and administrative structures. The coverage is different in each program, despite some overlap.

Medicare is the primary payer for dual eligibles with Medicaid secondary. Medicare pays for basic health services such as physician, hospital care and most prescription drugs. Medicaid pays for Medicare premiums, some cost sharing, and long-term care services, both in a nursing facility and in the community.

"Integration" in this report is defined as health care managed and delivered by a single managed care organization that receives two fixed monthly payments for each dual eligible enrollee—one from Medicaid and one from Medicare.

In the past Florida and other states have tested a variety of programs for seniors by seeking waivers from the federal government. The waivers allow states to offer a program on a limited basis without violating the federal requirements that all benefits be uniform for all Medicaid participants. While these waivers have been useful in trying new approaches, they are limited both in their scope and in their funding. Only a limited number of people can be served, funding is limited, and successful programs generate long waiting lists. Providers sometimes find waiver programs difficult to work with and often express concerns about whether funding will continue.

In the past few years the federal Centers for Medicare and Medicaid Services (CMS) have provided new mechanisms for the states to use to integrate Medicare and Medicaid that do not require waivers. Since 2003 the focus has been on integration through Medicare Advantage Special Needs Plans (SNPs).

This report describes the varying levels of integration that have occurred through Florida's current waivers and concludes that SNPs offer promise for full integration at the health plan level. There are hurdles to overcome in creating fully integrated SNPs, but the opportunities exist and are better options than continuing reliance on waivers. This is particularly true in light of there being no current Medicare waiver options available to states to integrate Medicare and Medicaid payment, since previously available Medicare payment demonstration authorities (i.e. 222 authority) have expired.

The best potential for integration on a large scale involves program design considerations for SNP, Florida Senior Care and the Nursing Home Diversion Program. This month CMS must submit an initial evaluation of the Medicare Advantage SNP operations. It will inform Congress of the impact of SNP operations to date and will be

used to assess what changes should be made to the program at the federal level to further integration and ensure cost effectiveness.

Medicaid is working with actuaries and national experts to remove barriers to integration through SNPs and current Medicaid managed care contracts. The immediate barrier is developing appropriate and budget-neutral wrap-around and/or cost sharing capitation payment for Medicaid beneficiaries who are also enrolled in the same contractor's Medicare SNP. Pursuing this course is preferable to seeking a waiver to accomplish service integration for dual eligibles.

1.0 Policy History and Report Requirement

Medicaid is the nation's health care program for low-income children, seniors and disabled adults. States operate the program using a combination of state and federal funds. The federal government requires all states to provide a minimum list of services and allows states to choose whether to offer some or all of a list of optional services.

Medicare is the federally operated health care program for seniors and disabled individuals.

In Florida, an average of 476,500 people are eligible for and receive services from both the federal Medicare program and Florida's Medicaid programs. Recipients of these services are commonly referred to as "dual eligibles." Across the nation, almost 7.5 million Medicaid beneficiaries are "dual eligibles" or low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to the National Health Policy Forum Issue Brief No. 794, "Health expenditures for the dually eligible population are more than double those of the non-dually eligible. In 1999, total annual health expenditures averaged $16,278 for each dual eligible compared with $7,396 on average for those who are not dually eligible." Most dual eligibles have long-term care needs.

The Medicaid and Medicare programs have different provider requirements, payment systems, quality assurance provisions, administrative infrastructures, and different but overlapping benefit packages. Policy makers regularly seek ways to improve the effectiveness and efficiency of serving this group, not only because it represents a large and costly group, but also because of the challenges of coordinating care and providers between the two separate programs.

For dual eligibles, Medicare is the primary health care provider with Medicaid secondary. Medicare pays for basic health services, such as physician and hospital care. Medicaid, in Florida, pays for Medicare premiums, cost sharing when the

Medicare benefit is less than what Medicaid would have paid alone, and critical benefits that Medicare does not cover, such as nursing facility and other long-term care services. Until 2006 when prescription drug services became available through Medicare, Florida paid those costs through its Medicaid program.

Dual eligible Medicaid and Medicare beneficiaries have low incomes, and according to the Kaiser Commission on Medicaid and the Uninsured, as of 2002, 73 percent of dual eligibles had annual incomes below $10,000. Most dual eligibles also have substantial health care needs with over half in fair or poor health, twice the rate of others on Medicare. Dual eligibles are also more likely to have mental health needs and to live in nursing homes when compared to other Medicare beneficiaries.

Like the Florida Legislature, the National Conference of State Legislatures, the National Governors Association, Congress and the federal Centers for Medicare and Medicaid Services (CMS) have all given heightened priority to Medicaid and Medicare integration over the past several years. In addition, foundations and health care policy organizations such as the Robert Wood Johnson Foundation and the Center for Health Care Strategies (CHCS) have funded research and demonstration grants to states to advance Medicare and Medicaid integration.

In 1996, the Department of Elder Affairs (DOEA) received a grant to develop the Community Long Term Care Diversion Pilot (also known as the Nursing Home Diversion Program), a program which coordinates Medicaid and Medicare service delivery for frail dual eligible Medicaid recipients. In recent years, Florida's executive agencies have capitalized on grant resources to help address budget rebalancing needs, alternatives to nursing homes and more recently, Medicare and Medicaid integration. The Agency for Health Care Administration (AHCA) and DOEA used a 2005 CHCS grant to identify barriers to integration and to help identify opportunities for integration in Florida, including developing a new integrated program known as Florida Senior Care. Through this grant, Florida participated in discussions with CMS and other states that led to CMS's "Integrated Care Roadmap." Most recently DOEA received a

CHCS grant to identify opportunities to transition the original diversion pilot into a more fully integrated home and community-based alternative. AHCA and DOEA work in partnership on all such grant projects that involve seniors on Medicaid.

As policy changes occur at the federal level and CMS unveils new opportunities for states such as integration through Medicare Advantage Special Needs Plans (SNPs) and alternatives to waiver authorities, Florida policymakers have more plentiful but pressing choices to make on the Medicare and Medicaid integration frontier.

This report addresses the requirements of Section 409.912(5)(f), F.S., that requires AHCA to submit a report by December 31, 2007, analyzing "the merits and challenges of seeking a waiver to implement a voluntary program that integrates payments and services for dually enrolled Medicare and Medicaid recipients who are 65 years of age or older." This report is also designed to organize information on trends, barriers, and opportunities for Medicare and Medicaid integration.

2.0 Medicare & Medicaid Integration Through Managed Care

For this report "integration" is defined as health care managed and delivered by a single managed care organization (MCO). The MCO receives two fixed monthly payments for each dual eligible enrollee—one from Medicaid and one from Medicare. This fixed payment is known as "capitation." The MCO operates two different health plans for these members, one delivering Medicaid and the other Medicare. The MCO's responsibility to deliver Medicaid community care services as well as at least some long-term nursing home care to dual eligibles is what makes the integrated plan comprehensive. An integrated program is easier for enrollees to navigate than a system with numerous entry points.

Managed care came of age in the 1990s in response to steeply escalating health care costs. Originally, state Medicaid agencies, including Florida, targeted managed care programs toward families and children. Later, efforts to manage and integrate acute and long-term care came through federally authorized demonstration programs and home-

and community-based waiver programs. Waivers and demonstrations are vehicles states can use to try new programs without violating the uniformity provisions of federal laws governing Medicaid and Medicare services. These projects demonstrated that managed care and integration play a key role in cost effective, quality health care for dual eligibles and long-term care recipients. Managed care programs offer budget predictability for states. In the area of managed care, CMS has provided new guidance to states through its "Integrated Care Roadmap" and related workgroup products and has relaxed some program restrictions to support improvements in Medicare and Medicaid program integration.

Managed Care Advantages

This report does not discuss the merits of fee-for-service delivery systems compared to managed care delivery systems. It assumes integration through managed care offers the following advantages:

- ✓ It offers cost containment alternatives in lieu of reducing enrollment; benefits, or provider payments; increasing co-pays; drawing down rainy day funds; and other short-term solutions to budget issues that arise because states have no authority over federal Medicare and Medicaid policies;
- ✓ It provides continuity of care for beneficiaries and providers;
- ✓ It increases flexibility in the types of services that can be provided to beneficiaries, i.e. nontraditional benefits may be available;
- ✓ It offers care coordination and management through a single health plan provider across Medicaid and Medicare;
- ✓ It supports interdisciplinary team service opportunities;
- ✓ It provides incentives to promote prevention services;
- ✓ Improved health outcomes are possible through coordinated care;
- ✓ It reduces the fragmentation of health care service delivery, care coordination and payments for both beneficiaries and providers;
- ✓ It decreases incentives to cost shift between Medicare and Medicaid; and
- ✓ It enhances budget predictability for state Medicaid agencies.

Capitation is an important tool in achieving budget stability. "By paying a single, fixed fee per enrollee, states limit their financial risk, passing part or all of it on to contractors. Also, states may hold one entity accountable for both controlling service use and providing quality care. That kind of focused accountability is impossible in the traditional fee-for-service system, in which the state pays many different providers for their respective components of care, but has no single entity to hold accountable for consumer or system outcomes." (American Association of Retired Persons, Issue Brief 79)

Barriers to Integration

Despite the stated advantages, there are difficulties inherent in integrating Medicaid and Medicare. As reported by the Congressional Research Service in 2006, "There are a variety of challenges in developing, enacting and implementing integrated Medicare and Medicaid programs. The specific circumstances will vary by state, but some of the challenges have included reconciling conflicting operational requirements between Medicaid and Medicare."

