Facesheet: 1. Request Information (1 of 2)

A. The **State** of **North Carolina** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

B. Name of Waiver Program(s): Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program
NC MH/IDD/SUD	State of North Carolina NC MH/IDD/SAS Health Plan	PIHP;
NC Innovations	NC Innovations	PIHP;
NC TBI	NC Traumatic Brain Injury	PIHP;
NC (i) Option	NC MH/IDD/SUD/TBI (i) option Services	MCO; PIHP;

Waiver Application Title (*optional - this title will be used to locate this waiver in the finder*):

April 2023 Amendment

C. Type of Request. This is an:

☒ **Amendment request for an existing waiver.**
The amendment modifies (Sect/Part):

This amendment is to move the Tailored Plan populations under the 1115 waiver and to adjust the (b) waiver population to include all populations that are legislatively carved out of the 1115 waiver. Please note that Tribal members who choose the Tribal Option will receive their (c) waiver services under the (b) waiver while the others will receive them under the 1115 authority. This amendment also ends (b)(3) waiver services and adds a 1915(i) option to replace Supported Employment, Individual Supports, Transitional Supports, Respite, In Home Skill Building, Community Transition and Intensive Recovery Supports. 1915(b)(3) DI services will end and individuals receiving those services will be transitioned to the NC Innovations waiver. 1915(b)(3) Community Navigator will end and be replaced with Tailored Care Management. 1915(b)(3) Physician Consult has been replaced by NC Medicaid's telehealth policy.

Requested Approval Period:*(For waivers requesting three, four, or five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **1 year**
○ **2 years**
○ **3 years**
○ **4 years**
◉ **5 years**

Draft ID:NC.042.05.08

D. Effective Dates: This amendment is requested for a period of 5 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)
Approved Effective Date of Base Waiver being Amended: 07/01/19
Proposed Effective Date: (mm/dd/yy)

04/01/23

Facesheet: 2. State Contact(s) (2 of 2)

E. State Contact: The state contact person for this waiver is below:

Name:

Deborah Goda

Phone: (919) 527-7640 **Ext:** ☐ **TTY**

Fax: (919) 715-9451

E-mail:

deborah.goda@dhhs.nc.gov

If the State contact information is different for any of the authorized programs, please check the program name below and provide the contact information.
The State contact information is different for the following programs:

☐ **State of North Carolina NC MH/IDD/SAS Health Plan**

☐ **NC Innovations**

☐ **NC Traumatic Brain Injury**

☐ **NC MH/IDD/SUD/TBI (i) option Services**

Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the

Section A: Program Description

Part I: Program Overview

Tribal consultation.
For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

Tribal officials of the Eastern Band of the Cherokee Indians (ECBI), which is the only federally recognized tribe in NC, were notified of the changes needed for Tailored Plan launch (populations moving to TP) on 10/8/21 via email and for the 1915(i) option feedback from the Tribe was received on 4/25/22.

Program History.
For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

Today, the 1915 (b) waiver operates concurrently with two 1915 (c) waivers: 1) NC Innovations Waiver, which serves individuals with intellectual and developmental disabilities; and 2) NC TBI Waiver, which serves individuals with traumatic brain injury, which became effective on May 1, 2018.

[9-1-22] Update: This amendment is to update the waiver the NC TBI Waiver to add the additional counties of Orange and Mecklenburg.
Additional history can be found in the previous waiver document.

While physical health services are the same for all individuals with Medicaid, some services for people with an intellectual/developmental disability (I/DD), mental illness, traumatic brain injury (TBI), or substance use disorder are only available in NC Medicaid Direct and/or through the LME/MCOs. The Request to Move to NC Medicaid Direct Process is to be used for beneficiaries currently enrolled in a health plan with NC Medicaid Managed Care who need services only available through NC Medicaid Direct and/or through the LME-MCOs. The Request to Move to NC Medicaid Direct (Fee for Service) or LME-MCO: Beneficiary form and Request to Move to NC Medicaid Direct (Fee for Service) or LME-MCO: Provider's form can be submitted indicating that the beneficiary has used or is in need of services only available through NC Medicaid Direct and/or through the LME-MCOs.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

   a. ☒ **1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
   -- *Specify Program Instance(s) applicable to this authority*

      ☐ **NC TBI**

      ☐ **NC Innovations**

      ☒ **NC MH/IDD/SUD**

      ☐ **NC (i) Option**

   b. ☐ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
   -- *Specify Program Instance(s) applicable to this authority*

      ☐ **NC TBI**

      ☐ **NC Innovations**

      ☐ **NC MH/IDD/SUD**

      ☐ **NC (i) Option**

   c. ☒ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
   -- *Specify Program Instance(s) applicable to this authority*

      ☐ **NC TBI**

      ☐ **NC Innovations**

☒ **NC MH/IDD/SUD**

☐ **NC (i) Option**

d. ☒ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).
-- *Specify Program Instance(s) applicable to this authority*

☒ **NC TBI**

☒ **NC Innovations**

☒ **NC MH/IDD/SUD**

☒ **NC (i) Option**

The 1915(b)(4) waiver applies to the following programs

☐ **MCO**

☒ **PIHP**

☐ **PAHP**

☐ **PCCM** (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)

☐ **FFS** Selective Contracting program
Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

2. Sections Waived. Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

a. ☒ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
-- *Specify Program Instance(s) applicable to this statute*

☒ **NC TBI**

☐ **NC Innovations**

☐ **NC MH/IDD/SUD**

☐ **NC (i) Option**

b. ☒ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
-- *Specify Program Instance(s) applicable to this statute*

☐ **NC TBI**

☐ **NC Innovations**

☒ **NC MH/IDD/SUD**

☐ **NC (i) Option**

c. ☒ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.

-- *Specify Program Instance(s) applicable to this statute*

☐ **NC TBI**

☐ **NC Innovations**

☒ **NC MH/IDD/SUD**

☐ **NC (i) Option**

d. ☒ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

-- *Specify Program Instance(s) applicable to this statute*

☐ **NC TBI**

☐ **NC Innovations**

☒ **NC MH/IDD/SUD**

☐ **NC (i) Option**

e. ☐ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

-- *Specify Program Instance(s) applicable to this statute*

☐ **NC TBI**

☐ **NC Innovations**

☐ **NC MH/IDD/SUD**

☐ **NC (i) Option**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

1. Delivery Systems. The State will be using the following systems to deliver services:

a. ☐ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b. ☒ **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

- ◉ **The PIHP is paid on a risk basis**
- ○ **The PIHP is paid on a non-risk basis**

c. ☐ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

- ○ **The PAHP is paid on a risk basis**
- ○ **The PAHP is paid on a non-risk basis**

d. ☐ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. ☒ **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

- ○ **the same as stipulated in the state plan**
- ○ **different than stipulated in the state plan**

Please describe:

f. ☐ **Other:** (Please provide a brief narrative description of the model.)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

2. **Procurement.** The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

☐ **Procurement for MCO**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☒ **Procurement for PIHP**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ◉ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for PAHP**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for PCCM**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for FFS**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Historical information can be found in the previous amendment.

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (1 of 3)

1. Assurances.

☒ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

☒ The State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries ability to access services.

PIHPs are local management entities (LMEs) coordinating publicly-funded MH/IDD/SUD services. NC General Statute 122C designates LMEs as the “locus of coordination” for the provision of all publicly-funded MH/IDD/SUD services in each LME’s respective geographic catchment area. The State believes that the PIHPs are in a unique position to bring together the services and supports (formal and informal) and providers (professional and paraprofessional) that are needed to meet the complex needs of these populations. The LMEs have decades of experience locating and developing services for consumers with MH/IDD/SAS needs, and have built strong, collaborative working relationships with the providers of these services. These providers support this initiative and enrollees have at least as much choice of individual providers as they had in the non-managed care environment. By delivering, managing and paying for services through this one public entity with the appropriate experience, the State has streamlined and simplified the delivery system, better identified those in need of services and better assessed enrollee service needs.

Members of the EBCI Tribe can choose Tribal providers.

2. Details. The State will provide enrollees with the following choices (please replicate for each program in waiver):

Program: " **NC Traumatic Brain Injury.** *"*

☐ **Two or more MCOs**

☐ **Two or more primary care providers within one PCCM system.**

☐ **A PCCM or one or more MCOs**

☐ **Two or more PIHPs.**

☐ **Two or more PAHPs.**

☒ **Other:**
please describe

PIHPs are local management entities (LMEs) coordinating publicly-funded MH/IDD/SUD services. NC General Statute 122C designates LMEs as the “locus of coordination” for the provision of all publicly-funded MH/IDD/SUD services in each LME’s respective geographic catchment area. The State believes that the PIHPs are in a unique position to bring together the services and supports (formal and informal) and providers (professional and paraprofessional) that are needed to meet the complex needs of these populations. The LMEs have decades of experience locating and developing services for consumers with MH/IDD/SAS needs, and have built strong, collaborative working relationships with the providers of these services. These providers support this initiative and enrollees have at least as much choice of individual providers as they had in the non-managed care environment. By delivering, managing and paying for services through this one public entity with the appropriate experience, the State has streamlined and simplified the delivery system, better identified those in need of services and better assessed enrollee service needs.

Members of the EBCI Tribe can choose Tribal providers.

Program: " **NC Innovations.** *"*

- ☐ **Two or more MCOs**
- ☐ **Two or more primary care providers within one PCCM system.**
- ☐ **A PCCM or one or more MCOs**
- ☐ **Two or more PIHPs.**
- ☐ **Two or more PAHPs.**
- ☒ **Other:**

please describe

PIHPs are local management entities (LMEs) coordinating publicly-funded MH/IDD/SUD services. NC General Statute 122C designates LMEs as the “locus of coordination” for the provision of all publicly-funded MH/IDD/SUD services in each LME’s respective geographic catchment area. The State believes that the PIHPs are in a unique position to bring together the services and supports (formal and informal) and providers (professional and paraprofessional) that are needed to meet the complex needs of these populations. The LMEs have decades of experience locating and developing services for consumers with MH/IDD/SAS needs, and have built strong, collaborative working relationships with the providers of these services. These providers support this initiative and enrollees have at least as much choice of individual providers as they had in the non-managed care environment. By delivering, managing and paying for services through this one public entity with the appropriate experience, the State has streamlined and simplified the delivery system, better identified those in need of services and better assessed enrollee service needs.

Members of the EBCI Tribe can choose Tribal providers.

Program: " **State of North Carolina NC MH/IDD/SAS Health Plan.** *"*

- ☐ **Two or more MCOs**
- ☐ **Two or more primary care providers within one PCCM system.**
- ☐ **A PCCM or one or more MCOs**
- ☐ **Two or more PIHPs.**
- ☐ **Two or more PAHPs.**
- ☒ **Other:**

please describe

PIHPs are local management entities (LMEs) coordinating publicly-funded MH/IDD/SUD services. NC General Statute 122C designates LMEs as the “locus of coordination” for the provision of all publicly-funded MH/IDD/SUD services in each LME’s respective geographic catchment area. The State believes that the PIHPs are in a unique position to bring together the services and supports (formal and informal) and providers (professional and paraprofessional) that are needed to meet the complex needs of these populations. The LMEs have decades of experience locating and developing services for consumers with MH/IDD/SAS needs, and have built strong, collaborative working relationships with the providers of these services. These providers support this initiative and enrollees have at least as much choice of individual providers as they had in the non-managed care environment. By delivering, managing and paying for services through this one public entity with the appropriate experience, the State has streamlined and simplified the delivery system, better identified those in need of services and better assessed enrollee service needs.

Members of the EBCI Tribe can choose Tribal providers.

Program: " **NC MH/IDD/SUD/TBI (i) option Services.** *"*

- ☐ **Two or more MCOs**
- ☐ **Two or more primary care providers within one PCCM system.**
- ☐ **A PCCM or one or more MCOs**
- ☐ **Two or more PIHPs.**
- ☐ **Two or more PAHPs.**
- ☒ **Other:**

please describe

PIHPs are local management entities (LMEs) coordinating publicly-funded MH/IDD/SUD services. NC General Statute 122C designates LMEs as the “locus of coordination” for the provision of all publicly-funded MH/IDD/SUD services in each LME’s respective geographic catchment area. The State believes that the PIHPs are in a unique position to bring together the services and supports (formal and informal) and providers (professional and paraprofessional) that are needed to meet the complex needs of these populations. The LMEs have decades of experience locating and developing services for consumers with MH/IDD/SAS needs, and have built strong, collaborative working relationships with the providers of these services. These providers support this initiative and enrollees have at least as much choice of individual providers as they had in the non-managed care environment. By delivering, managing and paying for services through this one public entity with the appropriate experience, the State has streamlined and simplified the delivery system, better identified those in need of services and better assessed enrollee service needs.

Members of the EBCI Tribe can choose Tribal providers.

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)

3. Rural Exception.

☐ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. 1915(b)(4) Selective Contracting.

○ **Beneficiaries will be limited to a single provider in their service area**
Please define service area.

◉ **Beneficiaries will be given a choice of providers in their service area**

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

2. Details. The State will provide enrollees with the following choices (please replicate for each program in waiver):

Enrollees have free choice of providers enrolled in the PIHP network for their geographic area and may change providers as often as desired. If an individual joins a PIHP and is already established with a provider who is not a member of that PIHP's network the PIHP will make every effort to arrange for the individual to continue with the same provider, if the individual so desires. The provider would be required to meet the same qualifications as network providers. In addition, if an enrollee needs a specialized service that is not available through the network, the PIHP will arrange for the service to be provided outside of the network. Enrollees are generally given the choice between two qualified providers. Exceptions are made for certain institutional or other highly specialized services that are usually available through one facility or agency within the geographic area.

Each year, LME-MCOs are required to submit a Network Adequacy and Accessibility Analysis and a Network Development Plan to the State. The LME-MCOs submissions follow a standard format and include a standardized form for requesting exceptions. The LME-MCOs are required to request exceptions for any services that do not meet the network accessibility requirements set by the state. Each exception request includes the following details:
1. The name of service requested.
2. The number of contracted providers with the LME-MCO.
3. The number of individuals in need of the service.
4. Reason(s) why the access and choice standard(s) cannot be met.
5. If an exception for the service has been requested previously, the date of the previous request.
6. How the LME-MCO will meet an individual's need for access to the service?
7. How with the LME-MCO offer a choice of providers to individuals needing the service?
8. What is the expected end date for the exception (not to exceed one year).
These documents are reviewed by cross functional teams from the Division of Health Benefits (NC Medicaid) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. The cross functional team determines if an exception is appropriate and if the LME-MCO has a plan in place to ensure member access and choice. If it is determined that the exception is appropriate, and members have access to needed services, an exception is granted and communicated to the LME-MCO thru an approval letter. If the exception is not appropriate and/or the LME-MCO does not have an adequate plan to ensure that members have access to needed services, the request is denied and a corrective action plan is issued.

Tribal providers are not required to meet licensure or accreditation requirements.

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.
   - **Statewide** -- all counties, zip codes, or regions of the State
     -- *Specify Program Instance(s) for Statewide*

     ☐ **NC TBI**

     ☒ **NC Innovations**

     ☒ **NC MH/IDD/SUD**

     ☒ **NC (i) Option**
   - **Less than Statewide**
     -- *Specify Program Instance(s) for Less than Statewide*

     ☒ **NC TBI**

     ☐ **NC Innovations**

     ☐ **NC MH/IDD/SUD**

     ☐ **NC (i) Option**
2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
14 Counties	PIHP	Partners Behavioral Health Management
6 Counties	PIHP	Alliance Behavioral Healthcare
11 Counties	PIHP	Sandhills Center
28 Counties	PIHP	Trillium Health Resources
10 Counties	PIHP	Eastpointe
31 Counties	PIHP	Vaya Health

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Partners Behavioral Health Management Counties served: Burke, Cabarrus, Catawba, Cleveland, Davie, Forsyth, Gaston, Iredell, Lincoln, Rutherford, Stanly, Surry, Union and Yadkin

Alliance Behavioral Healthcare Counties served: Cumberland, Durham, Johnston, Mecklenburg, Orange and Wake

Sandhills Center Counties served: Anson, Davidson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond and Rockingham

Trillium Health Resources Counties served: Bladen, Brunswick, Carteret, Columbus, Halifax, Nash, New Hanover, Onslow, Pender, Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell and Washington

Eastpointe: Duplin, Edgecombe, Greene, Lenoir, Robeson, Sampson, Scotland, Warren, Wayne and Wilson

Vaya Health: Alamance, Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Chatham, Cherokee, Clay, Franklin, Graham, Granville, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Person, Polk, Swain, Transylvania, Vance, Watauga, Wilkes and Yancey

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the States specific circumstances.

1. **Included Populations.** The following populations are included in the Waiver Program:

☒ **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☒ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☒ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☒ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☒ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☒ **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Childrens Health Insurance Program (SCHIP) through the Medicaid program.

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☒ **Other** (Please define):

Optional categorically needy families and children and all medically needy individuals; Medicaid for Infants and Children; Special Assistance for the Disabled and Special Assistance for the Aged; Medicaid for Pregnant Women (MPW)

Effective 4/01/23, the (b) waiver will include all populations with full Medicaid benefits that are excluded from enrolling or exempt from and not opting into a Standard Plan or Tailored Plan authorized under the 1115 waiver. This includes medically needy, Health Insurance Premium Program, Long-stay nursing facility (over 90 days), State Operated Healthcare Facility/VA home, foster care, former foster youth and adoption populations, full dual eligibles not enrolled in NC Innovations or NC TBI, and Tribal beneficiaries (who choose not to opt into managed care).

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the Aged population may be required to enroll into the program, but Dual Eligibles within that population may not be allowed to participate. In addition, Section 1931 Children may be able to enroll voluntarily in a managed care program, but Foster Care Children within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

☐ **Medicare Dual Eligible** --Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

☐ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

☐ **Other Insurance** --Medicaid beneficiaries who have other health insurance.

☐ **Reside in Nursing Facility or ICF/IID** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID).

☐ **Enrolled in Another Managed Care Program** --Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☐ **Eligibility Less Than 3 Months** --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☐ **Participate in HCBS Waiver** --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

☐ **American Indian/Alaskan Native** --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

☐ **Special Needs Children (State Defined)** --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

☐ **SCHIP Title XXI Children** Medicaid beneficiaries who receive services through the SCHIP program.

☐ **Retroactive Eligibility** Medicaid beneficiaries for the period of retroactive eligibility.

☒ **Other** (Please define):

Medicaid beneficiaries enrolled in a Standard Plan (PHP) under the 1115 waiver are not eligible for the (b)waiver.
Medicaid beneficiaries enrolled in a Tailored Plan (PHP) under the 1115 waiver are not eligible for the (b)waiver.

Limited benefit groups.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. Assurances.

☒ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the

State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

☐ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

   ☐ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

   Emergency Services Category General Comments (optional):

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

   ☐ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.

   ☐ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.

   ☐ The State will pay for all family planning services, whether provided by network or out-of-network providers.

☐ Other (please explain):

☒ Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

4. FQHC Services. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

☐ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

☐ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

☒ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

FQHC Services Category General Comments (optional):

5. EPSDT Requirements.

☒ The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

EPSDT Requirements Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

☒ This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

1915(b)(3) Services Requirements Category General Comments:

The State will end (b)(3) services on 3/31/23 and replace with 1915(i) services.
The following applies to all the (b)(3) services:
- Services are available statewide
- Reimbursement is made through a separate capitation rate certified by the State's actuarial vendor. Total (b)(3) expenditures cannot exceed the resources available in the waiver
- Service providers must be enrolled in the PIHP network and meet all state and federal requirements, including, but not limited to, those found in 10 NCAC 27G.0204
- Cannot be provided to children ages 3-20th year who are receiving Medicaid MH/SUD residential treatment Cannot duplicate services currently being provided by educational institutions or Vocational Rehabilitation (VR)
- Medicaid services require a service order
- Medical necessity for services must be documented in a treatment plan (Person Centered Plan, Individual Support Plan, etc.) unless otherwise noted
- Additional staff training may be required by the PIHP based on individuals served.

***Respite: Children and adults with I/DD as defined in GS 122C & children ages 3 – 20th year with SED; Services provided are consistent with the definitions for respite in the NC Innovations Waiver. Respite services should be documented in existing treatment plans; however, a treatment plan is not required for Respite services. Respite providers must meet the provider requirements indicated in the NC Innovations Waiver with applicable experience with the population served.
***Supported Employment: Enrollees age 16 and older with I/DD as defined in GS 122C, SMI and/or SED. Services include initial job development, job training and support. Enrollees with I/DD follow the NC Innovations Waiver definition for Supported Employment and may also receive long term vocational support. Enrollees with SMI and/or SED receive services in accordance with Evidence Based Practices approved by the State, as described by the 2012 Department of Justice Settlement Agreement. Providers can be reimbursed per unit or based on milestones, as determined by the PIHP. Providers of services for enrollees with SMI and/or SED must meet the standards outline in the Evidence Based Practice approved by the State. Mental health components of Supported Employment, such as peer support and outpatient therapy, may be provided to enrollees receiving VR Services. Medicaid (b)(3) services cannot duplicate services provided by VR.
***Individual Support: Adults age 18 and older with a diagnosis of SPMI. This service is a "hands on" service intended to teach and assist individuals in carrying out Instrumental Activities of Daily Living (IADLs) such as meal preparation, medication management, grocery shopping, money management, etc., so that they can live independently in the community. The intent of this service is that the need for the service would decrease over time as IADL skills develop and the enrollee becomes capable of performing activities more independently. Services are provided by paraprofessional staff with experience with the population.
***One-time Transitional Costs: Adults with I/DD as defined in GS 122C and/or SPMI. This service provides funding for an individual to move from an institutional setting into his/her own private residence in the community or to divert an enrollee from entering an adult care home. Institutional settings include adult care homes, Institutions for Mental Diseases (IMDs), State Psychiatric Hospitals, ICF-IIDs, nursing facilities, PRTFs, or alternative family living arrangements. Funds are used to pay for necessary expenses to establish a basic living arrangement. These expenses are described in the "Additional Information" section. The total amount of funding available cannot exceed $5,000 per enrollee. Funds can be used in conjunction with Transition Year Stability Funding (TYSF) and Money Follows the Person (MFP) start-up funds. Vendors, suppliers and commercial businesses can be paid directly by the PIHP, as appropriate. The PIHP may fund the expenses through a provider agency assisting the enrollee to move, as appropriate, and may allow providers to bill administrative expenses for time spent purchasing goods and/or arranging services. One-time Transitional Costs may be used for the following:
1. Equipment, essential furnishings and household products;
2. Moving expenses;
3. Security deposits or other such payments required to obtain a lease;
4. Set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating);
5. Environmental health and safety assurances, such as pest eradication, allergen control, one-time cleaning prior to occupancy;

***Physician Consultation: Enrollees age 3 and older with a behavioral health diagnosis. The service is a consultative service that provides brief to extensive levels of consultation between a psychiatric provider or a psychiatric consultation team and a primary care provider, or a provider functioning in the capacity of a primary care provider, to ensure appropriate management of psychiatric conditions by the primary care provider. Consultation can be available remotely (in-state) or on-site with the primary care provider. The enrollee must be a patient of the primary care provider and

cannot be an active patient of the psychiatric prescriber or another behavioral health and/or I/DD provider which has the capacity to address the primary care provider's consultation questions. This service allows for observation of the enrollee as a component of the consultation, either in-person or via video conferencing. All methods of communication must be HIPAA compliant. Consultation may take the form of email, telephone, videoconferencing, fax or face-to-face communication. This service is provided by a board certified/eligible psychiatrist with a current license in North Carolina. Consultative teams are led by a board certified/eligible psychiatrist with a current NC license. Other consultative team members may include one or more of the following operating within the appropriate scope of practice: A licensed clinician (LCAS, LMFT, LP, LPA, LPC, LCSW), a Master's level QP for linking to community resources, or an RN who meets QP status. Prior approval for this service is not required and a formal treatment plan, person centered plan and individual support plan is not required.
***Community Navigator: Enrollees age 3 and older with I/DD. Services provided are consistent with the NC Innovations Waiver definition for Community Navigator. Supports the individual in making life choices, provide advocacy and identify opportunities to become a part of their community; coordinates the use of generic resources to address the individual's needs in addition to paid services; assists with self directed services.
***In-home Skill Building: Enrollees age 3 and older with I/DD. This service is intended to provide short term (less than 6 months) intensive habilitative services to remediate one or more documented functional deficits, with a primary focus of positive behavior support. The service includes a comprehensive assessment to identify areas of functional deficit and coaching for family members on interventions. It is provided in the enrollee's home or community. Staff are professional level staff trained in curriculums that align with the CMS Core Competencies.
***Transitional Living Skills: Children age 16 to 21 with SED who are transitioning to adulthood with at least one deficit in an instrumental activity of daily living (IADL). This service provides support in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to be successful in employment, housing, education and community life and to reside successfully in the community. Activities are provided in partnership with youth to help the youth arrange for the services they need to become employed, access transportation, housing and continuing education. Services are individualized according to each youth's strengths, interests, skills, goals and are included on an individualized transition plan. This service may not be provided in a group. Housekeeping, homemaking, or basic services sole for the convenience of the child receiving the services are not covered. Staff are paraprofessional staff with at least 2 years of experience working with the population served and must complete training as identified by the PIHP.
***Intensive Recovery Support: Pregnant women ages 18 or older, or women ages 18 or older with a minor child, who meet all of the following criteria: Has a substance use disorder diagnosis, has been discharged from substance use disorder treatment within the last 60 days, has functional impairment(s) related to the substance use disorder that interferes or limits one or more major life activities (employment, education, money management, accessing community resources, etc.) and needs support to maintain abstinence through the development of relapse prevention skills, coping skills, and crisis management. Services are provided by Qualified Professionals.
***NC Innovations Waiver Services: Children ages 3-21 and adults who are functionally eligible, but not enrolled in the NC Innovations 1915(c) waiver program, who are exiting an Intermediate Care Facility for Individuals with Intellectual Disabilities. This service is consistent with the NC Innovations 1915(c) Waiver program. Providers must meet all NC Innovations Waiver requirements and be enrolled providers.

Tribal providers do not need to meet licensure or accreditation requirements.

7. Self-referrals.

☒ The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Self-referrals Requirements Category General Comments:

Basic benefits (outpatient) - 8 visits per year for adults, 16 visits per year for children
Medically managed detoxification (16 hours/episode)
Mobile crisis - 8 hours services allowed before being required to get prior authorization
Diagnostic assessments - two per year
Evaluation and management (E&M) visits by psychiatric providers - 22 visits per year without PA; no PA required for individuals with SPMI

8. Other.

☐ Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries access to emergency services and family planning services.

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services.

Please note below the activities the State uses to assure timely access to services.

a. ☐ **Availability Standards.** The States PCCM Program includes established maximum distance and/or travel time requirements, given beneficiarys normal means of transportation, for waiver enrollees access to the following providers. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Hospitals

Please describe:

6. ☐ Mental Health

Please describe:

7. ☐ Pharmacies

Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

b. ☐ **Appointment Scheduling**means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The States PCCM Program includes established standards for appointment scheduling for waiver enrollees access to the following providers.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

c. ☐ **In-Office Waiting Times**: The States PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. ☐ Other Access Standards

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

3. Details for 1915(b)(4)FFS selective contracting programs: Please describe how the State assures timely access to the services covered under the selective contracting program.

n/a

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

Additional Information. Please enter any additional information not included in previous pages:

Any Indian Healthcare Provider (IHCP) in the geographic area served by the managed care entity will be entitled to participate in the entity's network in order to ensure timely access to Medicaid services for Indian enrollees entitled to receive IHS- funded services and Medicaid managed care services.

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. ☐ The State has set **enrollment limits** for each PCCM primary care provider.

Please describe the enrollment limits and how each is determined:

b. ☐ The State ensures that there are adequate number of PCCM PCPs with **open panels**.