This report assumes that the following barriers to integration and quality exist:

- ✓ The current Medicare and Medicaid system is designed for acute care and results in fragmentation and poor transitions across care settings, preventing a systemic approach to care and prevention;
- ✓ Medicare and Medicaid maintain separate financing, contracting, reimbursement, and quality structures, while most high-risk beneficiaries use a full array of services from both programs;
- ✓ Medicare and Medicaid payment structures inspire mutual cost shifting;
- ✓ Medicaid and Medicare maintain conflicting disenrollment, marketing and data collection processes;
- ✓ Fee-for-service financing rewards providers for volume and procedures, not management of care;

- ✓ Uncertainty remains in capitated rate setting, especially in risk adjustment and bidding methods;
- ✓ Some Medicare Advantage managed care plans are reluctant to also become Medicaid managed care providers, creating problems in contracting and procurement; an integrated model requires the plan to be both;
- ✓ To be an approved plan, the MCO must follow separate requirements for Medicaid and Medicare;
- ✓ Because Medicare is the primary payer and states share in the federal cost of Medicaid, Medicare is likely to realize more cost savings than state Medicaid programs, except for nursing home stay reductions;
- ✓ States have a learning curve to prepare for a long-term care infrastructure for managed care;
- ✓ Plan benefits differ between Medicaid and Medicare;
- ✓ Medicare and Medicaid contracts cover different geographic service areas and contract periods;
- ✓ Providers worry about increased administrative burdens;
- ✓ Part D implementation (Medicare prescription drug coverage) is still experiencing program transition impacts; and
- ✓ Member grievance and appeals processes differ between Medicaid and Medicare programs.

3.0 Waiver Analysis and Integration Opportunities

The federal government may grant a state a waiver of specific Medicaid requirements. The waiver allows the state to operate a program that is not uniformly available to all eligible program participants. States including Florida pursue multiple waiver authorities to improve services for Medicaid recipients, as well as rebalance long term care budgets.

Until recently, waivers of specified sections of the Social Security Act were the primary vehicle for states to attempt any flexibility beyond the mandatory services every Medicaid program must offer and the optional services each state can elect to add to its

state plan. Attempts to provide long-term care in a setting less costly or restrictive than a nursing home were not possible prior to waivers nor were attempts to coordinate acute and long-term care.

Waivers to Integrate Payments:

Existing Medicaid waiver authorities do not however offer any opportunities to integrate Medicaid and Medicare payments for dual eligibles. In the past, states could apply for a Medicare Payment Demonstration (Section 222) waiver to fully integrated **payment streams** for these two programs. In fact, the states who have achieved the most progress toward fully integrating Medicare and Medicaid pursued these Section 222 waivers, which allowed CMS to authorize cost neutral Medicare payment demonstration waivers. These states advocated that, because dual eligibles usually have more costly and chronic needs than Medicare or Medicaid-only beneficiaries, the usual rate paid to Medicare MCO plans was not adequate to serve dual eligibles. Minnesota, Wisconsin and Massachusetts each obtained Medicare payment waivers under section 402/222, but these authorities expired and are no longer available to other states. This is due primarily to significant changes in Medicare's payment system for managed care plans which is now risk adjusted and deemed to be adequate to serve dual eligibles.

Some states have been frustrated by the demonstration nature of the waiver authorities and the fact that the authorities were temporary and subject to expiration. Further, after more than two decades of experimentation only a small percentage of dual eligibles are enrolled in integrated care programs nationally. The great majority remain in the Medicare and Medicaid fee-for-service systems, with little or no care coordination between the two systems. (Saucier, Burwell and Gerst, 2005)

Since 2003 the federal direction on Medicare and Medicaid integration has focused on integration through Medicare Advantage Special Needs Plans. Furthermore, Congress has not authorized CMS to continue the Medicare payment demonstration waivers. As a result, for Florida and other states, there is no current ability to fully integrate Medicaid

and Medicare payments and services for dual eligibles through Medicare demonstration waiver authorities.

Impact of Waiver Program Funding on Integration:

To further challenge integration potential, because waivers are optional, they often do not have dedicated funding sources and are therefore limited in their capacity to accommodate a significant portion of the long-term care population. This is in contrast to a Medicaid beneficiary's entitlement to an unlimited stay in a nursing home. A great deal of effort goes into designing waiver programs, but only limited numbers of people can be served due to the funding levels for HCBS waivers. There are often waiting lists for services. Additionally, these optional HCBS services are not covered by Medicare.

Also, any waiver designed for an integrated environment must incorporate managed care authority rather than fee-for-service. Fee-for-service waivers are not tools for true integration because multiple payments are made in fee-for-service (upwards of 20 if the waiver offers more than 20 home- and community-based services) as opposed to a single monthly capitated payment. Also, because Medicaid and Medicare services for dual eligibles do not match, a HCBS waiver as a stand-alone program cannot decrease fragmentation unless it is fully integrated with managed care.

Today, states are not limited to seeking waiver authority to integrate payments and services for dual eligibles. As new options for Medicaid and Medicare integration and the delivery of home- and community-based services have been presented by CMS, states have shifted away from waivers. Although new authorities beyond waivers have been presented to states in the past few years (Appendix A), Florida continues to have a large number of home- and community-based waiver programs. Florida should consider consolidating its HCBS waivers and/or other authorities available in Appendix A.

At the same time, waivers have merit and there are a number of Medicaid program waiver opportunities available to operate demonstration programs such as Florida's

Medicaid Reform pilots, to operate home- and community-based waiver programs such as the Florida Senior Care program, and to enter into managed care risk contracts as Florida does currently under both waiver and Medicaid State Plan authorities. There are, however, no Medicaid waiver authorities available that allow for integration of Medicaid and Medicare payment streams.

Varying Levels of Integration through Florida's Current Waivers

PACE

The merits of the managed care waiver have been demonstrated well through the Program of All-Inclusive Care for the Elderly (PACE), although the program faces expansion challenges. PACE began as a waiver, and the Balanced Budget Act of 1997 made PACE a permanent State Plan category. While PACE does integrate Medicaid and Medicare services and payment streams; this is a program that is difficult to replicate and has resulted in low levels of enrollment. As of June 2007, there were 37 operating PACE programs nationwide serving 14,000 older adults. There are ongoing efforts by providers and some states to expand the number of sites across the country.

PACE is a managed care approach to providing long-term care for disabled older adults who are eligible for Medicaid and are nursing-home certifiable. For each beneficiary, participating providers receive a capitated monthly payment from both Medicare and Medicaid. This allows maximum flexibility in meeting the person's primary care and long-term care needs. However, care is provided in an adult day health care setting and providers are limited to the adult day health care network. These provider choice restrictions, coupled with the complexity of the PACE application process, contribute to the concern that this model can not be efficiently duplicated on a large scale. The PACE application process requires a three party agreement, of which one part is a managed care organization application approved by Medicare. The second part requires an application to a state to be a Medicaid managed care organization. For the third party, a willing PACE provider, this entity is expected to invest significant capital and then endure a long process prior to generating any potential revenue. Additionally,

each PACE program requires a specific legislative appropriation. In the case of Florida's second PACE site, it was funded by the 2006 Florida Legislature, but the entity, on track to serve 200, is not operational as of the end of 2007 attributable to the very lengthy application approval processes.

Frail Elder Option

Florida's Frail Elder program is a Medicaid HMO that provides integrated medical and in-home long-term care to Medicaid beneficiaries in two counties in South Florida. It began in 1987 and serves approximately 3,000 Medicaid beneficiaries who meet nursing home level-of-care criteria, including dual eligibles.

Using a capitated arrangement, the Frail Elder program places contractors at risk for all long-term care services, including nursing home care for up to one year. The plan may then disenroll members who are long-term nursing facility residents in the next fiscal year of the contract. The only plan in operation is the Eldercare Plan offered by United Health Care.

Long Term Care Community Diversion Pilot

The Nursing Home Diversion Waiver Program targets frail dual eligibles that would otherwise qualify for Medicaid nursing home placement and currently serves almost 11,000 persons statewide. It provides them with a continuum of long-term care services that includes home- and community-based services, Medicaid-covered medical services not covered by Medicare (e.g., Medicare coinsurance and deductibles, dental, vision, and hearing services, and limited prescription drugs), assisted living facility care and nursing home care. This program operates through private managed care organizations that receive a per member per month capitation payment to provide, manage and coordinate all of the enrollee's care needs. The managed care plans are at full risk of payment for nursing home care.

Florida Senior Care

Florida Senior Care (FSC) is a managed, integrated care program that will serve Medicaid eligibles age 60 and over and dual eligibles age 21 and older. FSC targets 136,709 Floridians in the pilot areas (115,905 dual eligibles and 20,804 Medicaid only recipients over age 60). By including dual eligibles, FSC presents a managed care program that could serve a very significant population statewide (323,560 total: 71,067 dual eligibles aged 21-59, 208,495 duals age 60 or older, and 43,998 Medicaid only eligibles age 60 and older). The provision of home and community based services to enrollees is authorized by an approved Medicaid waiver and Medicaid managed care contracts are authorized under Medicaid state plan authority. All Medicaid services are to be available to enrollees in the pilot areas, including long-term care services. Florida Senior Care will be piloted in two areas: Central Florida (Orange, Seminole, Osceola, and Brevard Counties) and the Miami area (Miami-Dade and Monroe Counties). Enrollment is voluntary and a beneficiary may disenroll at any time.