Please describe the States standard:

c. ☐ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

Please describe the States standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. Details for PCCM program. (Continued)

d. ☐ The State compares **numbers of providers** before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal	

Please note any limitations to the data in the chart above:

e. ☐ The State ensures adequate **geographic distribution** of PCCMs.

Please describe the States standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

f. ☐ **PCP:Enrollee Ratio**. The State establishes standards for PCP to enrollee ratios.

Area/(City/County/Region)	PCCM-to-Enrollee Ratio	

Please note any changes that will occur due to the use of physician extenders.:

g. ☐ **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

3. Details for 1915(b)(4)FFS selective contracting programs: Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) for facility programs, or vehicles (by type, per contractor) for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

n/a

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

n/a

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (1 of 5)

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (2 of 5)

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. ☐ The plan is a PIHP/PAHP, and the State has determined that based on the plans scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208.

Please provide justification for this determination:

b. ☒ **Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State.

Please describe:

Each PIHP is required to identify clients who meet the following criteria:
Adults with severe, persistent mental illness
Children with severe emotional disturbances
Individuals with intellectual/developmental disabilities who are functionally eligible for ICF-IID
Female Temporary Assistance for Needy Families recipients with substance abuse dependency diagnoses
Individuals with co-occurring diagnoses
Individuals who are IV drug or opiate users
Individuals transitioning to a home or community based residential setting in accordance with the NC DHHS Settlement Agreement with the US Department of Justice.

Children with complex needs as defined by the State Settlement Agreement with Disability Rights North Carolina.

The LME-MCO identifies individuals with special health care needs as described in the contract between the LME-MCO and the state. Treatment plans are person centered plans that include an assessment of individual's strengths, natural supports and treatment needs. Enrollees may contact specialists directly - they are not required to contact the LME-MCO for referral.

c. ☒ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe:

Please describe the enrollment limits and how each is determined:

PIHP contracts require them to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate healthcare professionals.

d. ☒ **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan.If so, the treatment plan meets the following requirements:

1. ☒ Developed by enrollees primary care provider with enrollee participation, and in consultation with any specialists care for the enrollee.

2. ☒ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. ☒ In accord with any applicable State quality assurance and utilization review standards.

Please describe:

Treatment plans are person centered plans that include an assessment of individuals strengths, natural supports and treatment needs.

e. ☒ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollees condition and identified needs.

Please describe:

Enrollees may contact specialists directly – they are not required to contact the LME-MCO for referral.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (3 of 5)

3. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. ☐ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollees needs.

b. ☐ Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollees overall health care.

c. ☐ Each enrollee is receives **health education/promotion** information.

Please explain:

d. ☐ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

e. ☐ There is appropriate and confidential **exchange of information** among providers.

f. ☐ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.

g. ☐ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h. ☐ **Additional case management** is provided.

Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers files.

i. ☐ **Referrals.**

Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary

care case managers files.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (4 of 5)

4. Details for 1915(b)(4) only programs: If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

n/a

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

The LME-MCO will coordinate with the Tribal targeted care manager for individuals where appropriate.

Tribal members may receive services from tribal providers, from the LME-MCO, or from a combination of the two. If an enrollee receives services through both entities, the LME-MCO coordinates with the tribe to ensure that the individual is getting the services needed. The EBCI Tribe is not required to use the standard treatment planning forms.
The EBCI Tribe uses a person-centered planning process consistent with the process used by the LME-MCO but uses forms and documentation consistent with the Cherokee Indian Health Authority (CIHA) and the Federal Indian Health Service (IHS) program.

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for

approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☒ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.
The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on:
07/01/18 (mm/dd/yy)

☒ The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004.
Please provide the information below (modify chart as necessary):

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP	The Carolinas Center for Medical Excellence (CCME)/HSAG	X	Validation of performance measures; validation of performance improvement projects; on-site review	Encounter data validation / Information Systems Capability Assessment

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

☐ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part III: Quality

3. Details for PCCM program. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. ☐ The State has developed a set of overall quality **improvement guidelines** for its PCCM program.

Please describe:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

b. ☐ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below.

1. ☐ Provide education and informal mailings to beneficiaries and PCCMs
2. ☐ Initiate telephone and/or mail inquiries and follow-up
3. ☐ Request PCCMs response to identified problems
4. ☐ Refer to program staff for further investigation
5. ☐ Send warning letters to PCCMs
6. ☐ Refer to States medical staff for investigation
7. ☐ Institute corrective action plans and follow-up
8. ☐ Change an enrollees PCCM
9. ☐ Institute a restriction on the types of enrollees
10. ☐ Further limit the number of assignments
11. ☐ Ban new assignments
12. ☐ Transfer some or all assignments to different PCCMs
13. ☐ Suspend or terminate PCCM agreement
14. ☐ Suspend or terminate as Medicaid providers
15. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

c. ☐ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.
Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ☐ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. ☐ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. ☐ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
   - **A.** ☐ Initial credentialing
   - **B.** ☐ Performance measures, including those obtained through the following (check all that apply):
     - ☐ The utilization management system.
     - ☐ The complaint and appeals system.
     - ☐ Enrollee surveys.
     - ☐ Other.

       Please describe:
4. ☐ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. ☐ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. ☐ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. ☐ Other

   Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

☒ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

1. ☒ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
2. ☐ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

   Please list types of indirect marketing permitted:

3. ☐ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries).

Please list types of direct marketing permitted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

b. Description. Please describe the States procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. ☐ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

Please explain any limitation or prohibition and how the State monitors this:

2. ☐ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. ☒ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):

Materials are translated into the prevalent languages for each PIHP geographic coverage area. Prevalent is defined as 5% or more of the population and includes Spanish.

The State has chosen these languages because (check any that apply):

a. ☒ The languages comprise all prevalent languages in the service area.

Please describe the methodology for determining prevalent languages:

All written materials, including marketing materials, given to enrollees by the PIHP must be translated into the "prevalent" languages for the PIHP coverage area. Any language that is the primary language of 5% or more of the population is considered to be prevalent.

b. ☐ The languages comprise all languages in the service area spoken by approximately ☐ percent or more of the population.

c. ☐ Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:

n/a

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (1 of 5)

1. Assurances

☒ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (2 of 5)

2. Details

a. Non-English Languages

1. ☒ Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):

Enrollee materials are translated into Spanish. PIHPs translate enrollee written materials based on the prevalent languages in their geographic areas.

If the State does not translate or require the translation of marketing materials, please explain:

The State defines prevalent non-English languages as: (check any that apply):

a. ☐ The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines significant.:

b. ☒ The languages spoken by approximately 5.00 percent or more of the potential enrollee/enrollee population.

c. ☐ Other

Please explain:

2. ☒ Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

Please see Part IV: Program Operations B: Information to Potential Enrollees and Enrollees, Additional Information

3. ☒ The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

Please describe:

Please see Part IV: Program Operations B: Information to Potential Enrollees and Enrollees, Additional Information

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (3 of 5)

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

☐ State

☒ Contractor

Please specify:

Our enrollment broker supports enrollment and choice counseling for beneficiaries who are eligible to enroll in a PHP.

☐ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP.)

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (4 of 5)

2. Details (Continued)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

☐ the State

☒ State contractor

Please specify:

The PIHPs provide written information on the Medicaid waiver program to all new enrollees within 14 days of enrollment. Written information must be available in the prevalent non-English languages found in the capitated catchment area. All new enrollee material must be approved by the State prior to its release and must include information specified in the PIHP contract.

☐ The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

The NC DHHS has implemented a language access policy to ensure that people with LEP have equal access to benefits and services for which they may qualify from entities receiving federal financial assistance. The policy applies to the NC DHHS, all divisions/institutions within DHHS and all programs and services administered, established or funded by DHHS, including subcontractors, vendors and subrecipients.

The policy requires all divisions and institutions with DHHS and all local management entities, including the PIHPs, to maintain a Language Access Plan. The Plan must include a system for assessing the language needs of LEP populations and individual LEP applicants/recipients; securing resources for language services; providing language access services; assessing and providing staff training; and monitoring the quality and effectiveness of language access services. PIHPs must ensure that effective bilingual/interpretive services are provided to serve the needs of the LEP population at no cost to the enrollee. PIHPs must also provide written materials in languages other than English where a significant number or percentage of the population eligible to be served or likely to be directly affected by the program needs services or information in a language other than English.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. Assurances

☐ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

☒ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

The State seeks a waiver of section 1902(a)(4) of the Act, waiving enrollee disenrollment. There is no other MH/IDD/SUD system available in North Carolina to deliver these services to Medicaid enrollees. Additionally, the State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP per 42 CFR 438.52 as identified in section A.I.C of the waiver application. Enrollees are given choice of providers. Beneficiaries who have a choice of delivery systems (MCO or FFS/PIHP) do not have a lock in. Beneficiaries excluded from the MCO system are not permitted to disenroll from the PIHP system unless they are a member of a federally recognized tribe.

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

Please describe the States enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. Outreach

☒ The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

The State notifies all potential PIHP enrollees through written communication. The State notifies providers prior to program implementation and periodically thereafter through Medicaid Bulletins. Individuals with questions on eligibility and enrollment are directed to a toll-free number for the PIHP member services unit. The unit provides information and referral for benefits assessment as needed.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

☒ State staff conducts the enrollment process.

☐ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

☐ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name:

Please list the functions that the contractor will perform:

☐ choice counseling

☐ enrollment

☐ other

Please describe:

☐ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

c. Enrollment . The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

☐ This is a **new** program.

Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

☐ This is an **existing program** that will be expanded during the renewal period.

Please describe: Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

☐ If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

☐ Potential enrollees will have ☐ ○ **day(s)** / ○ **month(s)** to choose a plan.

ii. ☐ There is an auto-assignment process or algorithm.

In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs:

☒ The State automatically enrolls beneficiaries.

☐ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).

☒ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).

☐ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

Please specify geographic areas where this occurs:

☐ The State provides **guaranteed eligibility** of ☐ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

☐ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM.

Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

☒ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

☐ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i. ☐ Enrollee submits request to State.

ii. ☐ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii. ☐ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

☒ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

☐ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ☐ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollees health care needs):

☐ The State does not have a **lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

☐ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.

i. ☐ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

Please describe the reasons for which enrollees can request reassignment

ii. ☐ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

iii. ☐ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCMs caseload.

iv. ☐ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

n/a

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. Assurances

☒ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

☒ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

n/a

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

1. **Assurances for All Programs** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

    a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

    b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

    c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

    ☒ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

2. Assurances For MCO or PIHP programs. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

☒ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

n/a

☒ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. Details for MCO or PIHP programs

a. Direct Access to Fair Hearing

☒ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

☐ The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. Timeframes

☒ The States timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 60 days (between 20 and 90).

☒ The States timeframe within which an enrollee must file a **grievance** is 90 days.

c. Special Needs

☐ The State has special processes in place for persons with special needs.

Please describe:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

4. Optional grievance systems for PCCM and PAHP programs. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or

PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollees freedom to make a request for a fair hearing or a PCCM or PAHP enrollees direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

☐ The State has a grievance procedure for its ☐ PCCM and/or ☐ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure): The grievance procedures are operated by:

- ☐ the State
- ☐ the States contractor.

  Please identify:
- ☐ the PCCM
- ☐ the PAHP

☐ Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

Please describe:

☐ Has a committee or staff who review and resolve requests for review.

Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function:

☐ Specifies a time frame from the date of action for the enrollee to file a request for review.

Please specify the time frame for each type of request for review:

☐ Has time frames for resolving requests for review.

Specify the time period set for each type of request for review:

☐ Establishes and maintains an expedited review process.

Please explain the reasons for the process and specify the time frame set by the State for this process:

☐ Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review.

☐ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the

procedures available to challenge the decision.

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

n/a

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

☒ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

2. A person with beneficial ownership of five percent or more of the MCOs, PCCMs, PIHPs, or PAHPs equity;

3. A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCOs, PCCMs, PIHPs, or PAHPs obligations under its contract with the State.

☒ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;

2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;

3. Employs or contracts directly or indirectly with an individual or entity that is

a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or

b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

☒ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

☒ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

n/a

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under Evaluation of Program Impact.
  - There must be at least one check mark in one of the three columns under Evaluation of Access.
  - There must be at least one check mark in one of the three columns under Evaluation of Quality.

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
duplication	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ FFS	☐ FFS	☐ FFS	☐ FFS	☐ FFS	☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under Evaluation of Program Impact.
  - There must be at least one check mark in one of the three columns under Evaluation of Access.
  - There must be at least one check mark in one of the three columns under Evaluation of Quality.

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Accreditation for Non-duplication	☐ MCO ☒ PIHP	☐ MCO ☒ PIHP	☐ MCO ☒ PIHP

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO	☐ MCO	☐ MCO

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

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  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under Evaluation of Program Impact.
  - There must be at least one check mark in one of the three columns under Evaluation of Access.
  - There must be at least one check mark in one of the three columns under Evaluation of Quality.

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Accreditation for Non-duplication	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ FFS	☐ FFS	☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☒ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

Programs Authorized by this Waiver:

Program	Type of Program
NC MH/IDD/SUD	PIHP;
NC Innovations	PIHP;
NC TBI	PIHP;
NC (i) Option	MCO; PIHP;

Note: If no programs appear in this list, please define the programs authorized by this waiver on the

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: NC Traumatic Brain Injury

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.
For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity

- Frequency of use
- How it yields information about the area(s) being monitored

a. ☐ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organizations standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

b. ☐ **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

c. ☐ **Consumer Self-Report data**

Activity Details:

☐ **CAHPS**

Please identify which one(s):

☐ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☐ **Data Analysis (non-claims)**

Activity Details:

☐ **Denials of referral requests**

☐ **Disenrollment requests by enrollee**

☐ **From plan**

☐ **From PCP within plan**

☐ **Grievances and appeals data**

☐ **Other**

Please describe:

e. ☐ **Enrollee Hotlines**

Activity Details:

f. ☐ **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

Activity Details:

g. ☐ **Geographic mapping**

Activity Details:

h. ☐ **Independent Assessment** (Required for first two waiver periods)

Activity Details:

i. ☐ **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:

j. ☐ **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:

k. ☐ **Ombudsman**

Activity Details:

l. ☐ **On-Site Review**

Activity Details:

m. ☐ **Performance Improvement Projects** [Required for MCO/PIHP]

Activity Details:

- ☐ **Clinical**
- ☐ **Non-clinical**

n. ☐ **Performance Measures** [Required for MCO/PIHP]

Activity Details:

- ☐ **Process**
- ☐ **Health status/ outcomes**
- ☐ **Access/ availability of care**
- ☐ **Use of services/ utilization**
- ☐ **Health plan stability/ financial/ cost of care**
- ☐ **Health plan/ provider characteristics**
- ☐ **Beneficiary characteristics**

o. ☐ **Periodic Comparison of # of Providers**

Activity Details:

p. ☐ **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:

q. ☐ **Provider Self-Report Data**

Activity Details:

☐ **Survey of providers**

☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

s. ☐ **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:

t. ☐ **Other**

Activity Details:

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: NC Innovations

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.
For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ☐ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organizations standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

b. ☐ **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

c. ☐ **Consumer Self-Report data**

Activity Details:

☐ **CAHPS**

Please identify which one(s):

☐ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☐ **Data Analysis (non-claims)**

Activity Details:

☐ **Denials of referral requests**

☐ **Disenrollment requests by enrollee**

- ☐ **From plan**
- ☐ **From PCP within plan**

☐ **Grievances and appeals data**

☐ **Other**

Please describe:

e. ☐ **Enrollee Hotlines**

Activity Details:

f. ☐ **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined

questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

Activity Details:

g. ☐ **Geographic mapping**

Activity Details:

h. ☐ **Independent Assessment** (Required for first two waiver periods)

Activity Details:

i. ☐ **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:

j. ☐ **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:

k. ☐ **Ombudsman**

Activity Details:

l. ☐ **On-Site Review**

Activity Details:

m. ☐ **Performance Improvement Projects** [Required for MCO/PIHP]

Activity Details:

☐ **Clinical**

☐ **Non-clinical**

n. ☐ **Performance Measures** [Required for MCO/PIHP]

Activity Details:

☐ **Process**

☐ **Health status/ outcomes**

☐ **Access/ availability of care**

☐ **Use of services/ utilization**

☐ **Health plan stability/ financial/ cost of care**

☐ **Health plan/ provider characteristics**

☐ **Beneficiary characteristics**

o. ☐ **Periodic Comparison of # of Providers**

Activity Details:

p. ☐ **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:

q. ☐ **Provider Self-Report Data**

Activity Details:

☐ **Survey of providers**

☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

s. ☐ **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:

t. ☐ **Other**

Activity Details:

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: State of North Carolina NC MH/IDD/SAS Health Plan

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.
For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ☒ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organizations standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

PIHPs are required to be accredited by NCQA, URAC or other accreditation agency recognized by CMS for non-duplication and approved by the State. The state ensures that it does not duplicate these activity requirements to the extent possible.

☒ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☒ **Other**
Please describe:

URAC

b. ☐ **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**
Please describe:

c. ☒ **Consumer Self-Report data**

Activity Details:

PIHPs are required to be accredited by NCQA, URAC or other accreditation agency recognized by CMS for non-duplication and approved by the State. The state ensures that it does not duplicate these activity requirements to the extent possible.

☒ **CAHPS**
Please identify which one(s):

Experience of Care and Health Outcomes Survey (ECHO)

☐ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☒ **Data Analysis (non-claims)**

Activity Details:

The PIHPs are required to track grievances and appeals. The PIHPs provide this data to the DHHS monthly via a standard monthly monitoring report. The data includes the number of complaints and grievances received per month, and specifies who made the complaint (consumer or provider) and if the complaint or grievance is against the PIHP or a provider. The data also includes the number and percentage of authorization requests denied, the number and percentage of appeals received, and the number of authorization denials overturned due to the appeal. DHB reviews the information on a quarterly basis and may require a written plan of correction to address areas of low performance. The information is also included in the PIHP Quality Management reporting.
Grievance and appeals data is used to monitor grievances and complaints, timely access to services, network capacity, service authorization and quality of care. PIHPs maintain records of grievances and appeals within an internal Continuous Quality Improvement Program. Performance Improvement Projects are implemented when indicated.

☒ **Denials of referral requests**

☐ **Disenrollment requests by enrollee**

- ☐ **From plan**
- ☐ **From PCP within plan**

☒ **Grievances and appeals data**

☐ **Other**

Please describe:

e. ☒ **Enrollee Hotlines**

Activity Details:

NC DHHS operates a toll-free customer hotline to address consumer coverage questions and requests for assistance. The hotline operates 16 hours per day. Items that cannot be addressed by hotline staff are referred to the appropriate program or staff person within DHHS.
The PIHPs are required to operate a toll-free customer service line 24/7 to address enrollee needs and concerns. The PIHPs provide data to the DHHS monthly via a standard monthly monitoring report regarding the total number of calls received, the percentage and number of calls abandoned, the average speed to answer calls, and the number and percentage of calls answered within 30 seconds. DHB reviews the information on a quarterly basis and may require a written plan of correction to address areas of low performance.
Hotline information is used to monitor information to beneficiaries, grievances, timely access, coordination/continuity of care, coverage and authorization, provider selection and quality of care.
DHB's enrollment broker has a hotline for enrollment/disenrollment and maintains data on enrollment/disenrollment and beneficiary survey information which is available to the department which DHB uses to monitor trends and concerns.

f. ☐ **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained

improvement in significant aspects of clinical care and non-clinical service)

Activity Details:

n/a

g. ☒ **Geographic mapping**

Activity Details:

The PIHPs are required to maintain geographic mapping of the provider network for the DHHS's review. The geographic mapping identifies the distribution of provider types across the state. Examples of provider types shown through mapping include psychiatrists, psychologists, treatment programs and facilities. Geographic mapping is generated and reported on annually through the PIHPs' submission of Network Adequacy. DHHS staff review the information and may require a written plan of correction to address areas of concern. PIHPs are required to report on their progress in addressing gaps quarterly. Geographic mapping is used to monitor timely access, primary care provider/specialist capacity, and provider selection.

h. ☐ **Independent Assessment** (Required for first two waiver periods)

Activity Details:

n/a

i. ☒ **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:

The State, through its EQR, administers an annual survey to measure consumer satisfaction. This survey is used to collect demographic information and to assess cultural sensitivity. Results of the survey are used to identify issues related to quality of care, including racial and ethnic disparities. The measurement of disparities by racial or ethnic groups is used to monitor timely access and coverage/authorization of care.

j. ☒ **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:

The PIHPs are required to establish and maintain appropriate provider networks. The PIHP contract with DHB requires PIHPs to establish policies and procedures to monitor the adequacy, accessibility and availability of its provider network to meet the needs of enrollees. The PIHPs conduct an in-depth analysis of their provider networks to demonstrate an appropriate number, mix and geographic distribution of providers, including geographic access of its members to practitioners and facilities.
Network adequacy assurance is generated and reported on annually through the PIHPs' submission of Network Adequacy report. The PIHPs submit a network development plan to address any reported gaps in service capacity or access. DHHS staff review the information and may require a written plan of correction to address areas of concern. PIHPs are required to report on their progress in addressing quarterly. PIHPs submit requests for exception to DHHS for gaps in service coverage of specialty providers and institutions. PIHPs notify DHHS of any significant change in the PIHP network that would create a gap.
Measurement of network adequacy reports is used to monitor primary care provider/specialist capacity and provider selection.
Network adequacy data is used as follows: 1) develop a quantitative, regional understanding of the healthcare or service delivery system, including the subsystems and their relation; 2) identify needs for further data collection; and 3) identify processes and areas for detailed study.

k. ☐ **Ombudsman**

Activity Details:

n/a

l. ☒ **On-Site Review**

Activity Details:

The State administers annual on-site monitoring reviews through the EQR. Designated DHHS staff from DHB and DMH/DD/SAS participate in the EQR on-site reviews. The on-site reviews consist of both interviews and documentation review. The EQR process includes an extensive review of PIHP policies, procedures, processes and documentation of PIHP functions. The review focuses on monitoring services, reviewing grievances and appeals received and reviewing medical charts as needed.
The EQR on-site review allows a review of automated systems and communication with the contractor staff that perform each of the above processes. It also obtains additional information that was not gathered during the state monitoring. Data from all sources is analyzed for compliance. If indicated, the contractor is required to implement corrective actions. The EQRO compiles the information for all PIHPs
On-site review is used to monitor marketing, program integrity, information to beneficiaries, grievances, timely access, primary care provider/specialist capacity, coordination/continuity of care, coverage/authorization, provider selection and quality of care.

m. ☒ **Performance Improvement Projects** [Required for MCO/PIHP]

Activity Details:

PIHPs are required to conduct Performance Improvement Projects (PIPs) that are designed to achieve, through on-going measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. The PIHPs were required to develop, implement and report to the state a minimum of two PIHP-specific and self-funded PIPs during the first year of their PIHP contract with DMA. They were required to add a third PIHP in the second year and a fourth in the third year. At least one of the four PIPs must be clinical and at least one must be non-clinical. PIP topics are chosen based upon the information obtained through other monitoring processes.
PIPs must measure performance using objective quality indicators, implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the interventions, and planning/initiation of activities for increasing or sustaining improvement. Baseline measures for each PIP are established in the first year of each project and benchmarks are set based on currently accepted standards, past performance data or available national data. PIHPs will need DMAs approval prior to terminating a project. PIHPs will implement new PIPs as projects are terminated.
Two PIPs must be in process each year. The EQR reports the status and results of each PIP to DHB. Each PIP must be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year.
PIPs are used to monitor program integrity, coordination/continuity of care, quality of care and access to care. Data from PIPs is used to:
1. Develop a quantitative, regional understanding of the healthcare or service delivery system, including the subsystems and their relation;
2. Identify needs for further data collection; and
3. Identify processes and areas for detailed study.

The results of the analyses are reported to the DHB. DHB reviews the information on a quarterly basis and may require a written plan of correction to address areas of low performance.

☒ **Clinical**

☒ **Non-clinical**

n. ☒ **Performance Measures** [Required for MCO/PIHP]

Activity Details:

The State has established a comprehensive list of Performance Measures (PMs) for the PIHPs. These PMs are included and described in the PIHP / DHB contract. The PIHPs use Health Effectiveness Data and Information Set (HEDIS) technical specifications pertaining to the Medicaid population when applicable. PIHPs report on these measures on a schedule determined by the state. Reports are due on a monthly, quarterly or annual basis.
PIPs are used to monitor grievance, timely access, primary care provider/specialist capacity, coordination/continuity of care, coverage authorization and quality of care. Performance indicator data is reported in the annual Quality Improvement report and is reviewed by DHB on a quarterly basis and may require a written plan of correction to address areas of low performance.

☒ **Process**

☒ **Health status/ outcomes**

☒ **Access/ availability of care**

☒ **Use of services/ utilization**

☒ **Health plan stability/ financial/ cost of care**

☒ **Health plan/ provider characteristics**

☒ **Beneficiary characteristics**

o. ☒ **Periodic Comparison of # of Providers**

Activity Details:

PIHPs report annually on the number and types of Medicaid providers relative to the number and types of Medicaid providers prior to the start date of the contract. The state compares the PIHP provider network numbers and types on an annual basis using results from the PIHP's reported network capacity.
Periodic comparison of number and types of Medicaid providers before and after waiver is used to monitor information related to primary care provider/specialist capacity and provider selection.

p. ☐ **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:

n/a

q. ☒ **Provider Self-Report Data**

Activity Details:

The State, through its contractor CCME, administers an annual survey to measure provider satisfaction with the PIHPs' performance. The survey includes provider satisfaction with claims submissions, timeliness of payments, assistance from the PIHPs and communications with the PIHPs.
Survey results are analyzed to create a composite and to measure provider satisfaction with the PIHPs. This information is used to identify issues related to the impact of managed care programs on providers. DHB reviews these results and may require a written plan to address areas of low performance. Efforts to improve provider satisfaction are reviewed as part of the EQR process.

☐ **Survey of providers**

☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

n/a

s. ☒ **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:

PIHPs are required to conduct statistically valid sample utilization management (UM) reviews on required utilization measures. The PIHPs perform ongoing monitoring of UM data, on-site review results and claims data review. DHB reviews the PIHP utilization review process. PIHPs analyze over and under-utilization through the use of regular utilization and outlier reports. Data related to the utilization review are reported in the PIHP quality report and are reviewed DHB annually.
Utilization review is used to monitor program integrity, timely access, coverage/authorization and quality of care. The data is used to indicate opportunities for improvement and to assess compliance with utilization policies and procedures at the provider and contractor level. This information is primarily used for provider and enrollee monitoring and is part of the quality improvement statistical report. Analysis is reported to DHB. If areas for improvement are noted, the PIHPs work with the specific provider noted or incorporate the identified aspects into the implementation of performance measures. If the utilization review process identifies issues with program integrity, the contractor shall follow up with providers, recoup overpayments or report abusive or fraudulent claiming to the Medicaid Fraud Control Unit via the State Medicaid Agency.

t. ☒ **Other**

Activity Details:

PIHPs are required to administer Quality of Life Surveys (QOLS) as part of the August 23, 2012 settlement agreement with the US Department of Justice. The state implemented the QOLSs to be completed by individuals with mental illness who are transitioned out of an adult care home or a State psychiatric hospital to community living as a result of the settlement agreement. The goal of the settlement agreement is to ensure that services and supports to individuals with SMI and SPMI are of good quality, are supportive of these individuals in achieving increased independence and integration in the community, maintaining stable housing in a safe environment, and preventing unnecessary hospitalization and/or institutionalization. The PIHPs, through care and transition coordination and in-reach activities, are responsible for facilitating these transitions and making community based services available to support individuals in their transitions.
Three QOLSs are completed per transition. One is completed prior to transition, 11 months after transition and 24 months after transition. The QOLSs are used to monitor quality of care, timely access, coordination and continuity, and provider selection.
The QOLSs measure various domains which have been identified as indicators of an individual's perception of quality of life. Pre- and post-transition data is compared to determine if the State's goals for the settlement agreement are being met.