Within the FSC program, the plan to deliver services using MCOs is designed to accomplish both an integrated service delivery model and fixed payment financing. The creation of a capitated payment structure will give the MCO flexibility to expend resources on the care that is most needed. The coordination of the delivery of all Medicaid services under one MCO will establish accountability for the delivery of high quality care to Medicaid beneficiaries. In the case where an MCO has two separate contracts to provide both Medicaid and Medicare services to a dual eligible enrolled in both the MCO's Medicaid and Medicare plans, the MCO can further coordinate care at the health plan level. AHCA and DOEA are exploring the benefits and challenges of requiring that FSC MCOs be Medicaid managed care providers plus Medicare Advantage or SNP managed care providers, to further ensure integration and coordination.

FSC Voluntary Enrollment

The 2007 Legislature requested an analysis of the voluntary component of an integrated program for Medicaid and Medicare. A November 2007 draft consultant

report on Florida Senior Care reported discussion of the program's mandated voluntary enrollment as a potential pitfall since providers may not be able to anticipate or achieve an enrollment level high enough to yield capitation sufficient to support delivery of the required services. Furthermore, under this waiver, home- and community-based waiver services (HCBS) are not guaranteed unless waiver funding is available. This means the health plan provider must offer HCBS if funding is available through attrition from other HCBS waiver programs, or if the Legislature provides dedicated FSC waiver funding. As an alternative, the health plan provider could choose to offer HCBS as expanded services or substitute them for certain other services, however the health plan's enrollment levels and capitation payments must be sufficient to support this. The MCO is not required to offer HCBS if waiver funding is not available.

One other identified risk to success for Florida Senior Care, which includes a 1915(c) waiver as program authority, includes competing service delivery systems created by multiple waiver and other service programs in the mandated pilot areas. This risk may result in low enrollment levels and is compounded by the voluntary characteristic of FSC and the lack of dedicated home- and community-based waiver funding for implementation of this new program. Further, allowing a health plan to choose to cover either Medicaid eligibles over age 60 or all dual eligibles over age 21 also potentially dilutes enrollment in this integrated waiver program.

Florida Senior Careand Aging Network Providers

In Florida, HCBS funds for seniors typically are appropriated to the Department of Elder Affairs, which, in turn, allocates the dollars to Florida's Area Agencies on Aging (AAA) to manage and provide home- and community-based waiver services. Contracting with a managed care entity to provide HCBS that have previously been provided by Florida's aging network providers could affect Florida's AAAs. Instead of receiving funds directly to provide HCBS, the aging network providers would be in a position to become subcontractors with the managed care organization. By subcontracting with a Florida Senior Care managed care provider, aging network providers could function as care

managers or service providers. This arrangement has worked in a similar way with counties in Minnesota. (Brandeis) Similar contractual relationships exist in other states' integrated care programs as well, including Massachusetts and Washington state. Subcontract relationships with Florida's aging network providers may be piloted and encouraged as a part of Florida Senior Care.

4.0 Integration: Other Opportunities

While waivers have been useful in testing different kinds of services, they do not in themselves provide an opportunity for full integration of Medicaid and Medicare services and payment streams for dual eligibles. It would be wise to explore current integration opportunities further to help overcome the systemic barriers to integration and to provide more opportunities for integration for Florida's over 400,000 dual eligible Medicare and Medicaid beneficiaries.

As a result of new federal opportunities to integrate Medicaid and Medicare through the use of Medicare Advantage Special Needs Plans, CMS began the Integrated Care Initiative in December 2005 by forming a workgroup "to remove administrative barriers to implementing Special Needs Plans (SNPs) and to generate state awareness of the opportunity to better integrate care for individuals who are dually eligible." The overall goal of integrated care is to provide the full array of Medicare and Medicaid benefits through a single delivery system that will provide quality of care for dual eligible beneficiaries, better care coordination and fewer administrative burdens. CMS offers what it calls an "Integrated Care Roadmap" on its Web site at www.cms.hhs.gov.

The site offers four models that states and managed care plans have used to integrate Medicare and Medicaid services. They are:

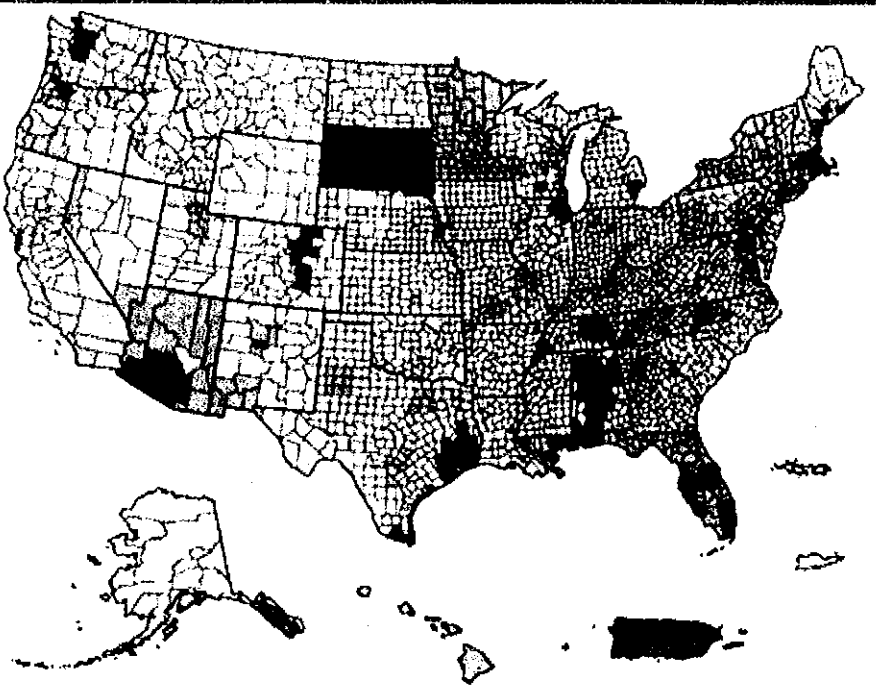
- ✓ Buy-in wraparound model, which partially integrates Medicare and Medicaid services
- ✓ Capitated wraparound model, also a partial integration approach
- ✓ Three-party integrated model; and
- ✓ Plan-level integrated model.

Appendix B provides details on each model from the CMS guide.

Special Needs Plans

The Medicare Modernization Act of 2003 (MMA) established the Medicare Advantage (MA) Special Needs Plan (SNP) program as a way to permit MA plans to demonstrate their ability to manage the care of certain high-cost elderly beneficiaries more efficiently and effectively. The MMA specifically required CMS to create a new type of Medicare Advantage coordinated care plan focused on individuals with special needs. Congressional intent was to give MA special need plans the ability to target a population and make a difference to that population by focusing on clinical outcomes in addition to cost savings. "Special needs individuals" were identified by Congress as: 1) institutionalized; 2) dually eligible; and/or 3) individuals with severe or disabling chronic conditions. The graphic below illustrates the types of special needs plans across the country.

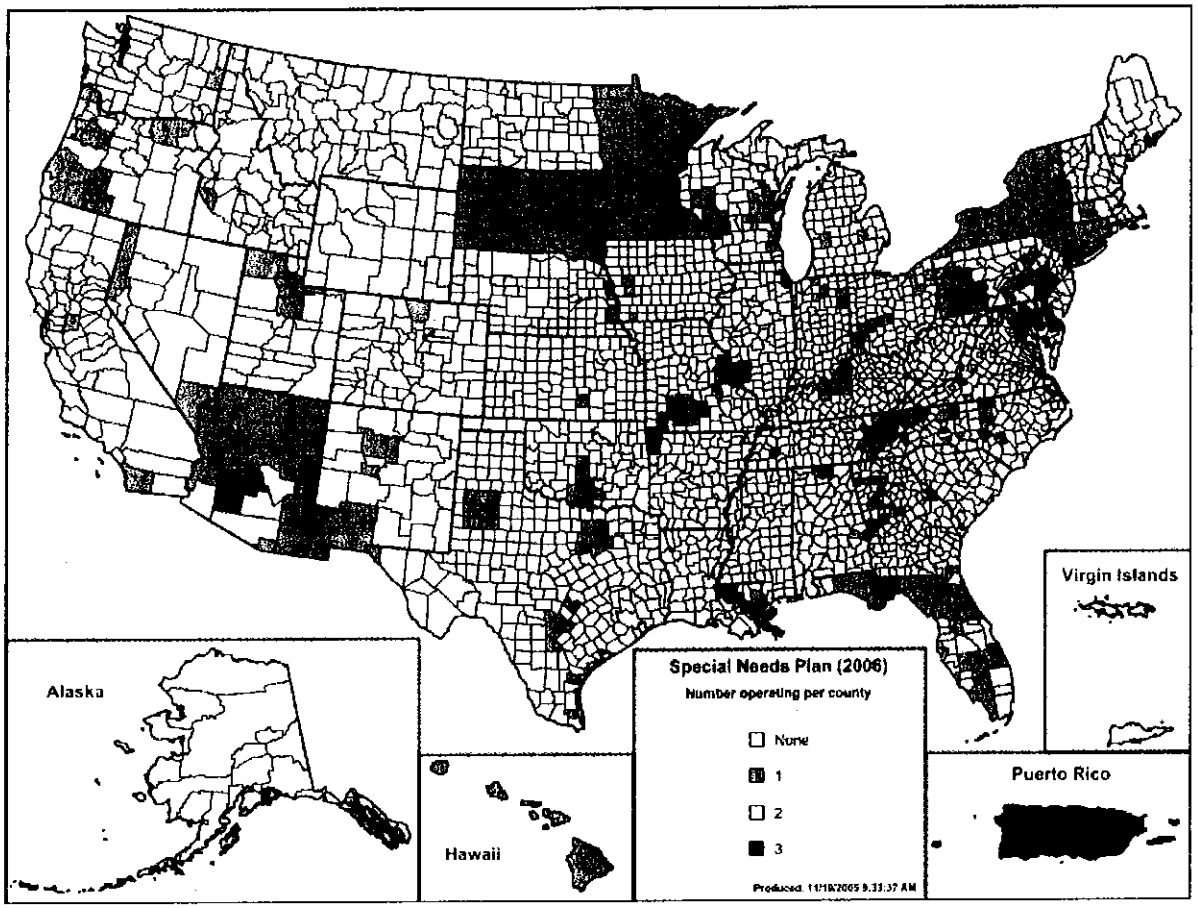
SPECIAL NEEDS PLANS by SNP type



- None
- Dual eligible
- Institutional
- Both dual eligible and institutional
- Chronic or disabling condition
- Both dual eligible & chronic or disabling condition
- Both institutional & chronic or disabling condition
- Dual eligible, institutional & chronic or disabling condition

MPR Source: Centers for Medicare & Medicaid Services

The map below represents the number of SNPs operating in each county as approved for 2006.



Because SNPs are specifically authorized under federal law, they offer states the opportunity to combine Medicare and Medicaid managed care contracting for dually eligible beneficiaries without having to secure special demonstration or waiver authority from CMS.

In 2007, CMS reported that 310 SNPs had already been approved, most of which (225) were dual eligibility SNPs. (CMS, 2007) First and foremost, however, SNPs are Medicare Advantage plans, and there is nothing in the Modernization Act that requires them to also provide Medicaid services or coordinate their activities with state Medicaid programs. In fact, it is entirely possible that the majority of SNP plans will simply provide Medicare-covered benefits for dual eligibles (at the higher capitation rate that CMS pays for this group) and *not* attempt to enter into managed care contracts with state Medicaid programs for coordinated coverage of Medicaid-covered benefits. (Thomson Medstat)

On the other hand, the Medicare Modernization Act also gave Medicaid plans a one-time opportunity to seek SNP designation and "passively enroll" dually eligible members into their companion Medicare plans as part of the initial Medicare Part D enrollment process between 2005 and 2006. With the current integrated care demonstrations serving as prototypes, SNPs are commonly viewed as the logical next step toward integration. A Medicare SNP willing to enroll as a Medicaid HMO provides new opportunities to better coordinate and even fully integrate.

However, based on the structure of the current Florida Medicaid program and current contracting strategies integration can occur only at the plan level, so the coordination of care would be limited (would not include coordinated enrollment, eligibility periods or payments). This means a MCO with a Medicaid plan contract and a Medicare plan contract could coordinate care for individuals who choose to enroll in both the Medicaid and Medicare plan offered by the single provider. The plan could then coordinate the beneficiaries' care across both plans. Under this scenario, the MCO would independently market to Medicare beneficiaries, and dual eligibles would still receive separate Medicaid and Medicare marketing and enrollment materials. Enrollment

timeframes would not be parallel, though some states have arranged with CMS to offer a single enrollment form for both the Medicaid and Medicare plans offered by the same provider. Florida is exploring streamlined enrollment and marketing through Florida Senior Care.

SNP integration could be better achieved with the following:

- ✓ Wrap-around Medicaid capitation,
- ✓ Coordinated SNP and Medicaid plan enrollment,
- ✓ Coordinated health plan benefit packages,
- ✓ Integrated marketing materials and evidence of coverage,
- ✓ Coordinated grievance and appeals processes,
- ✓ Integrated performance measures,
- ✓ Inclusion of long-term care.

State Perspectives on SNP Integration

In early 2007, in its "State Policy Perspectives on Special Needs Plans" Thomson Medstat reported numerous issues states believe need to be addressed to make the SNP option more attractive to state Medicaid programs. Information from Thomson Medstat and Florida Medicaid officials includes:

- ✓ *State role in dual SNP certification*: The most common issue cited by state officials was the absence of any role for states in the certification of dual eligible SNPs. The majority of dual SNPs certified to date have no affiliation whatsoever with state Medicaid programs. That is, they enter the market to provide Medicare services to dually eligible beneficiaries, with guarantee to execute a companion Medicaid contract.
    - o This makes it difficult to incorporate SNPs into a state's purchasing strategy for long-term care and other services for dually eligible beneficiaries.

- In active SNP markets like Arizona, Florida and Texas, officials note that dual eligibles in Medicaid managed care plans are sometimes being actively marketed by "unaffiliated" SNPs.
- In Florida, enrollment in a SNP that does not have a specific Medicaid contract, by state policy, results in disenrollment from a Medicaid managed care plan.
- A few states also reported that some unaffiliated SNP plans were approaching the state asking for Medicaid wrap-around contracts, as if they were somehow automatically entitled to those contracts. (The Medicaid wrap-around refers to how Medicare and Medicaid work together for individuals who are dually eligible for both programs. Specifically, Medicare serves as the primary payer, and Medicaid "wraps around" coverage to fill in gaps in Medicare coverage and pick up most or all Medicare co-payments.)

✓ *Marketing*: Marketing strategies of SNPs are governed by federal Medicare Advantage marketing provisions. Cognizant of marketing scandals in some early Medicaid managed care programs, most states have adopted Medicaid marketing controls that are more restrictive than Medicare Advantage provisions. This may give unaffiliated SNPs somewhat of a marketing edge over state-affiliated SNPs that have agreed to more restrictive marketing provisions in their Medicaid contracts.

✓ *Open Enrollment*: Dually eligible beneficiaries are free to disenroll from Medicare Advantage health plans (including SNPs) on a month-to-month basis, whereas Medicare-only beneficiaries may switch plans only during an annual open enrollment or special enrollment period. In theory, the monthly option protects dually eligible beneficiaries and allows those in integrated products to switch easily if they lose Medicaid eligibility. In practice, however, states are already noting higher levels of plan changes that are not related to changing Medicaid status, but rather results from marketing by unaffiliated SNPs.

- ✓ *Consistency of Medicare benefits and cost sharing*: SNPs' ability to vary their benefit packages and cost sharing requirements could potentially result in a lack of uniformity across state integrated products. For states, payment of cost sharing is difficult when they do not receive a bill from a Medicare managed care provider with adequate information on services provided. Further, Medicare managed care plans are free to impose cost sharing on members that are different from those employed in FFS Medicare, as long as the overall Medicare capitated benefit package is actuarially equivalent to coverage under traditional FFS Medicare.
- ✓ *Data sharing*: In order for SNPs to be viable partners on integrated products, states believe they need data to which they currently are not assured access. One important set of data to assist states in setting capitated rates are the bids that SNPs make to CMS. Also, the systems need to accomplish the sharing of data related to quality, enrollment and claims payments. Medicare encounter data is also not readily available to states, except through written agreements between states and Medicare. However, these written data sharing agreements and the available data are currently not geared toward informing integrated programs.
- ✓ *Alignment of incentives*: States believe that combined Medicare and Medicaid products are beneficial for dually eligible consumers and their families, but they note that state incentives for partnering with SNPs are unclear at best. To the extent that well-coordinated care results in decreased Medicare hospital costs, CMS and SNPs share in those savings, but states do not, directly.
    - o States would like to see a three-way incentive that allows state Medicaid programs, SNPs and CMS to share any savings that result from combined Medicare and Medicaid products.
- ✓ *Provider and county-based plans:* The early evidence suggests that small provider organizations or counties may not be well-suited or inclined to become SNPs. Issues include administrative burden, financial reserves to meet HMO solvency requirements, inexperience with acute care risk and, for counties, the political hazard of passing on financial risk to county taxpayers.

- ✓ *Medicare payments:* In the past, states with dual eligibility demonstrations negotiated special Medicare payments that they believe better account for the cost of dually eligible beneficiaries than Medicare Advantage's mainstream risk adjustment system. What remains to be seen is whether mainstream Medicare payments are adequate because the demonstration payments are not standard.

5.0 Florida's Current Integration Activities

Despite efforts to integrate, Florida's long-term care delivery system remains only partially integrated. The best potential for integration on a large scale involves Medicaid program design considerations for SNP, Florida Senior Care and the Nursing Home Diversion Program.

SNP Integration

Medicaid is working with actuaries and national experts to remove barriers to integration through SNPs and current Medicaid managed care contracts. This includes identifying and resolving systems issues that impact the ability for dual eligibles to be enrolled simultaneously in the same contractor's Medicaid managed care plan and Medicare SNP. The immediate barrier to SNP integration through our current Medicaid contractors is developing an appropriate and budget neutral wrap-around capitation payment for Medicaid beneficiaries who are also enrolled in the same contractor's Medicare SNP.

It is important to note that on the federal level, consideration has been given to including in reauthorization language a requirement that all SNPs contract with state Medicaid programs. It is however, too soon to tell how any reauthorizing legislation for the SNP program will impact state Medicaid programs and state purchasing strategies for providing coverage to the dual eligible population. On December 31, 2007, the Centers for Medicare and Medicaid are required to submit an initial evaluation of the Medicare Advantage Special Needs Plan operations. This CMS evaluation will inform Congress of the impact of SNP operations to date and will be used to assess what changes should be made to the program at the federal level with the intent of furthering

integration and providing a cost-effective option for providing integrated care for dual eligibles. Congress must then determine whether or not to extend the program beyond its current sunset date of December 2008.