Both the monitoring of the NC Innovations Waiver and the TBI Waiver as well as the 1915(i) services follow the monitoring protocol outlined for the MH/IDD/SAS waiver. Utilization review activities are completed by the PIHP. Waiver providers and beneficiaries are included in the annual consumer and provider services. Waiver providers are included in Network Adequacy evaluations. The waivers are included in the EQR review including validation of performance measures.

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: NC MH/IDD/SUD/TBI (i) option Services

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.
For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity

- Frequency of use
- How it yields information about the area(s) being monitored

a. ☐ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organizations standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

b. ☐ **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

c. ☐ **Consumer Self-Report data**

Activity Details:

☐ **CAHPS**

Please identify which one(s):

☐ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☐ **Data Analysis (non-claims)**

Activity Details:

☐ **Denials of referral requests**

☐ **Disenrollment requests by enrollee**

☐ **From plan**

☐ **From PCP within plan**

☐ **Grievances and appeals data**

☐ **Other**

Please describe:

e. ☐ **Enrollee Hotlines**

Activity Details:

f. ☐ **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

Activity Details:

g. ☐ **Geographic mapping**

Activity Details:

h. ☐ **Independent Assessment** (Required for first two waiver periods)

Activity Details:

i. ☐ **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:

j. ☐ **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:

k. ☐ **Ombudsman**

Activity Details:

l. ☐ **On-Site Review**

Activity Details:

m. ☐ **Performance Improvement Projects** [Required for MCO/PIHP]

Activity Details:

- ☐ **Clinical**
- ☐ **Non-clinical**

n. ☐ **Performance Measures** [Required for MCO/PIHP]

Activity Details:

- ☐ **Process**
- ☐ **Health status/ outcomes**
- ☐ **Access/ availability of care**
- ☐ **Use of services/ utilization**
- ☐ **Health plan stability/ financial/ cost of care**
- ☐ **Health plan/ provider characteristics**
- ☐ **Beneficiary characteristics**

o. ☐ **Periodic Comparison of # of Providers**

Activity Details:

p. ☐ **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:

q. ☐ **Provider Self-Report Data**

Activity Details:

☐ **Survey of providers**

☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

s. ☐ **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:

t. ☐ **Other**

Activity Details:

Section C: Monitoring Results

Renewal Waiver Request

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the States Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is a renewal request.

◉ **This is the first time the State is using this waiver format to renew an existing waiver.**The State provides below the results of the monitoring activities conducted during the previous waiver period.

○ **The State has used this format previously**The State provides below the results of the monitoring activities conducted during the previous waiver period.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

The Monitoring Activities were conducted as described:

○ **Yes** ◉ **No**

If No, please explain:

Monitoring activities were conducted as described. Additional monitoring activities and supplemental information is as follows:

Summary of Monitoring Activities: Other ways of collecting feedback include feedback from advocacy groups, provider organizations, etc. Additional information is collected through complaints and grievances.

Enrollee Hotlines: The NC DHHS Customer Service Center is open during normal business hours. LME-MCOs are required to have 24-hour accessibility.

Consumer Self-Report Data: The PIHPs are given individual reports that include the results for their area. The areas identified for improvement will vary based on PIHP. Each PIHP reviews the results as part of their continuous quality improvement process and determines the root cause for each problem identified in their area. Once the root cause(s) is(are) determined, the PIHP prioritizes action on the problems identified. Performance improvement projects are implemented for prioritized problem areas. These State reviews and approves each performance improvement project prior to implementation and prior to closing the project for completion. These performance improvement projects are reported on and monitored during quarterly Intra-Departmental Monitoring Team meetings with each PIHP. They are also reviewed during the annual External Quality Review.
PIHPs also address areas for improvement related to network accessibility and access during their annual Network Adequacy Analysis and through the development of their Network Development Plan.
Additionally, each PIHP is given the option to develop Medicaid in lieu of services to address gaps in their network. Several PIHPs have taken the initiative to develop Behavioral Health Urgent Care crisis centers in lieu of Medicaid State Plan services to address the access to urgent care gap for their catchment area.

Performance Measures: The 2018/2019 contracts between the PIHPs and North Carolina Medicaid include financial penalties for PIHPs that do not meet the identified benchmark for these measures. PIHPs are highly motivated to improve performance in these areas. Each PIHP has unique qualities based on geography, population, etc. and therefore, the strategies between PIHPs varies. Some strategies include automatic assignment to care coordination for individuals being discharged, co-location of PIHP behavioral health staff in hospital location, patient reminder calls, increasing availability of community providers include after hours and weekend appointments, etc.

Geographic Mapping and Periodic Comparison of Provider: Facility based opioid treatment is a Medicaid State Plan service. There are a limited number of facilities in North Carolina available to operate this service and access is limited in many areas. The goal is to ensure that Medicaid enrollees are getting the services they need. Rather than open new facilities, the State and the PIHPs are working to develop community based opioid treatment options, including the use of Medication Assisted Treatment (MAT) and specialized services by outpatient therapy providers.

Provider Self-Report Data: The EQR results indicate that the PIHPs are meeting the requirements of the appeals process in 42 CFR 438.400-424. There has not been an increase in the number of state-level appeals, nor has there been an increase in provider complaints against the PIHPs. The state does not have any concerns at this time.

Provide the results of the monitoring activities:

Consumer Self-Report Data
Summary of results: The Adult & Child ECHO surveys were each sent to approx. 3,900 enrollee households. The response rate was 18.9% for adults & 21.5% for children.
Problems identified: Areas for improvement in adult survey include access to urgent treatment, care coordination, information, person centered plan. Areas identified in child survey include responsiveness to cultural needs, helped by treatment, access to care, person centered plan and care coordination.
Corrective action taken: N/A. PIHPs discuss ECHO report findings at quality improvement committees and create performance improvement projects, as appropriate. The EQR process monitors PIHP steps toward improvement in problem areas.
System level program changes: N/A

Data Analysis
Summary: Rate of adverse decisions on service requests has remained low (under 3%), as has the rate of appeals per 1,000 persons served (under 2.0). Rate of appeals that resulted in an overturned decision has varied from 9% to 16%. Resolution of complaints and grievances occur within 30 days 96% of the time. NC Innovations waiver services received a high number of complaints in the months following the implementation of new programs/services. There were no other patterns of complaints.
Problems identified: Service changes increased complaints and grievances.
Corrective action: Continued education by state and PIHP to providers, consumers and other stakeholders.
System level program changes: N/A

Enrollee Hotlines
Summary: PIHPs meet required benchmarks in this area. Immediate access to PIHP staff is available 24/7 for urgent issues
Problems identified: N/A
Corrective action: N/A
System level program changes: N/A

Geographic Mapping
Summary: PIHPs report an adequate network of providers in most regions for most services. Exceptions were granted for extremely rural areas and specialty providers/facilities. All PIHPs report a gap in facility based opioid treatment.
Problems identified: Gaps in rural areas and for facility based opioid treatment
Corrective action: The State and PIHPs are working together through intradepartmental monitoring and DHHS waiver advisory committees. Goals include appropriate use and access to crisis services to avoid inappropriate ED use; co-location/coordination of primary and specialty care; increase access to psychiatric services in collaboration with the State' PCCM program; work with stakeholders to further the continuum of care for children and adults with substance use issues and to increase access to services in rural areas.
System level program change: Same

Disparities by Racial/Ethnic Group
Summary of results: Survey data shows between 65 and 71% of enrollees believe that their services are culturally competent.
Problems identified: No specific issue. PIHPs work toward increased cultural competence.
Network Adequacy Study
Summary of results: PIHPs report an adequate network of providers in most regions for most services. Exceptions were granted for rural areas and specialty providers/facilities. PIHPs report a gap in facility based opioid treatment.
Problems identified: Gaps in rural areas and for facility based opioid treatment
Corrective action: See corrective action for Geo Mapping
System level program change: Same

On-site Review
Summary of results: PIHPs had on-site reviews annually through the EQR process. Results summarized annual in individual PIHP and comprehensive reports.
Problems identified: Varies based on PIHP and are managed through a corrective action process.
Corrective action: The state provides TA as needed and monitors progress on corrective action items during the quarterly monitoring team meetings.
Program change: N/A

Performance Improvement Projects
Summary: PIHPs operate at least 4 ongoing PIPs each. These are validated annually through the EQR process. PIHPs report progress to DHHS during quarterly monitoring meetings.
Problems identified: Varies, based on PIHP.
Corrective action: PIHPs make changes to PIPs when benchmarks have not been met.

Program change: N/A

Performance Measures
Summary: Improvement noted across all areas.
Problems identified: Improvement needed for 7-day follow-up after discharge for mental health and substance use disorder services.
Corrective action: PIHPs are developing improvement strategies.
Program change: N/A

Periodic Comparison of Providers
Summary: PIHPs report an adequate network of providers in most regions for most services. Exceptions were granted for extremely rural areas and specialty providers/facilities. All PIHPs report a gap in facility based opioid treatment.
Problems identified: Gaps in rural areas and for facility based opioid treatment
Corrective action: See corrective action for Geographic Mapping
System level program change: Same

Provider Self-Report Data
Summary: 5,045 providers were sent surveys, with a response rate of 61.7% in 2017. Positive changes were seen in provider satisfaction with local Provider Councils and Provider Network meetings.
Problems identified: There was decreased satisfaction in PIHP service referrals and appeals process.
Corrective action: PIHPs determine if performance improvement projects are needed to improve scores.
System level program change: N/A

Utilization Review/Utilization Management
Summary of results: PIHPs have implemented strategies to identify over/under utilization, cost outliers and special needs populations, and are taking steps to ensure the appropriate level of care coordination is available to those who needed it. PIHPs conduct internal training in areas including medical necessity and special needs populations.
Problems identified: No significant problems have been identified.
Corrective action: N/A
Program change: N/A

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
Aid for Families with Dependent Children (AFDC)	
Blind/Disabled and Foster Children	
Aged	
Innovations CAP-MR	
TBI Waiver	
M-CHIP	
Medicaid Direct BH - meeting TP criteria	
Medicaid Direct BH - not meeting TP criteria	
Foster Children - not meeting TP criteria	
Foster Children - meeting TP criteria	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	08/01/2016	07/31/2017	08/01/2017	03/31/2018
Enrollment Projections for the	07/01/2019	06/30/2020	07/01/2020	06/30/2021

**Include actual data and dates used in conversion - no estimates
*Projections start on Quarter and include data for requested waiver period

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Time Period*				

**Include actual data and dates used in conversion - no estimates
*Projections start on Quarter and include data for requested waiver period

Section D: Cost-Effectiveness

Services Included in the Waiver

Document the services included in the waiver cost-effectiveness analysis:

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Inpatient Hospital - Psych	☒	☐	☒	
Emergency Room Services with Primary MH/SA/DD Dx	☒	☐	☒	
Outpatient Clinic - Psych	☒	☐	☒	
Psychiatrist Services - including E&M codes	☒	☐	☒	
Behavioral Health Long-Term Residential - Children	☒	☐	☒	
Mobile Crisis Management	☒	☐	☒	
Professional Treatment in facility based crisis	☒	☐	☒	
Diagnostic Assessment	☒	☐	☒	
Community Support	☒	☐	☒	
Targeted Case Management	☒	☐	☒	
Assertive Community Treatment Team	☒	☐	☒	
Multi-Systemic Therapy	☒	☐	☒	
Intensive In-Home Services	☒	☐	☒	
Child/Adolescent Day Treatment	☒	☐	☒	
Partial Hospitalization	☒	☐	☒	
Psychosocial Rehabilitation	☒	☐	☒	
SA-Detox	☒	☐	☒	
SA - Residential Rehab	☒	☐	☒	
SA - Rehab (SAIOP and SACOT)	☒	☐	☒	
Opioid Treatment	☒	☐	☒	
Innovations Waiver Services	☐	☐	☒	
TBI Waiver Services	☐	☐	☒	
Prescribed Drugs - BH	☒	☐	☐	
ICF-MR	☒	☐	☒	
Respite - end date 3/31/22	☐	☒	☐	

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Supported Employment	☐	☒	☐	
Personal Care (Individual Support)	☐	☒	☐	
One-Time Transitional Costs	☐	☒	☐	
Psychosocial Rehab (Peer Supports)	☒	☐	☒	
Innovations Waiver Services	☐	☒	☐	
Physician Consultation	☐	☒	☐	
Community Navigator	☐	☒	☐	
In-Home Skill Building	☐	☒	☐	
Transitional Living Skills	☐	☒	☐	
Intensive Recovery Supports	☐	☒	☐	
Community Living and Supports (CLS) - 1915(i) - Effective 4/1/23	☒	☐	☐	
Respite - 1915(i) - Effective 4/1/23	☒	☐	☐	
Supported Employment - 1915(i) - Effective 4/1/23	☒	☐	☐	
Community Transition - 1915(i)	☒	☐	☐	
Individual and Transitional Support - 1915(i) - Effective 4/1/23	☒	☐	☐	
Tailored Care Management - Effective 4/1/23	☒	☐	☐	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the States waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the States submitted CMS-64 forms.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when

the State Medicaid Director submits the application.

Cost-effectiveness spreadsheet is required for all 1915b waiver submissions.

b. Name of Medicaid Financial Officer making these assurances:

Al Greco

c. Telephone Number:

(919) 527-7125

d. E-mail:

alfred.greco@dhhs.nc.gov

e. The State is choosing to report waiver expenditures based on

◉ **date of payment.**

○ **date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.**

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

b. ☒ The State provides additional services under 1915(b)(3) authority.

c. ☒ The State makes enhanced payments to contractors or providers.

d. ☒ The State uses a sole-source procurement process to procure State Plan services under this waiver.

e. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete ***Appendix D3***
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

Section D: Cost-Effectiveness

Part I: State Completion Section

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in A.I.b.

a. ☐ **MCO**
b. ☒ **PIHP**
c. ☐ **PAHP**
d. ☐ **PCCM**
e. ☐ **Other**

Please describe:

Section D: Cost-Effectiveness

Part I: State Completion Section

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a. ☐ **Management fees are expected to be paid under this waiver.**
The management fees were calculated as follows.
1. ☐ **Year 1: $ per member per month fee.**
2. ☐ **Year 2: $ per member per month fee.**
3. ☐ **Year 3: $ per member per month fee.**
4. ☐ **Year 4: $ per member per month fee.**

b. ☐ **Enhanced fee for primary care services.**
Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. ☐ **Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization.** Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

d. ☐ **Other reimbursement method/amount.**
$
Please explain the State's rationale for determining this method or amount.