In addition, CMS continues to identify and remove barriers to integration where possible. This has been done through policy decisions at the federal level, including allowing states and health plans to target specific Medicaid recipients in integrated programs. In 2008, CMS will allow SNPs to limit their enrollment into a dual eligible SNP to coordinate with the enrollment groups that the state Medicaid program was targeting. This may include limiting an integrated product to waiver enrollees or certain special target groups. CMS states, "Specifically, the new policy applies to dual eligibles in SNPs, who are receiving care under a Medicaid program which has an integrated arrangement with that Plan. For example, if a State Medicaid Agency contracts for a Medicaid wraparound package for certain dual eligibles with a plan, which also contracts with a SNP, the SNP may limit enrollment to that subset of dual eligibles."

Florida's SNP activities include the Florida Senior Care pilot and policy developments related to cost sharing. Florida Senior Care represents an opportunity to pilot a higher level of Medicare and Medicaid plan level integration in a small (non-statewide) area. Medicaid is exploring a requirement for program providers to either be, or partner with, Special Needs Plans. Such a requirement would help Florida, the state with one of the highest percentage of Special Needs Plans, specifically test Medicare and Medicaid integration efforts similar to those already occurring in other states.

Agency activities related to cost sharing policies include:

- Historically, AHCA has not paid cost sharing (deductibles and co-insurance) for dual eligibles enrolled in a Medicare Advantage Plan or Medicare Special Needs Plan (SNP), both of which are reimbursed by Medicare via capitation payments.
- In 2000 CMS issued a Transmittal Notice notifying states of the requirement to cover Medicare cost sharing for Qualified Medicare Beneficiaries (QMBs). This

includes cost sharing for QMBs enrolled in Medicare capitated plans. QMBs are duals with incomes up to 100% of the federal poverty level.

- It is AHCA's understanding that this requirement only applies to SNPs (Medicare capitated plans that target only dual eligibles).
- Based on discussions with AHCA's actuary, the Agency can pay SNPs a capitation rate that is less than the fee-for-service experience for Medicare cost sharing.
- When AHCA implements payment to SNPs for cost sharing, it predicts a transition of QMBs will occur from the Medicare fee-for-service to Medicare SNP plans.
- It is anticipated that savings associated with this transition of QMBs will fully cover the cost of implementing capitation payments for QMBs currently enrolled in Medicare SNP plans, and, thus, implementation of Medicaid capitation payments for QMBs in Medicare SNP plans is anticipated to be budget neutral.

DOEA Diversion, CHCS Grant Opportunity

Utilizing a 2007 grant award to DOEA from the Center for Health Care Strategies, Florida is exploring enhancing and expanding its Medicaid Nursing Home Diversion Waiver Program. The program began in 1998 as a pilot in two counties serving 800 beneficiaries with a budget of $22 million. It now serves more than 10,000 beneficiaries in 30 counties and a budget of $217 million.

First, Florida would like to enhance current program operations by developing and implementing a system of performance and outcome measures. Second, Florida would like to expand the program with the goal of integrating Medicare and Medicaid. This would involve working with providers that now offer MA-SNP plans to better coordinate Medicare acute and Medicaid long-term care services.

Although the Nursing Home Diversion program is considered successful in providing integrated care with a focus on community-based long-term care for frail Medicaid beneficiaries, limitations to this model and models like the Frail Elder Option do exist.

They include the requirement that participants meet high frailty criteria (nursing home level of care) to enter these programs. This ensures that the programs serve only individuals that are most needy, but it also increases the financial risk to the managed care plans and denies the plans the opportunity to provide preventive services before frailty advances and caregivers burn out from their care duties.

These successful managed long-term care programs have therefore been unable to integrate the delivery of Medicare and Medicaid services for the majority of the dually eligible Medicaid population that do not meet nursing home level of care. The proposed Florida Senior Care pilot program attempts to remedy this by expanding beyond current models of care delivery in Florida to developing the state's most integrated care program to date.

Healthy Elders and Young Adults, the Potential of Florida Senior Care

The 2004 Florida Legislature directed AHCA to create an "integrated, long-term, fixed payment, delivery system for Medicaid beneficiaries age 60 and older," in partnership with DOEA. The 2007 Legislature approved the program but changed the design to also serve dual eligibles over age 21 and make it a voluntary enrollment program. This comprehensive health and long-term care service system, called Florida Senior Care, is to be piloted in two areas of the state with the goal of creating an integrated care management model designed to serve consumers in their community.

By having one managed care organization provide all Medicaid services for participants age 60 or older, 21 or older, or both; Florida Senior Care could provide a remedy for Medicaid beneficiaries to address the current fragmentation of service delivery. A Senior Care health plan enrollee would have one place to contact to arrange for health care services and would be assigned a care coordinator. A care coordinator will be especially beneficial for dual eligibles, who represent a large percent of those eligible for FSC in the selected pilot areas. These dual eligibles may continue to receive Medicare services as they do now, but the FSC care coordinator will be responsible for coordinating the delivery of Medicare and Medicaid services and helping with early

identification of people at risk of nursing home placement. Below are estimates of the populations that could be served.

FLORIDA SENIOR CARE ELIGIBLES As of December 2007	Duals 21-59	Duals 60+	Total Duals	Medicaid Only 60+	TOTAL (By County)
AREA 7					
Brevard	1,997	3,696	5,693	626	6,319
Orange	4,056	9,734	13,790	2,249	16,039
Osceola	934	2,330	3,264	670	3,934
Seminole	952	2,020	2,972	502	3,474
	7,939	**17,780**	**25,719**	**4,047**	**29,766**
AREA 11					
Dade	9,971	79,412	89,383	16,597	105,980
Monroe	270	533	803	160	963
	10,241	**79,945**	**90,186**	**16,757**	**106,943**
TOTAL (By Group)	**18,180**	**97,725**	**115,905**	**20,804**	**136,709**

The inclusion of all elder and dual eligible Medicaid beneficiaries in this proposed pilot program, rather than just those who are frail and in need of formal long term care services, will allow the Florida Medicaid program to deliver integrated Medicaid and Medicare services to more of the state's dual eligibles than ever before.

Conclusion

Planning for integration is very important though complex. As reported by the Center for Health Care Strategies, "For dual eligible beneficiaries, Medicare services should be integrated (with Medicaid) – resulting in a seamless system of care for the beneficiary. Recognizing this may not be feasible immediately, Medicaid purchasers, plans and policymakers can begin to put in place the essential building blocks necessary to move along the continuum of integration. Those are: (a) a system for managing care; (b) an entity accountable for doing so; (c) flexible financing to support getting the right services

to the right patients at the right time; and (d) mechanisms to involve patients and their caregivers in meeting their care needs."

Florida has varying levels of integration, or building blocks in progress. The most promising direction for the future is integration through Special Needs Plans, rather than home- and community based waiver programs. Medicaid will be working on the SNP integration policy opportunities through Florida Senior Care.

Special Note: On December 29, 2007, the President signed into law the Medicare, Medicaid, and SCHIP Extension Act of 2007. This Act affects SNPs in the following ways:

- *Extends the authorization for SNPs from December 31, 2008 to December 31, 2009.*
- *Imposes a moratorium on the approval of SNPs after December 31, 2007. This means Medicare Advantage (MA) organizations may continue to offer existing CMS approved SNPs through December 31, 2009. This also means MA organizations may not offer a SNP in any area where that SNP was not already offered prior to January 1, 2008. CMS will monitor and provide technical assistance to MAs with SNPs in accordance with existing contracts, but will not approve any reconfiguration of SNP type, SNP subset or SNP service area.*

It is unclear how this legislation will impact Medicare and Medicaid integration over time. In the near term, opportunities for integration using SNPs as vehicles are available.

Appendix A

CMS' At-A-Glance" Guide to Medicaid Authorities for Integrated Programs

Authority	Description	Key Flexibility/Limit
1915(a) Exception to State Plan Requirement for Voluntary Managed Care	Used to authorize voluntary managed care programs on a statewide basis or in limited geographic areas implemented through CMS Regional Office approval of the managed care contract.	No waiver or state plan required. No mandatory enrollment or selective contracting.
1932(a) State Plan Amendment	State plan authority for mandatory and voluntary managed care programs on statewide basis or in limited geographic areas. State may choose to include dual eligibles as part of broader managed care program authorized under section 1932(a).	No waiver, permanent state plan authority. No cost effectiveness test. Allows for selective contracting. No mandatory enrollment of dual eligibles, but duals may enroll voluntarily.
1915(b) Waivers	Two year, renewable waiver authority for mandatory enrollment in managed care and/or selective contracting with providers on a statewide basis or in limited geographic areas. 1915(b) waivers must demonstrate their cost-effectiveness and must not substantially impair beneficiary access to medically necessary services of adequate quality.	Permits mandatory enrollment of dual eligibles. May provide additional health-related services through 1915(b)(3). Waiver requirements are more administratively burdensome compared to 1915(a) or 1932(a).
1915 (c) Home and Community Based Services (HCBS) Waivers	Renewable waiver authority permitting states to provide long term care services delivered in community settings instead of institutional settings. 1915(c) waivers must be cost neutral and are renewable for 5 years following the initial 3 year approval.	Cannot waive "freedom of choice" of providers.

Authority	Description	Key Flexibility/Limit
Concurrent 1915(a)/(c) Authority	Used to implement a voluntary managed care program that includes HCBS services in the managed care contract.	Cannot waive "freedom of choice" of providers or selectively contract with managed care organizations.
Concurrent 1915(b)/(c) Waivers	Used to implement a mandatory managed care program that includes HCBS in the managed care contract. 1915(c) permits a State to target eligibility and provide the HCBS. 1915(b) allows State to mandate enrollment in managed care plans that provide HCBS services.	Allow selective contracting with managed care plans. Requires administration of two separate, concurrent waivers with separate reporting requirements.
1915(i) HCBS State Plan Option	Permits states to amend State Plans to offer HCBS as a state plan optional benefit effective January 1, 2007.	No level of care requirement. Cannot expand eligibility. Income can not exceed 150% of Federal Benefit Rate. States must establish needs based criteria. Can waive statewideness Can limit # of participants Can not waive/disregard comparability No renewal needed No cost neutrality requirement
Section 1115 Waiver Demonstrations	Broad waiver authority at the discretion of CMS to approve projects that test policy innovations.	Provides the most flexibility to waive Medicaid requirements. Must be budget neutral. Approval at the discretion of CMS and subject to federal/state negotiations.

Appendix B, Excerpt from www.cms.hhs.gov, "State Guide to Integrated Medicaid and Medicare Models"

"Model 1: Buy-In Wraparound Model - The "Buy-In Wraparound Model" partially integrates Medicare and Medicaid services. In this model, States encourage Medicare Advantage organizations ("MA organizations") to provide Medicaid benefits through a Medicare supplemental benefit package which the MA Organization offers to Medicare beneficiaries enrolled in the MA Plan. The State then would opt to pay the premiums for the supplemental package in its Medicaid State plan. Because Specified Low-Income Medicare Beneficiaries (SLMB), Qualified Medicare Beneficiaries (QMB), Qualifying Individuals (QI) and Qualified and Disabled and Working Individuals (QDWI) are not eligible for the wraparound Medicaid services provided under the supplemental benefit package, they would have to pay the supplemental premium in order to receive these benefits. In this model, the State Medicaid Agency acts as a financer, but has no oversight of the MA Plan. (Note that some QMBs and SLMBs also may be eligible for full Medicaid benefits, in which case they would be eligible for the wraparound Medicaid services provided under the supplemental package. Such individuals commonly are referred to as "QMB-Plus" and "SLMB-Plus" beneficiaries. QMBs and SLMBs who are not also eligible for full Medicaid benefits commonly are referred to as "QMB-only's" and "SLMB-only's.")

Model 2: Capitated Wraparound Model - The "Capitated Wraparound Model" also represents a partial integration model, under which States enter into a companion Medicaid capitated contract with health organizations which also have regular MA or SNP plan contracts. Unlike Model 1, however, the State Medicaid Agency has a separate agreement with the organization and oversees the Medicaid contract.

Also unlike Model 1, the Medicaid contract, rather than the MA Organization's supplemental benefit package, defines the Medicaid benefits for beneficiaries eligible for full Medicaid coverage. The Medicaid contract also can address payments for Medicaid beneficiaries eligible for Medicare cost-sharing assistance (e.g., QMBs). Because SLMB-only, QMB-only, QI, and QDWI beneficiaries are not eligible for full Medicaid benefits, individuals eligible for Medicare Part A and/or Part B premium assistance

under these groups would have to pay the Medicaid contract capitated rate themselves in order to receive the Medicaid benefits. CMS administers this model like any other MA Organization.

Model 3: Three-Party Integrated Model - The "Three-party Integrated Model" is a fully integrated model in which the MA Organization, the State Medicaid Agency and CMS enter into a three-way contract. The provision of acute and long-term care Medicare and Medicaid services are integrated at the health plan level through the use of a single managed care entity, and Medicare and Medicaid financing are integrated through use of capitated payments to the organization. PACE and the dual-eligible demonstrations that are now MA dual eligible SNPs in Minnesota, Wisconsin, and Massachusetts are some examples of programs that utilize this model.

Model 4: Plan-Level Integrated Model - The "Plan-Level Integrated Model" is a fully integrated model in which the health organization chooses to integrate separate Medicare and Medicaid contracts, negotiates the terms of its Medicare and Medicaid contracts separately with CMS and the State, and itself develops a single set of policies and procedures for the enrolled dual-eligible populations addressing both Medicare and Medicaid requirements. Because neither the State nor CMS initiates this model, both the State and CMS treat this model like any other non-integrated model. While this approach may result in some duplication of oversight by the State and CMS, the organization may find that this approach is faster to implement.

Specific Issue Considerations for Each Model – As a State or an MA Organization, and CMS attempt to develop an integrated delivery system there are a variety of issues to consider – issues that are inherent in attempting to integrate the health care delivery systems for two different statutory programs. The major specific issues are: enrollment, operations, benefits, payment, appeals, and Medicare Modernization Act implementation. "

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Public/Private Non-Medical Institutions - Previously known as Domiciliary Homes

State Plan related Pages for Domiciliary Homes:

*Attachment 41.9-B, Page 1
*Attachment 4.19-B, Page 6
*Attachment 2.2-A, Page 16
*Attachment 3.1-A.1, Page 13b
*Attachment 3.1-A.1, Page 19
*Attachment 3.1-D, Page 1

Code of Federal Registers:

*42 CFR 434.12 (PCS)
*43 CFR 435.135 (ACH)
*42 CFR 447.361 (Payments)
*42 CFR 447.200 (Public Private No-Medical Institutions)
*42 CFR 435.135

Personal Care Services:

*Attachment 3.1-B, Page 9

2008 Medicare Advantage Special Needs Plans for DUAL patients- No Gap Cvg in any
Data from CMS as of September 25, 2007. Includes all contracts/plans regardless of 2008 approval status, subject to change as contracts are finalized.

County	Organization Name	Plan Name	Special Needs	Monthly Consc	Annual Drug Deductible
Alamance	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Beaufort	Southeast Community Care	Southeast Community Care - Dual Plus	Dual-Eligible	$33.40	$275.00
Buncombe	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Carteret	Southeast Community Care	Southeast Community Care - Dual Plus	Dual-Eligible	$33.40	$275.00
Caswell	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Catawba	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Chatham	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Chatham	Southeast Community Care	Southeast Community Care - Dual Plus	Dual-Eligible	$33.40	$275.00
Cumberland	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Davidson	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Davie	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Durham	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Edgecombe	Southeast Community Care	Southeast Community Care - Dual Plus	Dual-Eligible	$33.40	$275.00
Forsyth	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Greene	Southeast Community Care	Southeast Community Care - Dual Plus	Dual-Eligible	$33.40	$275.00
Guilford	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Haywood	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Henderson	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Jones	Southeast Community Care	Southeast Community Care - Dual Plus	Dual-Eligible	$33.40	$275.00
Lenoir	Southeast Community Care	Southeast Community Care - Dual Plus	Dual-Eligible	$33.40	$275.00
Mecklenburg	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Onslow	Southeast Community Care	Southeast Community Care - Dual Plus	Dual-Eligible	$33.40	$275.00
Orange	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Orange	Southeast Community Care	Southeast Community Care - Dual Plus	Dual-Eligible	$33.40	$275.00
Pamlico	Southeast Community Care	Southeast Community Care - Dual Plus	Dual-Eligible	$33.40	$275.00
Pender	Southeast Community Care	Southeast Community Care - Dual Plus	Dual-Eligible	$33.40	$275.00
Person	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Pitt	Southeast Community Care	Southeast Community Care - Dual Plus	Dual-Eligible	$33.40	$275.00
Randolph	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Rockingham	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Rowan	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Stokes	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Surry	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Wake	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Wake	Southeast Community Care	Southeast Community Care - Dual Plus	Dual-Eligible	$33.40	$275.00
Wayne	Southeast Community Care	Southeast Community Care - Dual Plus	Dual-Eligible	$33.40	$275.00
Wilkes	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00
Yadkin	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Dual-Eligible	$31.10	$0.00

2008 Medicare Advantage Special Needs Plans
Data as of September 25, 2007. Includes all contracts/plans regardless of 2008 approval status. Employer sponsored plans (800 series) are excluded.
Note: data are subject to change as contracts are being finalized.
* Your premium may be lower depending on your eligibility for medical assistance. Call your plan for details.