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

a. ☒ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b. ☒ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c. ☒ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

Below is a chart that summarizes the historical membership trends by quarter and MEG used as the basis for determining the R1–P1 and P1–P5 membership trends:

MEG	R5-P1 Quarterly Projected Trends	P1-P5 Quarterly Projected Trends
MEG 01 AFDC	0.5%	0.5%
MEG 02 Blind/Disabled and Foster Children	0.5%	0.5%
MEG 03 Aged	0.0%	0.0%
MEG 04 Innovations CAP-MR	0.5%	0.0%
MEG 05 M-CHIP	0.5%	0.5%
Total	0.5%	0.5%

Effective January 1, 2018, the State implemented a 1915(c) waiver to provide HCBS services to individuals with a Traumatic Brain Injury (TBI). This program initially served as a pilot program in the Alliance catchment area, which includes Cumberland, Durham, Johnston and Wake counties. Effective 9/1/22, the NC TBI Waiver will include Alliances updated catchment area, Cumberland, Durham, Johnston, Mecklenburg, Orange and Wake counties. HCBS services will be provided in lieu of Institutional services that could have been provided in Rehabilitation Hospitals, Chronic Care Hospitals or Skilled Nursing Facilities. A new TBI Waiver MEG was built into the waiver to track these individuals separately. Mercer utilized the requested waiver slots for the 1915(c) waiver to assign enrollment for this MEG (49 and 99 eligibles for the first and second year, respectively). No additional growth was assumed for the population beyond the number of requested waiver slots

d. ☒ [Required] Explain any other variance in eligible member months from BY/R1 to P2:

[7-1-21 Update]: Additionally enrollment projections account for the anticipated changes due to the implementation of comprehensive managed care authorized by the 1115 waiver approved by CMS. A significant portion of members currently served under the 1915(b) waiver will transition to the managed care program under the 1115 waiver. Transitioning populations are planned to shift out of the 1915(b) waiver BH program statewide effective July 1, 2021. Adjustments have been incorporated into the enrollment projections to reflect these significant declines in membership in the P3 period. Innovations and TBI waivers will not be impacted by the initial implementation. The Aged MEG has also not been adjusted since dual eligible members are excluded from initial comprehensive managed care and the majority of Aged members are dual eligible.

The following adjustments were applied to the member months for the AFDC/MCHIP and Blind/Disabled Foster Care MEGs beginning in P3 of the waiver.

- AFDC/MCHIP: -94% adjustment to MMs as populations transition to Standard Plan
- Blind/Disabled and Foster Care: -32% adjustment to MMs as populations transition to Standard Plan

e. ☒ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

R1 – R4 reflect August through September time periods (e.g. R1 is August 1, 2013 through July 31, 2014 and R2 is August 1, 2014 through July 31, 2015). R5 includes data from the August 2017 through June 2018 time period.

Note upon comparison of the R1-R5 member months against other state reports used for capitation rate-setting, it was noted that the member months initially reported to CMS during the waiver renewal were overstated for certain periods. The member months have been adjusted on Appendix D1 that results in updates to the base PMPMs calculated on Appendix D3 that are used in the cost projections. These adjustments produced waiver PMPMs better calibrated to the capitation rates and ultimately higher D5 waiver cost projections.

Appendix D1 Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

F. Appendix D2.S - Services in Actual Waiver Cost

For Conversion or Renewal Waivers:

a. ☒ **[Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5.**
Explain the differences here and how the adjustments were made on Appendix D5:

The total actual waiver costs reported on Appendix D3, including total service and administration costs, are summarized directly from the waiver reporting schedules, specifically Schedule F. Total service costs were allocated to capitated state plan and 1915(b)(3) services using supplemental calculations. 1915(b)(3) costs are summarized from the separately certified 1915(b)(3) service rates multiplied by the actual member months under the waiver. The remaining costs were allocated to capitated state plan expenditures.

Appendix D5 reflects the statewide expansion effective P1 of three 1915(b)(3) services, including in-home skill building, transitional living, and independent support, which were piloted by Cardinal Innovations in the prior waiver. This change, along with other anticipated increases in 1915(b)(3) spending, are reflected in the P1 service adjustment on Appendix D5.

[7-1-22 Update]: Schedule D2.S has been updated to reflect the addition of Tailored Care Management Health Home State Plan service and the transition of 1915(b)(3) services to 1915(i) services.

Tailored Care Management was added to Schedule D2.S and was considered in the policy/pricing change adjustments within the State Plan services projection. Estimated payments for the service are based on anticipated levels of eligibility, engagement and acuity within the PIHP program.

Prior to April 1, 2023, NCDHHS uses 1915(b)(3) authority to cover a set of critical HCBS provided by PIHPs to Medicaid beneficiaries with significant behavioral health needs, I/DDs, and TBI. With the managed care transition, NCDHHS will use a new federal authority to offer Medicaid managed care and will no longer be able to use 1915(b)(3) authority to cover these HCBS for populations enrolled under the 1115 waiver authority. As a result, NCDHHS has developed a modified array of services to offer through the federal 1915(i) State Plan option upon launch of the Tailored Plans.

These services were added to Schedule D2.S and were considered in the policy/pricing change adjustments within the State Plan Services and 1915(b)(3) Services projections. The State Plan adjustments reflect the addition of 1915(i) services for populations that will remain in the PIHP program. These adjustments consider the discontinuation of some 1915(b)(3) services and changes in utilization expectations under the 1915(i) service definitions. The negative adjustments for the 1915(b)(3) Services reflect the transition of these expenses to the State Plan. Note Projection Year 4 reflects a partial year phase-in of these adjustments.

b. ☒ **[Required] Explain the exclusion of any services from the cost-effectiveness analysis.**
For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

Audited CMS 64 reports were used as the basis of the cost effectiveness analysis. All services covered under the waiver are included in the cost-effectiveness analysis. Costs for services in the Innovations Program are included in the analysis. Acute care services under the 1932 SPA are excluded from the cost-effectiveness. The State has documented that for a single beneficiary under the 1932 SPA and the (b)(c) concurrent waiver all costs for individuals are reported on either the CMS 64.9 Waiver forms for the 1915(b)(c) concurrent waivers or on the CMS 64.9 Base form with other 1932 SPA costs.

[7-1-21 Update]: As noted earlier, NC plans to begin implementation of comprehensive managed care under the 1115 waiver on July 1, 2021. This waiver amendment addresses the anticipated enrollment and PMPM projections for the population changes due to this implementation. These projections assume that Medicaid eligibles are only covered through either the 1115 waiver or the 1915(b) waiver.

[7-1-22 Update]: As noted earlier, NC will implement the Tailored Plan program on April 1, 2023. This waiver amendment addresses the anticipated enrollment and PMPM projections for the population changes due to this implementation. These projections assume that Medicaid eligible are only covered under managed care through either the 1115 waiver or the 1915(b) waiver.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Inpatient Hospital - Psych	☐	☐	☐	☒	☐	☐	☐
Emergency Room Services with Primary MH/SA/DD Dx	☐	☐	☐	☒	☐	☐	☐
Outpatient Clinic - Psych	☐	☐	☐	☒	☐	☐	☐
Psychiatrist Services - including E&M codes	☐	☐	☐	☒	☐	☐	☐
Behavioral Health Long-Term Residential - Children	☐	☐	☐	☒	☐	☐	☐
Mobile Crisis Management	☐	☐	☐	☒	☐	☐	☐
Professional Treatment in facility based crisis	☐	☐	☐	☒	☐	☐	☐
Diagnostic Assessment	☐	☐	☐	☒	☐	☐	☐
Community Support	☐	☐	☐	☒	☐	☐	☐
Targeted Case Management	☐	☐	☐	☒	☐	☐	☐
Assertive	☐	☐	☐	☒	☐	☐	☐

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Community Treatment Team							
Multi-Systemic Therapy	☐	☐	☐	☒	☐	☐	☐
Intensive In-Home Services	☐	☐	☐	☒	☐	☐	☐
Child/Adolescent Day Treatment	☐	☐	☐	☒	☐	☐	☐
Partial Hospitalization	☐	☐	☐	☒	☐	☐	☐
Psychosocial Rehabilitation	☐	☐	☐	☒	☐	☐	☐
SA-Detox	☐	☐	☐	☒	☐	☐	☐
SA - Residential Rehab	☐	☐	☐	☒	☐	☐	☐
SA - Rehab (SAIOP and SACOT)	☐	☐	☐	☒	☐	☐	☐
Opioid Treatment	☐	☐	☐	☒	☐	☐	☐
Innovations Waiver Services	☐	☐	☐	☒	☐	☐	☐
TBI Waiver Services	☐	☐	☐	☒	☐	☐	☐
Prescribed Drugs - BH	☐	☐	☐	☐	☒	☐	☐
ICF-MR	☐	☐	☐	☒	☐	☐	☐
Respite - end date 3/31/22	☐	☐	☐	☒	☐	☐	☐
Supported Employment	☐	☐	☐	☒	☐	☐	☐
Personal Care (Individual Support)	☐	☐	☐	☒	☐	☐	☐
One-Time Transitional Costs	☐	☐	☐	☒	☐	☐	☐
Psychosocial Rehab (Peer Supports)	☐	☐	☐	☒	☐	☐	☐
Innovations Waiver Services	☐	☐	☐	☒	☐	☐	☐
Physician Consultation	☐	☐	☐	☒	☐	☐	☐
Community Navigator	☐	☐	☐	☒	☐	☐	☐
In-Home Skill Building	☐	☐	☐	☒	☐	☐	☐
Transitional Living Skills	☐	☐	☐	☒	☐	☐	☐
Intensive	☐	☐	☐	☒	☐	☐	☐

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Recovery Supports							
Community Living and Supports (CLS) - 1915(i) - Effective 4/1/23	☐	☐	☐	☐	☐	☐	☐
Respite - 1915(i) - Effective 4/1/23	☐	☐	☐	☐	☐	☐	☐
Supported Employment - 1915(i) - Effective 4/1/23	☐	☐	☐	☐	☐	☐	☐
Community Transition - 1915(i)	☐	☐	☐	☐	☐	☐	☐
Individual and Transitional Support - 1915(i) - Effective 4/1/23	☐	☐	☐	☐	☐	☐	☐
Tailored Care Management - Effective 4/1/23	☐	☐	☐	☐	☐	☐	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*
The allocation method for either initial or renewal waivers is explained below:

- **a.** ☐ **The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees***Note: this is appropriate for MCO/PCCM programs.*
- **b.** ☒ **The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled.***Note: this is appropriate for statewide PIHP/PAHP programs.*
- **c.** ☐ **Other**
  Please explain:

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

a. ☒ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the States Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the States Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5.**

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
Inpatient Hospital - Psych			
Emergency Room Services with Primary MH/SA/DD Dx			
Outpatient Clinic - Psych			
Psychiatrist Services - including E&M codes			
Behavioral Health Long-Term Residential - Children			
Mobile Crisis Management			
Professional Treatment in facility based crisis			
Diagnostic Assessment			
Total:	$57,062,970 or $3.45 PMPM in R1 $60,847,741 or $3.32 PMPM in R2 $49,226,010 or $2.66 PMPM in R3 $76,724,508 or $3.83 PMPM in R4 $98,209,244 or $5.29 PMPM in R5	3.1% inflation and 77.2% adjustment equate to $4.69 increase in P2 3.1% inflation equates to $0.32 increase in P2 3.1% inflation equates to $0.31 increase in P3 3.1% inflation equates to $0.32 increase in P4 3.1% inflation equates to $0.34 increase in P5	$9.97 PMPM in P1 $10.27 PMPM in P2 $10.59 PMPM in P3 $10.91 PMPM in P4 $11.25 PMPM in P5

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
Community Support			
Targeted Case Management			
Assertive Community Treatment Team			
Multi-Systemic Therapy			
Intensive In-Home Services			
Child/Adolescent Day Treatment			
Partial Hospitalization			
Psychosocial Rehabilitation			
SA-Detox			
SA - Residential Rehab			
SA - Rehab (SAIOP and SACOT)			
Total:	$57,062,970 or $3.45 PMPM in R1 $60,847,741 or $3.32 PMPM in R2 $49,226,010 or $2.66 PMPM in R3 $76,724,508 or $3.83 PMPM in R4 $98,209,244 or $5.29 PMPM in R5	3.1% inflation and 77.2% adjustment equate to $4.69 increase in P2 3.1% inflation equates to $0.32 increase in P2 3.1% inflation equates to $0.31 increase in P3 3.1% inflation equates to $0.32 increase in P4 3.1% inflation equates to $0.34 increase in P5	$9.97 PMPM in P1 $10.27 PMPM in P2 $10.59 PMPM in P3 $10.91 PMPM in P4 $11.25 PMPM in P5

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
Opioid Treatment			
Innovations Waiver Services			
TBI Waiver Services			
Prescribed Drugs - BH			
ICF-MR			
Respite - end date 3/31/22	$5,983,621 or $0.36 PMPM in R1 $6,380,492 or $0.35 PMPM in R2 $5,161,837 or $0.28 PMPM in R3 $8,045,329 or $0.40 PMPM in R4 $10,298,217 or $0.55 PMPM in R5	3.1% inflation and 77.2% adjustment equate to $0.47 increase in P2 3.1% inflation equates to $0.03 increase in P2 3.1% inflation equates to $0.04 increase in P3 3.1% inflation equates to $0.03 increase in P4 3.1% inflation equates to $0.03 increase in P5	$1.02 PMPM in P1 $1.05 PMPM in P2 $1.09 PMPM in P3 $1.12 PMPM in P4 $1.15 PMPM in P5
Supported Employment			
Total:	$57,062,970 or $3.45 PMPM in R1 $60,847,741 or $3.32 PMPM in R2 $49,226,010 or $2.66 PMPM in R3 $76,724,508 or $3.83 PMPM in R4 $98,209,244 or $5.29 PMPM in R5	3.1% inflation and 77.2% adjustment equate to $4.69 increase in P2 3.1% inflation equates to $0.32 increase in P2 3.1% inflation equates to $0.31 increase in P3 3.1% inflation equates to $0.32 increase in P4 3.1% inflation equates to $0.34 increase in P5	$9.97 PMPM in P1 $10.27 PMPM in P2 $10.59 PMPM in P3 $10.91 PMPM in P4 $11.25 PMPM in P5