State	County	Organization Name	Plan Name	Type of Medicare Health Plan	Special Needs Plan Type
North Carolina	Alamance	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort	Local HMO	Institutional
North Carolina	Alamance	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort Plus	Local HMO	Institutional
North Carolina	Alamance	Fidelis SecureCare of North Carolina	Fidelis Secure Independence	Local HMO	Institutional
North Carolina	Alamance	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Alamance	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Alamance	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Alamance	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Alexander	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Alleghany	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Anson	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Ashe	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Avery	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Beaufort	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Beaufort	Southeast Community Care	Southeast Community Care - Dual Plus	Local HMO	Dual-Eligible
North Carolina	Bertie	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Bladen	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Brunswick	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Buncombe	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Buncombe	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Buncombe	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Buncombe	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Burke	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Cabarrus	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort	Local HMO	Institutional
North Carolina	Cabarrus	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort Plus	Local HMO	Institutional
North Carolina	Cabarrus	Fidelis SecureCare of North Carolina	Fidelis Secure Independence	Local HMO	Institutional
North Carolina	Cabarrus	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Cabarrus	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Caldwell	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Camden	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Carteret	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Carteret	Southeast Community Care	Southeast Community Care - Dual Plus	Local HMO	Dual-Eligible
North Carolina	Caswell	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Caswell	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Caswell	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Catawba	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Catawba	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Catawba	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Catawba	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Chatham	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Chatham	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Chatham	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Chatham	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Chatham	Southeast Community Care	Southeast Community Care - Dual Plus	Local HMO	Dual-Eligible
North Carolina	Cherokee	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Chowan	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Clay	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Cleveland	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Columbus	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Craven	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Cumberland	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Cumberland	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Cumberland	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Cumberland	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Currituck	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Dare	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Davidson	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort	Local HMO	Institutional
North Carolina	Davidson	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort Plus	Local HMO	Institutional
North Carolina	Davidson	Fidelis SecureCare of North Carolina	Fidelis Secure Independence	Local HMO	Institutional
North Carolina	Davidson	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Davidson	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Davidson	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Davidson	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Davie	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort	Local HMO	Institutional
North Carolina	Davie	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort Plus	Local HMO	Institutional
North Carolina	Davie	Fidelis SecureCare of North Carolina	Fidelis Secure Independence	Local HMO	Institutional
North Carolina	Davie	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Davie	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Davie	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Davie	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Duplin	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Durham	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort	Local HMO	Institutional
North Carolina	Durham	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort Plus	Local HMO	Institutional
North Carolina	Durham	Fidelis SecureCare of North Carolina	Fidelis Secure Independence	Local HMO	Institutional
North Carolina	Durham	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Durham	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Durham	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Durham	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Edgecombe	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Edgecombe	Southeast Community Care	Southeast Community Care - Dual Plus	Local HMO	Dual-Eligible
North Carolina	Forsyth	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort	Local HMO	Institutional
North Carolina	Forsyth	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort Plus	Local HMO	Institutional
North Carolina	Forsyth	Fidelis SecureCare of North Carolina	Fidelis Secure Independence	Local HMO	Institutional
North Carolina	Forsyth	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Forsyth	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Forsyth	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Forsyth	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Franklin	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Gaston	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Gaston	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional

North Carolina	Gates	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Graham	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Granville	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Greene	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Greene	Southeast Community Care	Southeast Community Care - Dual Plus	Local HMO	Dual-Eligible
North Carolina	Guilford	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort	Local HMO	Institutional
North Carolina	Guilford	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort Plus	Local HMO	Institutional
North Carolina	Guilford	Fidelis SecureCare of North Carolina	Fidelis Secure Independence	Local HMO	Institutional
North Carolina	Guilford	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Guilford	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Guilford	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Guilford	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Halifax	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Harnett	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Haywood	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Haywood	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Haywood	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Haywood	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Henderson	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Henderson	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Henderson	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Henderson	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Hertford	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Hoke	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Hyde	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Iredell	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort	Local HMO	Institutional
North Carolina	Iredell	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort Plus	Local HMO	Institutional
North Carolina	Iredell	Fidelis SecureCare of North Carolina	Fidelis Secure Independence	Local HMO	Institutional
North Carolina	Iredell	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Jackson	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Johnston	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Jones	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Jones	Southeast Community Care	Southeast Community Care - Dual Plus	Local HMO	Dual-Eligible
North Carolina	Lee	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Lenoir	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Lenoir	Southeast Community Care	Southeast Community Care - Dual Plus	Local HMO	Dual-Eligible
North Carolina	Lincoln	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Macon	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Madison	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Martin	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	McDowell	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Mecklenburg	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort	Local HMO	Institutional
North Carolina	Mecklenburg	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort Plus	Local HMO	Institutional
North Carolina	Mecklenburg	Fidelis SecureCare of North Carolina	Fidelis Secure Independence	Local HMO	Institutional
North Carolina	Mecklenburg	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Mecklenburg	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Mecklenburg	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Mecklenburg	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Mitchell	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Montgomery	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Moore	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Moore	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Nash	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	New Hanover	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Northampton	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Onslow	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Onslow	Southeast Community Care	Southeast Community Care - Dual Plus	Local HMO	Dual-Eligible
North Carolina	Orange	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Orange	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Orange	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Orange	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Orange	Southeast Community Care	Southeast Community Care - Dual Plus	Local HMO	Dual-Eligible
North Carolina	Pamlico	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Pamlico	Southeast Community Care	Southeast Community Care - Dual Plus	Local HMO	Dual-Eligible
North Carolina	Pasquotank	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Pender	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Pender	Southeast Community Care	Southeast Community Care - Dual Plus	Local HMO	Dual-Eligible
North Carolina	Perquimans	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Person	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Person	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Person	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Pitt	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Pitt	Southeast Community Care	Southeast Community Care - Dual Plus	Local HMO	Dual-Eligible
North Carolina	Polk	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Randolph	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Randolph	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Randolph	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Randolph	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Richmond	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Robeson	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Rockingham	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Rockingham	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Rockingham	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Rockingham	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Rowan	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort	Local HMO	Institutional
North Carolina	Rowan	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort Plus	Local HMO	Institutional
North Carolina	Rowan	Fidelis SecureCare of North Carolina	Fidelis Secure Independence	Local HMO	Institutional
North Carolina	Rowan	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Rowan	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Rowan	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Rowan	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Rutherford	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Sampson	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Scotland	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition

North Carolina	Stanly	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort	Local HMO	Institutional
North Carolina	Stanly	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort Plus	Local HMO	Institutional
North Carolina	Stanly	Fidelis SecureCare of North Carolina	Fidelis Secure Independence	Local HMO	Institutional
North Carolina	Stanly	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Statewide	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Stokes	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Stokes	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Stokes	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Stokes	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Surry	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Surry	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Surry	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Swain	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Transylvania	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Tyrrell	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Union	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort	Local HMO	Institutional
North Carolina	Union	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort Plus	Local HMO	Institutional
North Carolina	Union	Fidelis SecureCare of North Carolina	Fidelis Secure Independence	Local HMO	Institutional
North Carolina	Union	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Vance	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Wake	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort	Local HMO	Institutional
North Carolina	Wake	Fidelis SecureCare of North Carolina	Fidelis Secure Comfort Plus	Local HMO	Institutional
North Carolina	Wake	Fidelis SecureCare of North Carolina	Fidelis Secure Independence	Local HMO	Institutional
North Carolina	Wake	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Wake	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Wake	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Wake	SecureHorizons by UnitedHealthcare	Evercare Plan IH	Local HMO	Institutional
North Carolina	Wake	Southeast Community Care	Southeast Community Care - Dual Plus	Local HMO	Dual-Eligible
North Carolina	Warren	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Washington	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Watauga	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Wayne	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Wayne	Southeast Community Care	Southeast Community Care - Dual Plus	Local HMO	Dual-Eligible
North Carolina	Wilkes	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Wilkes	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Wilkes	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Wilson	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Yadkin	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition
North Carolina	Yadkin	SecureHorizons by UnitedHealthcare	Evercare Plan MH	Local HMO	Chronic or Disabling Condition
North Carolina	Yadkin	SecureHorizons by UnitedHealthcare	Evercare Plan DH	Local HMO	Dual-Eligible
North Carolina	Yancey	Humana Insurance Company	HumanaChoicePPO PPO SNP-OA R5826-049	Regional PPO	Chronic or Disabling Condition

Monthly Consolidated Premium* ❑(Includes ❑Part C + D)	Annual Drug Deductible	Drug ❑Benefit ❑Type	Type of ❑Extra Coverage Offered in the Gap	Drug ❑Benefit ❑Type	Demo Type
$31.90	$275.00	Basic	No Gap Coverage	DS	
$70.00	$0.00	Enhanced	No Gap Coverage	EA	
$85.00	$0.00	Enhanced	No Gap Coverage	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$0.00	$0.00	Enhanced	All Preferred Generics	EA	
$31.10	$0.00	Enhanced	No Gap Coverage	EA	
$33.40	$0.00	Enhanced	No Gap Coverage	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$33.40	$275.00	Basic	No Gap Coverage	DS	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$0.00	$0.00	Enhanced	All Preferred Generics	EA	
$31.10	$0.00	Enhanced	No Gap Coverage	EA	
$33.40	$0.00	Enhanced	No Gap Coverage	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$31.90	$275.00	Basic	No Gap Coverage	DS	
$70.00	$0.00	Enhanced	No Gap Coverage	EA	
$85.00	$0.00	Enhanced	No Gap Coverage	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$33.40	$0.00	Enhanced	No Gap Coverage	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$33.40	$275.00	Basic	No Gap Coverage	DS	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$0.00	$0.00	Enhanced	All Preferred Generics	EA	
$31.10	$0.00	Enhanced	No Gap Coverage	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$0.00	$0.00	Enhanced	All Preferred Generics	EA	
$31.10	$0.00	Enhanced	No Gap Coverage	EA	
$33.40	$0.00	Enhanced	No Gap Coverage	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$0.00	$0.00	Enhanced	All Preferred Generics	EA	
$31.10	$0.00	Enhanced	No Gap Coverage	EA	
$33.40	$0.00	Enhanced	No Gap Coverage	EA	
$33.40	$275.00	Basic	No Gap Coverage	DS	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$0.00	$0.00	Enhanced	All Preferred Generics	EA	
$31.10	$0.00	Enhanced	No Gap Coverage	EA	
$33.40	$0.00	Enhanced	No Gap Coverage	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$31.90	$275.00	Basic	No Gap Coverage	DS	
$70.00	$0.00	Enhanced	No Gap Coverage	EA	
$85.00	$0.00	Enhanced	No Gap Coverage	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$0.00	$0.00	Enhanced	All Preferred Generics	EA	
$31.10	$0.00	Enhanced	No Gap Coverage	EA	
$33.40	$0.00	Enhanced	No Gap Coverage	EA	
$31.90	$275.00	Basic	No Gap Coverage	DS	
$70.00	$0.00	Enhanced	No Gap Coverage	EA	
$85.00	$0.00	Enhanced	No Gap Coverage	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$0.00	$0.00	Enhanced	All Preferred Generics	EA	
$31.10	$0.00	Enhanced	No Gap Coverage	EA	
$33.40	$0.00	Enhanced	No Gap Coverage	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$33.40	$275.00	Basic	No Gap Coverage	DS	
$31.90	$275.00	Basic	No Gap Coverage	DS	
$70.00	$0.00	Enhanced	No Gap Coverage	EA	
$85.00	$0.00	Enhanced	No Gap Coverage	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$0.00	$0.00	Enhanced	All Preferred Generics	EA	
$31.10	$0.00	Enhanced	No Gap Coverage	EA	
$33.40	$0.00	Enhanced	No Gap Coverage	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA	
$33.40	$0.00	Enhanced	No Gap Coverage	EA	