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
	$457,876 or $0.03 PMPM in R1 $488,246 or $0.03 PMPM in R2 $394,992 or $0.02 PMPM in R3 $615,642 or $0.03 PMPM in R4 $788,036 or $0.04 PMPM in R5	3.1% inflation and 77.2% adjustment equate to $0.12 increase in P2 3.1% inflation equates to $0.00 increase in P2 3.1% inflation equates to $0.01 increase in P3 3.1% inflation equates to $0.00 increase in P4 3.1% inflation equates to $0.01 increase in P5	$0.16 PMPM in P1 $0.16 PMPM in P2 $0.17 PMPM in P3 $0.17 PMPM in P4 $0.18 PMPM in P5
Personal Care (Individual Support)	$7,868,230 or $0.48 PMPM in R1 $8,390,100 or $0.46 PMPM in R2 $6,787,617 or $0.37 PMPM in R3 $10,579,297 or $0.53 PMPM in R4 $13,541,758 or $0.73 PMPM in R5	3.1% inflation and 77.2% adjustment equate to $0.61 increase in P2 3.1% inflation equates to $0.05 increase in P2 3.1% inflation equates to $0.04 increase in P3 3.1% inflation equates to $0.04 increase in P4 3.1% inflation equates to $0.05 increase in P5	$1.34 PMPM in P1 $1.39 PMPM in P2 $1.43 PMPM in P3 $1.47 PMPM in P4 $1.52 PMPM in P5
One-Time Transitional Costs			$0.00 PMPM in P1 $0.00 PMPM in P2 $0.00 PMPM in P3 $0.00 PMPM in P4 $0.00 PMPM in P5
Total:	$57,062,970 or $3.45 PMPM in R1 $60,847,741 or $3.32 PMPM in R2 $49,226,010 or $2.66 PMPM in R3 $76,724,508 or $3.83 PMPM in R4 $98,209,244 or $5.29 PMPM in R5	3.1% inflation and 77.2% adjustment equate to $4.69 increase in P2 3.1% inflation equates to $0.32 increase in P2 3.1% inflation equates to $0.31 increase in P3 3.1% inflation equates to $0.32 increase in P4 3.1% inflation equates to $0.34 increase in P5	$9.97 PMPM in P1 $10.27 PMPM in P2 $10.59 PMPM in P3 $10.91 PMPM in P4 $11.25 PMPM in P5

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
	$25,125 or $0.00 PMPM in R1 $26,792 or $0.00 PMPM in R2 $21,675 or $0.00 PMPM in R3 $33,783 or $0.00 PMPM in R4 $43,243 or $0.00 PMPM in R5	3.1% inflation and 77.2% adjustment equate to $0.00 increase in P2 3.1% inflation equates to $0.00 increase in P2 3.1% inflation equates to $0.00 increase in P3 3.1% inflation equates to $0.00 increase in P4 3.1% inflation equates to $0.00 increase in P5	
Psychosocial Rehab (Peer Supports)	$30,195,211 or $1.82 PMPM in R1 $32,197,945 or $1.76 PMPM in R2 $26,048,237 or $1.41 PMPM in R3 $40,599,231 or $2.03 PMPM in R4 $51,968,007 or $2.80 PMPM in R5 $6,519,242 or $0.39 PMPM in R1 $6,951,639 or $0.38 PMPM in R2 $5,623,898 or $0.30 PMPM in R3 $8,765,504 or $0.44 PMPM in R4 $11,220,059 or $0.60 PMPM in R5		$5.16 PMPM in P1 $5.32 PMPM in P2 $5.48 PMPM in P3 $5.65 PMPM in P4 $5.82 PMPM in P5 $1.11 PMPM in P1 $1.15 PMPM in P2 $1.18 PMPM in P3 $1.22 PMPM in P4 $1.26 PMPM in P5
Total:	$57,062,970 or $3.45 PMPM in R1 $60,847,741 or $3.32 PMPM in R2 $49,226,010 or $2.66 PMPM in R3 $76,724,508 or $3.83 PMPM in R4 $98,209,244 or $5.29 PMPM in R5	3.1% inflation and 77.2% adjustment equate to $4.69 increase in P2 3.1% inflation equates to $0.32 increase in P2 3.1% inflation equates to $0.31 increase in P3 3.1% inflation equates to $0.32 increase in P4 3.1% inflation equates to $0.34 increase in P5	$9.97 PMPM in P1 $10.27 PMPM in P2 $10.59 PMPM in P3 $10.91 PMPM in P4 $11.25 PMPM in P5

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
		3.1% inflation and 77.2% adjustment = $2.36 increase in P2 3.1% inflation = $0.16 increase in P2 3.1% = to $0.16 increase in P3 3.1% = to $0.17 increase in P4 3.1% = $0.17 increase in P5 3.1% and 78.5% adjustment =to $0.51 increase in P2 3.1% = $0.04 increase in P2 3.1% = $0.03 increase in P3 3.1% = $0.04 increase in P4 3.1% = $0.04 increase in P5	
Innovations Waiver Services	$4,980,937 or $0.30 PMPM in R1 $5,311,304 or $0.29 PMPM in R2 $4,296,861 or $0.23 PMPM in R3 $6,697,162 or $0.33 PMPM in R4 $8,572,531 or $0.46 PMPM in R5		$0.99 PMPM in P1 $1.02 PMPM in P2 $1.05 PMPM in P3 $1.08 PMPM in P4 $1.11 PMPM in P5
Total:	$57,062,970 or $3.45 PMPM in R1 $60,847,741 or $3.32 PMPM in R2 $49,226,010 or $2.66 PMPM in R3 $76,724,508 or $3.83 PMPM in R4 $98,209,244 or $5.29 PMPM in R5	3.1% inflation and 77.2% adjustment equate to $4.69 increase in P2 3.1% inflation equates to $0.32 increase in P2 3.1% inflation equates to $0.31 increase in P3 3.1% inflation equates to $0.32 increase in P4 3.1% inflation equates to $0.34 increase in P5	$9.97 PMPM in P1 $10.27 PMPM in P2 $10.59 PMPM in P3 $10.91 PMPM in P4 $11.25 PMPM in P5

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
		3.1% inflation and 77.2% adjustment equate to $0.53 increase in P2 3.1% inflation equates to $0.03 increase in P2 3.1% inflation equates to $0.03 increase in P3 3.1% inflation equates to $0.03 increase in P4 3.1% inflation equates to $0.03 increase in P5	
Physician Consultation	$2,329 or $0.00 PMPM in R1 $2,484 or $0.00 PMPM in R2 $2,010 or $0.00 PMPM in R3 $3,132 or $0.00 PMPM in R4 $4,009 or $0.00 PMPM in R5	3.1% inflation and 77.2% adjustment equate to $0.00 increase in P2 3.1% inflation equates to $0.00 increase in P2 3.1% inflation equates to $0.00 increase in P3 3.1% inflation equates to $0.00 increase in P4 3.1% inflation equates to $0.00 increase in P5	$0.00 PMPM in P1 $0.00 PMPM in P2 $0.00 PMPM in P3 $0.00 PMPM in P4 $0.00 PMPM in P5
Community Navigator			$0.17 PMPM in P1 $0.18 PMPM in P2 $0.18 PMPM in P3 $0.19 PMPM in P4 $0.20 PMPM in P5
Total:	$57,062,970 or $3.45 PMPM in R1 $60,847,741 or $3.32 PMPM in R2 $49,226,010 or $2.66 PMPM in R3 $76,724,508 or $3.83 PMPM in R4 $98,209,244 or $5.29 PMPM in R5	3.1% inflation and 77.2% adjustment equate to $4.69 increase in P2 3.1% inflation equates to $0.32 increase in P2 3.1% inflation equates to $0.31 increase in P3 3.1% inflation equates to $0.32 increase in P4 3.1% inflation equates to $0.34 increase in P5	$9.97 PMPM in P1 $10.27 PMPM in P2 $10.59 PMPM in P3 $10.91 PMPM in P4 $11.25 PMPM in P5

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
	$1,013,487 or $0.06 PMPM in R1 $1,080,708 or $0.06 PMPM in R2 $874,296 or $0.05 PMPM in R3 $1,362,694 or $0.07 PMPM in R4 $1,744,280 or $0.09 PMPM in R5	3.1% inflation and 77.2% adjustment equate to $0.08 increase in P2 3.1% inflation equates to $0.01 increase in P2 3.1% inflation equates to $0.00 increase in P3 3.1% inflation equates to $0.01 increase in P4 3.1% inflation equates to $0.01 increase in P5	
In-Home Skill Building			
Transitional Living Skills			
Intensive Recovery Supports	$16,728 or $0.00 PMPM in R1 $17,838 or $0.00 PMPM in R2 $14,431 or $0.00 PMPM in R3 $22,492 or $0.00 PMPM in R4 $28,791 or $0.00 PMPM in R5		$0.01 PMPM in P1 $0.01 PMPM in P2 $0.01 PMPM in P3 $0.01 PMPM in P4 $0.01 PMPM in P5
Total:	$57,062,970 or $3.45 PMPM in R1 $60,847,741 or $3.32 PMPM in R2 $49,226,010 or $2.66 PMPM in R3 $76,724,508 or $3.83 PMPM in R4 $98,209,244 or $5.29 PMPM in R5	3.1% inflation and 77.2% adjustment equate to $4.69 increase in P2 3.1% inflation equates to $0.32 increase in P2 3.1% inflation equates to $0.31 increase in P3 3.1% inflation equates to $0.32 increase in P4 3.1% inflation equates to $0.34 increase in P5	$9.97 PMPM in P1 $10.27 PMPM in P2 $10.59 PMPM in P3 $10.91 PMPM in P4 $11.25 PMPM in P5

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
		3.1% inflation and 77.2% adjustment equate to $0.01 increase in P2 3.1% inflation equates to $0.00 increase in P2 3.1% inflation equates to $0.00 increase in P3 3.1% inflation equates to $0.00 increase in P4 3.1% inflation equates to $0.00 increase in P5	
Community Living and Supports (CLS) - 1915(i) - Effective 4/1/23			
Respite - 1915(i) - Effective 4/1/23			
Supported Employment - 1915(i) - Effective 4/1/23			
Community Transition - 1915(i)			
Individual and Transitional Support - 1915(i) - Effective 4/1/23			
Tailored Care Management - Effective 4/1/23			
Total:	$57,062,970 or $3.45 PMPM in R1 $60,847,741 or $3.32 PMPM in R2 $49,226,010 or $2.66 PMPM in R3 $76,724,508 or $3.83 PMPM in R4 $98,209,244 or $5.29 PMPM in R5	3.1% inflation and 77.2% adjustment equate to $4.69 increase in P2 3.1% inflation equates to $0.32 increase in P2 3.1% inflation equates to $0.31 increase in P3 3.1% inflation equates to $0.32 increase in P4 3.1% inflation equates to $0.34 increase in P5	$9.97 PMPM in P1 $10.27 PMPM in P2 $10.59 PMPM in P3 $10.91 PMPM in P4 $11.25 PMPM in P5

b. ☐ **The State is including voluntary populations in the waiver.**
Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c. ☒ **Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage:** Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.
Basis and Method:

1. ☐ **The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.**
2. ☒ **The State provides stop/loss protection**
   Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

   The State's capitated contract with the PIHPs contains a requirement for a risk reserve account. The State will explicitly include 2% in the administrative portion of the capitated rate to fund this account. This account will accumulate up to a maximum of 15% of annual premiums and be used to fund periodic shortfalls in capitation revenue if monthly expenses exceed revenue consistent with CMS financial solvency guidelines. Given this arrangement, the State has chosen not to require additional stop/loss protection for this programs.

d. ☒ **Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:**

1. ☒ **[For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program.** The costs associated with any bonus arrangements must be accounted for in the capitated costs (Column D of Appendix D3 Actual Waiver Cost). Regular State Plan service capitated adjustments would apply.

   Document

   i. **Document the criteria for awarding the incentive payments.**
   ii. **Document the method for calculating incentives/bonuses, and**
   iii. **Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.**

   [7-1-22 Update]: The Care Management Capacity Building Performance Incentive Program was implemented to incentivize activities that will support successful launch on April 1, 2023 and ongoing operations of the Tailored Care Management model. PIHPs are eligible to receive quarterly incentive payments for the achievement of milestones that support care management capabilities and care management providers. DHHS has defined milestones, such as developing Healthcare Information Technology infrastructure, hiring additional care managers, completing training with care management providers, and developing other operational competencies.

   The incentive cost projections in Projection Years 3 and 4 were based on actual payments made for quarters ending March 2022 and June 2022. This incentive program is intended to support the successful launch of Tailored Care Management on April 1, 2023. For purposes of the 1915(b) waiver, incentive PMPMs are assumed to be zero in Projection Year 5.

2. ☐ **For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (Column G of Appendix D3 Actual Waiver Cost).**). For PCCM providers, the amount listed should match information provided in D.I.D Reimbursement of Providers. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (See D.I.I.e and D.I.J.e)

Document:

i. **Document the criteria for awarding the incentive payments.**
ii. **Document the method for calculating incentives/bonuses, and**
iii. **Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.**

Appendix D3 Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (3 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (4 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (8 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (1 of 5)

a. State Plan Services Trend Adjustment the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **. This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. ☒ **[Required, if the States BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present).**

   The actual trend rate used is: 4.80

   Please document how that trend was calculated:

Overall, rate trends as documented in Appendix D3 reflect decreases consistent with historical trends in rate setting data through SFY 2016 (July 2015 – June 2016) due to the implementation of managed care. Subsequently, positive trends have been observed in more recent rate setting data between SFY 2016 and SFY 2017 (July 2016 – June 2017). The observed trends in D3 and more recent rate setting data have been summarized in the tables below.

Appendix D3 Data

MEG	R1 to R2	R2 to R3	R3 to R4	R4 to R5
MEG 01 AFDC	0.7%	-13.5%	-12.3%	-5.4%
MEG 02 Blind/Disabled and Foster Children	3.5%	1.2%	-4.4%	-3.1%
MEG 03 Aged	11.9%	11.2%	3.2%	9.6%
MEG 04 Innovations CAP-MR	10.3%	5.9%	-3.9%	2.3%
MEG 05 M-CHIP	13.1%	-6.1%	-20.6%	-2.8%
Total*	5.1%	-0.4%	-5.8%	-1.4%

*Total based on constant case mix with R5 MMs

Prospective trend factors consistent with actuarial analysis for rate-setting were used to trend from the end of the R5 base period (June 30, 2018) to the start of the renewal waiver (July 1, 2019). The factors were updated based on emerging trends exhibited in PIHP claims data and capitation rates. Subsequent to July 2018, the State observed trends in autism services for children, increases in ICF IID services particularly for the Aged population, and general emerging trends for the treatment of substance use disorder services.

The waiver trends were updated to better align with the recent capitation rate changes noted in the table below.

Annual Capitation Rate Changes

Medicaid Eligibility Group (MEG)	FY17->FY18	FY18->FY19	FY19->FY20	FY20-FY21	Revised Trend
Capitated - AFDC	-3.6%	-1.0%	10.3%	20.4%	7.0%
Capitated - Blind/Disabled and Foster Children	0.2%	1.0%	2.0%	6.0%	3.0%
Capitated - Aged	13.9%	12.3%	10.3%	12.5%	13.0%
Capitated - Innovations CAP-MR	6.8%	4.3%	0.8%	5.5%	5.0%
Capitated - TBI Waiver	0.0%	2.6%	1.9%	9.4%	5.0%
Capitated - M-CHIP	-3.6%	-1.0%	10.3%	20.4%	7.0%

[7-1-22 Update]: Under the new MEG structure, there are four new population groupings. The trend factors were set equal to those established in initial waiver renewal for the most applicable population. The Medicaid Direct – meeting and not meeting TP criteria groups are primarily dual eligible members who are Aged MEG; thus, the Aged MEG trend factor was used for these new MEGs in Projection Year 4 and 5. The Foster Children – meeting and not meeting TP criteria trend factors were set equal to the historical Blind/Disabled and Foster Children MEG assumption.

2. ☒ **[Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations)** *(i.e., trending from present into the future).*

   i. ☒ **State historical cost increases.**

   Please indicate the years on which the rates are based: base years. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the States cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

For the prospective trend analysis, as discussed above, five years of waiver reported data was available to assist in the development of the trend assumptions, in addition to capitated rate-setting data. An actuarial analysis consistent with the rate-setting process was used to develop assumptions by MEG with a focus on trends in the actual PIHP claims data which should be more indicative of future rate-setting trends.

The new TBI population will be accessing many of the same services as the Innovations population and the State expects the providers of these services (qualifications, etc.) to be similar, if not the same, as those serving the current Innovations waiver participants. Thus, the trends for this MEG have been set equal to those of the Innovations MEG.

In the analysis of waiver and rate-setting trends, Mercer considers historical year over year trends, as well as rolling averages in making these estimates. No adjustments for programmatic, policy, or pricing changes were necessary; therefore, trend estimates do not duplicate the effect of any changes. The final annual trend assumptions incorporating the twelve months of actual trend from the end of R2 to the beginning of P1 as well as the prospective trend for twelve months of P1 are documented in the following chart.

Time Period	Trend Assumption
End of R5 (9/30/2017) to Start of P1 (7/1/19)	3.5%
P1 (7/1/19-6/30/20)	3.5%
Annualized Trend From End of R5 to End of P1	3.5%
P2-P5 Trend Rate	3.5%

ii. ☐ **National or regional factors that are predictive of this waivers future costs.**
Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waivers future costs. Finally, please note and explain if the States cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. ☐ **The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase.**
Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).
ii. Please document how the utilization did not duplicate separate cost increase trends.

Appendix D4 Adjustments in Projection

Section D: Cost-Effectiveness

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J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (2 of 5)

b. State Plan Services Programmatic/Policy/Pricing Change Adjustment: This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit

coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1. ☐ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. ☒ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i. ☐ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Determine adjustment for Medicare Part D dual eligibles.

E. ☐ Other:
Please describe

ii. ☐ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii. ☐ Changes brought about by legal action:

Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Other
Please describe

iv. ☐ Changes in legislation.
Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA
PMPM size of adjustment

D. ☐ Other
Please describe

v. ☒ Other
Please describe:

[4-1-23 Update] Adequate response cannot fit into this field. Additional description on page 110 of attached document-several new program changes impacting Projection Year 4 including EVV/DCW rate increases, ASAM SUD, ED Bed Holds, ITS and ILOS rate increases, 1915(i) transition, Tailored Care Management service addition and acuity adjustments related to the population changes on 4/1/2023.

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Other
Please describe

Section D: Cost-Effectiveness

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J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (3 of 5)

c. Administrative Cost Adjustment: This adjustment accounts for changes in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. ☐ No adjustment was necessary and no change is anticipated.

2. ☒ An administrative adjustment was made.

i. ☐ Administrative functions will change in the period between the beginning of P1 and the end of P2.
Please describe:

ii. ☒ Cost increases were accounted for.

A. ☐ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. ☐ State Historical State Administrative Inflation. THe actual trend rate used is PMPM size of adjustment

0.00

Please describe:

D. ☒ Other

Please describe:

An adequate response cannot fit into this field. Additional description on page 106 of attached document. Adjustments applied due to implementation of 1115. Majority of service expenditures and admin remaining while enrollment substantially reduced.

iii. ☒ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate.
Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate.

Please indicate the years on which the rates are based: base years

2013-2018

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the States cost increase calculation includes more factors than a price increase.

Declining PMPM trends have been observed on admin data. Membership growth for lower cost populations are likely contributing to this PMPM decline. Given the population has reached a steady state, admin trends are anticipated to increase prospectively. The admin costs have been projected using a 2% annualized administrative trend factor.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate.
Please indicate the State Plan Service trend rate from Section D.I.J.a. above

4.80

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J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (4 of 5)

d. 1915(b)(3) Adjustment: The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in ***Section D.I.H.a*** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. ☒ [Required, if the States BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (i.e., trending from 1999 to present).
The actual documented trend is:

4.00

Please provide documentation.

To project P1 PMPMs for 1915(b)(3) services, trend consistent with State Plan levels were assumed prior to the application of the adjustment noted previously.

2. ☒ [Required, when the States BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (i.e., trending from present into the future), the State must use the lower of State historical 1915(b)(3) trend or States trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. A. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years

August 2013 through June 2018

2. Please provide documentation.

The 1915(b)(3) service utilization trends have increased in recent years and prospective trends for 1915(b)(3) services are expected to trend at levels consistent or higher than State Plan trends and has been set accordingly.

B. State Plan Service trend

Please indicate the State Plan Service trend rate from Section D.I.J.a. above

4.80

e. Incentives (not in capitated payment) Trend Adjustment: If the State marked **Section D.I.H.d ,** then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from Section D.I.I.a

2. List the Incentive trend rate by MEG if different from Section D.I.I.a

3. Explain any differences:

Section D: Cost-Effectiveness

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J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (5 of 5)

p. ***Other adjustments*** including but not limited to federal government changes.

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the States FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
- Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost

effectiveness process.

- For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)** *: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

  Basis and Method:

  1. ☐ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population **which includes accounting for Part D dual eligibles**. Please account for this adjustment in **Appendix D5.**
  2. ☐ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractors providers do not prescribe drugs that are paid for by the State in FFS **or Part D for the dual eligibles**.
  3. ☐ Other

     Please describe:

1. ☒ No adjustment was made.

2. ☐ This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5. Please describe

Section D: Cost-Effectiveness

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K. Appendix D5 Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in Section D.I.I and D.I.J above.

1. 1915(b)(3) Adjustment - This adjustment reflects anticipated changes in 1915(b)(3) spending in the projection period. Continued implementation of the State's settlement with the US Department of Justice will result in increased 1915(b)(3) spending. Utilization of 1915(b)(3) services has continued to increase, over 20% annually in recent years, due to increased provider capacity, as well as improved awareness & promotion of these services. Additionally, three 1915(b)(3) services, in-home skill building, transitional living, and independent support, which were piloted by Cardinal Innovations in the prior waiver, will be expanded statewide to all remaining PIHPs in P1. For these reasons, the P1 projections reflect the carry-forward of the approved 1915(b)(3) PMPMs from P5 of the prior waiver period specific to each MEG necessary to support the anticipated growth of 1915(b)(3) services.
2. TBI Waiver Coverage - Effective January 1, 2018, the State seeks to implement a 1915(c) waiver to provide HCBS services to individuals with a Traumatic Brain Injury (TBI). This program initially served as a pilot program in the Alliance catchment area, which included Cumberland, Durham, Johnston and Wake counties. Effective 9/1/22 the TBI Waiver began serving Alliances updated catchment areas, Cumberland, Durham, Johnston, Mecklenburg, Orange and Wake Counties. HCBS services will be provided in lieu of Institutional services that could have been provided in Rehabilitation Hospitals, Chronic Care Hospitals or Skilled Nursing Facilities.
The new TBI population will be accessing many of the same services as the Innovations population and the State expects the providers of these services (qualifications, etc.) to be similar, if not the same, as those serving the current Innovations waiver participants. Based on conversations between the State and Mercer regarding cost and utilization assumptions for the TBI population, the overall cost per member for the TBI population was assumed to be comparable to the current Innovations population. Since the new TBI population exhibits a similar cost profile to the current Innovations population, Mercer set the PMPM projections for the TBI Waiver MEG equal to the Innovations CAP-MR MEG. This is consistent with the development of the 1915(c) cost neutrality projections in Appendix J of that waiver as well.
3. [7-1-21 Update]:1115 waiver - Implementation of integrated managed care authorized by the 1115 waiver began July 1, 2021 with Standard Plan launch. Similar to the discussion noted in the 1915(b)(3) section, an adjustment has been applied in the development of P3 to account for changes due to the implementation of comprehensive managed care under the 1115 waiver.

Appendix D5 Waiver Cost Projection

Section D: Cost-Effectiveness

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L. Appendix D6 RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in Section D.I.E. above.

Appendix D6 RO Targets

Section D: Cost-Effectiveness

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M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in Section D.I.E.c & d:

[7-1-21 Update]: Additionally, adjustments were applied to account for changes due to the implementation of the 1115 waiver as discussed in detail in prior sections. These adjustments generally included reductions in enrollment due to the transition of eligible populations out of the 1915(b) waiver program and into the 1115 waiver program. The remaining populations have been observed to be much higher cost on average, thus PMPM adjustments were applied to reflect the significant change in average cost for members remaining compared to the program prior to implementation of the 1115 waiver. Note that while this waiver amendment results in significant PMPM changes from the initial renewal submissions, total projected waiver expenditures have decreased from P3 to P5. This is a result of the majority of costs remaining with the 1915(b) waiver program despite the significant changes in enrollment.
[7-1-22 Update]: Overall, the most impactful changes in this update are due to the implementation of Tailored Plan program under the 1115 waiver as discussed in detail in prior sections. These reductions in the population result in a significant decrease in the projected waiver costs under the 1915(b) waiver and also a lower average PMPM for the remaining populations. This update also reflects a shift to the new MEG structure which better reflects the remaining populations. Projection Year 1 and 2 were not impacted by these changes. Projection Year 3 has a minimal change due to the incorporation of the TCM capacity building incentive expenses. Projection Year 4 and 5 reflect the most significant changes due to the population changes noted above. The table below highlights these changes from the prior waiver amendment.

Total Projected Waiver Expenditures – from D7. Summary

Projection Period	7-1-21 Update	7-1-22 Update	Change
P1	$3,384,754,101	$3,384,754,101	0.0%
P2	$3,826,336,914	$3,826,336,914	0.0%
P3	$3,667,061,525	$3,702,543,594	+1.0%
P4	$3,526,591,296	$3,321,199,839	-5.8%
P5	$3,738,115,049	$1,551,984,229	-58.5%

Total Projected Waiver Expenditures – from D7. Summary

Projection Period	Approved Waiver Renewal Eff 7/1/19	Waiver Amendment	Change
P1	$3,227,210,568	$3,384,754,101	4.88%
P2	$3,446,593,186	$3,826,336,914	11.02%
P3	$3,681,872,256	$3,667,061,525	-0.40%
P4	$3,935,265,876	$3,526,591,296	-10.38%
P5	$4,208,289,354	$3,738,115,049	-11.17%

2. Please explain unit cost changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the States explanation of cost increase given in Section D.I.I and D.I.J:

The annualized rate change reflects both trend and other adjustments. In the analysis of waiver and rate-setting trends, Mercer considers historical year over year trends, as well as rolling averages in making these estimates. In the historical R1 through R5 time period, no major programmatic changes called for an adjustment to our trend data; therefore trend estimates would not duplicate the effect of any changes.

3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the States explanation of utilization given in Section D.I.I and D.I.J:

The annualized rate change reflects both trend and other adjustments. In the analysis of waiver and rate-setting trends, Mercer considers historical year over year trends, as well as rolling averages in making these estimates. In the historical R1 through R5 time period, no major programmatic changes called for an adjustment to our trend data; therefore trend estimates would not duplicate the effect of any changes.

As discussed previously, an adjustment in P1 was made to account for anticipated changes in 1915(b)(3) spending in the projection period. Additionally, an adjustment to account for lower administrative spend exhibited in R5 PMPMs was applied for P1. These adjustments contribute to the larger change reflected from R5 to P1.

b. Please note any other principal factors contributing to the overall annualized rate of change in Appendix D7 Column I.

Appendix D7 - Summary