$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$33.40	$275.00	Basic	No Gap Coverage	DS
$31.90	$275.00	Basic	No Gap Coverage	DS
$70.00	$0.00	Enhanced	No Gap Coverage	EA
$85.00	$0.00	Enhanced	No Gap Coverage	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$0.00	$0.00	Enhanced	All Preferred Generics	EA
$31.10	$0.00	Enhanced	No Gap Coverage	EA
$33.40	$0.00	Enhanced	No Gap Coverage	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$0.00	$0.00	Enhanced	All Preferred Generics	EA
$31.10	$0.00	Enhanced	No Gap Coverage	EA
$33.40	$0.00	Enhanced	No Gap Coverage	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$0.00	$0.00	Enhanced	All Preferred Generics	EA
$31.10	$0.00	Enhanced	No Gap Coverage	EA
$33.40	$0.00	Enhanced	No Gap Coverage	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$31.90	$275.00	Basic	No Gap Coverage	DS
$70.00	$0.00	Enhanced	No Gap Coverage	EA
$85.00	$0.00	Enhanced	No Gap Coverage	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$33.40	$275.00	Basic	No Gap Coverage	DS
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$33.40	$275.00	Basic	No Gap Coverage	DS
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$31.90	$275.00	Basic	No Gap Coverage	DS
$70.00	$0.00	Enhanced	No Gap Coverage	EA
$85.00	$0.00	Enhanced	No Gap Coverage	EA
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$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
$0.00	$0.00	Enhanced	All Preferred Generics	EA
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$53.00	$0.00	Enhanced	Some Generics and Some Brands	EA
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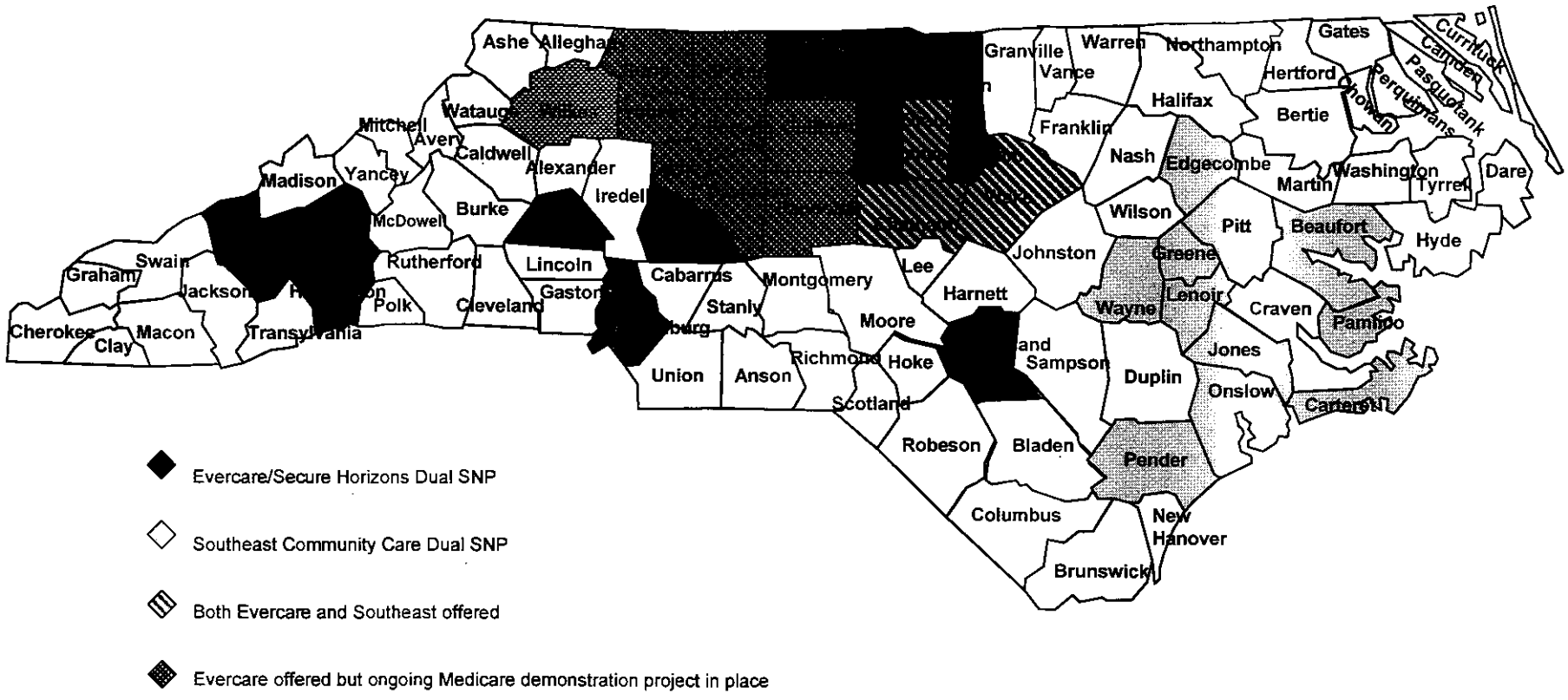
R5826	49	0

Dual Eligible Special Needs Plans

Offered in NC in 2008



CHCS Center for Health Care Strategies, Inc.

Integrated Care Program Development and Procurement Workplan

Key Steps	Estimated Timeframe for Completion[1]
Develop/Finalize Program Design *Major Activities Include:* • *Identify overall goal of program.* • *Solicit stakeholder input regarding key program design issues such as covered populations, covered services, enrollment options, and program size/scope.* • *Determine required federal/state authority options (as necessary).* • *Submit program for final approval from Medicaid Director, agency head, budget agency, sister agencies, governor, etc.* • *Identify any necessary MMIS modifications and plan accordingly.*	At least 1 year prior to implementation
Develop Waiver/Legislative Proposals and Submit to CMS/State Legislature *Major Activities Include:* • *Work with actuaries to get a high-level idea of rate structure.* • *Confirm whether or not state legislative authority is required and plan accordingly.* • *Determine whether or not there is a state or federal public notice requirement.* • *Begin early discussions and/or share a white paper with CMS re: program design in preparation for waiver request.*[2]	9-12 months prior to implementation
CMS Review and Approval of Waiver(s)	Will vary based on waiver(s), minimum of 90 days.
Identify/Address Infrastructure Needs *Major Activities Include:* • *Continue work on any necessary MMIS modifications.* • *Assess network capacity.*	6-8 months prior to implementation
Draft Policies and Procedures *Major Activities Include:* • *Solicit stakeholder input (including interested plans and appropriate advocacy groups) regarding education and outreach activities, enrollment/disenrollment processes, marketing materials and activities, grievance/appeals process, quality assurance activities, plan reporting requirements, etc.* • *Begin drafting model contract.* • *Begin drafting member handbook.* • *Begin more detailed discussion of rates with actuaries.*	6-8 months prior to implementation

[1] Timeframes provided for key steps are concurrent with one another unless otherwise noted.

[2] States may want to begin discussions with CMS at the Regional Office level for Medicaid managed care waivers.

Public Education—Phase I *Major Activities Include:* • *Finalize comprehensive outreach program for providers and beneficiaries.* • *Conduct provider and advocate meetings in targeted areas of the state.* • *Conduct meeting with all interested plans in the state.* • *Begin education of other affected state agencies, enrollment broker, etc.*	6-8 months prior to implementation
Develop Competitive Procurement Documents	8 months prior to implementation
Issue Competitive Procurement Documents to MCOs[3]	Upon CMS Approval (and legislative approval if necessary)/ 6 months prior to implementation
Review Provider Bids and Conduct Contract Negotiations	4 months prior to implementation
Notify First Group of Enrollees of the Enrollment Process	Upon award of contracts
Public Education—Phase II *Major Activities Include:* • *Implement comprehensive outreach program.* • *Conduct consumer education meetings in targeted areas of the state.* • *Targeted notification letters to providers and eligible participants.* • *Conduct policies and procedures training for appropriate state agency staff.*	Begin upon award of contracts (or no less than 1 month prior to implementation), ongoing thereafter
On-Site Readiness Reviews and Certification of Providers	2 months prior to implementation
Phase-In Enrollment	Will take place over a 6 month period.

[3] It is important to note that the timeframes provided for the procurement, contract awards, and program launch are very aggressive and may not be realistic for plans that do not already have a network in place and are essentially "starting from scratch." Timelines presented here are also based on a phased-in, rather than statewide, approach to implementation.